Deciphering Outcomes: Thirty Percent More of Nothing Is Still Nothing

written by Robert McNutt, M.D. | June 21, 2018

Trying to pass a Bill through a legislature demands a hardy

disposition. I have been involved in three attempts on different issues—one bill passed, one is still in limbo, and a third, the most salient for me, failed. In the latter case, I was the sole proposer of the Bill. My idea captured the imagination of a state representative who said she would sponsor it, but, first, she wanted to get some other views. Eleven lobbyist conversations later, my Bill was dead. Something about the legislator being worried that my Bill would be taking on the First Amendment, which allows us to say nearly anything we want, even if it is a lie.

My Bill, indeed, was about a form of lying: using relative numbers in medical advertisements. Maybe lying is too strong a characterization, but relative numbers do not fully communicate the tangible consequences of a medical choice, so, if you are making a choice for your health care, relative numbers could fool you—and fooling you is not what medical care should be about. My Bill proposed that only absolute, actual differences in outcomes should be presented for public consumption. Simple idea, failed execution.

Understand the Difference Between Relative and Absolute Numbers

A relative number is one that defines the proportion of change. For example, if my coffee costs 1 dollar and yours, 50 cents, you saved 50 percent (difference, or change, in cost—50 cents—divided by the greater cost—100 cents—is a 50 percent reduction in cost). But, the actual savings depend on the starting cost. If my coffee cost 50 cents and you saved 50 percent, your actual savings would only be 25 cents, not 50 cents. The relative number stays the same, but the tangible

benefit to you has changed.

This seems a simple notion, but every ad about medical care I observe presents the *relative* decline for one treatment versus another, not the *actual* decline. For example, one ad claimed that a treatment lowered heart attacks by 30 percent. Did that mean 30 percent of a 100 percent chance of having a heart attack, or 30 percent chance of a 2 percent chance of having a heart attack? The 30 percent decline from a 100 percent chance would be an absolute decline of 30 percent, but in the second situation, only a 0.6 percent decline (30 percent times 2 percent). These absolute differences matter to you; the relative value does not.

Six Numbers You Must Know to Decipher Disease and Treatment Outcomes

How do we know the actual, absolute differences? In all randomized treatment trials (the only ones that matter for you), patients get either treatment A or B. The study question is always the same: Is A better than B in terms of producing better outcomes of disease? This experiment sets up six numbers you must know.

First, there are two numbers for the percentage of people in the trial having a specified study outcome related to the disease the patients have. For example, in many cancer treatment trials, the outcome may be “live” or “die” over a given time period. There will be a percent of people who die when given treatment A and another percent of people who die when given treatment B. These are the first two numbers you must know; the percents of people having disease-related outcomes for compared treatments.

The third number is the simple subtraction of those two outcome measures. For example, if 10 percent die with treatment A and 20 percent with treatment B, the difference, absolutely, is 10 percent. The difference number is the foremost number; that number tells you how much better one treatment is than another. It is an actual number, not a relative number.

The other three numbers are for the percent of people being harmed by the treatments. Unfortunately, treatments that improve disease-related outcomes invariably produce greater percent chances of side effects, or complications. Again, there will be two percents of people being harmed for both treatments, and, following, a simple subtraction of those percents.

In summary, you must know the absolute differences in disease- and treatment-caused outcomes to compare options for your care.

Relative Numbers Are Biased and Can Be Misleading

Why did I try to pass a Bill to eliminate relative numbers for medical care communication? Because relative numbers are biased. Relative numbers are always larger than actual numbers, and, for some people, the size of a number matters. Researchers have found that patients will more likely take a treatment if the benefits are communicated as relative differences rather than absolute differences. I attended a lecture from an industry-sponsored speaker who presented benefits of the sponsored treatment in relative numbers (positive bias for treatment), but harm numbers were presented in absolute differences (also positive bias for treatment).

The use of relative numbers in reports to consumers is ubiquitous. Even government agencies responsible for our health use relative numbers rather than absolute numbers. The Centers for Disease Control (CDC) recommends shingles vaccine, for example. The CDC site states the vaccine is “over 90 percent effective” (a relative number). A Google search also finds numerous reports documenting the relative decline in shingles, but not absolute differences.

The 90 percent relative decline in shingles, however, is an absolute difference of less than 1 percent per year (0.3 per 1000 person-years with vaccine; 9 per 1000 person-years without; the absolute difference is 8.7 per 1000 person-years, or 0.87 per 100 person-years—hence, less than 1 percent). A 90 percent relative difference sounds remarkable; the 1 percent absolute difference per year, less so.

This sort of relative number obfuscation is common, and patients recount to me that conversations with their physicians rarely include discussions of absolute differences. I don’t think my Bill failed for fear of denting the First Amendment. My Bill failed because there is a bias inherent in the communication of today’s medical care; if a relative number spurs taking treatments, it is likely preferred by those who want the treatment plans followed.

Unfortunately, there is no “Bill of Rights to See Only Absolute Numbers” in the legislative pipeline, so you must be resolute to know the absolutes. Even if accurate, relative numbers limit your understanding of the medical care offered to you. If not outright lies, they are obfuscations that cloud already difficult choices. Don’t be deceived.

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Medicare Paths to Value-Based Health Care: Which Way is Up?

written by Dave Halpert | June 21, 2018

If you’re scratching your head about the direction of Value-Based Health Care (VBHC) in Medicare, you’re not alone. The current mix includes a swirl of separate initiatives, some new and others recently re-labled.

As CMS pushes toward VBHC, providers may feel confused and frustrated as concepts emerge that will affect multiple programs. Within the last several months, the Patients Over Paperwork and Meaningful Measures initiatives have shaken up CMS value-based care programs, particularly:

- Merit-Based Incentive Payment System (MIPS)
- Medicare Shared Savings Program ACOs (MSSP ACOs)
- Direct Provider Contracting (DPC)

Even more confounding, CMS is taking a non-linear development

path for each—from idea inception to initiative and program, and from scope to quality and efficient care delivery. Each component is its own piece, complete with its own quirks and jargon.

But all is not lost! Providers that assemble a cohesive strategy from the component parts stand to win in the CMS VBHC arena. While the programs may appear disconnected, common themes link together target priorities. Achieving those targets creates the "win" for providers. Those who can't establish a path to the right targets will remain stagnant and fall further behind their peers each year.

With so much at stake, let's see how the pieces fit, and how to set priorities.

How the Pieces Were Supposed to Fit Together

Let's review: The Quality Payment Program (QPP), created under MACRA, gives providers two options for transitioning from Fee-for-Service (FFS) payments to VBHC:

- The Merit Based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (APMs)

MIPS is the amalgamation of three legacy programs: (1) PQRS, (2) the Value-Based Payment Modifier and (3) Meaningful Use, plus an Improvement Activities participation component. Quality, Cost, participation in Improvement Activities and Promoting Interoperability (formerly Advancing Care Information) are scored, and that score is tied to future reimbursement.

Advanced Alternative Payment Models are initiatives in which providers band together to provide quality care at a lower-than-expected cost. An APM needs to meet three requirements: (1) two-sided risk, which rewards those who spend less than a target amount and penalizes those who spend more; (2) quality scoring based on established measures; and (3) EHR usage. Savings (or losses) are shared among the participants, but qualified participants will earn a 5 percent bonus payment.

For those who aren't ready for two-sided risk, there are MIPS APMs, such as Track 1 ACO Shared Savings Plans—they don't qualify for the APM bonus payment, but do protect against penalties. Failing to participate in MIPS or another Alternative Payment Model may lead to penalties; incentives are awarded to those who demonstrate high quality care.

The original goal of CMS's Quality Payment Program was to move providers into value-based reimbursement, but halfway through the second year of the program, it's clear that pieces are missing. In addition, recent feedback has brought uncertainty to both MIPS and APMs, specifically the MSSP ACO.

MIPS Quality Scoring Is Failing the Validity Test

We've previously described how MIPS is under fire from MedPac for being too burdensome, and that MIPS will not serve its purpose of bringing providers from FFS to Value-Based Health Care. MedPac has gone so far as to say that MIPS should be scrapped.

Since that report, providers and health care organizations have increased criticisms of MIPS quality measures.

To improve care, quality must be quantified. The abundance of MIPS measures means more options for more providers. But that's not necessarily a benefit. A large measure library also leads to more choices for providers on reporting. When one primary care provider reports on chronic condition management measures and another reports on preventive care and screening measures, there's no way to compare the two providers. Although one of the original assumptions in quality reporting was that it would lead to better consumer choice, the lack of a core set of reporting measures makes that infeasible.

Furthermore, dozens of MIPS measures are not benchmarked to statistically valid results. If two providers reported on the same measure, it's not accurate to claim that one provider outperformed the other, even if the numeric scores are different. This leads to the charge that the program cannot be used to accurately quantify quality of care. With providers' Quality score accounting for half of the total MIPS score, concern over the validity of that component strikes at the core of the MIPS program itself.

Additionally, MIPS has failed to achieve its originally intended breadth. Raising low-volume thresholds means that fewer providers are required to participate. Special scoring provisions are in place for providers in small practices, as well as for providers in rural and other underserved areas, meaning that those providers do not need to meet the same standards as others. Without the pressure of a looming financial penalty, these exemptions and exceptions enable providers to maintain their FFS course.

ACOs Are Failing the Participation Test

There is similar concern regarding an ACO's ability to shift the delivery model. CMS Administrator Seema Verma has strongly implied that the end of risk-free participation in ACOs is around the corner. Nearly three quarters of respondents stated they would leave an ACO if downside risk became mandatory. Consider the numbers: In 2018, 82 percent of the MSSP ACOs are in a non-risk track. In terms of future participation, the NAACOS survey indicates that less than half of the ACOs in 2018 would continue in a risk model.

It's easy to understand ACO participants' concern, since MSSP ACOs significantly missed the expectations of the Congressional Budget Office. In 2010, the CBO anticipated that ACOs would generate $1.7 billion in savings, but in actuality, spending increased by nearly $400 million. Disappointing results and a potential mass exodus certainly cast doubt on this model, as well.

With MIPS and ACOs taking a public beating, providers and organizations are scrambling to find the missing pieces for their VBHC puzzle and fit them together into a cohesive picture.

How Will CMS Fix Medicare Costs Without MIPS and ACOs?

If the main Medicare VBHC programs to save money fail, what happens? Let's assume that CMS will not gather its marbles and stop playing, because that will drive the budget over the brink. The imperative to save money, in fact, is reaching new levels. Far from stepping back, providers will be forced into

even more aggressive programs to cut costs. They just might be structured differently:

> Medicare may indeed attempt to force ACOs to adopt downside risk, as threatened by CMS in May. However, the recent disappointing news that ACOs with down-side risk actually did worse, along with poor ACO results, may temper Medicare's enthusiasm for expanding the ACO program at all. Other APM alternatives for providers might gather steam. While other APMs will have the same two-sided risk requirement, they may provide attractive options for those interested in teaming up with a more defined group of providers to care for a more focused population. Primary care practices may find that the Comprehensive Primary Care Plus (CPC+) program fits the bill, while specialists may target specific episodes of care under the Bundled Payments for Care Improvement Advanced (BCPI Advanced) Initiative.
> Medicare may use a different approach to directly reduce costs. CMS recently floated a Direct-Provider Contracting (DPC) model for providers seeking a primary-care-based APM, but who are not interested in ACO and CPC+. In this scenario, payers would contract directly with primary care or multi-specialty group practices in traditional Medicare (Part B), Medicare Advantage (Part C) and Medicaid contracts.
> CMS could also move to privatize Medicare, either through increasing Medicare Advantage plans or via another, broader program. Patients would choose to participate in one of these programs with the expectation that care would be readily accessible, high quality, but without compromised efficiency. If there is a greater emphasis on patient choice—such that patients select their practice and are

provided with tools to facilitate engagement and active participation in their healthcare—such a program may be acceptable to beneficiaries. Providers would have the opportunity to get into a two-sided risk arrangement without incurring additional administrative burden on the billing side.

Providers Have Even Greater Urgency to Develop A VBHC Strategy

Alas, "the best made plans of mice and men often go awry." Though carefully planned, MIPS is not producing enough results within the timeframe needed, especially since budget-imposed deadlines will undoubtedly be shorter. The flexibility that CMS touted has become a tangle of regulations that providers are struggling to unsnarl.

Patients Over Paperwork and Meaningful Measures initiatives allow CMS to justify an exit from the MIPS arena, telling providers that their concerns have been recognized, while preserving intentions to move providers into APMs or other risk arrangements. The concepts are not without merit, but clearly aimed at driving APM participation. For example, Patients Over Paperwork emphasizes EHR interoperability and patient rights to health data. This is critical for an APM, as it enables clinicians to track a single patient across the spectrum of care. Avoiding gaps, identifying potential risk and empowering patients to be their own healthcare advocates are all tactics for achieving APM success.

To succeed, providers need to step back and address a fundamental goal: cap costs without sacrificing patient care. Rather than developing a "MIPS strategy" or an "ACO strategy,"

it’s time to develop a real VBHC strategy. In the short-term, that strategy looks like this:

- Begin the APM journey. If your organization has a sufficient primary care base, it’s time to start an ACO or CPC+, and do so before rules change. Although the first ACO agreement period is less likely than the second or third to require mandatory two-sided risk, CMS rulemaking can be a surprise. In any case, the goal is to get claims data and begin the process of practicing ways to reduce costs. For organizations without a primary care base, consider BCPI Advanced—a small primary base will lead to an abundance of unmanaged, untethered and potentially high-cost patients.
- Squeeze the value out of MIPS. Although not perfect, measure reporting is still required, so make the most of it. Even if the results aren’t valid for comparing providers and organizations, they are valuable for comparing your own results this year compared to last. Narrow your organization’s focus to a key set of metrics for group reporting, but retain individual provider accountability. Outcome measures can help you identify trends likely to lead to high costs; developing strategies for improving results will be beneficial once you are in two-sided risk. In other words, don’t ignore the issue, even though you may choose to focus on a different outcome measure for MIPS.
- Invest in *Intra*operability. Remember that *intra*operability is as important as *inter*operability. It’s critical that providers are able to transmit and receive patient records across the system in order to provide appropriate care and consultation. However, this does not replace the need for development of internal metrics that enable participants to track costs and outcomes. A Clinical Data Registry designed

to integrate, aggregate and visualize a variety of data sources and types gives you the flexibility you'll need to identify trends and measure the effects of your interventions.

Despite the haze of confusion, the pieces are there and fit cleanly together—patient-centered outcomes, tracked without constraint across the spectrum of care, quantified through valid and visible measurement. A program built on top of these three pillars will help you succeed in any VBHC initiative, but therein lies the challenge. With so much at stake, and so little certainty, knowing what's out there now is not enough. Your plan must be nimble enough to successfully adapt to different programs, but robust enough to effectively provide efficient and high quality care

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Image Credit: Braden Jarvis

Where’s the Value for Physicians in VBHC? Four Strategies for ACOs and Other APMs

written by Theresa Hush | June 21, 2018

When we talk about “value” in Value-Based Health Care (VBHC), we’re referring to the high-quality/lower-cost services that buyers want from health care providers. Who are the buyers? Health plans, Medicare and other governmental purchasers, plus employers (for the most part, the term is notably *not* interpreted to include patients). What do buyers want? “Truth in purchasing” for the best health care they can get.

Indeed, the very term “Value-Based Health Care” implies that buyers are on a righteous quest for good care from irresponsible providers. Provider organizations, in turn, have sometimes adopted a similar attitude toward physicians. The generation of physician scores, workload requirements and incentives (which are not really bonuses but reductions in pay) for quality measure results are all stick and no carrot for physicians.

And herein lies the problem: physicians aren't getting enough in return for their participation. No one is asking what's the benefit of VBHC for physicians. And that may be why VBHC is meeting such resistance, with CMS expressing frustration with organizations for not moving fast enough to accept financial risk, and physicians threatening to leave if risk is imposed on them.

It's no real surprise that ACOs are loath to adopt downside financial risk. Health care organizations are vested in Fee-for-Service for revenue stability and growth. Providers' progress toward VBHC is incremental. The uncertainty of lowering costs, especially with no limits on patient choice of provider, is huge.

Physicians Are Bearing the Brunt of Change to VBHC

Leadership and finance directors aren't the only ones avoiding risk; physicians have an even bigger impact on the pace of reform. And the pace of VBHC acceptance is slow. According to one study, the rate of acceptance from 2016 to 2017 moved just three points, from 26 percent to only 29 percent among responders—mostly physicians. That's undoubtedly because physicians are the ones shouldering much of the change and collateral damage:

- Physician burnout;
- Coping with lack of tools and resources to operationalize VBHC models involving coordinated care, population health and case management;
- Loss of clinical as well as administrative autonomy and independence as practices have been purchased or merged;

Technology overload from EMR adoption and documentation requirements;
Changes in compensation tied to VBHC that they don’t feel they can control;
Pressures on time and productivity.

Consolidation in Health Care Has Affected Health Care Culture

What was once a clinical enterprise has been replaced by the administrative health care complex throughout the U.S., wherever hospitals have merged into systems and purchased physician practices. Layers of bureaucracy create and analyze analytics, implement EMRs and data repositories, and oversee physician and other clinical operations. Physicians who want to be more involved often don’t know how to start.

Even physicians who wished to remain independent have merged practices, responding to the need for scale to support technology and other VBHC requirements. Although these groups may not have their practice autonomy burdened by hospital operations, they still need to address the actual cost of hospital care under VBHC. Ultimately they will have to connect with hospital or health system enterprises to be relevant players in a VBHC provider network.

ACO and APM Costs are Determined at Physician-Patient Level

In defense of organizations, all understand that medical decisions—made by the physican, patient, or both—are driving costs. A physician’s decision to recommend a scientific inquiry of symptoms using certain diagnostic tests or images, or to

engage in more extensive diagnostic investigations, is rooted in preferences as well as training, access to technology and specialists, and the culture of the physician environment.

The organization, however, also enhances access to and value of diagnostic inquiry by rewarding physicians for ancillary referrals, implicitly through analytics of highly valued physicians or explicitly through compensation incentives. As a result, the physician gets mixed messages about how to practice and what the organization values.

Physician-determined interventions drive revenue for the practice owners and earn tangible benefits for physicians, especially under Fee-for-Service (FFS). The problem for providers: there is no equivalent reward system for VBHC. Why? Because health care organizations, still deriving most revenues from FFS, are ambivalent. While physicians may have some incentives tied to VBHC, particularly regarding quality scores and productivity, organizations don't really reward providers for bringing in *less* money. VBHC-optimized medical decisions are not accommodated in the reward structure.

Likewise, time is the resource that determines how much will happen between the physician and patient at a visit. The amount of time available controls how much information the physician will obtain from the patient before interrupting, and how willing the physician is to educate, explain and work with patient preferences.

Physicians who work under productivity standards that run counter to VBHC need to engage patients through processes like goal setting and shared decision-making, or to discuss options

for overcoming barriers to treatment. Surveys of both physicians and patients make abundantly clear that lack of time has damaged the physician-patient experience.

The Dilemma Of VBHC: Simultaneously Acting As Payers and Clinical Enterprises

Given physician frustration with the current medical environment, gratuitous efforts to correct time pressures and lack of clinical autonomy, or generalized advice like “involve physicians in the organization,” are not enough to shift the tide of burnout and resistance.

Organizations need to reconfigure their organizations to maximize clinical value, not administrative. In moving toward VBHC risk-based models, however, the health care system response has been akin to emulating health plans, versus achieving clinical excellence and cost-effectiveness. The structure of the provider organizations is administrative, with a heavy focus on technology and revenues to fuel growth. Both physicians and patients are becoming “assets” in a market play for more territory, rather than the central focus.

That’s perhaps one reason why so much energy is focused on low-hanging fruit for achieving ACO savings, such as curtailing readmissions and reviewing post-acute care. While those are important activities for immediate savings, the longer-term savings will only come from better medical decisions and lifestyle choices by patients, strengthened by a physician-patient partnership to achieve those goals.

In sum, we need to rethink how physicians should practice in health systems, both in ACOs and other VBHC models. We also

must address the patient in the central physician-patient decision-making team, but that's another blog post.

Four Key Tactics To Help Physicians Get Value from ACOs and other VBHC Activities

1. Invest in physician leadership skills.

Leadership results when one party recognizes the big picture—here, both the health care organizational mission and market imperative, and the patient needs—and others look to that leader for direction. A leader is given power by another party voluntarily, when the needs of the one giving up that power are satisfied.

There are really two options for physician roles in the organization: they can be either leaders or cogs in the wheel. To move from one to the other requires education, trust and willingness to collaborate.

Cultivating physicians as leaders helps them to embrace a different role in VBHC. The investment in physicians should not be for selected physicians—the skills must be cultivated for all.

What does it mean to create a leadership investment? A few examples of how this should work:

- Educate physicians on the challenges and successes of the organization, the market environment and the benchmarks imposed by that environment.
- Let physicians determine how they will provide input into the organization and its goals. Provide an ongoing channel

for communication at all levels. It will not be a same-size-fits-all approach but determined by individual skills and time.
Help physicians realize the trends of health care consumerism and embrace changes in how patients see their responsibility for care. One of the most difficult tasks will be the emerging role of physician as clinical educator and guide, versus sole decision-maker. Again, this role is crafted by leadership.
Ensure that physicians feel supported in keeping up with clinical expertise and knowledge.
Put physicians in charge of initiatives, rather than on committees, and facilitate their roles with support.

2. Create physician interaction with data and analytics.

Physicians should not see only *fait accompli* analytics. They should have the tools to interact with and respond to the data, query it and attest to its validity. This includes frequent sharing of data across the organization that is well beyond "need to know" data relevant to the physician's own patients or decisions.

Again, this sharing is best worked within peer groups and projects that will improve performance in quality:

Facilitate physician response to 'scores' of quality as well as individual patient outcomes.
Encourage physicians to get involved with experimentation and testing of interventions in performance improvement technology, enabling comments related to project structure as well as individual results.

Create response teams around organizational goals, financial targets and appropriate performance improvement budgets.

3. Select physicians to serve as leaders or stewards of all performance improvements, both cost-focused as well as those for improving quality and outcomes.

Engagement in the actual details of performance improvement gives physicians a better understanding of the detailed decisions that will affect the results and invests the physician in success. Physicians need to be involved at all levels of the organization, from practice groups to specialty departments, and across the organization.

Skills for attaining performance improvement are gained over a long period and require time to implement. Education is key to helping physicians work through project decisions and results. Obviously, the physician must be supported administratively to ensure both that clinical services do not suffer and that their expertise is focused on decisions rather than minutia.

4. Support physician activity in VBHC and redesign incentive structure for physician leadership.

Engaging physicians to support ACOs and VBHC requires a complete review of compensation, incentives and measures applied to physicians to participate in the clinical enterprise. This must include the following steps:

Carefully connect all reward structures to expectations under the future financial risk of VBHC, especially those

that highlight differences in groups of physicians:

- Rewards for specialists versus primaries, such as those built on attribution of inpatient or outpatient services to attending physicians;
- Physician referral tracking and rewards;
- Incentives for higher workloads that may inadvertently discriminate against women.

Ensure that physicians have compensation (part of value) dedicated to VBHC activities and participation, including leadership cultivation. This will also require time for physicians to gather patient preferences and discuss options with patients in value-based decisions.

Provide dedicated VBHC staff who can work under physician direction, as opposed to centralized physician staff.

Create a centralized library of materials for physicians to share with patients—clinical education, treatment options for various conditions and procedures, research data supporting those options, and cost information. Physicians should not have to produce these or construct these within practices.

Physicians can and will see value in Value-Based Health Care when the deck is no longer stacked against them. It will be up to individual physicians to embrace leadership functions; organizations cannot “demand” that physicians participate. As physicians are rewarded more clearly for being part of an innovative environment, the culture will shift. And everyone will gain value from growing leadership and pride among physicians working together to meet the goals of ACOs and VBHC.

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Image Credit: Earl Richardson

Why Patients Should Ask Questions—and Physicians Should Listen

written by Theresa Hush | June 21, 2018

For health care providers and payers, Value-Based Health Care (VBHC) is a hot topic, with most all payers pressing a shift toward financial risk contracts and ACOs based on quality and cost performance. But if you ask consumers about the trend, chances are you'll get a blank stare. Why? They're not really part of the conversation.

That's a major problem, because consumer involvement is essential for VBHC success. When outcomes fall short, providers may complain about poor "patient compliance" with physician orders, and ACOs may bemoan lack of "patient engagement." But they are minimizing patients' preferences and concerns, or perhaps haven't even bothered to assess what these are.

Instead, they’re planning for their own desired results in savings, patient outcomes and revenues, without necessarily taking into account what patients feel they want or need.

How can VBHC work if patients can’t stick to treatment plans because they doubt their value? That’s hard to envision. Providers must understand what patients value, and convey choices in that context. Who can help them do that? Patients.

VBHC Needs Patients to Verbalize Goals and Choices

Both payers and providers purport to speak on behalf of patients or patient interests. But payers like Medicare and commercial insurers are the main architects of VBHC, with terms negotiated by providers. They are defining what care delivery models are constructed, how patients get that care, how quality is measured and how providers are paid.

Left unanswered is how consumers can get what they really want and need out of health care: improved function, freedom from pain and longer lives. Having the right partner (physician and care team) and committing to an improvement plan are the two essential ingredients. Talking honestly is the magic whisk.

Let’s be absolutely honest: Consumers do not have the tools to adequately navigate the health care system. Valid data and quality information for decision-making are essential. Patients need a range of knowledge, from whom they can trust to provide quality care to reliable facts about treatment benefits and risks. Finding this information independently is a real challenge; whatever data and research exists is largely sequestered from consumers.

We have suggested how consumers can choose providers without comparative quality data, by assessing physicians' partnership value. In short, patients should seek providers who are willing to engage in a conversation about their health, goals, preferences and limits. But that choice is just the first step.

How do patients talk to their providers about their actual treatment options? First, the conversation needs to take place. While that seems like common sense, there are plenty of obstacles to clear.

Providers and Patients Don't See Eye-to-Eye on the Health Care Relationship

Providers and consumers disagree over who is responsible for the patient's health. A recent survey that questioned consumers, providers and employers about Value-Based Health Care highlighted those stark differences. While almost half of patients see health care as their personal responsibility, 75 percent of the providers who responded believe they are the ones responsible for their patients' health. No wonder neither feels satisfied with the results!

The same survey revealed that both physicians and patients believe the cost of care is an important part of the treatment conversation. However, both parties often lack the information and training to enable that discussion—for example, knowledge about how to calculate that cost accurately—so it rarely takes place.

Given conflicting views on who is responsible for patient health and little discussion of costs, physicians trivialize patient decisions and judge their decisions by provider

criteria. For example, the ability to pay or attend treatment is a real limitation for consumers, as illustrated by a recent study of patients who refused small cell lung cancer treatment. Unfortunately, yet not surprisingly, although the study identified patient rate of treatment refusal by various characteristics, no one collected data about the reasons the patients made their choices. However, "patients with Medicaid or no insurance consistently refused care no matter what the treatment." Whatever their ability to pay, when faced with lower odds of successful treatment for lung cancer, patients confronting a similar choice may well determine that the value is not there, and decide to forego treatment.

No Time for Talk? How to Prepare Physicians and Consumers for Treatment Discussions

A 15- or even 30-minute office visit provides little time for information gathering, let alone a thoughtful discussion of alternative treatment options. Physicians are pressed for time by schedules, productivity incentives or just productivity measurement and practice culture.

But patients need facts in order to determine the value of treatment options, and physicians need to understand their patients' barriers and circumstances before recommending those options. The best way to facilitate both objectives is for consumers to prepare for the visit.

In short, patients need to be assertive. For those who feel insecure about questioning their physicians due to lack of clinical expertise, rest assured that this isn't about knowing medicine. It's about learning to question the medical expert who also has access to medical knowledge and research, and

determining what kind of certainty and risks they can live with.

Most patient visits to the doctor begin with presenting symptoms or pain. Tests or exams often follow, with results forming the basis for discussion of next steps and treatment options. Follow-up appointments are rarely a surprise and allow time for the patient to come prepared with questions. This is key, because the most expensive decisions rest on test results. This is also the time for physicians to prepare patients to understand conditions that will be confirmed or ruled out by testing. Providing ready-made materials to patients can be the first step in educating them about the risks of those specific conditions, so they can more knowledgeably converse when the results are in.

An essential preparatory step is for the patient to get test results as soon as they are available. This may violate the norm of some practices, since physicians want to explain this information to patients. But patients should insist anyway (and make this clear when the tests are ordered), because they will need time to read and process the information and plan their questions.

It doesn’t help either patient or physician to hold information for the next encounter in order to discuss both difficult test results as well as the condition and treatment options. This simply burns up time to more objectively review alternatives. The focus for both parties should be on the pros, cons and costs of next steps for interventions.

Weighing the Value of a Treatment Plan

For patients, the best strategy is to learn from their physicians as much as possible about the proposed treatment options and then get access to the data that will quantify the benefits and harms. That includes new information that is emerging about effectiveness and risks with long-standing procedures and medications.

It is "okay"—in fact, essential—to question physicians about what choices exist and what those mean to future health. The physician may see one perfect alternative, but that alternative may not work for the patient because of life circumstances. Personal circumstances affect the tradeoffs patients make and are part of the value equation.

Every treatment has both known benefits and harms that have been detailed in medical or clinical research, and patients should seek answers about these risks from their physicians. These benefits and harms should be quantified statements of value, such as percentages of success in disease eradication, or months and years of survival, and percentage of relapse or secondary disease.

Additionally, the physician recommending treatment should be able to demonstrate its effectiveness in current scientific research. This means physicians must keep abreast of major developments in their fields and be willing to investigate further on the patient's behalf. Various surveys have revealed that this is a real challenge for clinicians to stay current in their own fields, given the vast numbers of clinical studies now published in hundreds of journals. Since all research is not equal—with biases, misinterpretations, and misapplications

of results to individuals—it is all the more important for the patient to gain confidence in the effectiveness of a recommended treatment.

Basic Questions that Patients Should Ask Before Decisions

Let’s assume that the physician has already discussed the health status of the patient, provided details about the prognosis, and that the patient is ready for the next step—determining value and commitment to a plan of care.

When given treatment recommendations or choices, patients should ask questions that will provide the essential information for their decisions. At the same time, it is also important for patients to express their own limitations, goals and preferences, so that the physician understands and may modify recommendations. Here’s a starter list:

1. Why are you recommending this particular treatment?

    What are its intended long-term effects?
    Can it fix my condition permanently? If not, what are the benefits?
    What are the side effects?
    Are there any possible long-term effects or future risks because of this regimen?

2. Would you show me research that demonstrates the benefits and risks of this treatment? Have there been any other studies that raise concerns about the treatment?

3. What alternatives to your recommendation are there? How do they compare in benefits and risks?

4. What is the cost of this treatment (also compared to alternatives)?

5. Can something else, such as changes in diet, activity or lifestyle, improve my condition without medical intervention?

6. What if I do nothing? Are there reasons why I need to take action immediately?

Value is Fluid—The Conversation Must Go On

Health status fluctuates over time. All patients experience physical issues that cause short or long-term impacts to their ability to function. Patients with high risk conditions that require ongoing care form a dynamic category; we may all eventually move into a high risk group as we age or develop impairments.

VBHC cannot eradicate patient risk, but it can help patients make choices of higher value. For both patients and providers, the talk is as important as the treatment.

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Image Credit: Luis Afonso Orellana

Tipping Point Test for ACOs: Consent to Financial Risk

written by Theresa Hush | June 21, 2018

Last week the conversation about financial risk for providers in ACOs took on a decidedly different and more contentious tone. After months of CMS reports of ACO growth and success,

while retreating on MIPS quality reporting requirements as concessions to “provider burden,” CMS signaled that they were finished waiting for providers to accept financial risk under Value-Based Health Care.

With a third of Medicare patients served by an ACO and an even higher number of patients receiving health care via private sector ACOs, the industry seems on track to adopt ACOs as the preferred model of health care contracting and reimbursement. All that tipping point talk, however, cannot mask a countervailing trend: while providers have been willing to set up and participate in ACOs, they have not been moving quickly to accept financial risk. This is even more the case for Medicare ACOs than private ACOs, which tend to have some down-side risk.

Indeed, according to some accounts, a majority of providers have declared that if Medicare insists they accept more risk, they will simply withdraw from the program, if not Medicare altogether.

For Payers, Value-Based Health Care Has Always Meant Financial Risk

From its inception, Value-Based Health Care (VBHC) has focused on the cost of health care relative to patient outcomes. The consistent message to providers from employers, private health plans,and government: stem rising costs.

Yet, payers were also eager to deflect criticism from consumer and patient groups about outright reductions in health care. Recalling backlash over HMOs and restricted access to care by patients, private health plans as well as Medicare took a

different approach. The “value” in VBHC was couched as efforts to evaluate quality and outcomes, as if the problem only involved getting more benefit for the current payout.

That kinder and gentler message persuaded providers to get on board with Value-Based Health Care. After all, who could really criticize the idea that providers should suffer if they could not meet an acceptable quality standard? Plus, the idea that they could “be” insurance companies was of great appeal to providers eager to eliminate the middleman.

Despite the emphasis on quality incentives and penalties, however, both Medicare and private plans took repeated aim at Fee-for-Service (FFS) reimbursement. ACO agreements with Medicare as well as most private health plan ACOs have spending targets that are clearly designed to transition to limits. Additionally, even under FFS, providers were scored and penalized by Medicare for higher cost than peers, first through the Value-Based Payment Modifier and then under MIPS. MACRA legislation and rules were forthright, stating that Alternative Payment Models that incorporated financial risk were the intended goal for Medicare.

So why the surprise and pushback from providers? Were they simply deluded by the voluntary nature of PQRS and MIPS regulatory programs into believing that FFS could continue as is? How could ACO providers not anticipate the direction of the model toward risk?

For Providers, Value-Based Health Care Has Meant Market Share

Prior years of managed care negotiations with payers have driven home a message to providers: You are at peril if you are not important to the other side of the negotiating table. Consolidation of health care organizations, which spiraled upward in response to proposals for ACOs and coordination of care, were sparked by perceived need to build leverage through market share and patients.

For an organization to be an ACO, it must leverage enough resources to provide all the services needed by patients. Providers have interpreted that as requiring ACO participants to offer as many clinical services as possible. Ironically, however, providers' attempts to stem leakage from the system have only increased their costs because that larger infrastructure is more expensive. Recently it has become clear that intense consolidation of provider organizations has raised costs and decreased market competition.

Consolidation has been further encouraged by the push to adopt EMRs and medical technology, as well as the need to support infrastructure for measuring and reporting quality under VBHC. Fee-for-Service reimbursement fuels this merger and acquisition frenzy, in turn generating a backlash against the lack of marketplace competition and furthering criticisms of FFS.

But those who continue on the consolidation path are not realistically evaluating heightened concerns about health care costs and affordability Nor are they appreciating health care consumerism's growing momentum, driven by unaffordable coverage and rising costs of care.

Outrage over the high cost of health care and lack of equivalent improvement in health outcomes is increasing, not going away. And as Medicare threatens other solutions—contracting with providers, for example, or forcing the issue on financial risk—providers will have a difficult public relations problem, at the very least. They cannot afford simply to oppose all solutions to controlling costs.

Nor can providers realistically turn down the opportunity to create their own systems of care under financial controls in a risk-based ACO. The solution is to carefully build the ACO to prosper in a risk environment, rather than trying to fashion an ACO out of the current tools built for Fee-for-Service. Here's our approach for a successful transition to risk.

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Image Credit: Sebastian Spindler

“Just the Facts, Ma’am”

written by Robert McNutt, M.D. | June 21, 2018

Communication, according to Webster’s: “exchange of information”

You and I talk all the time. We are constantly “communicating.” Communication is a huge idea that encompasses and displays our views of the world. But communication is more than just the sum of the words used to communicate; the words are contextual. Raymond Carver wrote with simple, universally understood words,

but I could not communicate like him even if I used the same words and labored intensively.

Communication, in a sense, is a five-syllable word that is nearly elevated to a sixth sense, like
taste, sight, touch, smell and sound.

But here's the rub. I don't taste things the same as you, don't see what you see, don't feel what you feel, don't smell odors you smell or hear what you hear. Your words and mine may mean different things to each of us. And if Raymond Carver, or any other celebrated author, can write using our collective common words and ideas in a way that you and I can't, then some fundamental deficiency is at work in the realm of communication.

Precision Is Essential to Exchange of Ideas in Medical Care

And, I argue, this deficiency makes verbal communication a poor conceptual model for the exchange of ideas in medical care. Medical care is a science. Science is not a professional domain of words; it is a professional domain of numbers. No matter how many words are used to explain scientific studies, the only thing that matters is "how much" better or worse is one medical intervention versus another.

In science, then, "better" or "worse" must be a quantifiable measure of the size of differences in outcomes of a person's illness produced by competing actions. Words are not a quantifiable measurement tool.

The gap between the explanatory power of words and numbers is

easy to show. Researchers asked people to assign a probability, a number, to words used to communicate the size of benefit and harm of alternative treatments. The word “rare” was assigned numbers from 1 to 15 percent. “Benefit” meant 100 percent cure to some and 10 percent better to others. “Commonly” elicited a nearly 75 percent range of estimates. The deficiencies of communication in medical care also extend to research reports. A commonly misused word is “significant.”

“Significant” Can Be Misleading

What does “significant” mean in the context of a research report? That is a dicey question. As with “better” or “worse,” the word lacks meaning. “Significant” may be used in the context of statistical testing of the treatments in the study. A difference in outcomes between alternative treatments may cross an arbitrary threshold, called the “p-value” and then be called a “statistically significant difference.”

Alternatively, the actual difference measurement may be called “clinically significant” to stress the importance of the researcher’s findings; unfortunately, this is sometimes used when the difference is not statistically significant. This is because the authors may interpret clinical significance from the viewpoint of their “senses” rather than our “senses.” In one study of communication in research reports, researchers found that the word “significant” was used more often in research papers *not* showing statistically significant differences than those that did. This is another example of a word’s inability to communicate the value of scientific information.

I am stressing only one aspect of miscommunication.

Unfortunately, some may use language to convince you of their point, not yours. This sort of egregious misuse should never occur in medical care. At the same time, of course, words are the tools for expressing compassion and hope. They are essential to conversations between doctor and patient for understanding the patient's needs, wants and concerns. Our emotions come alive in words.

Numbers Are Essential to Understanding Medical Outcomes

However, my point: without knowing the numeric measures of better, worse or significant, as examples, nothing is being accurately communicated about the value of medical care. I once implored a medical journal to publish only numbers in abstracts and papers so patients could see the actual measures of outcomes. I asked the editor to forgo any interpretations communicated by authors. Just the facts should be known. I failed to convince the editor-in-chief, despite earnest lobbying.

The title of this piece is, also, a miss-communicated assumption. The quote in the title was attributed to an actor portraying a detective in a long-running television show. A review of the episodes found that phrase was never uttered, and, instead, that another person supposedly used the phrase in a parody. But reviews of the parody found those words were never spoken. There is too much "poetic license" in communication, and medical care has nothing to do with poetry.

It would be a mistake, however, to take numbers at face value. In future articles, I will show that even numbers can be mis-communicated and suggest what numbers are worth knowing.

Following this, I will show how numbers, even if pristinely presented, may be incorrect—and what to watch for.

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Image Credit: Gemma Evans

ACOs and Specialty Physicians: How Episodes of Care Create a Win-Win Cost and Quality Strategy

written by Theresa Hush | June 21, 2018

Specialty care is a thorny cost and political issue for ACOs and physicians alike. No ACO can provide good or comprehensive patient care without specialists. But if ACOs are to produce savings, they will almost certainly need to address how, when and at what cost those specialists will be used.

The degree of concern about specialist-generated costs for most ACOs currently depends on the ACO's structure. ACOs that are hospital-led or formed by multi-specialty health systems or networks may be less apt to look to specialty care for savings, except when the specialists are outside the ACO. Physician-led groups with heavy primary care participation, on the other hand, are more eager to address specialty services. That may be one reason why physician-led ACO performance tends to outstrip hospital-led ACOs.

Regardless of how they are structured, however, all ACOs will

move to adopt methods of controlling both costs and patient use of specialty services. Why? Because payers are moving both Medicare and private sector ACOs toward accepting financial risk. ACOs and specialty groups must prepare for the new environment quickly.

The ACO-Specialty Conflict Arises from Perceived Business Risk

To reach targeted expenditures, ACOs must avoid overuse of specialty services, including the additional tests and technologies ordered by specialists. Medicare ACOs struggle with both maintaining continuity of patient care and controlling cost when assuming costs of specialty care. Because patients are free to go outside the ACO for services, the patient can easily be "lost" outside the ACO's purview once he or she is receiving specialty care. Additionally, the cost of direct services and any additional technology ordered by the specialist will impact the ACO's savings.

ACOs operating under a health plan contract may have less concern with continuity of care if the benefit plan restricts specialty care to the ACO's participating physicians and referral network. But health plan benefits are not always enough to deter patients from going out of network. Even if the benefit incentive structure works, since the ACO is "charged" the cost of specialty services, ACOs still must ensure that such costs are appropriate.

Thus, for ACOs there is a perceived risk of financial losses coming from specialty services. As a result, some ACOs are inclined to keep specialists outside the ACO participating physician panel, using them for referrals only.

For specialty physicians, ACOs are a potential threat to the continued flow of patients and their practice's survival. Single specialty groups with a regional base of patients must avoid being tied to a single ACO, yet are worried about how to maintain referrals from such an ACO.

The dilemma of how to participate in ACOs affects most groups, even those that are already participating in their own employed-physician-group- or health-system-sponsored ACO. Because the geographic referral area for specialists is much broader, such groups require a business strategy that will minimize the loss of volume, while rewarding them financially.

How to Reconcile the Needs of Specialists and the ACO

While the needs of ACOs and specialty physicians appear to be irreconcilable, certain strategies can benefit both. The key is to create win-win relationships that produce ACO savings while ensuring that specialists have adequate patient flow and a stake in the ACO's success.

Successful strategies must be bilateral, not unilateral. The ACOs and specialty groups have unique organizational structures, patient compositions and services. There is no one-size-fits-all strategy that will work for both ACOs and their specialty groups. However, there are common elements that must be present to meet the needs of an ACO or specialty group, respectively. In addition to sharing historical information of ACO costs of care and specialty episodic costs of care, the design of the future relationship should be founded on the following:

- Predictable costs/predictable patient referrals and revenues
- Cost measurement and performance
- Quality and outcome measurement and performance
- Continuity of care process
- Patient feedback of results
- Patient participation in medical decision-making

What's different about this list from past referral arrangements between health organizations? It is solidly built on the measurement of value in Value-Based Health Care (VBHC). While the relationship should be open and collegial, the newly added components speak to the triad of Cost, Quality and Patient Experience in VBHC. As such, it is a business venture that should respect the needs of both parties to control costs, yet maintain the professionalism and livelihoods of specialists, in order to engage in a transparent process of cost and quality measurement, as well as to include patients.

Implementing all these elements at once may sound challenging, but there is one mechanism that can tie everything together: episodes of care. It's worth examining how this might jumpstart the process for both specialists and ACOs.

Make Episodes of Care a Foundation for ACO-Specialty Ventures

Some physicians are wary of episodic payments based on experience with fixed capitation payments from the HMO years. While it's clear that Medicare as well as health plans are moving toward episodic payments, we need to be careful regarding how this works for ACOs. For starters, accounting for patient volume and how to recoup outlier complex cases will be vastly different in a smaller ACO setting versus health plans

and Medicare.

Second, there is a big difference between using episodes of care for cost and quality measurement, and producing episodic payments. The former can be used without the latter, at least initially. While there is a building movement that favors episodic payments as part of VBHC (The National Quality Forum released a paper that promotes them fulfilling patients' right to value in health care [PDF download]), it is fair to say that the magic formula for calculating fair fees has yet to be invented.

Episodes of care are the underlying clinical compilation of services related to a patient's care for a single diagnosis or procedure, within a determined range of time. In its first proposed MACRA rules, Medicare defined a vast number of care episodes that were later withdrawn in favor of a much smaller set. The longer list included, along with the usual clinical procedures, diabetes and breast cancer, plus other chronic illnesses. The inclusion of the long list clarified that episodes of care could be used to measure costs and other aspects of care across a wider spectrum than had been imagined; it was withdrawn due to concerns that such measurement might not respond fairly to differences in individuals and would too quickly morph into episodic payments.

The fact remains that current Fee-for-Service pricing has little future, and that some unit-based methodology for comparing costs of care is a necessity for specialty care. Episodes of care provide that basic methodology for aggregating all of the care inputs from various services across professionals, facilities, technologies and medications for

general episodes that can be compared patient-to-patient. Only through aggregation of costs and services by type of care is there is even a possibility to compare care results.

Build a Win-Win VBHC Relationship Using Episodes of Care

ACOs can establish episodes of care as central to their strategy with specialists. In the beginning, unless the health plan or Medicare is already making episodic payments for the services, the episodes can be used simply to measure cost of care, using claims data, and to compare the results between patients and between specialty groups.

The patient care episode can be the basis for capture of cost data from claims for professional, facility, technology and other services, as well as quality and outcomes data using EMR or registry data. Sharing that data with specialists will help them understand their own relative costs and may identify areas for intervention or improvement.

The episodes can also be used in population health modules to add patient feedback through outreach, electronic surveys or visit-based projects to capture patient data. For ACOs undertaking patient medical decision-making programs, measuring differences in cost or functional outcomes—as well as validating quality for patients in control groups versus those participating in medical decisions—can reveal whether cost performance can be improved even more with patient-focused projects.

Specialists can, likewise, use episodes of care to compile and evaluate the variations in care among patients and between

providers. This experience empowers specialists to collaboratively identify inefficiencies or problematic quality, and to define optimal care that is tailored to the individual. The knowledge gained through this exercise will inform the group how to identify cases of higher risk that, once episodic payments become a reality, should be established as outliers.

Analyzing episodes of care results can help specialty groups identify patients who are higher risk or face poor prospects without change in behavior, treatment change and so on. These patients can then be included in more tailored projects at the practice level to improve their outcomes.

Specialists who become comfortable with evaluating costs and quality in episodes can take the lead in developing marketing packages for employers and health plans, securing a better position than competing groups.

With a strategy based on cost rather than price, specialists and ACOs can use episodes of care to create dialogue and collaboration, instead of division. While this approach requires detailed data sharing and review of patient outcomes, the most important ingredient is not data but discourse. Episodes of care, within a provider-led ACO, can resemble peer review discussions—and as such, highlight the strength of the model. If “all health care is local,” as industry people love to say, then an ACO-Specialist solution that involves review of real costs and quality in patient care episodes is a promising venture.

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Image Credit: Jonatan Pie

Patients Deserve Truth-based Medicine—But Most Aren't Getting It

written by Robert McNutt, M.D. | June 21, 2018

“I have breast cancer; I read that I should not drink wine because it may cause my cancer to return. I always wanted to be a sommelier, but that dream is dashed!”

People, sensibly, read about their medical conditions, searching for things that might help or hurt them. However, patients are vulnerable. Their vulnerability may cause them to overestimate concerns, or, alternatively, hopes after learning of a medical advance. Physicians and medical reporters have a daunting, yet crucial obligation to give people information that is credible; strategically, we also need to thwart information that is useless. Giving poor, non-science information the light of day harms the vulnerable and diminishes opportunities to build a trusted system for patient care.

Medical Care Based on Hunches Jeopardizes Patients

There are two main circumstances in medical care where science is undermined, and, hence, decisions are promulgated without facts. The first circumstance is reprehensible: When tests and treatments offered to patients have no scientific prelude, they are merely “common sense” hunches. A few sobering examples will suffice:

> Radical mastectomy was performed for nearly 100 years before we studied it and found it wanting.
> We gave more than 40,000 women with breast cancer high-dose chemotherapy and bone marrow transplant before we studied if it helped (it did not).
> We are now offering bilateral mastectomy to women with early stage breast cancer even though we don’t know if it will make any difference.

These situations for patients with breast cancer were based on a theory that “thinking something makes sense is good enough science.” But there is nothing scientific about any of these treatments—and many downsides.

Observational Studies Promulgate Unnecessary Tests and Treatments

Here is the second circumstance that leads to tests and treatments being performed without any factual basis: when actions are proposed based on comparative data derived from observational studies. In these studies, a group of patients is followed over time, and individuals in the group are parsed on actions done or not done. For example, a group may be parsed

based on the amount of wine people drink, the amount of coffee they drink, the amount of exercise they do, what medicines they take, on and on. Then, those doing the study compare those people doing x versus not doing x to clinical outcomes, such as return of breast cancer or living longer. (Reading such an observational study triggered the comment and unneeded worry by the patient that introduced this blog post).

Observational studies are common, but they are useless to you as a decision maker. The reason they are useless is they cannot prove that what they find is independently good or bad for you. The word “independently” is the important concept of science. Observational data, alone, cannot prove independence of action to outcome because of confounding or “tag-along” personal and clinical factors that are linked to both the action being studied (e.g., wine drinking) and the outcome (e.g., breast cancer recurrence).

For example, perhaps those who drink wine are also those who smoke; smoking, then, becomes the link between action and outcome, not the wine drinking. If there is any clinical factor that is linked to both the action being studied and the outcome of the study, proving independence is impossible. What patients need is a rigorous scientific approach that fosters the best chance of determining if some action is independently better or worse for them.

Randomized Clinical Trials Offer the Only Scientific Basis for Medical Decisions

That science is the randomized controlled trial (RCT). RCTs are the only scientific method of clinical medicine, and the only reports patients should read.

Randomized controlled trials are scientific for two main reasons. First, they limit the treatments available to patients, thereby restricting a source of confounding due to concomitant actions being taken by patients. Second, RCTs balance potential personal and clinical confounding factors that may be associated with outcomes.

Specifically, RCTs compare options and produce numbers; they show the chance of outcomes for all options, which allows you to see differences. For example, a patient recently asked about taking an agent for HER2+ breast cancer. In a RCT, the agent reduced the recurrence of breast cancer over 5 years by 1 to 2 percent. Equally important, the RCT also showed the agent had side effects; nearly 40 percent of patients taking the agent developed severe, daily diarrhea. The 1 to 2 percent better disease-related outcomes versus the nearly 40 percent worse treatment-related outcomes set the stage for a decision.

(Note that RCTs must be subjected to the highest standards of data analysis and interpretation to be appropriately understood and applied to medical decisions. We will explore these issues in future blog posts).

Treatment Tradeoffs and Decisions Are Up to the Patient

We don’t expect patients to be familiar with the nuances of RCTs. However, we suggest they use only RCT, not theory-based or observational information, when they must choose. It is the venerated job of patients to interpret if the added benefit of an action studied in a RCT may be worth the added harm of that action.

The act of balancing and trading-off added benefit against added harm is truth-based medicine. It is truth because it is the patient who decides the balance of the trade-off. There is no such thing in medical decision making as "the same decisions for all," as people will vary in how they value gain and loss from added benefits and harms. Variations in choices, not uniformity, are the goal of best medical care. Hence, individuals—not groups of individuals, or even RCTs—define truth.

To recap, we are saying that hunch-based theories and observational studies are not science. Observational studies, at best, are a preliminary data-gathering method designed to propose a hypothesis for the care of people who are ill, but they are not science because observations are not proof of truth in medicine.

Some will disagree with us, citing the surplus of observational studies published in leading medical journals, a strength-in-numbers argument. Some will try to excoriate our idea by noting that smoking and its putative effects, and a few other dramatic examples, were learned via observational studies. We will have to agree with them to some extent; many observational studies are conducted and published, and a few have been so dramatic that a strong hypothesis based on the observations may lead to appropriate action (efforts to stop smoking, for example). But, these types of strong-hypothesis, observational studies are uncommon.

Some say medical care is a science informed by philosophy. Perhaps the only philosophy medical care needs is to demand science while, simultaneously, blocking non-science from

patient consumption. This principle is the only way to assure truth-based medicine.

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Image Credit: Ryan McGuire

Four ACO Development Decisions That Will Impact Return on Investment

written by Theresa Hush | June 21, 2018

“It’s not how you start, but how you finish” might be the way some ACOs must navigate a difficult path to success. But for organizations planning a new ACO venture, that rocky path may be avoidable.

The early days of ACO development are behind us, and ACO models to take on financial risk are now underway. Achieving a return on ACO investment has proven to be elusive for most providers. There is progress, but no victory yet in sight.

So ACOs and industry watchers are searching for the keys that allow some ACOs to experience more success than others. Whether physician-led or hospital-led, primary care- or specialty-lopsided, large or small, downside-risk or no—the question is how to replicate ACO features that will drive success.

Early Decisions Will Affect ACO Future

Many ACOs have grown organically, out of existing relationships and established networks formed for health plan contracting purposes; or, formed by health systems with their employed providers. The provider networks of ACOs can thus reflect familiar and political alignments. But history does not necessarily contribute an ideal structure for an ACO.

In particular, an ACO built on traditional Fee-for-Service relationships will be challenged when that ACO moves toward financial risk, unless it is willing to innovate its care delivery and customer service. Physicians must be able to share in the ACO development and learning process to accomplish this. Medical decision-making, use of resources, referrals to other providers, and patient relationships will all shape the ACO's quality and financial performance. Transparency of data and decision processes should be established for physicians as well as patients.

Partners of the ACO should realize that no magical formula has been discovered. ACOs have experienced success and failure across different governance structures, sizes and provider compositions, and even from year to year. In short, ACO success may best be determined not by concrete structural design, but, rather, by the transformational culture of the organization and the commitment of its participating providers.

In that light, we offer four critical decision areas that will influence the ACO's capacity for transformation and substantively affect its return on investment:

- Physician participation and ACO physician culture;

Data sharing;
Innovation and experimentation to improve care and outcomes, as well as costs;
Consumer and patient empowerment.

These resemble questions typically encountered by any good start-up company:

What is our market?
What are we selling, and how is it unique?
How do we engage our partners/employees?
How do we satisfy our customers?

Four ACO Development Principles that Will Benefit Return on Investment

1. Determine how physicians will be involved in the ACO beyond caregiving.

Physicians have joined ACOs for a variety of reasons, including the ability to afford infrastructure and participate in Value-Based Health Care. But participation and partnership are different. The need for dialogue with physicians and inclusion in ACO development cannot be overstated. Physicians must have the time and resources to change, as well as support for processes that demand more from them. For example, review of data and performance improvement will involve work over and above clinical time, detracting from patient care. Physicians must be allowed the extra time for such initiatives, along with conflict resolution, with compensation and other rewards.

Physicians must understand the shared commitment to ACO goals. That understanding comes from sharing of performance data in a

positive learning environment, experimentation of care redesign on a small scale, and development and evaluation of ACO initiatives.

It is especially important for physicians to understand the business focus and its expected return on investment. They should be able to identify where the savings will be generated, what it will take from them to do it, and how to explain new programs to patients. Physicians should see aggregate as well as their individual impacts on ACO success or failure.

2. Make data the bedrock of ACO communications with physicians and with patients.

Physicians should routinely review data on clinical outcomes, clinical quality and costs that are tied to ACO performance goals. But that is just a basic courtesy. Here's what is really important: the full story should be told through data, so that physicians are not seeing piecemeal results of separate initiatives or their own patients. Physicians should see the breadth of data that will reflect patient illness and difficulties reflected in outcomes and quality performance measures or cost, including variations in care, with the opportunity to investigate reasons, cost of care with episode comparisons, utilization and referral patterns, and other cost drivers.

Likewise, ACO patients will benefit by a deeper understanding of the ACO delivery system. First of all, they need to know how they compare to others in similar patient populations and against benchmarks. They should be able to see quality measure

data for which they qualify, and their results. And patients should understand how the cost of their care compares with others.

3. Embrace innovation and experimentation in the ACO to improve care and costs over the long run.

The “easier” cost reductions for ACOs usually involve efforts to reduce readmissions and inappropriate admissions, and to refocus post-acute care. Coordination of care and patient outreach may also help to keep services in-house, which will save time and money by avoiding duplication of services.

But the most significant inroads to quality and costs will eventually come from reforms that either re-engineer care delivery to high risk and vulnerable populations, helping physicians and patients make value-based decisions on lifestyle and treatment, or that reduce Fee-for-Service incentives for overuse of services, particularly specialty services, through episodic payment arrangements.

4. Empower consumers and patients with information that will facilitate their health status and value-based medical decisions.

Adoption of an ACO model does not necessarily change how the enterprise treats new and existing patients. We encourage ACOs to view patients as customers with legitimate preferences as well as health needs, respecting their rights to data, cost transparency and choice of treatment. This is a historical departure from the reality of most health care organizations, which unfortunately may not view patients as the real

customers. Instead, they may view patients as accounts, as assets, revenue sources and subjects in research or other activities who need management and controlled choices.

Only ACOs that respect their customers are likely to maintain patient loyalty and achieve better performance. All ACO functions must incorporate patient communication and patient choice into initiatives and foster a customer service culture throughout the organization. Of most importance, ACOs will need to ensure that patients receive the value information coming from research, accurate cost information, and enough time with physicians to make informed treatment choices.

As HMOs taught us, downside risk for providers and participating physicians—while incentivizing everyone to have "skin in the game" of achieving savings—may have the unintended consequence of negatively affecting patients. There is a risk of denying care, skimming populations for healthier individuals and redlining populations altogether. While ACOs may form on the concept of better quality, attitudes toward patients and consumers will affect that care in a risk-based model over time.

Consumers in private health plans may not easily be able to go out of network to non-ACO providers, but those in Medicare will vote with their feet. ACOs that work hard with patients to win trust, engage them with information and decision-making, and respect their right to data and information will be rewarded with patients who achieve better results and remain in the network.

ACO Return on Investment Will Require Culture Shift

ACOs spend most of their lead-up to development on governance, provider network formation and financing. Certainly, the form for the ACO is significant, and these decisions will determine ACO structure and presence. ACO functions, however, will be more important for achieving actual cost savings and improved patient outcomes. Those functions will be built on changes that are energized by mission, involvement and attitudes within the ACO.

A culture that embraces innovation and creativity will be required for an ACO to succeed. In the same way that any new business develops and gains ground, its stakeholder physicians must feel engaged in its purpose. And its customers must be attracted on their own terms, not those of the ACO.

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Unify ACO Quality and Cost Initiatives to Boost Long-term Results

written by Dave Halpert | June 21, 2018

Let’s face it. There’s a pretty low bar to meeting Medicare’s ACO Quality requirements. Most ACOs have achieved acceptable quality performance for Medicare Shared Savings Plans (MSSPs). They have not, however, achieved the savings needed to be successful.

ACO supporters point to the “Triple Aim” of achieving higher quality, cost savings and good patient experience through an ACO. To fulfill that tripartite goal, we must look past the hype and execute quality-cost initiatives that go well beyond CMS requirements.

Recognize the Gap Between Quality Reporting Requirements and Quality Care

Demonstrating quality and reducing costs are not mutually exclusive. While there isn't an automatic link between your ACO's success in reporting and its ability to control costs, your biggest savings should be realized by focusing your quality efforts on improving patient health status while designing better care delivery. Note that Quality and quality reporting are distinct.

The link between quality and cost, however, has not been well demonstrated in ACO performance. Quality reporting scores have increased in each of the last three years; in 2017, the average quality score was 94.65 percent. Although quality reporting is successful (both in terms of completion and performance), more than two-thirds of ACOs saw zero shared savings. Only 30 percent of ACOs reaped the benefits of the $700 million distributed by CMS.

To understand how ACO quality reporting can mean so little in terms of savings, let's examine the ACO quality requirements. ACOs are only required to report 15 measures; the remaining measures are calculated from patient surveys and through CMS administrative claims. Those measures are abstract and out of sight.

ACO quality measures also do little to demonstrate patient health outcomes. The 15 measures actively reported consist of 8 preventive care and screening measures, 2 care coordination measures and 5 measures related to chronic conditions. The majority are "process" measures that track whether basic services were provided to patients. In addition, the ACO only

reports measure results for a sample of 248 consecutively ranked patients; as a rule, ACOs don't track quality across entire populations nor establish standards based on patient risk. Considering that an ACO has a minimum of 5,000 patients, it is hard to see how quality reporting provides an accurate indication of the ACO's standard of care.

For many, the quality reporting process is simply a matter of hiring and/or reassigning clinical staff to review charts to determine whether an action was performed, or to record the most recent value for a given test. As a result, the "get it reported" mentality removes quality from the equation; the task of reporting becomes an exercise in administration and work-hours. This is perfectly illustrated by the 2018 and 2019 ACO Quality benchmarks. Certain measures are simply graded on a 10-point scale, without consideration of the ACO's past results, the existing population or other ACOs' results.

Predictably, the vast majority of ACOs succeed in reporting, but are not demonstrating their financial value to the level anticipated by the Congressional Budget Office (CBO).

Making Real Improvements in ACO Quality and Cost Savings Requires a Plan

To achieve cost savings in patient care while promoting better health outcomes, providers will need to unify their view of costs and quality. There are some quality metrics that do tie to cost, but since they're calculated by CMS, they're invisible. ACOs need to be proactive and move these into a unified quality-cost measure set for internal performance measurement.

The usual suspects of excessive costs—readmissions and preventable admissions, emergency department utilization, network outflow—often are ACOs' first targets for measuring cost performance. That's a good step in the right direction, but as a sole cost strategy, too limited. It's true that post-acute care coordination or similar processes will produce savings from long-standing issues like readmissions. But a more comprehensive approach to redesigning care for groups of patients most likely to generate these issues, such as patients with Chronic Heart Failure, can yield lower costs associated with readmissions as well as preventable admissions and emergency use. By combining measures associated with patient outcomes, population health processes and coordination of care, along with costs, ACOs can more effectively tackle the quality-cost performance challenge across all dimensions.

How ACOs Can Establish Integrated Quality and Cost Measurement

Integrating quality and cost performance will involve a holistic review of care delivery and costs. There are starting points within the existing quality measures that you may use to link quality and cost, but don't box yourself in! For example, there are no quality measures related to some of the specialty-specific Advanced Alternate Payment Models, such as Bundled Payments for Quality Improvement (BCPI) or the Oncology Care Model (OCM). If you are able to reduce costs on hip and knee replacements, however, creating joint replacement episodes may still be a viable, measurable quality outcome and will contribute to a larger shared savings pool.

You will maximize your performance by targeting high cost

conditions and establishing both quality and cost measures that reflect patient outcomes and cost. Let's see how this could be accomplished for patients with diabetes and heart failure, specifically focusing on hospital admissions:

1. Reduce admissions related to diabetes and heart failure.

ACOs that can shift spending to office and wellness visits are more likely to generate shared savings. CMS is already using its administrative claims to track Ambulatory Sensitive Condition (ASC) admissions for diabetes and heart failure; you can take proactive steps to influence these, rather than just wait for your results. Consider developing your own quality metrics and measure their impact on ASC admissions. Avoid the measures you're already reporting.

The most recently released results show that ACOs averaged 53 unplanned diabetes-related admissions and 75 heart-failure-related admissions per 100 eligible person-years (how long a patient has been an attributed ACO beneficiary). Person-years adjust annualization to make sure that ACOs aren't rewarded for controlling costs over a year for a patient when that patient was only attributed for a short-time (e.g. a patient became Medicare-eligible halfway through the year). ASC admission rates range widely for these conditions. Unplanned diabetes admissions range from as few as 35 to as many as 160, while unplanned heart failure admissions range from 40 to 187.

ACOs have an opportunity to drastically reduce preventable diabetes and heart failure admissions and their associated costs. Your strategy should focus on potential gaps or stagnant outcomes in your patients' care, and address the reasons for

it.

2. Review your provider network to ensure that your patients have access to the appropriate specialty mix.

To avoid a gap in specialty care for patients with high-risk conditions, you will need to fix the gaps in your network, either by engaging physicians as full participants or as “other entities.” If your ACO does have access to specialty providers, you will need to identify gaps in that access, such as lack of transportation or scheduling availability. Patients who cannot access necessary specialists will go out-of-network for such services, including for emergency and hospital care.

3. After establishing that your network has the breadth to handle patients with complex chronic conditions, develop metrics for tracking their care that can blend quality and cost.

For example:

> Develop and track a Shared Decision-Making (SDM) Initiative. If primary care providers can engage in a Shared Decision-Making processes with patients, including discussions about barriers to treatment, risks, and relevant research studies, you may build patient engagement along with lower costs of care. The ACO can track results of patient outcomes, costs, and appointments designated to discuss treatment options, as well as patient-selected treatment decisions. SDM must be carefully designed to

ensure appropriate time for physician-patient conversations, but with some patient groups, this approach can have a quality and cost pay-off for the ACO.

Encourage and track Annual Wellness Visits (AWVs). In addition to being a critical factor for ongoing patient attribution, these visits are an opportune time to discuss your patients' goals and the strategies to meet them.

Analyze data for the patients who had previous ASC admissions and/or readmissions. For readmissions, determine if is there a common thread (e.g. one post-acute facility vs. another) that will lead you to a coordination-of-care solution or post-acute negotiations.

Measure post-discharge follow up. For patients who have been admitted, look at who was seen within seven days of discharge. In addition to the visit itself, the ACO should track patient feedback from this visit to identify those at-risk for readmissions, such as patients who do not understand discharge instructions, or patients who do not have home care and/or support.

4. Engage patients and providers in immunization campaigns.

CMS tracks ASCs related to acute conditions, such as pneumonia, as well as ASCs for chronic conditions. The average cost for a pneumonia-related hospitalization is $9,700. These are not "expected" costs, and an ACO whose patients incur them will see a reduced savings at the end of the year—and a more vulnerable patient population. Therefore, immunizations (a quality reporting measure) and ASCs for the corresponding conditions (CMS cost calculations) should be tracked together.

As more patients receive the immunization, performance rates on the corresponding quality measures (ACO-14 and ACO-15) will improve. If you decrease preventable hospitalizations at the same time (ACO-43, the Ambulatory Sensitive Condition [ASC] Acute Composite), you will have secured your potential shared savings pool.

It's all too easy to see quality reporting as your sole ACO quality responsibility. But getting caught up in reporting nuts-and-bolts misses your ACOs real opportunity to achieve the Triple Aim. Consider, instead, how you can use your data to design quality and cost performance improvement using integrated metrics. Ambulatory Sensitive Condition Admissions (along with all cause re-admissions, SNF re-admissions, and patient experience) can provide a road map for your ACO, enabling you to identify areas of concern and to address them with long-term solutions, rather than short-term patches.

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