What Does #MeToo Have to Do With Value-Based Health Care?

written by Theresa Hush | February 1, 2018

Are we measuring the right things in Value-Based Health Care? That’s the question I am asking myself while reviewing recent

efforts by CMS to create better measures of health care value, called Meaningful Measures. Given current, widespread reports of sexual abuse and my recent reading about the dismal state of elder health care, I can't respond affirmatively.

A Value-Based Health Care System should curtail rising health care costs and promote better health for individuals. But we can't miss the forest for the trees. If we focus on the minutia of medical processes or even outcomes of moderate value, yet miss crucial quality-of-life issues, can we claim that our system is value-based? No, we just get one that is a little less expensive.

That failure to deal with serious issues that impact health and wellbeing happens not across the board, but group by group. It happens because we decide that this or that issue is not sufficiently broad to matter when we are deciding about what counts in quality of care. It also happens because we often see health care from the provider perspective, especially since providers as a group are largely defining the quality measures.

This is how we marginalize the interests of women, of people of color and of people who have health care issues beyond their control. We decide through our various systems, health care as well as political, that their voices are not relevant. And this is how we end up with a maternal mortality rate that is the highest in the industrialized world. To find a better path, we need to take a closer look at how we failed girls trying to excel at a sport. And how we end with adults losing choices in later life.

Health System Failed Girl Gymnasts

Reports of sexual abuse of girl gymnasts on the USA Gymnastics team percolated for decades, but were not taken seriously until a critical mass of young women stepped forward to raise their voices collectively. The significant issue here is not simply that a trusted physician was the perpetrator; many others in equally trusted positions have preyed on children, both girls and boys. Here, however, there were many serious lapses in the treatment milieu that enabled the physician to sexually abuse the girls:

> Medical treatment was questionable, at best, and should clearly have been reviewed for evidence;
> The gymnasts were required to submit to exams and treatments without any recourse to refuse or complain;
> Treatment was provided in some cases at the physician's private home, not in a health facility with the aid of a nurse or another adult. Even with parents present, he hid his actions from view;
> Internal "treatments" were conducted without gloves;
> No one followed up on suspected issues brought by patients.

It is a tragedy that the girls' parents were convinced by the authority of the gymnastics system and the physician's reputation, or were persuaded by presumed medical expertise, to override their daughters' concerns and miss the abuse. But that is also evidence of how important it is—especially in systems rooted in trust—to seek and include patient feedback.

What if those girls were given permission to respond, even in the most basic way, to their medical care as members of the gymnastics team? How different would the outcome have been?

Would they have raised concerns about their exams or the conditions in which they occurred? Would they have evaluated their "adjustments" as having functionally relieved their symptoms? Would it have made a difference?

We will never know for certain how the abuse might have been discovered earlier, curtailed or even avoided altogether by a system that respected the rights and feedback of the girls. But we do know that in health care—as in the workplace, in schools and in churches—the powerful are protected by silencing or minimizing the voices of the less powerful. If we truly want the patient to be at the center of health care, it is essential that we actively solicit patient input about quality of care.

Older Adults Lose Choices In Health Care, Along with Life

As the sentencing in the gymnast abuse case concluded last week, I finished rereading *Being Mortal* by Atul Gawande, MD. Its stark portrayal of end-of-life care in a medical system on autopilot is directly relevant to the question of ensuring value and avoiding excessive cost.

Dr. Gawande rightly points out all the reasons why providers are geared to do more, try more, even when there is little chance to reverse rampant disease or body failure. Advance Directives by patients, which feature in current Medicare quality measures as well as future Meaningful Measures, respond to this concern by, at least, stimulating the conversation about end of life.

Even if completed, however, Advance Directives may be written and signed before a crisis becomes real, only to be later

rethought by the patient, family or physician at the moment of care. But clarifying intent for further treatment must be part of an ongoing conversation related to patient life desires, revisited as circumstances change. The push to create the continual conversation—much like medication reconciliation—is being missed by the entire community involved in measure development.

This excellent book on dealing with decline and aging is also relevant to how our health care system affects quality of life. For a range of reasons, many older adults' need for stronger support systems has outpaced their ability to remain independent, and many of those adults cannot stay with their families. They reside, instead, in assisted living and nursing homes, most of which have strict regimens that proscribe their activities and choices. These facilities are required to participate in quality reporting for Medicare, which reimburses them for post-acute care only (custodial care is often covered by Medicaid or private pay).

Nursing home quality reporting addresses falls, infections and bedsores. It also includes measures to control costs, such as readmissions and cost per beneficiary. Nursing home and physician quality measures do not, however, reward patient choices, privacy, integrity and independence. While CMS Meaningful Measures include a placeholder category for patient-directed choices and input, there are—as yet—no measures assigned to this module.

Like the gymnast girls, older adults often lose their voices in managing their health care as well as in choosing their living circumstances. They are directed, expected to comply with

orders they may not accept, and mostly do not select their providers. The system of quality measurement may help protect them from physical harm, but—with the remarkable exception of new groups of very innovative providers and administrators trying to change the industry—the system does little to encourage higher functionality, more patient choice or more independence.

While change from industry leaders is positive, the CMS Meaningful Measures that reflect this area of health care aren't inspiring. The point of the measurement system is to guide the standard of care for *everyone*. Without an adopted standard of care and measures that determine how each part of the system—each facility and provider participating in Medicare, and each process and health outcome that comprise the definition of value—stacks up against that standard, there are consequences for the value of the system as a whole. Better patient options may be available because of compassionate leaders in the industry as well as family and patient desires. But the risk is that only to those who can afford the higher cost can choose those options. Where leadership and funds are average, the lack of a higher standard of care promotes the status quo and provides no blueprint for improvement.

There should be systematic adoption of measures that incorporate incentives for mainstream elders to make medical and reasonable life decisions. These include, among other preferences, self-determination of private time versus group activities, scope of involvement in group activities, diet preferences, ambulation as desired or capable, and participation in decisions about their treatments and care.

#MeToo Is Partly A Story of Deficient Health Care

I am energized by the army of women who have come forward and testified to our collective history of harassment and abuse. Sexual harassment comes in many forms and affects victims profoundly, whether or not they feel able to speak.

Abuse and sexual violence, however, should be protected health care territory for victims. They should be helped to acknowledge the abuse, not hindered, and supported in recovery. But there is not a single quality measure for screening of sexual abuse. The existence of sexual abuse as a "condition" is not even acknowledged, nor its harmful impact on the patient.

In CMS Meaningful Measures, there is an emphasis on measures that have significance in terms of outcomes, some of which have questionable data. There are measures related to smoking, blood pressure and hemoglobin A1C. Smoking, hypertension and diabetes have an unquestionable effect on mortality, health care costs and quality of life. But so does sexual abuse.

It is impossible to include every condition, every circumstance in a discrete set of quality measures that are intended to define what our health care system should look like. But should we not account, in some way, for patients who experience emotional trauma. Whether it is sexual abuse, rape, elder or child abuse, or another form of emotional trauma—shouldn't our health care system center as much on patients as on costs?

Ultimately, troubled people cost money and lives.

“Meaningful” Must Be Measurable and Patient-Oriented

The CMS Meaningful Measures effort is still in its infancy. But early signs indicate a preference for provider simplicity and cost containment without accounting for the other side of the equation: patients.

The drive to include consumers in their health care system should be more than a “patient engagement” scheme. It should start with measuring and sharing what is important to patients, and including them in both the process of measure development and the review of data. Performance measures, to be truly meaningful, should not be the exclusive terrain of providers. They were driven by a Value-Based Health Care system based on payments coming primarily from insurance and governmental payers. But now it is patients who are paying for much of their health care through premiums, copays, deductibles and uncovered charges. Those patients deserve to participate in the final round of Value-Based Health Care.

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Image Credit: GMB Monkey

BPCI Advanced Means Financial Risk Is Coming for Specialists

written by Theresa Hush | February 1, 2018

In case you missed Medicare's messages about its reimbursement direction in recent years, CMS just reminded us that financial risk is well on its way. If you're developing strategies that

assume the status quo, it's time to reassess your organization's financial footing. CMS has already stated its intention to shift 50 percent of Medicare provider reimbursement into Alternative Payment Models (APMs) by the end of this calendar year. And those APMs are quickly transitioning toward putting providers at financial risk, because CMS is rewarding them to do so.

CMS's goal to impose financial risk was front and center again this month, as they revealed a new part of their cost cutting strategy. Under the title BPCI (Bundled Payments for Care Improvement) Advanced, CMS selected 32 clinical episodes as part of a new voluntary, risk-based reimbursement program, covering 108 diagnoses. The episodes will each have a target cost, and participating providers or organizations will be held to the total cost of all episodes without the possibility of additional payment for services.

Financial Risk Equals Bundled Price for All Services with No Cushion

Total reimbursements tied to a price that is set by the payer? That's the definition of financial risk. Under BPCI Advanced, *participating providers might actually find themselves having to repay funds to Medicare.* Only three services qualify for extra money, and there is no allowance for outliers. The episodes appear to be risk adjusted, but with no cushion for catastrophic cases. Notwithstanding an aggregate stop-loss for up- and down-side risk of 20 percent from target, this is clear financial risk.

Under MACRA legislation and regulations that streamlined and integrated various Medicare Value-Based Health Care programs,

implementation of both financial risk and other direct cost scoring has been slower than originally planned. Providers got a reprieve in 2017, MACRA's first year, by a delayed implementation for transitioning providers, with no penalties for cost abnormalities. That reprieve has ended.

In fact, cost appears to be at the crux of the latest MACRA rules and CMS actions. BPCI Advanced is a revised iteration of the MIPS Cost module, wherein costs associated with episodes were scored, and providers received scores for being under the total cost target, influencing their total MIPS results and financial incentive or negative adjustment.

BPCI Advanced Has More Power Than Previous Episodic Payment Plans

BPCI Advanced may be voluntary, but that doesn't mean it's a sidebar initiative. As an Advanced APM, the program will allow CMS to test the results of the program with willing participants. But like other previous voluntary pilot programs, we expect the mechanism to move swiftly toward permanent status for all providers.

As a separate initiative, BPCI Advanced also serves as a blueprint for specialty reimbursement. Including episodes in MIPS Cost Scoring would have obscured the results from providers, since they do not generally view these formulas and reports. MIPS Cost Scoring applies to physician groups under a single Tax Identification Number, and the information does not easily reveal specific provider issues. By contrast, under BPCI Advanced, the costs of each provider in each episode will be apparent in data provided to the convening organization or providers. This will undoubtedly lead to the

identification—possibly erroneous—of providers who have higher costs or exceed targets.

BPCI Advanced is also a big change from the predecessor BPCI pilot episode payment initiatives. That BPCI program allowed for four different types of bundled payments, only one of which included all services. In BPCI Advanced, the clear direction is for inclusion of all services in a 90-day episode. Even if services from a non-participating provider are covered in the episode costs, there will be a strong incentive to bring as many providers under the tent as possible and to strongly direct or refer patients to participating providers.

Specialists and Acute Care Hospitals Are Targeted Under BCPI Advanced

BPCI Advanced episodes are distinguished by two features. First, 29 of the 32 episodes are only triggered for inpatient hospital stays. The cost of inpatient services is clearly a target for reduction, further reinforced by the fact that two of the seven quality measures are actually associated with readmissions and excess days, which are normally considered cost measures.

Second, the majority of BPCI Advanced episodes are managed by specialty physicians, not primary. Episodes include cardiac, orthopedic and neurosurgical procedures or conditions, but the program also includes general infections managed on an inpatient basis, stroke, CV and general surgery, COPD and other chronic or acute pulmonary conditions, renal failure, and gastrointestinal conditions.

The episodes do not fall evenly across all specialties.

Orthopedics and cardiology are the most targeted. Since spinal surgery features prominently in episodes, any cost comparisons between specialties such as neurosurgery and orthopedic surgery will no doubt raise physicians' concerns but may provide valuable information to other stakeholders, including patients and researchers.

How "Value" Is Swinging to Cost Over Quality

In the announcement of BPCI Advanced, CMS said the program "is an important step in the move away from fee-for-service and towards paying for value."

Moving from *fee-for-service* to *value* is a significant choice of words. The first is a reimbursement system that defines how providers get paid, which is currently by service. "Value" normally means that the outcome—in this case patient clinical results—should be worth the cost of those services.

To be sure, CMS has assigned seven quality measures in BPCI Advanced, and three of them relate to outcomes: post-joint replacement complication rates, mortality rate following CABG, and patient safety indicators. Two of the seven were defined as cost measures in previous CMS programs: all-cause hospital readmissions and excess days following an AMI. The remaining two are process quality measures of peri-operative antibiotic use and the existence of an advanced care plan.

Like many circulating proposals for Medicare quality measurement and reporting, BPCI Advanced weighs cost heavily, but for most of the episodes there is no assessment of patient outcomes or quality care. One of the concerns likely to emerge about the program will be its similarity to capitation and

other per-case payments denigrated in years past. These fell out of vogue because of claims that they skimped or denied care to patients in favor of lowering costs. Failure to address outcomes and quality as a balanced component of value is a significant issue.

Why Providers Should Consider BPCI Advanced

Providers perseverating about adoption of episodes based on the eventuality of limited payments should rethink their strategies. The pressure on Medicare finances will result in both cutting fees to providers and shifting costs to beneficiaries. Both tactics will soon be permanent, and BPCI Advanced along with risk-based ACOs signal providers that additional reimbursement changes are inevitable.

CMS has set a very fast pace for the program, with an applications deadline of March 12, 2018. Why should providers even consider it, given the risk?

> As with ACOs, a large pool of providers is likely to apply. Experimenting with at least a few episodes will give providers the needed experience as the program moves forward.
> CMS is offering a huge benefit of three years' prior episode data, with costs.
> Hospitals need to ensure the commitment of their independent specialists, by developing a joint strategy for reimbursement.
> Hospitals with employed specialists cannot afford to sit on the sidelines when both hospital and physician revenue is at stake.
> Participation in Medicare episodes can create the

> information and infrastructure needed to negotiate with private health plans, to drive more volume of patients. Competing on excellence and cost for patients will be a permanent feature as costs shift, and episodes of care can be used to market directly to patients.

Waiting Too Long to Launch Cost Agenda Could Hurt Competitive Edge

In the past few months, CMS has made two significant changes in its Value-Based Health Care programs to increase emphasis on Cost. First, the agency revised its MIPS methodology for 2018 to include a weight for Cost, which was previously reported to be zero in 2018. Second, BPCI Advanced makes clear the focus on cost reduction of both specialty and hospital costs.

Providers who have been seriously grappling with where to start their Cost agenda should consider episodes as a possibility. Without action in the near future, providers will find it more difficult to compete with other networks that have leveraged the program to cement relationships among their providers, as well as furnish the data they need to plan forward.

Which providers should hurry to the starting line? An organization with an alliance of providers who can deliver most or all of the needed services in one or more episodes, or in multiple episodes for a specialty, is a perfect candidate. Systems with large numbers of employed physicians will have the most potential, followed by those with strong relationships with one or more independent physician groups, and physician-hospital organizations with a history of payment distribution.

Solid networks, built on a history of sharing data, will need

technology to create episodes of care, cost measures and analytics to ensure that they remain solvent. Bundled payments, as they grow throughout all specialties, will disrupt the current system. But they also have the power to incorporate many other improvements to shave costs: medical decision-making changes to improve cost and patient outcomes; stronger physician relationships and better data for determining how to improve.

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Image Credit: Alexandra Rose

Time Out! How Strategic Pauses Can Enhance Medical Decision-Making to Improve Outcomes

written by Thomas Dent, M.D. | February 1, 2018

Health care providers are under increasing pressure to improve outcomes for patients with chronic conditions. There is pressure to meet quality measures, to establish programs that improve outcomes, to decrease costs for these conditions (utilization as an outcome)—or a combination of goals. At issue: what works, what is affordable, what is acceptable to patients and clinicians.

The answers are elusive because there are many factors involved in the care of patients who have numerous chronic conditions, co-morbidities and medications, as well as multiple healthcare professionals providing their care. Adding to this complexity, any outcomes improvement for patients with chronic conditions often depends on their making lifestyle changes that are not always within their control (e.g. homelessness, food insecurity, isolation).

Typically, office management of chronic conditions involves an ebb and flow between results (tests, physical findings, patient feedback) and therapeutic interventions (medications, lifestyle modifications). This focus may cause the clinician to overlook important changes in the patient's situation. The patient may have experienced a dramatic change in living conditions (if, indeed, they still have a home) or may have lost faith in their treatment plan. It's necessary to regularly "step back " and review everything about the patient, treatment assumptions, and results of the care plan. This approach is particularly important when provider and/or patient cannot control outcomes or when the patient's health is declining.

For all these reasons, providers—and patients—would be well served by "strategic pauses" in the management of chronic conditions. At key junctures, when outcomes hang in the balance, clinicians and patients should review and reflect on the patient's overall status and care plan.

Strategic Pauses Are Well-Established Medical Decision-Making Practice

This is not a new concept. For example, the World Health Organization surgical operative checklist details what must occur before the induction of anesthesia (confirmation of the patient's identity and the nature and site of the procedure); before skin incision (confirmation of all team members' roles, review of critical or unexpected surgical steps, antibiotic prophylaxis administration); before the patient leaves the operating room (key concerns for recovery, proper labeling of specimens). This checklist is akin to the pre-flight checklist used by airline pilots.

Another example of pausing and checking, one that should occur at all office visits (and is, indeed, a quality measure), is medication reconciliation. This potentially life-saving step helps to prevent duplicate prescriptions from multiple clinicians and serves to confirm for both patient and clinician all medications and other agents, such as herbal or OTC drugs, which a patient is taking.

How Strategic Pauses Apply to Treatment of Chronic Hypertension

Let's take a closer look at how a strategic pause could improve the care of a patient with hypertension. This involves four basic steps:

Step 1: Confirm the diagnosis.

The diagnosis of hypertension has changed significantly in the past year, given a revised definition with a lower threshold. Formerly defined as ≥140/90 (systolic blood pressure/diastolic blood pressure), hypertension is now diagnosed as ≥130/80. As a result, the prevalence of hypertension has increased from 32 to 46 percent among adult Americans. Accompanying this shift are changes in recommended therapy for selected patients with lower blood pressure levels, as well as more aggressive therapy for many patients.

Step 2: Confirm the results (blood pressure readings).

How blood pressure is taken merits scrutiny; a number of factors may influence results. Standards are very rarely followed, as they are time consuming and not widely known. Most

of the resulting errors contribute to a falsely elevated reading. If a clinician relies exclusively on office blood pressures, she may over-treat or under-treat the patient:

> 35 percent of people with elevated office blood pressures may have normal blood pressure readings when measured outside of the office (white-coat hypertension);
> 30 percent of patients with non-hypertensive office blood pressure readings have elevated readings out of the office.

Antihypertensive therapy can lead to orthostatic hypotension, mainly in the elderly. Measuring standing blood pressures in older patients receiving antihypertensive medications may help identify patients at risk for falls. In my experience, this is rarely done. Triggers for such a measurement include postural symptoms, light-headedness or faintness on standing; but patients are often not queried about such symptoms. Taking the time to confirm results and do additional blood pressure readings, as needed, can avert potential complications.

Step 3: Detect hidden risks.

Factors such as unhealthy alcohol consumption can contribute to hypertension (in the United States, alcohol may contribute to 10 percent of the population burden of hypertension). Identifying occult alcoholism is an important task and well worth a clinician's attention.

Step 4: Determine factors within the patient's control that can improve outcomes.

Lifestyle issues are key to managing hypertension. A healthy diet and regular exercise can dramatically lower blood

pressure. Assessing whether the patient understands the benefits of lifestyle changes and is willing to make these changes is essential. Managing hypertension is often up to the patient; the clinician has a critical role to play in educating and supporting the patient, as well as goal-setting. All clinicians caring for the patient should know the patient's important personal goals, outcomes and acceptable risks. Clinicians should also be aware of major changes in the patient's life circumstances, such as loss of home, family or friend.

Controlling blood pressure also requires that the patient reliably take antihypertensive medications. Patients may feel ashamed about not regularly taking their medications; clinicians are well-advised to make time to discuss how this might occur, exploring issues of cost and side-effect barriers. The new hypertension guidelines call for two medications from different classes for patients with a blood pressure of ≥140 (systolic) or ≥90 (diastolic), adding to the therapeutic complexity. Some side effects, such as erectile dysfunction, are embarrassing, but require discussion within a trusting clinical relationship. Reviewing the patient's beliefs on the treatment plan is an ongoing need. Patients won't take medications if they don't believe they work. This is especially true for hypertension, which is largely asymptomatic until the devastating consequences of uncontrolled hypertension become all too apparent.

Strategic Pauses Require Organizational Leadership and Resources To Succeed

For individual physicians and practices, implementing a

systematic process of strategic pauses may not be feasible, due to limited time and resources. Healthcare organizations, by contrast, have a greater capacity for such an initiative and can bring more resources to bear. By systematically identifying patients who are not improving, validating all the assumptions of their diagnoses and treatment modalities, and testing interventions that may be more fruitful, providers can enhance quality measurement and improve performance.

For organizations competing against one another for optimal cost and quality scores under MACRA MIPS, or for those under pressure to maintain attributed patients under Alternative Payment Models (APMs) such as ACOs, quality measurement of outcomes will become increasingly important. The impact of strategic pauses, when included in a performance improvement project, may be measured and compared by evaluating outcomes over time along with cost. This requires focused technology, such as a Qualified Clinical Data Registry's capacity to track individual patient outcomes as well as test the results of various interventions like strategic pauses.

Among the activities that organizations should finance and standardize:

- Identification of patients whose outcomes did not improve, or whose cost profiles indicate repetitive crisis points or testing patterns. Establishing criteria for patients who may be candidates for strategic pauses will help to control volume and better align potential benefit for the practice.
- Patient outreach to bring them back into the process, through a centralized mechanism.
- Development of patient criteria for the program and for

creation of goals, targets and measurements.
Training or protocols to reduce the potential for inaccurate outcomes measurement, such as standardized blood pressure readings.

By implementing strategic pauses through a Performance Improvement Activity (PIA) under MACRA MIPS, health care organizations will reap financial benefits by increasing the scored points associated with PIAs. Even more significantly, they will improve other quality cost performance scores, potentially tipping the organization into eligibility for an incentive.

Identifying patients for this program via system-wide data will allow for a more focused approach. The greatest value in treating hypertension is lowering extremely high blood pressures. Patients whose conditions are out-of-control or quickly worsening should be the initial targets.

Six Steps to Ensure the Success of Strategic Pause Performance Improvement Activity

While strategic pauses may offer a very promising opportunity for performance improvement, success will hinge on including clinicians in the process of program design, rather than overwhelming them with new requirements. These six areas can raise the chances of successful implementation and results:

1. Start with a small number of patients who are most at risk.

Patients whose hypertension is out of control or strongly trending toward higher blood pressures, particularly those with

a high risk of cardiovascular events, should be selected for strategic pauses. Most practices have limited resources, and the focus should be on who might benefit the most.

2. Prepare the patient by capturing information prior to the office visit.

Here is where a structured phone call to the patient is valuable. Match questions to the patient with a template in the EHR. Develop and follow a script. Suggest that the patient might consider bringing a spouse, relative or other trusted individual to the visit. This sets the stage for greater understanding and strengthens the patient's social support.

3. Be aware of the "tyranny of the urgent" in the office.

When discussing any changes or additions to their routine office work flow, primary care physicians repeatedly tell me, "I can't take the time to do anything more." This is a major challenge. These physicians are under significant time pressure, and productivity (upon which much of their revenue is derived) favors addressing acute or urgent problems. To successfully implement strategic pauses, move gradually and track steps taken. Integration into the existing workflow is essential. These strategic pauses are not a big, one-time event, but, rather, a culture shift.

4. Engage the patient's support system.

Clinicians need to know whom the patient trusts to share his or her health journey. Identify this individual (or individuals), maintain records and track any changes. Understand how much the

patient wants the health care team to include this individual in any discussions and medical decisions.

5. Sustain patient motivation and belief.

It will be critical to maintain contact with the patient over time and to identify barriers to care as they arise. Teach the patient to self-measure blood pressures properly and consistently; he or she will take a more active role and can see the results of therapy directly.

6. Change the strategic pauses based on observed outcomes.

For the patient with chronic hypertension, how has health status changed (if at all) with any change in blood pressure readings? Assessing how strategic pauses have played a role in these changes will illuminate their impact. Capture feedback from patients and clinicians about the strategic pauses and note where successes or failures occurred.

As stated above, successful implementation of strategic pauses should be incremental, part of a broader process that includes measurement of outcomes and ongoing evaluation. This process should increase the central role of the patient in medical decision-making.

Strategic Pauses Are Part of An Expanded VBHC Concept of Medical Decision-Making

Value-Based Health Care (VBHC) has begun to create an awareness among providers that we can no longer continue to accept poor patient outcomes as satisfactory, and that providers must engage in a continued process of questioning and engaging

toward improved results. But individual physicians and practices have neither the time nor other resources to establish processes required by the transition to value.

Obtaining an improvement in patient outcomes must occur through correcting diagnostic error as well as encouraging patients to modify lifestyles and to overcome their barriers to treatment. It is a notoriously difficult task that will demand a new medical decision-making process in which both the physician and the patient, and the patient's support system, must participate.

Strategic pauses and Shared Decision-Making are two tools that affect medical decision-making with much in common. Both involve validating and questioning the patient's symptoms, diagnosis, barriers, and belief systems. Both involve clinicians' willingness to modify their approach to reach joint goals with the patient. And both approaches will require an investment of organizational resources to help clinicians be effective and measure improvement.

Organizations may now be sufficiently motivated to employ strategic pauses and other aspects of a revised Medical Decision-Making approach. Doing so, especially by generating processes that engage patients and their support system, promises to strengthen clinicians' relationships with patients—key to building consumer loyalty—as well as produce better results.

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Image Credit: Johan Desaeyere

Reining In Medical Costs Might Work If We Could All Agree What "Cost" Means

written by Theresa Hush | February 1, 2018

A few days ago, a couple of providers commented on my recent posts about cost performance improvement in health care. The first of these posts reviewed obstacles to provider strategies for managing costs and how to overcome them, and the second addressed technology that providers would need to both measure and improve performance. One commenter took issue with my statement that providers have not embraced cost reduction because the reimbursement system rewarded growth and more services. Another stated that providers have undertaken cost control for years, and they have invested heavily in accounting and financial systems, as well as aggregation of clinical and financial data with risk-assessed scores.

I appreciated these comments. They made me realize that, in our national conversation about affordable health care, conflicting definitions of cost is one factor that leads to a failed strategy for getting what we want. We don’t, in fact, want the

same thing.

Purchasers Target Population-based and Per-patient Costs

Throughout my professional career, I have dealt with rising health care costs in one way or another. My early years were spent directing employer benefit plans, then governmental and commercial health plans. I saw how health care costs dragged down state budgets for Medicaid and employee health care, and I saw how employers and health plans were powerless to change the results.

As an employer, my experience working with other large employers only reinforced how difficult it was to change health care from this sector of market. It was hard to get data and to understand what was driving our increasing costs. It was harder, yet, to negotiate reductions in employee benefit plans or to design care programs that promised to reduce costs.

My experience in state government, heading Medicaid, was similarly frustrating, despite the common belief in governmental control. Providers imagine that running Medicaid is a powerful job because, as for Medicare, one can simply decide what the program will pay and who will get it. In that make-believe world, coffers are flush—and when there's not enough money to go around, fraud must be rampant. In reality, the process of getting money for a state agency is a lot like competitive wrestling, a hard battle with lots of mudslinging, and routing that money is like running through a minefield. There are never enough funds to provide needed access for children and others who can't afford health care. The reason? Because the costs keeping going up, for everyone.

Providers Define Medical Costs in Accounting Terms

My perspective on medical costs was, thus, honed by purchasing decisions and policy-making, as I balanced the goal of providing access to care against money to pay for it. That perspective matters, as I later discovered when switching "sides" and entering the provider world. In that environment, medical costs were recast as revenues and the mission was to ensure their continued flow and viability. Cost control meant budget control over hiring and purchases, and managing the cost of supplies and facilities.

In my provider world, "costs" were exclusively understood in terms of how they affected the organization's budget and bottom line. Our negotiations of health plan rates for institutional and physician services reflected a market price for our scale and sophistication in the health care arena. That price was defined by the health plan's leverage vis-à-vis ours, with respect to our relative positions in the market. The essential point here is that those prices had nothing to do with costs per se, but, rather, with how much the health plan needed us and how much we needed their covered patients.

On the provider side of the market, there was no cost strategy to address the overall cost of care, as purchasers envision. Instead, the struggle to manage costs was focused on living within the budget and available resources. That budget was derived from calculations of expense limits based on expected and historical volume of patients and services, and the payments by Medicare, Medicaid and commercial health plans for those services.

Building the provider budget in this way makes perfect sense, as does negotiating rates based on the market—for the survival and growth of the provider. The problem is that the provider's goal is (understandably) to always get more in an environment where (theoretically) we want to pay less. Calculating a budget based on how much the market will pay would produce a big Excel error as a circular reference.

It is true that providers have invested heavily in systems for accounting, finance and aggregation of clinical and financial data. But look at the purpose and output of those systems, and you will find that they are designed not to reach an understanding of the cost of care for a population or per patient, or to develop cost performance based on how purchasers view cost of care. Rather, they are designed to identify revenue potential, such as justifying risk for higher reimbursement or for reaching more patients to provide more services. These systems are growth tools, and while they could also be used to fuel cost performance in Value-Based Health Care, this is not a common use.

Consumers Focus on Cost of Coverage and the Mystery of Medical Pricing

Consumers are completely in the dark about the fact that "prices" in health care are a set by arrangement between health plans and providers, negotiated with commercial health plans and set by rules in government. These same arrangements also determine whether consumers are subject to balance billing by providers. To the consumer, the cost of health care is equal to what they pay in premiums to insurance carriers plus deductibles, copayments and non-covered charges.

Facing potential (and real) loss of coverage and the scaling back of benefits, consumers have begun to focus both on prices and medical costs as a reflection of those prices. This matters, because consumers are sharing a larger percentage of costs with their employers and, as a result, have birthed a political movement about access and the cost of health care—defined on their terms. As American mortality and morbidity rates increase, we can expect consumers' angst to grow and fuel increasing political pressure for change.

How a Common Definition of Medical Costs Would Benefit Everyone

If providers cannot understand what the market wants them to do, can they meet those expectations and constrain the costs of care? Not really. Those providers, unless they are able to measure cost using a standard similar to purchasers', cannot identify their care issues and support improvement.

Value-Based Health Care is built upon cost measures that reflect the perspective of purchasers, not providers. While current reimbursement incentives may slow the process of reform, ultimately those measures—such as Medicare's MACRA MIPS cost scoring and commercial plans' shift of expenses to consumers and narrowing of provider networks—will force reform.

Making improvements in the cost of care will benefit consumers as well as improve the provider's relative cost profile for purchasers. Indeed, consumers are critical to the endeavor, and including consumers in the development of solutions to lowering cost is essential. Medical decision-making, for example, can incorporate understanding of cost and clinical outcomes for both providers and consumers, leading to better long-term

results for patients.

Providers conceptually understand and agree to the concepts in Value-Based Health Care, and want to do well for their patients. They are gaining the expertise to better measure clinical results, but cost performance with respect to VBHC is still new territory for everyone. Moving in that direction, however, means fully appreciating how to begin measuring costs and cost drivers, and then constructing interventions to improve costs without sacrificing good patient results.

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Image Credit: Kawtar Cherkaoui

Can the New Year Bring A Real Solution to Affordable Health Care—From Providers?

written by Theresa Hush | February 1, 2018

Every New Year, we commence another round of solutions to fix our expensive health care system. 2018 will be no different. A predicted 5.5 percent increase in medical costs over last year will no doubt spawn new efforts to contain direct payments to providers or transfer costs to consumers—or both.

No solution has appeased health system stakeholders, including employers, health plans, consumers and providers. No matter where the system is pinched, another part reacts, and costs continue to outpace inflation.

Most solutions, however, have been implemented by payers—government and commercial health plans, as well as employers—against providers and consumers. Why have we been so unsuccessful? Perhaps because most solutions do not affect the real driver of health care costs: medical decisions.

Those medical decisions, made daily and individually by millions of patients and physicians, are what control cost trends. They are embedded in every physician visit, every decision to pursue further testing or imagery, in every treatment decision, in every drug prescribed but not taken because of cost or side effects. Yet those decisions and the decision-making process have remained outside the realm of reform. It's time for provider systems to get serious and take responsibility for reining in costs by facilitating better decisions by patients and their physicians.

Wait—am I actually saying that providers can fix health care so that it's affordable? Not quite, given the complexity of the system's many moving parts. I'm saying this is a prospect to consider seriously. Not only is facilitating better medical decisions one of the few options left for providers, but also health systems may eventually be compelled to do so, as they reckon with declining revenues.

Insurers Attempt to Fix Health Care Costs with Payments and Access

For more than forty years, action/reaction has characterized health care reform ideas: action by health plans and employers to remove costs from the system, and reaction from providers to stay afloat. Hugely unpopular HMOs that restricted consumers' access to services were virtually eliminated and replaced with broader PPO plans. The industry then quietly adopted narrow networks and transferred costs to employees through high deductible benefit plans. Health plans introduced price negotiations with providers, slowing the cost increases—until providers recognized the value of scale and consolidated to

gain leverage and market share.

This past decade, trending strategies rewarded providers for delivering better value through quality and cost performance (to be sure, this has been paired with strong efforts to continue shifting costs to consumers). But signs of moving away from Value-Based Heath Care (VBHC) are emerging. Provider pushback against MACRA regulations as overly complex and burdensome has already significantly reduced the pace of implementation by Medicare, the strongest influencer in VBHC.

The lesson is clear. Health care purchasers may have constrained access and temporarily shifted dollars, but not achieved a reduction in medical costs. The tools of finance are too blunt.

Employers Try Patient Engagement and Wellness

Employers bought into VBHC because, conceptually, getting value for their health care investment made sense. They have promoted “good” providers in health plan networks by creating incentives for employees to choose them amongst their employee offerings.

Employers are now equipped with data, including the health status consequences of inactive lifestyles and obesity, as well as risks in their employed populations. They have become more involved in “patient engagement” programs, incentivizing employees and dependents to achieve better health (or penalizing those who maintain bad habits). They have created care management programs for patients with chronic disease and substance abuse issues, and have sometimes mandated their use.

Employers have also shifted the cost burden to the consumer

under the premise of making employees more responsible for their health care investment. Health spending accounts, called Consumer-Directed Health Plans by many employers, are cast as rewarding employees who save money by making better medical decisions. Yet these are only financial accounts and neither provide access to the information that employees need to make better choices, nor address barriers to doing so. They reward well people, not sick people.

Employers have also established many wellness programs, although evidence of success for traditional employer wellness or disease programs is slim, with low participation and poor results on costs. Still, many companies believe such programs can be tweaked for better success, by better integrating them into the employee experience or compensation.

Employers certainly have made employees very aware of the cost of risky lifestyle decisions *to their employer* as well as to those patients. However, actions so far have not arrested the ascent of health care costs. Like health plans, employers' tools are predominantly financial. In the future those could prove important, however. Providing better tools—such as technology for self-monitoring employee health—could play an extremely important role in employee engagement decisions and create a bridge to provider efforts. The willingness to finance employees' efforts to self-monitor blood pressure, glucose levels and other risk levels may indicate that employers can direct their financial assets to meaningful solutions.

What Providers Can Contribute to Reverse the Cost Trend

That brings us to providers. Health systems absolutely can influence *who is making medical decisions (physicians versus patients), and how those decisions are being made, amidst an outcome of at least some uncertainty*.

Many providers believe that they are in the business of making medical decisions, and this has certainly been true. But the paradigm of provider decision-making is fraught with issues of patient economics and reimbursement incentives that reward providers for treating those patients. This is part of what VBHC has aimed to correct, by exposing those weaknesses.

Provider decision-making also can have unintended results. The opioid epidemic is a chilling example of flaws in decision-making by physicians who not did not understand the consequences of their actions for their patients.

A better strategy for who makes medical decisions is gaining traction: help the patient decide, with physicians providing guidance and data.

“An outcome of at least some uncertainty” is the second key principle that patients and physicians must acknowledge. Without recognizing that medical science is still developing, and that the use of diagnostics, knowledge about the effects of treatment, and the impact on an individual presenting patient are still in flux, patients and physicians cannot make reasonable, economical medical decisions. The push to do more testing and more aggressive treatment is too often based on assumptions that are not always borne out by science. For

example, we can “overcontrol” medical indicators (HbA1c is an example) and push patients into dangerous situations by trying to do more. That discovery and others were made by examining patient results after over-zealous efforts to do well failed.

We are only just discovering new associations between risk factors and disease. Many theories we thought true in the past have been debunked. Even some standardized quality measures used in measuring provider performance, vetted thoroughly by medical experts and specialty committees, may soon prove to be outdated, if not inappropriate, as we learn more about factors in diabetes, the effects of hypertension, and the interplay of seemingly irrelevant risk factors, such as sleep.

In the face of this scientific flux as well as an overwhelming information overload, it is appropriate to expect physicians and their provider systems to create new, cost-effective medical decision frameworks. Too idealistic? Perhaps, but here’s why they should: Taking back the medical profession from financiers will depend on provider action to reduce spending on technology and prescription drugs, and to get better results from and with their patients.

Three Steps Providers Can Take Now to Pave Way for Better Medical Decision-Making

Moving from theory to solutions requires time and a concerted, detailed effort. But there are immediate actions providers can take that will build the foundation for a cost-effective decision framework. All stakeholders in the system have bet on the patient’s ability to make better decisions. While payers have tackled this with financial tools, providers can play a more consequential role in the actual decision-making setting.

For providers to take charge of generating the solution to constrain costs, physicians and provider systems should utilize clinical and educational tools in their core competency. This means providing data and information to patients that enable them to make better medical decisions. The idea is to help patients make decisions that are not only in their own best interest, but also more cost-effective for the health care system.

1. Open avenues for patients to access data—their own as well as information sources for medical decision-making.

Providing a patient portal to the provider's data is a start, but it doesn't go far enough. Patients need easy access to their full records and images, with less bureaucratic entanglement, at no cost, enabling them to validate their diagnoses and treatment plans. And providers should encourage this. Patient loyalty cannot be mandated; generating information to patients is the best way to ensure that they will continue their relationship.

Creating avenues to other information sources about conditions and treatment alternatives requires health systems to compile that content (or purchase from outside entities). Some health systems have created an information bank and become trusted entities for patients as a result (e.g. Mayo Clinic). Unless patients can access this information, they cannot engage in results.

2. Facilitate patient education by all providers.

Not all interactions between physicians and patients involve medical decisions, but all involve patient education. Provider systems need to encourage methods of educating the patient, whether or not there is a formal medical decision or sequence of decisions to be made. A few possibilities:

Train physicians to cultivate motivational and persuasive conversational skills to distribute information;
Compile educational information for patients on their conditions and generalized issues, as appropriate;
Improve patient numeracy and literacy regarding medical results. Whether offsite, online or in distributed patient material, provider systems can incorporate methods to improve patient understanding of health care terms, how to distinguish symptoms and diagnoses, how to convey issues to physicians, and how to interpret lab and research results—enabling them to participate with confidence and ask relevant questions.

3. Analyze and continue to track longitudinal data to evaluate current state of medical decision-making, and evaluate both provider and patient attitudes about the decision process.

Current performance measurement does nothing to evaluate how medical decisions have been made, particularly with regard to cost. Primarily, these performance measures have focused on process and very limited patient results, and are used for external reporting of quality rather than to fuel improvement.

Instead, we need a constructive analysis of patterns of care, of longitudinal patient outcomes, and tracking of cost measures. This is not natural territory for provider systems, which will most likely need outside expertise and/or technology.

Health care systems have been worn down over the years by a system of control and external regulations to manage costs. That system may have slightly modified the rate of growth, but has been unable to significantly slow the escalation over time or improve outcomes for all patients. To avoid being sidelined in a market that will see growth of entrepreneurial mergers and freestanding clinics as a viable alternative to provider systems, providers must demonstrate that they can steward patient care while providing a system that is responsible both to patients and other care purchasers.

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The Crux of Shared Decision-Making: Who Is Actually Deciding?

written by Theresa Hush | February 1, 2018

Shared Decision-Making is an emotionally charged topic for both

physicians and patients. Physicians believe they have their patients' best interests at heart by guiding them into better health through therapies to improve their conditions. Physicians may believe, in fact, that by explaining health status and treatment alternatives (followed by asking the patient to decide), they are already using a Shared Decision-Making process. Patients, in turn, are facing a higher share of costs, yet an ever-worsening health status that requires improvement to avoid financial disaster.

Imagine a typical physician-patient discussion about an important medical decision or the path for improving outcomes for serious, chronic co-morbidities. Sitting together in the exam room, the physician carefully describes the patient's clinical issues, provides treatment alternatives she believes are appropriate, and asks the patient to make a choice among therapies. Is that not a Shared Decision-Making process?

No, and here is why. First, the physician never questions the patient on his goals or tolerance limits, support system or preferences. Therefore, any decision is totally based on the physician's estimation of the patient's situation.

The physician also assumes that the patient can be persuaded by her guidance and experience. The physician, in fact, has structured the patient decision process to suggest therapies she believes to be most efficacious and has not provided data for the patient to weigh benefit and harm (including cost). Unless the process includes the data necessary for the patient to make an informed purchasing and/or lifestyle decision about the potential value and harm of treatments, the patient is not making the decision. The choice is being made by the physician.

Every medical decision involves biases, previous knowledge, and sets of beliefs for both physician and the patient. The Shared Decision-Making challenge is for physician and patient to collaboratively review actual facts, share preferences, and then for the patient to reach a decision.

Six Shared Decision-Making Essentials

Shared Decision-Making is not simply a conversation about alternatives. Rather, SDM is characterized by a more formal process of reviewing data, information, and the patient's own circumstances. The discussion is characterized by detail, research, full explanations, and taking the necessary time to ensure that the patient has all criteria needed to make an informed decision. Here are six elements to include in that review:

1. Quantified patient status and risk. The patient needs, first of all, to understand his or her health status or risk, as expressed in data such as life expectancy or morbidity, likelihood of disease progression, or other possible outcomes relevant to the decision (e.g. fracture risk, heart attack or stroke risk, progression of diabetes). The consequences of doing nothing as well as alternatives should be addressed. Understandably, the ability to provide patients accurate data is limited both by availability as well as the complexity of the patient's conditions. However, an effort must be made to quantify the decisions for the patient and to explain the risks in factual and not emotional language.

2. Decision alternatives grounded in pertinent research data. "Bigger risk" is not a meaningful term for patients to make decisions. Nor are studies that may not be relevant to the

patient’s age, condition or gender. Information and data must be as unbiased as possible; the patient needs to know the limitations of medical science or the state of knowledge.

3. All alternatives, including those not within the physician’s repertoire. Surgeons who do not present other surgical approaches versus their own techniques do not provide full information to the patient, nor do physicians who present a more limited array of familiar or preferred medicines. The patient should be encouraged to explore information on his or her own.

4. Numerical benefits and harms associated with treatment options. Clear understanding of the benefits and harms associated with any treatment plan is essential for the patient to make an informed choice. This is an area, however, where advances in knowledge may change the actual analysis of benefit and harm; the data must be provided with this understanding.

5. Patient barriers and obstacles. A plan that is patient-centric must take into account the patient’s personal limitations, such as availability of home support for the treatment, ability to take medications as directed, time and affordability.

6. Opportunity to investigate options and make a decision—not necessarily now. Unless circumstances are time-critical, the physician should offer an avenue for further communications with the patient and a mutually agreed-upon time-line for his or her decision. As part of this process, the patient should have access to full medical records, including images and testing results, for review with other providers.

Physicians may respond to this list with a combination of horror and exhaustion. This reaction is justified. They know that they lack the infrastructure, time, information and technique to implement SDM. They will fear another layering of documentation and activities without resources.

The purpose of itemizing these essentials is to underscore the details required to revolutionize medical decision-making so that the patient takes charge. It doesn't mean that the physician has to do it alone. Accomplishing SDM goes way beyond physicians. It requires health systems and physician organizations to train, compile data, and remove obstacles that impede physicians from budgeting the time they need to work with patients, and to provide the tools for physicians to deliver information.

Why go to all that trouble and expense? Because this is the avenue to patient loyalty and to managing cost and quality under financial risk, which looms on the horizon.

Medical Science Is Imperfect

The goal of SDM is to rebuild the process and information involved in medical decision-making so that alternatives can be examined without physician bias.

Patients will often say "I'm not clinical" when they feel uncomfortable challenging a physician's treatment recommendations. I am suggesting that a benefit of rebalancing the roles of physician and patient in decision-making is acknowledging that there is not always a truth or a cure to disease, and that medical science is always in a state of growth. Decisions made by a physician are not "better" than

decisions made by a patient.

Medical science is changing. Headlines about new studies reverse the basic "knowledge" that patients—and physicians—held to be true about disease causes and associated factors in progression. Some research findings are false or premature while others reflect careful study and further science. Unfortunately, even physicians aren't always able to determine which is which, because they don't read the research—or may be too busy to put it into practice.

Savvy patients recognize that much discounted medical information still occupies a prominent position in physicians' advice. They don't know whether to trust the doctor or what they read. Those patients who want the real data do not have access to it independently because medical journal access is restricted to those who pay.

Helping the Patient be the Decision-Maker is Crucial—And Difficult

Physicians are trained to make decisions. Patients are not, overtly. Actually, however, patients often make decisions by avoiding recommendations that they don't believe or will not follow. Physician's decisions inevitably reflect their personalities, mindsets, assumptions and personal beliefs about what patients should do; patients are quick to sniff this out and react in ways that play out their own personal biases.

If the objective of SDM is to have the patient commit to a plan, the physician must be prepared to play the role of coach and facilitate the patient's decision. This will not be easy for either party, as each occupies a somewhat reversed,

unfamiliar role. The physician's primary role is to provide information in an understandable way to the patient, and the patient's role—not the physician's—is to make the final decision.

Emotionally and professionally taxing, SDM requires that physicians set aside some of their past training to take charge. They may not feel confident of the patient's willingness or ability to take over the lead. Patients, used to being told what to do, may feel insecure and afraid. Projects in Shared Decision-Making should be implemented in a way that will help physicians as well as patients achieve success. Defining the clinical areas that can benefit the most, and selecting patients who will be good candidates, are important considerations.

Physicians must also have the support to provide research-based data and decision-making tools to their patients. We cannot expect patients to make major, permanent medical decisions on the basis of verbal advice, without talking to their personal support team—or without seeking other opinions. The health system should establish tools for making that support available to both physicians and patients.

Shared Decision-Making alters the entire relationship and flow of factual information used in medical decision-making. Undertaking such an endeavor exceeds the bandwidth of almost all practices, and requires the development of tools for practices to deploy, as well as the development of motivational expertise for physicians. Without these capabilities, both the patient and physician will be thwarted.

SDM is a Process of Change, Not a One-Time Fix

Shared Decision-Making is not a one-time fix for health care outcomes. It assumes a learning process to work through various conditions, physician groups and patients. Creating the tools and gathering needed information will be iterative and imperfect.

How to determine if SDM is working? Ask both patients and physicians. Since they are collaborating in constructing a path toward the patient's better health, the patient should have a voice in evaluating how the process is working. The physician should be looking at individual and aggregate outcome data to determine the effect (or not), for process adjustment.

Like any partnership, SDM necessitates work by both parties to improve the patient's health. Examination of outcomes as well as patient attitudes over time are both critical measurements for physicians and health systems. The need for providers to engineer communication and information cannot be overstated; if SDM fails, it will likely fail because physicians are not properly supported through access to necessary information, productivity plans have not been adjusted to take pressure off physician time in SDM, or physicians have not received training to undertake complex educational roles.

Shared Decision-Making will not fail because patients make decisions.

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Is Shared Decision-Making the Path to Improved Provider Performance?

written by Theresa Hush | February 1, 2018

As an escalating percentage of Americans (including children) are diagnosed with diabetes and hypertension, the health care system is straining to control costs and demonstrate good clinical outcomes. No surprise that providers blame patients for lack of compliance with therapies or lifestyle changes that will improve their health status. Hence the uptick—some say warranted—in incentives or penalties assessed by insurers or employers on patients who don't "behave."

But this punitive finger pointing is neither equitable nor productive. Just as it's unfair to hold physicians, alone, to be fully accountable for patient outcomes in quality reporting and cost, without giving them enough support for helping patients to improve, it's equally unfair to blame patients for their unwillingness to do what they are told without including them in medical decision-making.

Patient Engagement is Code for Compliance

Patient engagement is the new catchphrase in health care, and businesses with patient portals or engagement systems are attracting investment. But in reality, patient engagement is too often interpreted by providers and insurers to mean compliance. In other words, patients should follow physician orders. Cost, inconvenience, contrary patient belief systems, and the patient's inability to execute the orders are often irrelevant for typical patient engagement initiatives. Patients have no agency in decision-making because the only, correct path is presumed to be agreement with physician orders.

Like provider quality scoring, patient engagement systems presuppose that reinforcing the message to patients about what they should do will make them do it. There is a heavy emphasis on performance documentation (by the patient), higher touch or messages to keep the health issue or desired therapy front and center, and an avenue for the patients to check in with results. While this approach may prove supportive for the patient who is following a particular regimen—for example, recovering from a joint replacement—the system's effectiveness for chronic disease management and lifestyle changes is questionable. Why? Because the patient who "must comply" is rarely involved in a continual process of commitment or decision-making.

Shared Decision-Making Involves Maximum Patient Engagement in Medical Decisions

Shared Decision-Making (SDM) alters the dynamic of the medical decision process as well as the roles of physician and patient. In SDM, the physician is no longer describing the plan to the

patient but, rather, providing detailed information and alternatives. In SDM, the physician offers expert guidance and defines benefits and harms of each alternative. But it is up to the *patient* to choose. That key distinction can be unsettling to the culture of most physician practices and difficult to engineer in practice.

The difficulties of health care culture change may well be outweighed by the major benefit of SDM: it increases the possibility that patients will commit to an approach. If patients have the necessary information and decide on a plan, they are more likely to be committed to achieving their goals and making progress towards a good outcome.

SDM may also help practices to avoid wasting resources on following after patients who have not, for a variety of reasons, made a commitment to a plan or to improvement, in general. Shared Decision-Making appeals to patients who choose to affect their own care.

This merits scrutiny. SDM may also favor patients who have the ability to pay for interventions, or those with a support system to help them reach their goals. As SDM processes become more widely accepted in health care, providers must make substantial efforts to capture what lies behind the choices made by patients, and to carefully research and address potential biases in the system that reward educated or affluent patients, alone.

Why Shared Decision-Making Should Be Part of Performance Improvement Strategy

There are several reasons to make SDM part of the health system's Performance Improvement strategy:

Increases potential for better patient outcomes. Making Shared Decision-Making a central feature of activities to improve outcomes rests on expectations that the patient's commitment to a path of treatment will lead to real improvement. Since patient engagement has been the Achilles' heel of most efforts to improve patient outcomes, SDM (properly implemented) addresses the core issues of commitment: respecting patient preferences and overcoming barriers to treatment alternatives.

Generates patient loyalty to the physician and health system. Just as the patient is engaged in a positive partnership with the physician, SDM also has the potential to create a bond with the physician and the health system that could have farther-reaching effects, such as loyalty to the provider and the health system, and willingness to trust other physicians and programs within the health system. This is a significant benefit for organizations anticipating the future of financial risk models, including ACOs and Medicare Advantage plans.

Creates opportunities to engage providers in designing the performance improvement process. For providers left out of traditional performance improvement initiatives, an SDM process that engages them in problem solving interventions to improve patient outcomes can be rewarding, especially for physicians who have become demoralized by more common performance scoring systems. SDM is a chance to reengage

physicians in the art as well as the science of medicine.

Caution: SDM Will Require Action on Exposed Vulnerabilities in Policies and Operations

Shared Decision-Making recognizes the current trend of consumers/patients who want more information and control over their health, health care services and health care financial decisions. These three areas are intertwined in the SDM process. SDM will push providers to offer realistic cost information relative to treatment alternatives, to recognize and address other customer service needs and, most significantly, to support practices with both patient tools and support for physicians' role in coaching patients.

It is naïve, however, to assume that one choice or set of choices by the patient will accomplish a change in outcomes. While SDM can winnow out patients who are willing to set goals and work toward good health, their commitment to those choices must be continuously renewed each day and across months and years. SDM must be an ongoing process, especially when the outcome change is experienced over years, as in chronic disease. Like any long-term goal, the cumulative effect on outcomes is what makes the difference.

SDM is also a remarkably different process for patients with chronic disease or long-term conditions, such as diabetes and cardiac issues, versus those facing decisions that are more specialized and short term, such as how to treat cancer. The complexity of SDM tools—as well as the effectiveness of interventions—will necessitate substantially more investment for patients with chronic conditions. Implementation of SDM in performance improvement strategies will require staging,

testing and gradual layering of technology and tools to determine successful patient groups, implementation styles and support needs.

Nine Steps to Improve Health System Performance Via Shared Decision-Making

1. Identify key target areas for clinical and cost improvements. Select your targets to achieve positive strategic or marketing goals, such as increasing market presence or highlighting excellence in a clinical area, or, defensively, to address known clinical or cost issues. Focus on one area to start SDM, as a pilot, because even one condition will require activities across the board to address project needs, and these will form a foundation for future SDM projects.

2. Establish your data/technology system or partner for SDM. In Shared Decision-Making, you'll need to carry out a number of discrete project activities in order to determine whether or not your investment in this exercise is proving its value. The health system's EMR probably won't be able to perform all of the SDM functions involved, so performance improvement (PI) technology will be required to track project management and measurement, and the EMR must be prepared with templates to trigger physician activity and gather data for submission to the PI system. For example, you may need to address how to:

- Analyze data to identify patients by condition, age and other criteria, such as risk or progress of disease;
- Load that patient listing into technology to track the project;
- Determine how those patients will receive outreach and/or invitations to participate in the process, and ensure that

the technology can track this;
Decide the scope of alternatives or interventions that will be provided generally to the patients, and what information needs will come from that list, and create the functionality for the data capture and performance testing of these alternatives;
Document activities such as first and subsequent SDM conversations between physician and patient, as well as patient preferences, through data capture tools;
Test the understanding of patients and physicians for the process, by gathering feedback from both groups, which will also likely be electronic;
Measure project performance;
Create a mechanism for patient-physician interactions during the ensuing process.

3. Establish a Shared Decision-Making Project Plan with the involvement of physicians, especially those participating in the initial pilots.

4. Educate physicians about the process, communication styles, and goals of Shared Decision-Making. Since physicians are used to making decisions and some may have strong belief systems about the appropriate path for patients, it may be hard for them to accept what can be perceived as a more “passive” role in the decision-making process. It will take time and multiple sessions to achieve a balanced process of decision-making; avoid short-cuts.

5. Ensure that your physician practices have the support they need for SDM. If the practice is totally paperless, patients will still need hard evidence of decision criteria on paper.

This will require adjustments in workflow. In addition, patients will need to be prepared for the SDM process; non-physician staff will likely be involved. The time required for SDM may tax productivity and thus must be evaluated in the context of other pressures on physicians to “produce.”

6. Prepare patient decision tools for physicians, with their involvement. Of all support needs for physicians, this is most critical. The foundation of Shared Decision-Making is the clear explanation of benefits and harms associated with various alternatives (or no action) for the patient. Defining the effectiveness (and cost) of different medications or other therapies, the risks associated with doing nothing and with each alternative, and the percentage of patients who are benefited (and by how much) are the heart of process. Discussions should include numeric values on benefits and harms derived from research, which should also be presented with information on the known limitations of such research. Since the success of SDM will depend on how well the patient understands this information, these tools will require a lengthy process of development and testing.

7. Measure physician and patient understanding of SDM before, during and after the project begins. These measurements will be associated with actual outcome values over time.

8. Evaluate outcomes over time, not for one-off instances, with a focus on improvement rather than absolute values. This differs from all quality reporting schemes that tend to focus on one value per year and do not include outcome trends. It is also essential to evaluate individual patient outcomes over time, not just aggregate performance, in order to reveal data

issues that may be affecting aggregate performance measurement and improvement.

9. Elicit satisfaction information about the SDM process from participants. This should also be compared with outcome results to see if attitudes affect behavior of either physician or patient, or both.

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Image Credit: Jakob Owens

For Tough Medical Decisions, Hard Choices Require Hard Facts—Not Conventional “Wisdom”

written by Robert McNutt, M.D. | February 1, 2018

What matters in medical decisions is what we *know*, not what we *think*.

In the late 1980's I cared for a pregnant woman with breast cancer. Breast cancer is the most common form of cancer in pregnancy, but uncommon in frequency, occurring in about 1 in 3,000 pregnant women. Providing and receiving treatment is certainly a complex emotional experience; at that time, uncertainty about how to treat was the norm. The woman had a mastectomy but did not take chemotherapy based on concern for her baby.

Three months after her delivery, now receiving chemotherapy for her aggressive breast cancer, the woman asked me to consider treating her newborn child with "mild" chemotherapy—a contrarian idea, given her reluctance to expose her child while in utero. Her reasoning, she said, after giving it "lots" of

thought, was that it made sense to her; she had cancer at a young age and reasoned her child would, also. In her mind it was rational and reasonable to give her infant treatment.

Fear and depression clearly fueled her concern. The woman would not live to see her child's second birthday and wanted to do what she could. But there was no evidence of benefit to the baby, making her request irrational. So, I did not comply. Indeed, what would you have thought of me if I had?

Proof of Treatment Benefit Is Essential Before Treating

In 1882, a surgeon reasoned that removing a woman's cancerous breast, nodes and muscles was the way to eradicate her breast cancer. There was no proof of benefit, but the idea spurred action. That idea and the radical surgery persisted as the treatment of choice, even after the publication of a randomized trial (NSAPB-04) in 1974 showing that more surgery was not better than less; about 5,000 radical mastectomies were still performed in 1983, a century after the first. What should we think of physicians who acted without proof of benefit and, even, after proof of no benefit?

In the 1990's more than 40,000 women received high-dose chemotherapy and bone marrow transplants if they had breast cancer. Some of those women died of treatment; I know so because I knew a few who suffered that fate. But conventional "wisdom" prevailed. Doing more and more to a woman with breast cancer was the default treatment philosophy, compelled by politics and legal threats for not performing the "best," and most—despite eventual publication of randomized trials showing that more and more was actually less. All this wrangling

occurred without knowing if the treatment plan was better than others. What should we think of those physicians, lawyers and insurers who forced compliance and then complied with an idea rather than knowing what was best?

There is data on bilateral mastectomy for Ductal Carcinoma in Situ (DCIS), but no information, as comparative studies with unilateral mastectomy have not been done. I was consulted by several women who were considering complying with the bilateral procedure based on the idea that getting rid of everything might be good for them. Their physicians had proposed the procedure.

What should we think of these physicians for proposing an unproven procedure based on an idea? Acting without knowing, in my view, should be considered an abdication of professional responsibility. A professional obligation includes informing patients that there is *no evidence of benefit* for some treatment plans, and then not proposing the plan.

Medical Decisions Must Be Based on Sound Research Comparing Treatment Outcomes

The only way a decision can or should occur is if there is a balance between compared options. These compared options must be examined in randomized studies that give the best chance of determining the independent contribution of one intervention versus another. Ideally, the balance between treatment outcomes and complications will become clear: some treatment will be shown to contribute independently to better disease-related outcomes that outweigh any treatment-related complications. The differences in outcomes of disease and treatment compete for a patient’s attention and ultimate choice.

Without such comparisons, no choice should be made. Ideas don't suffice; it doesn't matter whether the ideas are the physician's or the patient's.

How many hundreds of thousands of women underwent radical mastectomy before it took only 1,700 in a randomized trial to show that this treatment offered no benefit and increased harm? What about high dose chemotherapy and bone marrow transplant? Six randomized trials, reviewed in 2005, including a cumulative total of 850 women, showed high-dose treatment offered no significant benefit. Nonetheless, studies kept trying to prove the value until, finally, 14 randomized trials involving 5,600 women came to the same conclusion. Far more women underwent the procedure, not knowing what was best, than the actual number required to find out what truly isn't best. This should be a lesson to us all. Knowing is better than not knowing, and acting without knowing may be the worst a profession can do.

Physicians Should Not Allow Treatments of Unproven Benefit

I am writing this blog with a purpose: to make physicians and patients uncomfortable about acting on beliefs without evidence from comparative research trials. I believe patients are the best decision makers, but that will be demonstrably true only if they are informed and allowed to decide.

Physicians need to be on board, as well. They should not allow treatments of unproven benefit and, instead, they should demand study over action. There are too many examples of the failure of "good ideas" to subsequently help patients. What matters is what we *know*, not what we *think*. Informing patients that no evidence exists while promoting a dutiful process of scientific

inquiry could be a powerful way to change medical care for the better.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Mike Wilson

Convention Lesson: MIPS Improvement Activities Are Woefully Misunderstood

written by Dave Halpert | February 1, 2018

With only a month left of 2017, practices should be wrapping up their Improvement Activities. MIPS requires at least 90 consecutive days of participation in order for a group or clinician to attest that an Improvement Activity is complete—meaning that the last day to start was October 2. The Improvement Activity portion of MIPS is the only component that is not a direct descendant of a previous program, increasing the challenge of implementation.

Recently, we attended a national conference for those in healthcare practice and administration; one of our goals was to learn more about how practices were adapting to this new requirement. We had the right audience at the right time, shortly after the October 2 start deadline. Everybody should have something to share, we thought. As the convention hall cleared, however, we knew we'd learned something valuable, but not what we had expected:

Improvement Activities are still not understood and, therefore, neither is MIPS—a stunning finding that underscores the need for more and better education and strategic planning.

In advance of the convention, we created a short (10 question) survey for attendees to complete at our exhibit booth. We offered a nominal gift card as an enticement and were able to persuade about 30 attendees to complete the survey. Loyal readers will recognize the value of small group samples. While not enough for a scientific survey, a sample can help spot potential trends and inform strategic planning in advance of a full roll-out.

The shift to performance improvement is not easy, but it's an essential step for all providers to take in order to prosper under Value-Based Health Care. MIPS Improvement Activities provide a means to begin that transition—with a significant scoring incentive. Our survey uncovered some common misunderstandings and gaps in knowledge; those themes inform these five lessons for implementing successful Improvement Activities now and in the future:

Lesson 1: Understand the Relationship between Improvement Activities and MIPS

Upon compiling responses to the first survey question, we were startled to learn that fewer than a third of respondents recognized the term "Improvement Activity" as it relates to MIPS, even with verbal prompting. When asked to summarize the MIPS Improvement Activity in one sentence, the majority offered a surprising number of professional titles, corporate missions, "working on MIPS projects" and one very disheartening "revenue enhancement."

Improvement Activities are one of four components of MIPS, of which only three are scored. Those who neglect Improvement Activities are ceding at least 15 percent of their MIPS composite score. Why “at least?” Because when used strategically, Improvement Activities can pay dividends in other components of MIPS, improving outcomes (and therefore, responses) in quality measures, and decreasing costs. Even more importantly, Improvement Activities can lead to better care for your patients.

Lesson 2: Establish a Goal, and Work Toward It

We were also surprised that only half of those who could summarize their Improvement Activity could also describe their goal and the actions taken to achieve it. Fewer, still, could identify how the goal would be measured. In other words, they knew what they wanted to address, but had not established a plan for getting there or how to prove it. This problem was perfectly characterized in one response, where the method for achieving the goal was to “look at quality improvement.” Without defining a goal, establishing a plan for reaching that goal, and measuring whether that plan led to the desired results, improvement is unlikely to occur and impossible to demonstrate.

It may seem daunting to set a goal before knowing whether it’s feasible, but this is where a comprehensive (but flexible) Qualified Clinical Data Registry (QCDR) can help. By testing initiatives with small patient samples, you can preview results and adjust processes as issues surface—and do so before you roll out the program to everyone.

Lesson 3: Ensure Everyone Understands Their Role—and the Goal

Some of our respondents came from the same practices. In theory, as long as they were writing about the same activity, each should provide similar answers, right? Surprisingly, no. Not only was the concept of Improvement Activities misunderstood, but also the responses highlighted a lack of internal communication among players. One individual indicated that their group was not reporting data to any outside entity, but her colleague stated that the group was reporting to two. In another instance, two individuals rated their group's success differently, even though they both indicated that their practice was focusing on surgical procedures.

If different people within the same practice can neither describe the goal nor their responsibility in achieving that goal, there's no momentum, and the program will grind to a halt. Certain programs, including the Patient-Centered Medical Home model, require that the whole practice understands the goal and their roles. This is not an off-hand comparison—those in accredited PCMHs earn full points in the Improvement Activity category. Clear communication about goals, roles and strategies is essential to achieving real improvement..

Lesson 4: Measure Success Using Quantified Results

On a scale of 1 to 4, with "1" being "Not Successful" and "4" being "Very Successful," nearly all respondents picked "2" when asked to rate their Improvement Activity efforts. Regardless of whether the respondent could describe an Improvement Activity or responded "in general" to their practice's ability to

improve, the vast majority believed their efforts to be on the wrong side of the curve. No one answered with a “1” and only one respondent selected “4.”

Why such overrepresentation of the minor negative response or the nearly complete absence of an extreme positive or negative? Look at the previous lessons, and it becomes clear: without a defined goal, an understanding of how to reach it, and a clear sense of responsibility for doing so, no one is certain of the answer. Think back to school—if you didn’t want to be called on, how would you react to your teacher’s question? Would you make eye contact with the teacher, or stare intently at your desk?

To answer with confidence—meaning that you have a defined program in place, with a specific a goal, and you can confirm whether it’s been met—you need concrete results. A QCDR designed to track outcomes (clinical, costs, satisfaction and more) over time gives you this ability. Whether the results are positive, negative or neutral, being able to contextualize those results will illuminate the next step on the path to reaching your goal.

Lesson 5: Let Your Interests (and Needs) Guide Your Selections

The most encouraging responses to the survey came at the end, where respondents were asked to select from a set of broad topics of future interest for Improvement Activities (e.g. improving clinical outcomes, retaining patients, etc.). With a few exceptions (one person—yes, the same whose goal was “resource enhancement”—wrote in “none of the above”), respondents indicated interest in at least one of these

categories:

- Improving clinical outcomes (selected by two-thirds of the sample);
- Reducing costs for certain episodes of care;
- Identifying high risk patients;
- Retaining patients;
- Improving communication between patients and providers.

There is an inherent desire to improve. I daresay that one of the reasons most of us entered this field, either as clinicians or to support high quality care in other ways, is to ensure that patients receive the best care. Inevitably, some of us will become patients, as will our families and friends; improved outcomes and increased efficiency will benefit each of us, too.

Identifying opportunities for improvement is the first step. Using tools that CMS and other health plans have provided, including Quality and Resource Use Reports (QRURs) and Episodic Cost Field Test Reports, can help you isolate those areas. In the same way that a test question that everyone answers correctly is not useful, neither is an Improvement Activity that doesn't target a meaningful area.

Yes, we are passed the October 2 deadline to begin, but in this transition year of MIPS, starting now can still make a difference for next year—and also for your patients.

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Image Credit: Ryan McGuire

Choose the Right Strategies and Technology to Improve Cost Performance in Health Care

written by Theresa Hush | February 1, 2018

Fee for Service (FFS) reimbursement is going the way of the dinosaurs, but many providers are ignoring the signals. Here are two clear indicators: Medicare's adoption of episodic cost models and the planned movement to financial risk models for both Medicare and Medicaid. Indeed, most Medicaid plans have now transitioned the majority of beneficiaries into managed care plans.

Private health plans, many of which were burned by capitated HMO plans in years past, are aligning with providers to develop ACOs and moving again toward risk. Recent health care mergers and acquisitions evidence a blurring of lines between health plans and health care organizations. Health care system consolidations continue to be a major trend, resulting in larger systems with employed physician practices. Additionally, we're seeing a spike in vertical acquisitions, such as the purchase of Advisory Board's Healthcare operations by

UnitedHealth Group's subsidiary Optum, and PinnacleHealth's purchase of University of Pittsburgh Medical Center and other hospitals in Pennsylvania.

Despite these trends, most providers lag in adopting tools to measure and improve cost performance. Unwillingness to give up volume-based revenues in the short term and lack of cost data are two key factors. But equally important is the lack of experience and technology to focus on measurement and improvement of cost performance.

So, What Is Cost "Performance?"

Perhaps one reason that the industry has been so sluggish in curtailing health care costs is the lack of a good definition for "cost performance." At best, health plans and government have characterized acceptable cost performance by either what is missing (negative) or what others are doing (comparisons). "Acceptable" in that case means that there is no penalty associated with the cost, and there may be an incentive. Examples of unacceptable cost performance include:

- Cost per patient or per episode higher than other providers;
- Unnecessary admissions;
- Readmissions;
- Emergency room use, or ambulatory-sensitive inpatient stays.

Without a target and tactics to get to performance, providers tend to back into piecemeal cost initiatives that affect reimbursements now, such as reduction in readmissions, and use those as a proxy for comprehensive cost performance. This is a tactical mistake. At a minimum, during the time period when FFS continues to exist, providers should create and quantify their

goals, covering at least these areas:

- Per-patient costs according to conditions and procedures by patient risk level, inclusive of all settings of services;
- Episodic costs for high volume procedures and inpatient medical stays.

Providers should calculate their vulnerabilities in the cost arena as part of cost performance strategy development. This starts with quality and outcomes. The lack of a comprehensive quality and outcomes performance measurement process—and a quality "reporting" initiative is not a substitute—has a direct link to cost performance.

Problematic medical decision-making processes—including failure to have protocols for the use of certain prescriptions, imaging, tests and treatments—will result in higher costs. Therefore, the first action for cost performance is to measure performance in quality and patient outcomes, adjusting for patient risk, and capturing the trend in patient outcomes and improvement.

In addition to the data that falls out of quality measurement, providers should focus on cost-specific areas:

- Collect and analyze cost data that is available from health plans and Medicare/Medicaid—and deploy a contract negotiation strategy with health plans that ensures the availability of such data;
- Compute in-network services by primary/referred specialists, and determine how much care is being rendered outside of the health system boundaries;

Zero in on one the largest component of rising costs: imaging technology. Identify patients with multiple imaging or stepped up/down imaging to see patterns of care that may create unnecessary costs;
Examine prescription drugs and costs to target use of brand name versus generics, or higher cost drugs that should have a protocol for use;
Evaluate pricing and service strategies for imbalance in the costing of services. For example, Medicare data often shows that costs of outpatient services are higher than norms; this could result from pricing, inclusion of standing orders, or a higher risk population. Calculating this is key to finding the correct solution.

Invest in Technology for Cost Performance

Improvement in both quality and cost is an iterative process; the interventions for cost improvement are rarely clear cut, because the reasons are not known, and the solutions must be tied to the patient's protocol. Improving performance should be a process with an objective of identifying interventions that are or could be effective, measuring results along the way.

Health care systems are not always nimble users of their own systems. Expertise with both data and data analyses is uneven on the provider side, and the requirements will surpass the experience of most provider systems. The best solutions will be clinical data registries or other technology companies that offer both measurement and improvement of long-term outcomes and cost trends. Companies that can provide consultation and project management are important. In addition, the most desirable technology should permit the management of multiple cost and quality projects, manage health data of variable

integrity, remap and identify missing elements, and have the ability to collect both provider and patient data.

Technology requirements span both purely technical infrastructure, as well as functionality and guidance:

General Requirements

- Integrated patient data from provider source systems as well as external sources, such as claims from health plans; the system should be patient-centric, showing patient results across all clinician and hospital visits;
- Capability of input or digital feedback from patients and providers;
- Risk adjustment of patients by at least one standard methodology;
- Patient visits include multiple diagnoses, patient attributes, clinical values (not proxy procedure codes);
- Provider source data sufficient in detail to include specialty and subspecialty, and business details of the group and provider, and all transaction and coverage data for patient;
- Views specifically for physicians;
- Capability for patient-provided outcome data;
- Analytics show measure results, trends, associations, effectiveness of interventions, variability in patients and provider comparisons.

Performance Measurement

- Inclusion of cost measures and custom cost measures;
- Cost measures able to distinguish primary and specialty physicians;

Ability to set care team, not just individual attributed physician, for custom projects;
Episodes of care bundles, especially those currently being field tested by CMS;
Ability to capture financial detail if provided;
Distinction of in-network and out-of-network services;
Analytics to show variation in care by patient, across types of patients, and by outcomes;
Trended outcomes as opposed to once-per-time-period outcomes.

Performance Improvement

Project functionality: ability to set population (and randomize patients if desired) by criteria, vet and exclude patients on basis of exclusion criteria, and establish project workflow;
Distinguish individual improvement projects;
Share data with physicians, including feedback;
Log and track interventions, like shared decision making or educational appointments;
Permit user to conduct activities for project, such as send out letters for patient outreach or log calls;
Allow use of survey and other data that is patient-identified;
Provide for pilot or tests of performance improvement projects.

Adopt Consumer-Friendly Approaches and Technologies That Go Beyond Cost Performance

Because the shift in cost sharing to consumers is one of the key trends driving the need to curtail costs, health care

systems also need to evaluate and redesign processes for consumers. Specifically, providers will need to adopt methods that will provide better service to consumers and safeguard them from unnecessary and excessive costs. These service changes can be tested as part of Cost Performance Improvement, so that consumer acceptance is specifically tested and evaluated.

These changes in routine operating procedures are the highest priority for providers:

- Validate coverage and manage pre-authorizations. Patients cannot be left with costs by provider failure to ensure coverage for all services. Cases of an out-of-network anaesthesiologist, uncovered facility charges or inappropriate diagnosis code that cause claims denial are inexcusable. Providers in the new environment should have a customer service strategy that spans both the financial and clinical spectrum of care.
- Coach patients and physicians on medical decision-making. Health care systems should help providers cultivate the expertise to inform patients of benefits and risks, and provide the numbers for patients to make decisions. This will include provision of medical research results to which patients currently have limited access, rarely discussed in provider circles. Improvement activities can be structured around high risk patients that are likely to generate more costs, with shared decision-making as a measured intervention.
- Move forward on providing price transparency to consumers. Consumers need predictability. Providers can structure episodes of care with pricing, using cost data.

Make medical records easier to access, including images. Patients frequently go through complicated processes and time to get their data, simply so that they can make decisions. Providers should be able to provide patients with standardized digital versions of chart history, images and transactions that the patients can use for second opinions.

Health care systems have grown from small hospitals into hospital-plus-physician enterprises, and from there into large networks. Consolidation has made bureaucracies harder to maneuver at a time when costs are rising. Health care providers that take care to assist patients are more likely to attract loyalty and also achieve better results in both outcomes and cost performance.

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