Real Patient Empowerment Depends on Real Performance Measurement

written by Theresa Hush | January 25, 2017

“Patient empowerment” is a new term to watch. It’s a banner for

some health care reform initiatives being proposed in lieu of the Affordable Care Act (ACA). In fact, "Empowering Patients First" is the title of legislation introduced by Congressman Tom Price (nominee for Secretary of the Department of Health & Human Services, which oversees Medicare and Medicaid) to replace the ACA.

Empowering patients can be very positive, if they have the appropriate tools to make the health care system work to improve their health status.

What Exactly Is Patient Empowerment?

But what does "patient empowerment" actually mean within the current political context? So far, it does not encompass what most consumers would expect to change the dynamic in health care: for example, better information or data, shared decision-making, patient ownership of their records or data, patient choice of their spectrum of services, or patient access. Nor does the term address specific incentives for patients to improve their health status, such as smoking cessation, exercise or other choices.

Rather, the political term "patient empowerment" refers to the financing of health care, especially the replacement of insurance with various tax-incentives that allow patients to fund their own health care expenses, such as Health Savings Accounts.

Why does this distinction matter to both providers and patients? It's a simple economic equation: Health care costs will continue to rise. Shifting responsibility for those costs to consumers will create more debt for both consumers and

providers. If health care reform is to make a positive difference, then patients need the right information to make good health care choices.

Information and Transparency Are Key to Patient Empowerment

Patients can only be empowered by new financing mechanisms if they also have two additional tools:

> Information about comparative provider costs and outcomes, and transparency in health care choices; and
> Information about the cost and efficacy of their care, treatments and individual risks.

Where does that information come from? Measuring the performance of health care services, outcomes and providers.

Only through the efforts of the past several years, beginning with Medicare's PQRS program, have we begun to see how far we need to go to achieve care consistent with standardized protocols. MACRA continues that program under expanded MIPS and APM programs as well as a direct path to public reporting of the data. Those programs, while not perfect, have been a critical element to at least standardizing the measurement process for acceptance by most providers.

Do More Now to Empower Patients

Much more needs to be done to ready initial efforts for consumer "empowerment." We will address some of the particulars in the weeks ahead, but the movement from simply reporting services to evaluating outcomes is the critical feature. And,

the transfer of this information from the provider realm to consumers is key. Providers who are concerned about aligning with their patients to create value should consider how to inform consumers in a way that truly engages patients in their care and reinforces their link with physicians:

> Providers should inform patients about their quality measures. This helps involve patients in the process, realize what matters to their physicians, and focus on whether they are achieving their best health outcomes.
> Providers must demystify their charges and costs so patients can decide care responsibly. This is especially problematic when hospitals (now owning the majority of physician practices) have separate facility-physician group payer contracts. Consumers do not know the price or cost, don't know if there is coverage of all costs, and cannot navigate the separate relationships between the health plans and providers to ascertain their coverage or costs.
> Providers should educate and assist their providers in shared decision-making initiatives that help patients understand benefits as well as harm, including the cost.

Manage Your Public Provider Credentials Before the Public Does It For You

As populist sentiment grows, pressure on providers will intensify. Why? Because, first, health care is a huge expense for consumers as well as employers. Second, there are rapidly developing networks of people trading information, and more data will become more readily available—and put to use—by entrepreneurial technology with social media arms. And, health care is at the center of the boiling national debate.

Consumers will become bolder. We can expect technologies that grade health care outcomes, costs and patient experiences by integrating data from many sources. And consumers, especially younger ones, will exchange that information and act.

Providers will have a tough time making sure that crowd-sourced performance measures that influence their volume are grounded in the current, clinically legitimate foundation, and agreed to by their peers. If providers curtail their efforts to inform consumers or fail to take any of the efforts above, they could well lose control of the measurement process itself to more grass-roots efforts.

The era of regulatory-managed health care is ending. The new one is “empowerment,” and that applies to providers as well as patients

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: Christopher Burns

Roji Health Intelligence: Chart Your Course for the New Phase in Health Care

written by Theresa Hush | January 25, 2017

With 2017 we are predicting some big changes in how the health care industry moves forward. Having worked with health care organizations for 15 years, we know that most of them are not ready. Roji Health Intelligence was not just a name change for ICLOPS, but a signal that we are ready to help.

Roji Health Intelligence Website Signals Evolution of Services

Our new website is up and ready. It is light-filled and inviting, for a good reason. We believe the path to change can be collaborative yet still focused on results and real data. We refute contentious and negative approaches to measuring health care performance, because they do not lead to improvement. Strength comes from building a common vision for change and executing it through hands-on processes. We help health care organizations succeed through that process.

Two Platforms for MACRA: All 4 Areas Covered by Roji Clinical Data Registry

You will also notice big changes in our Medicare Services. With the advent of Medicare Quality Payment Programs (QPPs) defined by MACRA final rules, the groundwork is now laid for a universal program that measures quality and cost for all patients and all services. That is a very good thing. Roji Health Intelligence is a Clinical Data Registry (CDR) that is Qualified by Medicare (QCDR) to perform higher level functions related to this purpose—measuring outcomes over time, improving performance, and acting as an auditor and reporter for quality and improvement activities.

Roji Health Intelligence will help organizations achieve the higher bar in MACRA and get on the path to Risk through our CDR Platform and its Solutions. While we continue our Registry Reporting options for organizations to achieve basic reporting and attestation, we hope that you will prepare yourselves for Risk by using the full range of Roji Practice Transformation and Performance Improvement that are enabled by the CDR.

Top Positioning for Health Plan Contracts Through Roji Health Intelligence Solutions

ICLOPS was originally founded to help health care organizations and their disparate physician groups contract as a single entity with health plans through a Clinical Integration process. When CMS began to lead changes in the industry by fostering ACOs and Value-Based Health Care, ICLOPS created a major line of business in Medicare.

We think it is likely that CMS policies will move toward Risk in the next few years, as planned, but probably with less policy development and regulations. Let's be honest: providers have performed many of the Medicare functions because they had to comply with regulations, and less for the clinical value. We see that trend shifting as Risk emerges as the financial payment model, and as commercial health plans take Medicare's place in the spotlight for change.

The new environment can be exciting and innovative. We respect the enormous amount of policy development that came out of Washington, but because it was regulatory, it created both positive and negative effects. It pushed the agenda forward, but the gains were uneven. This is an unsurprising response from providers who have never like being told what to do!

Get Ready, Get Set, Go for Risk

Past ACO models did not require Risk to be passed on to participants, and so no one really understood that the incentives should be different. Not so with the post-MACRA world—and certainly not so for the likely reemergence of Medicare Advantage as the key conduit to budget control of Medicare.

Providers planned their ACO around ideas of market share instead of efficiency, with the idea being to create a large net to capture patients. That won't work for Risk, because the ACO landscape includes specialists and high cost services, providers regardless of their practice patterns, and patients regardless of their risk factors and ways of getting care.

Network development in the future will require more analysis,

more discussion with providers, and much stronger collaboration for the entire network to move forward together. That takes data, analysis and grass roots changes in practices. Roji Health Intelligence Solutions guide that entire path from start to finish.

Join the Positive Path to Better Health

Visit our website, https://rojihealthintel.com, and find a more positive way to improve your performance in the future.

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Image Credit: Sarah Crutchfield

Can Health Care Stay the Course of Reform Amidst Uncertainty?

written by Theresa Hush | January 25, 2017

With the new year finally here, health care organizations need to know: How should you proceed amidst uncertainty about Medicare policy, including Value-Based and Risk programs

initiated by the Obama administration?

In the crosshairs are the new, complex Quality Payment Programs under MACRA, including both MIPS and Alternative Payment Models (APMs) such as ACOs. Although MACRA had bipartisan support in the 114th Congress, it was the Affordable Care Act (ACA) that created the foundation for ACOs and other Value-Based programs. As the new Congress hurtles toward ACA repeal, the landscape for all of health care is murkier than ever.

The significant "Pick your Pace" scale-back of MACRA MIPS requirements for 2017 also makes MACRA seem tenuous. Add to that comments by Tom Price, the appointee for Secretary of Health and Human Services, who expresses weak support for existing Medicare initiatives. As Congressional leadership and the incoming administration brandish promises of large scale shifts in Medicare, Medicaid and health care finance, all the cards are up in the air. We could be in for a real slowdown.

What Is Health Care Reality Amidst All This Commotion?

Moving forward—even with MIPS—requires an investment in technology and people. You need to know that there will be a reasonable, long-term return on that investment. Also, who wants to stir up the organization with changes to go forward into an uncertain future and use up your political capital without reason? Yes, you already did some of this with PQRS and Meaningful Use, but MACRA is bigger and requires much more of your organization.

Certainly, it's easy get wrapped up in the politics and the difficulties of moving forward. But it's time for a reality

check. There are a few facts that will dispel all fantasies about going on with the status quo, or ever (ever!) getting more money from either health plans or government. Dealing with these realities now will put you in a position to be ready for whatever specific models emerge in the months ahead:

> Health costs will continue to rise beyond the level of affordability for employers, government and consumers.
> The population is continuing to age, get more chronic diseases and become higher risk. And potentially not all these people will have the insurance coverage they have now.
> Medicare and Medicaid will run out of money at some point without reform, and if health care costs are higher, it will happen sooner.
> The actions available to employers, health plans and government to stem costs are limited. They essentially boil down to either capping payments for providers or for consumers; likely, both. Even Value-Based Health Care is a temporary strategy on the way to imposing this financial risk.

Along with these issues, there is also a cultural change that is becoming more evident and will contribute to the economics. The disassociation of consumers from traditional institutions, including medicine, has been supported by continual changes in networks by health plans and providers themselves. What this means is that you can't count on your patient base to be loyal. Patients will be using criteria, including cost of care, to determine their choices.

What to Do Instead of Waiting for Definitive Policy Reform

This is the reality. How much time is there to get your health care organization in sync? You won't have enough time to meet the future if you are starting from scratch. If you have only done compliance-focused PQRS and Meaningful Use reporting, you are pretty much at the start line.

But in this uncertain climate, there is also the opportunity to think differently and creatively about how you will succeed in the years ahead. What will really work to improve the value of health care and to stem the costs? Perhaps the regulatory approach up to now has stymied creative thinking and pushed us into compliance mode. If so, you can jumpstart your plan of action by pursuing three meaningful tactics:

1. Invest in measuring performance and outcomes, both quality and cost.

Performance measurement is no longer a regulatory or compliance process. It's now a strategic exercise. If you used a sample-based CMS interface for PQRS reporting, or if you used EHR direct reporting, you probably don't have the long view of performance. The key is not absolute values or "scores," but what is happening to your patients over time. To improve your organization, your measurement should help you diagnose where outcomes are stagnant and where costs are hiding. These will clarify your strategy and tactics for improvement.

> Are your costs out of line because of a misalignment in your physician network, such as not enough primary care?
> Are costs out of line with others when evaluated by

episodes?
Have you analyzed your outcomes across time to see whether they are improving or worsening for individual patients and populations?

2. Understand and create value for your physician network.

With the rapid shift to hospital-owned practices and consolidation, we often find that health care systems don't understand the activities of their network physicians—aside from their admission statistics and bottom line. To implement real change, you need to involve physicians first, because they have the most to offer clinically and also strategically. The time is now to seriously evaluate the composition of your network, the interest and engagement of your physicians, and the impact that each participant has on costs and outcomes.

Have you assessed the costs of your network and compared these with other organizations?
What is the composition of your network in specialties, and how is it affecting your inflow and outflow of patients?
Do you know the costs of care for patients who are attributed to you but receiving services outside your walls?

3. Begin improving performance with a serious slate of projects.

Everyone is "doing" readmissions, and you are probably also addressing these. But you can also create projects that focus on root causes of sub-optimal outcomes, rather than dealing with problems after the fact. Your performance improvement should be creative and involve physicians, patients and family

caregivers in developing solutions with measurable results.

- Do you have improvement projects aimed at improving clinical outcomes and involving physician contributions?
- Are your patients involved in contributing to your strategic process beyond routine satisfaction surveys?

These are big action items, and the assumption is that you already have the underlying technology and support to help you achieve them. If you don't, that requires correction, and it need not require a massive investment.

Here's an added bonus: If you begin working on this list, you'll also make progress on fulfilling the major provisions of MACRA MIPS.

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Image Credit: Tim Mossholder

Onward to 2017 as Roji Health Intelligence

written by Theresa Hush | January 25, 2017

It’s been a momentous year in health care, with significant changes on the way for 2017. “Patient Empowerment” and cost shifting to the consumer are gaining political currency in

Washington. MACRA is looming on the horizon, with the coming year being the first under the Final Rule for measuring performance.

Health care organizations have significant strategic decisions to make as we move more intensively through an era of Value-Based Health Care and into Risk. Patients, too, will face serious questions about health care coverage and how to find accurate, comparative information for making choices about providers and networks.

It couldn't be a better time for us to transition our company's name to Roji Health Intelligence. Health care is at a crossroads, but what remains constant is the need for expert guidance and data to help providers and patients, alike, navigate a successful path to better health.

We look forward to 2017 as an opportunity to make a positive difference in the essential effort to improve health care.

Our best wishes for the holiday season and a New Year of peace and prosperity for all.

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