

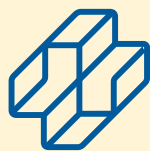


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The Future of Patient Engagement

A REPORT FROM HFMA'S NINTH ANNUAL THOUGHT LEADERSHIP RETREAT

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With more than 40,000 members, the Healthcare Financial Management Association (HFMA) is the nation's premier membership organization for healthcare finance leaders. HFMA builds and supports coalitions with other healthcare associations and industry groups to achieve consensus on solutions for the challenges the U.S. healthcare system faces today. Working with a broad cross-section of stakeholders, HFMA identifies gaps throughout the healthcare delivery system and bridges them through the establishment and sharing of knowledge and best practices. We help healthcare stakeholders achieve optimal results by creating and providing education, analysis, and practical tools and solutions. Our mission is to lead the financial management of health care.

**COMPETITION AND COLLABORATION:
SHARING DATA TO ENHANCE VALUE**

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A Message from HFMA's President and CEO

Dear Colleague:

Thank you for joining us for HFMA's 9th Annual Thought Leadership Retreat. I look forward to this event every fall; the expert speakers together with the thought leaders in attendance always make for a dynamic and thought-provoking conference. It was even more so this year, because the theme of the 2015 retreat, The Future of Patient Engagement, is particularly relevant and timely.

As Harvard professor David Cutler has written, the patient is the single most underused person in health care. Think about it: we share a goal of patient-centered care, yet the patient is often on the periphery—if not out of the picture—when decisions about care and payment models are made.

Today, we are on the cusp of the value-based era of health care. Population health management and other care models that will rely on engaged patients for success are gaining ascendancy. Now is the time, as Cutler put it, to “reimagine the role of the patient.” And that’s exactly what the speakers and participants at the retreat did. For example, they showed how engaged patients can:

- **Optimize their health decisions using clinically nuanced health insurance.** Value-based insurance design expert A. Mark Fendrick, M.D., demonstrated how people living with chronic conditions can avoid the pitfalls of one-size-fits-all cost-sharing, reduce their out-of-pocket costs, and improve their health outcomes with a health plan tailored to their medical condition.
- **Take control of their health.** AtlantiCare’s Special Care Centers offer an intensive care management approach to patients with multiple chronic illnesses that provides a one-stop shop designed around the needs of the patient—not the facility. The result is better health, not just better health care.
- **Face up to end-of-life choices.** Advance directives—too often, they are misunderstood, underutilized, or misaligned with a person’s changing needs. Gundersen Health System has developed a multi-step process that transcends these limitations. It helps people update their care preferences as their situations change, avoiding unwanted interventions and bringing peace of mind to surviving family members.

These and other innovative strategies for patient engagement are highlighted in the attached report. As you read it, I hope you will be inspired to take a fresh look at your organization’s approach to patient engagement and explore the wide range of options for engaging with patients in your communities. Finally, I want to thank you for your contributions to the in-depth discussions that set this conference apart and help our industry move forward.

Best regards,



Joseph J. Fifer, FHFMA, CPA
President and CEO
Healthcare Financial Management Association

the future of patient engagement

Providers and payers need to identify and implement strategies to fully engage patients in their care in order to achieve ambitious value-based care goals.

Healthcare providers are struggling to succeed financially amid a historic shift from fee-for-service payment to value-based models. Only now are many organizations beginning to recognize that engaged patients are needed to succeed under those new models of care.

Even when the primary role of the patient in health outcomes is recognized, many organizations struggle to identify the most effective ways to inform, motivate, and elicit perspectives from patients, who are increasingly seen as healthcare consumers.

During HFMA's Thought Leadership Retreat (TLR) this past October, 100 thought leaders in healthcare finance

shared ideas for how providers of varying types and sizes can develop and share technologies, data, and strategies to engage patients and enhance value. Although strategies have varied among organizations, the lessons learned may provide valuable insight.

A Changing Market

A growing share of providers' payments are moving from fee for service to alternative models, such as capitation, bundles, and other incentive-based programs. Although payers have placed varying levels of emphasis on moving to such arrangements, public payers such as Medicare have made it a priority. For instance, the U.S. Department of Health and Human Services (HHS) announced plans at the beginning of 2015 to move 50 percent of Medicare fee-for-service payments into value-based models by the end of 2018, and to link 90 percent of total payments to quality improvement efforts.

The push has led many organizations to undertake reorganization efforts to coordinate the care of many types of providers. One manifestation of that trend is the growing number of accountable care organizations.

But clinician and payer efforts to seamlessly connect care are not enough.

“Over the last few years, healthcare thought leaders have devoted a great deal of energy to aligning incentives between hospitals and health systems and physicians,” says Joseph J. Fifer, FHFMA, CPA, president and CEO of HFMA. “Yet, there is little talk about aligning incentives between providers and consumers, even though the success of value-based care depends in large part on patient or consumer engagement.”

Another emerging financial reality for patients is the growth of high-deductible health plans (HDHPs), in which 24 percent of workers were enrolled in 2015, according to the Kaiser Family Foundation’s (KFF’s) 2015 Employer Health Benefits Survey. Such plans have placed a large and growing financial obligation on patients that could either discourage them from seeking needed care or incentivize them like never before to seek value in their health care.

According to an attendee survey, 47 percent of TLR attendees see the impact of HDHPs at their organizations

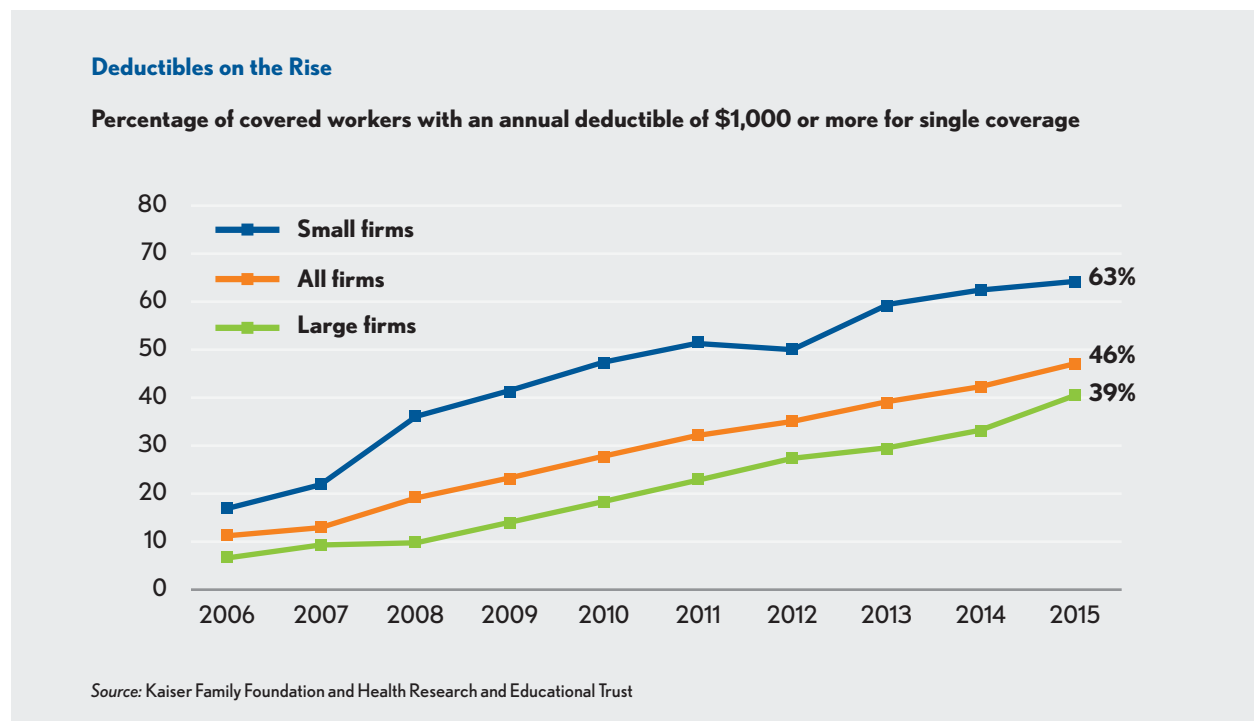
both in patients’ increasing willingness to ask questions about their care and in a greater tendency to delay recommended care because of cost concerns. Another 30 percent of attendees said HDHPs were having at least one of those effects on their patients.

“The fact that we know these things and can manage to that is really the first step,” Fifer says.

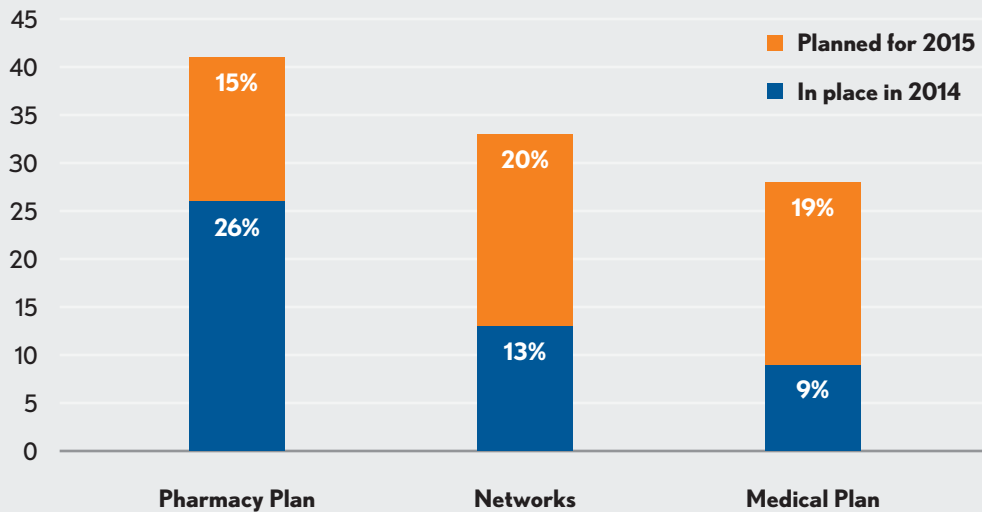
Realigning Incentives

Deductibles are just one of the out-of-pocket costs that are increasing for insurance customers. Rising copayments and coinsurance also can give enrollees more “skin in the game” to encourage wise use of scarce healthcare resources, according to supporters. But HDHPs also create disincentives for getting needed care, critics note.

“The one thing worse than being uninsured is paying premiums to be underinsured,” says A. Mark Fendrick, MD, director of the Center for Value-Based Insurance Design at the University of Michigan.



V-BID Momentum Continues



Source: 19th Annual Towers Watson/National Business Group on Health Employer Survey

A potential solution is to realign out-of-pocket costs to encourage needed services and discourage less-needed care. Value-based insurance design (VBID) encourages payers and providers to create payment models with out-of-pocket costs that vary by service, patient, and provider.

“Clinically nuanced cost-sharing” plans differ based on the benefit provided, Fendrick says. In turn, the clinical benefits of a service vary based on who receives it, who provides it, and where it is provided.

Examples of dynamic benefit designs would include lower out-of-pocket costs for high-cost drugs after other therapeutics have been tried and failed.

Insurers view VBID as attractive to people with chronic disease, but some industry analysts have raised concerns about adverse selection. However, UnitedHealthcare has an insurance plan that is based on VBID principles.

The approach is resonating, with about 1,000 self-insured companies utilizing some form of VBID, according to Fendrick. And one analysis projects that 40 million people would buy into an HDHP with V-BID elements—what Fendrick calls high-value health plans—that vary out-of-pocket costs based on the patient’s chronic health conditions and where services are sought.

Hospitals are seen as potentially the best organizations to establish VBID in a healthcare system because they are seen as health leaders in their communities, Fendrick says. The approach can reduce health insurance spending by healthcare purchasers. Such HDHPs with V-BID elements would cost less than PPOs or HMOs and only slightly more than existing HDHPs that use one-size-fits-all out-of-pocket costs, according to Fendrick.

However, such high-value plans would require changing Internal Revenue Service regulations that bar HDHPs from not applying the deductible for preventive services.

Similarly, VBID plans in Medicare were blocked by the anti-discrimination clause of the Social Security Act, which disallowed clinically nuanced consumer cost sharing. However, regulations issued in September by the Centers for Medicare & Medicaid Services (CMS) allowed Medicare to pilot-test VBID in Medicare Advantage plans in seven states.

Chronic Care Patient Focus

As the healthcare industry develops new care and payment models, Fifer says, bringing consumers into the conversation is essential. In particular, new ways are needed to connect with people at times when health care is front and center in their lives.

A high-profile example of such patient need occurs among patients with chronic disease and medically complex conditions, such as congestive heart failure and diabetes. Care for chronically ill patients comprises 75 percent of aggregated healthcare spending.

“Conventional care models are not optimal for meeting the needs of these patients, reducing the risks of complications, or keeping the costs of care down,” Fifer says.

Effective approaches to engage that population have been developed by AtlantiCare’s two Special Care Centers (SCCs). Originally developed in collaboration with a local union, the New Jersey-based SCCs are medical homes that provide intensive care management to patients with multiple chronic illnesses. The program initially had 27,000 lives covered by the union health plan, but has expanded to include accountable care organization members and continued access for those who become uninsured. It has a 97 percent retention rate.

The invitation-only practice concept aims to reduce barriers to care, including via waived copays for visits and prescriptions, walk-in access, and same- or next-day access for hospital discharges. The program also includes individual health coaches who coordinate and connect patients with needed primary or specialty care. The health

“You’re just saying, ‘Quit smoking and lose some weight; here, take this and I’ll see you later.’”

coaches—licensed practical nurses or medical assistants—provide tailored education and maintain contact with patients between visits.

“The focus is on getting patients engaged with their health,” says Ines Digenio, MD, medical director at AtlantiCare Special Care Center, Atlantic City, N.J. (AtlantiCare recently was acquired by Geisinger Health System.)

The goal of the program was to provide a one-stop shop where a range of patient needs could be met, including medical, social services, and pharmaceutical needs.

“They don’t go to see the psychiatrist, they go in to see their primary care doctor and the psychiatrist is there for them,” Digenio says. “We eliminate the barrier of stigma in that way.”

The results during the eight years of the program have included a 40 to 50 percent reduction in emergency department use and hospital admissions, a 5 percent average readmission rate, and a 98 percent prescription-fill rate—compared with a 50 percent adherence rate among people with chronic illnesses in the general population.

Cost benefits have included \$170 average savings per member per month for the program’s self-insured partners and a 20 percent reduction in pharmacy spending.

“Remember, we are talking about the sickest of the sick, and by design we take diabetes patients who have been

completely uncontrolled for the past 10 years,” Digenio says. “The risk is higher than the risk even within the same type of population, but even with that we are achieving all of these outcomes.”

The health coach-driven approach for chronically ill patients subsequently has been applied throughout AtlantiCare’s 50 primary care practices.

William Appelgate, PhD, executive director of the Iowa Chronic Care Consortium, says health coaching is an effective strategy for population health but has not become more widespread because healthcare organizations have tended to invest more heavily in big data. Additionally, because physicians and clinical leaders generally have not had training in coaching sciences, many lack confidence in effecting health behavior change and find it difficult to view patients as a resource.

Digital Assistance

Meanwhile, tailoring engagement strategies for the general patient population increasingly means incorporating mobile technologies.

The increasing importance of mobile devices in society was seen in the number of hours the general public spent on those devices in 2015—the total surpassed the time spent on laptops or other types of computers, according to one consumer survey.

“Mobile is now the dominant form of being digital across the United States,” Richard V. Milani, MD, chief clinical transformation officer for Ochsner Health System, says, noting that two-thirds of U.S. adults have smartphones.

In health care, consumers are seeking mobile technology that allows them to make appointments, receive medication and health check reminders, and obtain medical advice.

“In an average year, our patients whom we’ll see maybe two or three times will spend 52 hours on the Internet looking for health information, on average,” Milani says.

The time disconnect mirrors data that suggest healthcare providers impact an average of only 10 percent of the population’s health, compared with a much larger impact from an individual’s social circumstances and environment. The average visit between a patient with chronic disease and a primary healthcare provider lasts only about 15 minutes, and such providers generally are not trained in approaches that address societal factors.

“You’re just saying, ‘Quit smoking and lose some weight; here, take this and I’ll see you later,’” Milani says.

Meanwhile, providers generally have little effect on lifestyle changes that researchers have identified as having a much larger impact than medication on chronic disease progression.

“There are ways to affect that, it’s just that we don’t make investments in those resources,” Milani says.

For instance, research has shown that readmission rates are driven by social isolation, which is not reflected in an electronic health record.

“It has nothing to do with health care, but a great deal to do with health,” Milani says.

Emerging digital tools, such as mobile device applications, can help change patient behaviors and improve their health. And research indicates people with chronic illness are much more willing to use a mobile application than they are to fill a prescription.

“People are sick of taking pills, and they’ll do anything to avoid getting another pill,” Milani says. “If you can show them the way, they want to stop to listen.”

To assist patients in finding high-quality products among the 160,000 available health and wellness applications, Ochsner launched the O Bar to share physician-recommended health apps that are helpful, low-cost, and easy to use. Physicians “prescribe” their

patients to obtain a certain type of app—such as a nutrition app—from the O Bar, where staff members are trained to help them locate, download, and use the relevant type of app.

Based on patient feedback, the O Bar has increased engagement and given patients a greater sense of control over their health as opposed to leaving them dependent on a clinician's lead.

“In terms of behavior change, we needed to be engaging individuals to integrate them into the system and increase their activation, and we can use technology to help,” Milani says.

The approach has allowed the system to begin collecting ongoing data such as blood pressure readings from patients with chronic diseases. The data are sent to an analytics engine and utilized by an integrated practice within Ochsner Health System. That practice includes an entire care team that provides patients and clinicians with ongoing monthly reports and texts noting positive achievements.

“We're able now to spend time on their behaviors, spend time helping them with social isolation, and spend time talking about lifestyle changes,” Milani says.

The approach is credited with helping to cut readmissions by 44 percent and bringing nearly two-thirds of hypertension patients' conditions under control with 60 days.

“We currently operate in only 10 percent of the health-determinant pie, but if we're going to be taking on risk then we have got to go beyond that little 10 percent sector to get anywhere,” Milani says. “Health systems that embrace these changes can do very well in an era of value-based reimbursements.”

End-of-Life Engagement

Another crucial area of patient engagement is end-of-life care, which often is closely linked to chronic conditions. The financial impact of end-of-life care on the U.S.

“Health systems that embrace these changes can do very well in an era of value-based reimbursements.”

healthcare system is evident in the proportion of Medicare healthcare spending—25 percent—rendered in the last year of life.

“Much of that is spent on care that people would choose not to have if they fully understood their options,” Fifer says.

CMS was scheduled to begin paying providers as of Jan. 1 to have conversations with patients about their end-of-life care preferences.

The CMS decision followed years of efforts by Gundersen Health System's Respecting Choices program, which established end-of-life planning as a cultural norm within both the organization and the surrounding community.

“If anyone thinks that if we just let patients do this on their own then they'll get the job done, I don't buy any of it,” says Bernard “Bud” Hammes, PhD, director of medical humanities at Gundersen Health System, La Crosse, Wis. “They need help and they need a system of support.”

The organization has piloted and spread a multi-step process that allows patients to decide and clearly spell out to family members their wishes about end-of-life care under multiple scenarios. The results have prevented extensive use of unwanted procedures and treatments and provided more peace to surviving family members, according to research.

“Almost all Americans agree that they don’t want to die hooked up to machines,” Hammes says. The planning approach “is what the patients want and it’s a better use of resources.”

The financial results for Gunderson include lowest-in-the-country costs per Medicare patient for both end-of-life care and total care.

Care Engagement

Organizations have become increasingly focused on the patient experience as payers have started to use that metric in reimbursement determinations. However, the patient experience is not about patient happiness, says James Merlino, MD, president and CMO of the Strategic Consulting Division for Press Ganey Associates.

Instead, it is about delivering high-quality care in an environment where patients feel like providers care about them. For instance, when a clinician communicates more effectively and frequently, patients feel like the clinician cares about them, Merlino says. But better communication also drives value.

Merlino encourages the use of strategic human resources to improve clinician engagement in enhancing the patient experience. For example, organizations can onboard newly hired physician, nurses, and other clinical staff together to improve their communication, which is critical to improved care.

Such internal collaboration is critical, Fifer says, because so many hospital staff are involved in providing care for each patient and all have a role in patient engagement.

“If anyone thinks that if we just let patients do this on their own then they’ll get the job done, I don’t buy any of it.”

Obstacles Remain

The largest obstacle to an increase in shared decision making between clinicians and patients is the still-prevalent fee-for-service payment system that rewards volume, according to 44 percent of TLR participants.

That barrier is not a surprise to Fifer.

“We know what the future will look like. It’s this transition period that is so darn difficult,” Fifer says. “But you will see progressive health systems around the country finding a way through this.”

The financial challenge is clear when organizations say they are waiting for a share of their volume—frequently 30 percent—to move into value-based payment models before they are able to financially justify wholesale operational changes.

“That means you’re consciously making a decision that negatively impacts the other 70 percent,” Fifer says. “Yet we see that happening throughout the industry today. Kudos to you for doing that, but that is a difficult pill to swallow.” ■

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