

Mandating Value: Medical Conversations in B Major

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Introduction

If you're a practicing physician in the U.S. like me, April 1 will probably feel no different than any other busy day involved in patient care. But April 1 will be no April fools this year. With its first mandated bundled payment initiative set to start on that date, the Centers for Medicare & Medicaid Services (CMS) has sent with it, the first big signal that hospitals and providers will increasingly be expected to assume financial risk for the healthcare utilization and outcomes of their patients for a period of time after discharge. Huge dollars are at stakes that are meant to incentivize reimbursement for patient outcomes rather than for the quantity of services provided. While our orthopedic colleagues and hospital administrators will be the first to feel these growing pains through CMS' April 1 launch of the Comprehensive Care for Joint Replacement (CJR) initiative [1], this is a wakeup call to those of us across all other medical specialties. With new value-based programs set to launch under the Alternative Payment Models (APMs) and the Merit-Based Incentive Payment System (MIPS) of the Medicare Access and CHIP Reauthorization Act (MACRA) [2], CMS is driving a transition away from fee-for-service to value-based reimbursement at an incredible clip. Its goal is to have 30% of Medicare payments in alternative payment models by the end of 2016 and 50% by the end of 2018.

Outcomes are the New Income

With huge value-based financial penalties and incentives coming on line, hospitals and physicians are being forced to think about for the first time (or re-think) how to stay on top of patient status and progress beyond the four walls of the healthcare setting. No longer can one assume after the clinical encounter has concluded, that no news is good news. If we don't assess, after the patient has gone home, that he or she is staying on track with the discharge plan, and if we wait until after a treatment failure occurs, or until a non-compliance issue leads to an undesired outcome, then we will have already fallen behind the outcome curve so to speak. So, how do we close the gap around holding increasingly effective, meaningful, and frequent dialogues with our patients post-discharge in a manner that continues to keep them engaged in the process, without crushing our already burdened schedules as healthcare providers?

An interesting answer to this challenge may come from the convergence of emerging concepts in the digital era of medicine, the observations of an astute 19th century physician, and something as humble as the metronome.

The Point of Indifference

Karl von Vierordt (1818-1884), a German physician, scientist, and inventor (sphygmograph), discovered the human tendency to overestimate the speed of a slow tempo (for example, to overestimate

the rate of a slow metronome after the metronome was turned off), and to underestimate the speed of a fast tempo [3]. The fascinating implication, as Vierordt found, was that there was some intermediate tempo, later referred to as the "point of indifference," at which individuals reproduced the tempo correctly. In music, one such point of indifference is found to occur around 94-96 beats per minute. This is quite fascinating; in our minds, we tend to speed up slow tempos and slow down fast tempos to a common cadence at which we are perhaps innately "comfortable."

What can be learned by applying what is known as "Vierordt's law" to conversations with patients today? The art of the medical conversation; how to maintain and hold a meaningful, ongoing dialogue in which the patient continues to find value, is not unique to our time. Conversational cadence has long been a subject of linguistic and psychological research [4], but few of us have specific training in optimal physician-patient communication. And CJR as well as other bundled payment programs have added a new dimension to the conversations we now need to hold; a dimension of frequency over time. No longer is the conversation limited to a single encounter. It is now part of an ongoing dialogue over ninety days (and perhaps other lengths of time as new mandates come out).

CJR and other upcoming bundled payment programs have accelerated healthcare systems' interest in finding ways with which to keep the patient engaged in a dialogue over time. Since CJR was announced, we have seen hospitals scramble to install ancillary services to try to scale the reach of the physician for follow-up purposes. Such services include interactive voice response (IVR) systems making automated outbound phone calls to patients over the ninety-day post-joint replacement period. Other hospitals have added additional phone banks to their disease management programs ramping up manual phone call follow-up efforts carried out by nurses and physician assistants. Others have invested in digital patient engagement platforms that keep patients on track and gather feedback on patient status with automated secure messages sent over email. Some have increased the tempo of home health visits, while other have relied more heavily on additional post-discharge clinical encounters through traditional and/or telemedicine visits.

However, not unlike as occurs with the "robocalls" calls that many Americans are being flooded with by candidates during the current political primary process, there is a point at which the recipient of the outreach becomes saturated and disengages. Namely, the frequency of interactions in the dialogue with the physician and care team may be too high to maintain patient engagement, or they may be too sparse to detect problems in a timely manner. The inflection point is the point of indifference. Is, for example, two telemedicine encounters in the first week too many? Is one nurse phone contact in the second, third, and fourth week too few? The frequency of these touch points in the dialogue is not the only parameter. The volume of questions asked of

the patient at each interaction, and the time required are variables in the equation too. Are ten questions in a single IVR call an excess of volume? Does a patient's tolerance for the time it takes to complete the interaction change at two months post-discharge compared to the first week? In planning for CJR, we have seen hospitals placing estimates that IVR calls, if done on a weekly basis for ninety days post-discharge, will provide enough granularity to detect impending complications without being too frequent to be off-putting to patients. But the truth is, we don't really know quite yet. The challenge is that until now, no one has applied a science to this aspect of the art of medicine.

Usher in the Digital Era

The answers to the above questions may lie in how connected the patient feels to the care team, how personalized the dialogue feels—particularly when it is automated—how much time is demanded of the patient for the interaction, at what point the patient is in his or her post-discharge timeline, and what the patient perceives as the value to him or her, irrespective of what the hospital or healthcare professionals perceive as the value.

The good news is that the digital era of medicine enables us, for the first time, to apply a scientific approach to identifying where the point of indifference is. Using an operational definition of engagement such as the percent of times the patient engages with the outreach, we can learn actionable answers to important questions such as: How often should outreach, whether manual or automated, be done? How much content should be in each communication? How should cadence change over time relative to the date of the index visit? What are the effects of variables such as demographics, comorbidities, gender, and level of education, ethnicity, and personality, if any? Research to find the point(s) of indifference as a function of these variables, and to ascertain the impact on outcomes is unfolding and represents a truly fascinating new branch of health informatics with practical value around the way in which we will all pay for and be paid for medical care.

In the era of value-based initiatives, it is also noteworthy that the term “point of indifference” has a meaning in economics, describing when the rate of investment moves away from the rate of return. Investing more in an initiative increases the rate of return only to a point, and perhaps that is the point of indifference that CMS is targeting with its CJR and the value-based initiatives coming under APMs and MIPS.

Relationships

While technology has permeated the practice of medicine, the atomic unit of medicine is, and will likely always remain the personal relationship between the patient and physician (or other healthcare professional). New tools may help extend that relationship in scalable ways outside the four walls of the healthcare setting, but good communication is still at its core. Claude Debussy, a French composer once said that music is what happens between the notes. If we take Vierordt's learnings to heart, and find what matters to patients between visits, then we might be able to enrich the spaces between visits at just the right cadence, and with just the right content and guidance to make the ongoing dialogue effective, meaningful, and relevant to the patient, providers, and the healthcare systems that are becoming accountable under new value-based models.

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