From Asheville to Hickory: Transforming Our “Sick Care” System into a True “Health Care” Model

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It is only 75 miles from Asheville, NC, to Hickory, NC. The article by Bunting and colleagues, titled “The Hickory Project: controlling healthcare costs and improving outcomes for diabetes using the Asheville Project model” and appearing in this issue of the journal, offers a new perspective on the journey from Asheville to Hickory and its significance in transforming our current “sick care” system into a true healthcare system.

The concept of what is now known as the Asheville Project was developed by a think-tank group of North Carolina pharmacy leaders in Chapel Hill between 1994 and 1996, to demonstrate that community pharmacists could improve clinical outcomes and lower healthcare costs for people with chronic conditions.

The Asheville Project started with 1 self-insured employer—the city of Asheville—and 47 patients with diabetes participating in a voluntary program working with pharmacists in the Asheville community. Today in Asheville, there are 9 employers offering that program as an employee benefit and more than 1800 people are participating in programs for those with diabetes, high blood pressure, dyslipidemia, asthma, and depression. A multidisciplinary team of care managers is working collaboratively to help patients self-manage their chronic conditions.

As chronicled in the current Hickory Project article, the Asheville Project model has been replicated at many sites across the country with varying degrees of success. In 2005, I pondered, “Beyond the Asheville Project: are we in the middle of a tipping point?” The Asheville model has been discussed in the Washington Post, is taught in most pharmacy colleges, and is touted by leaders of national and state healthcare business coalitions. We have had 3 visits to Asheville by groups from Japan, and the program was featured on NBC’s Nightly News. Despite this notoriety and widespread replication in more than 35 states from Charleston, SC, to Honolulu, HI, the Asheville Project has yet to be readily accepted and eagerly adopted. I would suggest that we are still waiting for the tipping point.

What is delaying the acceptance of the Asheville model? Thomas Kuhn postulated that it takes 17 years from the discovery and announcement of new scientific knowledge to a paradigm shift and widespread implementation. Based on this logic, the first Asheville Project scientific articles were published in 2003, meaning we will be waiting until 2020 for the model to be common practice. Is it just a matter of time, or are there barriers that can be overcome? What strategies are needed to achieve further expansion of the Asheville model that can be learned from the Hickory Project?

Barriers to Acceptance of the Asheville Model

Solid data on return on investment for payer decision makers are lacking. No studies, other than the Asheville Project and now the Hickory Project, have published data as compelling or that demonstrate savings approaching those found in these 2 projects. In the patient self-management program, which included 5 sites based on the Asheville model, the savings were $918 per patient per year (PPPY), and the savings in the 10 sites in the Diabetes Ten City Challenge were $1079 PPPY. These savings were in comparison with the projected increased cost trend, not in comparison with baseline costs. In both studies, not enough data were captured. If more data had been captured, the results would have likely been better.

Medical claims administrators’ and pharmacy benefit managers’ reluctance to share data. In my experience, the greatest barrier to capturing meaningful data to identify cost-savings is the need to obtain data from third-party administrators and pharmacy benefit managers who are unwilling to share the data. This is especially frustrating for self-insured payers, who ultimately own these data, and all that is required is a standard paid claims report in a format that can be exported.

Enrollment and engagement of participants. Enrolling potential participants is challenging. Even with incentives for waived or reduced copays for condition-related medications, enrollment is generally less than
50% in the initial year of a program. Much of this is dependent on the culture of trust with the employer. Furthermore, once enrolled, getting people truly engaged in setting personal health goals and in self-management of their conditions is often difficult.

**Healthcare system territories and professional turf.** A recent article by Rideout summarizes the challenges we face in overcoming inefficiencies of the current US healthcare system. Although accountable care organizations, patient-centered medical homes, and value-based benefit design are currently being promoted, the system remains provider-centric, and competition between healthcare professionals for payment still prevails.

**Health benefit consultants and brokers still selling the current system.** The US healthcare system is our most change-averse industry, and although the Affordable Care Act has passed, it is now being challenged and its future is uncertain. Economic incentives are now in place to keep the current system intact, and until consultants and brokers buy into new models such as the Asheville or Hickory Projects, such programs may not get the consideration they deserve.

**Investment in current on-site clinic and health and wellness programs.** The health and wellness industry is expected to reach $600 billion in 2011, and growth for products and services in this area is one of the few bright spots in the economic downturn. This should be sufficient to have employers and payers amenable to the Asheville model and the Hickory Project. But because payers have made commitments to invest in wellness programs and on-site clinics, they do not think they need an intensive program for the 15% of their health plan members with chronic conditions who are driving 85% of the sick care costs.

**Lessons Learned from the Hickory Project: Strategies for Success**

- **Data systems should consistently collect measures and report meaningful results.** A distinct advantage of the Hickory Project over the original Asheville Project was the provision of a web-based virtual medical record that incorporated guidelines for care, medical claims, and pharmacy claims. This system was developed using the experience of the Asheville Project care managers and is now used by Mission Health System hospitals in Asheville to enhance data collection and consistency of care for current participants in the Asheville model. Having a system such as the one used in the Hickory Project is critical for ensuring standardized care in multiple sites and for generation of reliable reports for decision makers to demonstrate the long-term cost-savings and program sustainability.

- **Payers must insist the data are theirs and demand to share them freely.** In both the Asheville and Hickory projects, employers require their medical and pharmacy claims administrators to supply the necessary data for ongoing patient care and outcomes analysis. If a self-insured payer’s claims administrator will not or cannot share the data in a usable format, the payer needs to change to an administrator who will do this, and requests for proposals for future claims administration need to establish the data-sharing expectations.

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- **Provide incentives to drive high-enrollment rates and care management that engages participants in self-management.** In the Hickory Project, once the initial financial savings were apparent to the employer, and it was noted that enrollment was not as high as desired, medical benefit plan contribution options were identified. After legal review and approval from management, medical benefits were structured to drive enrollment, and participation increased significantly. Patient engagement has been enhanced in the Asheville and Hickory Projects, where care managers received training in intrinsic coaching. This has resulted in the participants accessing their “best thinking” for self-management of their conditions through goals they set for themselves, which results in improved personal outcomes.

- **Involving the patient as the focus of the system, promoting stakeholder collaboration, and realigning payment structure.** Crucial to the Hickory Project results were the lessons learned from the Asheville Project and adhering to the principles of that care model. Having the patient actively participate in a collaborative support system in which financial incentives are aligned for patients, providers, and payers is what turns the system from a sick care model into a true healthcare model.

- **Cultivating consultants and brokers as champions of health.** Key to the Hickory Project was that the health benefit consultant was also a consultant to employers who participated in the Asheville Project. A small group of consultants/brokers is now comprehending how the model works, and they are beginning to present the model as a transformative system. Having a group of champions from this area is key to communicating the
model to payers who are inundated by proposals with differing degrees of success or failure.

Understanding the full continuum of employee health benefits and how they work together. The employers in Asheville and Hickory who implemented the program had existing wellness and health clinic programs, and they knew their programs were not making an impact on the rising costs of chronic diseases. Through the Asheville and Hickory projects, they learned how to get the best from both efforts and create a continuum of benefits to support all members of their health plan, regardless of their current state of health.

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Transforming the Care Continuum

The model is beginning to gain renewed momentum. At the recent Centers for Disease Control and Prevention’s (CDC’s) Heart Disease and Stroke Prevention Practitioners Training, we presented a workshop that featured the Asheville model and how it is being replicated. It included presentations on the Maryland P3 Program, the South Carolina Department of Health and Environmental Control Stroke Belt Project, an overview of replication across the country, and data from the Hickory Project. The discussion stimulated interest from many states on how the Asheville model improves chronic care management and ultimately reduces the rate of heart attacks and strokes.

The CDC’s interest in spreading the model is timely: the CDC’s Million Hearts campaign was launched the same week. The meeting included a dialogue on how communities replicating the Asheville model will contribute to the national goal of preventing 1 million heart attacks and strokes in the next 5 years.

The data from the Hickory Project represent a milestone in transforming the sick care system into a healthcare system. Having these data in hand, and the lessons learned, will shorten the journey to implementing a chronic health management project named for your community.

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