

## The Business Case: Can High Quality Care "Pay-Off"?

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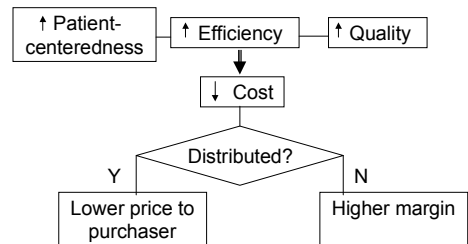
## The Business Case: Experience and Evidence to Date

- The Quest
- The Landscape
- A Brief History of Time
  - First Generation: Public performance reporting
  - Second Generation: Pay for performance
- The Path Forward

## The Quest: High Quality/High Value Care

- Better care at a lower cost
- Replication of purchaser experience in their own industries
- Purchasers pressed by top of the house
  - early and often
- Incremental progress vs. punctuated equilibrium

## Follow the Money: The "Business Case"



## Follow the Money: The Premise

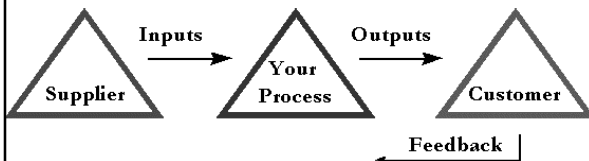
- Entity investing in intervention realizes financial return on its investment w/in a reasonable time frame
- Motivation
  - Profit
  - Minimize loss
  - Avoided cost

## The Complexity: The Case of the Normal Good

- Demand increases when income increases and:
  - Few barriers to entry
  - Information symmetry
  - Many buyers
  - Many sellers

**Not necessarily the hallmarks of healthcare...**

## Links in the Chain



## The Landscape

- Baby boomer tsunami
- Increased age, declining health status, more comorbidities
- Increased consumer cost sharing
- The rise of life science
- Frustration of “hitting the wall” in navigating care for aging parents
- Expectations of shared decision making
- Information about choices and care options becoming more available
- Sophisticated marketing

## What Patients Want:

- Delight me with coordination
- Healing care that makes a difference
- Give me the facts
- Make it easy, speedy, kind and credible
- Convenience
- Assure me
- Minimize my sleepless nights
- Make it seamless

## Pulse of Consumers

- 79% believe quality differs from provider to provider (Inguanzo, 1985)
- 72% want more information to feel more confident about medical decisions (National Coalition on Health, 1996)
- 47% are very concerned and 23% are somewhat concerned that error resulting in injury to you or your family (Kaiser Foundation, 2000)
- More than a quarter of adult Americans don't think hospitals do a good job of serving consumers (Harris Poll, 2003)

## Purchaser Mindset

- Create efficiencies; reduce rework; show me that “improvements” make dollars and cents
- Encourage purchasing behavior (real cost of visit, copay, etc.)
- Clinical best practices; Patient safety
- Manage chronic care and comorbidities
- Build awareness; focus communication, educate
- Create an environment of supportive decision-making
- Value for dollars spent
- Leading Edge Cleveland
- Sustain the gains

## Purchaser Payment Trends

- Cost-Sharing Sensitivity “Sweet Spot”
  - Discourage unnecessary/low value care
  - Prevent delaying needed care because of cost
  - Enough to engage in decision making
  - Not enough to prevent seeking needed care
- Payment at the Time of Service
  - Some risk on patients to help control costs
  - Relieve part of the administrative burden that contributes to unmanageable overhead
  - Allow providers to charge for time, as lawyers do
  - Enable physicians to help patients decide when to spend resources they control

## Purchaser Payment Trends, cont.

- Aligned Incentives (purchaser, provider, patient)
  - Knowledge, skills, incentives, and appropriate financial risk
  - Courage to pay for performance?
- Information for Engagement
  - Longitudinal medical record owned by the patient and accessible by any caregiver
  - Information infrastructure for payment model used

## Towers Perrin May 2003 Study: Employer-Employee Misconceptions

- Employees understand health care costs and are willing to absorb their fair share
- Changing consumer behavior=Magic Bullet
- Traditional communication channels suffice
- Communication can be one-size-fits-all

## Key Findings in the Literature

- Very little rigorous evaluation of inpatient cost, quality and patient-centered care; None at a market-level
- Patients who receive supportive interventions have shorter hospital stays and better clinical outcomes
- Increased clinician/patient communication decreases the cost of care

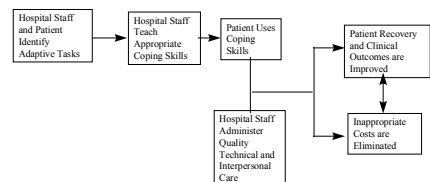
## Southeast Michigan, for Example.....

The Research Question: What is the relationship between patient-centeredness, technical quality and cost of inpatient care?

## Models

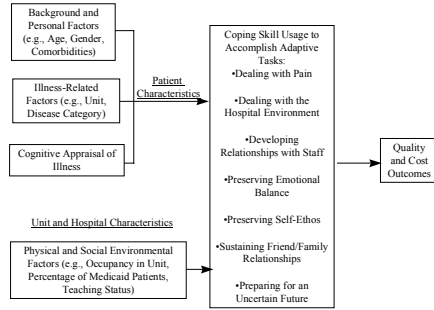
- Continuous Quality Improvement (Berwick, James, Laffel, Sahney) -- provides a framework that supports simultaneous quality and cost improvement
- Biopsychosocial Model (Moos) -- provides justification for use of Picker patient reports of care data

## CQI Model



Composite Health Care CQI Model

## Biopsychosocial Model



-Rudolph Moos, Biopsychosocial Model

## Research Design

### • Functions

- $Quality\ of\ Care = f(Cost) + (Patient\ centeredness) + (Medicare\ Case\ Mix) + (Length\ of\ Stay) + (Error)$
- $Cost = f(Quality) + (Patient\ centeredness) + (Medicare\ Case\ Mix) + (Occupancy) + (Disproportionate\ Share\ Hospital) + (Error)$

-D. Bechel, Relationships Among Quality, Cost and Patient-Centeredness in SE Michigan Hospitals

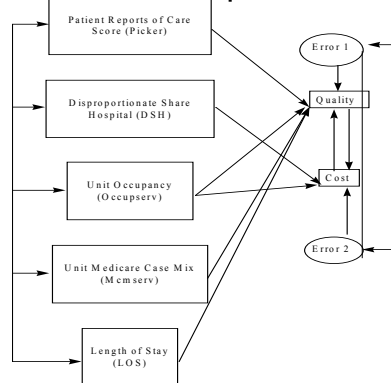
## Research Design, cont.

- Hypotheses
  - Care that is more "patient-centered" is associated with better quality;
  - Care that is more "patient-centered" is associated with lower costs;
  - Better quality care is associated with lower costs; and
  - Lower cost care is associated with better quality.

## Model and Method

- Ordinary Least Squares regressions on cost and quality (The Appetizer!)
  - Along w/ literature findings, considered in the selection of unique variables
  - Demonstrates need for two-stage least squares
- Simultaneous Equations (The Meat!)
  - Literature review and OLS results guided selection of exogenous variables (as well as unique variables for each equation)

## Simultaneous Equations Model



## Data Sources

Data Element	Source	Time Period	Population
Cost of care (Hospital-negotiated Diagnosis Related Group (DRG) price)	Inpatient Traditional indemnity hospital insurance claims	Discharges occurring in 1996 and paid in 1996 or the first quarter of 1997	Consortium employees, retirees, and dependents who were enrolled in Blue Cross and Blue Shield of Michigan (BCBSM) Traditional or Preferred Provider Organization (PPO) plans
Risk-adjusted quality outcomes	Inpatient discharge abstracts	Discharges occurring in 1996	All hospitalized patients
Estimates of patient-centeredness	Patient responses to surveys on reports of care	Discharges occurring in the first quarter of 1997	All hospitalized patients

## Results

Simultaneous Equations Regression Weights

Endogenous Variable in Parameter	Exogenous Variable in Parameter	Unstand. Coeff.	Stand. Coeff.	Standard Error	Critical Ratio	Expected Sign
<b>Quality</b>						
	Picker	1.275	.400	.367	3.48***	+
	Case Mix	.072	.389	.060	1.209	-/+*
	LOS	-.068	-.183	.041	-1.657**	-
	Cost	-.001	-.030	.007	-.087	-
<b>Cost</b>						
	Occupancy in Unit	8.509	.227	2.990	2.846***	-
	Picker	56.121	.366	33.470	1.677**	-
	DSH	2.634	.230	.965	2.730***	+
	Case Mix	8.033	.899	1.880	4.274***	+
	Quality	-26.093	-.542	23.670	-1.102	-

\*The literature is equivocal  
 \*\* Significant at p<sub>5</sub>.10  
 \*\*\* Significant at p<sub>5</sub>.05

## Results, cont.

Hypothesis	Parameter	Finding
Care that is more "patient-centered" is associated with better quality	The path from Picker to Quality	Significant at p <sub>5</sub> ≤ .05, with expected result
Care that is more "patient-centered" is associated with lower costs	The path from Picker to Cost	Significant at p <sub>5</sub> ≤ .10, but unexpected result
Better quality care is associated with lower costs	The path from Quality to Cost	Not significant
Lower cost care is associated with better quality	The path from Cost to Quality	Not significant

## Major Findings

- Better hospital performance on Picker = Better quality outcomes
- Better "Picker" performance = Better cost performance
- Price of improvement may be worth the investment

## Policy Implications

- Incorporation and acceptance of patient feedback in care
- Payment and financial incentives
- Accreditation
- Hospital closures
- Resource allocation w/in hospitals

## Purchasers' Brief History of Time:

- Generation 1: Create information symmetry with public reports
  - Requires trusted measures that are available at the window of need
  - Credible threat of market shift works in the short run, if at all

The screenshot shows the 'STANDARD EDUCATION SERVICES' website for Belleville High School, Michigan. It displays a table of performance metrics over a 5-year period (2001-2005). The metrics include MAP Participation (by grade and overall), ACT Mean Score, PSAT Combined Score, and AP Participation. The table shows that MAP Participation generally increased over the period, while ACT Mean Score and PSAT Combined Score showed a downward trend.

	2001	2000	1999	1998	1997	5 Year Average
MAP Participation (%)	34.0	n.a.	n.a.	n.a.	n.a.	n.a.
MAP Participation (%)	75.0	n.a.	n.a.	n.a.	n.a.	n.a.
MAP Participation - Transition (%)	40.0	48.7	45.7	n.a.	n.a.	n.a.
MAP Participation - Transition (%)	75.3	80.0	66.6	n.a.	n.a.	n.a.
MAP Grade 11 Exit/Pass Rate (%)	4.1	5.6	6.9	n.a.	n.a.	n.a.
ACT Mean Score	21.1	20.2	20.3	21.0	20.5	20.6
ACT Participation (%)	55.8	52.6	46.2	47.2	52.0	50.9
PSAT Combined Score	141	145	147	145	153	146
PSAT Participation (%)	31.4	18.9	16.1	24.1	18.9	22.1
PSAT Combined Score	n.a.	n.a.	1095	n.a.	n.a.	n.a.
AP Participation (%)	1.7	1.7	4.9	1.9	1.8	2.2
AP Scores 3 or Above (%)	47.8	55.0	65.4	60.0	54.5	56.6
AP Participation (%)	16.5	14.9	9.9	0.0	0.1	10.1
Graduation Rate (%)	90.8	95.6	n.a.	n.a.	n.a.	n.a.
Control Rate (%)	2.5	4.6	n.a.	n.a.	n.a.	n.a.

## Examples Abound

- California efforts
- CHQC
- CMS Hospitals.compare website
- Niagara Health Quality Choice
- Voluntary Initiatives
- Hospital Profiling Program

## The HPP, Consumers, and Care

- Fulfills Leapfrog purchasing principle (to "proactively provide information to enrollees at risk of hospitalization")
- Enables behavioral change
  - 61% said they would use to select a hospital
  - 52% to talk to a doctor
  - 46% to help a family member
- Catalyzed some local improvement

## Generation One: The Road is Long

- Many "consumer-oriented" efforts are not "consumer-friendly"
- Few distribution channels to deliver the message to recipients
- Little user-support
- No national approach
- Measurement isn't free
- Putting your money where your mouth is
- Information at the time of need

## Generation One: The Roadblocks

- Administrative data
- Some conditions are clouded by medical uncertainty
- Consumer advocates live on shoestrings
- All consumers will not use information, even if available
- Hospitals need a business case to improve performance (differential payment for better performance)

## Lessons Learned

- It takes a community
- Making information public alone may catalyze change but will not sustain it
- Access to data is a real issue and potential obstacle
- Reputation doesn't always equal performance
- Consumer behavior doesn't change overnight

## Purchasers' Brief History of Time

- Generation 2: Create incentives with pay for performance schemes
  - Enough to change behavior?
  - Who you distribute to matters
  - Avoiding "the check is in the mail"
  - The information enabler
  - Staging: pay for structure, then process and finally outcome

## Examples

- Bridges to Excellence
- RWJ Rewarding Results
- PBGH

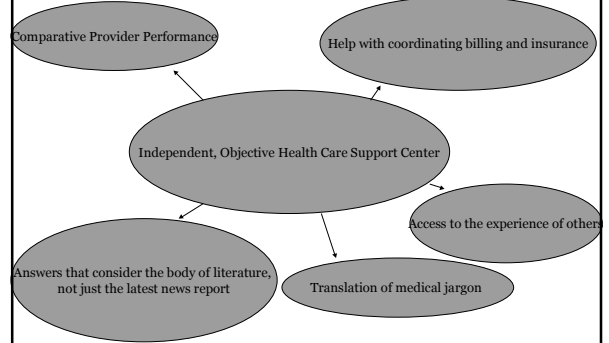
## But Consumers are Mixed...

- WSJ/Harris July 2003 Poll (n=2,357)
- "Do you favor or oppose plans paying more to hospitals and medical groups which have been shown to provide better care and paying less to those which have not?"
  - 44% favored
  - 16% opposed
  - 40% not sure

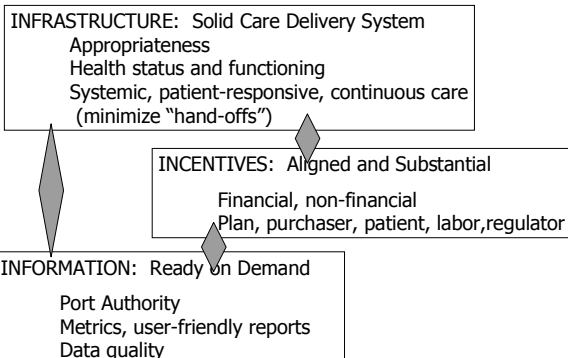
## The Path Forward

- Best thinking of all stakeholders
- Create a "What's In It for Me?" for all Stakeholders
- Involvement of clinical leaders early on
- Feedback, Reflected Change, Previews
- Media training and consumer testing
- Evaluation
- Long-term vision; Not flavor of the day

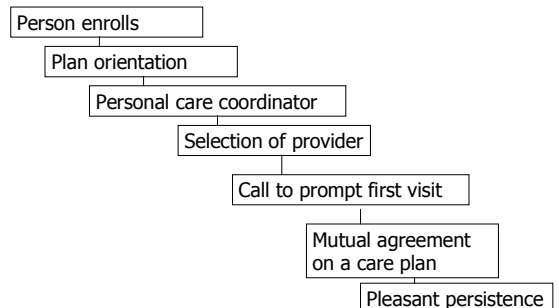
## What I Wish for Consumers



## A System of Care: Design

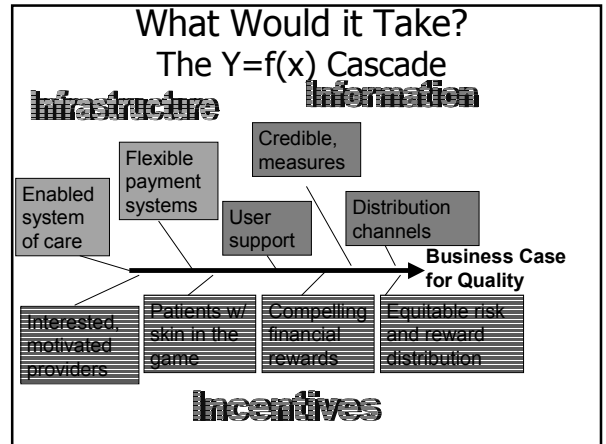


## Imagine a World....



## But in the Real World

- No one wants their margin cut
- Understanding the patient
- Stock market punishes those who can't deliver each quarter
- Few true Organized Systems of Care
- Antiquated payment system meets new frontier; Preventive care, support for lifestyle changes get short shrift
- Plans and providers perceive greater risk than gain from quality improvement
- Consumers have more skin in the game but little protective gear
- Few purchasers willing to wait for LT returns that quality may bring



## Patient-Integrated Care

- "Centeredness" puts patient and provider at ends of continuum
- Responsive means patient needs are acted upon in a way that is provider-friendly
- Integrated means patient is part of design, decision, and course of care; creation of a unified "whole" team

## Leveraging the Stakeholders

<u>STAKEHOLDER</u>	<u>LEVERAGE POINT</u>
• Purchasers	• ROI
• Plans	• Partner Alignment
• Regulators	• "Cover"; Constituency
• Consumers	• Skin in the game
• Providers	• \$ Payment/Margin/ Market/Recognition

## So What is Needed?

- Discourage redundant testing and services, patient "hand-offs", and breakdowns in provider-provider/provider-patient communication
- Increase the use of necessary, clinically efficacious and under-used care (may increase costs in the short run, but produce long term savings)
- Distinguish "me-too's" from breakthrough treatments and drugs
- Promote prevention and support of healthy lifestyles
- Leverage health status improvement by increasing understanding of diagnoses and treatment plans to boost compliance and adherence
- Sensitize to health care appropriateness and cost. Example: Equifax audit found that bills over \$10,000 contained an average of \$1300 in errors per patient (May/June 2001, p. 77, Modern Maturity).
- Address inappropriate services, low quality services, low adherence and compliance to treatment regimens, including prescription drugs

## Three Frontiers for Value Studies

- E-Prescribing
- Communication
- Hospice

## Vested Populations --Early Adopters?

- People with chronic illness
- Those caring for sick parents
- Frequent users of HC system
- Worried well

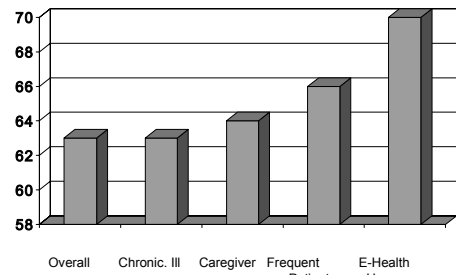
## Health Care Informatics: The Cornerstone

- Repeated messages
- Delivery at "teachable moment"
- Simplicity of language
- Psychometric testing of questions
  - Does question intent match responder's interpretation?
- Multi-year strategy
- Same-page displays and legends
- Multiple modes of information delivery
- Preparation and user support

## A Missing Link: The Promise of Information Technology

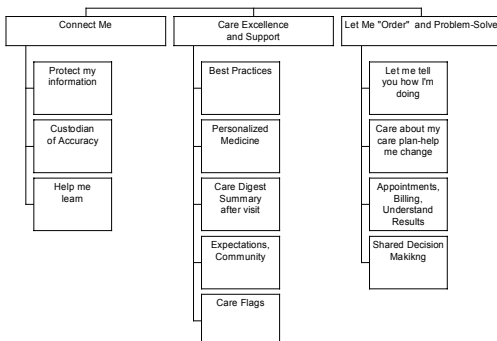
- Where it's at: Integrating patient voice -- in IT; in process of care; in system navigation
- Engage/involve/capture patients -- via the web, building community
- Good patient experiences engender political support
- Link tech to touch: User support
- Next generation: directory of information by individual
- Overcome legacy obstacles by moving information via the web
- Drain the supply chain of waste (business value proposition; revenue cycle enhancement)

## Who Would Use Now or In Future



National survey by FAAC of 1,246 online households in Connecting for Health Personal Health Workgroup. Final Report July 2003

## Growing Connectivity



## From Content to Care

Biotech Development

New Research Frontiers: Consumer Learning Lab; SF-36 Checks

Queue-Up Next Day's Care

TeleHealth, Second Opinions, E-Visits

System IT Business Efficiencies

Personal Health Records

Behavioral Change Mentoring; Chronic Disease Management

## Making it Flow

- DESIGN IT RIGHT – Efficiency, aligned incentives, positioning
- BUILD IT RIGHT – Best-of-the-best partners
- SELL IT RIGHT – bring consumers, clinicians, community, employers
- FIX IT RIGHT – Process improvement
- TREAT ME RIGHT – Reward, reassurance, gentle interface, navigation

## Six Sigma the Roadblocks

- Inertia
- Who pays, who benefits, where is ROI?
- Ever-present confidentiality concerns
- Shadow the user; walk the process; where is the rework?
- Feeder hospital challenge
- Sustain the gains
- User support
- Speed
- Aligned incentives

## Making Progress

