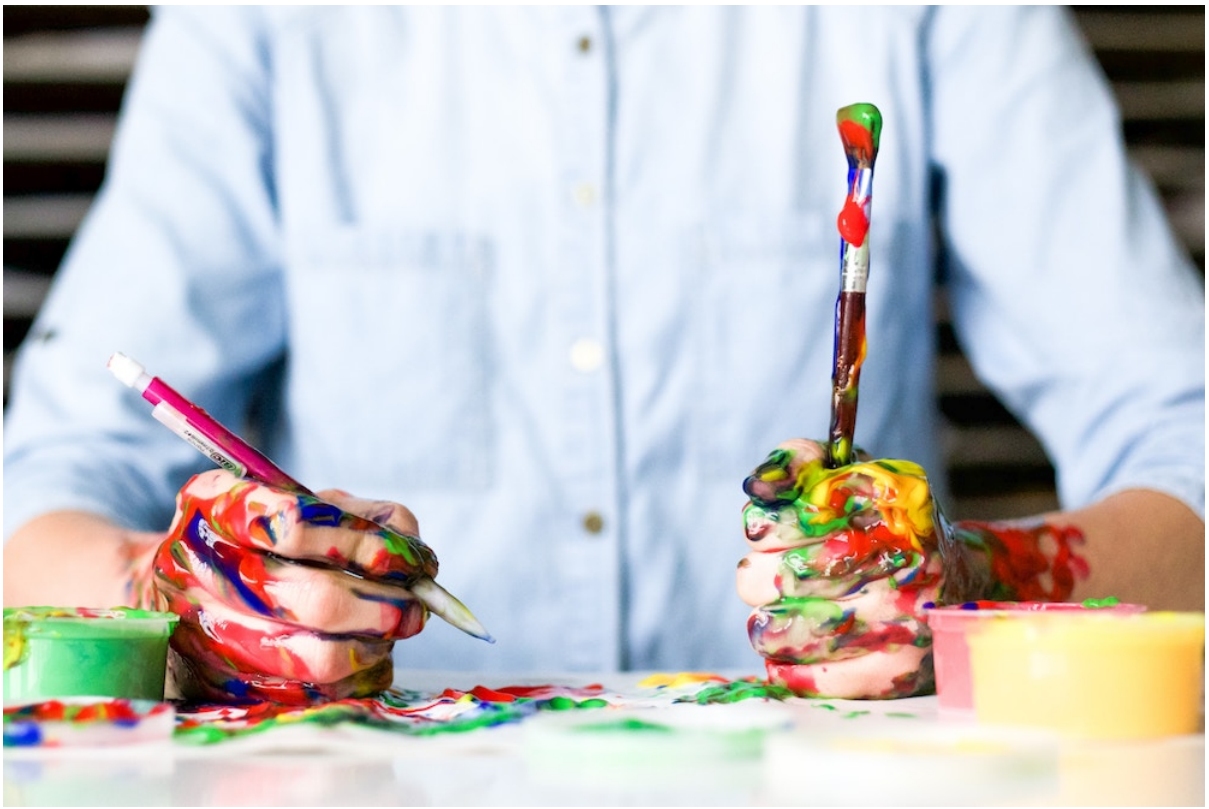
Can the New Year Bring A Real Solution to Affordable Health Care–From Providers?

written by Theresa Hush | January 4, 2018



Every New Year, we commence another round of solutions to fix our expensive health care system. 2018 will be no different. A predicted 5.5 percent increase in medical costs over last year will no doubt spawn new efforts to contain direct payments to providers or transfer costs to consumers—or both.

No solution has appeased health system stakeholders, including employers, health plans, consumers and providers. No matter where the system is pinched, another part reacts, and costs continue to outpace inflation.

Most solutions, however, have been implemented by payers—government and commercial health plans, as well as employers—against providers and consumers. Why have we been so unsuccessful? Perhaps because most solutions do not affect the real driver of health care costs: medical decisions.

Those medical decisions, made daily and individually by millions of patients and physicians, are

what control cost trends. They are embedded in every physician visit, every decision to pursue further testing or imagery, in every treatment decision, in every drug prescribed but not taken because of cost or side effects. Yet those decisions and the decision-making process have remained outside the realm of reform. It's time for provider systems to get serious and take responsibility for reining in costs by facilitating better decisions by patients and their physicians.

Wait—am I actually saying that providers can fix health care so that it's affordable? Not quite, given the complexity of the system's many moving parts. I'm saying this is a prospect to consider seriously. Not only is facilitating better medical decisions one of the few options left for providers, but also health systems may eventually be compelled to do so, as they reckon with declining revenues.

Insurers Attempt to Fix Health Care Costs with Payments and Access

For more than forty years, action/reaction has characterized health care reform ideas: action by health plans and employers to remove costs from the system, and reaction from providers to stay afloat. Hugely unpopular HMOs that restricted consumers' access to services were virtually eliminated and replaced with broader PPO plans. The industry then quietly adopted narrow networks and transferred costs to employees through high deductible benefit plans. Health plans introduced price negotiations with providers, slowing the cost increases—until providers recognized the value of scale and consolidated to gain leverage and market share.

This past decade, trending strategies rewarded providers for delivering better value through quality and cost performance (to be sure, this has been paired with strong efforts to continue shifting costs to consumers). But signs of moving away from Value-Based Heath Care (VBHC) are emerging. Provider pushback against MACRA regulations as overly complex and burdensome has already significantly reduced the pace of implementation by Medicare, the strongest influencer in VBHC.

The lesson is clear. Health care purchasers may have constrained access and temporarily shifted dollars, but not achieved a reduction in medical costs. The tools of finance are too blunt.

Employers Try Patient Engagement and Wellness

Employers bought into VBHC because, conceptually, getting value for their health care investment made sense. They have promoted "good" providers in health plan networks by creating incentives for employees to choose them amongst their employee offerings.

Employers are now equipped with data, including the health status consequences of inactive lifestyles and obesity, as well as risks in their employed populations. They have become more involved in "patient engagement" programs, incentivizing employees and dependents to achieve better health (or penalizing those who maintain bad habits). They have created care management programs for patients with chronic disease and substance abuse issues, and have sometimes mandated their use.

Employers have also shifted the cost burden to the consumer under the premise of making employees more responsible for their health care investment. Health spending accounts, called Consumer-Directed Health Plans by many employers, are cast as rewarding employees who save money by making better medical decisions. Yet these are only financial accounts and neither provide access to the information that employees need to make better choices, nor address barriers to doing so. They reward well people, not sick people.

Employers have also established many wellness programs, although evidence of success for traditional employer wellness or disease programs is slim, with low participation and poor results on costs. Still, many companies believe such programs can be tweaked for better success, by better integrating them into the employee experience or compensation.

Employers certainly have made employees very aware of the cost of risky lifestyle decisions *to their employer* as well as to those patients. However, actions so far have not arrested the ascent of health care costs. Like health plans, employers' tools are predominantly financial. In the future those could prove important, however. Providing better tools—such as technology for self-monitoring employee health—could play an extremely important role in employee engagement decisions and create a bridge to provider efforts. The willingness to finance employees' efforts to self-monitor blood pressure, glucose levels and other risk levels may indicate that employers can direct their financial assets to meaningful solutions.

What Providers Can Contribute to Reverse the Cost Trend

That brings us to providers. Health systems absolutely can influence *who is making medical decisions (physicians versus patients), and how those decisions are being made, amidst an outcome of at least some uncertainty*.

Many providers believe that they are in the business of making medical decisions, and this has certainly been true. But the paradigm of provider decision-making is fraught with issues of patient economics and reimbursement incentives that reward providers for treating those patients. This is part of what VBHC has aimed to correct, by exposing those weaknesses.

Provider decision-making also can have unintended results. The opioid epidemic is a chilling example of flaws in decision-making by physicians who not did not understand the consequences of their actions for their patients.

A better strategy for who makes medical decisions is gaining traction: help the patient decide, with physicians providing guidance and data.

"An outcome of at least some uncertainty" is the second key principle that patients and physicians must acknowledge. Without recognizing that medical science is still developing, and that the use of diagnostics, knowledge about the effects of treatment, and the impact on an individual presenting patient are still in flux, patients and physicians cannot make reasonable, economical medical decisions. The push to do more testing and more aggressive treatment is too often based on assumptions that are not always borne out by science. For example, we can "overcontrol" medical indicators (HbA1c is an example) and push patients into dangerous situations by trying to do more. That discovery and others were made by examining patient results after over-zealous efforts to do well failed.

We are only just discovering new associations between risk factors and disease. Many theories we thought true in the past have been debunked. Even some standardized quality measures used in measuring provider performance, vetted thoroughly by medical experts and specialty committees, may soon prove to be outdated, if not inappropriate, as we learn more about factors in diabetes, the effects of hypertension, and the interplay of seemingly irrelevant risk factors, such as sleep.

In the face of this scientific flux as well as an overwhelming information overload, it is appropriate to expect physicians and their provider systems to create new, cost-effective medical decision frameworks. Too idealistic? Perhaps, but here's why they should: Taking back the medical profession from financiers will depend on provider action to reduce spending on technology and prescription drugs, and to get better results from and with their patients.

Three Steps Providers Can Take Now to Pave Way for Better Medical Decision-Making

Moving from theory to solutions requires time and a concerted, detailed effort. But there are immediate actions providers can take that will build the foundation for a cost-effective decision framework. All stakeholders in the system have bet on the patient's ability to make better decisions. While payers have tackled this with financial tools, providers can play a more consequential role in the actual decision-making setting.

For providers to take charge of generating the solution to constrain costs, physicians and provider systems should utilize clinical and educational tools in their core competency. This means providing data and information to patients that enable them to make better medical decisions. The idea is to help patients make decisions that are not only in their own best interest, but also more cost-effective for the health care system.

1. Open avenues for patients to access data—their own as well as information sources for medical decision-making.

Providing a patient portal to the provider's data is a start, but it doesn't go far enough. Patients need easy access to their full records and images, with less bureaucratic entanglement, at no cost, enabling them to validate their diagnoses and treatment plans. And providers should encourage this. Patient loyalty cannot be mandated; generating information to patients is the best way to ensure that they will continue their relationship.

Creating avenues to other information sources about conditions and treatment alternatives requires health systems to compile that content (or purchase from outside entities). Some health systems have created an information bank and become trusted entities for patients as a result (e.g. Mayo Clinic). Unless patients can access this information, they cannot engage in results.

2. Facilitate patient education by all providers.

Not all interactions between physicians and patients involve medical decisions, but all involve patient education. Provider systems need to encourage methods of educating the patient, whether or not there is a formal medical decision or sequence of decisions to be made. A few possibilities:

> Train physicians to cultivate motivational and persuasive conversational skills to distribute information;
> Compile educational information for patients on their conditions and generalized issues, as appropriate;
> Improve patient numeracy and literacy regarding medical results. Whether offsite, online or in distributed patient material, provider systems can incorporate methods to improve patient understanding of health care terms, how to distinguish symptoms and diagnoses, how to convey issues to physicians, and how to interpret lab and research results—enabling them to participate with confidence and ask relevant questions.

3. Analyze and continue to track longitudinal data to evaluate current state of medical decision-making, and evaluate both provider and patient attitudes about the decision process.

Current performance measurement does nothing to evaluate how medical decisions have been made, particularly with regard to cost. Primarily, these performance measures have focused on process and very limited patient results, and are used for external reporting of quality rather than to fuel improvement. Instead, we need a constructive analysis of patterns of care, of longitudinal patient outcomes, and tracking of cost measures. This is not natural territory for provider systems, which will most likely need outside expertise and/or technology.

Health care systems have been worn down over the years by a system of control and external regulations to manage costs. That system may have slightly modified the rate of growth, but has been unable to significantly slow the escalation over time or improve outcomes for all patients. To avoid being sidelined in a market that will see growth of entrepreneurial mergers and freestanding clinics as a viable alternative to provider systems, providers must demonstrate that they can steward patient care while providing a system that is responsible both to patients and other care purchasers.

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: Alice Achterhof