The Hedge Bet for Risk is Patient Experience

written by Theresa Hush | October 17, 2019

Creating a good Patient Experience in health care has gained little traction, despite being touted as one of the Triple Aim's key goals in Value-Based Health Care. Health systems have been more focused on how to increase patients via health plan negotiations and consolidating regional providers, rather than focusing on the slower paced process of improving customer appeal.

But now Patient Experience appears to be gaining some attention, and some forward-thinking providers are innovating to be more attractive to patients. Why? Because in the fiscal landscape of Risk, growing patient volume is essential. Providers are beginning to realize that there actually is competition for those patients.

Patient Experience Should Address Issues Beyond Convenience, Including Quality and Cost

From choosing a physician to paying for completed services, consumers have registered many complaints about the Patient Experience. Let's examine just the highlights:

Lack of easy-to-find information (beyond basic credentials) to help decide choice of provider;
Difficulty accessing new provider within a reasonable timeframe;
No availability of online scheduling;
Restricted or no access to established provider (directly to office) for urgent needs;
Long waiting times at appointments;
Not enough time with physician during appointments;
Lack of data or information supporting treatment proposal;
Lack of cost information on treatment;
Cumbersome, time-consuming authorization and referral policies;
Billing issues.

However, the issues go deeper than convenience. We haven't really addressed what consumers have a right to expect from health care providers in Value-Based Health Care—including the safety and quality of the experience.

In fact, the measurement of Patient Experience is somewhat controversial, as defined by two different schools of thought. One school holds that Patient Experience should be informed by satisfaction with health care entities' convenience and responsiveness. The second school counters that measuring whether health care delivers a good Patient Experience raises a larger question that also incorporates the quality and safety of health care services. How to properly account for what consumers should expect, and how to measure it, is at the root of the World Health Organization's (originators of the Patient Experience discussion) efforts to examine how best to respond to consumers.

For providers, this broader definition means they should also assume responsibility for responding to a second set of issues as part of Patient Experience strategies:

Health care outcomes and quality measure results;
Mortality rates associated with key procedures and/or hospital diagnoses;
Readmission and surgical redo rates;
Costs associated with medical and procedural episodes;
Medical decision-making processes and information that will be provided to patients;
Inter-operability and policies on access to medical records;
Patient safety results, including MRSA and infection control policies.

Obviously these are not issues that can be resolved in the near term, but every provider needs to understand that patients cannot segment their experiences into convenience and quality. That fact is becoming clearer as we look at how young adults are deciding how to get their

health care services.

According to a 2018 Kaiser Family Foundation study, 45 percent of millennials between the ages of 18 and 29 have no primary care physician. The survey also found that young adults tend to rely on retail pharmacy clinics and online telemedicine sites. Conveniences in scheduling and hours, as well as cost, are responsible for the shift in thinking. However, that doesn't tell the whole story. Because if consumers could distinguish the value of health care and expect a Patient Experience of higher quality and known cost, the trends might well be different.

As Value-Based Health Care educates consumers, they will expect data and information on both convenience and quality to be standard fare. The Patient Experience, to convey more value, cannot be minimized as simply average wait times or hours of service. It has to ensure that the patient and consumer—as for any personal service or, in fact, even any retail experience—can make prudent decisions based on quality and price. To do that, providers must supply clear and accurate data to patients and consumers as they choose providers, seek services, and make medical decisions.

Provider Consolidation Too Often Works Against Good Experience

Consolidated health care has brought centralization and bureaucracy to health care, alienating physicians—but also their patients. Health care consumers are trading war stories about how to get through the health care system, especially the new centralized call centers and appointment scheduling, which now cover literally thousands of physicians.

The frustration of bureaucracy is just starting to emerge in data, which appears to indicate that while consumers are more satisfied with a high degree of insurance consolidation in their locale, they are much less satisfied with the effects of a big health care bureaucracy.

Efficiency and quality cannot be achieved by increasing the distance between clinicians and their patients, when they most need help, without affecting the Patient Experience. Ask patients what they want—and have always wanted: time with their doctors. Not surprisingly, physicians complain about the same thing.

Urgency of Strategies for Patient Experience Under Risk

The governmental health care market is moving Value-Based Health Care rapidly toward Risk. In addition to new Risk models for Primary Care and Accountable Care Organizations (ACOs),

Medicare has aggressively promoted Medicare Advantage (MA), approving inclusion of attractive benefits beyond straight Medicare, and favorably characterizing the plans. MA plans have continued to maintain high enrollment growth over several years, and now cover one-third of beneficiaries as the Medicare population surges. CMS predicts that MA plans will cover half of beneficiaries by 2025.

If Medicare patients continue to choose Medicare Advantage (MA) plans based on their costs and advantages, however, health systems will find themselves trapped in an insidious downward spiral of Risk. Intensifying the pressure, as MA plans grow, healthier, lower cost patients will go with them; as a result, providers will be less able to manage under the risk-based reimbursement being incorporated into Medicare ACOs, Primary Care Models, and Bundled Payments.

Medicaid is on a similar trajectory to Value-Based Health Care, although every state is slightly different. Medicaid Value-Based Health Plans and risk-based payments are a common theme, but with the lower rates that accompany that program.

Large, non-government health care is also transitioning—to employer-contracted narrow provider networks. With large health plans largely acting as financial intermediaries rather than actual insurers, employers are now directly working with local hospitals and physicians to supply services to employees. Walmart, the largest employer in the nation, is testing such a plan. Progressive providers, such as Cleveland Clinic, are implementing a strategy to expand through employer contracting of health care services.

As Value-Based Health Care matures, there won't be any "outs" for providers to find purchasers, either health plans or patients, who aren't motivated by Value. Consumers will have more access to comparative information on the Internet—truthful or not. Many strategies require a long lead-time, but that's all the more reason for taking action now.

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: Asa Rodger