

EXSUM Health Systems: Slaying the Unicorn: Deconstructing Cost, Quality, & Access

Question:

Healthcare costs in the United States are rising and causing declines in both access and quality. Beyond the argument of a fee-for-service incentive system driving costs and superfluous care, this paper highlights increasing costs resulting from a cyclical pattern of care for reasons other than physician greed. The pattern includes patients receiving technology-heavy diagnostics and interventions for reasons ranging from defensive medicine to chasing patient satisfaction. These treatments lead to decreased quality and poor outcomes. Poor outcomes lead to admissions in emergency rooms, inpatient hospitals, and visits for acquired comorbidities.

Domain/Competencies:

Leadership and Organization Management

Performance Measurement and Improvement

Method of research/Model: Literature Review- Kissick's Iron Triangle, Managed Care Quaternion

Through peer-reviewed articles, textbooks, and periodicals, this paper displays causes and metrics within this cycle of care. By identifying causality, debunking myths, and reviewing results from a practice in Seattle that changed the way healthcare is delivered, it is possible to increase quality and access, while reducing costs; effectively deconstructing the idea of an iron triangle.

Assumptions:

The models used by Group health in Seattle, Washington, and eliminating chasing patient satisfaction through excessive diagnostics and prescribing would be exportable to other facilities.

Overview:

Regarding healthcare, the iron triangle surmises there is simply no way to provide increased access to healthcare providers, who will then deliver quality healthcare to patients at low cost. This thought has held true for quite some time, but with advanced thinking and some creativity, it is possible to shift the paradigm. Improving cost, quality, and access is not the mythical unicorn many believe it to be.

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Contradictory to the many naysayers, at least one medical practice, Group Health, operating out of Seattle, Washington, launched a prototype clinic to determine if improving access to care, quality, and patient satisfaction at the same time was indeed an impossibility.

Healthcare costs in the U.S., as a percentage of gross domestic product (GDP), have been steadily rising and are (generally) the greatest barrier to access and quality. When compared to healthcare expenditures in other industrialized nations within the Organization for Economic Cooperation and Development (an international 34-nation-member economic group), the U.S. spends nearly two times the average. In primary care, the United States spends almost two times the nearest nation, Switzerland (Kane, 2012). Furthermore, these costs have been erasing the realized rise in net income, particularly for the middle class.

When ranking the quality of healthcare in the United States against economically comparable nations across ten metrics including quality, access, efficiency, equity, healthy lives and expense, the overall result is last place out of 11 other leading, industrialized peers. Contrary to the thought that an increase in spending is the result of the increase in number of physicians, the U.S., when measured against its peers on the number of physicians per 1,000 people, falls well below the average of 3.1 per 1,000. In fact, the United States only has 2.4 physicians per 1,000.

Findings:

There is no single cause for the dramatic rise in U.S. healthcare costs. However, it is possible to identify a few key factors as significant driving forces. After exploring the impacts of technology, defensive medicine, and chasing patient satisfaction, we are able to better understand a cyclic force responsible for driving the trends in rising healthcare costs. Compounding the problem of increasing costs are the negative clinical outcomes associated with many of the same drivers.

No other country has embraced advances in medical technology like the United States. In fact, the U.S. owns 151% as many MRI machines, per capita, as the industrialized peer-group average. With these machines, we conduct 111% more MRIs. Additionally, the United States owns 80% more computerized tomography (CT) scanners per 1,000 people and conducts 114% more CT scans than its peers.

Beyond diagnostics, on a per capita basis, the U.S. conducts 96% more tonsillectomies, 67% more coronary bypass surgeries, 86% more knee replacements and 26% more caesarian sections. Not all of these additional tests and procedures result in an increase in quality, longevity, or positive outcomes. What all of these interventions do contribute is an increase in costs. To illustrate this point, a brief analysis of one diagnostic procedure is required.

When evaluating a small sample of MRI costs in America, the median price for an MRI is \$2395 with a range of \$400 to \$4700. In France, for example, an MRI will cost about \$280. Whereas in Germany, the same procedure will cost around \$839, and the United Kingdom sets prices very

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low, at nearly \$180, on average. The most telling difference when comparing the prices of these procedures is in the fact that all three of these other countries outrank the U.S. when it comes to measures of quality.

Another trend contributing to rising costs, and potentially the decline in quality of care, is the practice of defensive medicine. A common idea or excuse behind practicing defensive medicine is to avoid frivolous litigation. Unfortunately, the belief of runaway malpractice lawsuits is largely a myth. In reality, there are far more actual instances of medical malpractice than there are malpractice lawsuits, and the rate of lawsuits due to medical malpractice is very low. Multi-state studies, across broad populations reveal only around 3% of malpractice cases terminate in trial. In New York, a study of 30,000 records found only 280 actual cases of malpractice. Of those 280 cases, only eight were brought to trial. Additional reviews of 15,000 records from Colorado and Utah revealed 161 cases of medical malpractice, of which only four were litigated. Additionally, medical malpractice payments in 2012 were 43.4% lower than in 2001. What is supported is the fact that increased treatment (whether defensive or not) increases the cost of care. When examining just orthopedics, defensive medicine is responsible for 24% of all tests ordered, resulting in over \$2 billion in excess healthcare costs. When examining costs associated with defensive medicine across the country, in all specialties, expenses in excess of \$650 billion are reported. This tells us that even though malpractice is not (or should not be) a threat, there is something driving the delivery of defensive medicine.

Chasing patient satisfaction is becoming a more common concept. As greater incentives are tied to pleasing patients, and as medical practices compete for business, providers are beginning to more often treat in the name of pleasing the patient. This includes ordering additional tests, procedures, and medications. As noted earlier, additional interventions contribute to rising costs and decreased quality outcomes. While rising costs in isolation are bad, the picture becomes bleaker when examining the negative outcomes associated with superfluous intervention(s). The data points to a negative correlation between patient satisfaction and actual quality outcomes; the relationship is inversely related. What this research found is patients with higher rates of satisfaction are actually the least healthy, spend more time in the hospital, cost more, and use more prescription medications.

In a 142,565 person-years study that ran from 2000 to 2006, the most satisfied patients (relative to the least satisfied) had a 26% greater risk of mortality. Additionally, the data clearly supports the correlation of patient satisfaction with greater medical intervention. There are higher prescription drug expenses, higher medical expenses overall, and higher hospital admissions associated with the most satisfied patients, who also happen to carry a greater risk of death.

In 2006, Group Health in Seattle, Washington launched a prototype primary care clinic to test a revamped patient-centered medical home model. They launched a similar program in 2000, which failed due to provider burnout from misaligned incentives.

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When developing the new prototype clinic, Group Health decided to hire more providers and support staff, reduce provider panel size, and increase scheduled visit times. In terms of quality outcomes, using the Healthcare Effectiveness Data and Information Set (HEDIS), at the 24-month mark, the prototype clinic improved by 20-30% as compared to control group clinics. When measuring access to care, the prototype clinic found patient utilization decreased by 6%. There was a large increase in virtual visits. Finally, when measuring costs, as you would expect, per-member-per-month costs in the test clinic rose slightly from the increase in staff; however, associated with the increase in quality, the decrease in emergency room use and decrease in inpatient hospitalization, the overall per-member-per-month costs fell by \$10.31.

Lessons Learned:

Currently, the U.S has a system that, while good intentioned, is contributing to a decrease in quality, a decrease in access to care, and an increase in cost. Increasing costs only serve to further prevent access and decrease quality. The cycle driving increased costs partially stems from providers using technology-rich practices, often in the name of defensive medicine or chasing patient satisfaction, which results in decreased quality and poor outcomes. Decreased quality and poor outcomes result in the need for further treatment. The need for further treatment drives a decrease in access for new patients, and the patients cycling back through are now more complicated and require greater care. The cycle creates more complex cases which require greater resources, which generate poorer outcomes. Breaking the cycle is imperative to the future of U.S. healthcare. Breaking the cycle is possible and proven.

When Group Health in Seattle used strategic thinking and expanded their primary care operations (at a nominal upfront cost), they experienced overall gains in access to care, quality outcomes, and a significant decrease in per-member-per-month costs. It was an innovative concept, and while the prototype clinic was somewhat small in scope when compared to the rest of the practice, it absolutely serves as proof of concept.