

AN HFMA REPORT

Health Care 2020

**A series of reports examining how to prepare for major
healthcare market trends over the coming years**

REPORT 2 of 4

Consumerism



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healthcare financial management association

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Health Care 2020

Report 2 Consumerism

Previously Released:

- Transition to Value

Coming Later This Year:

- Consolidation
- Innovation

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Contents

From the President	1
Executive Summary	2
Becoming ‘Consumer-Centric’	4
Promoting a State of ‘Health Ownership’	5
Understanding the Individual Consumer	7
How to Listen to Consumers	9
Overcoming Barriers to Consumerism	11
Consumerism’s Link to Value	13
Sidebars	
Expert Advice: Two Approaches That Work	6
Expert Advice: Do What You Do Best.	8
Consumerism and Patient-Reported Outcomes	9
Consumerism and Demographics	13
Interviewed for This Report.	14

Dear Colleagues

Consumers are paying more out of pocket for their health care, and that changes everything. As recently as a few years ago, the patient financial experience was not “a thing.” Now, a Google search for that term returns nearly 6 million results.

Healthcare organizations are coming to terms with the idea that healthcare transactions are no longer exclusively B2B, and that they need to adapt their business processes to deal with real people—all kinds of people, in all kinds of situations. Some people are making purchases they didn’t plan for or didn’t choose to make. When it comes to “shoppable” services, some are sophisticated consumers who are frustrated by a marketplace with no price lists and seemingly no one to ask for price information. Other would-be shoppers are dealing with language or financial literacy constraints and don’t know where to begin.

It’s easy to see that healthcare consumers have different wants and needs based on their unique circumstances. One of the key takeaway messages in *Health Care 2020: Consumerism* is that consumerism will not truly gain traction until organizations make a point of genuinely listening to consumers. That point cannot be stressed enough. Health care may be different from other consumer markets in some ways, but we share this in common—there is no substitute for listening to your customers. If you listen to the people in your community or your market describing the unique circumstances and challenges they face, they will tell you what they need.

Another key takeaway from this report is that health plans and providers that fail to respond to the imperatives of consumerism will risk losing relevance as the move to value-based payment gains traction, while consumer-savvy organizations will be positioned to thrive. Consumerism is a trend that is here to stay, and one that will continue to impact all healthcare stakeholders in the emerging value-based payment environment.

HFMA greatly appreciates the contributions of the following individuals who served as resources in the development of this report: Jean-François Beaulé, UnitedHealth Group; Angelo Dascoli, 32BJ Health Fund; Ishani Ganguli, MD, Massachusetts General Hospital; Donna Graham, MetroHealth System; Roger Holstein, Healthgrades; David Hopkins, PhD, Pacific Business Group on Health; David James, MD, JD, Memorial Hermann Medical Group; David Johnson, 4sight Health; Pat Mastors, The Patients’ View Institute; Greg Meyers, INTEGRIS Health; Jason O’Riordan, Kaufman, Hall & Associates, LLC; and Craig Richmond, MetroHealth System.

The *Health Care 2020* series, which also addresses the transition to value, the trend toward consolidation, and the need for innovation, is designed to provide strategic guidance for healthcare organizations to prepare for major healthcare market trends over the coming years. HFMA also offers comprehensive resources on consumerism in its Healthcare Dollars & Sense® initiative, which encompasses price transparency, patient financial communications, and medical account resolution ([hfma.org/dollars](https://www.hfma.org/dollars)). We hope you will find all of these resources useful.

Best,



JOSEPH J. FIFER, HFMA, CPA
PRESIDENT AND CEO, HFMA

Executive Summary

In conjunction with the release of this *Health Care 2020* report on the increasing impact of consumerism, HFMA issues the following guidance for industry stakeholders.

Improving the Patient Experience

The delivery of health care has always been a patient-centered endeavor. Unfortunately, the business of health care has not always been so. However, over the past 10 years two very different purchaser trends—increased patient cost sharing at the point of service and a shift to outcomes-based payment—have converged to catalyze a movement toward consumerism in the healthcare industry.

In response to this new consumer focus, we are seeing providers and health plans adopt tools and techniques traditionally found in other industries to gain a better understanding of consumer behavior and to make more information available to consumers. This deeper understanding is then used to inform strategies and tactics for both product development and care delivery. HFMA believes that, moving forward, the ability to generate and leverage consumer insights will be crucial to the success of health plans and providers. Consumers are demanding a better experience—which providers, health plans, and physicians will have to deliver to remain competitive.

Consumerism and HDHPs

Purchasers are leveraging both of the aforementioned trends in an effort to reduce their exposure to healthcare costs by turning patients into “shoppers” and incenting delivery systems to provide high-quality outcomes in the most efficient manner possible.

High-deductible health plans (HDHPs) are directly linked to the consumerism “movement.” And while the potential impact on providers—particularly high-cost providers—is clear, increased patient cost sharing also has subtle implications for health plans.

For providers, HDHPs have the potential to move volume from high-cost to low-cost sites of service. They also could

For health plans and providers to succeed under outcomes-based payment, both must understand and engage patients in two ways to manage the risks inherent in these new payment models. The ability to do so will hinge on the capacity to understand the attitudes, motivations, and preferences of the consumer/patient.

negatively affect patient satisfaction if patients are not aware of their obligation in advance of the service. Providing access to price estimates thus continues to increase in importance.

In response, many health plans are making transparency tools available to their members to support these benefit designs. But in many instances these tools are not broadly used because the plans have not managed to fully understand their members’ motivations and behaviors. Those plans that attain such an understanding have developed innovative member engagement strategies and have significantly higher rates of patients who shop for care, thereby lowering costs for both the patient and the plan.

Consumerism and Value-Based Care

If the link between consumerism and HDHPs is obvious, the connection to outcomes-based payments is less so. On the surface, the transition to outcomes-based payment models is about aligning the incentives between health plans and providers and reconfiguring the delivery system. However, a closer examination reveals that for health plans and providers to succeed under outcomes-based payment,

both must understand and engage patients in two ways to manage the risks inherent in these new payment models. The ability to do so will hinge on the capacity to understand the attitudes, motivations, and preferences of the consumer/patient.

First, this knowledge will be necessary to perform a diverse set of activities ranging from increasing convenient care-access points to engaging patients to change behaviors that drive adverse outcomes.

Second, success under outcomes-based payment means eliminating the “unnecessary” utilization that historically has helped support a delivery system’s fixed-asset base. Delivery systems that succeed financially under outcomes-based payment models will be those that can increase their number of lives under management, thereby ensuring sufficient revenue to cover fixed costs. In turn, a key to increasing the size of patient populations will be providing a consistently good experience of care from the patient’s perspective.

Understanding Consumers

From the discussion above, it’s clear that understanding what drives consumers and patients will be key to future success. However, the ability to generate actionable consumer insights historically has not been a core competency for most health plans or providers. To surmount this barrier, health plans and providers are quickly adopting techniques and analytics that previously have been used by “customer facing” businesses such as consumer packaged-goods companies and retailers to generate actionable insights about their target customers.

Progressive organizations are augmenting tools such as patient satisfaction surveys by implementing techniques to capture and share informal feedback from patients. These techniques range from incorporating weekly discussions of patient comments in every department meeting to including patients on care- and business-process reengineering teams.

In addition to incorporating direct patient feedback, health plans and providers are applying analytic tools to the disparate data sets at their disposal. Combining claims with nonhealthcare data can reveal insights that address issues ranging from how best to engage a segment of polychronic patients in their own health care to what is the optimal mix of access points to gain market share. When organizations are able to generate consumer insights and act on them, the results speak for themselves.

The ability to generate actionable consumer insights historically has not been a core competency for most health plans or providers. To surmount this barrier, health plans and providers are quickly adopting techniques and analytics that previously have been used by “customer facing” businesses such as consumer packaged-goods companies and retailers to generate actionable insights about their target customers.

The Potential of Consumer Insights

Two examples illustrate the ways in which organizations are embracing consumerism and using consumer insights to succeed in an increasingly competitive marketplace for healthcare goods and services.

Conventional wisdom holds that hospital-based delivery systems will lose volume as patients react to HDHPs. However, one system used its deep understanding of the price sensitivity of patients in its market to develop cash prices for “shoppable” services and procedures. After it acted on this insight, outpatient radiology volumes *increased* by 23 percent.

Similarly, outcomes-based payment coupled with consumer insights is creating business opportunities out of formerly unprofitable customer segments. A health plan leveraged a deep understanding of the attitudes and motivations of its diabetes population to develop an insurance product specifically for this segment. By tailoring the patient benefit design and provider network, the plan was able to improve health risk scores and reduce the cost of care by 4 percent.

Becoming ‘Consumer-Centric’

The United States has 95 percent fewer department store chains today than in 1962, when the first Walmart store opened with promises of low prices and good service. Healthcare providers should not ignore the lesson, says David W. Johnson, CEO of 4sight Health.

“Consumerism, when it’s fully unleashed, is a value-seeking machine,” he says. “The winners will be those that get on board the value train and figure out, ‘How do we as an organization really provide the best care at the lowest prices in the most customer-friendly way?’”

HFMA defines consumerism as “a trend that reflects the growing importance of consumer choice in the healthcare marketplace”:

Informed choices are based on solid information. As consumers take a more active role in choosing among a growing array of health-related goods and services, the healthcare industry is called upon to offer reliable, accurate, and timely information on quality, price, convenience, and experience, thereby enabling consumers to make choices that best serve their needs. Organizations that are committed to consumerism seek to improve all dimensions of value for consumers, including convenience, access, and experience.

The task is taking on urgency as the healthcare industry moves into an era in which patients have greater motivation and opportunity to make informed purchasing decisions. Patients are beginning to understand the wide variation in prices and, given their ever-increasing out-of-pocket responsibility, are seeking out lower-cost options. Consumer-oriented health plans and providers are considering how they can meet that demand.

“We all want to talk about the consumer, but the reality is that we’re still not living in a consumer-centric kind of healthcare system—it’s still a very provider-centric world,” says Roger Holstein, CEO of Healthgrades. “Health systems fully recognize the need to move there, but defining it is the challenge that they’re all dealing with because there are so many cultural, systemic, attitudinal, and behavioral things that would have to change to be a consumer-centric system.”

The lack of progress to date stems in part from the fact that most provider organizations continue to derive the vast majority of revenues from fee-for-service contracts. Thanks to volume increases and increased insurance coverage arising from the Affordable Care Act, some organizations may be seeing their financial performance improve despite not significantly increasing the value of the care they deliver.

“It’s tempting to think we can go back to the old way of doing things,” Johnson says. “But there’s a general belief that the U.S. healthcare system is remarkably inefficient on both a relative and an absolute basis, and that increasingly the organizations that are paying for this want more value.”

Health plans and providers that fail to respond to the imperatives of consumerism will risk losing relevance as the move to value-based payment gains traction, while consumer-savvy organizations will have an opportunity to gain market share. Thus, developing a consumerism strategy should be viewed not as another bullet point on a healthcare executive’s overcrowded to-do list but as a tactic that supports the paradigm shift to value-based care delivery.

“We see a lot of misconceptions that consumerism and population health, or value, are mutually exclusive,” says Jason O’Riordan, senior vice president, Kaufman, Hall & Associates, LLC. “We really think that consumer understanding and consumer strategy are foundational.”

→ KEY TAKEAWAY

With volume-based payments still holding strong, delivery systems need to attract and retain as many patients as possible to be successful. But appealing to consumers likewise is important for population health management and value-oriented payments. Meeting consumers’ needs and expectations is key to keeping them in a health system, which in turn is essential for optimal care management and patient engagement.

→ ORGANIZATION TO WATCH

Providence Health & Services is embedding 25 clinics in Walgreens stores in Oregon and Washington in the next year—and opening 25 freestanding walk-in clinics as well.

Open seven days a week, the clinics offer easy access to routine acute care services and will eventually offer chronic care management. Providence is also adding on-site employer-based clinics and experimenting with home visits to make it easy for consumers to access care.

Promoting a State of ‘Health Ownership’

The combination of increased cost sharing and value-based payment models is changing the dynamic between consumers, providers, and health plans because, for the first time, all three have a financial incentive to promote health.

“We consumers live our lives the way we lead them, then we get sick and we expect the system to pull out all the stops and take care of us,” says 4sight Health’s Johnson. “If we, as a country, are going to pull ourselves around this healthcare spending problem, there has to be shared accountability.”

The financial incentive for individuals to share accountability is coming in two forms.

High-deductible health plans are continuing to gain momentum. In 2015, 24 percent of all workers were enrolled in a high-deductible plan, meaning their plan carries at least a \$1,300 deductible for an individual and \$2,600 for a family, according to the Kaiser Family Foundation (KFF). PwC’s Health Research Institute reports that within the next three years 44 percent of employers are expected to offer high-deductible plans as the only option. Meanwhile, 88 percent of individuals who bought coverage through a federally facilitated or state-run insurance exchange in 2015 chose either a silver- or bronze-level plan, KFF reports. The average deductible for 2016 is \$5,765 for bronze plans (up from \$5,328 in 2015) and \$3,064 for silver plans (up from \$2,556).

Employers are increasingly implementing incentives and value-based design components to promote both healthy choices and better use of the healthcare system.

At least 70 percent of large employers offer wellness-related financial incentives for their covered population. These programs typically include a health survey or biometric screenings and incentives for efforts to stop using tobacco, lose weight, or take other proactive steps to improve health. The average incentive per individual today is about \$500 to \$600, although some are as high as \$1,000 per individual, says Jean-François Beaulé, executive vice president of design and innovation at UnitedHealth Group.

With this increased financial incentive for members to improve both their health status and their care choices, plan sponsors and physicians face increased pressure to offer more support and convenient resources to ensure the fairness of this new “healthcare deal,” Beaulé says. “We have to view the system as a whole where we are collectively architecting favorable conditions for a better experience that will motivate all of us to improve decision making about healthier choices,” he says.

→ KEY TAKEAWAY

Health plans and providers both will be increasingly responsible for providing the education, information, and tools that consumers need to take ownership of their health.

→ ORGANIZATION TO WATCH

UnitedHealthcare introduced its first value-based insurance design plan—the Diabetes Health Plan for individuals diagnosed with diabetes or prediabetes—in 2009. Plan members received free or reduced cost sharing for diabetes-related physician visits and certain medications and supplies. In turn, they were required to be engaged in the management of their disease by complying with guidelines for doctor visits, lab tests, and wellness programs.

The value of the Diabetes Health Plan was proven in a two-year study of 620 people with diabetes. Participants in the plan, on average, achieved compliance with 75 percent of the key treatment and testing requirements—for example, regular primary care visits and screening tests for blood sugar, cholesterol, kidney function, and eye disease—compared with 61 percent for people who had diabetes and were not enrolled in the plan. More than 20 percent of the participants reduced their health risk scores—and healthcare costs for study participants grew at a 4 percent slower pace than those of their peers who did not participate in the diabetes-specific plan.^a

Building from that success, UnitedHealthcare created a portfolio of benefit designs and resources organized in a framework called Motivating Health Ownership (MHO). Through the MHO framework, sponsors can choose to target specific episodes of care, a group of members with conditions such as diabetes, or their entire population. The various design features allow members to achieve better health and be rewarded with greater economic value from their health plan.

“Health care has to be more helpful, in terms of personalization and relevance, and then ultimately, as we know, economics will always play a role,” Beaulé says. “There is better value for some choices than others.”

Promoting a State of ‘Health Ownership’ (CONTINUED)

Holstein points out that consumers on average visit a physician three to four times a year—maybe an hour of face time with a clinician over the entire year. “In the 8700 hours or so that we are not with a physician is where our health is determined,” he says.

He believes the often-elusive concept of patient engagement will be realized when health plans and providers develop more effective ways of interacting with patients. Within the next few years, he envisions weekly or even daily contact, usually via technology, between providers and patients who have chronic health conditions. “When health systems and payers begin to reach out to us as consumers to see how we’re doing, we’ll be much more likely to engage with the system and, quite frankly, become aware of the issues that we need to manage in our own lives,” he says.

Beaulé and his UnitedHealth Group colleagues are evolving to refer to *individual health ownership* instead of *consumerism*. He points out that for the past decade,

individuals have had increasingly more financial “skin in the game” for their health care, but not the support and information that provides a fair and helpful experience to achieve that higher plan value.

That is changing. Beaulé identifies three key dimensions that together can lead to a state of mind of “health ownership”:

- A deeper and more sustainable motivation to achieve or maintain good health
- Better decision making—choosing high-value providers for the appropriate services
- Expectations of a better experience

He calls individual health ownership the “next generation of consumerism. We want to collectively achieve a ‘health experience’ that appeals more directly to our own life journey and that provides the opportunity to meet the health engagement goals that most plan sponsors seek,” he says.

EXPERT ADVICE: TWO APPROACHES THAT WORK

The following strategic approaches can help healthcare organizations optimize value in a consumer-oriented industry.

LOOK OUTSIDE HEALTH CARE

Consumers have been trained by Amazon, Open Table, Expedia, and other innovators that convenience can be the norm. That’s why Memorial Hermann Medical Group in Houston is introducing telemedicine visits.

“Technology is starting to enable people to self-serve lots of things on demand,” says David James, MD, JD, the medical group’s CEO. “We’ve seen it in industry after industry, and health care is somewhat late to the table.”

But leading health systems are catching up. Inova, based in Falls Church, Va., is one of several systems that allow patients to see physicians’ schedules in real time and jump into a slot that has opened up because another patient canceled. Consumers can access schedules and make appointments online or via a mobile app.

While residents in the Washington, D.C., metropolitan area wait, on average, more than 17 days for a medical appointment, the typical appointment made through Inova’s online access occurs within 24 hours because patients can see cancellations and no-shows.

Like many other health systems, Inova also offers a mobile app that lets consumers see and compare the wait times at its emergency departments.

ADD VALUE THROUGH PARTNERS

When patients call Memorial Hermann’s nurse triage line seeking help for a urinary tract infection, they are likely to be referred to a grocery store clinic close to home. Memorial Hermann has partnered with RediClinic, which operates quick-care clinics in grocery stores, to offer convenient, low-cost access to consumers who need minor care.

The clinics are staffed by RediClinic employees who have access to Memorial Hermann’s electronic health record, meaning all services become part of a patient’s complete medical record. Through physician collaboration agreements with RediClinic, patients are referred to Memorial Hermann physicians for follow-up care if needed.

Memorial Hermann has seen rapid growth in primary care clinics that are tied to a RediClinic both geographically and with a collaboration agreement, James says.

“In terms of their production and development of panel size and our ability to add new physicians, they ramp up almost three times faster than a primary care clinic that’s standing alone without any relationship to a RediClinic,” he says.

Understanding the Individual Consumer

While design levers can encourage good decision making, they do not necessarily affect the thorny challenge of individual motivation. Many health plans provide screenings, wellness visits, and certain drugs at no out-of-pocket cost yet still have compliance rates below 70 percent. And fewer than half of those who are eligible for wellness programs actually participate in them, Beaulé says.

“It’s not the money; therefore, we need to address the motivation,” he says. “We have to remove those human barriers that are preventing the person from doing the right thing for themselves. That’s a reality that sponsors and doctors and accountable care organizations have to recognize.”

Leading provider organizations and health plans are hoping that the “consumer insights” field, long established in retail and other sectors of the economy, may help. They are collecting and analyzing new kinds of data to better understand healthcare consumers and communicate with them more effectively.

“How do we use consumer insights to optimize patient engagement and make sure that patients are holding up their end of the bargain in population health?” O’Riordan says. “That comes down to really understanding their attitudes and motivations.”

For example, consumers want convenient access to services, but convenience means different things to different people, O’Riordan says. Some want to stop at a retail clinic on the way home from work, others want a video visit in the middle of the night, and others want a face-to-face visit with their physician in a traditional office setting.

Consumer-preference research is needed to develop the right mix of venues, services, and hours that attracts consumers—and keeps them in a health plan’s network or a provider’s system. Having such a mix increases the likelihood that an organization’s investments in care management will pay off. “If we really understand our consumers, what they need and want, we can improve the chances that they will still be with us years down the road when all of the work that we put in is going to show a return financially,” O’Riordan says.

Holstein points out that data embedded in health insurance claims and electronic health records generally do not reveal the social determinants (e.g., the neighborhood someone lives in) and psychographic factors (attitudes and personality traits) that may play a central role in determining consumer behavior and outcomes. So providers and health plans must merge their patient data with information from other sources to get insight into their patient populations.

→ KEY TAKEAWAY

Consumers are not monolithic. Health plans and providers that thrive in the consumerism movement going forward will be those that understand the wants and needs of various segments of their consumer base and act on that knowledge.

→ ORGANIZATION TO WATCH

“What people really want is on-demand access—particularly those we would call the ‘walking well’ who are healthy or have conditions that are stable,” says David James, MD, JD, CEO of Memorial Hermann Medical Group in Houston. “They just need to get things done, and we’re finding that, as customers, time has become a really big commodity for them.”

In response, Memorial Hermann is reworking its access strategy to make it easy for consumers to access care at a Memorial Hermann facility in new ways:

- Quick-care clinics at 23 grocery stores in the Houston metro area
- Convenient care centers in high-traffic areas throughout Houston that are open from 9 a.m. to 9 p.m. seven days a week and offer traditional primary care, a “fast-track” walk-in clinic, an emergency department, sports medicine, rehabilitation/physical therapy, outpatient imaging, and swing space available for different specialists on a rotating basis
- New urgent care clinics
- Telemedicine visits
- Around-the-clock access to a nurse triage phone line that allows consumers to get advice on whether immediate care is needed and, if so, what the best options are: a grocery-store clinic, a fast-track clinic at a convenient care center, an urgent care center, or the emergency department.

The massive overhaul of access points supports Memorial Hermann’s goal of succeeding in the era of value-based payments. By being the most convenient option, the system can attract healthy consumers and also give patients with chronic conditions the degree of access needed for better management and lower costs.

“We are going to get ourselves in a position to work with top-line revenue and move away from fee for service,” James says. “That is going to demand that we have a large number of lives under management and that we are caring for them in a very high-value and cost-effective manner.”

Understanding the Individual Consumer (CONTINUED)

“We all know that people with diabetes need to manage hemoglobin A1C, but merely telling me that isn’t going to move me to do that,” Holstein says. “It requires your understanding of the social context in which I manage my diabetes to determine what information and services would enable me to engage the system and become aware of my diet, my exercise, my lifestyle so that, in the end, I manage my care to the best of my circumstances.”

Providers and health plans that succeed in an era of consumerism will be those that understand their customers as individuals; group them into categories based on their attitudes, motivations, preferences, or other domains; and deliver effective communications and interventions tailored to each category.

An example can be seen at Boston Medical Center. Says Richard Silveria, MBA, senior vice president of finance and CFO, “We screen patients based on socioeconomic status, language barriers, and the stability of the home situation; apply analytics to predict which individuals are more likely to return to the hospital; and assign case managers to make sure we can follow these patients after release from the acute care setting.”^b

The use of psychographic information and other consumer data can be carried further to attract the kind of patients every organization wants: highly engaged individuals who are motivated to do what it takes to improve their health status.

“Consumer insights can be valuable, not just for managing existing populations but also for targeting who you want to attract to your system as you look to manage populations in a value-based world,” O’Riordan says.

This strategy does not attempt to “cherry-pick” healthy patients with low healthcare costs. In fact, value-based contracts will pay providers considerably more for patients who have chronic diseases, O’Riordan says, because therein lies the biggest opportunity to reduce total costs.

“So the sweet spot financially, assuming proper risk adjustment, is the sicker patients who are managed really well,” he says. “Understanding this attitudinal and motivational information can be very helpful in finding and attracting those patients in the market who aren’t currently using your system but who are willing to partner with you as a provider to maximize their health.”

EXPERT ADVICE: DO WHAT YOU DO BEST

Consumers consider many healthcare services to be commodities, but they are beginning to learn that such a description does not apply to everything—and that they need to do their own research to make the best decision.

“A lot of patients have traditionally fallen back on trusting their physician to get them to the right option, assuming that quality is all the same,” says Jason O’Riordan, senior vice president, Kaufman Hall. “But we are beginning to see that change in some areas.”

For example, the success rate for some surgeries can vary significantly, and consumers are beginning to understand that a surgeon’s experience level increases the odds of a good outcome. Providers and health plans need to understand the circumstances in which patients may value provider expertise and experience above other factors.

“The messaging that more volume is typically tied to better quality for major surgery tends to resonate with consumers,” O’Riordan says. “That’s a scenario in which folks may be less worried about price.”

That means providers and payers need to understand, by service line and by customer segment, what consumers care about.

Of course, not every hospital or health system can offer the most experienced surgeons. But any organization can redirect resources to focus on what it does best. That may mean providing routine ambulatory care services at the lowest cost and most convenience. Or serving patients who need long-term chronic care. Or focusing on a limited range of specialty services.

“They each have different business models, different resource requirements, different approaches to marketing, but health systems tend to smash them all together,” says David Johnson, CEO of 4sight Health. “I would be very clear as to what business I’m in and why I’m better at it than others. You can’t be all things to all people.”

How to Listen to Consumers

Research into consumer insights is vital because most health systems are playing catch-up in understanding what those consumers need and want.

So says Pat Mastors, president and cofounder of The Patients' View Institute, a nonprofit organization that collects individuals' stories about their interactions with healthcare providers. The Institute's goal is to organize and amplify the patient voice to speed improvement in the quality of care.

"You're looking at a culture change that's coming about, whether it's this year or five years or 10 years," Mastors says. "The industry has to see this coming. The salvation of the industry—the ones that will survive after this culture-change tsunami has gone by—are the ones that understand their customers."

Provider organizations used to snicker at drugstore clinics, but nobody is laughing now that more than 1,000 CVS MinuteClinic locations have received more than 18 million patient visits since the retailer tiptoed into the healthcare delivery space in 2000. CVS has clinical affiliations with 28 health systems and boasts a 95 percent customer satisfaction rating.

As they gain experience with retail healthcare services, consumers are going to expect high-quality care and a positive, humanizing experience, Mastors says, because they will be able to get both.

"What happens when CVS opens knee and hip replacement centers?" she says. "When customers show up for surgery, they will be greeted with a gift basket that has their

CONSUMERISM AND PATIENT-REPORTED OUTCOMES

In the United Kingdom, all patients who have surgery for hip or knee replacement, groin hernia repair, or varicose vein treatment are asked to answer survey questions about their functional health status following surgery. Results are scored and posted on a public website that allows provider organizations to be easily compared based on patients' perceptions of their outcomes.

U.S. consumers have no such information available—and are not likely to in the near future, says David Hopkins, PhD, senior adviser at Pacific Business Group on Health (PBGH) and lead author of "Action Brief on Patient-Reported Outcomes," published by PBGH last year.

"This is information that consumers would really like to have," he says. "It is hard to imagine that somebody who is about to undergo a hip operation or other kinds of procedures would not want to know how patients similar to themselves have done after the procedure and, in particular, [about] information specific to a given hospital or surgeon."

Partners HealthCare, the Boston-based system that includes Massachusetts General Hospital and Brigham and Women's Hospital, is one of several health systems that are developing a wide range of patient-reported outcome measures (PROMs). The primary focus is to use the information to improve patient care, but Partners is launching a new website featuring PROM data to help inform decision making by consumers and others.

"We would really like to empower patients to be able to make decisions based on some really relevant and patient-centered metrics," says Ishani Ganguli, MD, an internist at Massachusetts General who, until recently, served as medical director of PROMs for the hospital. "That's exactly what we're working on right now."

That said, it will take some time before PROMs are widely available for consumer use, Hopkins says. Among the barriers: lack of consensus on the best survey tool for various PROMs; lack of consensus on the measures to be reported; and—even if the first two barriers were overcome—lack of an infrastructure and of funding to collect, analyze, and report PROMs.

The Centers for Medicare & Medicaid Services has developed a standardized PROM for hip and knee replacement surgery as part of its new Comprehensive Care for Joint Replacement bundled-payment initiative.

Meanwhile, PBGH, a purchaser coalition representing 60 employers that collectively spend \$40 billion a year on healthcare services, is encouraging its members to promote the development and use of PROMs to increase the value of healthcare services. Specifically, it urges purchasers to build PROMs into value-based payment programs and to require accountable care organizations to collect and report PROMs at the physician and hospital level.

How to Listen to Consumers (CONTINUED)

favorite shampoo and favorite mints because CVS has spent decades learning their habits.”

The patient financial services staff at MetroHealth System, a one-hospital system in Cleveland, is missing no opportunity to learn what its customers want. As part of its initiative to improve patient financial communications, the health system solicits informal comments during every consumer interaction.

“Every single day, every time we talk to a patient we are not only addressing their issue or inquiry, we are also asking them for more information about what would they like to see occur, whether it is with scheduling, registration, collections, the service itself, patient statements, etc.,” says Donna Graham, executive director of revenue cycle. “Every single time we connect with a patient we are actually doing an informal survey.”

Consumer requests and comments are logged on a shared drive, and the information is discussed at weekly meetings. The team is always looking for things that can be done immediately to respond to consumer input.

For example, when some patients suggested a change to billing statements, MetroHealth sought guidance from a patient focus group—and promptly initiated the change, says Craig Richmond, senior vice president and CFO.

Comments from patients have triggered changes to scripts so that information is explained more fully; discussions with insurers to explain that patients were confused about their benefits; and new stopping points for MetroHealth’s recreational vehicle, which travels through the community to help consumers gain insurance coverage, learn about available services, and access the social services they need to live healthy lives.

“You’re looking at a culture change that’s coming about, whether it’s this year or five years or 10 years. The industry has to see this coming. The salvation of the industry—the ones that will survive after this culture-change tsunami has gone by—are the ones that understand their customers.”

— Pat Mastors, The Patients’ View Institute

“We have had patients call and say, ‘You actually listened and I see that you guys have made a change based on what I said,’” Richmond says.

→ KEY TAKEAWAY

Consumerism in health care will not truly gain traction until organizations make a point of genuinely listening to consumers.

→ ORGANIZATION TO WATCH

Mount Sinai Health System (MSHS) in New York City has a joint replacement bundled payment contract with Building Service 32BJ Health Fund, which provides health benefits to local union members. One of the central goals of the program is to make the entire healthcare experience easier for patients.

“We did focus groups with our members who have had total joint replacement to find out what they had struggled with, what was good about their experience, and what was bad about their experience,” says Angelo Dascoli, director of the Health Fund.

The Health Fund shared that information with MSHS, and the partners worked together on how to meet patients’ needs. Under the new agreement, MSHS provides a single point of contact for 32BJ patients who schedule joint replacement surgery, and a care navigator meets each patient at the health system’s Joint Class, which teaches about preparing for—and recovering from—surgery.

The navigator visits the member in the hospital to create a recovery plan, arranges for the transition to home, and is available for follow-up phone calls. For patients who need extra support, the Health Fund provides a choice of car service to take the patient home or grocery delivery service, and/or a home health aide, depending on the patient’s needs.

“This is really taking it to completely another level that goes beyond just a payment model or a clinical model,” says Niyum Gandhi, chief population health officer for MSHS. “It’s actually a holistic member experience, which we couldn’t have done without the complementary set of insights on what the consumer needs.”^c

Overcoming Barriers to Consumerism

If providers need extensive insight about consumers, consumers need education on how to shop wisely. Recent Healthgrades research found that when consumers were provided with a referral to a specialist for a specific problem and asked to select the right physician from three options, about 50 percent chose the lowest-value option. After they were given minimal information to help them understand measures of physician experience, hospital quality, and patient satisfaction, 98 percent of the consumers who made the wrong decision the first time made the right decision when they received a second referral.

“So we know that when we get information in the hands of consumers, they make decisions that will change their outcomes,” Holstein says.

Consumers are desperately seeking education: More than 70 percent of U.S. Internet users searched online for health information in the previous year, according to a 2013 survey by the Pew Research Center. The most common searches are for specific diseases or conditions, treatments or procedures, and doctors or other health professionals.

Health systems can help in the following ways.

Make basic information more accessible. Typical provider websites list their orthopedic surgeons without making clear that one specializes in anterior hip replacements and another in spine procedures, for example. Simply by offering readily available information, providers empower consumers to choose a surgeon who is most likely to yield a good outcome.

Improve price transparency. Consumers need to know how much services will cost so they can shop for the best value—and even decide whether elective services are worth the price. Price transparency tools provided by health plans and

third-party vendors have become ubiquitous in recent years, but research by Catalyst for Payment Reform and the Health Care Incentives Improvement Institute finds they often do not provide useful guidance.^d

“Shortcomings in methodology can lead consumers to pick the provider who appears to offer the best value, while—in

reality—consumers are overlooking the provider who offers the highest quality, most affordable care,” the 2015 report says. “Misleading information means the consumer loses. And, unfortunately, many of the products on the market today may have methodological flaws that cause them to generate inaccurate price estimates.”

A task force convened by HFMA has developed recommendations to guide physicians, hospitals, and health plans in their efforts to improve price and quality transparency for consumers.

“Value-driven consumer incentives, through benefit designs that promote smart decisions and enhanced personal responsibility, must be aligned with payment reform initiatives for us to really ‘bend the cost curve’ for health care.”

— Mark Fendrick, MD, University of Michigan
Center for Value-Based Insurance Design

Encourage shared decision making. Beyond using price and quality information when making healthcare decisions, consumers need to understand the value of a second opinion—and of their own opinion—when facing a serious diagnosis. Healthgrades research shows that when 100 orthopedic surgeons are presented a patient case, 25 will recommend a full knee replacement and 25 will recommend another surgery—even when the evidence-based protocol is to choose between watchful waiting, injection, and physical therapy.

Both value-based health care and consumerism will be advanced when patients gain sufficient knowledge and confidence to insist on shared decision making and on greater access to information about their condition and their options than they have had previously.

Shared decision making is a formal process in which clinicians and patients jointly decide on a test or treatment after discussing the clinical evidence associated with each option and the patient’s preferences and values. After Group Health, an integrated health system in Seattle, introduced decision aids to support shared decision making, it saw a 38 percent drop in knee replacement surgeries and a 26 percent reduction in hip replacements. These findings suggest that well-informed consumers choose less aggressive treatment options compared with clinicians.

Health Plan Approaches

Health plans are learning how to promote better decisions. Many are using value-based insurance design (VBID)—an approach that aligns patients’ out-of-pocket costs with the clinical value of services—to help plan members make better choices.

Overcoming Barriers to Consumerism (CONTINUED)

In testimony before Congress, Mark Fendrick, MD, director of the University of Michigan Center for Value-Based Insurance Design, said consumerism that stems from benefit design is essential to improving the value of healthcare delivery.

“Value-driven consumer incentives, through benefit designs that promote smart decisions and enhanced personal responsibility, must be aligned with payment reform initiatives for us to really ‘bend the cost curve’ for health care,” said Fendrick, who also presented on VBID at an HFMA conference in 2015.

Benefit design is one of the key “design levers” that health plans can apply to encourage good decision making, Beaulé says. Others include:

- Network design and transparency that encourage the use of high-value providers
- Population health incentives that reward individuals for managing their health
- Supports such as apps, online tools, and home interventions that help plan members achieve health ownership

Using the right mix of those levers is a challenge. In UnitedHealth Group’s large-employer commercial segment, members make the right healthcare decisions—for example, getting the appropriate screening in the appropriate care setting by a high-quality physician—only 57 percent of the time, as measured by the company’s Consumer Activation Index™. That percentage can be boosted significantly—“I can point to employers at which the Consumer Activation Index is above 70 percent,” Beaulé says—by the effective use of design levers.

“You can’t become an expert in orthopedic choices for your back if the first time you address it is when you’re 50 years old,” he says. “So there is truly a responsibility on the part of the health plan—and increasingly in partnership with the provider organizations—to create the set of conditions that gives the consumer a fighting chance of making good choices.”

→ KEY TAKEAWAY

Consumerism can improve health care only if those with expertise—including providers and health plans—support consumers with the information they need to make good decisions.

→ ORGANIZATIONS TO WATCH

The Centers for Medicare & Medicaid Services will introduce consumerism into benefit design next year when it launches a five-year demonstration of VBID in Medicare Advantage (MA) plans. Medicare beneficiaries in seven states—Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee—will be eligible to choose an MA plan that sets cost-sharing levels to encourage use of clinically appropriate healthcare services and high-value providers.

MA plans can offer “clinically nuanced” benefit designs for enrollees who suffer from diabetes, congestive heart failure, chronic obstructive pulmonary disease, past stroke, hypertension, coronary artery disease, mood disorders, or any combination of those conditions.

The plans must feature at least one of these strategies:

- Reduced cost sharing for high-value services
- Reduced cost sharing for high-value providers
- Reduced cost sharing for enrollees who participate in disease management programs
- Clinically targeted supplemental benefits (e.g., nonemergency transportation to primary care visits for individuals with multiple comorbidities; nutritional services)

In the private sector, INTEGRIS Health, an eight-hospital system in Oklahoma, offers deep discounts—up to 70 percent in some cases—for consumers who pay cash up front. The prices, most of which are bundled with physician fees, are posted online, allowing consumers to easily compare INTEGRIS with physician-owned ambulatory surgery facilities.

Since implementing this program, the health system has seen a 23 percent increase in outpatient radiology services, which is volume that formerly would have gone to freestanding imaging centers in the Oklahoma City market, says Greg Meyers, system vice president for revenue integrity.

Health plans that have huge deductibles—up to \$10,000—are common in the Oklahoma market, Meyers says. The system started posting prices online because patients are looking for the lowest price possible.

“There’s a tremendous amount of price shopping going on in this marketplace,” he says. “We were getting 700 to maybe as many as 1,000 calls from people doing price shopping each month.”

Consumerism's Link to Value

The rise of consumerism in health care, while long overdue, is coming more quickly than many health systems are prepared for.

Optimizing performance even in traditional fee-for-service systems requires understanding what consumers want so as to be an attractive option in a fiercely competitive marketplace. And as volume-based reimbursement gives way to value-based payment systems—and population health management becomes central to succeeding in value-oriented contracts—providers must serve consumers in a way that encourages them to seek all care within the system, optimizing care management and patient engagement.

O'Riordan says the greater role of consumers in the healthcare decision-making process supports the value movement in three areas.

Health plan decisions. More individuals are choosing their own coverage each year as public and private insurance exchanges gain traction. And employer-sponsored plans are offering more choices that allow workers to make

trade-offs—say, lower premiums in exchange for enrolling in a narrow network of providers. Over time, these trends will increase the share of lives in limited networks tied to accountable care organizations and enable more effective population health management.

Service-level decisions. An access strategy that appeals to consumers—low-cost care delivered at the time and venue that works best for the consumer—is a foundational strategy for delivering high-value care.

Patient engagement. Consumers require support to make good decisions, and providers and health plans need engaged patients.

The organizations that will thrive in the years ahead recognize that the traditional provider-centric delivery system must be replaced by one that seeks out, understands, and responds to the consumer's perspective—and that doing so will support their journey to value-based health care.

CONSUMERISM AND DEMOGRAPHICS

Consumerism and a mind-set of health ownership will gain traction in the healthcare industry because of demographic shifts, among other factors. Younger consumers are viewed as expecting more convenience compared with their parents, and they embrace the technology that can make healthcare less expensive, easier to access, and more omnipresent.

"I believe the generational shift will bring many positives in our ability to advance the health ownership agenda, whether it is the faster adoption of technology or hopefully a more responsible sentiment to the value of one's health," says Jean-François Beaulé, executive vice president of design and innovation at UnitedHealth Group. "This generational shift is also challenging the system about what it means to own, control, and share one's personal health data."

That's not to say that all older consumers are tech-averse. A study of individuals who were ages 65 to 79 and insured by Kaiser Permanente Northern California found that more than 80 percent had signed onto their patient portal at least one time in 2013. Nearly 60 percent had used the portal to send a message to a doctor, view lab test results, order a prescription refill, or make an appointment.^a

With a significantly aging population, helping older consumers understand their options and the importance of proactive decision making regarding end-of-life concerns will be a challenge that health plans, plan sponsors, providers, and policymakers must address collectively. "What we want is to avoid a situation where economics become the dominant factor in those critical end-of-life care choices," Beaulé says.

^a Gordon, N.P., and Hornbrook, M.C., "Differences in Access to and Preferences for Using Patient Portal and Other eHealth Technologies Based on Race, Ethnicity, and Age," *Journal of Medical Internet Research*, March 2016.

Footnotes

- ^a Study: UnitedHealthcare's Diabetes Health Plan Can Lead to Improved Health, More Effective Disease Management, Better Cost Control," UnitedHealth Group news release, Jan. 10, 2013.
- ^b "Empowering the Revenue Cycle in a Value-Based World," HFMA Executive Roundtable, *hfm*, June 2016.
- ^c Butcher, L., "Collaborating Around Bundled Payments," *Leadership*, Summer 2016.
- ^d de Brantes, F., Delbanco, S., and Perelman, N., "Getting Accurate Price Estimates from Price Transparency Tools," Health Care Incentives Improvement Institute and Catalyst for Payment Reform, February 2015.

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