“PATIENTISM”
A Movement which Seeks to Reduce the Cost and Improve the Effectiveness of Health Care While Making Best Outcomes Information Available to the Public

The most important step leading to both improved patient outcomes and reduced health care costs may be that of publishing Best Outcomes information. Medicare has historically provided forms of patient outcomes and health care statistical information through publishing its Home Health Compare and Hospital Compare reports and its more recently offered CMS Dashboard. Other organizations such as the Dallas Hospital Council report on a variety of hospital statistics which center on thirty day rehospitalization data. And, the firm of Dobson DaVanzo & Associates released four (soon to be five) working papers which examine the total cost of rehospitalizations for three distinct episode types. However, while such reports provide Information that is academically interesting, they offer few data points which are operationally “actionable”.

There is a growing body of health care cost information available to the public, but little of it is designed so that providers and/or patients can make informed decisions about services and medications which are most effective for various types of health conditions. But while hospitals and post acute care providers are encouraged to generate better patient outcomes, they are not provided with data that can be used to benchmark performance for specific categories of patients. Averages are interesting but what are the outcomes ranges, best to worst, which created the averages? And what clinical pathways have been proven to work best? If the records set by Olympic athletes were not made public, few of such records would be broken. Surely this is also true of patient outcomes.

Information about the cost of procedures is becoming more readily available. For instance, a consumer whose physician has recommended that she arrange to have a colonoscopy can shop for the various costs of this procedure. But if there is need for homecare services by a patient suffering from, for example, a combination of heart failure, COPD and diabetes, neither the patient nor her physician can know which agencies record the lowest rehospitalization rates, vitally important information to any patient and payer. The patient who is readmitted to a hospital within sixty days of her original discharge will generate expenses during that sixty day period which average 221% of expenses for a
similar patient who was not readmitted. The operative word is **average**. Some patients will generate far greater expenses than others. Who those patients are, and why their expenses are higher is not well understood, but could be. The data exists, but it is not being mined. Or if it is, the results are not being published.

People in this country are almost pathologically competitive. Few believe that they are or want to be average. Making best practices information public will drive providers to better performance as surely as night follows day. Average will suddenly be unacceptable and top performance will be the target to beat. Providers that prove superior performance with regard to a particular service will focus on spotlighting and growing that area of specialty, downplaying services for which they show lower levels of competence. Ultimately there will be fewer overlapping services offered which will result in better patient outcomes at lower cost.

Arguably Medicare owns the broadest and deepest health care data-set in the world. We can know by region, state, city and zip code what practice patterns result in the best, and worst, outcomes for virtually any type of patient having any type of condition. We can know what hospitals they went to and the number of days they were inpatients, which type(s) of post acute settings they were referred to, whether or not they routinely saw their physician, which payers were involved, which medications had been prescribed, on and on. And we can know this by patient age, average income, gender, health condition(s), rural or urban setting, ethnicity, on and on. Very little of Medicare’s data has been converted into reliable patient outcomes information and, in fact, the data is very difficult to obtain, even when de-identified. Medicare expects all providers to do a better job for patients at lower cost to the government, but to do so while blind-folded.

The mysteries deepen. Managed care organizations are now compensated by Medicare to manage the care of about one quarter of all Medicare beneficiaries. These are sophisticated organizations which own huge blocks of patient information and which, presumably, mine their own data in order to control costs. However, each of these organizations has an incentive for competitive reasons to keep the results of their data analysis secret. On the other hand, Medicare has, or should have, an incentive to make information available to the public that would enable more informed decisions. There are ways to thread the eye of this needle. And it is in the best interest of patients, tax.
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payers, government agencies and effective providers that benchmarking data be made public. Only providers responsible for less than good patient results have anything to lose.

How can this information void be corrected? First, the job of providing best practices information must be undertaken by an organization which can be trusted to generate fair and unbiased information. Secondly, the undertaking should not be viewed as a “project” but rather as an ongoing part of the Health Care Industry’s fabric. Patient care has long been driven by payment systems instead of patient outcomes. The “cart has been before the horse” for more than sixty years. By providing information to providers and the general public about best patient outcomes, payment systems that reward best low total cost outcomes can be developed.

“Low total cost” is a concept not well understood in health care. The reason is that patients are cared for by various providers which act in silos and therefore total patient costs can only be derived from payment claims data which is available, but not readily available. Providers; doctor, homecare agency, skilled nursing facility, hospital, outpatient service etc. are organized as “job shops” while patient care is best provided as a continuum. Patient care job shops are jealous of their patient relationships and have modest, if any, financial incentives to work as team members of other job shop silos. Therefore clinical information is trapped in many different provider data bases while claims data is owned by payers, not providers. For each patient, there will likely be many provider organizations but few payers. So in order to generate best practices information, claims data is the winner. If outcomes information derived from claims data can be made available to providers and patients, good decisions can be made about the relative value of care being provided.

The well known saying “If you don’t measure it, you can’t manage it” is true as far as it goes. But in order to improve performance, whatever is being measured and managed should be compared to the best outcomes being achieved. If our own results are best, then we know we must work hard to maintain our leadership role. But if others are achieving better results than are we, our objective should be that of catching up, or of recognizing that we can’t. If services we are providing are known to be sub-par, resources will be redirected in ways that make them more productive. Healthcare managements find this timeless process difficult to follow due to the lack of clinical benchmarking
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information, especially with regard to the outcomes of chronically ill patients. If such information is made available, the innovative minds which abound will find an unending number of approaches to improving patient outcomes at continually reducing cost.

Data required to create a benchmarking service is available; it is simply not being turned into usable information. The cost of doing so would be relatively negligible. What would be the result of providing this information? Better patient outcomes, a more effective allocation of health care resources and sharply lower costs. It may even be medicine strong enough to cure the Health Care Industry’s unique form of cancer—*the fee-for-service payment system*.

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