

Measuring Healthcare Outcomes: Better Care @ Lower Costs

What do we want from our healthcare? A “good outcome,” when we get better—sooner, rather than later—and at the lowest overall cost.

And how do we get a good outcome? By going to the best doctors and hospitals. The problem, however, is that we don’t know how to quantify outcomes and identify those best providers.

Lake Wobegon

We all think that our doctor is the best, but we don’t live in Lake Wobegon where all the children are above average. Exactly half of all children are above average, and exactly half are below.

It’s the same with doctors—and the specialists and surgeons that they refer us to, and the hospitals that they put us in.

It seems counter-intuitive, but going to a good doctor costs less overall than going to a bad one. 30% of healthcare costs are due to poor or ineffective care and the best doctors wring out those excess costs.

Inputs vs. Outcomes

Instead of ranking doctors on the outcomes that they achieve, we fall back to process measures that change the question from: “Did the patient get better?” to a question with an easy answer: “What procedures did their doctor perform?”

Other inputs that we use as proxies for a good outcome are patient satisfaction scores

and price transparency tools, which tell us what a doctor charges for a procedure or visit, without considering whether the doctor will get us better, and how much that will cost. Finally, there are the “narrow networks” that insurance companies tout. The best providers within their overall networks. Based on what? The inputs.

Health Insurance

There are two ways for an employer to provide health insurance to its employees. In the traditional way, the employer buys it from an insurance company, which bears the actuarial risk of the healthcare claims.

When an employer “self-insures” it bears that risk. The employer still engages an insurance company to process the claims and provide the network of doctors and hospitals, but the employer just pays the insurance company a fee for those services. And because the employer pays the claims, the employer owns the claims data.

HR Records

Self-insured employers therefore possess two disparate data sets that we can use to quantify outcomes: those medical and pharmacy claims, and their HR records—where the outcomes of the claims live.

We define a good outcome as the employee returning to work from their illness or injury. Having marked that point in time, we measure all the costs to get the employee there, which are more than just the claims. The absence costs of paying employees while out sick often exceed the claims costs, with the length of time that a doctor took to get an employee better and back to work doubling as an indication of the effectiveness of the care.

When HR records aren't available, we can still quantify outcomes. With the HR records, we ask how much it cost and how long it took for the employee to return to work? Using only the claims, we flip that and ask how much it cost to keep a person well? And we define someone as being well when they aren't in the healthcare system, such as for a hospital stay or a doctor's visit.

Calculations & Rankings

We categorize the calculations by root diagnosis because a PCP may be great treating patients with cardiac problems, but lousy when treating diabetes. We also make risk adjustments to give doctors credit for taking care of sicker patients, who you would expect to cost more.

And we task each provider with not only that provider's direct costs, but all the "downstream" costs from that provider's referrals too.

We then sort the providers into categories—because you can't compare a PCP to a surgeon—*and rank the providers by root diagnosis from the best to the worst.*

Example With HR Records

A specialist treating an employee for back pain is tasked with \$4,000 of claims and \$5,000 of absence costs. The employee's risk score is 1.200. The risk-adjusted cost to return the employee to work is \$7,500 ($(\$4,000 + \$5,000) \div 1.200 = \$7,500$).

Example Without HR Records

A PCP treating a patient with diabetes is tasked with \$13,000 of claims costs during the year. The patient's risk score is 1.300, so the patient's risk-adjusted claims are

\$10,000 ($\$13,000 \div 1.300 = \$10,000$). The patient has 35 non-functional days because of the diabetes (days in the hospital, visiting the doctor, etc.), so the risk-adjusted number of non-functional days is 27 ($35 \div 1.300 = 27$), and the functional days are 338 ($365 - 27 = 338$). Accordingly, the risk-adjusted claims per day to keep this diabetic patient well are \$29.59 ($\$10,000 \div 338 = \29.59).

Steering to the Best

After ranking the doctors and hospitals, we steer everyone to the best providers for what they need. There are two ways to steer.

First, provide the patients with an online portal where they can look up the best doctors for each diagnosis, and augment that portal with an 800# and online chat.

Second, make a portal available to all the doctors to look up the best specialists and surgeons when making patient referrals. This physician portal will capture most of the savings, without any of the effort or expense of rolling out something new to the employees and patients.

You won't get everyone to switch to a top doctor, but you don't have to. The opportunity for savings is so great that if just a fraction switch you will reap a windfall!

About IntegerHealth

IntegerHealth applies advanced analytics to quantify outcomes for health plans and workers' compensation programs—*Driving down the costs, while improving the care.*

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