

Many funds do not request even minimal information on quality or meaningful and useful cost information from their health plans and insurance companies. Quality and cost information are necessary to assess whether health plans and insurance companies offer value. Without this information, trustees lack a basis for making product comparisons and purchasing decisions. Holding health care plans, insurers, hospitals, physicians and other providers accountable for health care results benefits all parties, particularly members.

Monitor Health Care Results to Get Best Value and Quality

by Laird L. Miller and Joanne E. Miller

©2006 International Foundation of Employee Benefit Plans

“So, I am called eccentric for saying in public: that hospitals, if they wish to be sure of improvement, 1. Must find out what their results are. 2. Must analyze their results, to find their strong and weak points. 3. Must compare their results with those of other hospitals . . . 4. Must welcome publicity not only for their successes but for their errors. . . . Such opinions will not be eccentric a few years hence.”¹

—Dr. Ernest Codman, 1917

Unfortunately, Dr. Codman’s prediction was wrong. And many would argue that little has changed since Dr. Codman struggled to make surgeons and hospitals accountable by publishing their “end results.”

The End Results of Care

Ernest Amory Codman, M.D. (1869-1940), was a Boston surgeon. Like all of us, he was human and made mistakes. Unlike others, he made a lifelong systematic effort to follow up on each of his patients years after treatment and recorded the end results of their care. He recorded diagnostic and treatment errors and linked these errors to outcome in order to make improvements. He was sufficiently disgusted with the lack of such outcomes

evaluation of care at the Massachusetts General Hospital where he was on the staff, that he resigned to start his own private hospital, which he called the End Result Hospital.

From 1911 to 1916, there were 337 patients discharged from Codman's hospital. He recorded 123 errors and measured the end results for all these patients. He grouped errors by type. There were errors due to lack of knowledge or skill, surgical judgment, lack of care or equipment, and lack of diagnostic skill. In addition to the errors, there were four "calamities of surgery or those accidents and complications over which we have no known control. These should be acknowledged to ourselves and to the public and study directed to their prevention."

Codman paid out of his own pocket to publish this report so patients could judge for themselves the quality and the outcome of care. He sent copies of his annual reports to major hospitals throughout the country, challenging them to do the same. If he were alive and with us today, he would ask in a gentle way why (our) hospitals do not do the same (because) patients want (and deserve) to know.²

Today, almost a century later, health care purchasers such as Taft-Hartley trusts, employers, consumers and even providers (for example, doctors and hospitals) still struggle to answer questions about health care quality and cost, that is, value. (Figure 1 defines value.)

Indeed, the typical patient who is diagnosed with a life-threatening medical condition does not know where or how to find reliable and valid information to answer very basic questions such as the following:

- Has my condition been accurately and completely diagnosed?
- What additional tests, if any, should be done?
- Which doctors and hospitals are most experienced in treating my condition? Will my doctor's or hospital's experience be a factor in assuring a good outcome for me?
- Does my local clinic or hospital have state-of-the-art equipment or technology, which will help ensure that my treatment is effective? Is this state-of-the-art equipment the best option for me, that is, what treatment will give me the best outcome? Does my doctor understand what I think is a good outcome?

Figure 1

Defining Value

■ Value

- ▶ The amount we are willing to pay for the desired product or service that meets our requirements
- ▶ Value = Quality/Cost
 - For value to remain constant, quality must increase proportional to cost.
 - If cost can be reduced, value can increase if quality is held constant.

- Are my doctors telling me about all possible treatments—or only those which their medical centers provide?
- Are my doctors limiting my treatment options to those they believe my insurance will reimburse?

The ability to obtain accurate, timely information to these and other important questions may determine whether the patient lives or dies; whether the patient receives a treatment that is more effective and less toxic than another treatment; whether the patient will be a victim of a medical error; and whether the patient lives out his or her life in pain.

Those who ultimately pay the health care bills (Taft-Hartley trusts, employers, etc.) also need and want patients to have comprehensive and accurate answers to these and other important questions. More payers are becoming aware that credible government and other studies show that at least 30% of health care dollars spent on direct health care costs are wasted and result from poor quality medical care.³

Health care is one of the few industries where poor performance (medical mistakes, inaccurate diagnoses, wrong treatments, etc.) leads to financial gains—rather than financial losses. For example, poor doctor and nurse hand-washing hygiene practices, which often result in hospital- or clinic-acquired patient infections, will bring in more dollars as the patient is treated for the infection. Hospital-acquired infections can be very expensive. (See Figure 2.)

Most patients depend on their primary care doctor or referral specialist for guidance and help. But studies show physicians' decisions about even relatively common medical conditions are highly variable. For example, one study asked

135 physicians how they would treat a urinary tract infection in women; the result was 82 different answers.⁴

Many health care purchasers, patients and even providers are surprised to learn such variability is the "norm." Indeed, the type and amount of medical care the typical American patient receives often depends largely on where that patient lives; in short, geography determines "health care destiny."

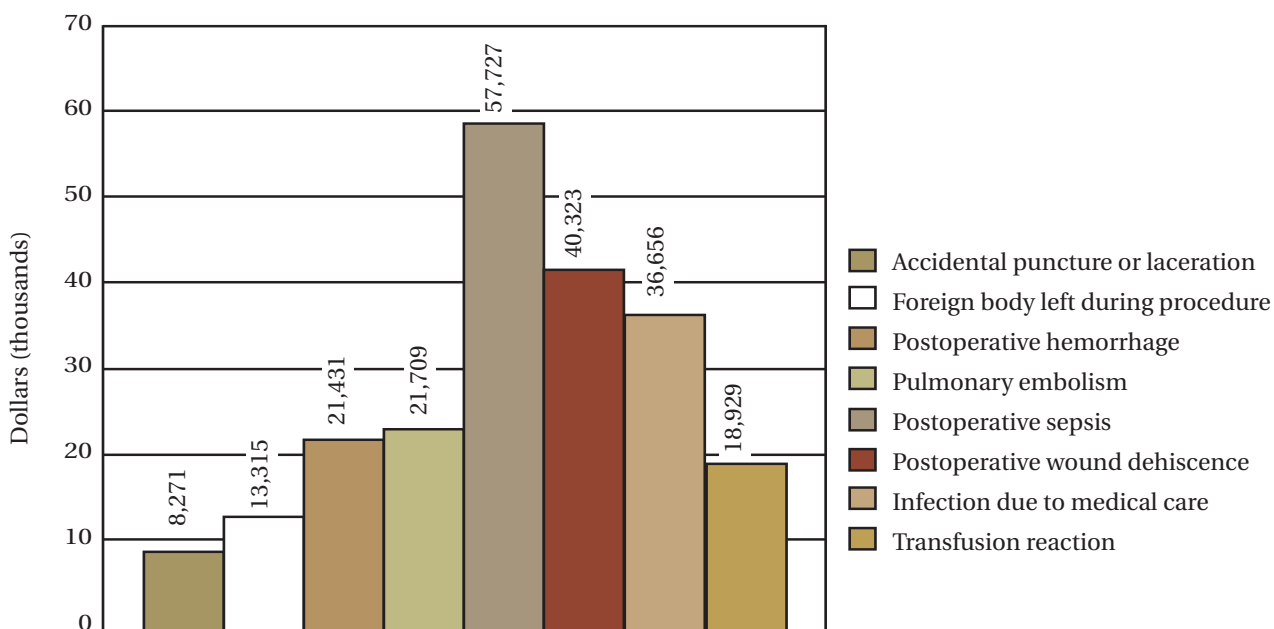
Exhaustive studies using many data sources have shown if the patient is diagnosed and treated in his or her local community, the amount of care received will be a function of that community's capacity. For example: If the community has a large supply of magnetic resonance imaging (MRI) machines, patients are more likely to receive such a scan—even when an MRI is not needed to accurately diagnose and treat the condition.

These and other large-scale studies also indicate local physician practice "style" will determine what type of care the patient receives. Local physician practice styles do not necessarily reflect what clinical trials and medical professional societies would suggest is optimal medical care and practice.

Why does this variation exist? Variation exists because many, if not most, commonly used treatments and practices are not "evidence-based." This means physicians have not carried out controlled clinical trials to determine whether the treatments actually benefit or improve the patients' conditions. For example: Before clinical trials in the 1990s were conducted, the standard practice was to use antiarrhythmic drugs to prevent heart attacks in patients with a history of a previous heart attack. Antiarrhythmic drugs are medicines that correct irregular heart-

Figure 2

Excess Charges Attributable to Medical Injuries During Hospitalization



Source: JAMA, October 8, 2003, Vol. 290, Nbr. 14, page 1872.

beats and slow down hearts that beat too fast.

When randomized controlled clinical trials were finally conducted, they showed that these therapies did more harm than good. Randomized controlled clinical trials are considered the “gold standard” for determining whether treatments are effective and what populations they benefit or harm.⁵

The Role of Patients

In an ideal world, patients would choose among treatment options. In today’s health care settings, treatment choices are determined by local doctor opinion about the value of a particular treatment. Often, physicians tell patients what their own clinic, hospital or health care system offers, neglecting to note that a more effective or more efficient treatment may be available elsewhere.⁶

Do these geographic and competitive factors affect patients and payers in a negative way? The answer from medical and health care quality experts is an unequivocal *yes!* For example: The National Academy of Sciences convened the National Roundtable on Health Care Quality, which

concluded that “very large numbers of Americans are harmed as a direct result of poor quality care.”

Serious and widespread quality problems exist throughout American medicine. These problems, which may be classified as underuse, overuse and misuse, occur in small and large communities alike, in all parts of the country and with approximately equal frequency in managed care and fee-for-service systems of care.

Millions of Americans are not reached by proven effective interventions that can save lives and prevent disability. Perhaps an equal number suffer needlessly because they are exposed to the harms of unnecessary health services. Large numbers are injured because preventable complications are not averted.⁷

Who Incurs the Costs?

Most Americans do not become concerned about health care cost and quality-related issues, including what and who their health care insurance covers, until

they or a loved one are confronted with a medical crisis. Maintaining an optimally healthy lifestyle, which can prevent serious illness and reduce the potential for high health care costs, is not always a high priority.

The good news is that 80% of Americans are essentially healthy; they have only sporadic requirements for health care services, the costs of which are often minimal. These healthy Americans are responsible for incurring approximately 17% of U.S. health care costs.

But others are not so fortunate. These individuals include the 1% of the population whose diagnoses and treatments are responsible for 28% of health care costs. Members of this 1% often suffer from multiple conditions. Many costly and complex procedures and other treatments are typically needed. Since these individuals receive more diagnostic and treatment interventions, they are also at higher risk of being a victim of one or more medical errors. Medical errors can be very costly both in terms of human suffering and health care expenditures. (See Table I.)

Nineteen percent of Americans incur health care costs that consume 55% of the

Waste and Inefficiency

Waste is commonplace throughout the health care system. This is similar to other industries. Health care quality experts believe the potential to reduce costs by eliminating inefficiency within health care is enormous. Other industries have found that 50% or more of total costs are costs due to waste and inefficiency. Health care examples include the following:

- ☑ Complex billing and reporting requirements, including changing Medicare requirements
- ☑ Inspection-based systems to manage quality and cost. The benefit of these reviews is not clear.
- ☑ Long waiting times for patients scheduled to see their physicians or receive hospital or other services. This leads to lost time from work and other productivity issues.
- ☑ Nurses spend 50% or more of their time on administrative duties, much of it on wasteful activities such as searching for lost medical records.
- ☑ Misplaced hospital medical records leading to increases in patient waiting time and medical errors. The Harvard Medical Practice Study found that 20% of errors were due to avoidable delays in drug treatment and inadequate staffing.

Source: Reducing the Costs of Poor Quality Health Care Through Responsible Purchasing Leadership, Midwest Business Group on Health and the Juran Institute, 2002.

health care dollars. These patients typically suffer from chronic illnesses, which require long-term (and often lifetime) management. *Chronic conditions* are defined as illnesses or conditions that last longer than three months and do not disappear on their own. They include diabetes, heart disease, chronic renal failure and asthma.

What surprises many health care payers is that a majority of individuals with chronic illness are in the workforce. Two-thirds of patients with chronic illnesses are under age 65.

Value-Based Purchasing

How can we resolve health care cost and quality problems? Is it possible to make a difference?

In their role of health care purchaser, Taft-Hartley trustees can and should play a pivotal role in supporting efforts to improve the quality of medicine and thereby reduce its cost. Trustees must make a commitment to do everything possible to make purchasing decisions based on value. This takes preparation, including time and efforts to gather valid (meaningful) and reliable data, planning and, most of all, determination.

Preparation and Planning

Taft-Hartley trustees must budget the time and resources necessary to become knowledgeable health care purchasers. Judging the value of medical care is no more complex than evaluating other types of products and services. Learning to do this, however, takes time and a great deal of commitment.

The trustee or trustees that make health care purchasing decisions should have a personal interest in medical care, health promotion and wellness, together with a strong desire to learn more. It also helps to have had personal involvement with the health care delivery "system" or experience in helping family or friends through a serious medical crisis. These experiences can provide insight into the fact that the health care system is not really a system and patients are very vulnerable.

Health care purchasing decisions, including selecting health care plans and insurers, should not be undertaken in a philosophical "vacuum." Trustees should carefully evaluate the role of health benefits relative to the total compensation strategy. What are trust fund and member objectives? Are we meeting fund and member objectives? What data are we us-

ing or should we use to measure whether objectives are met?

Trustees may want to evaluate how total compensation for members compares with that of local, regional and national peers. What data are available to make this assessment?

Health care purchasing decisions should be made within the framework of policies and guidelines. What is the culture of the membership? What do members want and expect of the fund and the trustees? Establishing and defining clear values for health care purchasing decisions is key to ensuring members' respect and satisfaction with their total compensation package.

An important step in selecting among health care products and vendors is to gather as much data as possible to help define health care needs. Demographic (age, sex) and other available risk (for example, incidence of hypertension, results from health risk assessments) and service utilization data can be used to determine what types of services will meet current and future health care needs of members and their families.

Needs and also expectations (that is, quality, cost and access requirements) should be defined in writing. What is most important to members? What is important to the entire organization, the fund? What data is available now to measure whether both trust fund and member needs and expectations are being met?

What do members want and expect of the fund and the trustees?

Establishing and defining clear values for health care purchasing decisions is key to ensuring members' respect and satisfaction with their total compensation package.

Most health plans and insurers or your third-party administrators can provide information about service utilization. Few, if any, are willing or able to provide quality information. For example: Did

Improving Quality and Reducing Cost

- Follow the dollars.
 - ✓ Identify the most costly injuries and conditions.
 - ✓ Current and future
- Identify individuals at risk or affected.
- Develop programs to address needs.
 - ✓ Identify providers that are “best in class.”
 - ✓ Evaluate and certify the best performers.
 - ✓ Negotiate performance-based contracts.
 - ✓ Hold providers accountable for performance.
 - ✓ Manage relationships over time.
 - ✓ Give these providers all the business they can manage.
- Monitor performance and manage the process.

members undergo their procedures at facilities that have the requisite experience and expertise to perform that procedure? Were procedures performed in physicians' offices where there is no oversight—and no system to track infections, complications and other problems?

Is there any system for examining outcome of care for members? For example: Are members satisfied with their outcomes? What data are available to make this assessment?

Demand Data and Information

Many funds do not request even minimal quality or meaningful and useful cost information from their health plans and insurance companies. This is unfortunate because quality and cost information are necessary to assess whether health plans and insurance companies offer value. Without this information, trustees have no basis for making product comparisons and purchasing decisions.

Requests for information also benefit health plans and insurance companies because they help them understand what their customers need and expect and to what extent these needs and expectations are being met.

It will take time to understand medical quality issues. Trustees, like most Americans, are often reluctant to question the quality of medical care or the value of health plan and insurance company products and services. Trustees are also very busy, with many responsibilities to carry out. These other important commitments often limit the time available to medical quality issues.

A large proportion of high medical care costs result from monies spent to correct preventable medical errors. Patients may be misdiagnosed or undertreated because their providers skimp on providing services, or they may receive far more services than needed to treat their conditions.

Taft-Hartley trustees and their members understand the concept of accountability: You do it right the first time and every time. When mistakes occur, you do not get paid extra to fix your mistakes. Holding health care plans, insurers, hospitals, physicians and other providers accountable for the “end results” benefits all parties, particularly members.

The question is when and if we will fulfill Dr. Codman's prophecy, which was made

almost 90 years ago! Will we demand to know the “end results”—and hold our suppliers accountable? Table II outlines what must be done to make this happen. **B&C**

This article is excerpted from the Foundation's Employee Benefit Issues—The Multi-employer Perspective—Volume 47. The authors presented this paper at the Annual Employee Benefits Conference in 2005. For information on ordering the above book or reprints of this article, call (888) 334-3327, option 4.

Endnotes

1. A. Donabedian, *Milbank Quarterly*, 1989; 67(2):233-56; discussion 257-67. The end results of health care: Ernest Codman's contribution to quality assessment and beyond.
2. D. Neuhauser, “Heroes and Martyrs of Quality and Safety: Ernest Amory Codman MD,” *Qual Saf Health Care*, 2002;11:104-105.
3. *Reducing the Costs of Poor Quality Health Care Through Responsible Purchasing Leadership*, Midwest Business Group on Health and the Juran Institute, 2002.
4. A. O. Berg, “Variations Among Family Physicians' Management Strategies for Lower Urinary Tract Infection in Women: a Report From the Washington Family Physicians Collaborative Research Network,” *Journal of the American Board of Family Practice*, 4:327-330.
5. *Health Affairs*, January-February 2005, pp. 41-51.
6. John Wennberg, M.D., *The Dartmouth Atlas Project: Center for the Evaluative Clinical Sciences at Dartmouth Medical School*. www.dartmouthatlas.org.
7. M. R. Chassin and R. W. Galvin, “The Urgent Need to Improve Health Care Quality,” Institute of Medicine National Roundtable on Health Care Quality, *Journal of the American Medical Association*, 280(11):1000-1005.



Joanne E. Miller is a principal with Health Systems Management, Inc., and has extensive experience and educational background in continuous quality improvement technology, including assessing customers' needs for professional services and developing quality indicators and processes. She is co-author of *Health Care Purchasing: A Value-Based Model* published by the International Foundation.

Laird L. Miller is president and founder of Health Systems Management, Inc. He also directs the development and management of quality-based centers of excellence networks. Miller has over 25 years' experience as a health care purchaser and provider. He has written 14 books including *Health Care Purchasing: A Value-Based Model*, published by the International Foundation. Miller received his undergraduate degree in journalism and master's degree in industrial and organizational psychology from the University of Minnesota.