National Patient Advocate Foundation

The Patient's Voice | since 1996

The Healthcare Imperative: Lowering Costs and Improving Outcomes

Patient Engagement Issues

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What is Patient Engagement?

Patient Engagement is defined as “actions that individuals must take to prevent disease and obtain the greatest benefit from knowledge of both disease prevention and the health care services available to them in though today’s U.S. health care.”*

The values of Engagement Behavior Frameworks are to help patients, caregivers, individuals, to seek out and make use of services, technologies, and drugs to interact with health professionals and institutions if they are to benefit from healthcare.

*Gruman, PhD, 2009

Pivotal Co-Factors in Managing Healthcare

These are fundamental questions that must be answered as each answer is a pivotal co-factor in managing healthcare decisions.

- What is it costing the patient?
- Where is the savings going: to the health care consumer, the health care provider, or insurer?
- Where is the savings potential?

Remedies must be clinically advantageous and cost effective for patients.

- Will the savings be recognized through taking advantage of alternative treatments or medicines for patients?
- Will patients be recommended for available alternative therapies to cut costs?
- Are patient out-of-pocket expenses expected to be reduced?
- What are the concerns involving bundled services that may not be ordered by treating physicians if the providers will not break event when they are reimbursed by the insurance company?
- What is the understanding for patients if they are purchasing drug (bundles)? What happens if they do not get used?

A universal question….

Since bundling is at its infancy in the United States, will bundling afford patients the ability to access the newest therapeutic protocols inclusive of imaging, surgery, pharmaceutical/ biotechnology services, rehabilitation service required and specific maintenance protocols?

A Step Forward…What's the Difference Between DRGs & Bundled Services?

"Emerging episode-based payment models have some relationship to existing payment systems that bundle services around a clinical condition or service event.

For example, Diagnosis Related Groups (DRG) bundle inpatient hospital services during a hospital stay for the purposes of prospective payment. The Medicare hospital outpatient prospective payment system also bundles many services provided during outpatient visits.

However, these systems focus on care provided in single settings, while emerging models of episode-based payments (bundled payments) attempt to capture the full range of services delivered in all or most settings during a clinical episode."

-"Episode-Based Payment Summary", Mathematic Inc.

History of DRGs

Diagnosis-related group (DRG) is a system to classify hospital cases into one of approximately 500 groups and were developed for Medicare as part of the prospective payment system. DRGs have been used since 1983 to determine how much Medicare pays hospitals for treating a certain diagnosis.

Instead of reimbursing hospitals separately for each service provided, hospitals are paid predetermined, set rates based on the patient's diagnosis under DRG.

DRGs are a precursor of bundled payments accelerating the concept of aggregate service billing for multiple services provided at one site of service to one bundle of billing for multiple services across multiple sites of care with one single point of payment

The risk to patients and the payor community is in how we define the components to be billed within the bundle.

Why Bundling?

- In its June 2008 report to Congress, MedPAC found that 18% of Medicare hospital admissions result in readmissions within 30 days post-discharge; accounting for $15 billion in spending in 2005.
- According to MedPAC, approximately $12 billion may represent potentially preventable readmissions.
- MedPAC recommended exploring the use of a bundled payment system for an episode of care where separate payments for distinct types of providers would be eliminated.
- Bundling goes beyond DRGs because it bundles payment for all acute care provided in hospitals as well as post-acute care provided in both acute care hospitals and nonhospital settings.
- Bundled payment system may be easier to implement for some conditions than for others (example: easier for a CABG or a hip replacement than for a chronic disease such as diabetes). Conditions with clearly defined treatment protocols with clear start and end dates may be more feasible for a bundled payment system.
- Bundling may provide an opportunity to reduce costs and encourage compliance by physicians using published treatment guidelines.

Implementation of ProvenCareSM

- In 2006, Geisinger Health System in Pennsylvania implemented ProvenCareSM which bundled payment for all non-emergency CABG procedures.
- The bundle included: the preoperative evaluation, all hospital and professional fees, all routine post-discharge care, and management of any complications occurring within 90 days of the procedure (Paulus, Davis, and Steele, 2008).
- Geisinger adopted a “patient compact” that was designed to engage patients as participants in ensuring favorable outcomes through compliance to treatment protocols.
- Hospital costs dropped by 5 percent and 30 day readmission rates fell from 15.5 percent to 7 percent.

Deere's Experience with New Consumer-Directed Plan

Bundling is an insurance process of reimbursement that holds promise of financial advantage to consumers.

- Requires extensive education
- Learning to become wiser consumers and more engaged in their healthcare
- Cultural Change and making the change understandable by translating their insurance benefits into improved health status
- Supports next generation consumerism
- Requires proactive consumer engagement and leads to sustained positive behavior

Deere's Experience with New Consumer-Directed Plan (continued)

Deere & Company , based in Moline, IL, replaced its existing health options with a consumer-direct plan in January 2007, after an extensive 18-month period of explaining to employees that reasons for the change and details of the new plan. So far, the company is pleased with the outcome.

- "Spending their own money, they (workers) became much wiser consumers and much more engaged in their health care," said Olson, Deere's manager of health and welfare plans. "We saw that focusing on the health status of our employees was really important to us, and our own medical trends as a whole moderated."

- One of the keys to the success to far, Olson said, was making the change understandable. At the same time, the company sought a "cultural change" that encouraged workers to become more involved in determining their health care insurance needs and translating their insurance benefits into improved health status.

-Ebri.org notes, March 2009, Volume 30 , # 3

National Education Campaign

There has been a paradigm shift from “do what your doctor says” to “study and analyze quality & cost information and make decisions.”

Need to educate patients to the value proposition and explain risk and benefits of all services.

How to Educate and With Whom?

- Non-profit groups
- Insurers
- Physicians
- Web
- Direct mail
- Site of Service

How to Interpret and Explanation of Benefits (EOB)

The EOB is the result of the ***claims process***. To better understand your EOB, let's look at the steps in the claims process.

- If your provider is part of a provider network, and you have an insurance plan using this network, the provider usually sends your bill to the network to have the network discount calculated. The network sends the claim to your insurance administrator.
- If your provider is not in a network, the provider may send the bill to you or your insurance company. If you're sent the bill, you will submit the claim to your insurance administrator.
- Your insurance administrator reviews the claim to determine your benefits. If another insurance company is involved, the insurance companies coordinate the benefits to determine which plan is responsible for the charges. Your health administrator sends you and your provider an EOB, and, when appropriate, your provider also receives a check. Your EOB may identify:
  - The patient and the service provided.
  - The amount charged by the provider.
  - The amount of the charges that *are covered* and *not covered* under your plan.
  - The amount paid to your provider.
  - The amount you're responsible for.

Medical bills need to be simplified. The more consumer's understand medical costs and quality, the better decisions they make

Your Health Insurance
P.O. Box 1999
Anytown, USA 12345

This is Not a Bill

(20) Customer Service 800-555-1212
(1) Enrollee: John Doe
(2) Patient: Jane Doe
(3) Patient #: 123-45-6789
(7) Enrollee Address: 555 Main Street, Hometown, USA 54321

(4) Provider Name: Mark Smith, M.D.
(5) Claim #: 99999999999
(6) Date Processed: 9/25/02

(8) Dates of Service		(9) Place of Service	(10) CPT Code	(11) Charge Amount	(12) Allowed Amount	(13) Not Covered	(14) Reason Code	(15) Deductible Amount	(16) Co-Pay	(17) Benefit Amount	(18) Due from Patient	(19) Payment Amount
8/9/02	8/9/02	3	99201	80.00	80.00				15.00		15.00	
8/9/02	8/9/02	3	10121-22	150.00		150.00	55			0.00	0.00	0.00
8/9/02	8/9/02	3	36415	20.00	10.00	10.00	44			80%	2.00	8.00
8/9/02	8/9/02	3	80050	40.00	10.00	30.00	44			80%	2.00	8.00

*These codes are explained in foot notes on the EOB.

Bundling Responsibility

"First Do No Harm"

-As translated from the Hippocratic Oath