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Mythbusters: Better Care Is Most Cost Effective

Written by Brooke Murphy | August 07, 2017

Ask 10 different healthcare professionals to define "cost," and their answers may surprise you.

That's because cost accounting in healthcare is increasingly about more than just the resources and capital spent to perform a medical procedure. As hospital systems begin to prepare for care delivery under value-based payment models, understanding their true operational costs has become a strategic priority.

During an Aug. 3 webinar sponsored by Strata Decision Technology and hosted by Becker's Healthcare, Jennifer Ittner, director of continuous improvement at Strata, and Tashar Pandey, vice president of decision support at Strata, discussed how clinical, financial and operational leaders can use data to gain clinician buy-in and drive cost and quality improvement initiatives at their organizations. Strata is a leading health IT company providing cost accounting, data and analytics technology to hospitals and health systems.

Ms. Ittner and Mr. Pandey unpacked three key financial issues at hospitals, separating fact from fiction in this healthcare-themed edition of Mythbutsers. The webinar included audience participation through a series of interactive poll questions, featured below.

Myth No. 1: "More services = more profitability and better patient care."

"Traditionally, cost accounting was the cost a hospital incurred to provide care," Mr. Pandey said. "But today being successful is about providing value, which is determined by the quality of care divided by the cost of providing the service."

Accounting for quality in a hospital's cost calculations is significantly different than traditional cost accounting under fee-for-service. In fact, the former often shows a hospital's true cost of care is much greater than originally anticipated. This is because value-based cost accounting requires an organization to include any additional medical costs incurred after the procedure was performed in its total expenses, such as the cost of treating a surgical complication, respiratory failure or hospital-acquired infection.

Strata uses Quality Variation Indicators (QVIs), developed by Yale New Haven Health System to measure cost and quality together. There are 27 quality variation indicators, or QVIs, that both directly and indirectly impact a hospital's costs of providing care. QVIs are defined as "rank-ordered, potentially preventable adverse events not present on admission that occur during an inpatient stay," Ms. Ittner said. "When organizations begin to incorporate QVIs into their cost data, they realize that the more services provided, the smaller a margin they have."

Including QVIs in costing methodologies has a substantial impact on an organization's bottom line. Therefore, myth No. 1 was proven false.

Myth No. 2: "Physicians don't know and don't care about costs."

A respectable portion of webinar participants said they believe physicians are interested in managing care costs to some degree. Participants said their organizations are encouraging physician cost awareness in several ways. About 35 percent of respondents said their hospital leaders discuss costs with physicians retrospectively during case reviews. About 42 percent said their hospital has made select cost information available to physicians.

Mr. Pandey cited a recent survey by Bain & Corp. which shows physicians do care about reducing high healthcare costs; about 80 percent of physicians surveyed agreed that it was part of their professional responsibility to bring healthcare costs under control.

Despite physician willingness to take responsibility for cost reduction, Mr. Pandey cited a second study published in a 2014 issue of Health Affairs showing only one in five orthopedic physicians are able to correctly estimate the costs of 13 commonly used orthopedic devices.

"Physicians have the largest impact on cost of care and are willing to make a difference," Ms. Ittner said. "Part of that battle is bridging the gap between desire to learn and actually engaging them in cost initiatives."

Myth No. 3: "Good data alone cannot drive action."

Sixty-five percent of webinar participants agreed that good data

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alone cannot drive meaningful action, especially when it comes to aligning operational, financial and clinical stakeholders on cost reduction initiatives.

A 2017 study published in JAMA found giving physicians pricing data alone was insufficient to drive meaningful action, thereby confirming myth No. 3. The study presented prices of various in-patient lab tests in EHRs to physicians at the time of ordering. The result: displaying lab prices had no affect on physicians' ordering habits.

"Physicians had the data, they want to change healthcare costs, but in this case it didn't affect change," Ms Ittner said. "Why? Because it's up to the organization to reframe and contextualize that data in a way that engages its physicians in the end goal."

Organizations can improve physician engagement in several ways. First, change management should come from the top down and involve every layer of the organization. Leaders also need to define a common purpose and reframe values and beliefs to gain buy-in from staff. Then, organizations can identify the most effective ways to engage staff meaningfully across the enterprise.

"Accurate costing and quality variation has a huge impact on understanding cost of care," Mr. Pandey said. "By bringing together quality and cost data for physicians, organizations can identify the most impactful areas to target quality initiatives, improve patient care and reduce costs."

To view the webinar recording, **click here.**