

# **Making a Business Case for Reducing Racial and Ethnic Disparities in Health Care: Key Issues and Observations**

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## Making a Business Case for Reducing Racial and Ethnic Disparities in Health Care: Key Issues and Observations

The persistence of racial and ethnic disparities in American health care is an important problem for society, for medical caregivers, and of course for the people disadvantaged.<sup>1</sup> Numerous remedial efforts have been launched, including the Finding Answers program of the Robert Wood Johnson Foundation (RWJF),<sup>2</sup> along with other public and private initiatives.<sup>3</sup> Central components of the disparities-reform agenda are

- documenting the existence of consequential disparities in treatment or results;
- developing and disseminating information about interventions that successfully reduce disparities in care or improve the quality of care for minority patients; and
- generating supportive business cases for improvement.

This brief report focuses upon the third aspect of building the case for change—the need for disparities-policy innovators and researchers to create business cases that support useful interventions across a wide variety of caregivers and health plans. The core idea is that ways are needed to encourage caregivers and related organizations to spend the time, effort, and money needed to make effective improvements. Thus, this report does not address the difficulties in obtaining solid evidence of significant health improvements for disadvantaged populations, which is arguably the central thrust of RWJF’s Finding Answers program.<sup>4</sup> We address the issues and challenges in developing the business case for ongoing implementation of improvements that are found to be effective in improving clinical processes or outcomes.

Our report draws in part upon information and insights developed as we assessed ways to help improve the operations of Finding Answers and its national program office (NPO) at the University of Chicago.<sup>5</sup> Finding Answers projects address disparities in

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<sup>1</sup> Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, Eds, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care (Washington, DC: National Academies Press, 2003); John K. Iglehart, ed. Racial & Ethnic Disparities, *Health Affairs* (symposium issue) 24(2):312-521 (March/April 2005); Agency for Healthcare Research and Quality. *2008 National Healthcare Disparities Report* (Rockville, MD: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality; March 2009) AHRQ Pub. No. 09-0002 <http://www.ahrq.gov/qual/nhdr08/nhdr08.pdf>.

<sup>2</sup> Finding Answers: Disparities Research for Change, program webpage <http://www.solvingdisparities.org>; Amy E. Schlotthauer, Amy Badler, Scott C. Cook, Debra J. Pérez, and Marshall H. Chin, “Evaluating Interventions To Reduce Health Care Disparities: An RWJF Program,” *Health Affairs* 27(2):568-73 (2008).

<sup>3</sup> See, for example, the National Center on Minority Health and Health Disparities (NCMHD), legislated in 2000 within the National Institutes of Health <http://www.ncmhd.nih.gov/>; the AHRQ National Health Plan Collaborative [http://www.chcs.org/info-url\\_nocat3961/info-url\\_nocat\\_show.htm?doc\\_id=253141](http://www.chcs.org/info-url_nocat3961/info-url_nocat_show.htm?doc_id=253141); and the National Partnership for Action To End Health Disparities <http://www.omhrc.gov/npa/>.

<sup>4</sup> See note 2 above.

<sup>5</sup> Harry P. Hatry, Randall R. Bovbjerg, and Elaine Morley, *Interim Assessment of Finding Answers: Disparities Research for Change*, Washington, DC: The Urban Institute, Final Report to the Robert Wood Johnson Foundation, Draft of December 15, 2008. This assessment was done to suggest improvements based on observations of much of one round of grantee experience. At the time of this additional report, even the first round of grantee experience remained incomplete, as final reports had not yet been delivered.

caring for three chronic conditions—cardiovascular disease, depression, and diabetes—which are rather common, have great impact on patients’ lives and on health care spending, and whose care is believed to feature wide disparities yet relatively clear standards of care.<sup>6</sup>

The goal of this report is to make suggestions about future activities under the Finding Answers program that affect business-case development, as well as to illustrate more general lessons with specifics from early program experience. We seek to lay out the issues involved in establishing a case for wider adoption of promising health care interventions. Developing good business cases is an important aspect of developing the “*practical* blend of strategies and interventions that work to measurably reduce” disparities [emphasis added], which is the goal of Finding Answers.<sup>7</sup>

## I. What Is a Business Case and Why Is It Important?

Leatherman and colleagues provide a useful definition of a business case.<sup>8</sup>

*A business case* for a health care improvement intervention exists if the entity that invests in the intervention realizes a financial return on its investment in a reasonable time frame, using a reasonable rate of discounting. This may be realized as “bankable dollars” (profit), a reduction in losses for a given program or population, or avoided costs. In addition, a business case may exist if the investing entity believes that a positive indirect effect on organizational function and sustainability will accrue within a reasonable time frame.

Caregivers and many other actors in health care likely do not mainly think of themselves as in *business* or as making *investments* in search of a return. They are mainly seeking to provide good care for their patients. Yet this definition usefully focuses attention on the need to support disparity-reducing actions based on some form of “payoff” in the future. The payoff needs to be at least commensurate with the effort needed to implement and operate the intervention in question. Most interventions come with some cost, if only to overcome the inertia of accustomed ways of providing services. In well managed offices, clinics, and other organizations, there is likely also a new administrative cost associated with overseeing new modes of operation and, one hopes, also tracking their effectiveness in meeting organizational goals, including provision of good care and staying on budget.

Another way to frame the issue is not to use the financial term “investment,” which connotes a one time purchase of a tangible asset, but rather to speak of up-front expenses to implement an intervention, followed by ongoing costs over time to continue to affect

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<sup>6</sup> RWJF 2006, above.

<sup>7</sup> RWJF, *Finding Answers: Disparities Research for Change, Call for Proposals*, Proposal Deadline March 16, 2006, page 3 [http://www.solvingdisparities.org/media/file/Finding\\_Answers\\_CFP.pdf](http://www.solvingdisparities.org/media/file/Finding_Answers_CFP.pdf).

<sup>8</sup> Sheila Leatherman, Donald Berwick, Debra Iles, Lawrence S. Lewin, Frank Davidoff, Thomas Nolan, and Maureen Bisognano, “The Business Case for Quality: Care Studies and an Analysis,” *Health Affairs* 22(2):17-30 (2003), at p.18.

patient care over time. The expected stream of future operating costs can be thought of as an investment, in that an entity adopting an innovation commits to them in advance, and they have a predictable current value. Thus, there is a business case if the current value of all expected costs is less than the current value of all expected payments, or, in other words, if the net present value of expected cash flows is positive.<sup>9</sup>

This definition also helpfully emphasizes that *a business case must be made from the perspective of the actor undertaking an initiative*. Making a business case implies a narrow framework of assessment—what’s in this for us? In the case of health care disparities, particularly for Finding Answers, the usual perspective is that of the health *caregiver* treating a minority patient. For example, a clinic’s initiative may promote *professionals’* ethical norms or add value by improving its *patients’* health status or even just making care more convenient for them. However, from the clinic’s *business* perspective, those benefits do not matter in and of themselves—unless they somehow generate sufficient revenue, cost savings, or other things of value to the *clinic* to warrant spending on the initiative.<sup>10</sup>

The viewpoint is also narrow in that it is almost wholly a *business* or *fiscal* perspective. That is, what matters most are cash outflows and inflows. (Broader economic or social perspectives are also important in the larger picture, and are considered in the next section.) However, indirect impacts are also relevant, and other things than service-generated or other future revenues may have practical business value from the perspective of an innovator. For example, a disparities-reducing initiative might better align care processes with the entity’s mission and better motivate staff productivity, or better quality might attract more paying patients or more talented professionals. Such matters seem likely to be highly situation-specific and hence warrant detailed explication.

The *timeframe* or time horizon is another major point. The longer an entity must wait to cover its expenses, the higher the eventual payoff must be. Formally, this means that business cases compare *present values* of expenses and revenues, after discounting future cash flows for the time value of money and expected inflation.<sup>11</sup>

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<sup>9</sup> Reiter KL, Kilpatrick KE, Greene SB, Lohr KN, Leatherman S, “How to Develop a Business Case for Quality,” *Int J Qual Health Care* 19(1):50-5 (Epub 2006 Dec 15); Nicholson S, Pauly MV, Polsky D, Baase CM, Billotti GM, Ozminkowski RJ, Berger ML, Sharda CE, “How to Present the Business Case for Healthcare Quality to Employers,” *Appl Health Econ Health Policy* 4(4):209-18 (2005). There are other ways to measure return on investment, as Reiter et al. discuss; the cash flow approach is the most straightforward and readily interpretable.

<sup>10</sup> Kilpatrick and Brownson discuss such values in “Beyond Return on Investment: Other Financial and Nonfinancial Business Cases for Self-Management Support in Diabetes Care,” chapter 2 in Kerry E. Kilpatrick and Carol A. Brownson, *Building the Business Case for Diabetes Self Management: A Handbook for Program Managers*, St. Louis, MO: Diabetes Initiative National Program Office at Washington University School of Medicine, report for the Robert Wood Johnson Foundation, February 2008) <http://www.diabetesinitiative.org/lessons/documents/BusinessCasePrimerFINAL.pdf>.

<sup>11</sup> See, for example, “Time value of money,” in *Dictionary of Financial Terms* Lightbulb Press, Inc., accessed via <http://financial-dictionary.thefreedictionary.com/Time+value+of+money>.

It is important for disparities reduction to consider business cases because promising interventions, such as those emerging from Finding Answers grantees, almost inevitably add some new costs to the “production” of care. Such expenses may be attributable to adding personnel, better educating patients or providers, or undertaking another activity found to be useful. Especially in this time of very tight funding and increasing focus on controlling health care costs, any new cost can pose a substantial barrier to a health care organization’s willingness to introduce new interventions. This practical reality holds true even though the intervention may be expected to add value, by reducing disparities in care provided, by raising the quality of minority services, by reducing the “downstream” need for services, or by improving the future health of disadvantaged patients.

Finally, as Dunston and colleagues persuasively suggest,<sup>12</sup> just indicating “the right thing to do” to reduce disparities often may not provide enough motivation to act—or the wherewithal for even well motivated entities to take action. Rather, “to be sustainable,” changes “may require linking to financial incentives.” In short, some form of positive business case is likely to be needed to encourage ongoing use of an initiative among initial innovators and, even more, to encourage others to change accustomed practices and adopt new modes of operation.

## **II. Business Cases Compared with Broader Perspectives**

A business case focuses relentlessly on finances. It may be complained that, as some say about economists, a business case knows the cost of everything and the value of nothing. More precisely, a business case simply seeks to recognize fiscal reality and to help health care actors cope with it. Existing funding mechanisms are arguably the fundamental force in shaping such practical reality for caregivers and other actors in health care. Service-based payment methods and insufficient appreciation of quality differences are widely seen as substantial impediments to creating a business case for better care<sup>13</sup> and for reducing disparities.<sup>14</sup>

To improve care and reduce disparities thus also likely calls for building broader cases for change. These cases need to recognize values beyond increased revenues or decreased costs at the level of an innovation in care. Leatherman and colleagues distinguish two types of such cases, either of which might be used to promote more thoroughgoing change. The first they term the “economic case.” This broadens the perspective of a business case to ask whether “discounted financial benefits exceed discounted costs, [regardless of] whether they accrue to patients, employers, providers or

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<sup>12</sup> Frances J. Dunston, Andrew C. Eisenberg, Evelyn L. Lewis, John M. Montgomery, Diana Ramos, and Arthur Elster, “Making a Business Case for Small Medical Practices to Maintain Quality While Addressing Racial Healthcare Disparities,” *Journal of the National Medical Association* 100(11):1318-1325 (2008), at page 1320.

<sup>13</sup> Molly Joel Coye, “No Toyotas In Health Care: Why Medical Care Has Not Evolved To Meet Patients’ Needs,” *Health Affairs* 20(6):44-56 (2001).

<sup>14</sup> Nicole Lurie, Stephen A. Somers, Allen Fremont, January Angeles, Erin K. Murphy, and Allison Hamblin, “Challenges to Using a Business Case for Addressing Health Disparities,” *Health Affairs* 27(2):334-8 (2008).

payers, or some other segment of society.”<sup>15</sup> An analogous example comes from a study of disparities in care between the uninsured and insured: Near-elderly populations that lack health insurance receive less medical care and can be expected to cost the federal government more when they become later eligible for Medicare.<sup>16</sup> A provider taking care of uninsured near-elderly patients has no business motivation to give them uncompensated care so as to benefit Medicare later—but there is an overall economic case for improving insurance coverage.

The “social case” goes even further, to consider the *value* of non-fiscal benefits achieved for patients, families, and society. These include better health and functioning, longer lifespan, and greater contributions to the community. In this context, extending lives is a good rationale for authorizing new funding, even though it may not create fully offsetting savings elsewhere.

Making economic cases calls for assessing more data, over a longer timeframe than are available to the grantees of Finding Answers projects, for example. The method of comparing discounted financial costs and benefits remains the same, however. Making the social case calls for some form of cost-effectiveness or cost-benefit analysis, which use different forms of valuation. The former typically compares two activities, e.g., standard treatment vs. innovation, in terms of their cost per standardized outcome, e.g., number of life years saved, possibly quality-adjusted, again in terms of present values.<sup>17</sup> Cost-benefit analysis calls instead for assigning a monetary value to benefits in order to compare them directly with the costs of any proposed activity, also in present values.<sup>18</sup>

Positive economic or social cases are needed to change private and public funding flows and other rules that affect the delivery of care, e.g., conditions of participation in health plans. Those changes could in turn affect funding flows so as to allow more positive business cases to be made for improving quality generally and for reducing disparities.

### **III. General Observations about Business Case Perspectives**

The main players in a position to take action—or support action—to reduce disparities are the following:

- Health care organizations—the clinics, physician groups, and hospitals that directly provide health care services and routinely interact with patients;
- Patients and their families—who directly bear the non-monetary costs of chronic conditions and also pay for some care themselves, a higher share if they are uninsured;
- Private health plans and workplace groups—the entities that pay for most care of working age people and families through insurance or self insurance; and

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<sup>15</sup> Leatherman et al., above, at pages 18-19.

<sup>16</sup> Jack J. Hadley and Timothy Waidmann, “Health Insurance and Health at Age Sixty-five: Implications for Medical Care Spending on New Medicare Beneficiaries,” *Health Services Research* 41(2):429-451 (2006).

<sup>17</sup> See note 11 above and accompanying text.

<sup>18</sup> *Ibid.*

- Public funders—including Medicare, Medicaid, and public health departments, which disproportionately fund care for minorities, mainly through service payments, but also through grants, disproportionate-share hospital payments, and otherwise.

This section sketches some important issues from the perspectives of these groups.

### *Health Care Organizations*

Caregivers are the central actors for many or most initiatives to reduce disparities, including under the Finding Answers program. A particular focus is front-line or primary providers that serve as regular sources of care for people with chronic conditions. Their decisions influence patient education, directly determine the routine and preventive services that hold promise of improving health, and indirectly influence other care via their referrals to specialists and inpatient care. Hence they seem to be central to reducing disparities in care and in outcomes and perhaps also in modifying patient behavior in positive ways. Almost all of the Finding Answers projects in the first two rounds of grants were health care providers.

Much of the discussion above of business cases took the perspective of caregivers, who need to be able to pay for disparities initiatives. A number of challenges are notable. A key issue is how providers are paid. Almost all grantees interviewed appeared to receive fee-for-service payment from third-party health plans, private and public, and many initiatives involved using non-traditional staff to help educate patients or help them navigate their treatment. A key issue for such interventions is thus simply whether that additional service is billable on its own or as part of a clinic or office visit, and thus increases revenues.

If, on the other hand, an improvement reduces the need for future services provided by the entity itself, the improvement will reduce its own future revenues. In that case, the financial impact or effect on the business case will depend upon whether the lost service would have earned net revenues. (Analogously, hospitals can lose financially by improving quality and reducing readmissions.<sup>19</sup>) Capitated providers, in contrast, benefit by providing good care through fewer services. Most Finding Answers grantees have been safety net clinics and hospitals. Some of them seem to receive grants or other blocks of funds in recognition of their key role in serving uninsured people, including minorities; the fiscal incentives of such blocks of funds are similar to capitation, in that the entity benefits by reducing utilization through better care.

If an improvement reduces the need for future services provided by other health organizations, the innovator will still not benefit. The fiscal benefits created by an intervention will then mainly go to others, a form of what public finance terms

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<sup>19</sup> Reed Abelson, “Hospitals Pay for Cutting Costly Readmissions,” *New York Times*, May 9, 2009. An aside: Where hospitals receive lump sums of DSH payments, it may be cost effective for them to shift uninsured inpatient care or emergency room care to an outpatient setting, as revenues are unaffected and costs are lowered. The same holds true for improvements in disparities that may reduce utilization; the key is that revenues not be reduced thereby.



“externalities.” A classic example is preventable hospitalizations. Better diabetes management may reduce hospitalization rates, which may be professionally satisfying for a clinic’s care team, but only the payer for hospitalization and, often, the patient benefit financially from this effect.

Savings from an intervention will be most obviously helpful to the intervening entity if they take the form of reducing the cost of producing a service. For example, improved patient-educational materials, the use non-physician staff, or other changes in the process of care might reduce the physician time needed to provide a service or care for a patient. If the same fee-for-service payment is earned, the provider will benefit. Lowered costs of producing care will be most helpful of all if they occur in the short run.

Otherwise, where future savings or other benefits occur too far into the future, they will not be of much help to innovators’ business case, as already noted. This effect is a kind of temporal externality. The time discount already mentioned is one reason for this, but there are at least two others. One is that the fiscal year is often the decisionmaking time horizon for providers, especially safety-net facilities that receive line-item or grant funding of some kind. Another is that staff and management often seem to expect that their patients are sufficiently transient that some other provider is apt to reap any future benefits achieved by the first provider’s efforts.

On the face of it, chronic illnesses cause great harm and high health spending but do so over a patient’s whole lifetime. Accordingly, the payoffs from better care or modified behavior may occur much later in life. The very high costs of diabetes, suggested one interviewee, were sufficient to offset the time delay. The accuracy of that observation goes beyond the scope of this brief. It also goes beyond what Finding Answers grantees can address in their short-term projects. But estimating reasonable time series of effects of reducing disparities ought to be a priority for others at the foundation or the NPO.

### *Patients with Chronic Conditions*

Minority patients, like others, have a role to play in improving their health status and health care. However, the “business case” for living healthier lives and seeking out better treatment—seemingly strong for people who suffer directly from shortcomings—appears insufficient. If patients could act effectively on their own, disparities in care and outcomes would not be the problem that they are. Many interventions seek to engage patients in better managing their conditions or better navigating health services. Some interventions involve a financial incentive, typically a positive one, as an encouragement to patients. In Finding Answers projects, such incentives included bus vouchers to cover transit to health care and a free DVD player on which to watch educational materials. The business case for such efforts seems best assessed from the perspective of the provider of the incentive—likely a health provider or public health program—than of the patient-recipient of any incentives. The practical and ethical aspects of using negative financial incentives as a motivator go beyond the scope of this report.

### *Private Payers and Workplace Groups*

For working Americans and their families, private insurance pays for the bulk of care.<sup>20</sup> Although one cause of racial and ethnic disparities is that minorities are disproportionately likely to be uninsured and hence underserved, disparities exist even where minorities are insured. Accordingly, a business case may exist to make quality improvements for insured people, especially for minority enrollees and especially for chronic illnesses.<sup>21</sup>

The Finding Answers program sought to attract health plans as demonstrators of the effectiveness of disparities interventions. Only a single plan participated in the program's first two rounds of grants, however.

Some general observations about health plans can still be made. The good news is that insurers pay for most health care services, so cross-provider externalities are not a problem, and any utilization savings achieved should be reflected in reduced benefit claims. Moreover, insurers have data systems that should be able to track changes in patterns of spending. However, whether cost-of-production savings will be passed through in lower provider fees is uncertain. Moreover, insurance contracts run only year to year, so health plans that themselves sell to individuals and small employer groups that frequently change carriers lack a long time horizon for cost recovery as the basis of a business case.

Workplace health plans, however, reflect the interests of their employer purchasers, and self-insured plans *are* the employers. Moreover, larger employers can expect employee-patients to remain with the firm for longer periods (perhaps especially so if they have chronic medical conditions that make it difficult to shift medical plans). Further, employers also internalize the added costs of sub-optimal health care, including disparities. Shortcomings in care may not only raise employees' medical/insurance costs but also likely increase absenteeism and reduce their productivity while on the job. Fellow workers' productivity may also be affected.<sup>22</sup>

The less good news is that tracking race and ethnicity is more of a challenge, and so is crafting effective interventions. Prominent large employers and some large insurers have

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<sup>20</sup> John Holahan and Allison Cook, "The U.S. Economy and Changes in Health Insurance Coverage, 2000-2006," *Health Affairs* 27(2):w135-44 (Epub 2008, Feb 20); CMS (Centers for Medicare and Medicaid Services). 2008. National Health Expenditures by type of service and source of funds, CY 1960-2006, accessible from

[http://www.cms.hhs.gov/NationalHealthExpendData/02\\_NationalHealthAccountsHistorical.asp](http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp).

<sup>21</sup> "Nearly three-quarters of the money spent by private insurers goes to treat people who suffer with chronic illnesses such as diabetes, asthma, heart conditions, and depression." RWJF, "Quality & Equality in U.S. Health Care: A Message Handbook," May 2009, p.25.

<sup>22</sup> Nicholson S, Pauly MV, Polsky D, Baase CM, Billotti GM, Ozminkowski RJ, Berger ML, Sharda CE. How to present the business case for healthcare quality to employers, *Appl Health Econ Health Policy* 4(4):209-18 (2005).

supported disparities reduction.<sup>23</sup> It may well be that working in tandem with health care providers could have the most effect, as health plans would appear able to create strong incentives but to have fewer direct levers over patient care or behavior. Employers, however, do have direct influence over workers, although issues of confidentiality arise over generating person-specific information.

For efforts like those of Finding Answers, a key to attracting employers may well be to provide evidence that available interventions are sufficiently promising to warrant employer/insurer investigation of their business cases from the health plan's perspective.

### *Governments and Public Health Plans*

The final perspective of interest is that of government. Medicare, Medicaid, and lesser public health plans pay for over a third of American health care.<sup>24</sup> Moreover, government departments of public health address population health as well as care for the disadvantaged. Across levels of government, public entities disproportionately fund care for minorities, mainly through service payments, but also through grants, disproportionate-share hospital payments, and otherwise.

Medicaid and Medicare also serve as the ultimate funder for people whose chronic conditions worsen to the point of disability or other exit from the workforce. Within those programs, chronic care claims a dominant share of spending.<sup>25</sup> Furthermore, only government can adopt a lifetime perspective on chronic conditions, can redistribute resources across sectors of care and timeframes, and has a clear responsibility for promoting general welfare. Government regulation also addresses social norms of equity through licensure, conditions of participation in public coverage, and in other ways.

For all these reasons, government can play many roles in addressing disparities. Numerous government agencies have already begun to address disparities.<sup>26</sup> Descriptive analysis suggests numerous potential federal influences or controls.<sup>27</sup>

Finding Answers does not involve governments directly, although at least one grantee is a public hospital system. It reported that the Los Angeles County Health Department has indicated interest in the Round 1 grantee experiments with the use of regular screening of patients for depression.

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<sup>23</sup> National Business Group on Health, *Eliminating Racial and Ethnic Health Disparities; A Business Case Update for Employers*, February 2009,

<http://www.businessgrouphealth.org/pdfs/Final%20Draft%20508.pdf>; Patricia Hassett, "Taking on Racial and Ethnic Disparities in Health Care: The Experience at Aetna," *Health Affairs* 24(2):417-20 (2005).

<sup>24</sup> CMS (2008), above.

<sup>25</sup> Kenneth E. Thorpe and David H. Howard, "The rise in spending among Medicare beneficiaries: the role of chronic disease prevalence and changes in treatment intensity," *Health Affairs* 25(5):w378-88 (Epub 2006 Aug 22).

<sup>26</sup> See sources in note 1 above.

<sup>27</sup> Nicole Lurie, Minna Jung, and Risa Lavizzo-Mourey, "Disparities and Quality Improvement: Federal Policy Levers," *Health Affairs* 24(2):354-64 (2005).

#### **IV. Specific Observations about Finding Answers Business Cases**

##### *Round One Projects' Cost Assessments and Relevance to Business Cases*

Findings Answers projects that we reviewed in the course of our interim assessment faced large challenges in making strong business cases for their intervention under existing financing mechanisms. Our central observations follow.<sup>28</sup>

One difficulty was built in from the start of the first round of grants. The program began with the assumption that grants could either be made to “projects or initiatives that are underway in different health care settings” or that grantees would have secured “other funding sources for the bulk of program start-up and implementation costs.”<sup>29</sup> Such projects could be expected either to have funding and other supports already in place or to have already “sold” the project to another internal or external source of new support—either of which suggests that the implementer would already have developed a business, economic, or social case for their intervention. But interviews suggested that business cases were not prominent in innovators’ thinking.

Our interim interviews done toward the end of round one found that almost all those grantees were new start-ups, so that their projects were essentially pilots rather than mature operations. As pilots, the projects appropriately had to be most focused on the myriad issues of implementation of the intervention itself and of the research on effectiveness. Large efforts were often needed to win staff acceptance and to recruit and retain adequate numbers of patients. When interviewed, first-round grantees were all aware in a general way that they would need to document the costs of what they were doing. However, this effort was not seen as a high priority, or a difficult undertaking, compared with running the project and seeking to document health benefits.

Grantees generally were planning to track the costs of their interventions as an adjunct to reporting on how they spent RWJF grant funds. However, the main costs of intervention were by design to be borne elsewhere. Some appeared to constitute in-kind “donations” of staff time, others piggy-backing on implementation efforts under a separate research grant, yet others possibly general institutional funds related to safety net funding. How well grantees’ final reports will be able to account for such support was not clear.

Another difficult issue appeared to be distinguishing between start-up costs and ongoing costs of operation at the demonstration site. This seems especially hard for pilots, many of which seemed to involve mid-course corrections in processes, especially for patient recruitment and retention, which appeared to overlap somewhat with general communication with chronic patients. Moreover, there seems to be a learning curve for

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<sup>28</sup> Our interim review covered the period of Finding Answers’ first round grants, made to 11 entities. These comments are based on examination of project applications, grant reviews, and other written documentation, augmented by on-site or telephone interviews with important staff for 9 grantees, plus interactions with first and second round grantees at the national program meeting in November 2008. Almost all grantees evidently received time extensions, and at the time this report was undertaken, no final reports were available from the first round of projects.

<sup>29</sup> RWJF (2006), at page 3.

implementing new processes, not a clear line of demarcation between start-up and routine operations.

Two interviewees raised an important point for their projects, on diabetes and depression: New patient support and education provided by a form of new health coach or by enhanced screening seemed to be reducing the physician time needed to provide good care. It was unclear how well projects could track such secondary effects on care processes not directly involved in the intervention. Such effects could be positive like this perceived savings in time, or they could be negative, like the additional record-keeping work for staff nurses cited at another project, or the potential that better educated patients could be more demanding of their physicians' attention.

The short time frame of the interventions and their siting largely within primary care delivery both appear to complicate full assessment of the interventions' potential downstream impacts on care and on health care spending. A partial exception here was the health plan, which was prepared to do health-system-wide accounting, but which had severe problems in obtaining patient participation.

Finally, the main point of documenting the costs of disparities-reducing interventions is to encourage other entities to follow or improve upon the interventions being demonstrated. This calls for clarifying how costs might change past the pilot stage or in other sites that might have different staffing patterns, cost structures, or revenue sources. Grantees interviewed generally appreciated that it is appropriate to document costs in terms of actual resources (e.g., staff time) and not just dollars spent.

However, clarifying the nature of the enterprise within which the initiative was undertaken remains important. For instance, were there diseconomies of scale as the project geared up? Did the intervention benefit from economies of scale because of a clinic's size, for example, that might not exist for subsequent adopters? Was there some "slack" in staffing patterns that facilitated adding responsibilities for some staff? Was the physical layout conducive to altering patient flow? Did the entity have computerized billing and accounting, medical records, and patient communication modalities that facilitated caregiver decision support or some other intervention?<sup>30</sup>

In short, substantial challenges looked likely for the first round of grantees to contribute information fully suitable for building business cases. This should not be too surprising. Assessments of quality-promoting interventions evidently seldom produce the information needed.<sup>31</sup> Moreover, making a business case as such was not a requirement for the projects. Formal guidance on how to do cost analyses was issued after our

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<sup>30</sup> Kilpatrick and Brownson, above note 10, discuss some of these issues under "Reporting the Effects of Capacity Constraints," at page 7.

<sup>31</sup> "Only 15 of 1968 articles identified contained sufficient information on both the costs of implementing quality-enhancing interventions and the resultant changes in costs of care or revenues to permit the calculation of a return on investment," according to the systematic review of Kerry E. Kilpatrick, Kathleen N. Lohr, Sheila Leatherman, George Pink, Jean M. Buckel, Caroline Legarde, and Lynn Whitener, "The Insufficiency of Evidence to Establish the Business Case for Quality," *Int J Qual Health Care* 17(4):347-55 (Epub 2005 Mar 23).

interviews occurred, at the end of the initial grant period. Accordingly, subsequent efforts may be better placed to track expenses and revenues and contribute to business cases.

### *Other Observations*

Many interviewees clearly felt that research evidence and business cases were not the only or the best way to promote change. Such qualitative indications suggest that that some progress is feasible without strong empirical justification.

Many small elements may make a big difference in receptiveness to change. The following points emerged from interviews:

- Key staffs at innovating institutions were unanimously glad to have participated in Finding Answers, even though grantees almost without exception believed their projects had been underfunded. A substantial pool of professionalism and altruism appears supportive of initiatives, certainly within the self-selected group of safety net leaders and researchers with whom we met. (We talked with fewer lower level staff, some of whom showed less enthusiasm.) This pool can be tapped if circumstances are right.
- The perception of management and medical staff that a substantial health care gap exists is influential. Some health care professionals (many, said some round one grantees) believe that disparities in health care do not exist in their organizations, or at least that they themselves do not discriminate. Others may believe that even if such disparities exist, they are not an important influence on patient well being.
  - One intervention featured a survey of the entity’s physicians about perceived racial disparities in providing diabetes care. Prior to the intervention, just over half (57 percent) of intervention group physicians felt disparities in diabetes care existed somewhere within their system of health care providers, fewer in their own health center or among their own patients (45 percent in each case). Perceptions of disparities increased following the intervention, including perceived disparities in treatment of their own health center and patient panel.<sup>32</sup>
  - Many Finding Answers participants believed that such consciousness-raising has a role in changing behavior, even if that was not the focus of their effort. The size of the perceived gap was also seen as influencing staff responsiveness.
- Physician belief is important because the level of support from the medical staff seems a key to achieving change. So reassuring them that new processes will be helpful to doctors matters—perhaps save them time, provide them more information they are likely to want, or encourage patient compliance with recommendations for exercise, medication, and diet. In addition, keeping new burdens low is important.

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<sup>32</sup> Summary findings presented in 2008 Annual Grantee Conference Materials, Finding Answers: Disparities Research for Change (November 20-21, 2008, Chicago, Il.). Based on Sequist, T.D., Ayanian J.Z., Marshall, R. Fitzmaurice GM. Safran D.G., “Primary Care Clinician Perceptions of Racial Disparities in Diabetes Care.” *Journal of General Internal Medicine* 2008.

- In general, perceived new costs need to be small, especially in projects like those in round one, which did not feature new financial incentives (e.g., pay for performance). An important element here is the initial start-up costs, both money and effort. So the availability of existing start up materials is important, such as training materials, software, questionnaires, in appropriate languages. Even for attractive interventions, large initial efforts can discourage adoptions. A particular dislike that medical staff mentioned is added paper work.
- Not surprisingly, most round one efforts were designed to have low costs, or to create materials usable by subsequent adopters at low cost.
  - One grantee, for example, used existing depression screening tools (the PHQ-2 and PHQ-9) for its intervention which involved administering the tool to adult patients when they arrive at the clinic for their appointment. The intervention was designed for settings that have little or no funding available for introducing an intervention. The main added costs were for reproducing the screening tool and training for clinic personnel on the purpose of the intervention, how to score the instrument, and cultural sensitivity regarding depression, all low cost items. Refresher training was provided in the first year of the intervention, but on-going training has not been needed.
  - DVDs were developed in another project to promote patient self-care, medication adherence, and communication with doctors to reduce cardiovascular disease. Designers explicitly sought to create materials that might be used “as is” by other providers serving low-income African American clients. The DVDs would likely need to reach other minority groups, as the depicted patients are all African Americans and recommendations are culturally targeted. Nonetheless, these DVDs could serve as a model for content and approach for other groups, which should lead to substantial savings in time for other adopters.
  - Similarly, another project created training and patient self-care materials on diabetes and translated them into Spanish and Vietnamese for its coached-care intervention. Developing the materials took a considerable amount of time, both to revise them so they can be understood by those with lower literacy levels and to translate them. The availability of materials in three languages was reported to be of interest to the California Medical Association.
- Some flexibility in the way an intervention can be implemented is likely to make it more attractive to other organizations. That way, an intervention be “adjusted” to better fit new circumstances.
  - One depression screening intervention was implemented somewhat differently in the two clinics where it was used. One clinic used a two-step screening process. A two-question version of the instrument was administered to all patients. The full instrument was then administered only to those whose responses indicated

- depression might be present. The other clinic found the two-step process to be too cumbersome and administered the full instrument to everyone. Additionally, one of the clinics had a computerized disease registry that enabled it to track when patients had been screened. That clinic only administered the screening tool at three month intervals. The other clinic administered the instrument at each visit.
- Two of the three DVDs developed by one project were intended for home viewing, with the first video to be viewed at the clinic. Intervention staff indicated that an alternative approach other organizations could use would be to play the videos in clinic settings rather than give them to patients. This would avoid the project's cost of giving patients DVD players to use at home.
  - Finding Answers seeks to generate strong research evidence on the effectiveness and affordability of interventions. This is not the only approach supported by grantee-interviewees.
    - Important as research evidence may seem, some grantees contemplating how to “sell” their ideas to others suggested that the inherent logic of their intervention and consistency with professional norms carry great weight. Even some of the *unsuccessful* interventions observed seem to hold appeal for other health care organizations, which assume that future implementation procedures can be improved.
    - The simplicity and understandability of the innovation is also believed to facilitate subsequent dissemination.
    - Dissemination should not be limited to medical literature but should include networking, publicity, and media support (both the professional media and public media) for a successful innovation. These efforts focus on persuading medical organizations and the public, not researchers.
    - Gaining researcher support should make it easier to implement innovations. However, this was felt by a number of the grantees we visited that this was considerably less important. Of course, negative assessments of the innovation by researchers could become a major obstacle.
  - Availability of revenues to pay expenses of the new intervention is much desired, notably from Medicaid in the case of these grantees. However, even small outside funding to cover out-of-pocket costs seemed important, including for items that insurers will not cover, such as donated merchant gift cards to encourage patient participation.

## V. Concluding Discussion

Finding Answers projects faced great challenges in generating strong business cases for their interventions as of the end of their initial grant periods. This is not surprising: most



quality initiatives fail to generate all needed data. Moreover, Finding Answers projects had limited timeframes, and the innovating organizations oversee only a modest share of medical spending on chronic care. For round one grantees, lack of cost-assessment guidance early enough to affect data collection planning was an additional handicap.

Improvements should occur under rounds two and three. Still, it is difficult to capture all cost impacts, including indirect ones, even within the implementing entity. Estimating likely costs for future implementers also adds a degree of difficulty.

Our encouragement is to supplement formal analysis with other approaches. One way is to have grantees also provide substantial qualitative information to allow others to interpret whatever level of quantitative estimates they can generate on effects on clinical measures and on organizational finances. It is very important simply to provide a detailed description of the intervention and of the innovating organization's circumstances. Such information includes, for example,

- the logic of the intervention;
- what mid-course corrections occurred;
- why it was attractive or not to different staff and decisionmakers within the organization;
- what revenue flows support the organization, both earned by services provided and obtained in other ways; and
- key attributes of the organization, especially with regard to staffing.

Another approach to thinking about the business case of a project is to observe its aftermath. The best evidence about the true nature of cash flows and other costs and benefits may come from observing whether the interveners decide to continue using the innovation rather than from their production of peer-review-ready research findings about their results. For a start, observing people's actions often more reliably shows their beliefs than does what they write or say. Moreover, interveners may have strong and justified beliefs that are simply not well documented because of shortcomings in the project design or an unexpected byproduct of the intervention. Another good indicator is whether they are proselytizing for their innovations and with any success.

Moreover, the presence of successful *replications* of a successful innovation is likely to help to provide more convincing, more credible, evidence that a particular approach works—and was affordable. RWJF does not appear to have provided for this, though provision may have been included in the proposed new grant to Chicago.

Given the somewhat constrained perspectives and timeframes of the projects, it may be appropriate to develop the economic and social cases for disparities reduction in a broader context. Such effort might address, for example, the likely effects of a change in payment methods that may occur under national health reform or private insurers' efforts to promote evidence based medicine and value based benefits. Disparities reformers need to assure that pay or performance and like ideas contain risk adjustors that recognize the differential needs of minorities. If it is harder to obtain the same quality for minority

patients within a fixed quantum of payment, a new disincentive will be created to care for disadvantaged patients.

It could be also helpful to assess the prospects for enhancing revenues in a broader context. Grantees may not have the best expertise in how to maximize insurance payments, especially from Medicaid and Medicare. In light of the literature-review finding that nurse led initiatives show great promise, the ability to use nurse interveners could be investigated; states differ in the extent to which nurses can operate rather independently and bill for their services.

Finding Answers explicitly separates itself from how to help the uninsured and finance their access to care. This is also a big issue for minority populations. The extent to which care is funded, however, influences the development of a business case for reducing disparities.

Business case assessment by caregivers may seem callous or even unethical. It's a practical reality, however. No entity can remain in business, whether with an altruistic mission or otherwise, if it consistently operates at losses that funders are not willing to subsidize. To quote one safety-net mantra, "no margin, no mission."

On the other hand, the social case is also important, including the ethical dimension of disparities. Medicare does not cover end-stage renal disease because it saves money by paying for ESRD care. It pays for dialysis and transplantation because they save lives, disproportionately minority lives. Despite the focus in this report on business cases and net fiscal impacts, developing the value proposition for improving minority care remains important.

In the long run, the most important perspective may indeed be that of government. Financially, government pays for over a third of American health care, including most safety net care; and its payment reforms and rules often drive private methods. Public programs also end up caring for people whose chronic conditions keep them from working. Finally, only government can adopt a lifetime perspective or redistribute resources, and it has a clear responsibility to promote general welfare.