

## How a Small Oklahoma Town Reduced Costs Through Patient Literacy

Cheryl Clark, for HealthLeaders Media, December 16, 2009

Might [the city of Duncan](#), a community of 22,000 people 80 miles southeast of Oklahoma City, hold the secret to squelching healthcare costs without sacrificing quality?

Offhand, I wouldn't have thought so. But what they've done bears consideration.

Five years ago, the self-insured city's officials realized their health costs were spiraling "out of sight, at about a 20% to 25% increase a year," recalls city manager Clyde Shaw. That was about \$2.38 million a year, a lot for just 200 employees and 400 dependents and retirees.

Shaw and the city developed a partnership with [MedEncentive](#), a pay-for-performance healthcare administrator, which claims a unique twist.

Instead of just rewarding physicians for following guidelines in a variation of the pay-for-performance model, MedEncentive incentivizes patients as well. They receive as much as \$30 or a refund of their copayments if they fill out an online questionnaire, read material about their conditions that their doctors assign them, and then pass a multi-choice test about their diagnosis.

"It's about doctor-patient mutual accountability," says Jeff Greene, MedEncentive's CEO.

MedEncentive tosses around words like "triangulation," which means connecting the health payer, which in this case would be the city, with the patient and the doctor. Patients read about their conditions in a part of the process called "information therapy," which may also be called "patient literacy."

And doctors sign statements that they will adhere to evidence-based practices, set forth through accepted models established by entities, such as the Intermountain Healthcare System or the Mayo Clinic. And they can deviate from that depending on the patient's needs, and still receive payment rewards. The only caveat is that they are asked to fill out an online form to explain why the patient's course of care needed variation.

Patients and doctors can evaluate each other through the process in terms of whether the doctors are following guidelines, and whether the patient is being compliant.

I wondered if physicians would bridle at a system that might require anything even remotely resembling "cookbook medicine." But William Stewart, MD, a family practitioner in Duncan, says doctors met with MedEncentive officials "many times early on and developed a trust relationship."



"The plan rewards practices which do good medicine, with better outcomes for patients," Stewart says. And, he says, practicing by a so-called cookbook "is typically good medicine. The greater the variance in practice, the greater that practice should be looked over cautiously."

Physicians receive a fee of \$10 or \$15 for responding to patients' e-mails and patients get most or all of their copay refunded if they read materials and answer the questions.

"The patient education part of the program is probably the most important as chronic illnesses [diabetes, hypertension, and heart disease] eat most of medical dollars," Stewart says.

After five years of the Duncan experiment, the city has some exciting news, Shaw says. Instead of continuing its gradual increase in healthcare costs, employees, retirees, and dependents are costing the city roughly the same amount as they were five years ago, \$2.3 million, Shaw says.

Now the nearby hospital, Duncan Regional, is looking at partnering with MedEncentive as well for its 500 employees.

Six other companies, in Oklahoma, Kansas, and Washington, have installed the system as well, expanding the "MedEncentive solution" from Duncan's 600 enrollees to 7,000 nationally.

How did they do it? Hard to tell.

Shaw thinks it's because patients are managing their chronic conditions better, and thus aren't hospitalized as much. "Patients are continuing to go to the doctor, but now, they look at their healthcare and they are asking 'is the test I want to get really necessary?'"

MedEncentive's Greene points to [a report by the Rand Corp.](#) which found that physicians practice evidence-based guidelines only 55% of the time. That variation must mean that many patients aren't getting care that is known to work most of the time.

"Doctors get stuck in their ways, medicine advances, and they don't keep up. They're in a hurry. Often they don't pay enough attention on what they need to do," Greene says. With the MedEncentive program, there's only been a 1.3% deviation from evidence-based guidelines, he says.

Stewart isn't sure why the program seems to be working, but he agrees that it is. "Major [health] events still occur," Stewart says. "But I think patients do take better care of themselves when they're better educated. It's made patients more aware of the importance of their insurance and medical costs."

And they are less likely to choose more expensive options when they're knowledgeable about what the guidelines recommend, he says.

In its recently-released five-year report of the Duncan experience, MedEncentive noted the system "offers great hope for improving healthcare quality, while at the same time empowering and motivating people to be healthier, all of which will lead to more affordable healthcare."

---

*Note: You can sign up to receive [HealthLeaders Media Community and Rural Hospital Weekly](#), a free weekly e-newsletter that provides news and information tailored to the specific needs of community hospitals.*

---

*Cheryl Clark is a senior editor and California correspondent for HealthLeaders Media Online. She can be reached at [cclark@healthleadersmedia.com](mailto:cclark@healthleadersmedia.com).*

[Follow Cheryl Clark on Twitter.](#)