

## Understanding the Needs of the Health Care Consumer

*MD Anderson Cancer Center's Dr. Joseph Steele offers insights into what drives health care consumer behavior and how providers can harness it to improve the value of "high-credence" health care services and build loyalty.*

By Diana Mahoney

The shift toward consumerism in health care, spawned in large part by the transfer of greater financial responsibility to patients, narrowing provider networks and increased transparency into provider performance and costs, has been well-publicized, but the implications are just beginning to be understood, according to Dr. Joseph Steele of the University of Texas MD Anderson Cancer Center.

A professor of interventional radiology and deputy division head of operations for Diagnostic Imaging at MD Anderson, Dr. Steele has research interests in quality, patient safety and health care delivery, and as a cancer survivor, he has a personal interest in the advancement of high-value, patient-centered care.

The concept of consumerism is built on the premise that informed consumers have a greater capacity to understand the impact of their purchasing decisions and make choices that best meet their needs and expectations. When applied to health care, "the idea is that when people are given more responsibility, choice and information about where and how they are going to receive health care and from whom, they will become more active participants in the management of their own care and actively seek options that align with their preferences, values, needs and expectations," said Dr. Steele.

While there are many similarities between consumerism in health care and in other industries, there are important differences that get to the heart of a critical challenge in an increasingly competitive health care market: building patient loyalty.

In comparison with other goods and services, health care is complex and multidimensional, and consumers face unique limitations when making decisions about their care. These include the necessity, urgency and availability of their care; their level of insurance coverage; and their choice of physicians and health plan administrators. Often, the most intractable constraints may be consumers' limited medical knowledge and information about the quality of care delivered by providers.

In a recent interview with *Industry Edge*, Dr. Steele offered his unique perspective on how meeting the evolving needs of today's consumer-patients requires identifying those needs, creating "digestible" information that is available at the patients' fingertips when they want it, "and meeting patients where they are" physically, emotionally and intellectually.

**Q:** In comparing consumerism across industries—particularly between the hospitality and health care industries—you have talked about the division of goods and services into three groups (search goods, experience goods and credence goods) based on how their quality is evaluated by consumers. Can you explain the differences among the three groups?

**A:** Search goods are those that can be evaluated easily before purchase—we as consumers can kick the tires of a car, try on a pair of shoes, and so forth, before we buy them. Experience goods are those products or services that we can only evaluate after we buy or consume them—a meal at a restaurant, the quality of a hotel stay. We can read online reviews and hear from friends and neighbors about their experiences, but we have to try the product or service ourselves in order to evaluate it. Credence goods are like experience goods—they can only be evaluated after they've been purchased or tried. But the difference is that, for these, we don't have the knowledge or experience to judge the value of the good. Examples include things like car repairs and education. For these, we tend to rely on brand recognition, testimonials and reviews by trusted experts.

### AT A GLANCE

- Most health care services are "credence" goods, in that their utility or value to consumers is hard to determine, even after the experience.
- Providers must reduce the inherent uncertainty associated with credence goods by understanding the unique needs of their patient population and transparently providing patients with the accurate, understandable, easily accessible information they need to make care decisions that are consistent with those needs.
- The ROI of strategies to understand patients' needs and values and design care processes that best reflect them are patient loyalty and retention, as well as top-line revenue growth.

Most health care services are considered to be high-credence goods. Like an experience good, you may know after you visit a doctor whether or not you like them, but if you have a procedure done, you really have no idea whether the doctor did a good job or a terrible job. You can tell a little bit by how you feel, but you really can't gauge the quality of the service. So, as a consumer, when it comes to high-credence goods you try to get as much information as possible to make care decisions.

**Q:** What is the role of the provider in terms of reducing the uncertainty that is inherently associated with credence goods?

**A:** The role of the health care provider is to be transparent with cost, quality and performance outcomes by providing as much accurate, understandable, easily accessible information as possible and providing enough information for the patient to be able to make that informed decision. This can be a moving target. You have to be ready to meet people where they are and provide information at the level they desire. You might have patients who want every detail, and then others who want the high-level information. The key is to give them what they want, when and how they want it.

**Q:** In terms of "meeting patients where they are" and providing "digestible" information, how can providers find that sweet spot?

**A:** We just had a paper accepted about what our patients know about ionizing radiation. We have the largest single-site imaging facility in the U.S. We see between 1,500 and 1,800 patients per day in diagnostic imaging here at MD Anderson. We wanted to find out how much our patients know about their imaging studies. We sent a questionnaire to more than 10,000 patients, and we found out that half of them didn't realize a CT scanner uses radiation, and one-third of them thought MRI uses radiation. The surprising thing is that these patients had, on average, eight imaging studies each. They are very familiar with what we do, yet they didn't really understand it at all.

We don't track the education level of our patients, so to get a sense of their education level, we conducted an analysis of about 3,000 of our patients—a slice of our population—and we found that our patients are actually more educated than the average population. Ninety-five percent have a high school diploma, and a full 80% have some college experience.

In order to meet our patients where they are with information, we have to appreciate that this is not only an educational consideration. It's also a cultural one. Some patients want to know everything—the risks, the side effects, the advantages. Others only want a certain level of depth, but their families might want more. So we have to be prepared to give each of them what they want and need. The key is to make sure they have access to as much information as they are looking for.

**Q:** Is there a risk of information overload, and if so, how do you know when that line has been crossed?

**A:** Absolutely. And there is a fine line. You want to provide information that the patient and family want and need to understand their choices, but not so much that they get overwhelmed or confused. Information overload is a large risk with any credence good. Just like when your car is in the shop and the mechanic starts talking too much about technical details and your mind starts to wander. With information about health care quality, safety and performance, providers should present the high-level picture and encourage questions. Envision a high-level dashboard that provides a quick snapshot, but offers multiple layers and as much depth as patients need.

**Q:** In a recent research paper,<sup>1</sup> you report on a collaborative pilot study with hospitality/service science experts to identify and rank the specific needs and expectations of patients undergoing diagnostic imaging procedures at MD Anderson, and explore the application of "service science" as an approach to improving the patient experience. What did you discover?

**A:** Health care and hospitality are certainly not the same, but some of the guiding principles of the hospitality industry have been successfully applied in other industries. We wanted to leverage the decades of hospitality research to better understand the needs and desires of patients who visit our department. The patient experience of health care, as with the consumer experience of hospitality services, is a reflection of how well the care meets patients' needs and expectations, but these needs and expectations are highly variable by patient population. Cancer patients in particular have needs that differ from the needs of other patient groups. They are often anxious and emotionally stressed during their visits, and thus may be more sensitive to the process of care, in addition to the outcome. What they value may also be different.

What we found in our study is that with the exception of one or two patient populations, our patients didn't care that much about waiting. They don't like to wait, but they don't have a problem waiting 15 or even 30 minutes. Many of them come from far away, and they know they are receiving a high-value good. People will wait for something they value. It's completely different if they think the good or service is a commodity. For example, one of the populations that did take issue with waiting was breast screening. These are otherwise healthy women; they've got a life to live, they're busy. They think of it more as a convenience, and if they have to wait more than 15 minutes, it's an annoyance. It's a very different perspective from that of a stage 4 breast cancer

<sup>1</sup> Steele, J.R., A. Kyle Jones, Ryan K. Clarke, et al. 2015. "Health Care Delivery Meets Hospitality: A Pilot Study in Radiology." *J. Am. Coll. Radiol.* 12[6]: 587–593.

patient who is concerned about her prognosis. If they have to wait for 15 or 30 minutes to find out whether they're getting into the trial that is potentially going to save their life, they're OK with it.

Obviously, we always make it a goal to be timely, but when we focused our resources, that wasn't on the top of the list of factors contributing to the value of the experience for most of our patients. What they did value—what they do need and want—is to be heard. They want someone to listen to them, acknowledge their fears, treat them with respect and treat them like a person and not just a patient.

Being able to identify patients' needs at this level and adjust care delivery practices and processes to meet these needs is what will drive patient trust and loyalty.

**Q:** How can hospital and health system CEOs use this information to successfully navigate consumer-driven health care?

**A:** The first goal is for the CEO to understand that one size does not fit all. Different patient populations have different needs and values, so attempting to fit cookie-cutter strategies to their operations won't work. High-level leaders have to provide the resources and infrastructure to allow the teams who work for them to identify, meet and monitor the needs of their patients—to figure out who these people are and what's important to them. The CEO must also appreciate that HCAHPS won't provide this information. Fulfilling the HCAHPS requirement is a way to keep from getting penalized financially, but HCAHPS alone isn't a financial strategy. The ROI on understanding your patient population and what they need is so much greater. It's about building loyalty and patient retention. That is what will drive top-line revenue growth.