

Can Physicians and Health Care Purchasers Collaborate to Improve Quality?

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INTRODUCTION


In his book *Medical Ethics* (1803), British physician Sir Thomas Percival wrote the following about the use of a “hospital register” to help physicians improve the quality of care they deliver:

Let the register consist of...tables...specifying the number of patients admitted, cured, relieved, discharged or dead, the...diseases of the patients, with their events,...the sexes, ages and occupations of the patients... By the adoption of the register...*physicians and surgeons would obtain clearer insight into the comparative success of their hospital and private practice; and would be incited to a diligent investigation of the causes of such difference.* (emphasis added)

Two things make Percival’s writing noteworthy:

- Two centuries ago he saw outcomes-based quality improvement as essential to the ethical practice of medicine;
- Medicine has made so little headway in this area over the last 200 years.

A century after Percival (and still almost a century ago), Boston physician Ernest Codman established a hospital based on his “end result” system, which entailed following each patient “...long enough to determine whether the treatment given has permanently relieved the condition or symptoms complained of.” This would... “give a definite basis on which to make an effort at improvement.” (Codman, 1916) He, like Percival, saw outcomes-based quality improvement as an ethical issue. Codman left his post at the Massachusetts General Hospital when that institution




refused to institute his plan. Codman was later instrumental in the founding of the American College of Surgeons, and his example is much better known today than Percival's. The lesson from both men, however, is the same: almost two centuries after Percival and a century after Codman, no hospital operates on Codman's principles and very few physicians participate in the type of quality improvement activities both authors described. Though a small number of contemporary quality improvement programs (such as the Northern New England Cardiovascular Disease Study Group) are justly praised for their activities, such groups are isolated cases, not the norm.

This paper describes a new approach to this centuries-old issue. In this approach, physician organizations such as specialty societies would have the responsibility for designing and administering outcomes-based quality improvement programs for their members. Although the individual patient and physician data in these programs would be confidential, the programs themselves would be externally accountable to purchasers, to whom the programs would report on:

- their activities (what are they doing to improve quality?)
- their participants (which physicians are active in these QI activities?) and
- their aggregate results (on average, are outcomes-based benchmarks being achieved? are there significant uncorrected under-performers? if so, what is the process for helping them to achieve standards?).

In return for this level of accountability, purchasers could provide a range of incentives to participating physicians, from designating them as preferred providers and giving patients incentives to seek them out, to lessening the bureaucratic burden on physicians (eliminating pre-certification, for example) or providing participating physicians with higher levels of reimbursement.

Much of the information in this paper was generated for and by a meeting sponsored by the Economic and Social Research Institute (ESRI), funded by the federal Agency for Healthcare Research and Quality and Aventis Pharmaceuticals, and held at the Institute of Medicine in Washington, D.C. on January 19, 2000. Meeting participants included representatives of large private- and public-sector purchasers of health care, and representatives of specialty societies. A list of participants is included in the Appendix.




The approach we propose combines outcomes-based quality improvement with direct purchaser incentives, rather than utilizing the more indirect route of the “consumer choice model” which assumes that market mechanisms (based on consumers’ individual choices of providers) will eventually either drive poor performers from the market or inspire them to improve. This new approach also differs from most current quality measurement and reporting efforts in that reports on these measures are not end-products for consumers but instead inputs for QI programs whose effectiveness (in actually improving outcomes) could be monitored externally by purchasers.

- Many details of how a QI program would run could be left up to the physician organization, but purchasers and physicians should agree on what to measure. For MIs and CABGs, for example, purchasers might want to progress over time from outcomes such as mortality or in-hospital complications to measures more relevant to their immediate concerns, such as functional status or return to work.

The ultimate objective of such a program would be on-going assessment by physicians of the relationship between process and outcomes in an environment that encourages changes in process (*i.e.*, in physician behavior) to improve outcomes. The challenge here is to “hard-wire” and replicate the final step (feedback and re-assessment) in the quality improvement process.

HOW WOULD THIS APPROACH BENEFIT PURCHASERS?

Frustration with the slow pace of change created by provider “report cards” is one impetus for this new approach. There are limitations to a consumer choice strategy based on publishing data on physician or hospital outcomes or providing incentives to steer patients toward certain providers of care and away from others. This new approach would create the “feedback loop” to close the gap that occurs in the consumer choice model when information on quality does not result in better care. All patients and purchasers of care, not just those with better information and the opportunity to go to the best providers, would like to see across-the-board improvements in quality. Not everyone can go to providers whose patients enjoy the best outcomes, and some patients have no alternative but to be treated by providers with a record of less favorable outcomes. Also, some health care



purchasers, including the nation's largest purchaser - the Health Care Financing Administration (HCFA) - do not have the ability to selectively contract, and would benefit more from an initiative that raises the quality of medical practice throughout their community.

This approach would provide purchasers with something they do not currently have: a mechanism for accountability so they can know what is being done to improve quality, which physicians are participating in such a program, and how successful they are in improving the outcomes of care. Why is external accountability important? Because experience has shown that without outsiders looking in, physicians have little incentive to change their behavior. Yet, the ideal approach is *not* the one in which individual physician results appear on the front page of the local newspaper; this only fuels a "bunker mentality" within the medical profession and almost guarantees that the data behind that front-page story, no matter how valuable or useful, will never be used by physicians to assess and improve the care they provide.

Why does this new approach emphasize outcomes as quality measures? Because outcomes are what purchasers understand. The details behind process-of-care quality measures can be difficult to understand without medical training, and many process measures are not backed up by research clearly linking them to better outcomes. But purchasers understand outcomes measures since they use outcomes (profit and loss, stock price) in their own businesses every day.

How interested are purchasers in the quality of care? Only a few large purchasers (a handful of corporations and a few prominent health care purchasing coalitions) are knowledgeable about and interested in the quality of medical care *per se*. But many if not most large purchasers of care are interested in quality because they believe that the quality of the care they purchase for their employees will eventually have some bottom-line effect on employee satisfaction, job performance and productivity. Length of recuperation/rehabilitation, rate of return to work, restoration of function, recurrence of illness and absenteeism, etc. are the outcomes that interest employers. This is why agreement between purchasers and physicians on which outcomes to measure would be an essential part of this approach.




HOW WOULD THIS APPROACH BENEFIT PHYSICIANS?

Physicians are increasingly aware that attempts to report the outcomes of care will happen whether they participate in quality initiatives or not. A major impediment to wider use of quality indicators to improve care has been the adversarial relationship between those being reported on and those producing the reports. The confrontational nature of public quality reporting puts the medical profession on the defensive and sometimes discourages quality improvement. There is fear that scrutiny of individual data and concern about the adequacy of risk adjustment deter physicians from taking on difficult cases, and that small caseloads do not permit valid statistical comparisons for low-volume physicians. How outcomes data are analyzed, utilized and reported, however, can address these issues. Most practicing physicians consider their specialty society a credible source of information on clinical practice, and pay attention to its pronouncements on quality issues. Getting the physician's attention and delivering information from an authoritative source are key to changing physician behavior.¹

One of the objectives of this new approach is to change the adversarial relationship between physicians and those who report on the quality of care by creating a way in which quality can be improved to benefit all patients, rather than simply reporting on hospitals and physicians. It is in physicians' best interest to be central to this process and use the information, rather than stand aside from the process and criticize it.

Quality improvement programs under this new approach would give physicians a needed framework for clinical improvement. Although much has been done to "spread the gospel" of quality improvement, administrative systems in place in medical groups and health plans for utilization review and financial control are still much more sophisticated and well-integrated into operations than any systematic attempt at clinical QI. Most current provider organizations could not even meet purchaser requests for a strategic quality improvement plan that feeds into provider organizations' planning, programming and budgeting cycles. This is a major and pervasive shortcoming of health care organizations, and an area in which they can learn from other industries. As physician organizations change in size and scope, as organizational relationships and financial arrangements continue to evolve, creating effective strategic plans for clinical improvement seems beyond the reach of most




medical groups. How to organize, run and assess a QI program (choose objectives, monitor progress, etc.) are important issues for organizations providing medical care, and this new approach can help physicians to address them.

An additional advantage of this approach is that it would address the issue of the safety of medical care. The recent Institute of Medicine report, *To Err is Human: Building a Safer Health System*,² on preventable adverse events found that “most third party payment systems provide little incentive for a health care organization to improve safety, nor do they recognize and reward safety or quality.” This approach would address outcomes that reflect adverse events, and focus on the kind of process re-engineering that can save lives as well as improve the effectiveness of care.

WHAT DISTINGUISHES THIS APPROACH FROM OTHER QUALITY-OF-CARE INITIATIVES?

Mis-aligned economic incentives, organizational barriers and a lack of political will, more than technical limitations, are the current impediments to developing large-scale quality improvement programs. Since specialty societies are an important source of scientific information and legitimate authority on clinical practice for thousands of physicians, their participation could accelerate QI discussions among physicians, health plans, purchasers, et al. Purchasers would gladly accept a collaborative rather than confrontational role if it were shown to be more effective.

The use of quality measures by the general and patient populations to help them choose physicians, hospitals and health plans has been much less popular than expected, leading some observers to question the “consumer choice model” of market-based health care reform. ESRI’s own research has found continuing faith expressed by focus group participants that “someone” (regulators, accrediting bodies, the medical profession) is ensuring that the quality of care is uniformly high.³ This is why we propose the creation of programs where the emphasis is on *improving* practice through feedback of outcomes and linking outcomes back to care processes, then measuring progress toward outcome-based benchmark as more physicians use care processes that produce better outcomes. Experience has taught us that this will not happen without some sort of external accountability.



There are currently several national initiatives to improve the quality of medical care. How does this new approach differ from those? There are several dimensions on which we can compare what we are proposing with existing programs. One is the *structure/process/outcome* model for assessing the quality of care (Donabedian, *The Definition of Quality and Approaches to Its Assessment*, 1980); another is the *CQI process feedback and evaluation* model (Health Care Advisory Board, *Outcomes Strategy: Measurement of Hospital Quality under Reform*, 1993). With respect to these dimensions we believe this approach is distinctive in that it combines several characteristics:


- It would measure outcomes of care rather than measuring only provider characteristics (such as the number of procedures performed per year or the process of care);⁴
- It would measure outcomes that are relevant to the purchaser community;
- It would set up QI programs whose targets would be outcomes-based benchmarks. These programs would match outcomes with the care processes that produced them to close the “feedback loop” in the process feedback and evaluation model;
- These QI programs would be monitored externally by purchasers to assess the degree to which they improve outcomes.

REACTIONS OF PURCHASER AND SPECIALTY SOCIETY REPRESENTATIVES

ESRI has had the opportunity to discuss this concept of QI with a number of leaders in both the medical and purchasing communities. Recommendations coming out of our January 19, 2000 meeting (see Appendix for participants) and subsequent discussions have encouraged the planning of one or more small pilot programs to test the concept of externally-accountable QI programs set up by physicians and collaborating purchasers.


The January 19th group emphasized, among others, the following points:

- The failure of the health care system to do as well as it could is pervasive. There is a huge gap between the quality of care most patients receive and the quality of the best care that we know is delivered by certain physicians and in certain




institutions in this country. To quote one participant: “We think that’s true for everybody. We think that’s true for the middle class and the upper class. This is not about insurance or non-insurance. Average care in the U.S. doesn’t come anywhere near what we’re capable of.”

- There is unfortunately no sense of urgency regarding QI in the medical profession. Physicians do not sense the “sword of Damocles” hanging over them; if they did, they would have already made the changes and investments necessary to improve quality. Furthermore, “neither the feds nor any other regulatory agency are demanding these (quality) data in order to practice and so (physicians) are sitting there and they won’t move,” said one participant. Yet, as the experience of one large purchaser illustrates, holding health plan management accountable often results in positive outcomes.
- A change in the culture of medicine (and acceptance of “a culture of change” within the medical profession) is an important factor in making a new approach to quality improvement work. This must begin in medical school and permeate the professional lives of physicians. This is a lengthy and daunting task of which initiatives such as we propose can be only a small part.
- Time and money represent the largest potential obstacles to large-scale implementation of QI programs. If most physicians can conduct an economically and clinically successful practice without participating in data-based QI programs, they will not participate. Nevertheless, one physician stated that “it’s time that those of us in the medical profession...do what the rest of the American industry has been doing for years – measuring our performance in an objective way.”
- Purchasers assume that higher quality will eventually mean lower overall costs for keeping their workforce healthy – that’s why they are interested in QI programs. Sophisticated health care purchasers have a vision for what they want to buy, and need providers who are willing to implement that vision. This is no different from how those purchasers buy all inputs for their businesses – they have specifications for what they purchase, and leave it up to suppliers as to how those specifications are met. When these sophisticated purchasers deal with HMOs, they expect the HMOs to be “hands-on” with *their* “suppliers” – physicians, hospitals, *et al.*

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- The individual data and the process for quality improvement must be confidential in order to gain the trust of participating physicians. At the same time the process must be externally accountable and non-confrontational (i.e., *not* by listing “bad physicians” on the front page of the local paper). Publicly-released “report cards” on physicians might actually be an impediment to the development of outcomes-based feedback and quality improvement programs for physicians. So as not to discourage the search for best practices, participants voiced the need for a system that would hold physicians accountable while *not subjecting them publicly to individual scrutiny*. The Northern New England Cardiovascular Group’s “round robin caregiver exchange program” was mentioned as an example of a model program which encourages physicians to *observe* and repeat the best practices and procedures of other physicians.


The next step in testing this new approach to QI would be to plan a number of small pilot programs around the country. The following issues will be discussed in attempting to test whether this model for QI can be effective:

- Such programs should involve purchasers and physicians in determining the program’s structure, objectives/expectations, reporting, and what will be measured. It is important not to lock participants into a model they don’t feel comfortable with, or that doesn’t meet participants’ unique needs.
- Are purchasers willing to provide a significant incentive for physicians to participate, possibly starting with “preferred provider” designation, moving later to selective contracting and easing of administrative burdens (pre-authorization, for example) for participating physicians, then to higher reimbursement?
- Some purchasers are leery about providing higher reimbursement for QI programs. They fear that financial rewards could produce perverse incentives and lead to “gaming the system,” fears resulting from years of experience with phenomena such as “DRG creep.” Payments tied to particular care process could distort utilization patterns (or at least documentation of care) without really improving outcomes.
- Some purchasers feel that QI programs like this should happen without any incentives - indeed should have been in place long before now. If even the medical profession feels QI should be a standard part of medical practice, why



should purchasers pay more for it? This is essentially a disagreement over who should bear the cost: should physician incomes decline by the amount necessary to implement these programs, or should the cost of medical care to purchasers increase by that amount, or alternatively should there be some sharing of this economic burden?


- Private-sector purchasers are interested in using their time and resources to promote QI programs if they anticipate receiving a unique benefit (lower treatment costs, higher productivity, lower absenteeism) that can translate into a competitive advantage for their firm. However, if advantages from QI programs accrue to the community as a whole, the concept of “free riders” (companies that benefit without having to have invested any time or money) makes private companies think twice about participating. In their minds, if quality improvement is a “public good”, it might be more appropriate for government to pay for it, instead of private firms. This is a line of reasoning that needs more consideration and discussion.
- To what degree can physician organizations such as specialty societies both represent the profession to the outside world and also be an agent of change within the profession? Can they become publicly-accountable standard-setters? Leaders in the medical community and in many specialty societies are often vigorous champions of better QI programs, but when it comes to moving the “rank and file” members of the societies it might be difficult for the organization to take a role different from the “common denominator” of its members. Specialty societies heretofore have developed and disseminated guidelines and practice standards, but have not taken on the challenge of “closing the feedback loop” and demanding anything of this kind of their members.
- Health care markets differ with respect to how competitive they are in specialties that might be included in a pilot QI program. For example, the supply of cardiac surgeons, a market’s managed care penetration and degree of selective contracting, the number of cardiac surgery programs in local hospitals, etc. will play a role in determining how attractive this approach would be to purchasers and cardiac surgeons in a community. Since we are proposing programs voluntarily entered into by both purchasers and physicians, different competitive conditions might make purchasers and physicians more or less



eager to participate. For example, in a buyer's market, purchasers might not feel the need to offer any special incentive to get higher quality.

- Most health care purchasers are in some other business – their interest in health care is as a input to their primary business, whatever that might be. As health care costs have been escalating less rapidly and concerns about access and quality in managed care have been addressed by market shifts and legislation, businesses have often turned their attention and energies to other matters such as marketing, hiring in an increasingly competitive labor market, or the challenge of technological change in emerging areas such as electronic commerce. If health care becomes a “back burner” issue, it might be difficult to get business's attention at a time when its agenda is full elsewhere.
- There is a genuine feeling among purchasers that they do not want to dictate how physicians practice medicine. They are more than happy to let physicians decide on best practices, guidelines, etc. But purchasers do want to require the medical profession to be actively engaged in these activities, and in a way that makes sense to businesses who themselves have had to adopt modern quality improvement processes to stay competitive. There is a genuine sense of unease in the purchaser community that medicine is relatively “backward” in this area, and resistant to change. Frustration with this situation produces some of the more aggressive initiatives (public reporting, selective contracting, etc.) by purchasers.

In summary, our discussions highlight the need to further the quality agenda and suggest that collaborations between purchasers and physician organizations might lead that effort. Their collaboration can lend credibility and significance to QI programs and could potentially overcome limitations of current attempts to assure high-quality care. Further research and pilot projects will help to define the process by which QI programs should be designed and administered.



Meeting participants include Eugene Freund, MD, Health Care Financing Administration; Frederick Grover, MD, University of Colorado/Health Sciences Center; Stephen Jencks, MD, Health Care Financing Administration; Randy Johnson, Motorola Corporation; Mark Legnini, DrPH, Economic and Social Research Institute; Jack Matloff, MD, Society of Thoracic Surgeons; James Ritchie, MD, University of Washington School of Medicine; Steven Ringel, MD, University of Colorado School of Medicine; Patricia Salber, MD, General Motors; Kenneth Shine, MD, Institute of Medicine; Cole Tremain, LTV Steel Co; Richard Whitten, MD, Washington State Health Care Authority.

NOTES

¹ Eisenberg, John M. *Doctors' Decision and the Cost of Medical Care*, The Health Administration Press, 1986.

²² Kohn, Linda T., Corrigan, Janet M., and Donaldson, Molla S., "To Err is Human: Building a Safer Health System," Committee on Quality of Health Care in America, Institute of Medicine, National Academy Press. 2000.

³ Legnini, Rosenberg, Perry, and Robertson, "Where Does Performance Measurement Go From Here?" *Health Affairs*, Volume 19, Number 3, May June 2000.

⁴ Adams, Johansen, Brand, Rennie and Milstein, "Selective Referral to High-Volume Hospitals," *JAMA*, Volume 283, No. 9, March 2000.