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DOING WELL BY DOING GOOD:
IMPROVING THE BUSINESS CASE FOR QUALITY

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Executive Summary

American health policy is focused on quality as never before. In legislation, regulation, enforcement, policy development and market demands, many initiatives are under way to improve the quality of health care in the United States. However, few of these initiatives have targeted the critical role of physicians in propelling the quality agenda. Because of the centrality of the doctor-patient relationship to the delivery of health care services, improved quality of health care will not achieve its full potential unless physicians are enthusiastically engaged in such efforts.

Confronting the essential role of the physician in American health care delivery, this paper sets forth an approach to meaningful engagement of physicians which could produce (1) improved quality, particularly with respect to evidence-based care; (2) enhanced margins for those providers who can organize systems to deliver evidence-based care; (3) better patient outcomes and patient perceptions of care; (4) reduced costs for purchasers and payors; and (5) reduced overall administrative and regulatory burden in the health care system.

Our proposition incorporates the thoughts and suggestions of a unique group of American health care leaders (see list Appendix A) who attended a working conference on March 28th, 2003, to consider, respond to and critique the basic theory and principles set forth here. These leaders are responsible for some of the most innovative and forwarding-thinking physician groups, academic health centers, hospital systems, and health plans in the nation. Three of the conference participants—Mark Smith, M.D., Robert Galvin, M.D., and Lee Newcomer, M.D. – played vital roles as faculty members and panelists, and made a particularly strong impact on our thinking. We are profoundly grateful to all the conferees for their contributions, but we, alone, bear responsibility for the intellectual content of the framework presented in this white paper.

The Problem

Throughout the health care system two universal laments are heard: "why does quality lag behind optimal levels?" and "there is no business case for quality." Before addressing new payment models in response to these laments, however, we acknowledge that there are many quality improvements that could be accomplished within the current payment framework without fundamentally changing payment methods or incentives. Nevertheless, there are still many barriers to a strong business case for reducing misuse, overuse and underuse of health care services.

Most of the barriers cited by the conference attendees fell into four general categories: (1) inadequate recognition of quality in payment; (2) perverse financial incentives and irrelevant payment systems; (3) lack of infrastructure and organizational capacity to make necessary changes; and (4) lack of policy agreement on quality targets by those who would seek improvement. (See Appendix B for a complete list of barriers cited and other observations of conferees.) Any efforts to make a business case for quality and propel its improvement in a new way would have to come to grips with those barriers.

Current Attempts to Address the Business Case

While there are few programs which pay physicians for quality, there is a developing approach in "pay-for-performance" initiatives which have recently emerged. Essentially, these projects pay physicians an additional bonus for something deemed to enhance quality. Usually this is something the physicians have not done previously or have been doing but the effort remained financially unacknowledged.

These programs use three basic tactics: (1) paying for performance of evidence-based care processes and achievement of related care outcomes, such as HEDIS measures above a benchmark; (2) paying for similar measures, but on a tiered, normative basis; (3) paying a capped share of savings achieved by any of a variety of methods, including reduction in overuse of harmful services. The first two programs principally target those services plagued by under-use. In other words, the bonus is available either for (1) increasing the provision of a service that is perceived to be under-provided, such as certain preventive services, or early detection such as diabetic retinal screening, or even actual treatment such as beta-blocker use in myocardial infarction or for (2) reporting the performance of something which has not been identified previously as meriting any additional payment such as the use of diabetes flow sheets or asthma action plans. The third model rewards physicians for reducing costs, and because short-term cost reduction is principally achieved by reducing utilization, from a quality perspective this sort of program focuses more on overuse.

Whether physicians appreciate truly improved margins in these programs is basically unknown. If the direct expense costs and direct time costs to get the bonuses are higher than the relatively small revenue bonuses obtained, the margins are inadequate to sustain the business case over time. In the gainsharing model, whether any benefit will be realized by any particular physician group is completely unknown, since the degree of savings is dependent on the other physicians participating in the program and where the savings are realized. While these programs are a good first step to address the absence of direct payment recognition for quality, they appear to be transitional and short-lived in terms of their potential impact.

The real challenge is to develop a program which increases physician margins, improves quality and is sustainable over a longitudinal time frame. But for such a program to engage physicians, and not add to their administrative burden, attention must be paid to the disparate forces that prevent physician engagement on quality. For any such solution to have real value, it must (1) preserve and enhance the critical quality-relevant aspects of the doctor-patient

relationship; (2) reduce administrative and regulatory burden; (3) propel the best science and improved outcomes, and do all of this in a dynamic and quickly changing health care landscape.

The Essence of the Doctor-Patient Relationship

To design a program which will have meaning for the diverse stakeholders in the system while it engages physicians, the first step is to focus on those aspects of the doctor-patient relationship which are fundamental to health care quality. The core activity of the physician in relation to the patient is to "take information about health and transform it to a higher order of information, not just as an intellectual exercise, but to satisfy the three fundamental needs of explanation, prediction and change." As the Institute of Medicine has noted in "Crossing the Quality Chasm", these interactions are so essential that the physician's capacity to explain and predict the patient's condition defines health care: "Transferring knowledge is care." High quality care, therefore, can only exist where that transfer is made in the most effective way. The third component, to change patients' futures for the better, is the application of science. To enhance the doctor-patient relationship where information is transferred based upon that evidence also requires an engaged patient. Patient engagement, as noted by the IOM, will require that patients

> *"…be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. . . The system of care should be designed to meet the most common types of needs but have the capability to respond to individual patient choices and preferences. . . Clinicians and patients should communicate effectively and share information based on the best available scientific knowledge."*

Taken together, these features signal a shift to patient-centered care. It is these two fundamental precepts – evidence-based medicine and patient-centeredness – which define our new understandings of the essential aspects of the doctor-patient relationship and must be supported and propelled by any successful business case for quality.

In order to develop a better business case for quality, we must first have a real understanding of the forces which impede the goals of evidence-based, patient-centered care. Central to that understanding is an appreciation of the key role of *time* in developing the kind of relationships between physicians and patients that allow for truly patient-centered explanations, predictions, and evidence-based, effective care plans.

Time-Stealers

In the current health care system, there are countless forces which steal time from the doctor-patient interaction: for example, Federal regulation of quality, reimbursement, and fraud and abuse alone has created a patchwork of both inconsistent and redundant quality controls which distract physicians from core activities by virtue of their compliance mandates. Conference attendees cited four main aspects of the current system which steal time from essential doctor-patient interactions:

(1) required documentation of many types – from patient encounters, to the medical necessity of a test, to requisitions for orders for services—almost all of which is not only clinically irrelevant, but is also confounded by conflicting purchaser and regulatory documentation requirements;

(2) health plan programs and systems that are designed to control utilization, double check physician work, and provide redundant safeguards to the delivery of care including prior authorizations, patient encounter forms in addition to capitation payment, ministerial minutiae such as certificates of medical necessity for durable medical equipment, inconsistent formularies among plans and repetitive and redundant credentialing;

(3) administrative meetings and paperwork both to respond to hospital needs and hospital committees as well as in work to manage physician practices; and

(4) messaging and work flow interruptions in general, including the need to dispense prescriptions, refill prescriptions, arrange patient discharge and interact with drug manufacturer representatives.

Dominating this list is one theme: the essential clinical irrelevance of the payment systems with which physicians must contend. Current payment models create intense volume demands -- more patients must be seen in limited time thereby undermining the quality of the doctor-patient interaction to explain, predicate and change futures.

It is noteworthy that there is consistency among both the barriers to a business case for quality and those forces which steal time from the doctor-patient relationship. Many are the same problem viewed from different perspectives. No wonder physicians are not engaged in quality initiatives. To engage physicians for quality, permit broader and deeper applications of science, and provide patient-centered care, basic aspects of the physician work environment must change. We propose five central principles to guide new approaches.

Five Principles for Change

(1*) Standardize*: the more physicians standardize their care to the best science available, the more time they will have to custom-craft the art of medicine to the specific needs of individual patients.

(2) *Simplify*: we need to pare out of the system the complexity, redundancy and jumble of controls, incentives and conflicting demands which distract physicians from their most critical roles and instead define their environment with overarching, consistent principles of care delivery.

(3) *Make Clinically Relevant*: in administrative demands and payment itself we need to make the systems with which physicians contend clinically relevant to the way we want them to practice, with primary attention to the best science available to be applied in patient-centered care.

(4) *Engage the Patients*: true patient engagement around evidence based options for care will go a long way to strengthening the doctor-patient relationship while it lowers malpractice risk and the actual costs of care, since patients presented with options tend to choose less risky, lower cost choices than physicians acting alone would.

(5) *Fix Accountability at the Locus of Control*: Transparency – open, understandable information about patterns of care delivery – is critical to a quality driven environment where all the stakeholders are oriented to a common view of quality care. But many current report cards and other types of data disclosure imply that physicians are individually responsible for aspects of care which they personally cannot control. Physicians are responsible for their application of science in care and the quality of their interactions with their patients. Many other aspects of quality reside more appropriately with the groups and institutions at which they practice. Physicians should be held accountable for practicing the science of medicine as teams, and the art of medicine as individuals. The application of the first four principles makes these distinctions possible and potentially more measurable at the proper locus of responsibility.

The Unified Field Theory

Each of these five principles is powerful in its own right. Widespread application of any one of them would change significant aspects of health care in this country. But to bring them all to bear simultaneously would transform the health care system. The concerted coordination of the principles permits the development of a unifying theory of how to reorder fundamental aspects of health care delivery in payment, documentation, administrative systems, public accountability, infrastructure development, personnel administration – indeed throughout the health care system-- that can lead to more evidence-based, patient-centered care. Linked to payment, a unified field theory applied (UFT-A) as a unitary platform for health care system design would make a strong business case for quality—one that would engage the hearts and minds of physicians. To do so requires that we address evidence-based medicine (EBM) or clinical practice guidelines (CPGs).

(1) **CPGs Applied**

A CPG for a common condition can become much more than simply a specification of the care that should be given. It can also be a template on which to simplify the physician's work environment and reduce administrative burden. A good CPG can be translated into both the applicable diagnostic codes it incorporates and the CPT codes describing the services to be provided. That means that CPGs can be used to speak in traditional payment terms to payors, who want to substantiate care delivered, while simultaneously improving the physician work environment and patients' outcomes. All good CPGs make clear what evidence in the medical record (documentation) would support conformity of the care with the CPG. A good CPG would therefore allow the creation of documentation templates for standardized care for that condition. Deviations from CPGs should be expected, and ought to be anticipated in designing templates. CPGs would allow care delivery systems to address the question of "highest and best use" of the various members of the professional team responsible for the patient's care. Standardizing

aspects of care permits care systems to deliver more of the care using well-trained, but less expensive professionals, and can fortify the business case for quality.

(2) **Evidence-Based Payment**

The real power of this approach to organizing care lies in the ability to price the services provided because by using EBM/CPGs as the foundation for payment, it is possible to determine literally what it should cost to deliver evidence-based, patient-centered care to each patient, for that patient's particular combination of conditions. The actual costs of care are not only the fixed costs associated with the setting in which care is delivered ,but also the variable cost of supplies and equipment which the physician practice must use to treat specific conditions. The biggest category of costs, however, is the cost of the people – including physicians– needed to perform all the care-related actions such as scheduling, examining, advising, treating, documenting, coding, billing, measuring, and complying with contracts and regulations. A good CPG defines what services are to be brought to bear to treat the patient, and therefore provides a roadmap to analyzing all the actual costs (fixed, variable and staffing) of that care.

This approach to pricing care is based on medical science and cost accounting, rather than actuarial science. It is a revolutionary idea; and depends on something that is not commonly found in care delivery organizations: good systems to determine the actual costs of caring for individual patients and conditions.

(3) **Advantages**

UFT-A would have a number of positive benefits for patient care, physicians, and other stakeholders such as employers. The more EBM is brought to bear throughout the physician environment – in payment, documentation, billing systems, and public performance reporting – the more it encourages uniform clinical management of patients. The entire approach speaks to physicians the way they think and treat so it is easily understood. UFT-A would increase touch time by comparison with the jumbled, quality-impeding work environment physicians experience today. The broad application of these principles would permit patient-centeredness to rise to the fore as a bedrock value in delivering care because it would, among other things, allow time for those engagements around science and patient preference. A major benefit of this model would be reduction in documentation requirements, because explicit reliance on well-articulated CPGs essentially eliminates the need to document medical necessity and scope of services. It also virtually eliminates the fraud and abuse liability that turns on false claims, over-utilization, absence of medical necessity, poor quality, and over response to managed care incentives. To organize and deliver care in this way would enhance physician efficiency while improving quality of care—a value proposition in itself.

If physicians dealt with managed care plans and other payors on this basis, they would stand a far better chance of eliminating intrusive medical management programs which inspect their care after the fact, thereby further saving time and expenses spent in responding to those often conflicting and overlapping initiatives. Where physicians applying UFT-A measure their conformance with the selected CPGs, design care plans based on patients' choices, analyze the

implications of the outcomes, and refine their behavior, not only could physicians create a method for learning how to improve care, but they would also finally have available meaningful data upon which to base their negotiations with plans.

(4) **Boundaries of UFT-A**

This unified field theory applied in this way is not a panacea for everything that is wrong with health care, nor is it proposed as a vast revolution for the entire health care system. Many physician groups would not be able to work in such a manner. This approach would find its best outlet among those groups which are both already moving on the road to quality using quality principles such as standardization and simplification in their practices, and are also willing to step up and be both measured and paid on a different basis. This approach, at least initially, will only work for innovators and is not proposed for legislative reform

The discussion here sets forth an untried approach to care. We believe that many new ideas in health care have faltered in the past because of grandiose implementation strategies and a desire to create programs for the vast middle of the system – the average player for whatever strategy is at hand. We believe this theory will also fail if it is interpreted to apply broadly without evaluation and data.

We believe that at the outset it should be attempted in short-term, small-scale trials in settings where there is the capacity to try "small tests of big ideas," with subsequent cycles of learning and refinement. We believe it is important to state explicitly that such learning cycles, and this overall approach, could be used by some physician groups, but not by others, based on the cultures, systems, and quality capabilities of the groups. At this point in health care's history, we strongly believe it is time for employers, payers, and regulators to acknowledge that some physician groups will be better able to demonstrate the evidence-based and patient-centered care that the IOM papers call for, and others are not ready to do so. Those that can should be financially recognized and rewarded appropriately for doing so.

UFT-A will not work for all patient conditions. It will have its best effect, we believe, in chronic conditions which generate 80% of health care expenditures.

Even in the absence of major payment reform for any physician group, we do believe still that standardization and simplification are worth physician effort because those principles in practice will save time and increase efficiency while they improve care. Anything which lowers the administrative burden on physicians today will enhance the capacity of the system to be patient-centered at the place it most matters, the interface between doctor and patient.

(5) **Effects on Others**

UFT-A offers several opportunities for hospitals and physicians to work together in significant ways that advance the physicians' interests while fulfilling the hospital's agenda--and all in furtherance of improved quality. UFT-A is a case in which, astonishingly, the Stark regulations offer a real positive option. Generally speaking hospitals may not provide economic

benefits to their referring physicians (who refer Medicare and Medicaid patients) unless that financial relationship conforms with an explicit Stark exception. In the final Stark phase I regulations there is an explicit exception for hospitals to provide compliance training. CPGs applied as the foundation for billing, coding, and determining reasonable and necessary services serve exactly these purposes in addition to quality.

UFT-A applied consistently within the hospital to drive its processes, documentation principles, flow and organization could provide a significant basis on which to revitalize the medical staff. To reframe the purpose of medical staff activities in this way would make the work of the hospital and physicians more consistent, more seamless and more powerful from a quality perspective.

The hospital could also pick up the UFT-A gauntlet in a different way – to reorient its fundamental organization. If the hospital's infrastructure including computerized physician order entry (CPOE), other information technology for documentation, policies and procedures, hiring and personnel allocation within the facility, capital expenditures and administrative organization were to reflect the principles of explicitly articulated CPGs, hospitals and their physicians would work together far more effectively to benefit patients and improve quality of care. The result might well be better coordinated care to meet the needs of the patients, which, after all, is the hospital's core mission.

For health plans, adoption of UFT-A in collaborative relationships with physicians would make the health plan's programs meaningful to physicians and a positive force in their practices. To assist physicians to drive to quality in this way by adopting payment reflecting evidence, clinical relevance and lowered administrative burden can lower the plan's own expenses while permitting it to market credibly for quality. UFT-A applied in the health plan context would fundamentally change the relationship between physicians and plans.

Implementation Issues Generally

UFT-A would address many of the current barriers to the business case for quality, promote positive engagement of physicians to deal with some of our most vexing problems in over, under, and misuse, and drive fundamental improvements in patient-centeredness and touch time. But it would not solve every problem. The five principles and a theory described in this paper have not yet been tested. We have presented ideas which we believe merit further refinement and implementation. There are a host of implementation quandaries. In the conference, health care leaders listed five issues most prominently.

(1) How to quantify for the physician piece of payment – This problem exists in any payment system. Some approaches may be used to calculate the financial contribution of physicians to a case rate, for example, but in the last analysis UFT-A is no better nor worse than any other system to deal with this issue;

(2) The expense of infrastructure to do it – Some would argue that to make UFT-A work requires significant technology investment. We do not believe this is true and that good pilots

can be mounted without such investment until proof of concept is clear. Then the technology which is necessary will be far more evident;

(3) Costs of transition – unless there is a magical shift to a single new payment approach overnight, this problem will exist in any effort to change or improve the business case for quality. Initially there will be added complexity, but with time this factor should diminish.

(4) Cost accounting to price evidence based care will prove elusive –any better, even if incomplete analysis of what it costs to deliver evidence-based medicine to patients will improve the negotiations between payors and providers and will clarify what it costs to deliver care at the level of quality we want.

(5) Payors may not actually get on board for this approach – Payor representatives at our conference were both supportive and intrigued by this approach which solves some problems for them. We know that innovative, enlightened payors are searching for a better approach for themselves in their interactions with physicians. Some will lead the way.

Conclusion

Clearly, the barriers to a business case for quality are ubiquitous and strong. Yet the application of our five core principles – (1) standardize; (2) simplify; (3) make clinically relevant; (4) engage the patient; (5) fix public accountability at the proper locus of control – would create a changed environment for physicians and those who work with them. While many efforts are afoot in health care to propel quality beyond current levels, it is the implementation of these principles in far broader applications than "mere" quality assurance activities that would make real change.

To apply these principles using CPG/EBM based standardized protocols throughout the individual elements of the health care delivery system (in physician office care, at the hospital, in PHOs and IPAs) and in the many processes which define health care delivery (documentation, billing, information systems design, manpower planning and recruitment, capital budgets, organization structures and, above all, physician payment) would be revolutionary. It is the **unified** application of these principles using CPGs as the foundation which distinguishes our approach from others.

To date, many health care systems have bogged down in the day-to-day struggles to manage sustainable businesses where costs rise and reimbursement shrinks. When managers of hospitals and physician groups try to meet these operational challenges, they often find themselves frustrated and defeated. When it comes to working collaboratively with physicians, many managers have simply given up.

We believe we have made a case for the centrality of physicians in health care and therefore, why their engagement is critical to real quality improvement. While other efforts to enhance quality are aimed at other points in the health care system, it is time to confront the utter chaos with which physicians must contend if we are really to promote change. UFT-A is about

both rethinking their absolutely essential role in providing the best science in patient-centered care, as well as reordering their work environments to achieve those goals.

The complexity of the health care delivery system is profound and daunting. Its purpose, however, is simple: to deliver the marvelous capabilities of current scientific knowledge and technology to diagnose, treat, cure and heal people who need care and to do so with the goal of the highest quality with compassion and humanity. UFT-A is a construct to facilitate that lofty and real purpose. It engages physicians in ways we believe can resonate for them, for the other clinicians who work with them and for the facilities and institutions in which they act with a logic that is clear to them as well as patients and payors. We look forward to reports from the field.