Rewarding Results – Press Conference 11-15-05
Peter Basch, MD

As medical director for eHealth and a general internist in Washington, I have used an advanced electronic medical record in my practice for nearly a decade, and have the privilege to work in the first Bridges to Excellence site in the District of Columbia.

Today's awardees should be congratulated for their efforts. Labeling and measuring quality can be contentious; financially rewarding results prior to clear return on investment can be risky; and frankly just getting doctors and payers to sit in the same room is next to impossible. Your work should help to set a clearer path for others who must follow, and who will implement lasting system-wide change to healthcare reimbursement policy. My comments will focus on three key lessons learned: financial incentives; engaging physicians and public reporting.

Financial Incentives

It may be obvious to physicians why financial incentives are necessary in moving quality to the next level, I am not sure this is quite as obvious to others. An insurance company and/or patient should simply expect that when they pay a physician for a service, that service is done to the highest of professional standards. For example, should we pay a surgeon $1000 for an operation, and throw in an extra $5 if he/she used sterile instruments?

However, the majority of our problems with quality and safety don't arise from substandard high-tech procedures. Rather, they come from very mundane failures in applying accepted medical knowledge to routine care situations, and more importantly, between routine visits. The Commonwealth Fund released a study that confirmed the systemic lack of such basic activities as care coordination and chronic care management are responsible for most of our costly errors; with the US ranks among the worst of the developed countries studied.

Does our current method of paying for healthcare unwittingly allow for suboptimal care? I believe the answer is "yes." In our current payment system, *procedures* are reimbursed reasonably well, *office visits* reasonably poorly, and *care coordination and chronic care management*, not at all. When doctors, reacting to declining reimbursements and increasing expenses, spend more of their time on reimbursable activities, and less time on the unpaid tasks of management, quality suffers.

Our practice has recently added advanced point-of-care decision support forms and a disease registry to our existing electronic medical record. This allows us to provide better care during office visits and better manage patients between office visits. To make optimal use of these tools, more of my time is spent with patients, in addition to several hours a week working with the registry; time that would otherwise have been spent on seeing patients (and generating revenue). If not for our participation in the Bridges to Excellence program, we could have never afforded to make these changes. Let me stress the fact that this value adds to our EMR while practice style is not trivial in terms of cost and effort – however, I believe they produce most of the benefit of health information technology for the public. Thus

"rewarding results" pays for new necessary services, which most people agree will improve quality and safety, as well as save the healthcare system money.

Engaging physicians

If the reimbursement system is fixed, physicians will be on board, right? Not necessarily…Pay-for-Performance programs across the country have had difficulty-engaging physicians for pilot programs. One might be tempted to believe the excuse, "Bad doctors don't want the bright light of performance measurement pointing in their direction;" and while that is not wrong, it doesn't explain the aversion of many good doctors who practice high quality medicine.

I believe the problem includes mistrust and misunderstanding. Misunderstandings can be removed through educational efforts with these endeavors best run by medical professional and specialty societies. Mistrust will be more difficult to tackle. While we have seen many admiral examples of health plan–physician collaborations, they are the exceptions.

Furthermore, while Pay-for-Performance is relatively new, measuring and reporting performance is not. As Dr. Volpe alluded to, many physicians have seen years of examples of payer-generated quality report cards formulated with inaccurate information. While physicians have shrugged off such poor reporting when the report cards were merely "FYIs;" we will not do so when they are used as the basis of payment differentials and public reporting.

Public reporting

The public expects that they will be provided with reliable information; information that will help them to make better decisions about services and about providers. While these expectations are reasonable – operationalizing them in a meaningful way is another story. The public wants to know which doctors are best in several dimensions (such as quality, efficiency, and so forth). However, what they will actually see may be only narrow proxies of quality. Will these numeric measures really give patients adequate information to make decisions on quality; or will they mislead?

For example, my patient panel contains around 5% smokers. One of my colleagues has no smokers in his practice. If reported as such, perhaps in a future edition of the Health Section of the Post, I assume that the public would conclude that Dr. X is a "better" doctor than me. Of course what is not reported is what generated the difference in our performance measures, I work with smokers and my colleague utilizes a practice, which I would call patient dumping. When a patient joins his practice and doesn't quit smoking within 4 weeks, he/she is discharged from the practice. Doctors feeling threatened by public reporting and differential payment for quality could take regressive actions including "cherry picking" (where the very sick, complicated, difficult, and "non-compliant" are not welcome in the practice). Another is medical paternalism, where the physician no longer advises and collaborates but instead makes decisions for patients.

Conclusions

If rewarding results the right way is complex and risky, would we be better off leaving things as they are? Absolutely not…The combination of doing some things right (resulting in increasing numbers of people with multiple chronic diseases living longer), an aging population, and the increasing numbers of un- and underinsured make for a perfect storm that could cause our healthcare system to implode. Keeping on the same course is not an option. Thoughtful redesign of medical practices, enabled by health information technology whose optimal use is based on incentive by reimbursement reform (of which rewarding results is a part), gives us the opportunity, perhaps our only opportunity to provide better care for more people at an affordable cost.

Thank you.