Establishing Accountability for Quality and Costs

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Causes and Consequences of Health Care Intensity
Dartmouth Atlas of Health Care

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Variations in spending across U.S. Regions
The paradox of plenty
What do higher spending regions -- and systems -- get?

Resource levels
More hospital beds per capita (32%)
More medical specialists (65%) and internists (75%)

Content / Quality of Care
Technical quality worse
No more major elective surgery

Supply-sensitive services
More hospital stays, visits, specialist use, tests, procedures

Health Outcomes
Slightly higher mortality
No better function

Physician-reported quality
Worse communication among physicians
Greater difficulty ensuring continuity of care
Greater difficulty providing high quality care

Patient-reported quality
Lower satisfaction with hospital care
Worse access to primary care

Trends over time
Lower gains in survival (following AMI)
Greater growth in per-capita resource use

What's going on?
What explains the differences in practice?

Patient preferences -- can't explain the differences observed
Capacity and payment -- are important drivers

Slide 3

Slide 4
What’s going on?
What explains the differences in practice?

Patient preferences -- can’t explain the differences observed
Capacity and payment -- are important drivers
Clinical judgment -- in the grey areas -- is critical

<table>
<thead>
<tr>
<th>Average percent of patients for whom physicians would recommend the specific intervention across regions of increasing spending. Spending</th>
<th>Q1</th>
<th>Q5</th>
</tr>
</thead>
</table>
| Cardiology referral for angina and +ETT | 91 | 93 | n
| Oral agent for isolated elevated cholesterol | 44 | 53 | ↑ |
| Urology referral for mild BPH | 23 | 32 | ↑ |
| MRI for back pain and new left foot drop | 69 | 82 | ↑ |
| PSA test for 60 year old white male | 68 | 78 | ↑ |
| Recommend office visit for vaginitis | 45 | 57 | ↑ |

Likely diagnosis
Local capacity and culture drive practice and spending

Clinical evidence (e.g. RCTs, guidelines) and principles of professionalism are a critically important -- but limited -- influence on clinical decision-making.

Physicians practice within a local organizational context and policy environment that profoundly influences their decision-making. Payment system ensures that existing (and new capacity) is fully utilized.

Consequence: reasonable individual clinical and local decisions lead, in aggregate, to higher utilization rates, greater costs -- and inadvertently -- worse outcomes

A focus on technical quality (guideline adherence) cannot fix the problems of rising costs and inadvertent harm.
Why might this be important?

Current approaches to P4P could make things worse
Individual provider focus will reinforce fragmentation
Limited measures risk making bad apples look good -- on both quality (narrow technical measures) and costs (episodes).
Will fail to address the problems of rising costs and the key role of judgment in clinical practice

Controlling costs (and improving quality) will require addressing underlying causes of rising costs and poor quality:

<table>
<thead>
<tr>
<th>Cause</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to recognize key role of local</td>
<td>Foster development of local organizations</td>
</tr>
<tr>
<td>system (capacity, culture) as driver</td>
<td>(delivery systems) accountable for care</td>
</tr>
<tr>
<td>Assumption that more is better</td>
<td>Balanced information on risks / benefits</td>
</tr>
<tr>
<td>Equating less care with rationing</td>
<td>Comprehensive performance measures</td>
</tr>
<tr>
<td>Payments system that rewards more care,</td>
<td>Reform of payment system (long term)</td>
</tr>
<tr>
<td>increased capacity, high margin treatments</td>
<td>Shared savings as interim approach</td>
</tr>
</tbody>
</table>

Organizational accountability

Key attributes of an ACO and how they might be defined

Essential attributes of an Accountable Care Organization

Provides (or can effectively manage) continuum of care as a real or virtually integrated local delivery system
Sufficient size to support comprehensive performance measurement
Capable of prospectively planning budgets and resource needs

Potential Accountable Care Organizations

Large multi-specialty group practices that own their own hospitals
(Mayo, Virginia Mason, Scott White, Cleveland Clinic, Partners)
Physician-Hospital Organizations / Practice Networks
(Middlesex Health System)
Hospitals that own physician groups
(Intermountain Healthcare, many rural hospitals)
Extended Hospital Medical Staff (virtual multi-specialty groups)
* Feasible to define: all MDs and beneficiaries are “affiliated” with a hospital
* High degree of patient loyalty: physician group is responsible for their care
* Performance measurement tractable: on important dimensions of care
Growth in spending can be measured
Per-beneficiary spending in EHMS (n = 4772) sorted into quintiles

<table>
<thead>
<tr>
<th>Absolute increase per benef.</th>
<th>Percent increase 99-03**</th>
<th>Average Annual Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$936</td>
<td>46%</td>
<td>9.5%</td>
</tr>
<tr>
<td>$675</td>
<td>33%</td>
<td>7.3%</td>
</tr>
<tr>
<td>$551</td>
<td>27%</td>
<td>6.1%</td>
</tr>
<tr>
<td>$431</td>
<td>21%</td>
<td>4.8%</td>
</tr>
<tr>
<td>$198</td>
<td>10%</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

* Using standardized payment, using 2003 RVU
** Percent increase calculated relative to average 1999 per-beneficiary spending

Other issues -- with long term consequences

Insights from the Dartmouth Atlas Project

Rethinking the physician workforce:
We will deploy (and pay for) the physicians we train
Future needs are uncertain and could radically change
Evidence suggests current GME approach is worsening costs and quality

Coverage expansion:
Delivery system redesign is as important as insurance (access to what?)
Consider carefully the implications of discretionary "supply-sensitive" care.
Under universal insurance with wisely designed global budgets (ensuring providers aren’t paid more), covering the uninsured would not increase costs (other than for drugs). The previously insured would simply see their physicians slightly less often (perhaps to their benefit); the uninsured would receive needed care -- and substantial benefit.
Consider supporting statewide experiments to test this hypothesis.