CECS
Center for the Evaluative Clinical Sciences

Establishing Accountability for Quality and Costs

Elliott S. Fisher, MD, MPH
Professor of Medicine and Community and Family Medicine
Center for the Evaluative Clinical Sciences, Dartmouth Medical School
Senior Associate, VA Outcomes Group, White River Junction VT

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

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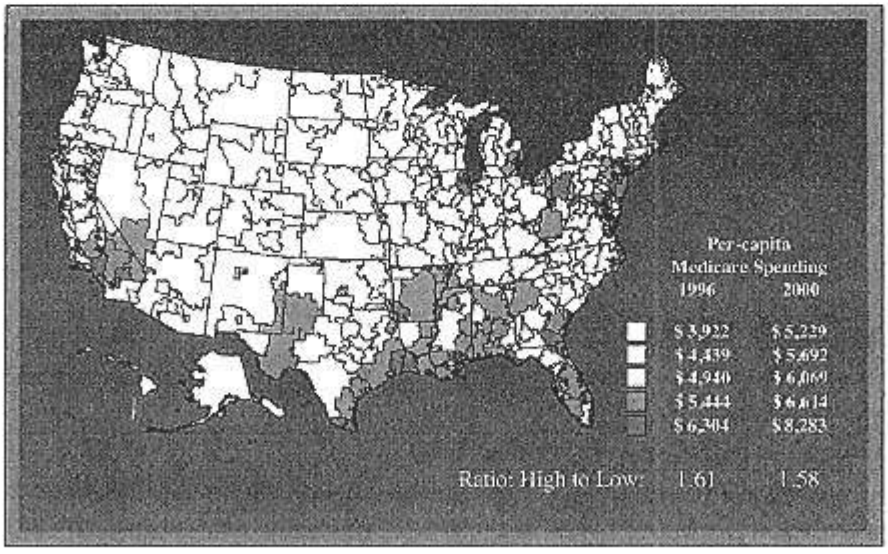
Jonathan Skinner, PhD
Dartmouth Medical School
Elliott Fisher, MD, MPH
VA Outcomes Group, Dartmouth
Denise Anthony, PhD
Dartmouth College
Brenda Sirovich, MD, MS
VA Outcomes Group, Dartmouth
Doug Staiger, PhD
Dartmouth College
Amitabh Chandra, PhD
Harvard University
Jack Fowler, PhD
University of Massachusetts, Boston
Patricia Gallagher, PhD
University of Massachusetts, Boston
John Wennberg, MD, MPH
Dartmouth Medical School
Julie Bynum, MD, MPH
Dartmouth Medical School
David Wennberg, MD, MPH
Maine Medical Center
Lee Lucas, PhD
Maine Medical Center
Dan Gottlieb, MS
Dartmouth Medical School
Amber Barnato, MD, MPH
University of Pittsburgh
Therese Stukel, PhD
University of Toronto

Slide 1

Variations in spending
across U.S. Regions



Slide 2

The paradox of plenty

What do higher spending regions -- and systems -- get?

Resource levels[1]	*More hospital beds per capita (32%)* *More medical specialists (65%) and internists (75%)*
Content / Quality of Care[1,2]	*Technical quality worse* *No more major elective surgery*
Supply-sensitive services →	*More hospital stays, visits, specialist use, tests, procedures*
Health Outcomes[1,2]	*Slightly higher mortality* *No better function*
Physician-reported quality[5]	*Worse communication among physicians* *Greater difficulty ensuring continuity of care* *Greater difficulty providing high quality care*
Patient-reported quality[1,3]	*Lower satisfaction with hospital care* *Worse access to primary care*
Trends over time[4]	*Lower gains in survival (following AMI)*
Supply-sensitive services →	*Greater growth in per-capita resource use*

(1) Ann Intern Med: 2003; 138: 273-298
(2) Health Affairs web exclusives, October 7, 2004
(3) Health Affairs, web exclusives, Nov 16, 2005
(4) Health Affairs web exclusives, Feb 7, 2006
(5) Ann Intern Med: 2006; 144: 641-649

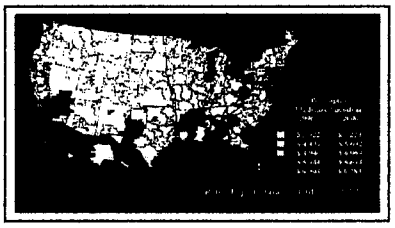
Slide 3

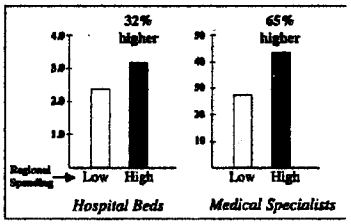
What's going on?

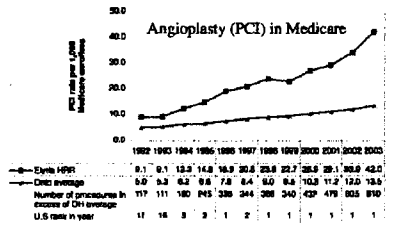
What explains the differences in practice?

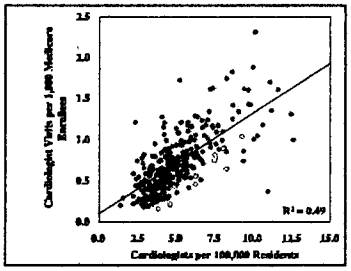
Patient preferences -- can't explain the differences observed

Capacity and payment -- are important drivers









Slide 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 gray areas -- is critical

Average percent of patients for whom physicians would recommend the specific intervention across regions of increasing spending

	Spending Low Q1	Spending High Q5	Trend?
Cardiology referral for angina and +ETT	91	93	ns
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	↑

Sirovich *Archives of Internal Medicine.* 165(19):2252-6, 2005 Oct 24

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Likely diagnosis

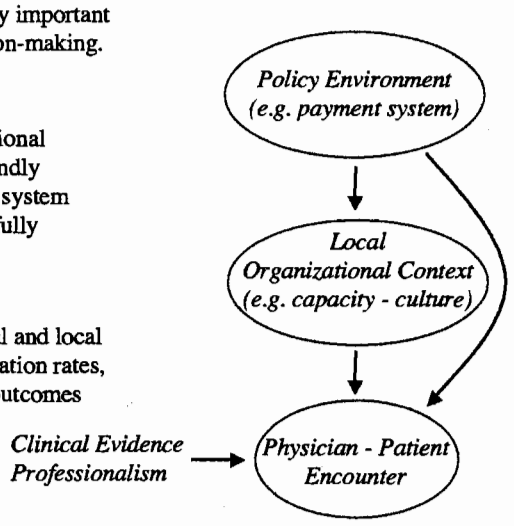
Local capacity and culture drive practice and spending

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) can not fix the problems of rising costs and inadvertent harm.



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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:

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

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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

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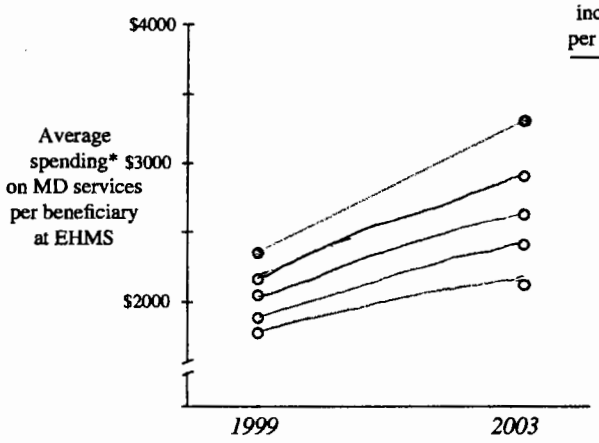
Growth in spending can be measured

Per-beneficiary spending in EHMS (n = 4772) sorted into quintiles by magnitude of per-beneficiary growth (1999-2003)



Absolute increase per benef.	Percent increase 99-03**	Average Annual Rate
$936	46%	9.9%
$675	33%	7.3%
$551	27%	6.1%
$431	21%	4.8%
$198	10%	2.4%

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

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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.

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