



# Efficiently Measuring Efficiency: Is Judgment the Correct Path

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# Cost Efficiency: Competition and Judgment

- Urgent need for Cost Efficiency
- Current in vogue models involve public reporting, tiering, limiting panels
- Inherent in these models are competition and judgment



# Cost Efficiency: Competition and Judgment

The core measurement for cost efficiency is the efficiency index – a comparison of one practitioner's case-mix adjusted costs to peers

Based on responsible or total costs

Can be age and sex adjusted

Cost variables such as facility or pharmacy costs can be flattened to focus attention on what can be changed

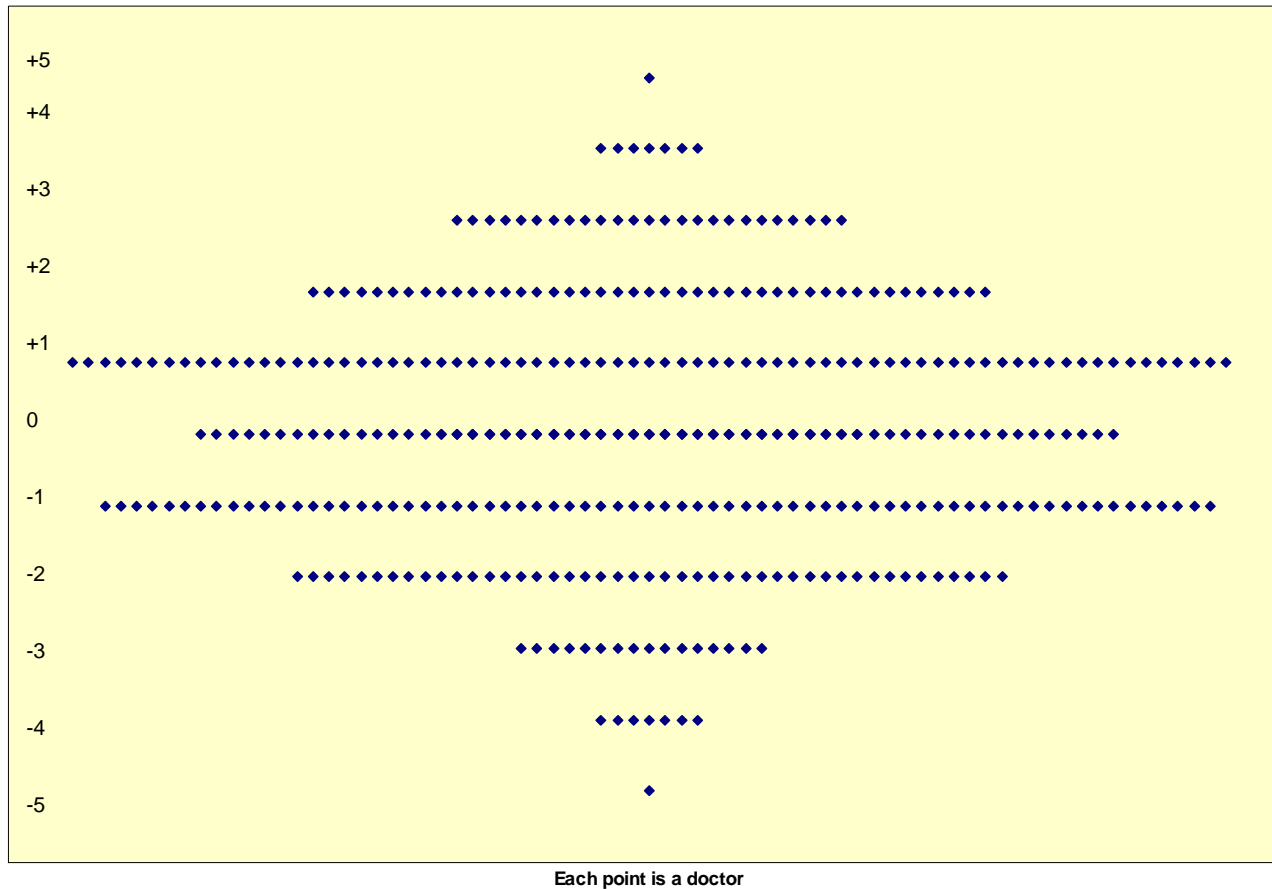
# Efficiency Indexes – Pros and Cons

- + Based on comparisons with peers or benchmarked group
- + Comparisons encourage a response
- + Case mix adjusted through episode grouping software
- Judgmental - evaluates doctor, not behaviors
- Reductionistic – assumes generally + or -
- Limited actionability – costly to get to action
- Not adequately severity adjusted

# Internal Medicine and Family Practice Number of Measures



A Doctor is 25% Above or 25% Below Peers In Specialty



## Methodological Problems with Efficiency Indexes

- Practitioners are generally efficient at some things but not others (82% in the middle)
- Few distinctly better (11%) and worse (8%) overall physicians
- Focusing on the practitioner creates defensiveness, humiliation and the creation of committed enemies

# Conclusions

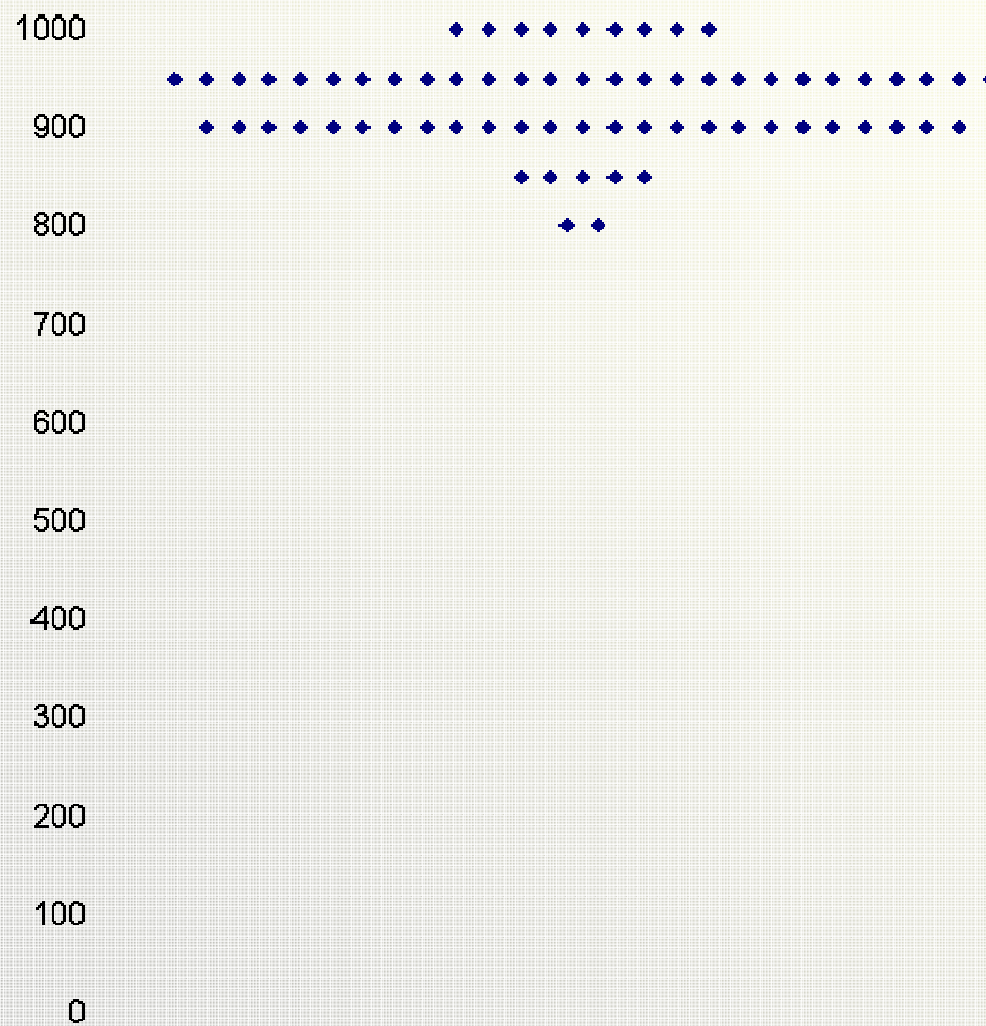
- For cost efficiency, the physician is not the most effective unit of analysis
- Efficiency indexes are too indirect and personal to be actionable
- Fear as the motivational tool does not promote collaboration
- Focusing on appropriately selected behaviors is a more logical strategy



# The Next Generation: Adding Overuse and Underuse Measures to the Quality Paradigm

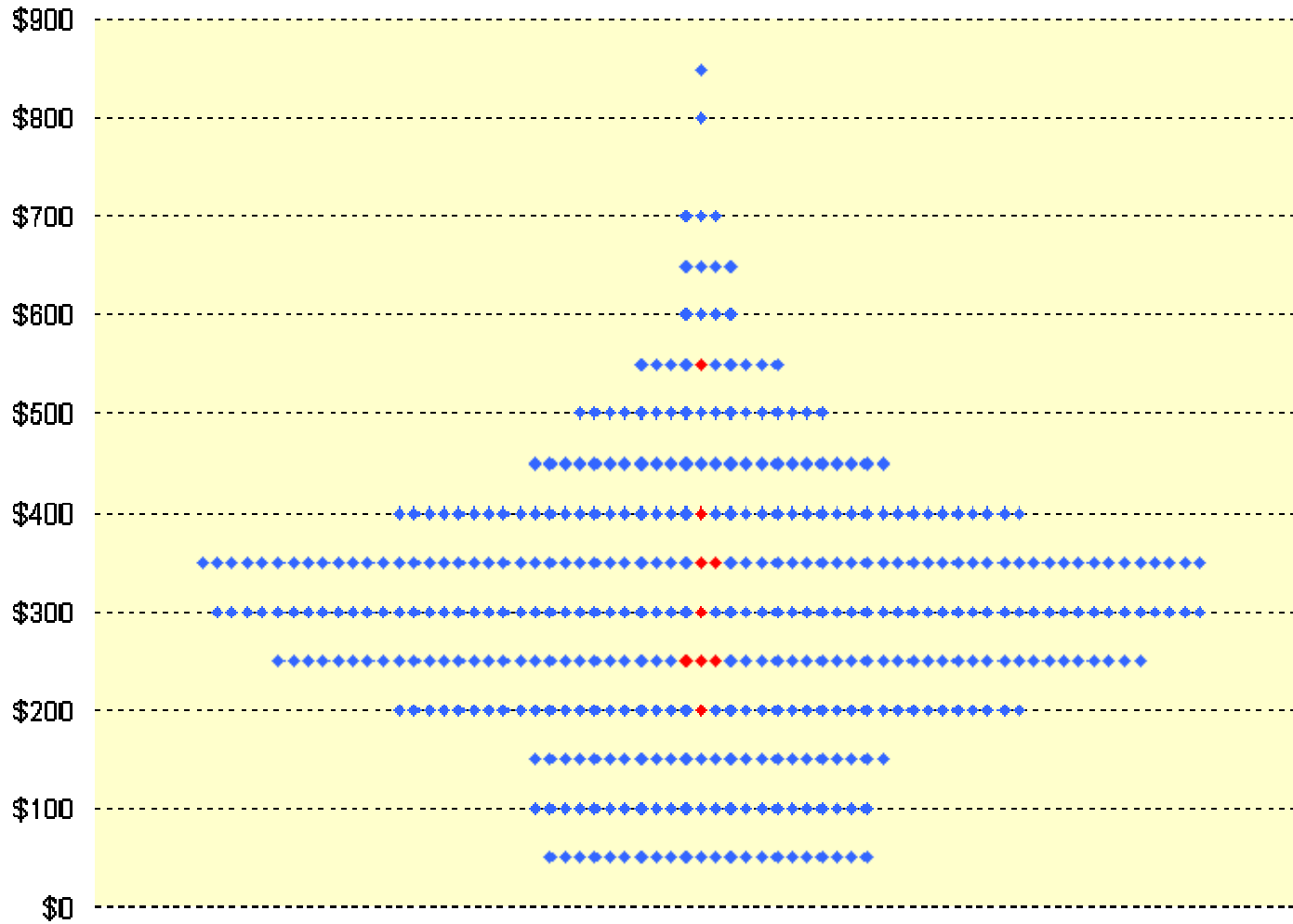


### Childhood Immunization Rates 2003 Among pediatricians with at least 20 eligible





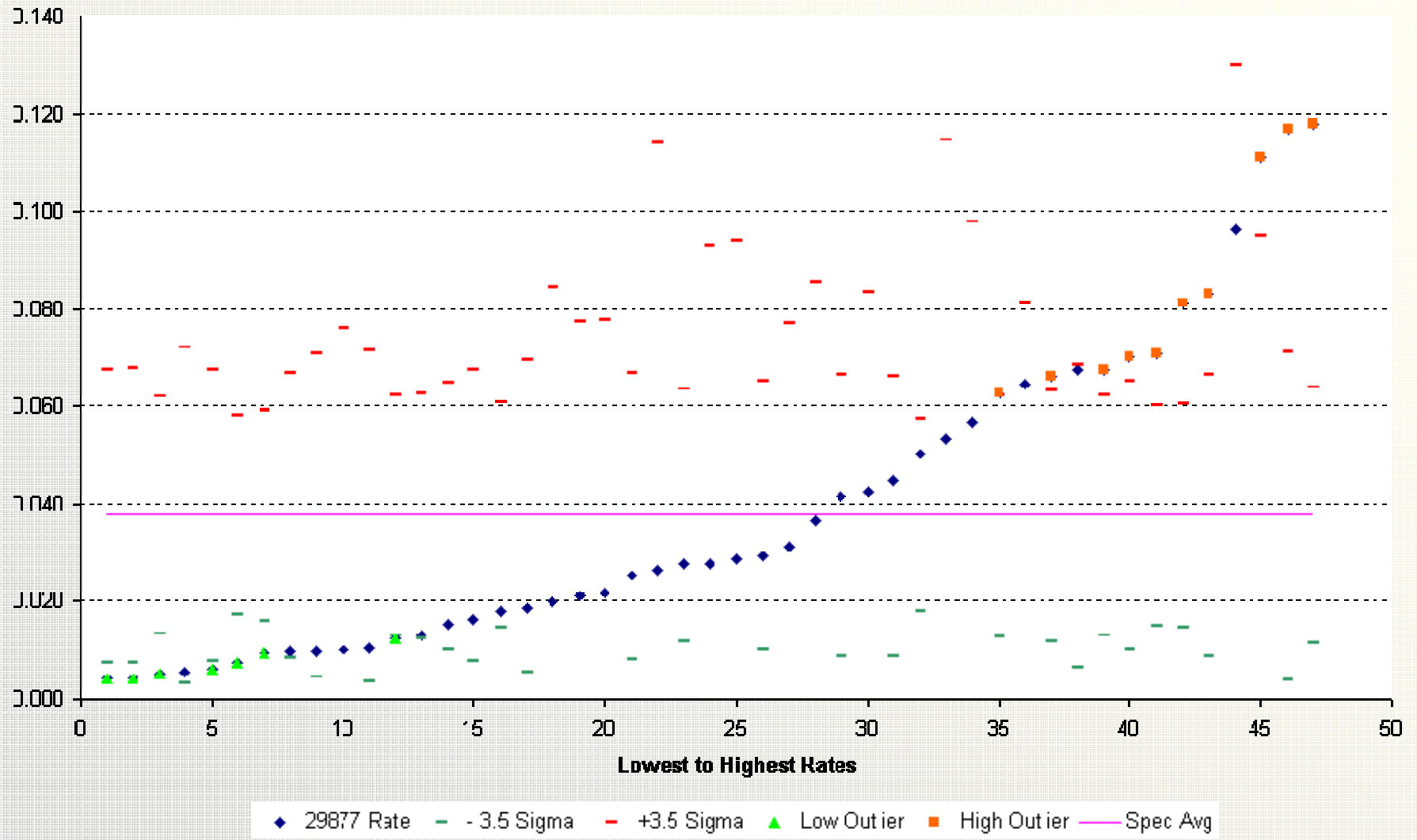
### Internists HTN Rx Costs per Episode 1/1/2002-12/31/2003 data load



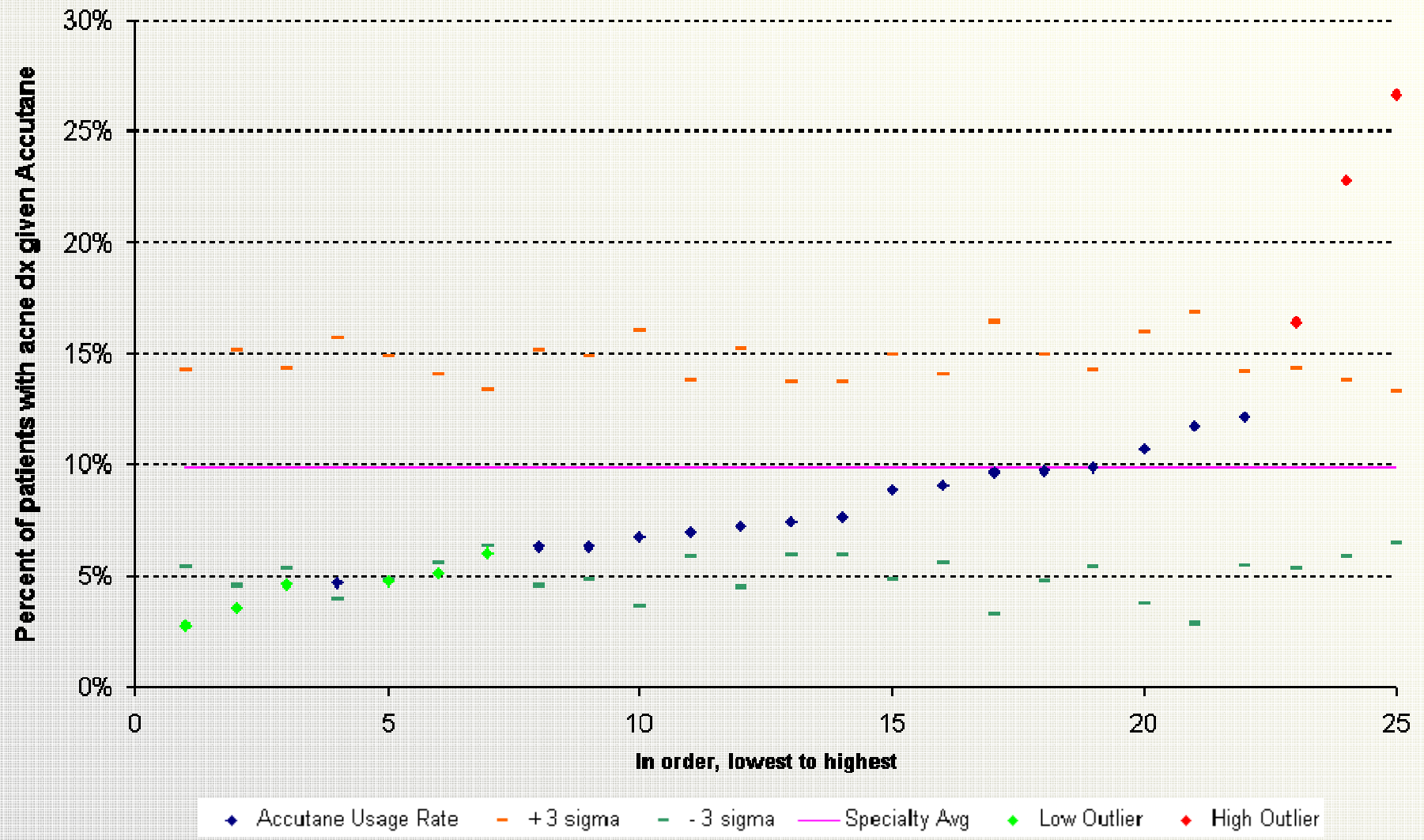
Advisory Committee members show in red.



### Arthroscopic Debridement 29877 Rates Among all patients, 2002-2003, Selected Orthopedicists



### Accutane Usage Rate Among Dermatologists with 10 or more patients on Accutane, 2002-2003



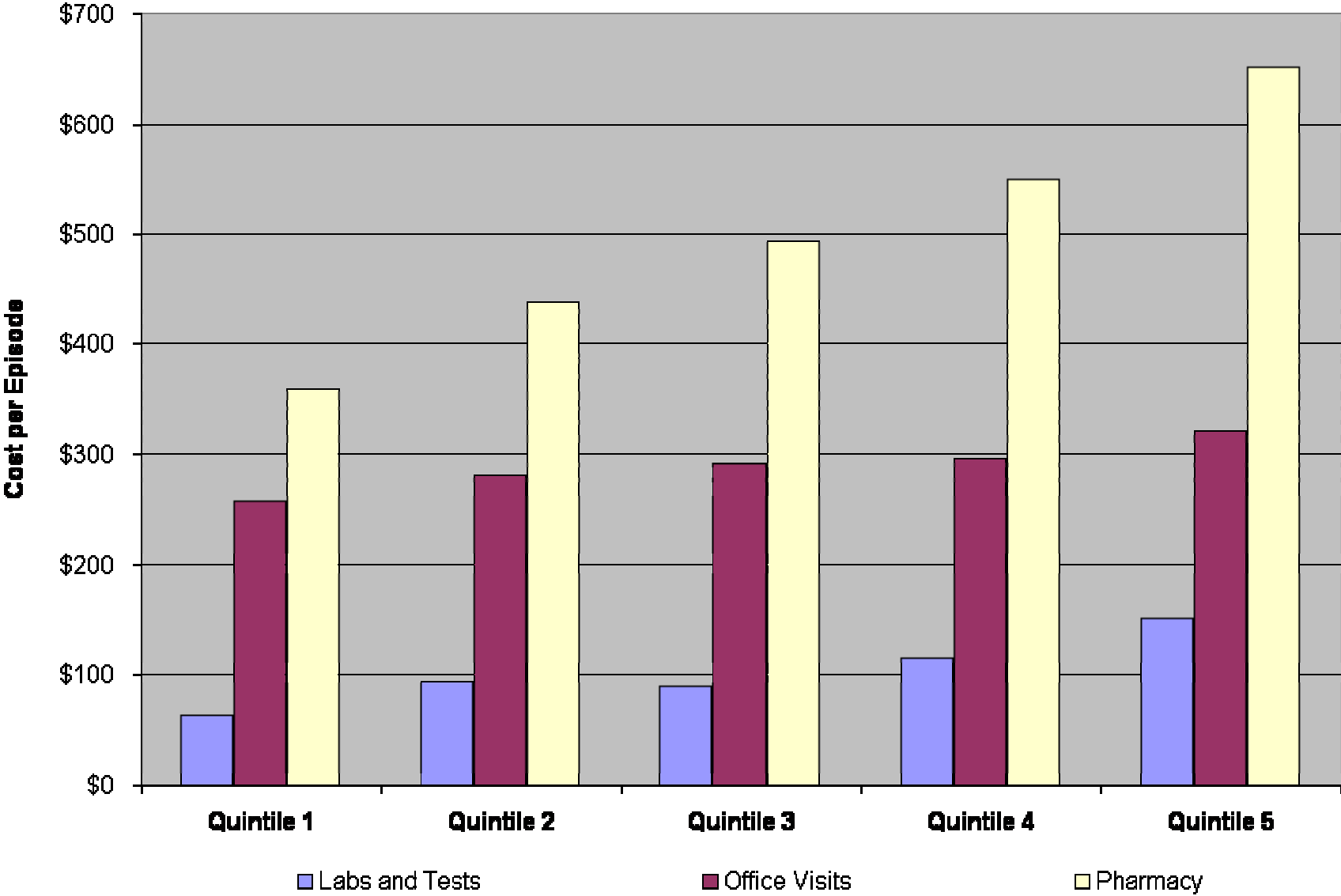
# What Is Needed



- By condition, find the **local-regional** variation in specific services
- Understand if the variation represents overuse or misuse – have the quality conversation
- Find overuse-misuse reduction opportunities for a whole specialty = find best practices
- Create a series of measures based on reducing overuse or underuse offering interventions based on best practices
- Reduce costs while improving quality – not by chance, but by DESIGN

# MPPT™ Analysis of Hypertension\*

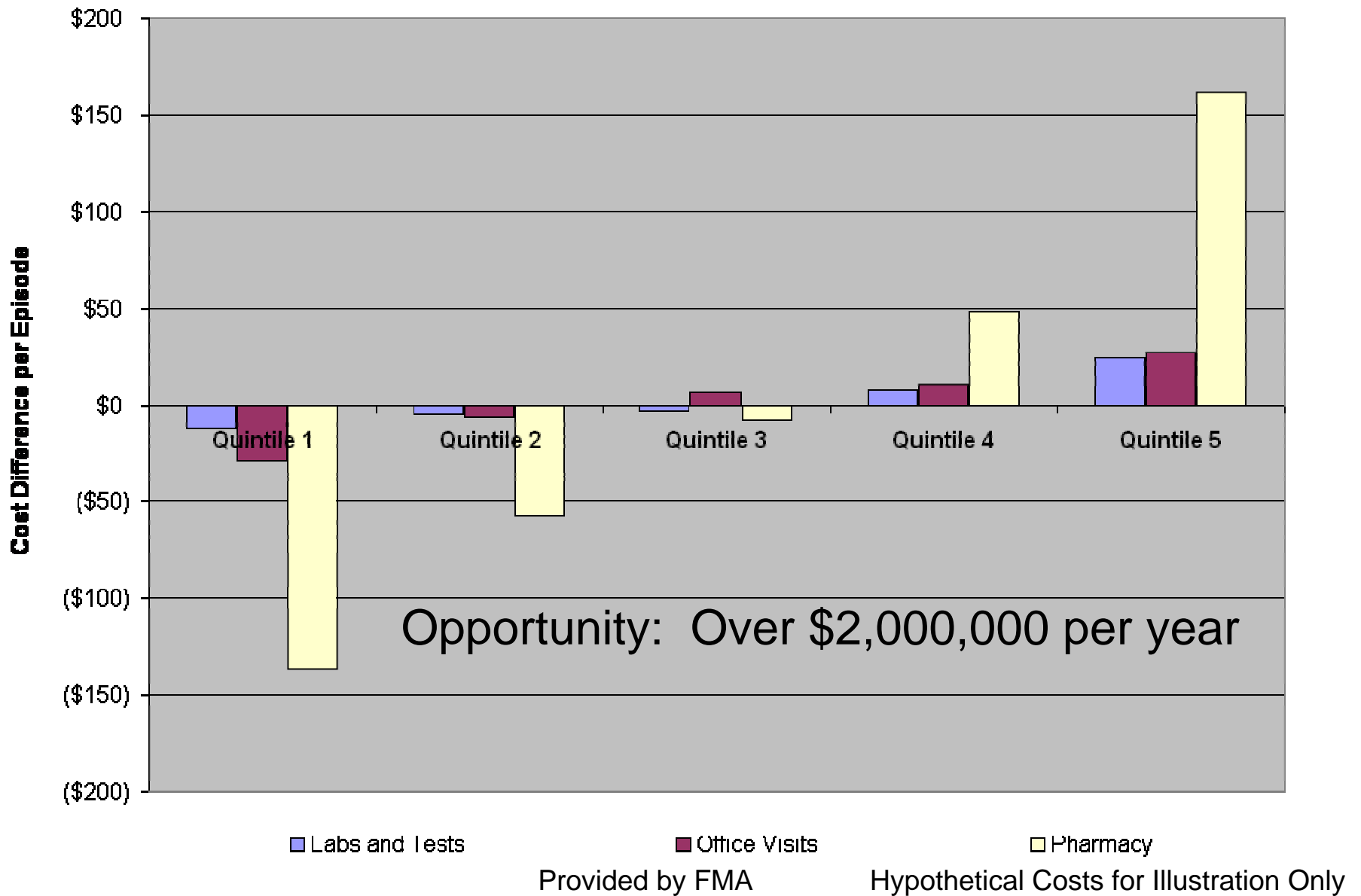
(ETG 0281, Benign HTN w/o comorbidity, among 260 internists)



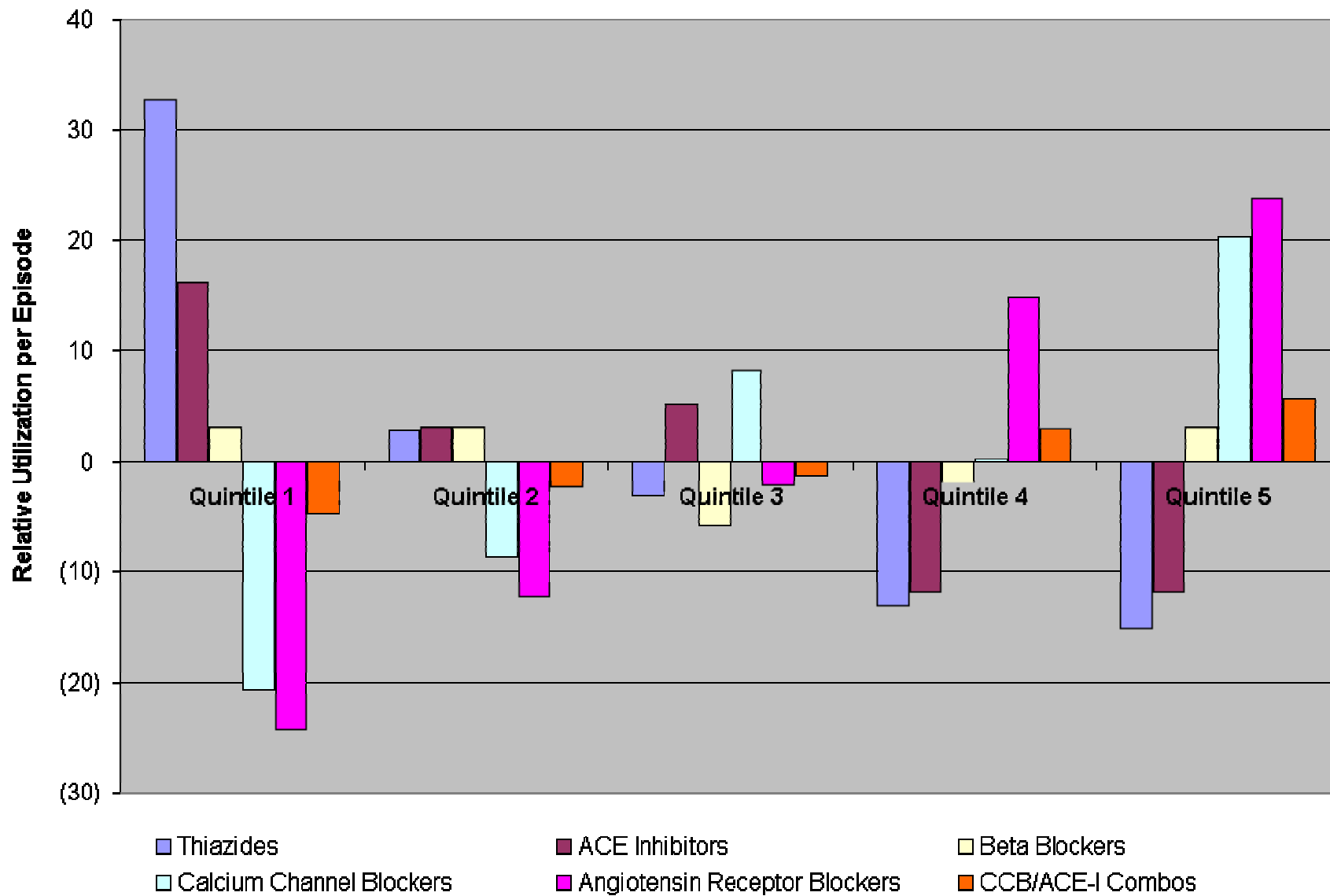
\* Provided by FMA

Hypothetical Costs for Illustration Only

# Cost Variation – All in Pharmacy



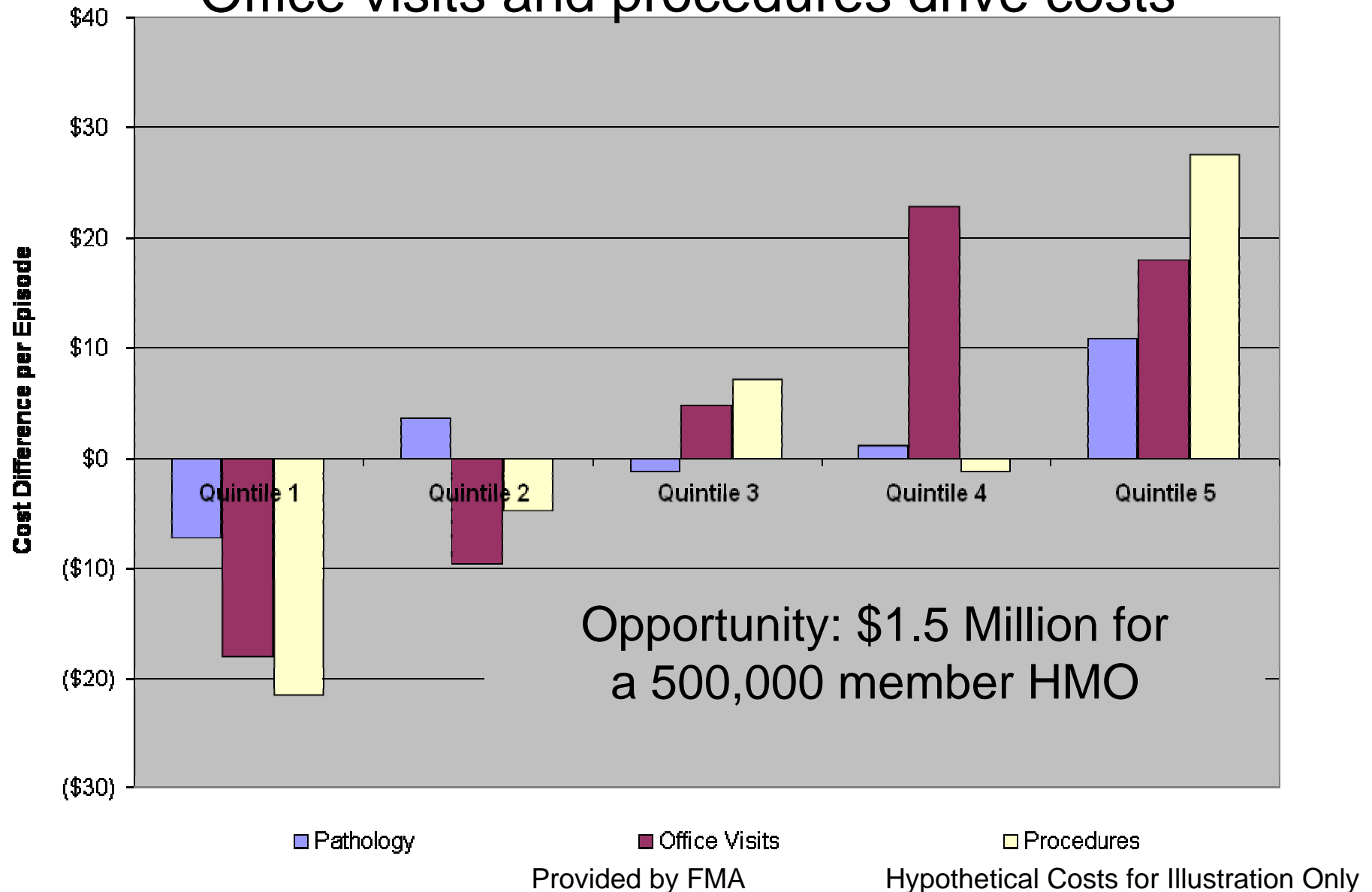
# Pharmacy Analysis: Best Practice is Quintile 1



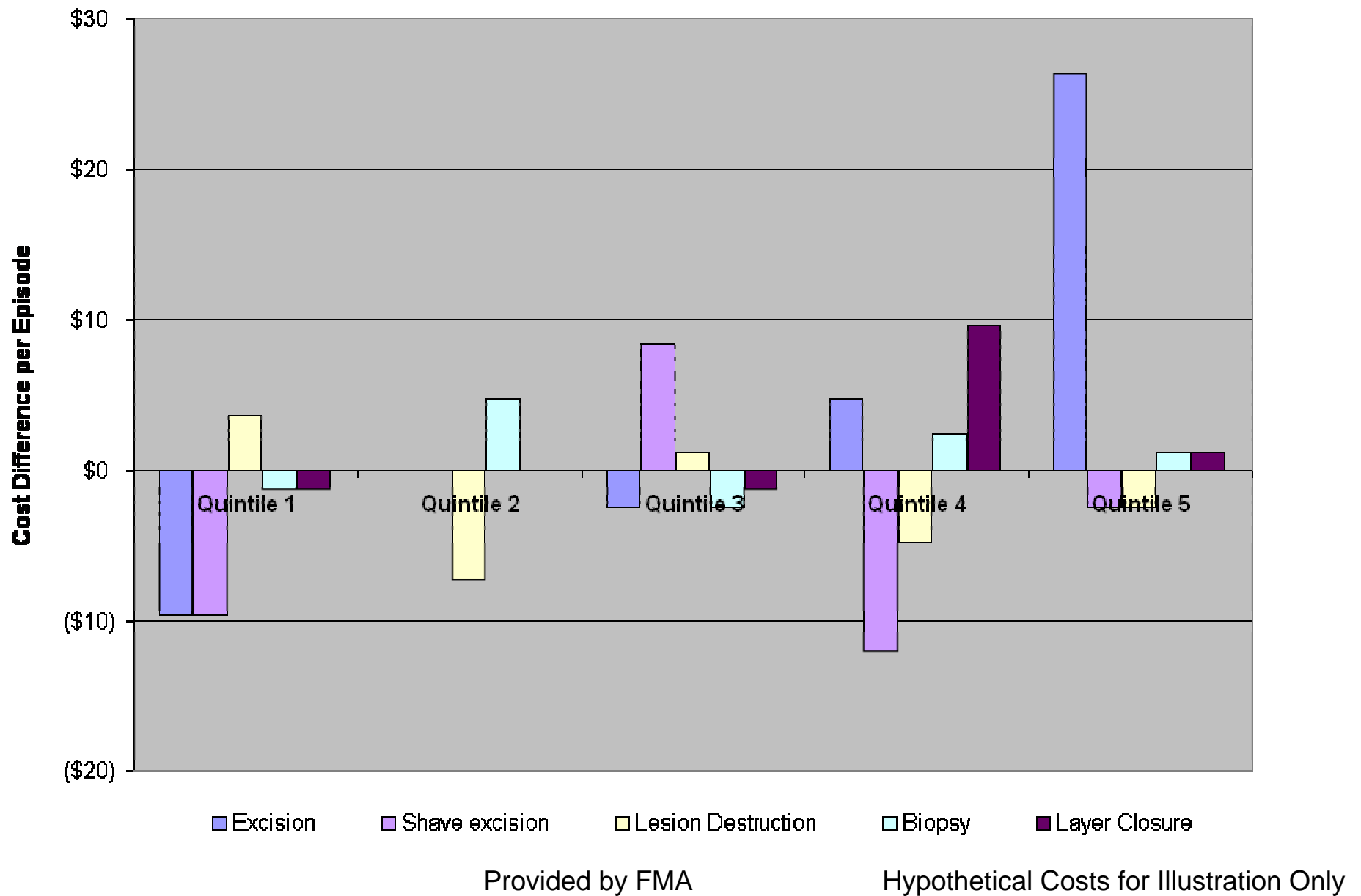


# Removing Benign Skin Growths

## Office visits and procedures drive costs



# Drilling Down on Procedures





# Conclusions

- Focus on reducing overuse instead of relying on efficiency indexes
- Find specific action items to improve value
- Direct attention to meaningful action items to engage practitioners as partners
- Change physician behavior through incentives, avoid “punishing bad docs” as primary motivational strategy