Efficiency 2008
Can Quality Methods Work?

A Medical Group Perspective

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- 150 Medical Groups in CA
- 13 Million people in HMO delegated model
- 59,000 MD's
- Strong Supporter of P4P
- Collaborator Culture
- Intense interest in affordability

Today's Affordability Crisis

- Cost of coverage no longer merely a "medical" issue—societal security at stake.
- Industries sagging/driven out of the state
- Purchasers angry: cost up, quality flat
- Policies getting lean, risky to families
- CA Reform collapsed: skepticism re affordability…yet status quo is also toxic

Condensed History: UM & QI

- Managed care '90's: mostly aimed to pinch utilization
- Overbold UM behavior → backlash '00's
- Quality "Assurance" token in 90's, but…
- QA → QI "systems" transformation in 00's
- P4P supported QI boom in HIT
- Collaborative approaches soared

But… “Chasm” of 2008 is Cost

- We’re steadily deploying QI methods, but…
- Old, blunt UM tools disabled
- Wennberg variations persist, maybe worsening
- Entrepreneurial pressures: Expensive tech, drugs, and procedures proliferating
- Consumer entitlement behavior persists
- Paradoxical appeal of poorly managed products with better cost-shifting flexibility

Can we use QI Approaches for Efficiency? *Yes and No*

- Sophisticated data to support practice change, engage individual MD's—yes
- Use of local group structures to engage MD's with trust and personal stake—yes
- Collaborative learning processes—yes
- Best practice sharing—yes
- Financial incentives—*careful*….

Now the No's: Unlike Quality…

- Many efficiency variables not in group control: i.e. hospital rates, local cartels, regulatory mandates for CA HMO
- Group public reporting—Very tricky; populations and localities ARE different
- Individual physician *public* profiling: major vulnerability to gaffes & backfires

Perception Problem for "Efficiency"

- $ Incentives for quality win-win-win for providers, plans, and public, but…
- Public unaware of health cost dynamics
- Incentives for cost reduction by payors distrusted by public. "Rewards for depriving patients of needed care."
- Provider antipathy intense

Practitioner Pushback

- "By Efficiency, you really mean profit.
- I work for my patients...
- I don't work for the insurance company and a bunch of Wall Street creeps...
- I don't give a hoot about some Cape Cod CEO's yacht and his stock options...."

Reframe to Overuse and Misuse

- Excessive care is dangerous to patients
- Inappropriate use of drugs, procedures, radiation exposure, and hospital stays can all cause real casualties for real people.
- "Waste" goes beyond money—concepts of safety, risk, justice, access, social responsibility

Hippocratic Wrinkle

- Cost of care for my patient is not my concern. I'm a doctor, not a businessman

…Well, OK, but….

- Money wasted is gone. It cannot be used for another, equally deserving patient for mainstream services of proven value.

What's working in CA

- Sophisticated data analytics, identifying patterns deviating from local peers
- Individual doctor to doctor session—ask first why, understand "rest of the story."
- Specialty peer groups to engage outliers
- Feedback longitudinally
- Transparency among peers

CA, Continued

Presentations Oct '07 P4P conference

1. Hill Physicians—Specialist ETG's with medical director "coach role"
2. UCLA—coding analysis for priorities
3. PMG Santa Cruz reframe avoidable ER use as quality of care issue + access, patient experience

Collaboratives

- Best way to teach, penetrate, spread
- No entity alone can change environment
- California Quality Collaborative (www.calquality.org)
- Learn from vertically integrated systems:
  - Kaiser
  - VA
  - Hybrids