

THE QUALITY COLLOQUIUM ON THE CAMPUS OF HARVARD

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Should Physicians be accountable for quality care and outcomes?

If not, why not?

If not physicians, then whom?

To paraphrase, *“The house of medicine divided shall not stand!”* On the issue of quality and best possible outcomes of care, the physician community should loudly and boldly reply, YES, we along with our patients, will do everything in our power to employ best practices and assure best outcomes.

Every physician individually believes this; everyone has sworn an oath to protect his or her patients’ best interest. Our profession and our professionalism are being questioned because, in too many cases, our beliefs and our oaths do not match the healthcare reality. There is growing and irrefutable evidence of faults in the healthcare delivery system, particularly in measurements of safety, incorporation of best practice, use of evidence of medicine guidelines, and adoption of point of care decision support technologies. The result, sadly, is a growing public skepticism about our professional commitment to serve the public’s best health interest.

So what may be the answer? As always, there are many views on the deficiencies noted, lots of issues with fair pay, clear direction, arguments over scientific validity of metrics, and on and on. As a profession, let’s clearly examine the facts and move boldly into a future of positive commitment toward best process and outcomes, combined with transparency and accountability, with incentives aligned to accomplish the task.

First the sad evidence - A quick recitation of the IOM findings, “Crossing the Quality Chasm”¹ finds much publicity over up to 98,000 unnecessary deaths/year. HealthGrades, in a study of three years of MediCare data suggests that this number is underestimated by half. The work of Rand researchers suggest that only 55% of adults in 12 different areas of the U.S. received best recommended care.² Many studies have documented deficiencies in optimal care across chronic diseases, including diabetes, CHF, and cancer care to name a few. Elliot Fisher and his colleagues at Dartmouth have asserted and shown that current fee-for-service incentives can produce unmanaged care leading to over-utilization, needless testing, poor quality and complications.

You may ask, appropriately, why in this system of ours, in many respects the best in the world, led by dedicated professionals, are we continuing to tolerate such deficiencies? The answers and solutions are complex and multiple. There are, however, examples of

many successful strategies to improve the care we deliver. Among these is early evidence that aligning quality incentives with pay for performance, combined with accountability, transparency and including public results reporting can work. Some examples of this may prove useful. Gellies, et. al.³ reported that more frequent use of recommended care management processes, which resulted in improved chronic illness care in California, was directly correlated to higher use of quality pay incentives. And while direct pay for performance systems are relatively new and, therefore, it is too early to show a lot of direct causal impact, there is growing documentation that supports significant, even breakthrough, improvements. Indirect measures of quality incentives accompanied by transparency of results, support this thesis. There is clear evidence of the value and impact of public reporting. The following results in 2003 as reported by NCQA⁴ showed significant improvements among health plan HEDIS data, between those plans who reported publicly and those which did not.

	<u>Public</u>		<u>Non-Public</u>
- Adult immunization rate	53%	vs.	30%
- Cholesterol control	63%	vs.	50%
- HbA1C testing	84%	vs.	73%

Over time, the combination of quality metrics and public reporting resulted in significant advances in HEDIS results, such as appropriate B-blockers use improvement from 62% in 1996 to 93% in 2002.

Other examples of improvement over time documented by NCQA public reports document the positive influence of incentives (accreditation) and public reporting across other important process measures:

<u>Measure</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>
Controlling High Blood Pressure	39.0%	51.5%	55.4%	58.4%
Cholesterol Management to target	45.3%	53.4%	59.3%	61.4%
Diabetes Care-Lipid Control	36.7%	44.3%	49.8%	54.8%
Chicken Pox Vaccine	63.8%	70.5%	75.3%	82.0%

Evidence is growing that health plans which primarily use a network of coordinated care physician groups and IPA's who report HEDIS scores, rate consistently and statistically higher in 17 of 26 HEDIS measures⁵.

From these trends and evidence we can infer, but not yet prove, that direct incentives to improve care quality and outcomes can work. In several eastern cities, the Bridges to Excellence and Physician Recognition Programs in diabetes, heart disease and stroke are showing significant gains in quality metrics. Within California there is a bold experiment in Pay for Performance. Almost all physician groups and IPA's in the state are voluntarily part of this effort. Key metrics in preventative, acute and chronic clinical measures, service and incorporation of technology to improve results and reporting are rewarded. A business case for quality, which has been a sorely needed ingredient, is being built. The proof is being collected, but the efforts among these physician-led

organizations to improve and share results in an increasingly consumer savvy and consumer driven healthcare environment are encouraging.

Let's bring the House of Medicine together. Physicians should lead and embrace this effort. America deserves the best healthcare that we can provide.

¹“*Crossing the Quality Chasm*”, National Academy Press, 2001

² McGlynn et.al., “*The Quality of Health Care Delivered to Adults in the United States*”, NEJM, June 2003

³ Gellies et.al., “*How Different is California*”, Health Affairs, October 2003

⁴ NCQA Annual State of Health Care Report

⁵ Crosson and Chernok, pre-publication data