

More than Rearranging the Deck Chairs

Performance Measurement: Challenges and Opportunities

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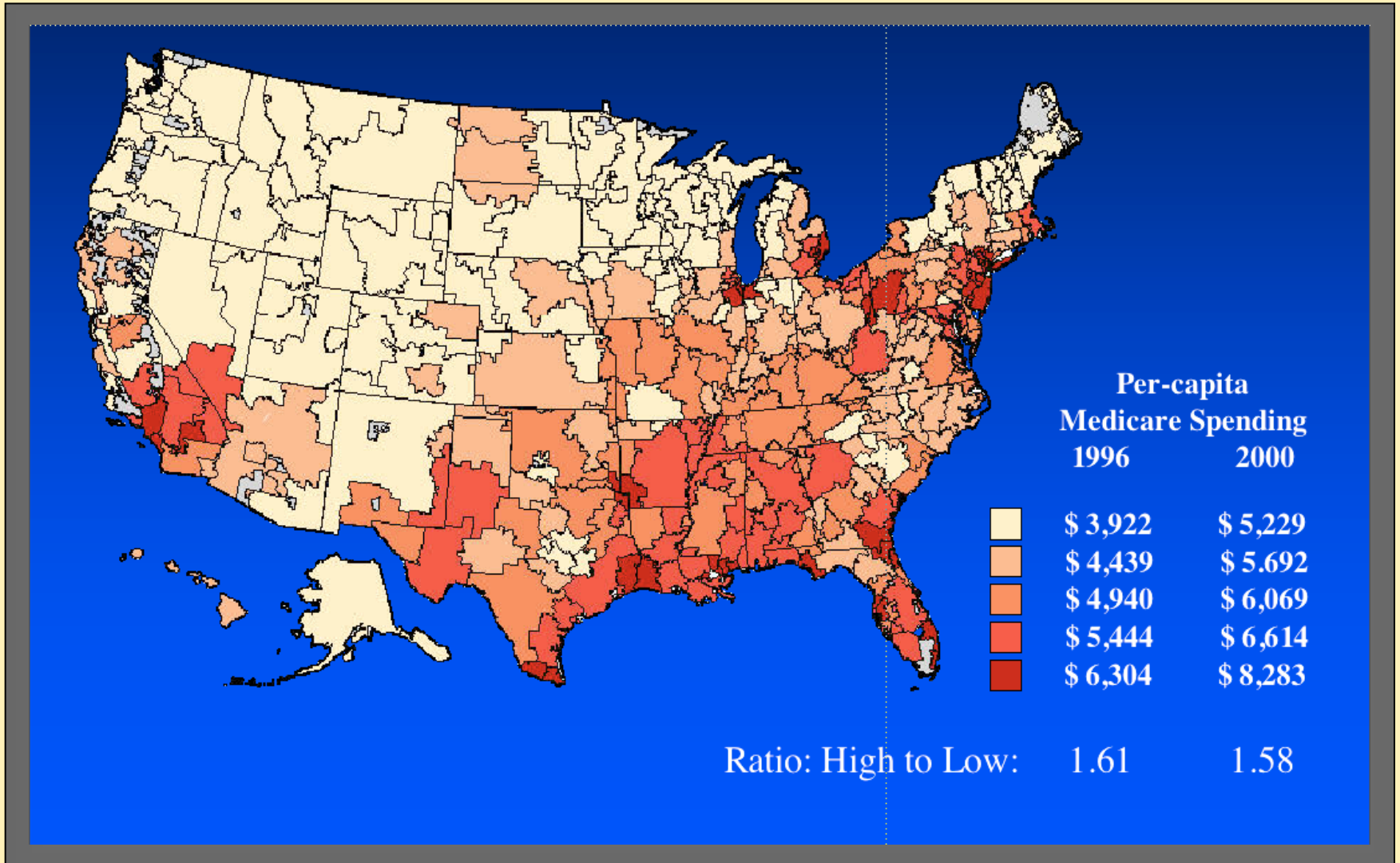
Performance Measurement: Challenges and Opportunities

Some theory: underlying causes of the current mess

Implications: don't miss the forest for the trees

Moving Forward: Some thoughts on current initiatives

Variations in spending *across U.S. Regions*



The paradox of plenty

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

Resource levels¹

More hospital beds per capita (32%)

More medical specialists (65%) and internists (75%)

Content / Quality of Care^{1,2}

Effective Care: Technical quality worse

Preference Sensitive: No more elective surgery

Supply Sensitive: More inpt stays, visits, specialist use, tests

Health Outcomes^{1,2}

Slightly higher mortality

No better function

Physician-reported quality⁵

Worse communication among physicians

Greater difficulty ensuring continuity of care

Greater perception of scarcity

Patient-reported quality^{1,3}

Lower satisfaction with hospital care

Worse access to primary care

Trends over time⁴

Lower gains in survival (following AMI)

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

“What do we know about the performance of health care providers in the US?”

Tom Miller, email, 10/29/07

Physicians in higher cost health systems are providing worse care than those in lower cost health systems (whether defined on regional basis or for the populations served by the top 100 U.S. academic medical centers).

In theory, we could send a third of the U.S. health care workforce to Africa and improve the health of both continents.

Differences in spending

What do we know about underlying causes?

Patient preferences?^{1,2}

Can't explain magnitude of spending differences

Malpractice environment^{3,4}

*About 10% of state differences in spending
Some impact on growth in utilization across states*

Capacity / payment system⁵

*Capacity strongly correlated, but explains less than 50%
Payment system ensures all stay busy*

Clinical judgment^{6,7}

*No difference in decisions with strong evidence
More likely to intervene in “gray” areas
(when to see patient, when to refer, when to admit)*

- (1) Pritchard et al. *J Am Geriatric Society*; 46:1242-1250, 199
- (2) Anthony et al, under review
- (3) Kessler et al. *Quarterly Journal of Medicine* 1996;111(2):353-90
- (4) Baicker, Fisher, Chandra, forthcoming
- (5) Fisher et al. *Ann Intern Med*: 2003; 138: 273-298
- (6) Sirovich et al. *Archives of Internal Medicine*. 165(19):2252-6.
- (7) Sirovich et al, *J Gen Intern Med*. 2006;21(Suppl4):164.

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.

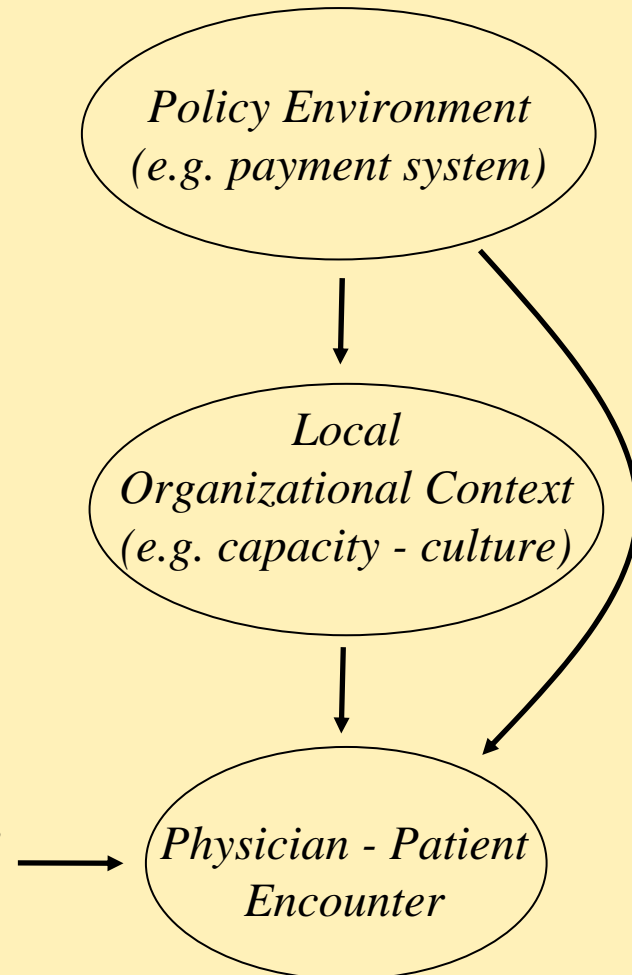
Physicians practice within a local organizational context and policy environment that profoundly influences their decision-making. Payment system ensures that existing (and new capacity) is fully utilized.

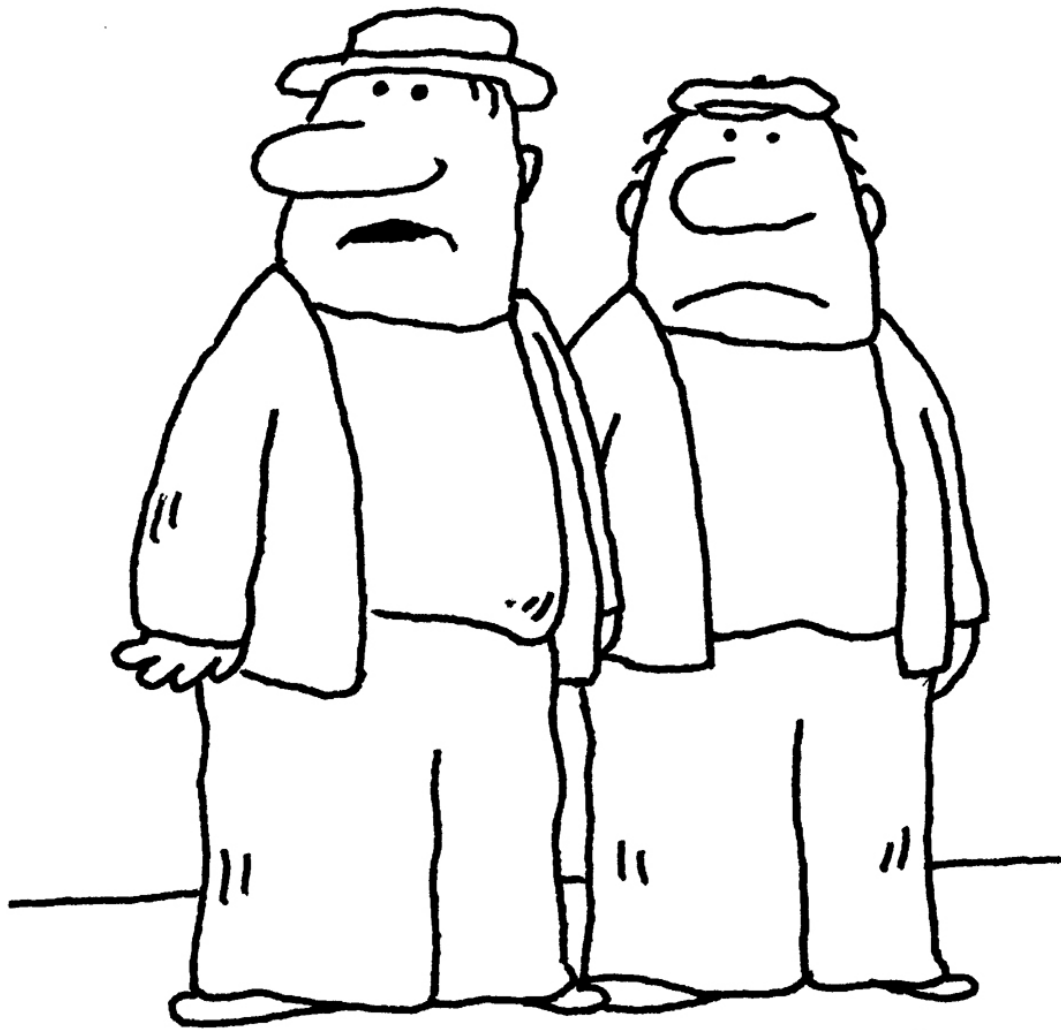
Consequence: *reasonable* individual clinical and local decisions lead, in aggregate, to higher utilization rates, greater costs -- *and inadvertently* -- worse outcomes

The more complicated care becomes, the more likely mistakes are to occur.

Hospitals are dangerous places if you don't need to be there.

Clinical Evidence
Professionalism





C. Borsatti

“There, there it is again—the invisible hand of the marketplace giving us the finger.”

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Why might this be important?

Our current conceptual model of practice is flawed

Limitations of current professional model

Current model assumes that good outcomes are produced by individual clinician in one-to-one patient encounters.

Many failures of current system are a direct consequence:

- Poor communication
- Inadequate continuity
- Lack of care coordination

Focus on individual physician performance reinforces flawed model

We must therefore manage the tension between two aims:

Engaging physicians: professional knowledge, values, leadership

Moving toward a new conceptual model of clinical practice focusing on
(1) shared accountability (among all providers who contribute to care)
(2) the care of populations (and individuals) over time

Many-to-many relationships; teams; populations

Why might this be important?

Current policy approaches...

Focus largely on individual providers and their silos

Risk reinforcing fragmentation, poor coordination

Why might this be important?

Current policy approaches...

Focus largely on individual providers and their silos.

Constrained by currently available performance measures

Current quality measures focus on technical process of care.

Limited scope of measurement risks making bad apples (on unmeasured domains) appear good.

Consensus-based approach risks capture by providers.

“Efficiency” measures target brief episodes and largely ignore the role of volume (frequency of episodes)

Why might this be important?

Current policy approaches...

Focus largely on individual providers and their silos.

Constrained by currently available performance measures

Face substantial technical challenges

- Attribution of patients to physicians

- Implementation of performance measurement in office practice

- Small numbers problems: few physicians with adequate numbers of patients (many physicians unevaluated);

- Avoiding gaming and potential harm to patients

Why might this be important?

Current policy approaches...

Focus largely on individual providers and their silos.

Constrained by currently available performance measures

Face substantial technical challenges

Ignore the organizational context of care -- where overuse of supply-sensitive care occurs.

Moving Forward

Underlying causes -- and strategies to guide reform (and implications for performance measurement)

Underlying cause

Failure to recognize key role of *local* systems (capacity, clinical culture) as determinant of both quality and costs.

Inadequate information on risks and benefits of clinical interventions.
Assumption that more medical care means better medical care.

Payment systems that reinforce unfettered growth, fragmented care and provider-dominated decisions.

Suggested strategies

Foster development of local organizations (health systems) accountable for care of population they serve.

Comparative effectiveness research to clarify actual outcomes of interventions.
Comparative performance measurement of health systems costs, quality and outcomes.

Reform payment systems to provide incentives for high value care. Shared savings models as interim approach to payment reform.

Moving Forward

*Underlying causes -- and strategies to guide reform
(and implications for performance measurement)*

Suggested strategies

Foster development of accountable care organizations.

Performance measurement that focuses on important, meaningful domains.

Provide incentives for high value care. Shared savings models as interim approach to payment reform.

Implications for Performance Measurement

Allow physicians to choose to report as groups

Individual MD measures carefully chosen
Move toward *true* efficiency measures: outcomes, key processes, total costs

Expand Physician Group Practice demonstration program

Develop and pilot test approaches to bundled payments

Rewards will accelerate movement toward groups -- and toward better measures

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Moving Forward

How can we strengthen current efforts?

Individual physician measures?

Make sure they are meaningful: (1) patient experience, (2) outcomes/costs of physician group to which they belong.

If not -- report publicly at group level; use internally to motivate

Value exchanges; AF4Q, merging public-private admin data

Move beyond narrow measures of technical quality

Report at medical group & hospital medical staff:

- Technical quality (e.g. blood sugar control; mammography)
- Utilization rates (surgery, hospital, physician services)
- Spending / resource use
- Risk-adjusted health outcomes: AMI, hip fracture, cancer

Fund development and implementation of new measures