Doing Well By Doing Good:
Improving the Business Case for Quality

By

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American health policy is focused on quality as never before. In legislation[1] regulation[2], enforcement[3], policy development[4] and market demands[5], many initiatives are under way to improve the quality of health care in the United States. However, few of these initiatives have targeted the critical role of physicians in propelling a quality agenda. Because of the centrality of the doctor-patient relationship to the delivery of health care services, improved quality of health care will not achieve its full potential unless physicians are enthusiastically engaged in such efforts. Not only do physicians have plenary legal authority – the broadest scope of professional jurisdiction of any clinician in the health care system – but patients primarily experience the health care system through their one-on-one relationship with a physician. Physicians perform some of the most personal and critical procedures that define health care. They write the orders that drive the provision of services and goods by hospitals, other clinicians, ancillary service providers and even drug manufacturers. They are the patients' portal to the rest of the system through their referrals, their interpretation of insurance benefits and their education of their patients regarding their health care needs. Most aspects of health care are ultimately derivative of physician behavior.

Confronting the essential role of the physician in American health care delivery, this paper is intended to set forth an approach to meaningful engagement of physicians which could produce (1) improved quality, particularly with respect to evidence-based care; (2) enhanced margins for those providers who can organize systems to deliver evidence-based care; (3) better patient outcomes and patient perceptions of care; (4) reduced costs for purchasers and payors; and (5) reduced overall administrative and regulatory burden in the health care system.

Our proposition incorporates the thoughts and suggestions of a unique group of American health care leaders (see list Appendix A) who attended a working conference on March 28th, 2003, to consider, respond to and critique the basic theory and principles set forth here. These leaders are responsible for some of the most innovative and forwarding-thinking physician groups, academic health centers, hospital systems, and health plans in the nation. Three of the conference participants—Mark Smith, M.D., Robert Galvin, M.D., and Lee Newcomer, M.D. – played vital roles as faculty members

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[1] See Patient Safety and Quality Improvement Act, S.270 (108th Cong, 1st Sess); Quality Health Care Coalition Act of 2003, HR 1247 (108th Cong, 1st Sess); Proposed HJ Res 30 proposing an amendment to the Constitution of the United States regarding the rights of citizens of the United States to health care of higher quality.

[2] See Gosfield, "Legal Mandates for Physician Quality: Beyond Risk Management," HEALTH LAW HANDBOOK, pp 285-322 (A. Gosfield, ed. 2001) West Group.

[3] See for example, nursing home quality enforcement initiatives of the Department of Justice and the focus of the Office of the Inspector General of DHHS on quality reported in "Health Care Fraud and Abuse Control Program," DHHS and DOJ, Annual Report for FY 2001, (April 2002) www.usdoj.gov/dag/pubdoc/hipaa01fe.19.htm#f

[4] Corrigan et al, CROSSING THE QUALITY CHASM, Institute of Medicine, National Academy Press, Washington, D.C., 2001.

[5] www.leapfroggroup.com

and panelists, and made a particularly strong impact on our thinking. We are profoundly grateful to all the conferees for their contributions, and to Sanofi-Synthelabo for sponsoring the conference, but we, alone, bear responsibility for the intellectual content of the framework presented in this white paper.

The Problem

Throughout the health care system two universal laments are heard: "why does quality lag behind optimal levels?" and "there is no business case for quality." Before designing new payment models in response to these laments, however, it should be noted that there are many quality improvements that could be accomplished within the current payment framework without fundamentally changing payment methods or incentives. For example, (1) reduced intensive care unit costs within hospitals from improved work flow, (2) lowered hospital lengths of stay, (3) closed unit structures in intensive care units, and (4) broader application of standing orders would all lower costs and improve profit margins for hospitals, without any changes in payment models.

Physicians also have opportunities to improve financial performance by improving quality, within current payment frameworks. Many of their complaints regarding the absence of a business case reflect their own self-inflicted disorganization, cottage-industry mentality and ideological reliance on traditional modes of care delivery. Improved efficiency in physician office practice alone would reduce overhead, save time and thereby reduce their costs. Standardizing care according to evidence-based protocols could decrease practice operating costs and improve margins, without the necessity for any increases in revenues or payment incentives specifically focused on improved quality. These types of changes for hospitals and physicians would enhance the value proposition of care without changing the payment system. Consequently, there is much to be done to propel and support improved quality even in the absence of an altered approach to payment. Nevertheless, there are still many barriers to a strong business case for reducing misuse, overuse and underuse of health care services.

For the purposes of this discussion, we accept the definition of a 'business case' set forth by Sheila Leatherman and colleagues in their recent consideration of several case studies of various efforts to improve quality and have a positive impact on the business of health care.

> *A business case for a health care improvement intervention exists if the entity that invests in the intervention realizes a financial return on its investment in a reasonable time frame, using a reasonable rate of discounting. This may be realized as 'bankable dollars' [profit], a reduction in losses for a given program or population, or avoided costs. In addition a business case may exist if the investing entity believes that a positive indirect effect on organizational function and sustainability will accrue within a reasonable time frame.*[6]

[6] Leatherman et al, "The Business Case for Quality: Case Studies And An Analysis," 22 Health Affairs 17 (March/April 2003)

This definition is broad and flexible. It allows for a wide variety of measures and effects to judge whether a case has been made that the intervention at hand will improve both the quality and the business impact of the services at issue. Even with its breadth, it is apparent that there are many barriers to a strong business case for quality interventions and programs.

Most of the barriers cited by the conference attendees fell into four general categories: (1) inadequate recognition of quality in payment; (2) perverse financial incentives and irrelevant payment systems; (3) lack of infrastructure and organizational capacity to make necessary changes; and (4) lack of policy agreement on quality targets by those who would seek improvement. (See Appendix B for a complete list of barriers cited and other observations of conferees.)

(1) By far the most significant barrier cited by conference attendees was the absence of programs to explicitly pay for quality. Even in pay for performance models (see p. 6 below), the amount paid, compared to the costs incurred to achieve the quality targets, is often insufficient to motivate physicians.

In addition to weak rewards for higher quality, current payment systems also obstruct quality by fragmentation--physicians must cope with a multiplicity of different payment systems. Incentives are often so complex that they can motivate no physician behavior because the physicians don't even understand how the incentives are intended to work. The common denominator in most payment models is that physicians do better financially with better patient volume/throughput—whether in fee-for-service or capitation. As we shall see later, this pervasive incentive—see more patients, faster—is hardly conducive to improved quality, whether from the patient's, or the physician's perspective. From a payment perspective, other issues noted by the conference attendees included the following:

- return on quality investment is not immediate:
- there is little capital available for investment in new ways to interact with patients:
- money spent on patient safety distracts from broader quality initiatives:
- no one is addressing who pays for charity and indigent care.

(2) The second most often cited barrier was the absence of true consumer demand for quality—in particular, for the critical quality dimensions of effectiveness and efficiency cited by the Institute of Medicine (IOM) in its landmark study "Crossing the Quality Chasm."[7] For example, purchasers and business leaders perceive pressure from consumers to demand easy access to broad networks of care, unrestricted formularies, and reduced costs, but they feel little pressure from consumers for evidence-based care, data on outcomes, and efficient use of resources. As a result, there are few patient incentives to choose health care based on these quality attributes or to participate in initiatives that focus on these dimensions of quality. Not only are patients passive on

[7] See CROSSING THE QUALITY CHASM, n. 4, above.

these issues, physicians note that patients often request services and drugs in a way that drives overuse of services that cannot possibly be of benefit, and underuse of services that could have helped the patient.

(3) The third strongest barrier noted was the dearth of coordinated data and sophisticated information technologies to support quality initiatives, including the absence of an integrated patient medical record, discontinuity of available data, and lack of electronic solutions at the bedside. And those physician organizations that are trying to address these information technology barriers note that information technology systems improvement itself has uncertain returns, given the daunting investment costs and the absence of a clear path between the resulting quality improvements and better margins.

Within physician groups, hospitals, and other care delivery organizations, additional barriers cited include the cost of influencing and changing physician behavior, lack of physician skills to manage change within medical groups including little clinical quality leadership, insufficient group integration to enhance coordination of care, and physician mindsets which lead them to believe they are, in fact, providing evidence-based medicine when the data shows otherwise. Participants also cited traditional physician training as an impediment to moving to these new approaches.

(4) In addition to these barriers, many regulatory programs enacted to improve quality are an inconsistent hodgepodge of initiatives with no overarching principles. In fact, attendees cited the absence of policy, regulatory and market agreement on quality targets and priorities as a fundamental barrier to a business case for quality.

Current Approaches to Address the Business Case

While there are few programs which pay physicians for quality, there is a developing approach in "pay-for-performance" initiatives which have recently emerged. Essentially, these projects pay physicians an additional bonus for something deemed to enhance quality. Usually this is something the physicians have not done previously or have been doing but the effort remained financially unacknowledged. These programs use three basic tactics: (1) paying for performance of evidence-based care processes and achievement of related care outcomes, above a benchmark; (2) paying for similar measures, but on a tiered normative basis; (3) paying a capped share of savings achieved by any of a variety of methods, including reduction in overuse of harmful services.

In the first approach, physicians are paid a bonus for achieving a threshold of HEDIS scores (or something similar but not specifically HEDIS, such as creating diabetes flow sheets or asthma action plans). Examples include Blue Cross/Blue Shield of Illinois, Touchpoint of Wisconsin, and Highmark of Pittsburgh. Payment may be a fixed amount (e.g. $50 per patient) or an additional percentage on top of base payment.

The second version is typified by the Central Florida Health Care Coalition. Here the program evaluates participating physicians as a group and stratifies them into tiers, rewarding the best performers with more money than the other participants. In addition, some of these programs further sweeten the best performing physicians' bonuses with lowered administrative burden by eliminating prior authorizations or discontinuing an imposed formulary. Other examples include Anthem in New Hampshire, and the developing "Bridges to Excellence" program involving diabetic and cardiac care for employees of GE, Ford, Verizon and UPS in Boston, Cincinnati and Louisville. Some programs pay extra for clinical measures along with other practice attributes which are not explicitly clinical including electronic claims submission, use of electronic medical records and personal digital assistants (PDAs) for prescribing, or openness to additional company subscribers. Some programs focus on clinical quality measures with added payment for enhanced patient satisfaction scores. Finally, some programs reward good performers by making such PDAs and other technology enhancements available at no cost.

The third model appears to be that proposed by CMS for its Doctor's Office Quality Program[8] and offers a capped percent of savings model. It represents a type of 'gainsharing' approach – a long-standing concept in manufacturing relationships that the workers who are in a position to influence the productivity and quality of production are permitted to share in the positive economic impact of their improvements to process.[9] Not yet implemented at CMS, this program is described in an extensive Request for Proposal establishing complex requirements for entry.

Except for the gainsharing approach, these programs principally target those services plagued by under-use. In other words, the bonus is available either for (1) increasing the provision of a service that is perceived to be under-provided, such as certain preventive services, early detection such as diabetic retinal screening, or even actual treatment such as beta-blocker use in myocardial infarction or for (2) reporting the performance of something which has not been identified previously as meriting any additional payment, such as the use of diabetes flow sheets or asthma action plans. The third model rewards physicians for reducing costs, and because short-term cost reduction is principally achieved by reducing utilization, from a quality perspective this sort of program focuses more on those services which are over-used.

In their impacts though, these programs are not just about the opportunity to realize bonuses. There are also costs involved in achieving any increased revenues. In both the first and second models, in order to produce the proof of the additional service provided, practices must incur additional direct costs, whether in the time spent producing quality reports, or in the time of staff members to produce and deliver

[8] See "Doctors Office Quality Project," http://cms.hhs.gov/quality/doq and Solicitation for Proposals for the Physician Group Practice Demonstrations, 67 Federal Register 61116 (Sept 27, 2002)

[9] See Gosfield, "Making Quality Happen: In Search of Legal Weightlessness," HEALTH LAW HANDBOOK, pp 609-78 (A. Gosfield, ed. 2002) West Group.

evidence-based planned care for chronic diseases and preventive care. Still further, keeping track of the data on which bonuses will be paid causes both direct costs as well as additional staff time. Given the time pressures physicians face before the additional demands are added, it is fair to assume that whether spent by the physician or other staff, yet more time will be required for these administrative purposes leaving less time for vital patient interactions addressed more fully below (p. 10). At the working conference, physician leaders from around the country echoed the sentiments of one practice leader, when interviewed about "pay for performance programs":

> *"[Our] seven physician group earns only about $15,000 from Anthem's quality bonus," Dr. Kelsey said. "The practice spends some of that money paying staff to fill out plan forms and double check claims data – all of which are necessary to earn the bonus."*[10]

In addition, some of the same group's own support staff does chart review to validate the plan's information which determines the amount of the bonus.

Interestingly, whether the physicians appreciate truly improved margins in these programs is basically unknown. If the direct expense costs and direct time costs are higher than the relatively small revenue bonuses obtained, the margins are inadequate to sustain the business case over time. In the gainsharing model, whether any benefit will be realized by any particular physician group is completely unknown, since the degree of savings is dependent on the other physicians participating in the program and where the savings are realized. For example, a primary care physician group which reduces hospital and specialty physician costs by managing congestive heart failure (CHF) patients better might experience increased revenue if their behavior contributes to overall savings. On the other hand, if reduced excessive visits to primary physicians for upper respiratory infections along with reduced unnecessary antibiotics produces savings on those services, but overall the program is not successful in its broad impact in terms of lengths of stay, hospital admissions and unnecessary surgeries, then depending on the basic payment system upon which the savings enhancement is added, the primary physician group's revenue will go down.

Because of the real questions pertaining to enhanced profit margins, despite the apparent benefit of additional revenue, these forms of "pay for performance" not only fail to create a clear business case for the physician provider, but they also fail to line up the incentives for the other principal stakeholders—patients and employers. Those programs aimed at underuse only will appeal to patients who seek more services, but will increase overall costs in the short term, particularly pharmaceutical costs. In contrast, programs aimed at constraining overuse tend to be deeply distrusted by patients, but by lowering costs would serve employers and other purchasers' interests well.

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[10] McGuire, "As They Struggle to Improve Quality, HMOs Try a New Incentive: Bonuses," Jun 2001 ACP-ASIM Observer. www.acponline.org/journals/news/juno1/bonuses.htm

All of these features of the various pay for performance models are summarized in Table 1 below:

Table 1: **Comparison of "Pay for Quality Performance" Models**

	Tiered Q Bonus	**Threshold Q Bonus**	**Lower Cost Bonus**
Revenue to MD	Increased, but only for those in top tier	Increased for all who hit threshold	Uncertain: e.g., bonus could be offset by fewer RVUs
Direct time costs	Increased, due to measurement, documentation, and other burdens to assure bonus	Increased, due to measurement, documentation and other burdens to assure bonus	Uncertain, but probably increased due to systems to manage utilization
Other direct costs	Increased, because primary targeted conditions involve under use	Increased, because primary targeted conditions involve under use	Reduced, because principal target is overuse
Margin impact to MD	Uncertain: depends on whether group hits the top tier, the costs of getting there, and where the bonus pool comes from	Uncertain: depends on whether group hits the threshold, the costs of getting there, and where the bonus pool comes from	Uncertain
Primary Quality Target	Underuse	Underuse	Overuse
Patient impact	Better care, more services, less touch time	Better care, more services, less touch time	Better care, fewer services, less touch time
Payer impact	Higher costs in short term, unless bonus pool created out of general provider payment pool	Higher costs in short term, unless bonus pool created out of general provider pool	Lower costs in short term

Finally, while these programs are a good first step to begin to address the absence of direct recognition for steps to improve quality, they appear to be transitional and short-lived in terms of their potential impact. We would challenge advocates for these models to answer questions such as:

- In the threshold and tiered bonus programs, as the physicians respond to the incentive, once the vast majority of the patients have diabetes flow sheets, for example, what happens?

- If, in this example, the program then shifts to new quality targets, what will happen when the continuing costs of meeting the diabetes measure are no longer recognized?

- As more care becomes "bonusable," where will the money to create the bonus pools come from? (Note: Many physicians believe that even these first few bonus programs are being paid for out of the existing overall pool of payments to providers. There really is no "additional" payment.)

- If the bonus pools come from payors rather than merely shifting dollars among the physicians, will employers and taxpayers really accept increased costs, to get what they thought they were buying all along—i.e. high quality care?

- Will the focus on a few discrete measures cause physicians to achieve these targets at the expense of other, unmeasured, but perhaps even more important aspects of quality?

The real challenge is to develop a program which increases physician margins, improves quality and is sustainable over a longitudinal time frame. But for such a program to engage physicians, and not add to their administrative burden, attention must be paid to the disparate forces that prevent physician engagement on quality. For any such solution to have real value, it must (1) preserve and enhance the critical quality-relevant aspects of the doctor-patient relationship; (2) reduce administrative and regulatory burden; (3) propel the best science and improved outcomes, and do all of this in a dynamic and quickly changing health care landscape.

The Essence of the Doctor-Patient Relationship

To design a program which will have meaning for the diverse stakeholders in the system while it engages physicians, the first step is to focus on those aspects of the doctor-patient relationship which are central to health care quality. The fundamental transaction which occurs between physician and patient

> *"…as complex, multifaceted and enigmatic as it is can be captured in just three questions that people seek answers to when they are sick:… [P]eople basically look to their physicians to (1) explain nature: 'what is happening to me?'; (2) predict nature's future: 'what is going to happen to me?' and (3) alter nature's future for the better: 'what can be done to improve what happens to me' "* [11]

The core activity of the physician in relation to the patient is to "take information about health and transform it to a higher order of information, not just as an intellectual exercise, but to satisfy the three fundamental needs of explanation, prediction and

[11] Cohen, "Remembering the Real Questions," Annals of Internal Medicine, 128: 563-566 (April 1, 1998)

change."[12] As the IOM has noted, these interactions are so essential that the physician's capacity to explain and predict the patient's condition defines health care: "The transfer of knowledge is care."[13] High quality care, therefore, can only exist where that transfer is made in the most effective way. The third component, to change patients' futures for the better, is the application of science.

> *"For this is the real miracle that science brought to medicine. To truly alter the future, the doctor must have an effective craft – one worth knowing, not just a sham – and must use that craft with wisdom."*[14]

The broad application of evidence-based medicine, or "using all the science we know" is fundamental to improved quality.[15] To enhance the doctor-patient relationship where information is transferred based upon that evidence also requires an engaged patient. Patient engagement, as noted by the IOM, will require that patients

> *"…be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. . . The system of care should be designed to meet the most common types of needs but have the capability to respond to individual patient choices and preferences. . . Clinicians and patients should communicate effectively and share information based on the best available scientific knowledge."*[16]

Taken together, these features signal a shift to patient-centered care. Patient-centeredness combined with science is the quality goal of emerging health care policy articulated in "Crossing the Quality Chasm." It is these two fundamental precepts – evidence-based medicine and patient-centeredness – which define our new understandings of the essential aspects of the doctor-patient relationship and must be supported and propelled by any successful business case for quality.

In order to develop a better business case for quality, we must first have a real understanding of the forces which impede the goals of evidence-based, patient-centered care. Central to that understanding is an appreciation of the key role of *time* in developing the kind of relationships between physicians and patients that allow for truly patient-centered explanations, predictions, and evidence-based, effective care plans. In essence, any forces that steal time from this transaction undermine quality. Consequently, a focus on time-stealers in the doctor-patient relationship is critical to the design of any meaningful solution.

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[12] Reinertsen, "Healthcare: Past, Present and Future," Group Practice Journal 38 (May/April 1997)

[13] See CROSSING THE QUALITY CHASM, n. 4, above at 72.

[14] Reinertsen, n. 12, above.

[15] See CROSSING THE QUALITY CHASM, n. 4, above at 155-174

[16] Id at p. 8.

Time-Stealers

In the current health care system, there are countless such undermining forces: for example, Federal regulation of quality, reimbursement, and fraud and abuse alone has created a patchwork of both inconsistent and redundant quality controls which distract physicians from core activities by virtue of their compliance mandates.[17] When asked, "What are the main stealers of "touch time" for your physicians?" conference attendees cited four main aspects of the current system: (1) required documentation of many types – from patient encounters, to the medical necessity of a test, to requisitions for orders for services—almost all of which is not only clinically irrelevant, but is also confounded by conflicting purchaser and regulatory documentation requirements; (2) health plan programs and systems that are designed to control utilization, double check physician work, and provide redundant safeguards to the delivery of care including prior authorizations, patient encounter forms in addition to capitation payment, ministerial minutia such as certificates of medical necessity for durable medical equipment, inconsistent formularies among plans and repetitive and redundant credentialing; (3) administrative meetings and paperwork both to respond to hospital needs and hospital committees as well as in work to manage physician practices; and (4) messaging and work flow interruptions in general, including the need to dispense prescriptions, refill prescriptions, arrange patient discharge and interact with drug manufacturer representatives. All of these stealers of touch time reduce the potential for physicians to provide their patients with explanations, predictions, and healing—the essential elements of the physician / patient relationship.

In terms of discordant infrastructure and lost touch time, conference attendees also cited the lack of real-time information on which to act, paper-based records, few true systems to support clinical work, and the demands of coordinating complex care. Fear of liability, both from malpractice and federal regulation (fraud and abuse, false claims) and physician response in terms of defensive medicine, also ranked high as impeding focus on essentials.[18] (See Appendix B for a list of all time-stealers noted.)

Dominating this list is one theme: the essential clinical irrelevance of the payment systems with which physicians must contend. Current payment models create intense volume demands -- more patients must be seen in limited time thereby undermining the quality of explanations, predictions, and changed futures. Although some researchers

[17] Consider for example the "anti-dumping" rules governing physician on call responsibilities, federal false claims liability, Health Care Quality Improvement Act process requirements, the Office of the Inspector General's Model Compliance Guidance for Physician Practices and more, discussed in Gosfield, "Legal Mandates," n. 2, above.

[18] This anxiety has been found to lead physicians to limit new Medicare patients. Medicare Payment Advisory Commission, "2002 Survey of Physicians About the Medicare Program", http://www.medpac.gov/publications/other_reports/Mar03_PhysSurvRpt.pdf

have attempted to debunk this view,[19] conference attendees perceive clinically irrelevant payment to be a major problem. Not only do existing payment systems exacerbate loss of touch time, but the very core of the most common designs thwarts quality. Fee for service rewards overuse, and capitation rewards underuse.

It is noteworthy that there is consistency among both the barriers to a business case for quality and those forces which steal time from the doctor-patient relationship. Many are the same problem viewed from different perspectives. No wonder physicians are not engaged in quality initiatives. To engage physicians for quality, permit broader and deeper applications of science, and provide patient-centered care, basic aspects of the physician work environment must change. We propose five core principles to guide new approaches.

Five Principles for Change

(1) **Standardize:** Physician practice today is characterized by self-determined, idiosyncratic, custom-crafted approaches to clinical problem-solving. Highly individual styles of practice are not only tolerated but actively supported by physician office operations, support systems, and hospital medical staff policies. There are currently excellent ongoing efforts to systemize and reorder basic aspects of physician office design to further quality goals.[20] While much can be done to make physician clinical practice more efficient from a business point of view, one broad change concept--standardization of clinical care to evidence-based medicine, supported by efficient and simple documentation techniques--would make a profound change in the clinical quality of care provided by physicians, while simultaneously giving them a major return--*time.*

While this principle--standardization—is a potentially powerful driver of quality and efficiency, it also faces a potent obstacle within the culture of medicine: autonomy. Documentation templates, standing orders for specific clinical conditions, and other mechanisms of standardization require physicians to give up some individual clinical autonomy. In essence, in order to take advantage of this principle, physicians would need to undergo a major professional change—to begin to practice evidence-based care as a team, rather than as individuals.[21]

While the opportunities to standardize care are often more obvious for treatment plans than they are for diagnostic evaluations, there is still an enormous amount of care that could be improved by standardization to the evidence. Most important, this principle—"standardize what is plainly standardizable around the science of medicine"--would likely free up considerable amounts of time for physicians to build relationships

[19] Mechanic, McAlpine and Rosenthal, "Are Patients' Office Visits with Physicians Getting Shorter?", NEJM 344: 198-204 (Jan 18, 2001)

[20] See "Idealized Design of Clinical Office Practices" at www.ihi.org/idealized/idcop/index.asp

[21] Reinertsen, "Zen and the Art of Autonomy Maintenance," Annals of Internal Medicine. (in press)

with patients, and to practice the patient-centered, custom-crafted art that is also essential to high quality care.

Physicians have long decried standardization of their methods as rigid, cookbook medicine. Yet cooks use recipes, airline pilots use checklists, and every physician in America has read and likely has on his shelf right now a clinical textbook which sets forth appropriate treatment for specific conditions. Many of the efforts at clinical standardization to date, have been imposed on physicians from without – by PSROs[22] and PROs[23] in norms, criteria and standards[24], by health plans in Milliman and Robertson guidelines[25], by hospitals based in utilization review committee imposed InterQual criteria [26] and are therefore suspect in their eyes. Today, it is abundantly clear that physicians need to recover time in their day for many reasons. Standardization ought to be fervently desired by them to reorder their approach to their patients, their staffs, and their business significant others (hospitals, systems, payors and health plans) – not only for the high social good of improved health care quality but for the self-interested purpose of improving their own work context. Physicians who step up to initiate these efforts will have far better control over their destinies.

(2) **Simplify:** The multiplicity of health care management initiatives imposed on physicians and the complexity and array of payment and administrative systems with which they must comply to get paid are daunting. The true extent to which this complexity distracts from real quality initiatives is not known, but it is repeatedly cited by physicians and health care leaders as problematic. The sheer volume of requirements and the convolutions they require to respond steal time and resources from truly essential functions. The conference attendees were very clear on this point: if there were a design that could simultaneously simplify the physician work environment, regulatory requirements, market demands, and contractual obligations, consistent with fundamental principles of quality, such a design would be a deep, compelling force for positive change in the delivery of health care.

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[22] Professional Standards Review Organizations established in 1972 to review the cost and quality of Medicare and Medicaid services which were then supplanted by Utilization and Quality Control Peer Review Organizations (PROs).

[23] The review organizations established in the Social Security Act (42 USC 1320c et seq) which review the cost, quality and appropriateness of services paid for my Medicare which have now been relabeled as Quality Improvement Organizations (QIOs). For more information see, Gosfield, "Utilization Management, Quality Assurance and Practice Guidelines," pp 25-1 to 25-80, Chapter 25 American Health Lawyers Association, HEALTH LAW PRACTICE GUIDE, West Group, 2002.

[24] Required by the PRO law, these measures of care were supposed to be established and used by PROs to review the care provided by physicians and institutions as well as Medicare+Choice organizations.

[25] Proprietary indicators of care published by the private company, Milliman and Robertson, initially as indicators for optimal care which were adopted by many managed care organizations as the basis for their review of medical necessity and eligibility of care for payment.

[26] Indicators by severity of illness of the intensity of services appropriate for certain services published by the private company InterQual and widely used by hospitals in utilization review.

(3) **Make Clinically Relevant:** Much in the physician work environment that purports to be intended to enhance quality, provide safeguards and lead to appropriate practice incentives is not only clinically irrelevant, it is meaningless to evidence-based, patient-centered care. For example, clinical documentation of services to support evaluation and management (E/M) codes[27] for a visit has been required purely to substantiate to a post-payment auditor the level of visit rendered. The notations required have little meaning to physicians in their treatment of the patient, nor do they reflect anything about evidence-based care of the patient's specific clinical condition.

Fee for service payment, while traditional and familiar to physicians, rewards volume with no reference to clinical appropriateness or medical necessity, and affirmatively masks problems of misuse, underuse and overuse. While physicians are accustomed to managing within its requirements, fee for service does not necessarily reflect the way physicians think in treating patients, nor does it reflect anything about what *should* be done to treat a given patient.

Capitation in its typical form – per member per month payment to a clinician or group for a broad scope of services – similarly bears little relationship to evidence-based medicine. Based on actuarial principles of insurance premium construction, it takes into account past performance, whether it was good, bad or inappropriate, and projects it forward based on some assumptions regarding incidence of conditions within the projected population. Its incentives are so broad – "if you provide unnecessary care to some there will not be enough money to pay for appropriate care for others" -- as to have little clinical meaning. Capitation also gives to the physicians a risk they cannot control in any way – incidence risk: the risk of inaccurate assumptions regarding occurrence of clinical conditions in the covered population.

Many have observed that capitation does motivate prevention because it rewards physicians for healthier populations who do not use physician services. But beyond that there is little which has been shown, even today, regarding the *clinical* incentives of capitation. Studies have at least demonstrated that there are few outcomes differences between care delivered to patients where reimbursement is on a fee for service versus capitated basis[28], but these comparisons may well amount to damning with faint praise: If these payment methods were either intended to produce high quality or even appropriate care, or actually did so regardless of intent, there would be no question about a business case for quality. Variations of these basic payment models such as percent of premium risk assumption as a form of capitation or fee for service within a targeted budget, merely reconfigure the same incentives and still do not propel quality.

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[27] Cognitive services described by procedure codes and adopted by Medicare to be substantiated as to the scope of the visit performed by a physician in accordance with specified documentation criteria.

[28] See AAHP, "Health Care Quality: Utilization of Health Services," www.aahp.org/Content/Navigationmenu/About_AAHP/For_Consumers/Fact_Sheets_About_Health_Plans/hcqoutcomes.pdf; Schuster, McGlynn and Brook, "How Good is the Quality of Health Care in the United States?" The Milbank Quarterly 76: 517-563 (1998)

To pay physicians explicitly for the costs of caring for patients for clinical conditions according to evidence based care and to make the documentation requirements associated with payment consistent with those goals, would present a major change in the system that could not help but improve the delivery of care.

(4) **Engage Patients:** Each individual patient represents a unique combination of health conditions, support resources, and care preferences. Still further, few patients come to physicians with a single diagnosis; most who represent the bulk of resource consumption in the health care system present with multiple conditions – e.g., diabetes with hypertension with coronary artery disease (CAD). Furthermore, the individual aspirations, fears, beliefs, and risk tolerance levels of each patient must be taken into account when devising patient centered care -- a truly personalized care plan. As a result, actuarial science and risk adjustment methods will never be able to predict with precision the costs of high quality care for any one patient. The "clinical relevance" principle described above, therefore, needs to be balanced by a patient-centered approach in which the patient is presented with evidence-based options, and then the patient and physician together work out a care plan based on the evidence, filtered through each individual patient's personal lens. A payment model that could be founded at its core on the costs of providing evidence-based care, but modified to accommodate individual patient goals and treatment preferences, would be a strong driver of improved effectiveness, patient-centeredness, and efficiency.[29]

(5) **Fix Public Accountability At the Locus of Control:** Transparency – open information about the performance of the system, including physicians' quality -- is a core tenet of "Crossing the Quality Chasm." Although physicians have increasingly become the subjects of report cards, performance measurement, and publicly reported evaluations,[30] they decry many of these efforts because they focus on measures the physicians do not feel they can personally control. Furthermore, the report cards often rely on inaccurate or inadequate data, usually at the plan level. While some physicians lament any public accountability as not sufficiently risk adjusted – "my patients are sicker so my results are worse and the comparison is therefore unfair" -- we would postulate that in a system where the first four principles—standardization, simplification, clinical relevance, and patient-centeredness--are brought to bear, physicians would be more likely to be willing to step up and be held publicly accountable, in particular, for those aspects of care which they can control: (1) their application of evidence-based medicine; and (2) the patient-centeredness of their care – the quality of their doctor-patient relationships. Moreover, it is important to distinguish those quality features for which individual physicians can be held accountable (i.e., their application of knowledge of the craft of medicine, and the quality of the relationships they build with patients) and those quality attributes which reside more at the level of groups of physicians (group practices, PHOs, and other organized systems of care) for

[29] Mulley, "Assessing patients' utilities: can the ends justify the means?" Med. Care 1989;27:5269-5282

[30] See Gosfield, "Health Care Report Cards: Quality in the Public's Cross Hairs," HEALTH LAW HANDBOOK pp 501-542 (A. Gosfield, ed. 2000) West Group.

which, more appropriately, the group should be held accountable. Accessibility of members of the care team to the patient, the effectiveness of communication among the multiple providers addressing the patient's needs, the broad application by the group of clinicians of evidence-based care for each patient, and very often the true clinical outcomes of care are vital aspects of the quality of the care provided, but do not rest solely within the control of a single physician. In essence, taken together, physicians should be held accountable for practicing the science of medicine as teams, and the art of medicine as individuals. The application of the first four principles makes these distinctions possible and potentially more measurable at the proper locus of responsibility.

The Unified Field Theory

Each of these five principles is powerful in its own right. Widespread application of any one of them would change significant aspects of health care in this country. But to bring them all to bear simultaneously would transform the health care system. The concerted coordination of the principles permits the development of a unifying theory of how to reorder fundamental aspects of health care delivery in payment, documentation, administrative systems, public accountability, infrastructure development, personnel administration – indeed throughout the health care system-- that can lead to more evidence-based, patient-centered care. Linked to payment, a unitary platform for health care system design would make a strong business case for quality—one that would engage the hearts and minds of physicians.

Any model that proposes to simultaneously standardize the science applied to care, simplify the work environment and make payment and administrative systems clinically relevant to patient-centered delivery of care, requires that we address evidence-based medicine (EBM) or clinical practice guidelines (CPGs). While there are disputes regarding the significance of these two terms, in general they reflect differences in the strength of the evidence upon which they are founded. EBM relies explicitly on evidence in the literature regarding effectiveness and appropriateness of care. CPGs as defined by the Institute of Medicine are "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances,"[31] which may be based on evidence or consensus. The IOM described eight attributes of good CPGs, including that they describe the quality of the evidence upon which they are based. Where peer reviewed data or randomized controlled clinical trials are not available to address the care at issue, a good CPG will still go a long way toward improving the individualistic, atomistic approach to care delivery which typifies physician practice today. Consequently, reliance on either EBM or good CPGs creates a strong foundation on which to standardize, simplify, make clinically relevant and patient-centered, and above all pay for the clinical care we seek to encourage.

[31] Field and Lohr, GUIDELINES FOR CLINICAL PRACTICE: FROM DEVELOPMENT TO USE. National Academy Press, 1992, at p. 27.

(1) **CPGs Applied**

A CPG for a common condition can become much more than simply a specification of the care that should be given. It can also be a template on which to simplify the physician's work environment and reduce administrative burden. For example, CPGs can drive the creation of standard care processes, patient information handouts, and referring physician communications, for all the physicians and staff in a given office. Moreover, a good CPG can be translated into both the applicable diagnostic codes it incorporates and the CPT codes[32] describing the services to be provided. That means that CPGs can be used to speak in traditional payment terms to payors to substantiate care delivered, while simultaneously improving the physician work environment and patients' outcomes. Finally, a CPG, well-applied, can save time for physicians, and therefore increase their opportunity to listen, explain, and comfort—not just provide evidence-based care.

All good CPGs make clear what evidence in the medical record (documentation) would support conformity of the care with the CPG. A good CPG would therefore allow the creation of documentation templates for standardized care for that condition. Deviations from CPGs should be expected, and ought to be anticipated in designing templates. In fact, such deviations are often important opportunities to learn about how to improve CPGs.[33] Furthermore, if the CPG is agreed to by both physicians and payers, recording the medical necessity of what is in the CPG becomes superfluous, since the medical necessity of the services is inherent in the evidence/consensus based determination of appropriate treatment which the CPG sets forth.

To the extent that good CPGs are an evidence-based description of *what* should be done, rather than *who* should do it, use of CPGs would allow care delivery systems to address the question of "highest and best use" of the various members of the professional team responsible for the patient's care. Standardizing aspects of care permits care systems to deliver more of the care using well-trained, but less expensive professionals, and can fortify the business case for quality.

Other positive effects of using CPGs to drive care delivery would turn on making this approach the explicit contractual basis for providing care. In this case, the quid pro quo is that the physicians agree to standardize to the evidence and the payor agrees to eliminate intrusive, time stealing medical management programs, like prior authorizations for tests, procedures, or anything on the continuum of care in the CPG. Some CPGs state the applicable frequency of office visits, as in the guideline for treatment of chronic asthma in patients over age 5 published by the Institute for Clinical

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[32] Common Procedure and Terminology manual published by the American Medical Association which is the basis for describing most physician services for fee for service payment purposes.

[33] East, Bohm, Wallace, et al. "A successful computerized protocol for clinical management of pressure control inverse ratio ventilation in ARDS patients." Chest 1992; 101: 697-710

Systems Improvement[34]. Others are less explicit. Whether they address frequency of office visits or not, a good CPG can define a longitudinal course of treatment during which time, so long as the physicians treat in conformity with the CPG or document good reasons for not doing so, a CPG applied in this way can obviate much of the prior justification, concurrent explanation and post hoc administrative hassles currently defining the physician environment. Further, to require neither documentation of the medical necessity for each encounter, nor the scope of individual evaluation and management services, nor the need for each procedure performed, would save substantial time, administrative burden and associated expense. Eliminating restricted formularies because proper pharmaceutical choices are covered by the CPG would save even more time and expense. Such an explicit contract would get intrusive inspection systems out of the way to free physicians to do what we need and want them to do. It understates the case to say that such changes would be significant improvements in the physician work environment and would drive increases in "touch time."

Now imagine taking the time saved by standardizing care to the science, applying principles of "highest and best use," reducing administrative burden, and using that recaptured time to actively engage patients in making choices about goals and alternatives using those CPGs as frameworks. The resulting evidence-based, patient-centered care plan could not only simplify the context in which payment is made, it could drive the actual amount of payment.

(2) **Evidence-Based Payment**

The real power of this approach to organizing care lies in the ability to price the services provided because by this approach it is possible to determine literally what it should cost to deliver evidence-based, patient-centered care to each patient, for that patient's particular combination of conditions. The actual costs of care are not only the fixed costs associated with the setting in which care is delivered (in the office this is the heat, the light, the rent, the water, the basic examination room equipment), but also the variable cost of supplies (tongue depressors, syringes, sputum cups, finger cots, eye drops, sutures, etc) and equipment (the various scopes, sphygmomanometers, speculae, spirometry machines, laboratory auto-analyzers, etc) which the physician practice must use to treat specific conditions. The biggest category of costs, however, is the cost of the people – including physicians (see p. 34 below) – needed to perform all the care-related actions such as scheduling, examining, advising, treating, documenting, coding, billing, measuring, and complying with contracts and regulations. A good CPG defines what services are to be brought to bear to treat the patient, and therefore provides a roadmap to analyzing all the actual costs (fixed, variable and staffing) of that care.

[34] Institute for Clinical Systems Improvement Asthma guideline at www.icsi.org/knowledge/detail.asp?catID=29&itemID=162

This approach to pricing care is based on medical science and cost accounting, rather than actuarial science. It is a revolutionary idea; and depends on something that is not commonly found in care delivery organizations: good systems to determine the actual costs of caring for individual patients and conditions. Even in the most sophisticated physician practices, the managers, and sometimes the physicians, may know what their 'overhead ' is – how much they pay in rent, salaries, dues and subscriptions, their computer systems and software licenses, supplies, capital purchases and their malpractice expenses, but they almost never can tell you what it costs them to treat a patient for a condition. As a result, most of their negotiations over payment rates are conducted in the dark, from both the payor's perspective and the physicians'. Neither party knows whether the negotiated rates are sufficient to support the care which the payor has contracted to provide under the insurance premium and the physicians have agreed to provide for the payment made. And, since these negotiated rates are based on actuarial projections which are themselves based on a mix of overused, underused and misused services, the resulting payment amounts have no relationship to the costs that might be incurred by delivering evidence-based, patient-centered care.

While this "pay for the cost of doing a CPG" approach lends itself most logically to case rates – a single payment to a physician group to treat a patient for a specific condition over a period of time -- it can be used in other ways as well. It can form the basis for merged case rates involving physicians and hospitals, where the CPG-based approach would make it crystal clear what the physicians' actual costs are in treating the patient, (always a major stumbling block where physicians and hospitals are paid together). Where enough CPGs can be brought to bear, a roll up of CPG-determined costs, modified by good incidence data for the insured population could be used to construct risk adjusted capitation for specific segments of care which would finally reflect actual patient treatment needs. The most significant aspect of the "unified field theory applied" (UFT-A) to payment is not how the resulting cost information is tallied and reallocated, but that the payment for care is based both on evidence based clinical needs, and on the actual costs which would be incurred by a specific group to meet those needs.

To be more precise, this is not physician diagnosis related groups (DRGs)[35] or ambulatory payment categories (APCs)[36] modified by CPGs. DRGs were constructed based on past resource consumption frozen at a moment in time to analyze where there were similar patterns of expenditures or costs which could be grouped and rates constructed around them. The development of DRGs was driven by cost-reporting by hospitals and not by anything having to do with evidence-based patient care. In essence, like premium construction, DRGs reflected whatever was done at the time they were

[35] Medicare's system for paying hospitals which groups admissions by diagnoses that entail similar resource consumption and generally pays for all cases in each group on a single flat rate basis regardless of length of stay or actual resources consumed, except for unusual circumstances which qualify as recognized outliers.

[36] The Medicare payment system for outpatient services which follows many of the conceptual principles of DRGs applied in an outpatient context.

created, and therefore include a mix of appropriate use, misuse, overuse and underuse. UFT-A for payment is not about contact capitation[37] which pays a per member per month payment to a specialist, not for an assigned panel of patients, but each time a patient actually presents on referral from the primary care physician. That method is simply a variant on actuarially determined capitation, and like DRGs, has little to do with what it would cost to do evidence-based care. The substantial difference between all other approaches to date and UFT-A applied to payment is that this payment model reflects evidence based care in very explicit terms, taking into account actual costs, to the extent they can be quantified, to treat a patient for a specific condition or constellation of conditions.

Now let us consider the changes in the quality of care delivered, the interaction between doctor and patient, the improved context for physicians and the potential payment impacts represented in the following example of UFT-A used for care design, payment, documentation and accountability based on these principles:

Case Example

Consider a 59 year old woman with diabetes, a prior myocardial infarction with significant loss of left ventricular function, and moderate congestive heart failure (CHF), with one previous admission for acute CHF. Under UFT-A, she meets with her physician, who presents an outline of the evidence-based approaches to her situation, including aggressive insulin therapy, exercise and weight control, lipid management including statins, and enrollment in a nurse-run CHF management clinic, operated jointly by the hospital and the medical staff. He gives the patient some videos and other materials about these conditions, and asks her to view them, think about them for a week or so, call him with any questions that come up, and to choose some goals and treatment options.

After considering the pros and cons, at her next visit with her care team she sets the following goals for the next year: to maintain her hemoglobin A1C level under 7.5, blood pressure of 130/85 or better, weight under 140 pounds, total cholesterol under 200, low density lipoprotein (LDL) under 130, and to avoid any episodes of CHF requiring hospitalization. The care plan is to implement the core elements of the diabetes, CAD, and CHF CPGs. The costs for the implementation of these processes have previously been estimated and agreed upon by both the physician's practice and the health plan. The goals and plan, signed off on by the patient, are entered into a pre-designed template, and communicated to the health plan, all members of the care team, and the patient.

The annual costs of delivering the care plan are totted up, and a monthly payment is made to the care team as long as the patient remains under their care. Any unforeseen events (e.g. the patient falls and breaks her leg, or notices a worrisome breast lump

[37] Carlson, "Contact Capitation and its Cousins," Managed Care, Nov. 1997, http://www.managedcaremag.com/archives/9711/9711.capitation_part2.shtml

which generates a separate, major investigation) would be paid for using conventional payment approaches such as fee for service, or per diem, etc. The template outlining the care plan would be used to drive the delivery and documentation of the care, as well as to measure and establish accountability for the outcomes of the care.

As to accountability, each part of the system would be responsible for what is most directly under its control, at both the process and outcome levels. In the example given, the patient would be responsible for weight control and for remaining engaged in the overall care plan. The individual physician would be responsible for the process measures in doing the CPG (timely hemoglobin A1C measurements, for example), and for the patient's perception of the quality of the relationship with the physician. Finally, the care delivery system (the group practice, PHO, or other aggregation) would be responsible for achieving the outcomes of care—in this case, the goals set by the patient: Hemoglobin A1C levels, avoidance of admissions for CHF, etc.

Over time, as new evidence regarding treatment advances emerged, it could be reviewed by the patient, care team, and payer at any time, and the plan modified accordingly, with appropriate changes in goals, care process design, documentation templates, and payment. In any event, the care plans would be reviewed and updated annually.

While this example of the application of UFT-A to payment glosses over some of the significant implementation issues which are discussed below (see p. 34 below), the point is that such an approach applies the five principles enumerated above as necessary to create a business case, places science and the patient at the center of the undertaking and still cannot help but save time and administrative burden for the physician.

Now let us contrast this approach with the earlier described pay for performance quality bonuses to demonstrate why we think UFT-A has better longitudinal vitality. We also believe it has better inherent safeguards against the "be careful what you measure" syndrome, where what is being measured will result in the distortion in care delivery, particularly that care which goes unmeasured, in order to garner good scores or bonus payments. The essential difference in UFT-A is that it is consistent with evidence-based treatment for a meaningful period of time for a specific patient condition. It is focused neither on overuse nor underuse, but addresses both, along with misuse, letting the payment chips fall where evidence-based, patient centered care plans say the chips should fall. For many chronic conditions, where underuse of valuable services is the norm, costs and payments (e.g. for underused pharmaceuticals) would increase. For other conditions, where overuse is the norm, costs and payments would decrease. If, as Wennberg and others would indicate, overuse dominates underuse, [38] the wide application of UFT-A would decrease overall costs to employers and taxpayers. Furthermore, patients who make informed choices about alternatives in care tend to be

[38] Fisher, Wennberg et al: "The implications of regional variations in Medicare spending, parts I and II." Ann. Int. Med. 138; 273-298, 2003

more conservative than physicians[39], and so the engagement of patients in the process of choosing goals and care options will also tend to decrease costs.

If, under UFT-A, payments rise for currently underused services, and drop for overused services, what might the net effect be on physician practice margins? Physician groups paid on this basis would find that their variable expenses would increase as they corrected underuse problems to provide EBM, while variable expenses would decrease in overuse situations. On the revenue side, revenue would increase where the group has been not doing enough and would decrease where the group has been doing too much or something inappropriate and more expensive than necessary. But standardization of care in a CPG-based approach would allow the group to redesign care delivery to focus on the highest and best use of physicians, working as a team with other clinicians – nurses, therapists, physician assistants. This would very likely reduce overall expenses. Finally, if physician practices could standardize and simplify both their care processes and documentation techniques, and could coordinate their billing systems and office work flow to reflect the UFT-A model, other operating overhead costs, and physician and staff time costs would likely decrease dramatically, and practice margins would therefore improve. These effects are summarized, and contrasted with other pay for performance models, in Table 2, below:

[39] Mulley n. 29 above

Table 2: Pay for Quality Performance contrasted with UFT-A

	Tiered Q Bonus	Threshold Q Bonus	Lower Cost Bonus	Pay cost of doing patient-centered CPGs (UFT-A)
Revenue to MD	Increased, but only for those in top tier	Increased for all who hit threshold	Uncertain: bonus could be offset by fewer RVUs	Increased for under use, decreased for overuse
Direct time costs	Increased, due to measurement, documentation, and other burdens to assure bonus	Increased, due to measurement, documentation and other burdens to assure bonus	Uncertain, but probably increased due to systems to manage utilization	Significant decrease, due to standardization, simplification, highest and best use of staff
Other direct costs	Increased, because primary targeted conditions involve under use	Increased, because primary targeted conditions involve under use	Reduced, because principal target is overuse	Increased for underuse, decreased for overuse (in proportion to revenue)
Margin impact to MD	Uncertain: depends on whether group hits the top tier, the costs of getting there, and where the bonus pool comes from	Uncertain: depends on whether group hits the threshold, the costs of getting there, and where the bonus pool comes from	Uncertain	Increased (assumes significant decrease in direct time costs)
Primary Quality Target	Underuse	Underuse	Overuse	Over, under, misuse
Patient impact	Better care, more services, less touch time	Better care, more services, less touch time	Better care, fewer services, less touch time	Better care, more or fewer services but patient chooses care plan, more touch time
Payer impact	Higher costs in short term, unless bonus pool created out of general provider payment pool	Higher costs in short term, unless bonus pool created out of general provider pool	Lower costs in short term	Higher costs for underuse, lower for overuse, but net lower costs because of predominance of overuse, and effect of informed patient choice

(3) **Advantages**

UFT-A would have a number of positive benefits for patient care, physicians, and other stakeholders such as employers. The more EBM is brought to bear throughout the physician environment – in payment, documentation, billing systems, and public performance reporting – the more it encourages uniform clinical management of patients. The entire approach speaks to physicians the way they think and treat so it is easily understood. UFT-A would increase touch time by comparison with the jumbled, quality-impeding work environment physicians experience today. The broad application of these principles would permit patient-centeredness to rise to the fore as a bedrock value in delivering care because it would, among other things, allow time for those engagements around science and patient preference. A major benefit of this model would be reduction in documentation requirements, because explicit reliance on well-articulated CPGs essentially eliminates the need to document medical necessity and scope of services. It also virtually eliminates the fraud and abuse liability that turns on false claims, over-utilization, absence of medical necessity, poor quality, and over response to managed care incentives. To organize and deliver care in this way would enhance physician efficiency while improving quality of care—a value proposition in itself.

By explicitly defining the standard of care, it addresses both expensive defensive medicine and physician fears of malpractice liability by eviscerating malpractice actions, which always turn on whether the physician deviated from the standard of care. Where care conforms with EBM, a malpractice case is extremely difficult to make in the event of mere therapeutic misadventure. Encouraging the patient to make informed choices about goals and therapeutic alternatives, in order to create personalized care plans, would also dramatically decrease the likelihood of malpractice actions, both by promoting excellent patient / physician communications, and by increasing the patient's understanding of the realities and risks of the disease and care processes. Also, since time that was once spent in documentation, billing, and other activities might now be spent in "touch time," it is likely that better therapeutic relationships will exist, and reduced malpractice risk would follow. Finally, if the point of the whole undertaking is to reduce over, under, and misuse, and therefore to produce better outcomes, UFT-A would lower the overall risk of mishaps and harm.

If physicians dealt with managed care plans and other payors on this basis, they would stand a far better chance of eliminating intrusive medical management programs which inspect their care after the fact, thereby further saving time and expenses spent in responding to those often conflicting and overlapping initiatives. Where physicians applying UFT-A measure their conformance with the selected CPGs, design care plans based on patients' choices, analyze the implications of the outcomes, and refine their behavior, not only could physicians create a method for learning how to improve care, but they would also finally have available meaningful data upon which to base their negotiations with plans.

(4) **Boundaries of UFT-A**

This unified field theory applied in this way is not a panacea for everything that is wrong with health care, nor is it proposed as a vast revolution for the entire health care system. Many physician groups would not be able to work in such a manner. This approach would find its best outlet among those groups which are both already moving on the road to quality using quality principles such as standardization and simplification in their practices, and are also willing to step up and be both measured and paid on a different basis. This approach, at least initially, will only work for innovators and is not proposed for legislative reform. It is intended to provide a basis for those who are capable of performing better to be recognized for doing so. In essence, it creates a business case for better quality for those who can produce improved evidence-based, patient-centered care.

UFT-A will not work for all patient conditions. It makes no sense, even if there is evidence or good CPGs on point, to pretend that a payor is likely to be willing to approach a physician group in this way for a relatively low cost, simple treatment such as urinary tract infections. Rather the win-win in this approach will most likely be found for those twenty-percent (20%) of patients which generate eighty-percent (80%) of costs in their utilization of services to meet their chronic care needs.

The discussion here sets forth an untried approach to care. We believe that many new ideas in health care have faltered in the past because of grandiose implementation strategies and a desire to create programs for the vast middle of the system – the average player for whatever strategy is at hand. We believe this theory will also fail if it is interpreted to apply broadly without evaluation and data. We believe that at the outset it should be attempted in short-term, small-scale trials in settings where there is the capacity to try "small tests of big ideas," with subsequent cycles of learning and refinement. We believe it is important to state explicitly that such learning cycles, and this overall approach, could be used by some physician groups, but not by others, based on the cultures, systems, and quality capabilities of the groups. At this point in health care's history, we strongly believe it is time for employers, payers, and regulators to acknowledge that some physician groups will be better able to demonstrate the evidence-based and patient-centered care that the IOM papers call for, and others are not ready to do so. Those that can should be financially recognized and rewarded appropriately for doing so. UFT-A implemented should begin as a niche program for selected, innovative, high-quality physician organizations. Over time, as we learn from its impacts, we may find ways to apply it to less sophisticated medical groups, but today it will be better to start small and smart.

Even in the absence of major payment reform for any physician group, we do believe still that standardization and simplification are worth physician effort because those principles in practice will save time and increase efficiency while they improve care. Anything which lowers the administrative burden on physicians today will enhance the capacity of the system to be patient-centered at the place it most matters, the

interface between doctor and patient. In addition, reduced administrative burden through standardization also lowers expenses.

But this approach to payment and care delivery is not limited in its positive potential only to physicians. Its approach to unifying significant aspects of medical care based upon clear clinical principles can have power for those who are the physicians' significant business 'others' – namely, hospitals and health plans.

(5) **Effects on Others**

In the era of creating integrated delivery systems after failed Clinton health reform, hospitals sought to create 'a seamless web of the full continuum of care' by purchasing physician practices, ancillary providers (like home health agencies and durable medical equipment suppliers) and other facilities providing varied levels of care. Much of the fantasy associated with these schemes turned on clinically managing a full continuum of care, in a risk-assuming financial context. Virtually none of it ever materialized. These strategies ended up being more about merger and acquisition lawyers' workloads and unsuccessful physician practice ownership than anything having to do with clinical care delivery. The failures of most of these efforts, and some quite spectacularly[40], have done nothing, however, to eliminate the impetus behind them.

Hospitals have no business to conduct without the physicians who admit patients to them and order the hospital's services. Hospitals are eager, therefore, to encourage physician loyalty. They also have cost pressures of their own which can be exacerbated or improved by physician actions that recognize the financial implications of their orders. This latter phenomenon led to the development of 'gainsharing' programs whereby hospitals would share with their physicians a piece of the savings they generated from helping the hospitals lower their costs.[41] At first almost completely rejected by the Office of the Inspector General as violative of the anti-kickback statute, and then slightly resuscitated in a single approving Advisory Opinion[42] for one such program, hospital-physician gainsharing is at best a short-lived strategy. Once the physicians have reduced the hospital's costs to minimally acceptable levels, there are no more savings to share. UFT-A offers several opportunities for hospitals and physicians to work together in significant ways that advance the physicians' interests while fulfilling the hospitals' agenda--and all in furtherance of improved quality.

UFT-A is a case in which, astonishingly, the Stark regulations offer a real, positive option. Generally speaking hospitals are forbidden to provide economic benefits to their

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[40] Burns, "The Fall of the House of AHERF," 19 Health Affairs 7 (2000).

[41] See Gosfield, "Making Quality Happen," n. 9 above and King and Louthian, "Gainsharing – Life Before and After the Bulletin", pp 195-214, HEALTH LAW HANDBOOK, (A. Gosfield ed. 2000) West Group

[42] OIG Advisory Opinion No. 01-1, http://oig.hhs.gov/fraud/docs/advisoryopinions/2001/ao01-01.pdf (Jan 18, 2001)

referring physicians (who refer Medicare and Medicaid patients) unless that financial relationship conforms with an explicit Stark exception. In the final Stark phase I [43] regulations there is an explicit exception for hospitals to provide compliance training which under the regulation means

> *Training regarding the basic elements of a compliance program (for example, establishing policies and procedures, training of staff, internal monitoring, reporting) or specific training regarding the requirements of Federal health care programs (for example, billing, coding, reasonable and necessary services, documentation, unlawful referral arrangements.)*[44]

CPGs applied as the foundation for billing, coding, and determining reasonable and necessary services serve exactly these purposes in addition to quality. Compliance programs which reflect these principles can be far more integrated into the day-to-day mission of the hospital rather than a separate department of internal inspectors who play "gotcha" with the hospital staff. Hospitals can provide training in these activities to their physicians which will advance both of their interests. This kind of effort will have far more impact on the physicians themselves and is more sustainable over time than any gainsharing programs.

Another aspect of the vital connection between hospitals and their medical staffs is the need to have an organized medical staff in the first place. Required by law and accreditation, this aspect of hospital-physician interaction has lagged in many ways in recent years as medical staff physicians, challenged by reduced payments, increased administrative burdens, and pressures already discussed, find themselves not very eager to do the hospital's work. Many medical staffs around the country have stagnated as they work only on credentialing issues, if they engage in any quality activities at all. UFT-A applied consistently within the hospital to drive its processes, documentation principles, flow and organization could provide a significant basis on which to revitalize the medical staff. To reframe the purpose of medical staff activities in this way would make the work of the hospital and physicians more consistent, more seamless and more powerful from a quality perspective.[45] When the medical staff works with the hospital to design how UFT-A can be applied in the facility, not only will the hospital's costs be mediated, but the physicians' working environment can be improved there as well, by focusing on highest and best use, clinical relevance and standardization of hospital processes of care. That the medical staff is critical to the hospital's ability to implement such initiatives is obvious. A medical staff organized around designing and

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[43] The Stark regulations are being published in two phases. The first segment was published on January 4, 2001. Some features of the Phase 1 regulations may be changed when phase II regulations are published.

[44] 42 CFR §411.357 (o)

[45] See Gosfield, "Whither Medical Staffs?: Rethinking the Role of the Staff in the New Quality Era". pp 141-217 HEALTH LAW HANDBOOK (A. Gosfield. ed, 2003) West Group; Reinertsen, "It's About Time: What CEOs and Boards Can Do for Doctors, Nurses and Other Health Care Professionals," Doctors Management and Quality Improvement Report 2:1-7 (April 2002), www.reinertsengroup.com/article02.htm

implementing the best evidence-based care practices, as a team activity, would serve both the physicians' and the hospital's needs.

The hospital could also pick up the UFT-A gauntlet in a different way – to reorient its fundamental organization. If the hospital's infrastructure including computerized physician order entry (CPOE), other information technology for documentation, policies and procedures, hiring and personnel allocation within the facility, capital expenditures and administrative organization were to reflect the principles of explicitly articulated CPGs, hospitals and their physicians would work together far more effectively to benefit patients and improve quality of care. The result might well be better coordinated care to meet the needs of the patients, which, after all, is the hospital's core mission.

For health plans, adoption of UFT-A in collaborative relationships with physicians would make the health plan's programs meaningful to physicians and a positive force in their practices. To assist physicians to drive to quality in this way by adopting payment reflecting evidence, clinical relevance and lowered administrative burden can lower the plan's own expenses while permitting it to market credibly for quality. UFT-A applied in the health plan context would fundamentally change the relationship between physicians and plans. In the furtherance of these goals, it is noteworthy that the ways in which physicians can come together in relationship to a health plan can strengthen the whole undertaking.

One of the barriers to a business case for quality, as noted by the conferees, has been insufficient group integration to be able to develop programs and systems to standardize, simplify and make clinically relevant the physician work environment. Yet, the antitrust laws have impeded many efforts that might have been mounted among physicians within a community because of the mythology that the only integration which permits otherwise competing and independent physicians to speak as one with plans is financial integration in the form of a single practice group or significant financial risk assumption by the physicians in an IPA, for example. While the mandates of financial integration have eluded many physician groups who have tried them, and in some markets these approaches are not available because health plans won't contract on that basis, in fact, the antitrust regulators have provided a major boost to an approach like UFT-A in their recognition of 'clinical integration' among otherwise competing physicians in a market. This approach, which permits collective bargaining for fee for service payment, was published in 1996[46] but has received scant attention and even less review. To date, there is only one opinion that the FTC has issued approving a clinically but not financially integrated physician network.[47]

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[46] "Statements of Antitrust Enforcement Policy in Heath Care, Issued by the Justice Department and Federal Trade Commission, Aug, 28, 1966, BNA Health Law Reporter (8-29-1996), at p. 1312

[47] In re MedSouth, Feb,. 19, 2002, http://www.ftc.gov/bc/adops/medsouth.htm. Still, even in orders to dissolve a violating IPA, the FTC continues to offer "clinical integration" as an option to avoid enforcement. "New Mexico Physician's Group Resolves FTC Price Fixing Charge" 12 BNA Health Law Reporter 725 (May 12, 2003).

Although the enforcers do not provide a checklist or series of criteria which define clinical integration, they describe hypothetical circumstances in which they would not be likely to take enforcement action. Consider this statement:

> *The IPA will implement systems to establish goals relating to quality and appropriate utilization of services by IPA participants, regularly evaluate both individual participants' and the network's aggregate performance with respect to those goals, and modify individual participants' actual practices, where necessary based on those evaluations. The IPA will engage in case management, preauthorization of some services, and concurrent and retrospective review of inpatient stays. In addition, the IPA is developing practice standards and protocols to govern treatment and utilization of services, and it will actively review the care rendered by each doctor in light of these standards and protocols….. The IPA will provide payors with detailed reports on the cost and quantity of services provided and on the network's success in meeting its goals….*
> *The IPA's physicians will be paid by health plans on a fee-for-service basis; the physicians will not share substantial financial risk for the cost of the services rendered to covered individuals through the network. The IPA will retain an agent to develop a fee schedule, negotiate fees and contract with payers on behalf of the venture….*
> *The network is structured to achieve its efficiencies through a high degree of interdependence and cooperation among its physician participants. The price agreement, under these circumstances, is subordinate to and reasonably necessary to achieve these objectives.*[48]

Although other features are also present in the hypothetical situation the enforcers describe, the purposes and goals of the approved entity are completely consistent with the purposes and goals of UFT-A. If otherwise competing physicians were to come together solely to bargain collectively over rates, the arrangement would not pass muster. But where the goals of the integration are to standardize, simplify, make clinically relevant, improve quality and lower administrative burden by the application of EBM and CPGs, the fee negotiations are quite ancillary to the fundamental reason to come together. This approach could be adopted for treatment of specific conditions – like CHF or breast cancer – or for a broader array of clinical conditions, or for all treatment by the network. The point is that plans would appreciate efficiencies, controlled costs, better medical loss ratios and higher quality through these mechanisms. Otherwise independent physicians would have reason to join in the common cause of applying our five core principles in a meaningful way. This would address the cottage industry problem that permeates medicine. Care would improve and patients would benefit. And if plans are forced to accept any willing provider[49] in states with legislation requiring open access by physicians then they will be even more motivated to work

[48] "Statements of Antitrust Enforcement Policy in Heath Care, Issued by the Justice Department and Federal Trade Commission, Aug, 28, 1966, BNA Health Law Reporter (8-29-1996), at p. 1312

[49] Kentucky Association of Health Plans Inc. v. Miller, No. 00-1471 (US April 2, 2003); http://supremecourtus.gov/opinion/02pdf/00-1471.pdf

collaboratively with sub-groups of physicians who want to improve care and function more efficiently.

Yes, But …: 10 Challenges Defused

Some have raised concerns regarding the conceptual framework of UFT-A. We recognize that the theory is not perfect, but we believe it is a robust response to important obstacles to propelling a quality agenda and engaging physicians in that effort.

(1) **CPGs have been around for years and no one ever uses them.** There is no question that trying to apply CPGs devoid of any connection to other principles of health care organization and payment will simply accrete more administrative burden, time and potential expense on physicians. Other CPG efforts to date have arisen in the current system which is functionally toxic to their application because of the other conflicting demands imposed on those of whom CPG implementation has been expected. Given all the other pressures on them, why would physicians have a reason to use CPGs? Most CPGs have been used either in hospitals for quality assurance review alone or in rare instances in practices to assist physicians in thinking about doing the right thing clinically. To our knowledge, they have never been applied in a system which has explicitly and purposefully used them as a unitary platform for multiple basic, critical functions in the delivery of care. In the setting we envision for UFT-A, the entire predicate for the application of CPGs is different. The theory not only welcomes and accommodates their use, it affirmatively makes CPGs the centerpiece of the strategy rather than an adjunct.

(2) **There aren't enough CPGs to make this work for an entire system.** We do not propose UFT-A as a sweeping revolution for the entire system. We believe it can work for isolated conditions, and in defined markets and institutions, although, obviously, its potential for positive impact will expand as its applications are extended. It is likely that if the conditions addressed in any implementation represent something of the 80-20 chronic conditions, the benefits will be improved contexts for physicians, patients, payors and hospitals and even limited applications could produce major change.

(3) **There isn't enough evidence and no one agrees on what needs to be done.** For some conditions this is true. But there are certainly enough quality and payment problems in health care where the evidence is clear so that selecting conditions or CPGs which focus there would be a good first step. To the extent that there is not enough evidence based on randomized controlled clinical trials or meta-analysis in the literature to establish the highest levels of evidence, this problem exists in health care anyway. Physicians are choosing what to do every day based on imperfect information. To standardize to some agreed upon statement of what should be done, if nothing else, will begin to provide data on which evidence can be determined. Reasonable standardization of some sort, even if not idealized evidence, is better than nothing.

(4) **The emphasis on the doctor-patient relationship, and the need for 'touch time' is a cloaked desire to return to the world of Marcus Welby.** UFT-A is emphatically about the broad and deep application of the best science available in patient centered care. While some of the aspects of the effective transfer of knowledge will turn on caring, healing relationships between doctor and patient, to the extent those reflect the values of a world of Marcus Welbys so be it. Obviously, such transfer, as we have discussed, requires sufficient time to center the care on a specific patient. On the other hand, actively engaged patients participating in evidence-based standardized care is hardly what we understand the Marcus Welby analogy to imply.

(5) **Cookbook medicine doesn't work.** Happily, this old saw is gradually disappearing from the debates on these issues. Cookbooks have recipes which describe what generally should be done to produce the described dish. Good CPGs describe what should be done to produce the outcomes they stand for. At the same time, good CPGs anticipate expected deviations and allow for unexpected ones based on reasoned decision-making by a clinician applying good science in an individualized situation. The argument here is solely about how rigidly CPGs are applied. That is the choice of those applying them. Slavish rigidity in any system does not work, but appropriate flexible CPGs can standardize what is clearly standardizable and leave room and time for the rest.

(6) **If CPGs are widely applied, innovation will stagnate.** One of the attributes of good CPGs, is that they reflect changes in science and are sunsetted as appropriate, refined and changed in a dynamic, on-going process. We would expect no less here. However, there is a legitimate concern that intended innovation can be stifled if there is no mechanism to allow any care not based on CPGs. Again, since this proposal is not intended to change all of health care, we believe there is little risk of that happening. Further, we do not propose uniformity. We believe that physicians desiring to move forward on innovative non-standard clinical approaches can use the same principles for payment, bargaining with their payors over how they will proceed with their non-standard work as long as they do so in a standardized way which explicitly accumulates and analyzes data regarding the effects of the innovations.

(7) **It's a sword if you don't follow through.** This is another aspect of the old shibboleths regarding guidelines; "if we write down what we should do and then we don't do it, we have increased our liability." Physician malpractice liability turns on whether there was a bad outcome as a result of negligent deviation from the standard of care. To the extent a physician negligently deviates from the standard, whether it was written somewhere or not, the liability will be there. If the CPG upon which UFT-A rests states something which ought to be done, and the physician does not do it, he ought to document why he didn't. If he doesn't and there is a bad result, whether that is actionable will turn on the facts. If the CPG speaks to the standard of care, which most do, then not acting that way has its own risks. In the last analysis, though, two points matter: The application of CPGs is intended to improve care and outcomes so it is worth

doing even though malpractice risk exists. Moreover, the single most powerful risk management technique is a strong doctor-patient relationship and a core design principle of UFT-A is to provide a basis on which to strengthen that relationship in patient-centered care and recaptured time.

(8) **CPGs are created by conflicted parties who produce the results desired by their sponsors.**[50] The same can be said of the peer reviewed literature which provides the basis for determining what is EBM. The concern is a real one, but the mere fact of a potential conflict does not always undermine the value of the CPG. If we support EBM then it is useful to understand whether those who produced the guideline or evaluated the evidence were biased, and to have such information might well be a warning that it would be appropriate to look carefully at the evidence upon which the CPG is based. But knowing the creators' biases or conflicts need not deny the ability to rely on the CPG. To standardize care there must be a standard to look to. If the standard cannot be based on what is reported in the literature because there is insufficient data or the data reported or CPGs suggested are tainted by conflict, then consensus judgments will have to be used. Our point is that while guidelines based on true EBM are best, a well designed CPG based on consensus is also good, but to go through the exercise and discipline of articulating and applying some standard, which although not optimal gets as close to the attributes of good guidelines that the IOM enunciated as is possible, is still better than a clinical context without standards.

(9) **Patients don't present in neat one-diagnosis-at-a-time packages.** This is true and makes the application of UFT-A to their circumstances more complex, but it does not vitiate the viability of the approach. Many patients with multi-systemic disease present with common constellations of problems – e.g. CHF with diabetes and hypertension. UFT-A's use of patient preferences in setting goals, and choosing among therapeutic alternatives, and the subsequent individualized determination of payment and measurement of success, all tend to make these limitations of individual CPGs less problematic.

(10) **Physicians will just game the system and patients will be given diagnoses they don't really have, in order to trigger payments.** There is always a risk that someone will game any system that is designed around payment. The issue here is to develop reasonable safeguards – limited post-service audits -- which do not overload the system with prevention techniques that undermine the ease of application. The key is to select the right players for proof of principle. They will have a good incentive to make the program work for all their stakeholders because to do otherwise will surely kill the positive potential the approach might realize. In the last analysis, those who game the system can be terminated from its participation.

[50] Choudhry, Stelfax and Detsky, "Relationships Between Authors of Clinical Practice Guidelines and the Pharmaceutical Industry", JAMA 287: 612-617 (2002)

Implementation Issues Generally

It has been said that "You can't solve every problem, but you can often choose which problems you want to live with." UFT-A would address many of the current barriers to the business case for quality, promote positive engagement of physicians to deal with some of our most vexing problems in over, under, and misuse, and drive fundamental improvements in patient-centeredness and touch time. But it would not solve every problem. The five principles and a theory described in this paper have not yet been tested. We have presented ideas which we believe merit further refinement and implementation. There are a host of implementation quandaries. In the conference, health care leaders listed five issues most prominently. (See Appendix B for a list of all which were mentioned.)

(1) One of the most critical conundrums in this approach to a payment system, which literally takes into account the costs to provide an algorithm or guideline for care, is how to quantify for physician time. It is fairly easy to determine staffing costs for nurses, receptionists, and other personnel, but physicians' "salaries" are a function of historical market patterns and personal income targets. Just as in current payment methods, this cost would need to be determined by a negotiation process—in other words, it is a problem that UFT-A would not solve.

Physicians have long been known to be income targeters. In a fee for service dominated context, they set their fees in a way which produces, for the most part, their income expectations. One of the major problems of the managed care revolution for physicians has been that capitation payments changed the financial predicates and rewarded a different approach to care (healthier patients who use no services). The reality of their reduced incomes by comparison with their expectations has frustrated many physicians. Ultimately in UFT-A, efforts might be spent to value physician time by benchmarking to salary comparisons by specialty, factored by case mix and incidence in the population, but all of these efforts will be no more certain or valid than the seat of the pants approach which operates throughout health care today. To expect UFT-A to solve that problem is unrealistic. If all of the other aspects of the costs taken into account to treat a patient are appropriately addressed, the decisions made on the issue of quantifying physician time will be no worse in this model than the unexplored assumptions in any other payment models.

(2) Some are concerned that to do this well will require expensive infrastructure and information technologies. Actually to begin with small pilot projects requires nothing more than the will to do it, the time and attention to design it, and pencil and paper. Undoubtedly better physician practice infrastructure in electronic medical records, coordinated billing systems combined with documentation, and better electronic communication generally would make the whole undertaking go more smoothly. The absence of such integrated programs plagues the entire system, even though some say the solutions may be just over the horizon.

The challenge of creating a business case for quality that engages physicians in patient-centered evidence based care is immediate and urgent. To wait for appropriate infrastructure may waste significant opportunities today. At the conference one of the attendees described, as if it were in operation in his office, a phenomenally seductive vision of a software package that linked his office records with those of the hospital in a complete way which gave him access to diagnostic results, radiological images on the spot, called up applicable formularies, provided documentation templates, prompted him with guideline suggestions and produced the applicable bills and claims for payment -- all within moments, in the natural workflow of his care. The participants held their breaths, dazzled at why they weren't aware that such a product existed. Unfortunately, the system he was describing was fictional, but its description was useful, in that it pointed out how powerful such systems could be in facilitating radical new models such as UFT-A. Meanwhile, conference attendees did not believe that we should wait for his fictional system to become real before we try ideas such as UFT-A on a smaller scale.

(3) Another problem that UFT-A will not solve is what might be termed "the costs of transition." In the process of developing and implementing UFT-A based programs, the complexity of the system would temporarily increase, not decrease, as we add yet another payment model to the ones already in play. Unfortunately unless by some magic stroke the entire system changes overnight to a single payment mechanism, that problem will exist for any payment method change. There will be an unpleasant period of transition, where time will have to be spent in development – when time is the most dear commodity physicians need – and then new systems will have to be implemented to make this work. While this is true, we still believe that standardization even without payment is worth doing anyway, so some of the principles we propound can alleviate some of that problem as the payment dilemmas are confronted.

On the other hand, we do believe that there are economies of scale issues here. To the extent that UFT-A was used to design care processes, documentation, payment, and accountability measurement for only one or two conditions, and physician practices would continue to deal with a hodgepodge of other models for all the remaining aspects of the care they delivered, it would have little impact on the business case for quality, unless the conditions chosen were high volume in the practice, and the payors accepting the approach represented a large proportion of the group's payor mix. Physician practice costs come in varying degrees of "granularity," and would not necessarily be reduced by standardization and simplification for one or two conditions. During any transition to a system like UFT-A, therefore, complexity might increase (i.e. one additional payment model to deal with) without definite reductions in cost or improvement in margins.

(4) Some attendees were skeptical that the cost accounting entailed in really paying for what should be done to treat a given patient's set of conditions could be created in a way that truly would drive a different pricing system. Some thought that even if such a system could be developed, the time, energy and expense of doing it

would obviate the value it might bring. Frankly, we have no answer to that concern, but believe there is consensus that the current systems are not producing what we want. Something has to be tried. If not UFT-A, then what?

Finally, the fifth major concern was whether payors would actually get on board for this approach. While we make no predictions, we were encouraged by the responses of three major payor representatives who participated and were enthusiastic about the potential to meet their needs along with the support of a major employer with real sophistication on these issues. If payors are moving to pay-for-performance programs which only address very limited aspects of underuse, to work collaboratively with high end physician groups in this way, will, we believe, meet the needs of those payors who are more enlightened. Once we start having reports of success from the field, those who might lag initially likely will get on board.

There are, of course, many other practical challenges to bring this theory to fruition:

- If we pay for adhering to a CPG and the adherence is only partial, how should that be dealt with in terms of payment?

- Should we pay for overall performance in conformity with CPGs as demonstrated in aggregate data of a group over time, allowing for a certain degree of variance (e.g. payment remains the same if deviation is less than 10% and then how would that variance be measured)?

- Should we prorate the individual components of the CPG to seek repayment for elements not performed? Or should it all be a zero sum game – "if you don't perform at a confidence level of 95% CPG conformity, you will be terminated from the program"?

- How much post-service auditing of care will give the payor enough confidence it is getting what it bargained for without adding more post-care inspection requirements that add physician burdens, costs and time?

- How large does a group of physicians have to be to make this work?

- Is there any reason well-motivated, otherwise independent physicians cannot work together this way on a single chronic diagnosis even if they don't work together on anything else?

The answers to these and a wide range of other issues will only be found in the trying of the theory. We expect that those who are persuaded that UFT-A is worth attempting will generate varying approaches to the breadth of problems UFT-A is intended to address as modified to meet the specific circumstances of their health care markets. Even at our conference, just for the exercise of thinking very briefly about potential UFT-A projects

and specific regional circumstances, three very different proposals emerged: (1) one dealt with payment for treatment of congestive heart failure and would involve physicians, hospitals and a major payor working together; (2) one was about addressing follow up treatment of depression in the physician office practice with nurse-run clinics; and (3) the third was a new way of approaching treatment of Vancomycin-resistant enterococcus and Methicyllin-resistant staph aureus.

The point is not the content of any of the proposals but rather that given one day to focus on a significant problem (the business case for quality) and a specific construct to address it (UFT-A), thinking about the possibilities immediately led to some creative notions that could have meaningful local ramifications. Considered in a more focused, less time-constrained context, involving more of the significant actors in any one setting who would be necessary to make something new happen, we think many different possibilities can be generated using UFT-A and the five core principles. It is also noteworthy that both in the room during the discussions and in written evaluations afterwards, virtually every one of the conferees was sufficiently compelled by the dialogue that they stated they wanted to keep in touch on these issues and any projects to implement UFT-A in any way.

Conclusion

Clearly, the barriers to a business case for quality are ubiquitous and strong. Yet the application of our five core principles – (1) standardize; (2) simplify; (3) make clinically relevant; (4) engage the patient; (5) fix public accountability at the proper locus of control – would create a changed environment for physicians and those who work with them. While many efforts are afoot in health care to propel quality beyond current levels, it is the implementation of these principles in far broader applications than "mere" quality assurance activities that would make real change.

To apply these principles using CPG/EBM based standardized protocols throughout the individual elements of the health care delivery system (in physician office care, at the hospital, in PHOs and IPAs) and in the many processes which define health care delivery (documentation, billing, information systems design, manpower, planning and recruitment, capital budgets, organization structures and, above all, physician payment) would be revolutionary. It is the **unified** application of these principles using CPGs as the foundation which distinguishes our approach from others.

To date, many health care systems have bogged down in the day-to-day struggles to manage sustainable businesses where costs rise and reimbursement shrinks. When managers of hospitals and physician groups try to meet these operational challenges, they often find themselves frustrated and defeated. When it comes to working collaboratively with physicians, many managers have simply given up.

We believe we have made a case for the centrality of physicians in health care and therefore, why their engagement is critical to real quality improvement. While other

efforts to enhance quality are aimed at other points in the health care system, it is time to confront the utter chaos with which physicians must contend if we are to promote change. This is not about pandering to diehard physician traditionalists who bemoan their lost autonomy and high incomes. UFT-A is about both re-thinking physicians' absolutely essential role in providing the best science in patient-centered care, as well as reordering their work environment to achieve these goals.

We hope that readers will be interested in pursuing some of the avenues only suggested here. We hope to facilitate ongoing communication among those who might try through our list serve **(**www.uft-a.com**)**. We hope to continue to share what we and others learn through real pilot projects. We already have (and expect to continue) to write and speak on related aspects of this work including the role of the hospital board in UFT-A, how medical staffs can be reorganized around this work, how current regulatory and other legal demands can be navigated while moving in these directions.

The complexity of the health care delivery system is profound and daunting. Its purpose, however, is simple: to deliver the marvelous capabilities of current scientific knowledge and technology to diagnose, treat, cure and heal people who need care and to do so with the goal of the highest quality with compassion and humanity. UFT-A is a construct to facilitate that lofty and real purpose. It engages physicians in ways we believe can resonate for them, for the other clinicians who work with them and for the facilities and institutions in which they act with a logic that is clear to them as well as patients and payors. We look forward to reports from the field.

Appendix A.

C O N F E R E N C E A T T E N D E E S

March 28, 2003

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Appendix B.

C O N F E R E N C E O B S E R V A T I O N S

(*Numbers indicate frequency of mention*)

1. Barriers to the Business Case

- Not enough pay for performance programs and even within groups – failure to motivate physicians for performance, (8); amount of reimbursement even in pay for performance does not provide enough to physicians

- Perversity of financial incentives and absence of case rates, (5); absence of business incentives to quality; absence of patient incentives to quality, (2); Not enough patient activism on quality of care and evidence-based medicine; lack of consumer demand for quality including affirmative asking for misuse

- Absence of an integrated patient medical record; lack of continuity of available data; records don't related to evidence-based medicine; lack of coordinated date including patient registries; Cost and absence of availability of electronic solutions at the bedside or in patient medical records, (3); Systems improvement is not rewarded

- Cost of influencing and changing physician behavior; lack of skills to manage and change within groups including absence of clinical quality leadership; not enough group integration; cottage industry mentality including physicians think they are doing evidence-based medicine, (2); Physician training

- Lack of agreement on quality targets and priorities, (2)

- Malpractice risks, (2)

- Locus of performance measurement, absence of uniformity of data sets

- Fragmented payment by payor including different payment systems

- (Volunteer Clinic) multiple providers from different systems working on the same patient

- Not enough links to outcomes in the system generally

- Need for productivity
- Failure to address who pays for charity and indigent care when it is significant to the provider
- Absence of clarity where the savings actually land
- Return on investment not immediate
- Niche competitors take money out of the system
- There is no money for new ways to interact with patients
- Time and cost spent on patient safety distract
- There is no time to spend on change
- Absence of an integrated infrastructure to patient centered care, difference with regard to pediatrics versus adult care
- Lack of consumer / purchaser / provider education on quality
- Not enough choice / competition in local markets (hospital consolidation)
- Absence of ways to support individual-innovating physicians
- Few ways to connect physicians to population issues
- The need to rely on claims data to get to quality
- Capitation does not relate well to high-risk patients
- No money available for risk-taking
- Not enough analysis of the return on investment quality
- There is cynicism and bifurcation between the administrative and clinical sides of physician practice
- No activity-based accounting and physician income expectation
- Traditional CME time

2. Time-Stealers

- Documentation – not clinically relevant, time to create asynchrony, flow, language, (9); Conflicting purchaser / regulatory requirements to document quality
- Health plan programs and systems, (5)
- Administrative meetings, (5); administrative paperwork
- Messaging and workflow interruptions; dispensing scripts refilling prescriptions; arranging discharge; drug representative interruptions, (5)
- Coordinating complex care, (3)
- Lack of real time information, (3)
- Paper-based records, (3)
- Pressure to meet volume requirements which translates as doing well by doing more
- Demands of the revenue cycle, (2)
- Lack of systems or teams to support clinical work
- Broken chronic disease system based on an acute disease model
- Dialogue about “the nature of quality”
- Mission conflict
- Lack of automatic processes
- Fear; defensive practice
- Trying to communicate with the rest of the team
- Lure of alternative sources of income including clinical trials, joint ventures
- Staff turnover

- CME activities
- Super specialization

3. How UFT-A Would Address Barriers to the Business Case for Quality

- Would increase touch time by decreasing bureaucracy
- Would reward efficiency on a condition-specific basis
- Focus attention on quality
- Encourage standardization
- Improve clinical outcomes
- Addresses challenge to clinical integration in the form of antitrust
- Optimizes inpatient margin because of optimal resource utilization under case rates
- For academic health centers, it can help standardize teaching
- Lower costs to plans on the inpatient side
- Better align physician incentives with quality and outcomes
- Address malpractice concerns
- Address the cottage industry approach of physicians
- Foster systems and infrastructure improvements generally
- Foster team approaches generally
- Might help with bad debt problems
- Standardize care within institutions
- Incentivize cost management of the health care business
- Increase touch time by eliminating documentation and paperwork

- In terms of the work flow disruptions and care coordination, it will make that easier; it could help give focus to the administrative time spent in meeting by giving these meetings a purpose

- Define value agreement between providers and payors

- Focus the deliverables one needs from information technologies

- Improves the documentation demands

- If we can identify some process outcomes for a limited number of conditions and show accountability for results with the public, there will be benefits. Some business barriers are broken down by rewarding best process and indicators

- It pays for performance

4. What It Will Not Address

- How to make teams work

- Paying won't solve the problem of inadequate infrastructure

- Peter who was robbed to pay Paul might block the program. There is a potential for gaming the system

- Where does the physician's money come from for the initial investment?

- Case mix? Adjustment is problematic, it will only work with large numbers

- It does not pay attention to actual outcomes

- It creates other perverse incentives

- Does not provide a model for small groups

- It will not eliminate the necessity for meetings

- Does not address the lack of consumer demand

- Will create a mixed reimbursement system which adds to increased complexity for physicians

- It requires activity cost accounting which itself might be expensive; adequate funding for the infrastructure dictates the success of implementation
- There must uniform acceptance of guidelines
- Does not address how multiple physicians will get money or if they get money
- There is no clear payor incentive
- Will be physician resistance to change
- Does not enhance or ease implementation at the bedside
- Does not provide an integrated model
- Time saved in administrative meetings will be lost to set up and maintain the guidelines
- It is not clear where the intervention lies in the system
- Does not address inactive patients or the uninsured
- It requires much more sophisticated information technology for optimal use
- Lack of agreement among physicians on the evidence and resistance to using guidelines
- It does not address consumer demand
- Requires proof of principle
- Consumers might need more incentive than just knowing they are being treated according to EBM
- It is not wrong, it is incomplete – there is no single solution that works but that should not keep us from starting with guidelines that do
- There is an opportunity to bundle guidelines
- It does not address the payment scheme – will payors play?
- It does not address the need to engage the consumer

- It does not address information technology needs for this to work
- Do individual medical groups have enough influence on the entire system that patients use to get care?
- Increased complexity of payment is problematic
- Patient compliance with guidelines is problematic
- Can this actually be priced?