Quality Care

Better margins, better quality: seizing the moment

Alice G. Gosfield, JD | Alice G. Gosfield and Associates PC, Philadelphia, PA

Oncologists are confronting a sea change in their traditional business model. At the same time, policy and market forces are focused intensely on improving quality. By concentrating on the business case for quality, and implementing five principles based on the broad and deep application of clinical practice guidelines, oncologists can find a new way to orient their delivery of care and payments for them. Clinical integration may improve quality and facilitate collective bargaining for fees.

Oncologists are at a watershed in their business lives. The dramatic shift in Medicare's rules for reimbursement challenges the very sustainability of the typical oncology business practice model. But removing the distorting effect of Medicare payment for drugs bought at a discount will actually help oncologists focus on a real business case for quality.

Withdrawal of Medicare "drug money" coincides with other developments that mandate all physicians focus their efforts on the business case for quality. While the costs of health insurance premiums escalate, most physicians paradoxically believe they are being inadequately reimbursed. Yet employers who are paying the bill believe they are getting suboptimal quality for the dollars they spend. In the meantime, there is an increasing focus on performance measurement and pay for performance (P4P).[1] This, even as the fraud and abuse laws have expanded their sweep to include Stark, false claims liability, gainsharing prohibitions, premature discharge risks, and anti-kickback proscriptions. Violation of the fraud and abuse laws can lead to civil money penalties, criminal liabilities, exclusion from the federal programs, exclusion from commercial programs,[2] and expensive settlements. The pressure of the malpractice insurance crisis only adds to the tension.

Taken together, it is abundantly clear that oncologists, like all physicians, ought to heed these market and regulatory forces. However, to consider a business case for quality only in a reactive and responsive posture misses the real opportunity of the moment. Precisely because of the distorted impact of the drug reimbursement, oncologists—perhaps more than any other specialists—have not paid enough attention to how they can enhance the operation of their practices to improve their professional lives, boost the quality of care they render, and increase their financial margins, if not their actual revenues. Focusing on the relationship between the physician and patient offers a way to develop a business case that accomplishes those goals.

KEY POINTS

- The essence of the doctor-patient relationship requires "touch time" to optimize transfer of information.
- Enhancing time and touch by removing time stealers from the system can lead to a business case for quality for oncologists.
- Five basic principles applied in oncology practices would improve quality, save time, and increase financial margins.
- The use of clinical practice guidelines to drive administrative processes as well as clinical processes can facilitate implementation of the five principles.
- Clinical integration for quality can provide a basis for oncologists to collectively negotiate for better payment from health plans without merging their practices.

Stealing time

In every medical practice there is a daily grind of administrative burdens: Documenting evaluation and management codes, completing certificates of medi-

Correspondence to: Alice G. Gosfield, Alice G. Gosfield and Associates, PC, 2309 Delancey Place, Philadelphia, PA 19103; telephone: 215-735-2384; e-mail: agosfield@gosfield.com

Manuscript received June 28, 2005; accepted August 18, 2005

Commun Oncol 2005;2:441–444

The doctor-patient relationship[3]

THE CRITICAL ROLE of physicians in the American healthcare system is a significant lever to quality improvement. Although hospitals and healthcare systems advertise their services so as to develop brand recognition, patients tend to go to the physician referred by their primary care doctor. In the cancer community, patients have an intense interest in where "the best care" can be obtained. Much of this turns on the reputation of individual physicians.

James L. Reinersten, MD, offers this profound characterization of the physician's role:

We 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 change. We can do other things in the course of our day but all are secondary to this primary task.[1]

To appreciate this crucial role is to understand that high quality care means making this information transfer in the most effective way. The most effective transfer occurs when physicians offer their patients two essentials—time and touch. To customize the application of science, "the physician must listen, explain, examine, comfort, teach, treat, perform procedures or surgery, and otherwise address the specific and variable needs of the individual patients. This 'touch time' is what defines the art of medicine."[4]

cal necessity, obtaining prior authorizations from health plans, managing the patients' drug regimens consistent with their particular formularies. Hospitals impose their own time-chewing demands, asking physicians to spend time on committee work, in medical staff organization, and on the hospital board. All of this impedes the fundamental needs of patients: time and touch from their doctor.

Patients themselves—especially those with cancer—steal time when they bring to the office visit reams of printouts from the Internet, questions prompted by the latest direct-to-consumer ad, and demands for the doctor's blessing to use alternative therapies. What is lost in all this noise is the essential signal: meaningful clinical dialogue between doctors and patients.

The most significant time stealer, however, is the payment mechanisms which, whether in the form of capitation, fee for service, or percent of premium, do not have any clinical relevance to the way physicians treat. Even the new pay-for-performance programs are add-ons to a system that already fails to give us what we want in terms of quality.[5] The current environment is one that undermines physician productivity and efficiency and thwarts the physician's ability to deliver optimal quality.

The five commandments

Five principles brought to bear throughout the healthcare system, but especially in physician offices, would dramatically alter this environment and improve physicians' circumstances and the quality of healthcare.

1. Standardize

In order to save time, physicians should standardize their care as much as possible, using the best science available. That includes documentation, outfitting examination rooms with identical equipment and supplies, and saving staff time by avoiding custom-crafted processes. In oncology this should be far less daunting than for other specialties that do not have as deep a history of standardized clinical trial protocols. Standardizing documentation alone—to clinically relevant, evidence-based templates—can save more than 3 minutes per patient. This one act would enhance margins, not to mention physicians' quality of professional life. And it will enable doctors to custom craft the art of medicine to each patient.[9]

2. Simplify

Many of the systems oncologists must use in their interface with hospitals—for transcription, documentation, and administrative tasks, among others—are inordinately complex. In addition, oncologists' own office processes are overly complicated. We need to make things simpler throughout the healthcare system. For example, physicians at the Park Nicollet Health Services in Minneapolis, Minnesota, designed standing orders for their coronary care unit. Developed among the nursing, administrative, and medical staff, physicians are given the option of completing the standing order sets or writing their own notes. Almost overnight, they improved their conformity with evidence-based medicine, saved extraordinary amounts of time, and improved the outcomes for their patients.[10]

3. Make it clinically relevant

A clinically relevant payment system would create a radically different practice environment for oncologists. For example, delivering care encompassed in clinical practice guidelines (CPGs) to treat stage II breast cancer for a fixed price could eliminate all the administrative burdens of documenting medical necessity of services, evaluation and management codes, prior authorizations, "brown bagging" drugs, and more.

Using CPGs to drive everything else in the healthcare system would produce more efficient care with better outcomes for patients. For exam-

Improving financial margins

THERE ARE TWO WAYS to improve the financial circumstances of a practice: increase revenues by charging higher fees and/or treating more patients; lower expenses to improve financial margins. Raising fees seems almost impossible, and many oncologists are so pressed for time they could not handle any more patients. As for lowering expenses, physicians are usually far more focused on enhancing revenue than on what it costs them to gain the additional revenues.

The Bridges to Excellence pay-for-performance program is a case in point. To qualify for an additional $100 per diabetic patient per year, the program estimates a physician must spend 15 minutes per medical record to abstract data to be reported to the National Committee for Quality Assurance.[6,7] Another example: The Rand Corporation estimates that 45% of evidence-based services are not provided to Americans.[8] In order to render these services, practices would have to incur expenses for additional equipment, tests, supplies, and personnel. Physicians rarely consider whether the extra revenue even covers the increased expenses. Against this background, the application of the five principles described in this article would improve physician financial margins.

ple, imagine if hospital capital budgets were based on their projected patient population's clinical needs rather than interdepartmental turf wars. Similarly, human resource decisions, whether in office or hospital settings, should be based on which clinicians (RNs, NPs, MDs/DOs) ought to deliver which services. By drawing on every professional and support staff's highest and best use, the system saves physicians for their highest and best use. It would reinvigorate healthcare delivery. Moreover, this kind of approach to human resource allocation would foster a more team-oriented approach to delivering care that would improve communication and reduce handoffs. All this would enhance patient safety, outcomes, and satisfaction.

4. Engage the patient

Patient-centric care is one of the values articulated by the Institute of Medicine seminal study, "Crossing the Quality Chasm."[11] Engaging patients actively in their care is the right thing to do, and it also directly speaks to the business case for quality: An engaged patient is more likely to adhere to clinical direction. An engaged patient is also less likely to manifest counter-productive behavior such as seeking bad information on the Internet. In fact, one of the best time savers for physicians, especially oncologists, is to provide patients early and proactively a list of credible Internet resources. It's important to remember that over the past 30 years, it has been shown that the single most effective risk management technique available to physicians is a good doctor-patient relationship. Engaged patients do not sue doctors they love.

5. Fix accountability at the locus of control

The advent of widespread performance measurements is inherent in the pay-for-performance initiatives.[12] Physicians are fearful of current report cards and performance measurements because they believe they are being held accountable for things over which they have little control. Those who resist these measurement efforts are engaged in a futile battle. Physicians should embrace this phenomenon, but insist that the reporting reflect the appropriate locus of control. An individual oncologist can rightly be evaluated for only two aspects of his or her care: application of science to patients, and the quality of interactions with patients. Many of the other measures currently at issue are more appropriately attributed to a system, network, hospital, or even a group practice, not an individual physician. If we were to adopt each of the previous four principles, not only would this significantly change the delivery of healthcare, but physicians would likely be far less fearful of performance measurement and report cards.

Clinical integration

Physicians who apply the five principles may also experience a powerful effect in their relationship with the health plans whose dollars fund their business. Oncologists who use practice guidelines can avail themselves of an opportunity made available by the Federal Trade Commission (FTC) since 1996 called "clinical integration." In order for competing physicians to bargain collectively with health plans, they must be integrated. Financial integration can qualify, whether it is achieved by forming a single group to contract with the plan, or by taking financial risk in the form of withholds or capitation. But financial integration has proven difficult for most oncologists. However, clinical integration does not require the integration of a complete practice.

The FTC characterizes physicians who have achieved clinical integration as those who:

Use protocols such as clinical practice guidelines in their care delivery;

Use an internal process to review and profile participating physicians, both to benchmark good performers and take corrective action against those who do not meet standards;

Share data regarding these activities with payers;

Spend time and money developing the infrastructure to imbed science in their care delivery.

This is not a mandatory list; various approaches are likely to be acceptable.[13]

The FTC has issued one advisory opinion approving the operation of an independent physician association (IPA) in accordance with clinical integration principles.[14] The FTC has entered into many settlements with physician and physician-hospital networks that were not sufficiently integrated either clinically or financially. In each of them, the commission has held out the opportunity for clinical integration. When they enforced against Brown and Toland, a very large physician IPA in California, they ordered the network not to proceed with bargaining for PPO fees until the FTC had approved their activities as sufficiently clinically integrated. That approval has now been issued.[15]

Clinical integration can also occur when hospitals integrate with physician practices. One Stark regulation allows hospitals to pay for and train medical staff members in recognizing fraud and abuse. Clinical integration using practice guidelines can eliminate the risk of committing fraud and abuse such as premature discharge, false claims from poor documentation, over-utilization, and more. So hospitals can help oncologists standardize their care and improve their margins in ways that are legitimate under the Stark statute.

The key to acceptable clinical integration is making the fee bargain ancillary to the reason to act collectively. Physicians who are clinically integrated can bargain together for fee-for-service payment from health plans and can refuse fee schedules that are unacceptable, without running afoul of the antitrust laws. A cautionary note: if there is not a good reason to act collectively, without any change in payment, then coming together just to bargain for fees will create liability rather than eliminate it.

Conclusion

Oncologists need to find a new business model to support their critical work. They ought to do so in a way that recognizes other forces at large in healthcare. Demands for improved quality, more transparency in performance measurement and report cards, and patient-centric care delivery are all here to stay. Against that background, the five principles set forth above—which make practice guidelines the bedrock of physicians' clinical and administrative processes—will save time, permit added touch between doctors and patients, improve quality, and enhance financial margins in oncology practices. All this, even if no payer changes the payment model. Adopting the five principles provides the foundation for clinical integration where oncology practices come together to measure their performance, improve their care delivery and learn from each other. To do so in a meaningful way is clinical integration which permits the physicians to bargain collectively for improved reimbursement. Oncologists should position themselves for a better future for themselves and for their patients. The moment is now.

References

1. Gosfield AG. Pay for performance: transitional at best. Managed Care 2005:64-69. Available at: http://www.managedcaremag.com/archives/0501/0501.p4p_gosfield.html. Accessed August 16, 2005.
2. Gosfield AG. Legal mandates for physician quality: beyond risk management, in Gosfield AG ed. Health Law Handbook. St. Paul, Minn: West Group, A Thomson Company; 2001:286–321.
3. Gosfield AG. The doctor-patient relationship as the business case for quality. J Health Law 2004:197–224. Available at: http://www.gosfield.com/PDF/DrPatientRelationship.pdf. Accessed August 16, 2005.
4. Gosfield, AG. J Health Law 2004;37:203.
5. Gosfield AG. Contracting for provider quality: then, now and P4P. In Gosfield AG, ed. Health Law Handbook. St. Paul, Minn: West Group, A Thomson Company; 2004:103–182. Available at: www.gosfield.com/PDF/ch3PDF.pdf. Accessed August 16, 2005.
6. Bridges to excellence. Available at: www.bridgestoexcellence.org. Accessed August 16, 2005.
7. NCQA Measuring the Quality of America's Health Care. Diabetes physician recognition program (DPRP) frequently asked questions. Available at: http//www.ncqa.org/dprp/dprpfaq.htm. Accessed August 26, 2005.
8. McGlynn EA, Asch SM, Adams J, et al. The quality of healthcare delivered to adults in the United States. N Engl J Med 2003;348:2635–2645.
9. Reinertsen JL. Zen and the art of professional autonomy maintenance. Ann Int Med 2003;136:992–995.
10. Reinertsen JL. It's about time. What CEOs and Boards can do for doctors, nurses and other health care professionals. Dis Mgt & Quality Improvement Rpt (April 2002) Available at: http://www.uft-a.com/PDF/leadarticle.PDF. Accessed August 16, 2005.
11. Colloquially referred to as the STEEEP Values which stands for the fact that care should be safe, timely, efficient, effective, equitable and patient centered.
12. Gosfield AG. The performance measures ball: too many tunes, too many dancers? In: Gosfield AG, ed. Health Law Handbook. St. Paul, Minn: West Group, A Thomson Company; 2005:227–283. Available at: http://www.gosfield.com/PDF/Ch4Gosfield.pdf. Accessed August 16, 2005.
13. Liebenluft RF, Weir TE. Clinical integration: assessing the anti-trust issues. In: Gosfield AG, ed. Health Law Handbook. St. Paul, Minn: West Group, A Thomson Company; 2004:27–74. Available at: http://www.gosfield.com/PDF/ch1PDF.pdf. Accessed August 22, 2005.
14. Federal Trade Commission. MedSouth opinion, (February 19, 2002). Available at: http://www.ftc.gov/bc/adops/medsouth.htm. Accessed August 136, 2005.
15. Brown and Toland (press release; April 13, 2005). Available at: http://www.brownandtoland.com/publish/en/about/news_room/press_releases.-Par-0009-DownloadFile.tmp/FTC%20press%20releaseFINAL.pdf. Accessed August 16, 2005.

ABOUT THE AUTHOR

Affiliation: Alice G. Gosfield, JD, is the President of Alice G. Gosfield and Associates, Philadelphia, PA.

Financial conflicts: None reported.