Building a Better Business Case for Quality: Innovative Payment Methods

James L. Reinertsen, M.D.
President, The Reinertsen Group
Senior Fellow, Institute for Healthcare Improvement

"The payment model for quality care is in question," began Dr. Reinertsen, pointing to a juxtaposition of articles he read last December–one by Dr. Brent James in the *New York Times,* stating that the incentive system is perverse since it exacts punishment for providing better care, and a letter written in *Health Affairs* by Donald Berwick, M.D., president and CEO of the Institute for Healthcare Improvement. Dr. Berwick congratulated the Centers for Medicare & Medicaid Services (CMS) for its Premier Hospital Quality Incentive Demonstration (HQI) project on pay for performance (see Guterman presentation for more on HQI).

But an even more vivid illustration of the questionable incentive system is a recent study by MIT scientists. They projected the effect on various stakeholders when perfect evidence-based medicine was applied to residents in Whatcom County, Washington, with diabetes and congestive heart failure based on current payment models.

The biggest winners were CMS, whose payment rates were lowered, and pharmaceutical manufacturers for an increase in otherwise under-used medications. The biggest losers: physicians and hospitals, who invested in services, systems and staff to deliver under-used services. "The model is not set up correctly to produce quality," he said. "Those who can make it happen have to make the investment but instead, they stand to lose substantial amounts of money."

Dr. Reinertsen said that if we believe the premise that every system is perfectly designed to produce the results it gets (a Dr. Berwick quote), our current system will not generate quality improvement in the care of patients with chronic disease. "There is an obvious need for change," he emphasized.

Where We Stand Today

Although quality improvement has been around for a long time–Reinertsen dates it back to 1987 when Dr. Berwick invited colleagues to explore industrial quality methods in health care under a Hartford Foundation grant–here is what's really happening today:

"We have a grand history of science projects that apply quality methods to a unit in a hospital, an office in a physician's practice or to a particular disease and have shown some kind of improvement. Often these projects have been nicely written up and provided many photo-ops for CEOs."

"We have a grand history of science projects that apply quality methods to a unit in a hospital, an office in a physician's practice or to a particular disease and have shown some kind of improvement," he said. "And often these projects have been nicely written up and provided many photo-ops for CEOs."

What they failed to do, however, was to be scaled for and spread throughout an entire organization. They also have not provided system-level results, such as adverse drug episodes per 1,000 doses, hospital standardized mortality rates, per capita and per discharge costs, percent of those dying in the hospital, inpatient satisfaction and voluntary nurse turnover, which are aligned with the IOM Health Care Quality Initiative.

Dr. Reinertsen likened the failure to produce system-level results by comparing the goal of landing a boat of soldiers on the coast during World War II to the larger goal of invading Normandy.

He described three driving forces behind quality improvement: moral reasons, business imperatives and regulatory requirements, the latter being the strongest force–as judged by changes hospitals actually make.

The tide is changing somewhat as clinical quality becomes a hot topic spurred by moral imperatives and new business pressures, such as the CMS Premier Hospital Quality Incentive Demonstration, Bridges to Excellence and "voluntary" CMS reporting.

At a recent meeting, which Dr. Reinertsen moderated, hospital executives were asked how important clinical quality is to their strategies. The numbers of those acknowledging quality as critical have risen considerably when compared to just a year ago. Executives admitted that their views have changed as they accept more personal responsibility for quality, usually surrounding a bad event occurring in their hospitals. Meeting quality goals is becoming more of a criterion for keeping one's job.

Dr. Reinertsen reviewed four business rules that apply to any industry in improving margins through better quality, but challenged their applicability to health care and relationship to current pay-for-performance models.

They are:

- More standardized, reliable methods of producing products and services will lead to lower unit costs.
- On the provider level, more efficient management of patient flow will lead to higher throughput.
- If you demonstrate better quality, you can command higher prices.
- If you have higher quality, you can attract more customers.

"If you do the first two things, you don't need to be paid for performance," Dr. Reinertsen said. "They illustrate the biggest, lowest-hanging fruit. There is a business case for quality for the taking if organizations apply quality improvement methods and just focus on the first two rules above." On the other hand, the last two rules, he said, are the weakest business cases for quality, even though commanding higher prices through better quality is the basis of most pay-for-performance models.

Looking at Pay-for-Performance Options

Various managed care organizations, CMS and corporations pay bonuses for quality to hospitals and doctors–models that fall under three basic categories: tiered, threshold and cost. Tiered forms are exemplified by the CMS model, which rewards hospitals in the top decile with a two percent bonus for completing performance measures for certain conditions. It's what Dr. Reinertsen calls "grading on a curve."

The threshold model, though similar, rewards everyone who reaches a particular level of performance. The lower cost bonus structure, the least common method, pays more for doing less and rests on the idea that less is the right thing to do. All three models pay limited bonuses and apply to only a few conditions.

Dr. Reinertsen applauds their efforts for channeling attention to quality even if the three models have several shortcomings:

1) bonuses that focus on under use and fail to address overuse and misuse;
2) bonuses being created out of the general provider pool; and
3) small total bonuses, which have a small revenue effect and won't necessarily translate into higher margins. His biggest concern is that these pay-for-performance models will deflect attention away from the real business issue–reducing costs through waste reduction.

Dr. Reinertsen introduced a completely new model called the Unified Field Theory-Applied, known as UFT-A, or as he jokingly said, Norwegian for "oy vey." An alternative model moving beyond pay for performance, UFT-A was created around the notion that instead of paying more for quality, we should reward higher quality by reducing providers' regulatory and administrative costs, which Dr. Reinertsen believes would align incentives for all stakeholders.

He firmly believes that UFT-A would address under use, overuse and misuse of services, engage physicians and follow the IOM's Quality Initiative principles of patient-focused care, evidence-based medicine and integrated health care systems.

Attributing credit to health care attorney and consultant, Alice Gosfield, for the development of UFT-A, Dr. Reinertsen stressed that the model is founded upon a unified care system that integrates all operations and systems. Gosfield's five principles are:

- **Standardize.** As Dr. Reinertsen learned through experience in his own practice, standardizing procedures, such as detailing treatment for rheumatoid arthritis during the first three months, reduced staff and provider time, costs and errors caused by variation. Lessons learned: you can practice health care within evidence-based medicine, not necessarily practicing it to the letter, and you can win back time in the process.
- **Simplify.** Current systems are cumbersome. It would make sense to develop a single, point-of-care template that combines billing documentation (which has little clinical relevance) with proof that the evidence-based care pathway was followed and accountability accepted for delivering the evidence-based care. A documentation template for delivering care for a clinical condition would save an enormous amount of time and expense in the care system.
- **Make payment clinically relevant.** Easily applied to physician payment, Dr. Reinertsen questioned why physicians are not paid for the cost of delivering a service based on what it actually costs according to cost accountants, rather than actuaries. For instance, add up total costs for delivering appropriate care to all diabetic patients in your practice and that is what you will be paid–even if it's more than it now costs.
- **Engage patients.** Services rendered must imprint patient values onto the care plan.

“Much of what is measured in report cards today grades physicians for things they cannot control, but are really the responsibility of the care system in which they work.”

- **Fix accountability at the locus of control.** Much of what is measured in report cards today grades physicians for things they cannot control, but are really the responsibility of the care system in which they work. If, however, we adopt the first four UFT-A principles, physicians will be more willing to be measured for what they ought to be held accountable for–their application of evidence-based medicine and their relationships with patients. Extra minutes gained from more efficient administrative processes give physicians more touch time to answer questions or take a hand, which makes physicians feel better about their profession and work.

Getting Started

Dr. Reinertsen spelled out the steps needed to get the UFT-A ball rolling:

- Select a clinical practice guideline, preferably a national one.
- Translate it into applicable ICD-9 and CPT codes.
- Develop necessary documentation templates for the guideline.
- Document the guideline for all practitioners.
- Account for variability.
- Engage the patient.
- Price services based on the cost of delivering care, not on billing charges.
- Measure compliance.
- Analyze and refine.

Putting the Theory to Work

Dr. Reinertsen used a 59-year-old woman with diabetes, a previous myocardial infarction and moderate congestive heart failure (CHF), for which she has been hospitalized, as an example. She meets with her physician, who outlines evidence-based approaches to treating her conditions–aggressive insulin therapy, exercise and weight control, lipid control including statins and enrollment in a nurse-run CHF management clinic operated by the hospital and the medical staff.

The physician gives the patient some videos and other materials about her medical conditions and asks her to review them, absorb them for a week, call if she has any questions and develop goals and treatment options.

During a subsequent visit with her care team, she sets the following goals for the next year–maintaining her HbA1c level under 7.5, weight under 140 pounds and blood pressure at 130/85 or better; lowering her cholesterol level to under 200 with LDL less than 130; and avoiding hospitalizations resulting from CHF.

The goals and care plan, signed off by the patient, are entered into a template and communicated to the health plan, care team and patient. The template not only drives the delivery and documentation of the care, but also measures and establishes accountability for outcomes.

So who is accountable for what? The patient must take responsibility for losing weight and staying engaged in the care plan; physicians must be accountable for process measures, such as timely tests for HbA1c levels and foot exams, and for the patient’s perception of the quality of her relationship with the physician. The health care delivery system must take charge of achieving overall outcomes–the goals set by the patient, including appropriate HbA1c levels and avoidance of hospital admissions for CHF.

The annual cost of delivering the care plan is estimated and confirmed by activity-based cost accounting applied to health care rather than by actuaries, who usually make the estimates. Based on annual costs, a monthly payment is made to the care team for as long as the patient remains under its supervision. And the biggest surprise is that an agreed upon payment to the physician and care team has been established at a margin above the costs of doing the right thing for the patient.

UFT-A: Advantages and Challenges

Dr. Reinertsen quickly summed up the UFT-A model's prime advantages:

- Is both patient-centered and evidence-based, not one or the other. When patients are brought into the care plan design, he believes that they may be more concerned about evidence-based medicine than their physicians.
- Speaks to physicians the way they think–getting paid for what they do right.
- Creates touch time.
- Deals with overuse and under use by providing a margin at or above the cost of delivering services rather than relying on historical cost patterns.
- Reduces administrative burdens.
- Provides incentives for innovation and cooperation.
- Creates common goals among all stakeholders and provides a win-win situation for all–patients receive higher quality care, providers earn a payment margin and health plans and payers dole out less as overuse is eliminated.
- Pays for the cost of practicing evidence-based medicine and lets the under use and overuse chips fall where they may.
- Can eliminate intrusive medical management and documentation requirements.
- Mitigates malpractice claims and lowers liability risk by more fully engaging the patient. Physicians who use guidelines have a six-fold lower risk of being sued.
- Has implications extending well beyond payment.

Yet with all of its advantages, the theory has its challenges. For example, it is not applicable to all organizations because many delivery systems aren't mature enough to deal with it. The single biggest challenge is the lack of good methods for doing activity-based cost accounting for health care.

Although Dr. Reinertsen presented a list of "yes, buts," (protests from providers), he managed to poke holes into most of them. Leading the roster is the idea that clinical practice guidelines have been around for years and no one uses them; there are not enough to make them work; and there isn't enough available evidence resulting in agreement.

On the contrary, he described McLeod Regional Medical Center in the town of Florence, S.C., which followed all of the guidelines related to acute myocardial infarctions for 99 percent of its patients with the condition and cut its mortality rate in half.

As reflected by its superb outcomes based on evidence, the medical center takes a no-nonsense approach to following evidence-based medicine. When the head of quality wants to make sure physicians toe the line, she looks them in the eye and says, "Is your autonomy more important than patient outcomes?" That usually does the trick.

"Let's not start with the hardest evidence-based medicine problem, but with the most solid and build on it," Dr. Reinertsen concluded. Reiterating his initial theme–every system is perfectly designed to produce the results it gets–Dr. Reinertsen admitted that our current payment system is inadequate. When only 55 percent of evidence-based services are being delivered to patients with chronic disease, there is a need for a different model with different results.

This chart compares revenue to the physician, direct time and other costs, patient and payer impact, and margins for the three more traditional models–tiered, threshold and cost–with UFT-A, which emphasizes clinical practice guidelines.

	Tiered Q Bonus	Threshold Q Bonus	Lower Cost Bonus	Pay cost of doing CPG
Revenue to MD	Higher for top tier only	Higher for those at threshold	Uncertain: Offset by lower RVU's?	↑ Underuse ↓ Overuse
Direct time costs	Higher	Higher	Uncertain, probably higher	Much lower: standardize, simplify, highest and best use of staff
Other direct costs	Higher (primary target is underuse)	Higher (primary target is underuse)	Lower (primary target is overuse)	↓ Overuse ↑ Underuse
Patient Impact	Better care, more services, less touch time	Better care, more services, less touch time	Better care, fewer services, ? Touch time	Better care, more or fewer services but driven by evidence and patient choice, more touch time
Payer Impact	Higher costs short term, unless bonus pool is self-funded by providers	Higher costs short term, unless bonus pool is self-funded by providers	Lower costs in short term	Lower costs because of predominance of overuse, effect of patient choice
Margin	?	?	?	***Improved, mainly due to lower direct time costs***

Source: Reinertsen and Gosfield, "Doing Well by Doing Good: The Business Case for Quality." http://www.uft-a.com.

Bridges to Excellence

Quality initiatives currently on the board are making a dent in the move towards rewarding providers for high-quality performance. The IOM's "Chasm" report has certainly left its imprint on the way health care is delivered–challenging insurers, purchasers, providers and patients.

Bridges to Excellence, a coalition of those stakeholders, emerged to realign incentives around quality. Its objectives rest on three primary principles: 1) reengineering care processes to reduce errors and being rewarded for those changes; 2) significant decreases in misuse, overuse and under use, leading to reductions in waste and inefficiencies in the health care system; and 3) increased accountability and quality improvements, encouraged by sharing comparative provider performance data with consumers.

Three Bridges to Excellence programs have evolved out of these principles. Physician Office Link provides physician practices an opportunity to earn financial rewards by implementing processes to reduce errors and increase quality. Each office's performance on certain measures is disseminated through a report card.

Diabetes Care Link enables physicians to earn one-year or three-year recognition for high-quality diabetes care through bonuses. The program also offers a variety of tools and products to help diabetes patients become engaged in their care, achieve better outcomes and identify physicians who have satisfaction quality measures.

Cardiac Care Link, a similar program, rewards physicians for high-quality cardiac care and provides tools targeting cardiac patients.

Resources

Reinertsen and Gosfield, "Doing Well by Doing Good: Improving the Business Case for Quality" http://www.uft-a.com

Reinertsen, "Zen and the Art of Autonomy Maintenance," Annals of Internal Medicine, (June 17, 2003)

Gosfield, "Making Quality Happen: In Search of Legal Weightlessness," HEALTH LAW HANDBOOK, 2002 Ed, WestGroup, pp. 609-678 http://www.gosfield.com/chp13pdf.pdf

Reinertsen, "It's About Time! What CEOs and Boards Can Do for Doctors, Nurses, and Other Healthcare Professionals," Disease Management and Quality Improvement Report (April 2002) http://www.reinertsengroup.com/leadarticle.pdf)

Gosfield, "Making Quality Happen: Confronting the External Challenges to Time and Healing Relationships," Healthcare Leadership and Management Report (August 2002) http://www.gosfield.com/leadaug.pdf

Gosfield, "Quality and Clinical Culture: The Critical Role of Physicians in Accountable Health Care Organizations" http://www.ama-assn.org/ama1/pub/upload/mm/21/quality_culture.pdf