

Improving Clinical Quality and Sharing the Profits with your Physicians

By James Reynolds and Daniel Roble

In the world of health care today, it is widely recognized that quality initiatives must be implemented to:

- Reduce needless mortality and morbidity
- Provide best practice care
- Reduce variation in methods of care
- Develop a reimbursement system that rewards best practices and penalizes unacceptable and unnecessary care
- Reduce costs through substantial elimination of overuse and misuse of health care resources

The health care industry cannot sidestep these changes. As a result, “pay-for-performance” initiatives by insurers and employers that offer some form of financial incentive to either physicians or hospitals for delivering the “right kind of care” are quickly spreading throughout the country.

These initiatives, however, have not yet been applied to hospitals and physicians working together because of perceived practical difficulties in collaborative physician-hospital relationships and various legal impediments. But they’ll be commonplace soon.

Who’s behind the demand?

Six industry forces are supporting new and wide-ranging demands on hospitals and physicians for patient safety and clinical performance improvements.

1. Scientific leaders—The IOM’s 1999 report, “To Err is Human,” which focused on clinical quality, patient safety and avoidable deaths in hospitals, led to a continuing series of IOM reports calling for key changes in the organization, delivery and reimbursement of hospital-based care.
2. Buyers—The Leapfrog Group, one of the nation’s leading employer coalitions, adopted some of the IOM’s recommendations and is focusing its efforts on

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Take an inside look at quality gain sharing—the legally compliant, customized incentive program that permits the sharing of some of the cost-saving benefits of hospital quality improvements with the physicians who make them possible.

the adoption of quality and safety standards for hospital care, payment programs based on incentives and rewards, public recognition and a shift of volume to hospitals and doctors who meet Leapfrog standards.

3. Financial intermediaries—Insurers, managed care organizations and the Centers for Medicare and Medicaid Services are implementing pay-for-performance programs that provide rewards for physicians and hospitals that meet their established quality and cost targets.
4. Consumers—Patients are becoming more empowered through easy access to performance-related information on the Internet and are being put more at risk for the cost of their health care benefits as their employers shift to defined contribution plans.
5. Technology vendors—The use of continually evolving hi-tech capabilities such as computerized physician order entry, electronic medical records, clinically-oriented information systems, evidence-based protocols and clinical process redesign, while expensive, are becoming almost mandatory to meet the expectations of purchasers.
6. Capital markets—Lenders are quite willing to make investment capital available for these investments to credit-worthy hospitals, and credit-worthiness is best demonstrated by a track record that shows consistently above-average returns on such investments.

The measurements of quality

Health care technology vendors are offering hospitals an array of sophisticated computerized information systems that support proactive management of the clinical care process.

Severity-adjusted comparisons of clinical quality at the subspecialty level permit physicians and managers to identify poor outcomes and then set priorities for the investment of scarce staff time and resources to redesign clinical pathways that obtain the greatest return on investment in terms of improved clinical outcomes and cost per case. (Figure 1)

Similar comparisons of outcomes among physicians can allow a hospital to identify which have better/worse outcomes and test hypotheses on relationships between differing practice patterns and outcomes.

At the payer level such comparisons permit hospital managers

to identify problems with contract terms, payment rates and cost per discharge that can be used to reveal unexpected numbers of denials, serve as a basis for renegotiating some contract terms, or even focus on resource consumption patterns.

Moreover, such comparisons may allow managers to negotiate better payment terms so that the hospital, as the investor in quality improvement initiatives, will share the return on investment with the payer.

Direct physician involvement is an absolute must in accomplishing clinical performance improvements, some of which are directly physician-driven (such as over-ordering imaging studies) while others are a function of the hospital's operating policies (such as delays in reporting imaging results). In either case, physician understanding and support is critical to identify, implement and monitor improvements.

(See figures 2 and 3 for examples of clinical performance measures.)

Quality gain sharing takes root

Quality gain sharing programs are being developed to actively engage physicians in the clinical improvement process and overcome their frequent lack of interest and/or resistance to participating in hospitals' quality improvement efforts.

Four factors are key to the success of gain sharing:

1. A sufficient number of improvement opportunities
2. Available cost savings to be shared with participating physicians
3. Ongoing objective measurement and monitoring to assure that the results support the performance improvement goals and merit sharing of related cost savings
4. An appropriate legal framework

The program's success is based directly on achieving measurable

figure

1

Severity-Adjusted Comparisons of Clinical Quality and Efficiency at the Subspecialty Level Permit Managers to Identify Poor Outcomes

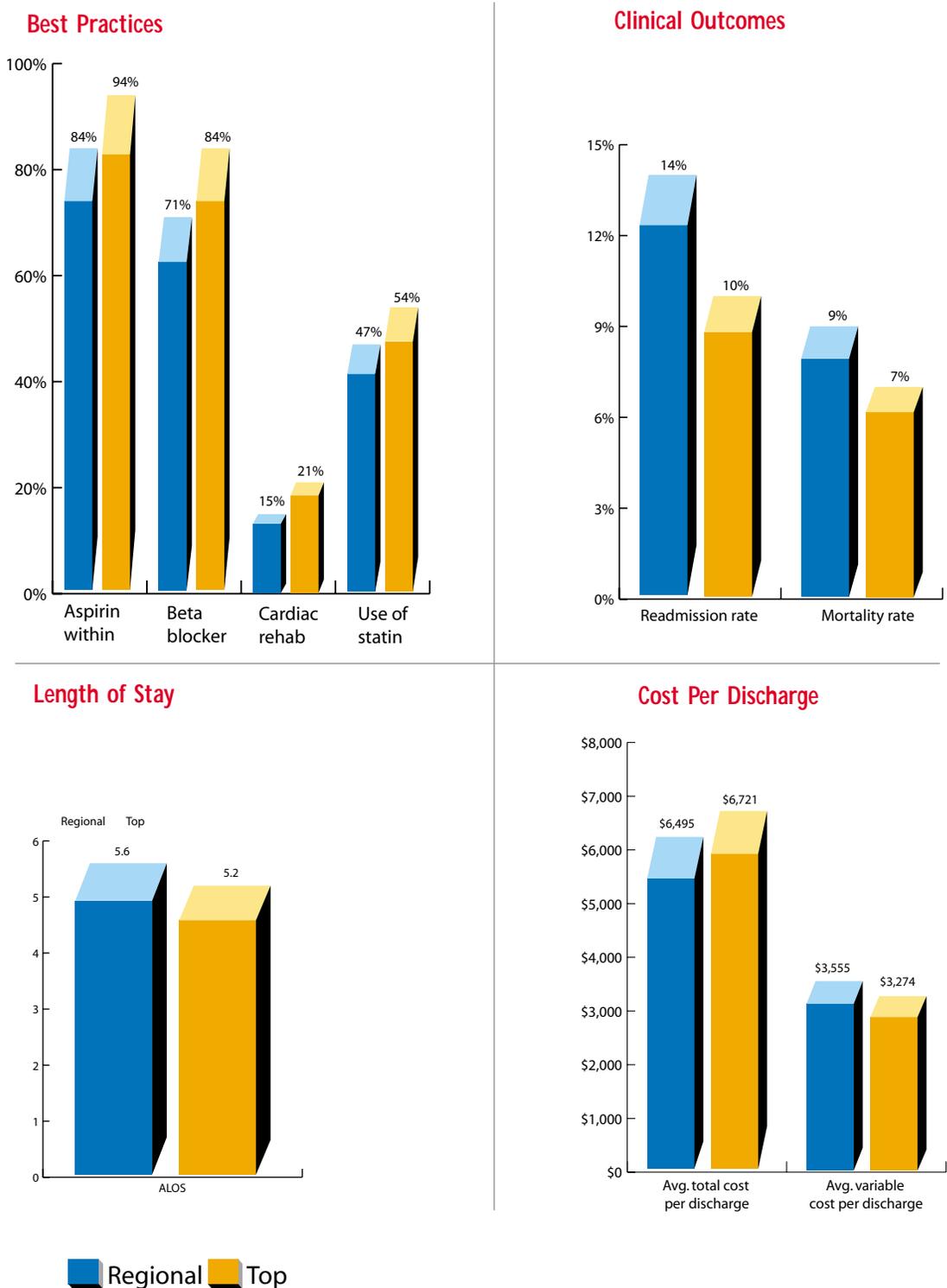
Inpatients by Product Line (Subspecialties)	Clinical Quality Rates above/below expected value: severity adjusted			Economic Efficiency Financial Results	
	Mortality Rate*	Complications Rate*	Length of Stay*	Net Revenue Margin*	Total Profit/(Loss)
All Product Subspecialties	-16	-5	+9%	-9%	(\$6,805,000)
General Surgery	-8%	-12%	-2%	+5%	\$411,000
Complicated Newborns	+2%	+21%	+24%	-13%	(\$383,000)
Cardiac Catheterization	-92%	-6%	+11%	-27%	(\$876,000)
Surgical Oncology	+48%	-1%	+16%	-38%	(\$672,000)

* Clinical quality values greater than zero are not desirable. Negative financial results are not desirable

Benchmark Comparisons of Clinical Practices, Outcomes and Costs

Medically Managed Acute Myocardial Infarction

figure 2



cost savings that are tied directly to clinical performance improvements. To accomplish this, the program:

- Clearly identifies process improvement targets
- Is built on a foundation of explicit performance measures, computerized monitoring systems, accurate clinical process and outcome data, and ongoing evaluation of clinical quality improvements, care process changes and cost savings
- Develops a payment distribution policy with participating physicians
- Formalizes legal and contractual relationships between the hospital and participating physicians
- Requires that predetermined quality improvement thresholds are met before cost savings can be shared

- Provides explicit safeguards that neither quality nor needed services will be diminished

Potential limitations in customizing a quality gain sharing program must also be considered:

- Sophisticated clinical and financial information systems are needed to monitor and manage the incentive payment program
- Incentive payments may not be sufficient to change physician behaviors
- Special arrangements will likely be necessary to reward physicians who already comply with targets for clinical outcomes
- Potential legal and regulatory constraints need to be addressed, including those related to the civil money penalty statute, anti kickback law, Stark Law and tax-exempt hospital laws

- Life expectancy for sharing of savings for a specific improvement initiative is generally limited to two or three years

Although most, if not all, members of a hospital's medical staff may be eligible to participate in a quality gain sharing program, some groups of physicians may be better candidates during the initial phase of the program.

For example, hospital-employed physicians (including hospitalists), physicians in specialties that are procedure-oriented or who are generally comfortable using clinical protocols, and physicians/groups who champion clinical improvement efforts, are all likely to be well-suited to participation in early efforts.

There are many opportunities to engage physicians in valid clinical improvement activities for a gain sharing program. Examples include the creation and application of

figure

3

This Hospital's Mortality Rate Can Be Reduced 17% While Its Costs are Cut by \$553,000 in this AMI Example

Template for Estimating Potential Benefits of Improving Clinical Quality/Efficiency and Quality Gain Sharing for a Regional Medical Center (RMC) and its Physicians

Potential Improvements in The Clinical Quality and Efficiency of Patient Outcomes	Required Changes in Related Care Process and Physician Behaviors (Up to 5)	Number of RMC Discharges in FY2002	Estimated RMC Variable Cost Per Discharge	Benchmark For Variable Cost Per Discharge	Potential Total Cost Savings for RMC
<p>Acute myocardial infarction inpatients with PCI:</p> <ul style="list-style-type: none"> • Reduce inpatient mortality from 8.9% • Reduce readmission rate from 14.3% to 10.2% • Reduce length of stay from 4.4 to 4.0 days 	<ul style="list-style-type: none"> • Follow pathway and order sets during hospitalization • Aspirin within 24 hours of arrival • Beta blocker within 24 hours • Increase use of cardiac stepdown • Start Cardiac Rehab before discharge 	940	\$3,862	\$3,274	\$552,700

Some Examples of Performance Improvements that Would Support the Payment of a Quality-Related Bonus to Participating Physicians

figure 4

- ✓ Diabetes Provider Recognition Program (ADA/NCQA)
- ✓ Patient Education Programs
- ✓ Establishment of Clinical Information Programs in offices (Electronic medical records etc.)
- ✓ Breast Cancer Screening
- ✓ Childhood Immunizations
- ✓ Following nationally recognized clinical care pathways for certain diseases (e.g., administering aspirin to heart attack victims within set time frame)



evidence-based clinical protocols, utilization and participation in quality education sessions, routine screenings and participation in provider recognition programs. (Figure 4)

Sharing the cost savings with participating physicians could include an established fair-market value fee for a physician's participation in the creation of evidence-based clinical protocols, provider recognition protocols or education programs.

If the physicians participate in a clinical protocol that results in quality improvements and significant cost savings, the physicians could participate in a percentage of the cost savings so long as:

- The quality improvements and clinical cost savings are monitored and certified by independent third parties
- The payments to the physicians are not based on the volume or value of services

- The payments are at fair market value and satisfy the legal requirements

Obeying the law

Compliance is required to ensure that the payments made to the physicians as part of a quality gain sharing initiative meet relevant regulatory requirements. Here are some issues to consider:

1. Clinical and financial transparency of quality indicators:

- Use of specific, objective, generally accepted clinical indicators
- Separate calculation for each quality indicator

2. Safeguards against adverse impact on patient care:

- Based on credible, objectively measured medical support

- Ongoing monitoring and measurement by independent third parties to determine the program's success and to confirm that the program is not having an adverse impact on clinical outcomes

3. Safeguards against disproportionate federal health care program costs:

- Absence of procedures that are disproportionately performed on federal health care program beneficiaries
- Payments to the physicians based on all procedures with respect to each performance indicator regardless of the patients' insurance coverage
- Capping potential savings
- Calculations based on the hospital's actual out-of-pocket acquisition costs and not on accounting conventions
- Absence of steerage

4. Safeguards against inappropriate reductions in service:

- Use of objective historical and clinical measures
- Use of baseline thresholds

5. Meaningful patient and physician disclosure and freedom of choice

- Use of a program mission statement
- Voluntary physician participation
- Termination of physician participation if non-compliant
- Disclosure of program in writing to patients

figure 5

This Approach to Developing a Quality Gain Sharing Program Calls for a Wide Range of Skills, Teamwork and Effective Project Management

Analytical and Design Tasks	Clinical Care Process Physician	Management Consultant	Legal Counsel	Hospital Management
1. Analyze Situation and Quality Sharing Possibilities: <ul style="list-style-type: none"> Identify clinical process improvement possibilities Consider relevant performance measures Sketch out payment model for physicians 	Shared Shared Shared	Shared Shared Shared	Collateral Collateral Shared	Shared Shared Shared
2. Evaluate Anticipated Financial Results: <ul style="list-style-type: none"> Analyze related resource consumption and financial data Estimate financial consequences of possible quality improvements Establish hospital-funded budget Estimate size of physician payment pool 	Collateral Collateral Collateral Shared	Lead Lead Shared Shared	— — Collateral Collateral	Collateral Collateral Shared Shared
3. Assess Readiness for Quality sharing: <ul style="list-style-type: none"> Clinical opportunities Physician readiness Organizational readiness Clinical tracking Financial tracking 	Lead Lead Collateral Lead Collateral	Collateral Collateral Lead Collateral Lead	— — Collateral — —	Collateral Collateral Collateral Collateral Collateral
4. Design the Quality Sharing Program: <ul style="list-style-type: none"> Clinical process improvement targets Performance measures and monitoring Distribution criteria and payment methodology Legal and contractual relationships 	Lead Shared Shared Collateral	Collateral Shared Shared Collateral	— Collateral Shared Lead	Collateral Shared Shared Collateral
5. Coordinate/Manage Activities and Launch Program <ul style="list-style-type: none"> Sequence tasks and input/output relationships Finalize workplan, responsibilities and schedule Coordinate tasks, inputs and outputs Keep project on schedule and report on status Maintain project budget records Prepare program description and final report 	Collateral Collateral Collateral Collateral — Shared	Lead Lead Lead Lead Lead Shared	Collateral Collateral Collateral Collateral — Collateral	Collateral Collateral Collateral Collateral — Collateral

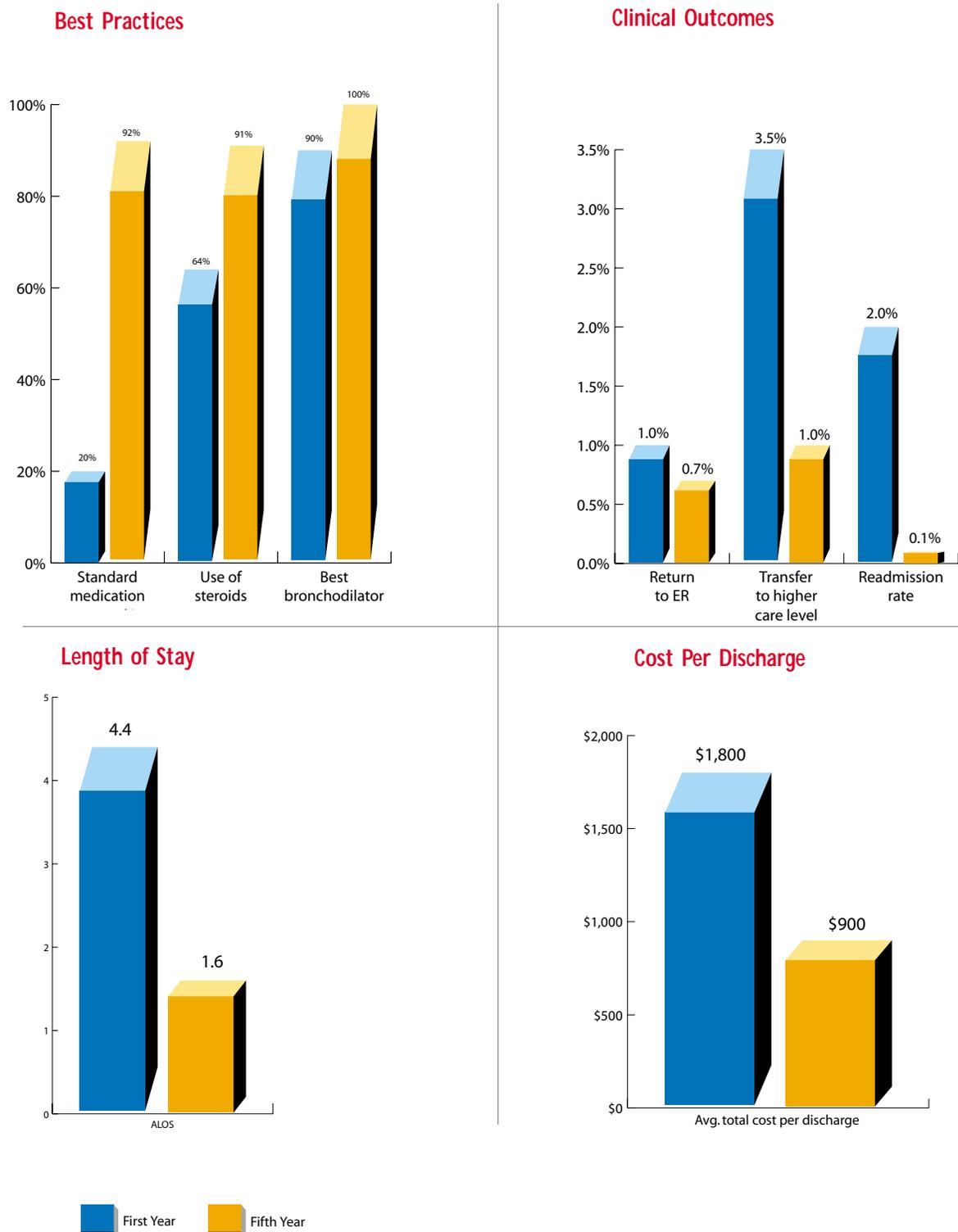
Lead = Primary Responsibility Task

Collateral = Secondary Responsibility Task

Shared = Shared Lead Responsibility For Task

figure 6

Dramatic Improvements In Performance Have Been Documented Treatment of Children for Asthma Admission



6. Limitations on financial incentives to participating physicians:

- Payments may only be made to physicians participating in the quality gain sharing program if the quality of care at the hospital is improved as evidenced by satisfying the pre-established quality goals and the cost savings are generated as a result of the program
- Financial incentives to physicians are reasonably limited in duration
- Fair market-value compensation is defined in advance with the physicians
- Payments are based on quality results, not cost savings
- Program is not used to attract new referring physicians or to increase referrals from existing physicians
- Total savings are limited by meeting appropriate utilization standards

improved clinical quality and financial performance can be considerable. (Figure 6)



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Designing a quality gain sharing program

The work involved in testing the readiness of the hospital and its physicians to undertake a gain sharing program, developing the final design, implementing the program and continuously monitoring its operations is relatively complex and time consuming.

In general, hospitals and physicians should undertake a five-step readiness/pilot/feasibility study before considering full-scale implementation of a program. (See Figure 5)

Even though the implementation of a quality gain sharing program may require a substantial investment of time and resources, the return on investment in