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Proem

This week I compared large screen monitors, care planning apps, clinicians, vacation packages, and high-end chocolate - all efforts of privilege, except the clinicians. I can afford them; I don't really need them. I actually purchased nothing. Mostly, I'm curious about comparing apples to apples, enough information, marketing to emotion, marketing with facts. I also attended a day-long cost measure meeting, the NQF (National Quality Forum) Cost and Efficiency Measure Standing Committee. This meeting evaluates measures that Medicare uses to compare physicians performing common high-cost surgeries: heart surgery, hip replacement, and spine surgery. Ideally, we compare to find the best quality, lowest cost, and most accessible – whether it's surgery, monitors, apps, vacations, or chocolate. The more I explore comparison, the less I know. I asked around, and Bill Lawrence at PCORI (Patient-Centered Outcomes Research Institute) referred me to Bob Phillips. Remember that links to organizations, articles, and concepts can be found in the transcript and show notes.

Introducing Bob Phillips 01:42

Dr. Bob Phillips is the Founding Executive Director of the Center for Professionalism & Value in Health Care at the American Board of Family Medicine Foundation. Dr. Phillips practices part-

time in a community-based residency program and is a Professor of Family Medicine at Georgetown and Virginia Commonwealth Universities. He served as vice chair of COGME (the Council on Graduate Medical Education) and co-chair of Population Health on the National Committee on Vital and Health Statistics. Dr. Phillips was elected to the National Academy of Medicine in 2010.

Health Hats: Bob Phillips. Welcome. Thank you so much for joining us today. I need your help. I've been trying to explain, understand myself, this whole issue of comparing clinicians, comparing clinics, comparing institutions, just this entire comparing business. And it seems like nobody likes to be compared unless they feel they're better. So, it's a dicey business this comparing. And when the most significant thing I hear when we're we look at comparison is it's not fair. It's not apples to apples. I'm different, which is true. Let's just jump in with you telling us about yourself and how you're connected to these issues.
Bob Phillips: Danny, I'm a practicing family physician. I have been now for 25 years. But most of my time is spent at the Center for Professionalism and Value in Healthcare. We're trying to align how health professionals are measured. What are the quality measures used to gauge? Whether you're a good doctor or a bad doctor. We're trying to align that with the things we do that provide good care and what we value and what patients value. And I'm in this space because I know that alignment is important to reducing clinicians' burnout and delivering good care. The things that we work at hard-to-get good scores on are not the things that we do those help patients the most. And I've seen that in my own practice for a long time.
Health Hats: So, for example…

Tension between accessibility and continuity 05:17

Bob Phillips: For example, in primary care, we have good evidence that continuity, having a trusted healing relationship with a primary care clinician, has good outcomes over time. And yet we destroy that when we try and maximize access, try to ensure that any patient who wants to get care gets that care as soon as possible. And why you would think that's important, too. That is about keeping my schedule full to maximize our dollars per hour. And that gets right in the way of making sure that someone gets to see me when they need to because we've been together for a long time. And that's not always valued by young people who don't have a lot of health issues, but as we get older, or if we have chronic health conditions, having the same person often means that things will turn out better
Health Hats: So, are you saying that sometimes there's tension between different ways of measuring quality: Access versus continuity?
Bob Phillips: There absolutely is a tension there, and both are important. Someone should be able to see, be seen soon, and someone should be able to see someone that they need to see. And those are in tension because one of them has an economic engine attached to it. And that practice or the health system's incentive is to ensure my schedule stays full. But it's not just

tension. If that fundamental measure so important in primary care is not made high value, I'm just getting churned. I'm just seeing different people all the time, and I have no relationships with them. It's harder for me to learn what they've been through, their priorities, their values, and what they're scared of. And it's hard for me to change their behavior because it's hard for me to relate to them personally when it's just a transaction. Okay. So that's one example of a high-value measure that doesn't get measured because it is in tension. And because we have a hundred other measures we're trying to work to every day.

Comparing and burnout 07:15

Bob Phillips: We just published a paper with Larry Casalino at Columbia University last month showing that physicians with higher quality measures based on disease measures are more likely to be burned out.
Health Hats: Oh, really? That's interesting.
Bob Phillips: Burned out, at least emotionally exhausted if they get all the way to being callous, meaning they just stop caring, then that falls off. But they're burned out because they're working hard to maximize these quality scores. So, they're expending so much time and effort to check boxes, and it gets in the way of good care. And it's not what they think patients need. It's not what they want to be doing.
Health Hats: So, check boxes like immunizations?
Bob Phillips: Yeah. Like my patients coming in for anxiety and going through a divorce, they need someone to help them manage that problem. But over here, I see a list that says you haven't had a colonoscopy this year. Oh, gosh, you have diabetes, your A1C score is too high, and your blood pressure's up. It's distracting to work at those when they aren't the patient's priority today. And it's not what I should be doing today to make them feel better and be better.

Measuring what's important? 08:30

Health Hats: I'm trying to think about this from the public's point of view. So, I have MS. My primary care doc and neurology are my primary or most important clinicians. And when my neurologist left town and I needed a new neurologist, I had no idea how to use publicly available data to compare one to the other. I knew what was important to me. The doc needed to use the portal and couldn't be intimidated by me as an engaged patient. Those are the two crucial things that and they're not in measurement.
Bob Phillips: No, that's right.
Health Hats: I'm a member of NQF, serving on several NQF panels. When I look at the National Quality Forum, I look at what they're measuring. And I can't imagine using those measures to decide what and where to get care when I have the luxury of a few minutes to think about it. As opposed to when I need to go to the ER and something's a crisis. So how does this whole measure to compare line up with what people might use to decide where to get care?

Care Compare.gov. Primary care referral. 10:10

Bob Phillips: So that's a great question, Danny. So, you can go to medicare.gov and pull up what used to be called Physician Compare, which is hard to find. It's now called Care Compare. And you can look up a health system, or you can look up a clinician and the measures they have. You can compare physicians, but I'm not sure that it will be very useful if you do that. That's a shame because that's what this is supposed to do. It's supposed to give you, as a patient, the way to differentiate whether I should go to this doctor or that doctor?

Health Hats: Or for my mother, I'm a caregiver and for them, so you not just for me, for my family.

Bob Phillips: And you'd like something better than Yelp for physicians, right? But gosh, if you put into any search engine the name of a physician, you'll get eight different things that rank that physician based on patient-reported data. And unfortunately, that's what most people have to rely on unless they're fortunate like you to have a primary care doc who might be able to say, I recommend this neurologist.

Health Hats: Yes. Yes. That is big. I found a urologist that my neurologist recommended. My primary care doc was interested that I liked the urologist. So, she added that information to her recommendation to other people. She's hungry for feedback. If she refers somebody, she'll ask me, what was your experience? Was that a good referral? When she sends me to somebody, it's more likely that it's a good referral. So yeah, I trust her, my PCP.

Comparing quality in its infancy 11:54

Bob Phillips: So, I would say, I think that this ability to compare physicians on quality is that it's not a bad idea. It is undoubtedly in its infancy. It's far from baked. And I think the processes we've set up, like the National Quality Forum, where patients are supposed to have a voice. And I'm so glad you're there. Or CMS is an endorsement process driven by National Quality Forum, but not entirely. It's just not quite got it right yet. And it's why we have worked on measures that matter. And we're trying to come up with a very small bucket of important measures to patients. Very important to clinicians and is related to the quality of life and costs, so we have continuity right at the top. NQF already endorses it, and it's in the process for CMS. We have comprehensiveness, the ability of a primary care doctor to deliver most of the care that a patient needs or at least to guide their care to people that they trust. We have a measure. A patient-reported measure called the Person-centered Primary Care Measure was developed by patients, clinicians, and payers. 11 questions from the patient's voice about the quality of the care and the quality of the relationship they have with their clinician. And then we're working on two others that are still exploratory. One is around the total cost of care. It matters more to payers than it does to patients certainly. And in primary care, its continuity and comprehensiveness, how much they keep you from going on to unnecessary, costly care. And then the last one is trust. We developed trust measures 20 years ago but never

implemented them. We will test those with patients to see how they relate to other quality measures.

Trust, always trust 13:44

Health Hats: Oh, there's so much in what you're saying. Let's take the last one first, trust. I often compare all my decisions as a person with a chronic progressive illness. It's like putting in a kitchen. There are so many decisions to make, and I want to reserve only certain decisions for myself. Like I don't want to mess with my pathological optimism. I don't want to hurt myself. I want to keep playing my saxophone. These are important to me. For the rest of it, I want to trust my clinicians. I don't understand why I take a hundred thousand dollars infusion for my MS. I'm intelligent, and he's explained it to me five times. I still don't quite understand it. But he thinks I should do it. So, I do it. And I need to trust, so I don't have to make all these decisions because it's exhausting.

Check out the eleven questions in the Person-centered Primary Care Measure*. Do they matter to you? Would you find them helpful? I would. I've never used the* Yelp of physicians*. I find the Yelp of restaurants entertaining but not helpful. Seems like an evaluation of the values of the rater. I suppose official measures also reflect the values of the measure developers and payers of that development.*

Cost, always cost 15:26

Health Hats: So go to the cost one. It seems like more and more is out of pocket. The part of that is just having some transparency about it. And so, for privileged people, like me, who have a Medicare Advantage Program that pays for quite a bit. Each year there's more out of my pocket. And that is such a complicated conversation because people don't know.

Bob Phillips: That's improved over the last couple of years with hospital cost transparency about what it costs to have a procedure done. I had a hernia repair in October of 2020 before that law went into effect, and my initial charge for the hernia repair was $55,000. So, you can look that up now.

Health Hats: Oh, my goodness.

Bob Phillips: And discounted for my out-of-network plan. It was $33,000. It was ridiculous. Now, if you look at the cost of that procedure on the hospital website, it says $7,500. So, the transparency requirements now by law, I think, will drive down prices and allow patients to compare hospitals on things. And I think that's important, but even upstream of that, I had a hernia. It needed to be repaired. But there's a lot of care that doesn't need to happen. There are a lot of MRIs for headaches out of the gate before we've ruled out other things. There are just a lot of procedures done. I have a patient with what now turns out to be long COVID. But he was a lot shorter of breath than usual, which is often a trigger of having heart disease. He is a 60-year-old gentleman new onset of shortness of breath. And he went through the full

workup before he got back to me, and I just started. It was all normal. Thank goodness. But I started working backward from that symptom, and his cluster of symptoms was just classic for long COVID. Had I known that ahead of time, I probably could have spared him some of that treatment or some of that investigation? It's that kind of relationship, prior knowledge of the patient, and trust that lets you protect them from downstream costs. And the other important reason, Danny, is not just downstream costs. Sometimes those things are harmful. Sometimes those investigations can cause problems. And that's my job, and I can't do it very well if someone doesn't know me and trust me.

Risk adjustment for payment 18:02

Health Hats: Another thing that I've tried on my podcast to explain and haven't done a very good job of is risk adjustment. And I know that when I look it up, it says *risk adjustment is a statistical process that takes into account the underlying health status and health spending of the enrollee and an insurance plan when looking at their healthcare outcomes or healthcare costs.* And I was on an NQF panel about risk adjustment. And I can't say that I came out of the panel understanding any more than I went in. This is how I found you because I went to Bill Lawrence at PCORI and said, I need somebody to talk to. And he recommended you.

You can find a detailed explanation of how risk adjustment is calculated here https://omcare.com/risk-adjustment/. However, I'm not sure you will feel more knowledgeable after you read it. Listen on.

Health Hats: But it seems to me that I know enough about statistics to be dangerous. And I know that when you adjust things, you're diluting something. So, if you're going to average something that happens to a two-year-old and a 90-year-old and you get a 44-year-old, you're not looking at anything of use. So, like in your work, how can we better understand what it is, what risk adjustment is and why it's important, and what it does for us?
Bob Phillips: So, risk adjustment. It's not a two-year-old and a 90-year-old, and now you get a 44-year-old or 45-year-old. If my panel of patients is more complex than another physician's panel of patients and my quality score is lower than that person's, if you don't adjust my quality score, you may think I'm a worse doctor when I'm given the complexity of the patients, I take care of, I may be doing a better job. Risk adjustment is largely to make sure that we're comparing apples to apples when you're deciding do I pay this physician more or less? Because they're doing a better or worse job. From that point, it makes sense. It gets lost when I'm in control of my risk score. And that's driven because it's caused by how many diagnoses I put down for every one of my patients and how many diseases I say they have. And it's not to say that anyone's committing fraud, but it certainly creates an incentive for me to maximize and capture everything I can, making that person look complex. And so, you wind up with some plans who do that exceptionally well. There are electronic health records that have that as an

app on them. Some places get scored very well or paid well compared to others. And it's not really because they're caring for more complex patients. They just do a better job of capturing all those diagnoses, and that's unfair. And some of our Medicare Advantage plans have been criticized because it pulls so much money out of the Medicare trust fund that it will go bankrupt sooner. After all, their panels are risk-adjusted to be very complex, and they get more dollars for that reason. So, it is troubling.
Health Hats: Risk adjustment has to use specific data to decide. And you're talking about one feature, which is complexity, and complexity is the number of diagnoses. But it could be that complexity is the availability of transportation. It's harder for them to get to the doctor. That's the complexity, but that's not anywhere in the numbers.

Risk adjustment for quality 22:39

Bob Phillips: It is not currently. You are right. So, people may have different social issues that worsen their care outcomes, which should also be in the risk adjustment. So let me differentiate. Risk adjustment for payment. Risk adjustment of quality measures.
Health Hats: Oh, okay. Yes. Go ahead.
Bob Phillips: Those are two different things. We've been working very hard on the risk adjustment for payment because we are underpaying clinics that take care of people from poor neighborhoods and rural areas. Because like you said, those people lack fundamental things like housing stability, food security, or transportation. And those things affect their health far more than their diseases. We've been working on creating a new way to adjust payments and consider those things to avoid the gaming problem revealed for diagnoses. We've focused on using your neighborhood.
Health Hats: Okay. Like a zip code?

Census tracts 23:45

Bob Phillips: Yeah. Or even smaller than zip code. Census tracts are usually about 2000 homes, designed to be more like that. All the people living there are more like others living there than people in a different census tract. Based on your census tract at the poverty level, the unemployment level, the homeownership, and a single-family household education level, all those things roll up to a risk score. We can demonstrate those things are related to how long you live, whether you're likely to have a disease like diabetes, and whether you're likely to show up in an emergency room. We can use those to adjust payments so that the clinic taking care of the people in that neighborhood gets more resources to help with housing, food, and transportation. So that's an accurate adjustment on that side.
Health Hats: That's interesting. I hadn't heard it explained like that before. That's helpful.

Now a word about our sponsor, ABRIDGE.

Use Abridge to record your doctor's visit. Push the big pink button and record the conversation. Read the transcript or listen to clips when you get home. Check out the app at abridge.com or download it on the Apple App Store or Google Play Store. Record your health care conversations. Let me know how it went!"

Risk adjustment controversy - one hand gives, and the other takes away 25:36

Health Hats: So, what do you think we should have discussed that we haven't related to comparing and risk adjustment measures.

Bob Phillips: That second bucket of risk adjustment for quality measures, the enemy is the one that is the one that everyone's wrestling with because if you start using those social risk adjustments for neighborhoods, some people are concerned that you'll be hiding poor care for poor people. Some of us have argued back that's not the purpose of risk adjusting the quality measures. It is so that you can understand, based on the social risks of that neighborhood, are we providing better care than it looks like we are? And while we could be doing better, we probably need more resources to achieve that. And if you give more money based on social risk on the one hand and take away money as a penalty because of quality scores on the other. Ultimately, the balance is that clinics may not get any more resources than they did before. And so, we need to pay them more, and then we need to know are they doing better or worse than they should be based on that population. And that's how we're trying to balance.

Measures across time 26:47

Health Hats: One thing that is weird about measures is that they seem like they're point in time rather than over time. To me, the purpose of measuring is to see if I acted how it changes over time. Is it working? How is that part of the deal?

Bob Phillips: That is a fantastic question. The problem is that our measure efforts are in such infancy that we can't yet do that on the measure side. But we're not just in the measure business at my center. We're also part of a certifying board. The role of a certifying board is to help our docs, our family physicians know where am I now? And what can I do to get better? And did I get better? That's part of the certification, and that's why the certifying boards and the measures world, like CMS, need to work together to know where people are at the point in time but then help them improve and demonstrate it.

The Joint Commission certifies hospitals and health care facilities, and the National Commission for Quality Assurance (NCQA) certifies health plans. The mission of The Joint Commission is to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. The National Committee for Quality Assurance (NCQA)

exists to improve the quality of health care. We work for better health care, better choices and better health. *Both certifying boards host a series of quality measures as well. In my career as a quality management professional, I led several health systems and managed care organizations prepare for Joint Commission and NCQA certifying surveys.*

Health Hats: Is a certifying board like the Joint Commission and NCQA, or is it different?

Bob Phillips: So Joint Commission works that way for hospitals. Certifying boards tend to function that way for physician specialties. So, we certify family docs. There's another board for general internists. There's another one for pediatricians. Okay. Those boards should be working collaboratively with the measure world to build better measures, which is what we're trying to do but also to develop ways to help them improve.
Health Hats: Wow. Oh, a lot of food for thought here. I appreciate this. Thank you for your time. I must chew on it.
Bob Phillips: I'm grateful to you for helping me think about how people outside my world understand this. And as you chew on it, if you think of better ways for us to talk about it, I'm happy to come back, Danny.
Health Hats: That's great. Thank you.

Reflection 29:56

Clearly, I care about comparisons and risk adjustment, or I wouldn't devote yet another episode on the topic. I care because I want the best for myself, my loved ones, and you. However, as we've heard, defining **best** challenges us all. Best at what moment in time, under which circumstances, with what values, needs, and wants? Let's take comparing the quality and cost of fine chocolates. I gave my wife a birthday gift of twelve-monthly shipments of various high-end chocolates. We both like dark chocolate. She can't/won't eat white chocolate. I will. The gift costs me $45 per month. That would be way too much for her to spend. Complicated when it's chocolate. The healthcare industry of regulators, funders, and providers compare what they can measure. Measurement, in its infancy, can't yet mass produce measurement of what's important to the public and their clinician partners. How can we manage cost if we can't compare. I know I'm getting $45 a month worth of chocolate. How could the hernia repair range from $55k to $7,500? Makes no sense. What can we do at this point? Most of us, it's likely not on our radar. For those of us with interest and time, we can pay attention. Ask our providers and health plans about cost and quality. Talk with referring docs about what's important to you when obtaining referrals. Give them feedback about the referral. Expect to know the cost of treatment and service in advance. Make a ruckus. Let me know how it goes.