The worst doctor in the worst clinic

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A double distortion lies at the heart of paying for primary care: Clinicians are paid for throughput, charges and piecework—sometimes called efficiency—and are increasingly being "paid" for quality. The piecework creates a process—high volume, high cost, and high charges—that is antithetical to the proper role of primary care in the process of care.

Primary care providers need to spend adequate time and effort on the management of multiple complex problems of individual patients using clinical judgment that is both cost effective and evidence based. They also should target higher risk groups within a practice population that need more attention and creative strategies for care. Doing less pays less under the current system, even if less, in many cases, is better for patients. The term "production" used by health systems to pay primary care doctors is a wonderful metaphor for what medicine feels like. Charlie Chaplin in the factory scene in *Modern Times* captures the feeling better than anyone could describe it.

The term quality is the second distortion—at least how it is used in US health care as determined by insurance companies and the National Committee for Health Care Quality (NCQA), the self-appointed guardian of quality. The current term used is "pay-for-performance" and conjures images of dogs being rewarded with treats for jumping through hoops in the circus. No one, of course, argues against quality, but a lot of clinicians argue about what quality means and how it should be measured. Linking quality measures to payment raises a whole raft of issues for primary care when those payments are also linked to reimbursement for billable services and don't take a practice population into consideration.

A study of pay-for-performance comparing physician attitudes between family doctors in California and general practitioners (GPs) in Britain showed that the British GPs felt better about the process and its subsequent effect on their income compared to the California family doctors who felt overburdened and under resourced.[1] This should come as no surprise. In England, GPs have a base average salary of 100,000 pounds (roughly $180,000) upon which pays for quality can be added but not subtracted. The results are a much better achievement of quality improvement and an increase in compensation of the British GPs compared to the US doctors who, depending on meeting quality grades, put up to one-third of their basic income at risk. In addition, British GPs use quality measures derived from their own practices while California physicians were judged by external criteria, mostly from the NCQA.

I have been in practice at a residency teaching clinic for almost 17 years, a clinic whose population, in contrast to other practices in our health system, is ethnically diverse with disproportionately lower incomes, with a high percentage of Medicaid, permanently disabled and uninsured patients. Every month I get an individual report on how patients of mine meet NCQA measures of "control" of diabetes and most months since this started, I have ranked dead last and our clinic ranks last of all the clinics in the system. So, by externally derived quality measures, after 40 years of being a doctor—at least for diabetes—I have been deemed the worst doctor in the worst clinic.

As I go through my list, I recognize names of patients who are uninsured or, because of high deductibles or co-pays, are effectively uninsured who have enormous economic and social burdens, who struggle with paying to come to our clinic, spreading their medications over longer periods of time than they should because they need to buy food and pay rent. My clinic colleagues and I have looked at our diabetes patients and found that, despite these challenges, we are improving their HgbA1c levels but not making the magic "7.0 or less" benchmark. If we were British GPs, we would be rewarded for progress, but because we are in the United States, we are punished for not meeting externally driven "standards." The quality system in the US is pass-fail, not improvement.

Higher risk practices, just like higher risk school systems, need more and different resources than those at lower risk. Research repeatedly supports the view that more resources improve care in higher need primary care. In the British National Health Service (NHS), community nurses, paid by the NHS, work with each practice to broaden care by doing home visits to patients who are missing care and do care management in the com-

munity, not simply in the office. Higher need communities get more nurses than those with less need. In our practice, we get supported for office-based staff at the same rate or less than practices with less demanding populations. But the current production driven reward system assures that practices with patients who have socioeconomic as well as medically complex problems will have less to invest in care. Disparities in health outcomes in society often mirror the disparities in practice support for clinics trying to care for socioeconomically burdened communities, a concept first identified almost 40 years ago,[2] which stated that "the availability of good medical care tends to vary inversely with the need for it in the population served."

I realize I am not the worst doctor and I know my clinic is not the worst practice—we have been providing consistently high quality care for over 35 years to our community. We are all—whether an "A" doctor or "F" doctor—locked into narrow definitions of quality that are often poorly tested. For example, a recent study demonstrated the risk of increased mortality for type 2 diabetic patients whose HgbA1C is driven below the NCQA goal of "less than 7.0." This study was interrupted before it was completed because of the danger to patients who were treated aggressively.[3] But the "standards" for the diabetes report card hasn't changed. Even if loosening the standards of quality might actually save patients lives', it doesn't seem to matter. Pushing primary care clinicians to put our patients at risk to achieve increased pay-for-performance goals presents an intolerable conflict of interest.

Any attempt to improve the morale and quality in primary care requires changing not only *how much* primary care providers are paid but, more importantly, *how* they are paid. Large groups or collaboratives and insurance companies can find ways to experiment in primary care by paying for populations, which would let the practices concentrate more on innovation than on throughput. An experiment at Group Health in Seattle, Washington, showed that investment in primary care that is not production driven can lower costs, free up more time for patients, and increases both provider and patient satisfaction.[4]

Why not try giving primary care doctors a dependable base income and reward improvement? Ask them to improve the health of their overall practice population rather than meet arbitrary and evidence-poor "benchmarks." Push collaboration with many different health professionals who can divide both the work and the reward for doing better. Discovering new ways of delivering care that would not pit the "high producers" against the rest, and concentrate on health not billings. It would be a better world for doctors and patients alike. It is not too late to try.

References

1. McDonald R, Martin Roland M. Pay for performance in primary care in England and California: comparison of unintended consequences. *Ann. Fam. Med.* 2009;7:121-127.
2. Hart JT. The inverse care law. *Lancet.* 1971;1(7696):405-412.
3. Riddle MC, Ambrosius WT, et al. Epidemiologic relationships between A1C and all-cause mortality during a median 3.4-year follow-up of glycemic treatment in the ACCORD trial. *Diabetes Care.* 2010;33(5):983-990.
4. Group Health Cooperative Shows Investing in More Primary Care Pays for Itself. http://www.redorbit.com/news/health/1707507/group_health_cooperative_shows_investing_in_more_primary_care_pays/. Accessed August 19, 2010.

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