

BY JEFFREY J. DENNING

Does Quality of Care Matter? You Bet!

Of all the managed care buzz words, “quality” is right near the top of the list. The acronyms CQI (for continuous quality improvement) and TQM (total quality management) are shorthand that MBAs use to refer to the approach to manufacturing that the Japanese have used so effectively on us over the past 30 years. Now it’s medical directors lecturing their colleagues on the topic. Is there anything there?

Even in commodity businesses like mining, ranching, and farming, quality issues are used to differentiate products. Before Zackey and Foster Farms, chicken was chicken; now shoppers pay a premium for a brand. Ironically, they are often the same chickens, raised by the same ranchers (now formed into a marketing cooperative) but sold at a higher price. The same is true for Chiquita bananas and Sunkist oranges.

HMO as commodity marketer

Is this starting to sound like HMOs? In most metropolitan areas, there are HMOs, PPOs, IPAs, and other managed care organizations with largely overlapping physician memberships. They are all selling their quality and price advantages to employers and senior citizens, but the doctors, hospitals, and labs doing the work are those that have always done it.

The brand name technique doesn’t always work with commodity products or services. For example, gasoline either burns without knocking or it doesn’t. Any attempt to sell me on how “clean” it is for my car or the environment is way down my list compared to convenience and price. And there’s very little consumer loyalty in that industry. Evidently, there’s commercial value in making a supportable (or believable) case that your product or service is better.

Commodity health care?

This is where it can get contentious with some physicians: “Who said one physician is the same as the next?” They’re right. Health care

isn’t really a commodity service; there are huge variations in quality.

Yet many folks in the managed care business think of physicians’ services as a commodity. To them, like electricity, telephone service, and rental cars, one “provider” is pretty much like the next. Oddly, lots of dispirited physicians we meet think so, too. They throw up their hands in despair when confronted with tough competitors for the loyalty of their patients.

And the patients? Survey after survey shows that patients, in fact, often have strong — uninformed — opinions about which of you are qualified and which are quacks. As to the physicians they don’t know, however, the perception is more like that of, say, gasoline—it either works or it doesn’t.

Here’s what to do: Determine and demonstrate your quality. Sure, it’s unscientific to define quality and then measure it in your own practice. But this isn’t the academy, this is business.

Smart practices are already at work making the quality case to their buyers: MCOs and, within their plans, referring physicians. They’re doing it to get listed on successful plans, to keep from getting ejected from plans, and to get more than their fair share of the business. Spend a weekend thinking about how to do it in your practice now — before you need it. Here’s how you can go about doing the analysis that will give you the marketing ammunition you need.

Step 1. Decide what quality is

List the elements of high quality care, as many as you can. If you believe in and practice evidence-based medicine, for example, put down on paper exactly how you do so, why it’s good, and how it distinguishes you from lesser mortals. Your hospital may have a quality officer who can help you with this quality identification exercise. So can academic experts in your field. Don’t re-do their work if you can avoid it. This research will also give you reported norms to compare your results against.

Step 2. Decide what is relevant

Go back over your list and put a check mark by the quality elements that will be of interest to managed care organizations. They are usually interested in only two or three things — let's call them the "business-relevant" issues:

- absence of patient complaints that result in lost enrollment;
- absence of litigation centered on the physician/patient relationship, such as malpractice and access to required care; and
- lowest possible total cost.

First, notice we said "total" cost. Yes, your fee is part of that cost, but only a small part. Physician fees account for only 15 to 20 percent of the total cost, varying by specialty. But because your pen orders nearly all other costs, you are the focus of the debate. If you can show that your management of patients results in low total cost, your fees can be higher than your competitors' and you will still keep the business.

Second, notice that preventive care isn't on the list. Neither is readmission rate, mortality rate, C-section rate, or all the rest. Some of these may result in lower cost to the plan, but you're going to have to make that connection for them. The executives at the MCO are not trained in what is obvious to you. You explain it to them, you get the business. If you let a competitor do it, you've lost control of the game. Who knows what will happen?

Step 3. Measure it

Now figure out how you'll determine your performance on each of the business-relevant issues. If possible, use retrospective analyses of your existing data or the hospital's. You'll get an answer you can use faster. It's usually more economical to massage the data in your billing system, for example, than to set up a study based on collecting and compiling new information for the next 24 months.

If some of your medical records are on a computer, great. More likely, though, the data file in your hospital's computer will be the source you should mine. The data processing folks over there are always being asked to work up reports on the medical staff. You have probably seen some of them. Ask if they will help you. Go through channels, and be polite.

There's one more source for these data. Well-run MCOs have their own database that you might be able to search. They may have reporting mechanisms already in place or be willing

to help you. Just asking them with a positive attitude is a sign of your quality consciousness.

If the information isn't readily retrievable, maybe you should start collecting it. You could excavate it from your charts or start capturing it with new patients. While that's higher cost, it may be worth it. Get yourself a database management program for your PC, and go to it.

Step 4. Use the results

If the results aren't good enough to brag about, start to improve them. That's what CQI is about. Without the study feedback, your performance is as likely to deteriorate as to improve. And, if the plans come to inspect you, be ready to show steps you've taken to improve.

Even if your results are meritorious, though, it's not enough. Spread the word. Share the good news with the medical directors of all your major plans and, especially, the "closed" plans you'd like to join. Let them see what a mistake they are making by continuing to exclude you from the panel. You have a chance to change the perception of your practice from being ordinary, commodity medicine to one of premium quality at reasonable cost — in other words, good value.

Jeffrey J. Denning, a practice management consultant in Long Beach, Calif., (<http://www.ppgconsulting.com>) is editor of the newsletter Uncommon Sense.
