GET READY TO PLAY THE PROFILING GAME

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These are turbulent times for those of us in the medical profession. We are witnessing extraordinary forces pressuring change in virtually every aspect of health care delivery. As these forces are likely not to recede any time soon, it is the obligation of every physician to be prepared to embrace new ideas and approaches that hold true promise for creating a better health care system. The consumers and purchasers of health care are demanding accountability, and every one of us has a role to play.

Demands for Accountability

What has happened to suddenly thrust issues of accountability into the health care delivery spotlight? For one, widespread concerns about patient safety—sparked by the 1999 Institute of Medicine (IOM) report that up to 98,000 patients die in U.S. hospitals each year as a result of medical errors [1]—have given a whole new meaning to the notion of quality improvement, a concept that, while much talked about in recent years, remains largely unfocused in terms of any major movement. As the *To Err is Human* report suggests, quality of care begins with ensuring that the care we provide does not endanger the health or well-being of patients [1]. So far as addressing the broader issues of health care quality are concerned, the IOM's 2001 follow-up report, *Crossing the Quality Chasm*, indicates that the job will be bigger and tougher than previously thought [2]. Serious and systemic quality problems have been documented across all populations of patients, clinical conditions, and modes of health care financing and delivery.

While the blast of publicity from these two IOM reports has placed the health care industry in the crosshair of public and political scrutiny, economic forces also are raising expectations about accountability. With the recent return of double-digit inflation of health care costs, those who pay the bills are demanding value for their money. Meeting these demands will be difficult at a time when the industry is trying to recover from a period of gross overspending and losses. The 1990s witnessed an array of dynamic industry mergers, many of which were significant failures [3–5]. A large number of health systems experienced fiscal crisis during this period, including hundreds of millions of dollars in operating losses [4] and eventual bankruptcy [5].

Thus, as health systems struggle to maintain necessary operating margins in order to remain viable, they also face pressures to invest in quality-driven strategic operational approaches—a delicate balancing act. Cost and quality, at one time mutually exclusive concepts, are now equally important bottom-line considerations. The consumers of health care—both patients and the employers footing the premium bills—will no longer settle for less than good value for their health care dollar. As a result, quality improvement strategies aimed at uniform care delivery, efficiency of practice patterns, and performance improvement are coming into sharper focus. A call also has been sounded for a new "culture of safety" in the practice and administration of health care delivery [6], including a systems-oriented strategy for error management rather than a "finger-pointing" approach [7]. As Donald Berwick, internationally known leader of the Harvard-based Institute for Healthcare Improvement, stresses, improvement will not come from defense of any status quo but rather from aspiration and bold changes in the ways we provide care [8]. Berwick notes, "As the quality improvement slogan goes: 'Every defect is a treasure.'"

Performance Matters

In *Crossing the Quality Chasm*, the IOM cites six goals for improving the performance of the health care system in the 21st century (**Table**) [2]. The IOM envisions an ideal health care system providing care that is safe, effective, patient-centered, timely, efficient, and equitable. If this vision is the future, how will we get there and what role will physicians play in the process?

It seems safe to say that one principle guiding this improvement process will be the establishment of health care performance standards against which physician and health care organizational performance will be measured [9]. This method is already in place for hospitals and health plans in the form of accreditation. Hospital accreditation by the Joint Commission on Accreditation of Healthcare Organizations is based on

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meeting established standards for patient safety. Health plan accreditation by the National Committee for Quality Assurance is based on meeting established standards for quality in key areas of clinical care and service. In the future, health care organizational performance standards will likely reflect the concerns of all major stakeholders in health care (ie, patients and other consumers, purchasers, providers, and payers) [9].

The clinical performance of physicians also is currently being measured in the form of *practice profiling*, a method that has been variably applied by managed care organizations (MCOs) for some time and that most physicians practicing today can expect to encounter. MCOs often see physicians as a natural focus for gathering performance-related data that can be subsequently reviewed and used to guide initiatives to improve the quality, outcomes, or cost-efficiency of care. Generally speaking, profiles provide physicians with feedback about their practice patterns relative to their peers and to established local or national benchmarks. Profiles usually contain aggregated data that reflect physician performance, typically in the form of rates and averages pertaining to a specified population at risk, and that allow comparisons of patterns of resource use, charges, and patient outcomes.

That said, not every physician will have the same profiling experience because the reasons for and methods of profiling vary in current practice. Therefore, physicians need to understand why and how they are being profiled. For example, is profiling being done purely to educate physicians about performance improvement? Or is it being done to identify more effective providers for economic credentialing purposes? Economic credentialing refers to the use of cost-related criteria independent of quality of care or professional competency to determine a provider's qualifications for initial or continuing hospital medical staff membership or privileges. Although controversial because of ethical concerns, economic credentialing remains the most powerful method of controlling physician behavior.

The intent behind profiling is often solid. Nevertheless, physicians should beware the disorganized or poorly supported effort that has the appearance of a quality initiative, but with little substance behind the program. To properly profile a provider requires considerable resources and the accumulation of data in a given set of fields. Furthermore, the data must be appropriately defined and then "scrubbed" for the highest degree of accuracy possible. Often, the information system personnel handling a profiling effort have a variety of other high priority projects at the same time, making it difficult for them to correctly define data sets that fairly represent a given provider's activities. When this occurs, the provider often is left with the residue of the profiling or must take many hours to cross-check the quality of the profiling effort, typically through the laborious task of formal chart audit and review. Institutions and insurers that use profiling have an obligation to ensure that the effort is supported with appropriate human and financial resources, given the potential high stakes such reporting will have in the future.

Thus, in addition to understanding why or how one is being profiled, it is critical to know that the profiling data can be trusted as accurate. As our experience at Thomas Jefferson University and Hospital in Philadelphia, PA, indicates, a healthy dose of skepticism is appropriate. We have chart-audited many performance profiles (all sophisticated claims-based reports) from several well-known health care insurance entities, only to find time and again that these are often upward of 40% to 50% inaccurate [10]. As important as profiling is to performance improvement, it is equally important that the process be carried out responsibly and in an objective, scientifically valid manner using accurate

Table. IOM Proposed Goals for Improving the Health Care System in the 21st Century

To function as it should, health care should be:
Safe—avoiding injuries to patients from the care that is intended to help them.
Effective—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
Patient-centered—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
Timely—reducing waits and sometimes harmful delays for both those who receive and those who give care.
Efficient—avoiding waste, including waste of equipment, supplies, ideas, and energy.
Equitable—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

IOM = Institute of Medicine. (Adapted with permission from Institute of Medicine Committee on Quality of Health Care in America. Crossing the quality chasm: a new health system for the 21st century. Washington (DC): National Academy Press; 2001:5,6.)

data, as individual careers and the integrity of entire health systems are affected by the process.

Ideally, the future will bring the development of improved profiling methods. Until such a time, we must seek to provide care that is safe and consistent with evidence-based best practices. John Wennberg [11] sounded the clarion call years ago regarding the need to identify and reduce unexplained geographic variations in the care received by similarly ill patients, and as the latest IOM reports suggest, these problems were just the tip of the iceberg. Enormous work must be done to ensure that the care provided to all patients is indeed safe, effective, patient-centered, timely, efficient, and equitable [2]. Profiling, even as it exists today, offers a valuable tool for clinical performance improvement, and every physician should be prepared to participate.

This readiness will depend on appropriate training. Yetman [12], in a discussion on medical error management in a previous issue of *Seminars in Medical Practice*, properly identifies the key role of medical student and resident training as an ultimate performance improvement tool. This approach has been embraced by the Jefferson Medical College of Thomas Jefferson University, where senior medical students and third year primary care residents are exposed to a 1-week curriculum of interactive, problem-based modules on health care quality improvement, evidence-based medicine, and clinical performance improvement. This curriculum repeats every 6 weeks of the academic year and since January 1999 has gone through 23 cycles. Both the Federal government, through the Undergraduate Medical Education in the 21st Century (UME-21) program [13], and the Pew Charitable Trusts and Robert Wood Johnson Foundation, through the Partnerships for Quality Education (PQE) [14], have recognized the importance of supporting such focused curricular efforts by awarding significant grants to U.S. medical institutions for student and resident training.

In this issue, Nadkarni and colleagues [15] present a compelling example of resident training in the methods of practice profiling. It is exciting to see that this successful attempt to use performance profiling with the intent to enter a "Plan-Do-Check-Act" process improvement cycle suggests a future for this approach in every student and resident curriculum. As an industry, we have the chance once and for all to embrace the work of Shewart [16], Deming [17], and Berwick [8] and to carry out their vision of health care performance improvement.

This is a time like no other, when the implications of accountability are profound and the people who use and fund health care will indeed be heard. The rise in patient consumerism, evident in the tremendous surge in the use of Internet-based health information resources, means that patients increasingly will arrive at physician offices demanding answers, explanations, and actions. With double-digit inflation once again raising the specter of more under- or uninsured individuals, those bearing costs of premiums—employers, government, and the self-employed—will expect much more for their investments. The most dramatic evidence of purchaser influence is seen in the recent emergence of the Leapfrog Group, a coalition of Fortune 500 companies seeking to use their collective purchasing power to promote performance accountability in key areas of patient safety [18]. Initiatives such as these will bring demands for computerized medication order entry systems, the use of hospital-based intensivists or hospitalists in acute care, and evidence-based outcomes performance measurement [19].

In the future, profiling will likely become a critical tool that is important not only to those bearing large financial risk (eg, health systems, insurers) but also to the interests of providers and the patients they serve. To effectively create a culture of safety within the health care system, we will need to rely on tools that allow for the scrutiny and assessment of our clinical interventions, diagnoses, and treatments. I have yet to meet the practitioner who does not readily embrace any strategy that can improve his or her performance as a physician. At Jefferson, our attempts to define performance improvement tools have led us to choose the term *support card* over *report card*, in recognition of the importance of stressing "process" over "person" in developing instruments that are not punitive or individualized to the point where practitioners fear the process rather than embrace it.

All physicians, whether new to practice or veterans of the profession, must be prepared to be participants in creating a better health care system that meets these demands. This does not mean blindly adopting every new idea that comes along in the name of quality improvement but, rather, having the knowledge and insight to recognize when true improvements can result from doing things differently. So, be wary but be ready, or else you may not be in the game.

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