

The Problem with “Best Practices”

By David W. Allen, Jr.

Much attention is being paid to encouraging physicians to adhere to “best practices” in their treatment of patients. An open letter written by 14 health policy luminaries was published in a recent *Health Affairs* advocating that reimbursement, particularly Medicare reimbursement, should be adjusted to reflect compliance with best practice standards. The letter states: “The human and financial costs of medical error and substandard care have been exhaustively documented. A robust inventory of measures and standards for quality improvement has been developed and continues to grow”.

In Minnesota, seven health plans have enlisted numerous medical groups to participate in the Minnesota Community Measurement Project, an effort to quantify and publish compliance with “best practices”. Several major Minnesota health plans have expressed their intention to adjust payments to physicians based on their “performance” vis-à-vis “best practices”. The Minnesota Medical Association has affirmed its support for “best practices”. And, a bill is moving through the Minnesota legislature that will establish a role for the state in measuring and disseminating information about “best practices” or “practice guidelines”.

The fact is that few dispute the value and importance of practicing evidence-based medicine; physicians have long been vigorous advocates of this principle. Nor is there a dispute that health care costs are one of the biggest challenges we face as a society; most agree that we need to bring the tools of the medical profession into harmony with economic necessities. But will legislating compliance with “best practices” or “practice guidelines” improve quality or control costs? And will health plans penalizing physicians that fail to comply with such practices or guidelines further progress or cause greater problems?

To answer these questions, it’s important to begin by recognizing that we’re not dealing with well-defined terms. The implication of our state legislature seems to be that “best practices” means adherence to clinical guidelines. Yet others aver that “best practices” means compliance with evidence-based medicine. And there’s even less consensus about how to measure “best practices” or compliance with “practice guidelines” – the proposed state legislation leaves this issue to be addressed by the state’s Department of Health. The result of this lack of clarity is a danger to the quality of medical care.

Clinical guidelines are useful tools that have been developed by organizations like the Institute of Medicine (IOM) and the Institute for Clinical Systems Improvement (ICSI). Yet strict adherence to clinical guidelines should not be confused with evidence-based medicine or “best practices”. Evidence-based medicine, a well-defined term, is not rigid adherence to clinical guidelines; evidence-based medicine takes into account the experience of the practitioner and the uniqueness of the patient. Medicine has not advanced to the point where a cookbook or a computer is an adequate substitute for an experienced physician.

Many advocates of “best practices” and compliance with “clinical guidelines” are oblivious to the distinction between these terms and evidence-based medicine. Simply measuring compliance with clinical guidelines inevitably results in negative scores for the physicians whose experience allows variations of treatment based on nuanced patient assessments, as well as for physicians with patients who are in some way skewed from the “average”.

Some of efforts to measure physician “quality” skip compliance with cookbook medicine and focus instead on the measurement of clinical outcomes. For example, the aforementioned Minnesota Community Measurement Project measures factors like hemoglobin A1C and LDL-cholesterol levels in patients with Type 2 diabetes. Yet it is virtually impossible to separate the influence of physician performance on these outcomes from other factors such as the patient’s behavior (e.g., as influenced by their education and economic status), the patient’s demographics (e.g., age, sex and co-morbidities), or their insurance benefits (e.g., whether their health plan fully reimburses the cost of their diabetes treatment and covers all appropriate drugs). One published study estimates that HgA1c levels are only 3% correlated to physician treatment.

Experiences in other states also confirm that measuring and reporting outcomes does not necessarily lead to improved quality. A number of geographic regions, including Cleveland, Pennsylvania and New York, have published outcome statistics on heart surgery. The New York effort, spearheaded by their Department of Health, has been one of the most sophisticated. The state publishes mortality rates following coronary artery bypass grafts at New York hospitals. Before publishing this information, the state audits patient medical records and adjusts scores by taking into account such factors as the status of the patients’ left ventricular function and co-morbidities. Even after taking into account these risk factors, there’s concern that the publication of this information is causing cardiac providers to turn away the sickest patients who might adversely affect their outcome scores.

So, under the best of circumstances, legislating compliance with “best practices” and encouraging health plans to use “pay-for-performance” to reward compliance with clinical guidelines or good clinical outcomes will have adverse consequences. Physicians who care for the sickest patients, or who treat non-compliant patient populations, will almost certainly be penalized. Physicians with the capability to prescribe treatment in a more nuanced fashion than the most advanced clinical practices will also be penalized. And, there is a real likelihood that all physicians will practice medicine even more defensively with the possible result of yet further increasing costs.

The situation may be even worse than this, however, when physicians are penalized under the name of “quality” for behavior that is only about costs. For example, the state of Minnesota’s DOER health plan (providing health care coverage to state employees and dependents) was cited by the Durenberger Commission as an example of a plan design that rewards quality providers. The truth, however, is that DOER does not reward quality, it rewards negotiating leverage and, sometimes, low fees (N.B., “low fees” is not synonymous with “low cost”). The DOER plan design, which places physicians and hospitals into three tiers, does not have sufficient actuarial basis for assessing quality

(nor, in many cases, for assessing cost) – yet it penalizes physicians and hospitals as though it does. The result is that people are misinformed about the quality and cost-effectiveness of Minnesota providers.

In addition, pay-for-performance schemes announced by major Minnesota health plans are frequently much more about controlling costs than promoting quality. Wrapped in a guise of promoting quality, the initial focus of at least two major health plans is on encouraging the use of generic drugs. While using more generic drugs may or may not be appropriate, it is clearly not about improving the quality of care. Other initiatives (e.g., imaging guidelines for the initial diagnosis and treatment of low back pain) seem also to be chosen not for the impact they will have on quality, but for the impact they might have on costs.

In this difficult environment, the challenge for physicians is to maintain support for worthy goals like evidence-based medicine, promoting quality, economic responsibility and the informing of patients, while simultaneously debunking fallacious “report cards” based on faulty comparisons of outcomes and “pay-for-performance” schemes purportedly assessing the relative quality of physicians. Efforts to encourage the adaptation of measures that truly enhance quality, like clinical guidelines, should be redoubled – but not at the expense of compromising the physician’s exercise of good judgment or the consideration of unique patient circumstances. Patients should be empowered with information about quality, cost and other relevant factors. But false governmental and HMO publications allegedly measuring “best practices” should be exposed for the hoaxes they are.

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