Accountability

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"Accountability" is a candidate for recognition as the most overused word in health policy this year. Yet a Google search produces an abundance of scholarly papers proving that there is no consensus on the meaning of the word, which has been called a "chameleon" and "a subjective construct, informed by experience of it, and one that changes with context, as much as it is a formalized process of reckoning." For purposes of the discussion below, let us agree that "accountability" entails participating in a performance measurement system and accepting the results of public disclosure of one's ratings.

The purpose of this discussion itself is to challenge ASA members to suggest ways of holding health plans accountable.

Leaders in the field of health care Pay-for-Performance (P4P) are calling for accountability among various providers, which in practical terms signals a shift in emphasis from monetary incentives to public reporting. "Publicity for Performance" does not offer much in the way of reward to most anesthesiologists, whose referral base consists of surgeons and hospitals to a far greater extent than it depends on patient choice. Public reporting is, however, an effective way to hold primary care physicians and health care organizations accountable, since it permits comparative rankings. High-ranking providers may attract more patients than those at the bottom of the list. The value of comparative performance information has been the premise of numerous publications, including the feature articles on "America's Best Hospitals" that began appearing in *U.S. News & World Report* nearly 20 years ago.

What about accountability for health plans and not just for physicians and hospitals? There are consumers who have options among the Blues and the Cignas and local HMOs, particularly if they are employed by a very large organization such as the federal government. A health plan can include the area's finest physicians on its panel, but if it incentivizes them to adhere to questionable clinical guidelines or prevents them from providing high-quality care through too-restrictive payment policies, consumers may want to enroll elsewhere. Shouldn't health plans, like physicians and health care organizations, be given incentives to promote quality health care?

Some health plans are in fact being ranked very publicly. In 2005 the National Committee for Quality Assurance (NCQA) collaborated with *U.S. News & World Report* to place in front of 10 million people its ranking of 75 HMOs and point-of-service organizations (PSOs) that contributed standardized performance data. Figure 1 shows the type of information available to consumers who wish to compare HMOs and PSOs of interest.

The executive summary to NCQA's corresponding "State of Health Care Quality 2005 Report" argues that "regular measurement and public reporting drive improvement." NCQA's own data are of limited value, however, if the measures on which health plans are measured may not be valid or meaningful or representative of overall quality. The quality of the measures used is a fundamental issue in all performance-incentive programs.

What if NCQA or another accreditation organization were to measure and report physicians' evaluation of managed care plans? *U.S. News & World Report* bases its hospital rankings on three major elements, one of which is "reputation." In a survey sent to a large random sample, physicians are asked to list the five hospitals they feel are best in their specialty for difficult cases, without consideration of cost or location. The number reported for each hos-

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Figure 1: Commercial Plan Comparison

Plan Name (type)	ConnectiCare (HMO, POS)	Health New England (HMO, POS)	Anthem Blue Cross & Blue Shield (HMO, POS)
Rank	6	11	14
Score	90.8	89.8	89.6
NCQA accreditation	Yes	Yes	Yes
Access to care	★★★★★	★★★★★	★★★★
Children and adolescents	★★★★★	★★★★★	★★★★★
Getting needed care (Avg=79.4%)	85.4%	86.3%	82.9%
Overall member satisfaction	★★★★	★★★	★★★★★
Member satisfaction with care (Avg=77.6%)	81.6%	83.2%	85.5%
Member rating of personal doctor or nurse (Avg=77.1%)	76.0%	77.1%	78.7%
Prevention	★★★★★	★★★★★	★★★★★
Child and adolescent immunizations	★★★★★	★★★★★	★★★★★
Antibiotic overuse in children	★★★★★	★★★★	★★★★★
Cancer screening	★★★★★	★★★★★	★★★★
Regular mammograms (Avg=73.4%)	79.9%	80.3%	77.3%
Treatment	★★★★★	★★★★★	★★★★★
Diabetes care	★★★★	★★★★★	★★★★
Diabetes: glucose testing (Avg=86.5%)	90.0%	92.5%	85.5%
Diabetes: eye exams (Avg=51%)	72.0%	75.9%	64.2%

Chart based on information and figures reported in *U.S. News & World Report,* 2006.

pital represents the percentage of responding physicians who named the hospital among their top five. Physicians' opinions of the health plans paying for significant numbers of their patients might likewise be of interest. One domain on which doctors could provide unquestionably valuable information would be whether the health plan covered all indicated services and procedures in their respective specialties. Another question could ask physicians how likely they were to be participating in the given plan two or three years from now.

Taking this idea one step further, consider whether the target audience for public reporting of anesthesiologists' perceptions of the quality of their managed care plans should include anesthesiology practices. Potential measures include appropriate medical policies and incentives to patients and physicians, fair and honest contract negotiations, lack of attempts to change contract terms during the term of the agreement and prompt payment of claims. If the president of NCQA is correct in saying that the process of measuring and reporting causes performance improvement, and she probably is right, health plans that sacrifice quality to profits may find it harder to compete. Patients and physicians stand to benefit from this form of accountability.

Source Materials:

- *U.S. News & World Report* articles and statistics on best hospitals and health plans: <www.usnews.com/usnews/health/best-hospitals/tophosp.htm>.
- The State of Health Care Quality 2005. National Committee for Quality Assurance 2005 <www.ncqa.org/Docs/SOHCQ_2005.pdf>.

New Manual Available on Ambulatory Surgical Centers

Robert E. Johnstone, M.D., Chair of the Committee on Practice Management, is proud to announce the publication of the latest manual in ASA's Practice Management series. Display copies will be available at the Practice Management booth in the ASA Resource Center at McCormick Place during the 2006 Annual Meeting in Chicago.

There were 239 ambulatory surgical centers (ASCs) in the United States in 1983, the year Medicare recognized them. By 2005 there were 4,900, and this year, the number of ASCs will probably exceed the number of hospitals (4,919 at last count). Surgeons and patients like ASCs. Their rapid, market-driven growth is a prime reason anesthesiologists should understand them.

A new ASA monograph titled "Ambulatory Surgical Centers: A Manual for Anesthesiologists" provides extensive and useful information about ASCs. Judith Jurin Semo, Esq., who specializes in representing anesthesiologists and serves as outside counsel for ASA, authored the monograph in consultation with the Committee on Practice Management.

The manual is available in electronic format only as a file with 254 pages divided into 12 chapters and nine appendices. It contains numerous sample documents, informative tables and practice pointer boxes. The manual has 367 references and hyperlinks to many outside sources. Headings and subheadings, as well as bolded and underlined passages, make finding and identifying important information easy. It is written so well that it could be read from beginning to end, although it is primarily designed as a reference resource. Table 1 shows the basic organization of the manual.

Ms. Semo describes the goal of the manual as to aid anesthesiologists in understanding the practical and legal issues associated with ASC practice and the regulatory environment in which ASCs operate. The manual includes practical considerations involved in evaluating an ASC opportunity and contracting with ASCs, the regulation and accreditation process for ASCs, the Medicare payment structure for ASCs, federal and state laws that apply to physician investments in and practice at ASCs, medical-legal issues relating to ASC practice, benchmarking ASC performance and performance standards in the ASC arena.

Members of the Committee on Practice Management who reviewed the text uniformly praised it. Michael W. Champeau, M.D., wrote, "Overall I think it's superb. Ms. Semo really hits the nail on the head when discussing the political realities of surgeon-owned ASCs."

Randall P. Maydew, M.D., notes, "The chapters are very thorough and complete … Semo's work is always excellent." Karl E. Becker, Jr., M.D., agrees, "It is extremely well written, comprehensive and complete." Asa C. Lockhart, M.D., adds, "As always, Semo excels."

ASA members can purchase the monograph through the ASA Web site for $150. The cost for nonmembers is $350. Find it under "Continuing Education Resources" or go directly to <www.ASAhq.org/continuinged.htm>.

Table 1. Chapters and Appendices of the ASC Manual

1. Overview of the ASC industry and ASC growth
2-3. Evaluating an ASC opportunity and contracting with ASCs
4-5. ASC regulation and accreditation and ASC payment
6-7. Legal issues relating to ASC investment and practice
8-9. Federal antikickback and anti-self-referral (Stark II) laws, and state antikickback and self-referral laws
10. Medical-legal issues relating to ASC practice
11. Benchmarking, pay-for-performance and performance standards
12. Conclusion

Appendices:

A. Checklist — Assessing an ASC Opportunity
B. Sample Medical Director Agreement
C. Sample Anesthesiology Services Agreements with ASCs (annotated) — favorable and unfavorable
D. Sample requests for proposal issued by ASCs and follow-up questions
E-F. Resources for additional information on ASC practice and pay-for-performance
G-H. Glossaries of acronyms, terminology and ASC-related organizations
I. Sample professional courtesy policy

Dr. Johnstone, who is a Professor of Anesthesiology at West Virginia University and serves as the Director from West Virginia in addition to chairing the Committee on Practice Management, can be reached at <JohnstoneR@rcbhsc.wvu.edu>.