REMAPPING DEBATE
Asking "Why" and "Why Not"

What about bending the quality curve?

Original Reporting | By Mike Alberti | Health care, Medicine, Regulation

WHAT IS STORY REPAIR?

As noted in a recent article in The New York Times, "Policy makers on both sides of the aisle see rising health care costs as the central threat to household budgets and the country's fiscal health." With costs treated as the enemy, the prime target has become "overutilization" of medical care, caused both by patients who supposedly devour medical care promiscuously and by doctors who over-prescribe expensive tests.

With this mindset, it's not surprising that the article reported as a happy development that the growth in health insurance plans that require people to pay more out of pocket "means thousands of consumers with an incentive to think twice about heading to the doctor."

Similarly, another recent article, this one reporting on a study that found that doctors using electronic medical records ordered more imaging procedures than doctors who used paper records, was cost-obsessed, having only one throwaway line in the entire article from the study's author that electronic medical record "can improve the actual practice of medicine."

It seemed to us that the question of quality of care was taking a back seat to questions of cost of care — if it got a seat in the health care policy car at all. And it also seemed like the cost-cutting reformers didn't want to acknowledge either that underutilization of health care services is a problem, or that electronic medical records could be a tool by which doctors would be able to identify and rectify situations where their patients were getting less care than they needed.

We thought this enormous hole in the health care debate deserved to be reported on.

— *Editor*

May 2, 2012 — A recent study showing that the adoption of information technology by physicians did not reduce the number of procedures performed was seen as worrisome both by the popular press and by some of the many health care observers for whom the paramount objective of incentivizing providers to embrace health technology is to cut the costs of care.

But further inquiry into the study — and the responses to it — reveals more far-reaching implications: according to several researchers, the overriding focus on cost-cutting has subordinated the goal of improving access to and quality of care, and has ignored entirely the phenomenon of *underutilization* of appropriate medical interventions.

What about underutilization?

The study, published last month in the journal Health Affairs, used survey data from the National Center for Health Statistics to measure the usage of digital imaging, such as CT scans and MRIs, across a broad

sample of doctors and patients. It found that physicians who had access to digitized imaging results — through an electronic health record (EHR), for example — were significantly *more* likely to order imaging tests than those who did not.

Among health policy experts and some members of the Obama Administration, the study is alarming because it calls into question one of the central assumptions undergirding much of the Administration's health policy: that its reform efforts will yield significant cost-savings by helping doctors to reduce the frequency with which they prescribe various medical procedures.

Over the last decade, several studies have found that there is significant overuse of medical imaging in the United States, with some researches estimating that up to a third of all CT scans are duplicative or unnecessary. EHRs and other forms of health IT have been widely touted as having the potential to reduce long-term costs by discouraging unnecessary and potentially harmful treatments, and in 2009 the Health Information Technology for Economic and Clinical Health (HITECH) Act — part of the American Recovery and Reinvestment Act — authorized up to $29 billion in to incentivize the adoption of EHRs.

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> — Rosemary Gibson

"A lot of the conversation about the benefits of health IT has focused on its ability to decrease test-ordering," said Danny McCormick, an assistant professor at Harvard Medical School and the lead author of the study, "but, so far, that does not seem to have happened."

McCormick said that he believes that health IT may have the potential to reduce wasteful care, which he called an "admirable goal." But he also said that, if properly implemented, it has much broader potential: to increase the overall quality of care, not only by eliminating some harmful tests and procedures, but also by helping doctors ensure that they deliver medically valuable care that they currently fail to provide.

"There is a tremendous amount of overutilization, and that's where the conversation has been, but there is also a tremendous amount of underutilization," McCormick said. "If we are serious about improving the quality of care, in some settings that will imply fewer tests. In other settings, some people are going to be getting care that they are not getting now. That makes the question of overall costs a lot more complicated."

Trying to bend the cost curve down, not the quality curve up

McCormick pointed to several studies that have shown that, on average, patients receive far *less* care than would be recommended by basic medical standards. Along with several other health policy ex-

perts, he said that the policy constructed around health IT — and more broadly around issues of payment, delivery, and access — has largely subordinated the goal of improving quality and access to the goal of reducing costs.

Rosemary Gibson is a health policy expert and the author of a book that warns about over-testing. She said that reducing overutilization is essential because unnecessary care can have serious, harmful effects, but she also said that it is improper not to address underutilization at the same time. She has been disappointed in the Obama Administration's efforts, she said, because "what's best for patients has taken a back seat to what is politically feasible in terms of cutting costs."

Indeed, some of President Obama's advisors have framed the goals of health care reform exclusively from the perspective of the need to cut costs, as opposed to the need to increase access of quality of care. David Cutler, a professor of economics at Harvard who served as a senior health care advisor to President Obama, has written that the "true measure of health care reform's success is whether it drives down medical costs over the long term."

Unrepresentative institutions?

The current Obama Administration has fiercely contested the study's findings. Farzad Mostashari, the national coordinator for health information technology in the Department of Health and Human Services, responded by saying that "systematic reviews of the evidence show that EHRs have the ability to give providers the information and tools to provide better care and reduce waste."

> "Electronic medical records are being developed to reduce errors and to eliminate waste," said William Hendee of the Medical College of Wisconsin. "Underutilization is the most difficult part of the conversation to have, and we haven't gotten there yet."

But several independent researchers said that the evidence that health IT can reduce costs on a large scale is inconclusive, and point out that many of the studies attributing cost-savings to Health IT have focused on a handful of so-called "benchmark" institutions, such as the Veterans Administration, which have adopted sophisticated, customized technology infrastructure.

"When you look at the leading adopters, there are usually [cost] benefits," said Jeff McCullough, an assistant professor of health policy and management at the University of Minnesota. "When you do studies of large numbers of institutions, we find that the cost-savings are very small or non-existent."

And health policy experts pointed out that, even in those benchmark institutions, much of the technology has focused primarily on reducing unnecessary care, not increasing necessary care.

In terms of medical imaging, for example, Massachusetts General has adopted a much-referenced system of electronic health records that includes a "decision-support" feature. According to James Thrall, the hospital's radiologist-in-chief, when a physician orders a imaging test, the system analyzes the patient's health history and symptoms and, using medical guidelines, rates the appropriateness of the test. If administrators and supervisors see that individual physicians have ordered many tests that were not rated as highly appropriate, Thrall said, "then we have an intervention with them." Between 2006 and 2009, Massachusetts General reduced the number of high-cost imaging studies performed per 100 patient visits by 25 percent, without negatively affecting outcomes, according to Thrall.

But according to William Hendee, a professor of radiology and public health at the Medical College of Wisconsin and an expert on health technology, EHRs have not been developed so far with the idea of increasing care in mind.

"Electronic medical records are being developed to reduce errors and to eliminate waste," he said. "Underutilization is the most difficult part of the discussion to have, and we haven't gotten there yet."

Thrall acknowledged that the Massachusetts General system was not designed to remedy underutilization, by, for example, suggesting that a test may be appropriate if it has not been ordered. When asked whether he believed that the Administration should develop policy that is more oriented toward decreasing underutilization, Thrall said, "That is not the conversation we're having. The fundamental policy question is not how much health care we need, it's how much health care we can afford."

Other health policy experts said that while the latter question is the one most people are asking, the former is the question that *should* be asked.

Meaningful use

In order to receive federal subsidies for adopting EHRs, providers must first demonstrate compliance with a set of "meaningful use" guidelines that have been designed by the Office of the National Coordinator of Health Information Technology (ONC).

Joshua Seidman, the director of the Meaningful Use Division at the ONC, said in an interview that the criteria are being developed with a three-part aim for health IT: to improve care, reduce costs, and improve population health.

The guidelines, which are in the process of being implemented, specify what kinds of functionality the technology must have, and were intended to ensure that providers do not receive federal money for adopting technology that does not have a clinical purpose (technology that is non-clinical prominently includes systems designed to reduce administrative costs by simplifying the billing process).

"What we are really concerned with is figuring out how we ensure that we can bend the cost curve in a way that does not compromise care," Seidman said. "We think health IT can greatly improve the value we get for the money we spend on health care."

Seidman called the recent study in Health Affairs "just one part of a mosaic of evidence" about the effects of Health IT on costs, but acknowledged that the evidence showing cost-savings has not been conclusive.

However, when asked whether the program to incentivize EHRs would be deemed successful if it improved outcomes but did not succeed in reducing costs, Seidman declined to say that it would. Instead, returning to his talking point, he said, "Again, on balance, the research has shown that the impact on costs is positive."

> "We would be thinking differently if we thought that the fundamental crisis is that millions of people are not receiving the care that they need."— Danny McCormick, Harvard Medical School

Remapping Debate asked Seidman whether any of the meaningful use criteria specifically addressed the question of underutilization. He pointed to provisions that require EHRs to include "patient reminder" functionality, which prompts physicians and hospitals to follow up with patients and make sure that they are following the recommendations of their doctors.

But aside from those provisions, Seidman said there was nothing in the criteria that would encourage physicians to perform interventions that they are not already doing.

"Obviously some providers are already doing a lot of really important stuff," he said. "It would be hard," he claimed, "to ask them to do something new that could take their attention away from an existing priority."

A focus on quality

According to McCormick, the philosophy that cutting costs means reducing care has profound implications for health policy. If the primary focus was on increasing the quality of care, with reducing costs as a secondary focus, he said, we would be making policy around health IT differently.

"I think we would be less concerned with getting this adopted very quickly by everyone, and more concerned with making sure that it's being adopted in the best possible way," he said.

"The cost of care is acknowledged now as the fundamental crisis in the health system, and that's where the policies are coming from," he said. "We would be thinking differently if we thought that the fundamental crisis is that millions of people are not receiving the care that they need."