Op-Ed

Accountability for Health

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AFTER A TERRIFIC 2014 SEASON IN WHICH HE WON 14 GAMES FOR the Baltimore Orioles, pitcher Bud Norris struggled in 2015. He lost 9 games and won just 2. On August 8, 2015, in the middle of the season, the Orioles fired him.

"It's not the way we expected things would go," the Orioles general manager Dan Duquette told the *Baltimore Sun*. "He had a great year last year, but that didn't have a bearing on things [in 2015]."

It's hard to find a job with more accountability than that of a starting pitcher. His statistics are all over the Internet, and candid opinions on his value are all over the radio. A pitcher who plays well can count on lucrative continuous employment, while one who plays poorly finds himself on the business end of the question, what have you done for me lately?

If only accountability were so simple in health care. The professional success of very few health administrators is dependent on the value that their organizations provide for health. One reason is the complexity and controversy surrounding the metrics themselves. For example, there are multiple systems for ranking hospital quality, with little agreement among them.¹ A recent review identified 1,367 measures used in health care, only one-fifth of which are common across measurement programs.²

Efforts to simplify reporting on quality and outcomes have not been easy. Recently, journalists at ProPublica posted surgeon-specific complication and death rates for 8 elective procedures in Medicare (<https://projects.propublica.org/surgeons>), only to face criticism that the data were misleading and counterproductive.

A more fundamental limitation to health metrics is that they may not matter much for professional success, which remains driven by clinical income from the volume of medical services provided. A study of more than 1,800 nonprofit hospitals found that CEO compensation was most closely linked to the number of beds and the use of advanced technology.³ While greater patient satisfaction was associated with a

small bump in salary, CEO compensation was not associated with care quality, patient outcomes, or community health. No points are awarded for improved community health under the health care criteria of the Malcolm Baldrige National Quality Award, considered “the nation’s highest Presidential honor for performance excellence.”

A recent review of experience with the Triple Aim reported cases in which fee-for-service reimbursement worked at cross-purposes with community efforts to improve outcomes and lower costs.⁴ At the physician level, a recent national survey found that more than 95% of the compensation of primary care clinicians, regardless of whether they worked as part of accountable care organizations (ACOs), was based on salary and productivity and that less than 5% was based on quality and community health outcomes.⁵

Nonetheless, there is reason to hope that emerging innovations in health care will spur greater accountability for outcomes. Hospitals on global budgets, patient-centered medical homes, ACOs, and other arrangements have the flexibility—and the incentive—to pay and reward their leaders differently.

A new accountability for health will require a clear and consistent set of metrics. The Institute of Medicine recently published a consensus report of 15 core metrics for health and health care (Table 1). Wide adoption of these measures could bring a much-needed focus, with the resistance to these measures likely to center on two areas: (1) health care leaders will point out that many of the factors contributing to failure are outside their control, and (2) community leaders will note that many of the factors contributing to success are outside the control of health care institutions too.

Both perspectives are right. Yet the reason to press forward is that aligning incentives, even if imperfect, can lead to substantial improvements in community health. When health care organizations, and their leadership, are offered a major financial benefit for achieving the core health metrics in their communities, many initiatives that have little traction now will gain energy. Today, for example, hospital executives may see drug addiction as a community problem largely outside their institution’s control. Yet a hospital can ensure effective screening and counseling in the emergency department, provide treatment on demand, coordinate care, prescribe reversal drugs, and support recovery programs. A hospital can also partner with and invest in a community coalition fighting for broader options for individuals in recovery.

Table 1. The Institute of Medicine’s Best Current Measures for 15 Core Measures^a

Life expectancy at birth
Self-reported health
Body mass index
Addiction death rate
Teen pregnancy rate
High school graduation rate
Childhood immunization rate
Unmet care need
Hospital-acquired infection rate
Preventable hospitalization rate
Patient-clinician communication satisfaction
High spending relative to income
Per capita expenditures on health care
Health care literacy rate
Social support

^aInstitute of Medicine. Vital signs: core metrics for health and health care progress. Washington, DC: Institute of Medicine; 2015.

Similarly, an ACO can invest in a health center’s community family-planning services, which in turn may lower teen pregnancy rates, or support access to healthier food in partnership with a community organization seeking to improve nutrition and reduce obesity.

The scale of rewards available to health care organizations should be based, in part, on demonstrated investments in genuine community partnerships. Accordingly, the performance metrics for these organizations’ leaders should reflect the approach to and the outcomes of health in their community. The fear that organizations and leaders will be punished for events out of their control can be mitigated by providing an opportunity for a compelling explanation (and a potential adjustment) should their efforts fail to deliver results.

Establishing financial incentives for community health should be a priority for the Centers for Medicare and Medicaid Services and other major payers. The enormous sums of money spent for health care make such a profound shift in accountability and reward possible. The need for health improvement across the country makes it necessary.

In baseball, the best pitcher in each league wins the Cy Young Award, which in turn brings fame and fortune and puts the player's team on a path to win the World Series. Such an alignment between individual performance and a community's victory would be a home run in health care too.

References

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