An Interview with Jerry Reeves, MD, National Chief Medical Officer of the Hotel Employees and Restaurant Employees International Union (HEREIU) Welfare Trusts

The new focus on accountability

By Brian Klepper, PhD

A pediatric oncologist by training, Dr. Reeves began his practice in the US Air Force, eventually rising to become Chief of Clinical Medicine in Europe. After leaving the military, he served Sierra Health Services in Las Vegas as chief medical officer and then, in 1997, joined Humana Inc., as chief medical officer, where he focused on aggressive medical management and performance improvement programs.

In 2000, Dr. Reeves became CEO of WorldDoc (www.worlddoc.com), a health management firm in Las Vegas for employees and patients. Subsequently, he was recruited as president of Las Vegas operations for the Culinary Fund Health Plan which, as part of a larger labor-management multi-employer healthcare coalition, implemented healthcare improvement and medical cost management programs for about 320,000 Las Vegas residents. Under Dr. Reeves's guidance, quality and cost outcomes improved and he was asked to oversee the health programs of HEREIU workers around the country. These health plans provide health insurance coverage for about 185,000 people in 22 states.

As a prominent and highly effective health plan executive, and someone whose experience and sympathies lie with cancer care, we asked Dr. Reeves to talk about the dynamics of the healthcare environment and how the coming changes will affect community oncology practice.

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Community Oncology: You have had a varied career that has evolved from direct patient care to population-level management. Did your oncology experience color your understanding of the must-dos in running a health plan?

The key lesson I learned from practicing pediatric oncology was that protocols and flow sheets facilitate disciplined patient management. Most of my kids were on clinical trials, and every patient visit included a flow sheet with all the parameters that I tracked. It served me well in taking care of patients. This routine began when I entered my first practice in the military, and I thought everyone practiced this way. So when I took on executive leadership and medical management roles as a civilian, it was natural to think that all healthcare could be monitored and managed this way. I was surprised to learn that much of healthcare lacked good tools to identify care gaps. And often, the gaps that we knew existed were simply ignored.

So where do you see oncology practice fitting in between public health policy and private care?

To me, oncology practice is more akin to the population management and care management approaches that are traditionally applied in larger healthcare organizations. It is a natural to transition from one to the other.

Do you see oncologists aligned with evidence-based medicine?

I think as a group they are. As a medical director, I constantly reviewed clinical records from physicians in every specialty. As a rule, oncologists' charts are highly organized and focused on best practice. They learn to track the scientific literature for what is most effective, and then they apply that rigorously. But they're also devoted to the emotional needs of their patients. The doctor-patient relationship in oncology is often intense and open. There's a great deal of sharing, trying to ensure that patients make informed decisions.

Dr. Jerry Reeves

The picture is getting a lot more complicated. Tell us what you see coming down the healthcare pike.

As the payers for Medicare, Medicaid, and job-based coverage, the federal government, state governments, and employers have the most skin in the game. And they are extremely worried about the cost explosion and

the survivability of their health coverage programs. They know they have to do something that is more than tweaking the dials and trimming the edges.

This is forcing a new, energetic focus on transparency, accountability, and efficiency. There's tremendous waste in healthcare, much of it hidden in sloppy behaviors. Lucian Leape, the Harvard physician famous for his work on medical errors and safety, showed a slide recently that compared error rates in different industries and for different activities: healthcare versus flying an airplane, riding motorcycles, bungee jumping, and so on. By far, healthcare was the least safe of any of these activities.

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The irony is that we've known for years which processes will eliminate the safety discrepancies and the care gaps. The evidence is there, and nobody balks at whether the practices make sense, but they're followed less than half the time. Purchasers have a significant appetite for and a rapid ramp-up to reporting and addressing problems and opportunities. There's a push to use information technologies to identify care gaps in real time and to reach out to people and close those gaps. Just as important, they're beginning to make doctor and hospital performance scorecards available to the public and to the boards of directors of major healthcare organizations.

There's a lot of talk about such accountability. But so far there is really very little activity in this area. Are health plans actually responding to these issues?

I believe the healthcare marketplace is clearly moving in this direction. I don't know that the health plans are necessarily championing accountability yet. But many others are. The Centers for Medicare and Medicaid Services [CMS], Leapfrog, the National Quality Forum, and a number of employer healthcare coalitions are posting hospital performance scores on publicly available websites.

For doctors, it's more daunting and more difficult. Some organizations are identifying Centers of Excellence, based on their efficiency—or cost—and effectiveness—or quality—and referring people to them preferentially. So the notion of value-based purchasing is gaining more acceptance. This interest in using data to drive buying decisions is at the root of recent pay-for-performance initiatives that apply to hospitals and doctors.

How are you putting these initiatives into pratice in your plan?

Our plan compares both hospitals and doctors. We're fortunate to have a quality improvement organization for Nevada and Utah that measures our hospitals' adherence to CMS core measures. But it goes a step farther and compares every hospital's performance to the performance of the 3,000 hospitals that report to CMS each year. Each hospital is given a composite percentile ranking for the 9 or 10 measures used. The percentile rankings compared to national benchmarks range from very good to very bad.

The variation is very interesting to the employers and unions who are members of our healthcare coalition. Right now we're going through the decision-making process for our next contract renewals with the hospitals. Deciding who we're going to contract with has become one of our top priorities.

For some time now we've taken our medical, pharmacy, and laboratory claims and generated reports on all physicians who in a year have received at least $10,000 from us and taken care of at least 50 patients with various episode types. We use a measurement system called Episode Treatment Groups, or ETGs. The system groups all care and costs associated with a particular condition—the doctor's work, the laboratory, prescription costs, and the clinical facility. In that way you can compare physicians in terms of how costly they are for those episodes.

Typically, to get the same outcome, the most expensive doctor is eight times more costly than the least expensive doctor. This may be comparing family practitioners' management of ear infections, internists' treatment of urinary tract infections, cardiologists' management of chest pain, or orthopedists' performance of knee replacement. We discovered that the obstetricians in our town have primary C-section rates ranging from 7% to 60%. That kind of variation is pretty difficult to explain on a purely evidence-based, scientific, medically necessary basis.

So we feed the performance comparisons back to the doctors, showing their rank compared to their peers, including episode treatment costs, prescribing patterns, and workload distributions. This gives them a heads-up on whether we think their performance seems reasonable. Many doctors haven't had this kind of feedback since they left residency.

This kind of information also helps us decide whether we can afford that doctor, and we let them know that. Often, they have legitimate variables that explain why they are more expensive than their peers. We see this, for example, with back surgery, where certain surgeons are the ones who take all the worst backs, so naturally their efficiency looks worse.

Doesn't the ETG analysis account for that?

It does account for some of it. But when you drill down into the details,

you can see that these administrative tools are only a good start. You realize there's no single measure. In addition to cost efficiency, there are a number of variables at play. There may be a physician who is the only one who speaks Spanish for 10 miles around or the only one with extended hours. Lots of variables can influence whether we keep a doctor in our network. We need to take those variables into account when making a contracting decision. But the larger point is that this kind of information is getting to be more available and will be shared with physicians, including oncologists.

The message you're sending is that, "Physicians need to pay attention because purchasers are going to make network decisions based on the numbers." That really is new. That was the threat of managed care, but it was never carried out. Now you're saying that it's actually happening.

It is happening. People can't afford the things they were willing to afford before. It's just not sustainable. In your own work, you've given examples of business leaders who say that their health benefits cost more than the raw goods needed to produce their services and products. In 2005, the average cost of health insurance was higher than the minimum wage across the country. When the benefits cost more than the wages—and that's happening more and more—it doesn't take a genius to figure out that something's got to give. So the heat is on.

Lets turn for a moment to Medicare, which is squeezing community oncologists in several ways. First, there is the looming prohibition on directly providing drugs, which could have an enormous impact on income. Second is the just-dodged but likely inevitable reimbursement cuts to all physicians. Will these trends provide a precedent for private-sector health plans?

The private sector has followed Medicare all along, because it represents the largest bucket of money paid for healthcare services. Often, it sets the tone and others follow. If you want to see what the private payers will be doing, look at the public payers.

To understand the issue of oncologists keeping their heads above water by redistributing available margin, it may be helpful to look at the pharmacy benefit management [PBM] arena. For years, PBM managers made much of their money in ways that were not clear to the people paying for their services. They were profiting on the spread between the average wholesale price discount and what they were actually spending by buying drugs in bulk and repackaging or by keeping rebates available from volume purchases.

But more and more, purchasers are saying, "We'll pay you for the services you do, but that money from rebates, spreads, discounts, and the like is not your money. It's our money. We'll pay you a fair price for processing the drugs, but we want everything else back. We'll audit you, and we'll pay you more per transaction to make sure that you can stay in business."

These principles apply to oncologists as well. The payers will be willing to pay more for the oncologists' time, materials, and services. But I think that having the oncologist as the broker for chemotherapy agents is going to phase down.

So given the external forces, what's your advice to the community oncologist? What steps are in the best interests of the patient and the physician?

If I were a practicing community oncologist, I would be collecting data and information that prove my value to the people who pay the bills. I'd try to show higher-than-normal patient satisfaction, better-than-average efficiency, and more-than-normal transparency of what it costs me to deliver the services. I would try to negotiate fees that cover my costs and allow me an income, but I would decrease the obfuscation and hiding the details behind the scenes. I might put together reasonable pricing for packaged care of a group of diseases, including my services and those of the radiotherapist and the surgical oncologist. The world is moving toward accountability, fairness, and transparency, and the first people through that gate will be the winners. The total cost and results of what practices do are more important than the price per unit of each activity.

I'd also increase the efficiency of my office practice as much as possible. It doesn't all have to be electronic, but the new tools can add to your efficiency if you can afford them.

Go to the people who pay the bills and ask, "What do you need that I may be able to deliver?" I would do my best to deliver the efficiency and effectiveness that the healthcare system needs and demands.

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