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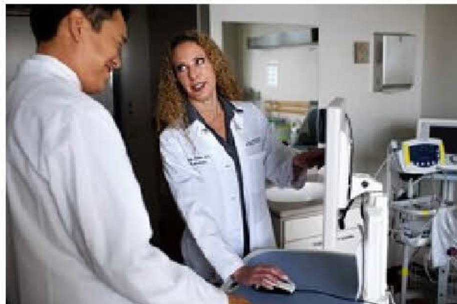
Hospitals Prescribe Big Data to Track Doctors at Work

By ANNA WILDE MATHEWS

Marnie Baker, a pediatrician at California's MemorialCare Health System, has an easy manner and ready smile. Now, though, her job is to be the bearer of a serious and, for some of her colleagues, unwelcome message.

She's the voice of a program that digitally tracks their performance, informs them when they don't measure up—and cajoles them to improve.



Dan Krauss for The Wall Street Journal

Marnie Baker, a pediatrician whose job is to win over colleagues to data-tracking efforts, shows equipment to fellow doctor David Kim.

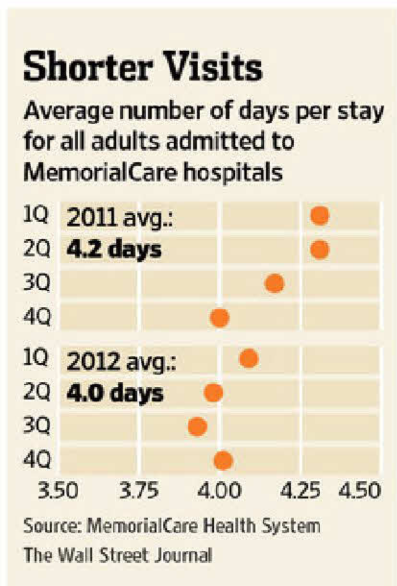
MemorialCare is part of a movement by hospitals around the U.S. to change how doctors practice by monitoring their progress toward goals, such as giving recommended mammograms. It isn't always an easy sell. At one clinic earlier this year, physicians grilled Dr. Baker, who is director of performance improvement at a MemorialCare-affiliated physician group.

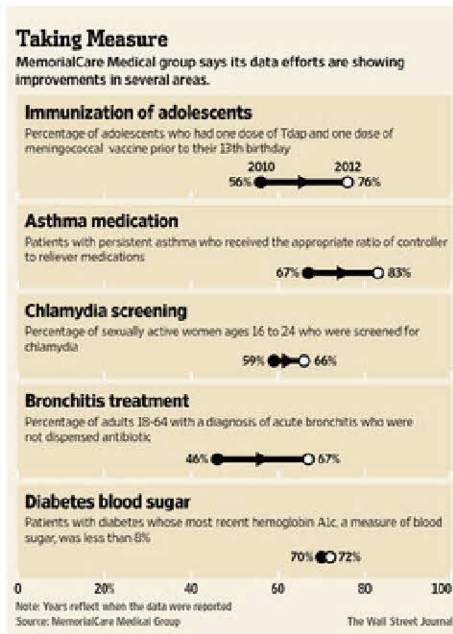
Cardiologist Venkat Warren said he worried that "some bean-counter will decide what performance is." He wondered whether doctors would be pushed to avoid older and sicker patients who might drag down their numbers.

"If it isn't cost-cutting, what is it?" Dr. Warren asked.

"It's providing better value," Dr. Baker responded.

Encounters like these are one result of the changes sweeping American health care. Technology is making it easier to monitor doctors' work as patients' details are compiled electronically instead of on paper charts. Software makers are selling new tools to crunch the data. Software called Crimson offered by the Advisory Board Co. now includes information on more than a half-million doctors, up from fewer than 50,000 in 2009.





At the same time, more physicians are going to work for hospital systems, which are under pressure to hit quality goals and cut costs. Many are striking deals with insurers that pull them away from traditional "fee-for-service" reimbursement, which pays for medical procedures individually.

Insurers—which themselves increasingly track physician results—are moving toward providing a set payment for the overall care of a patient. This system means that doctors who provide costlier-than-average care could break the budget.

The federal health law is speeding these trends. Under the law, hospital payments and penalties from the federal Medicare program will be linked to their performance on quality gauges, particularly rehospitalizations, which are costly. The law also created a new Medicare initiative for "accountable care organizations," providers that get extra rewards for efficiency and quality performance.

To succeed under the new health-care economics, hospital executives say, they must lean on doctors, who make nearly all the key decisions on what treatments, tests and drugs patients get. "The last frontier is the physicians," says Thomas Heleotis, vice president of clinical effectiveness at Monmouth Medical Center, part of New Jersey's seven-hospital Barnabas Health system.

A few years ago, he ordered up a list of the 20 physicians practicing at Monmouth who were costing the most money and sat down with each to go over their data. Several trimmed services like repeat lab tests and daily X-rays, he says, and those 20 are no longer among the costliest. Their patient-mortality and complication rates also improved, he says.

Some of this has been tried before, with mixed results. In the 1990s, hospitals bought up doctor groups, and insurers tried paying for care based on per-patient fees instead of charges for each service. Patients and doctors pushed back, and many of these initiatives failed financially. Tying doctors' pay to their performance isn't a new idea, either, and the effectiveness is debated.

What is different this time, some hospital executives argue, is that new technology enables closer, faster tracking of individual doctors, and the new insurance payments factor in quality goals. But partly because many of the efforts are new, broad results are scarce. The Advisory Board says that among hospitals using its software for three years, lengths of inpatient stays fell 2.9%, on average, and readmissions fell 4.5%.

Hospital executives nationwide say that many doctors, particularly younger ones, are receptive. But others feel second-guessed. "The whole way you get trained is to be the decider, the captain of the ship," says Michael Sills, a cardiologist and technology executive at Baylor Health Care System in