OBG MANAGEMENT

Pay for performance: We'll be better off

How P4P benefits our practices and our patients

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Like everything else, Pay for Performance (P4P) has inherent rewards and risks. For our patients, rewards include improved clinical care and outcomes, and for us, enhanced earnings. Among potential risks are a failure to earn higher compensation if we don't participate in a voluntary P4P program, and/or finding our practices excluded from "preferred" status as more plans move toward tiered networks. P4P might be one way a plan decides which practices to include in a preferred network, advertising only practices that meet the "higher standards" of P4P.

Like it or not, P4P programs are already a reality for many of us, and their continued proliferation seems inevitable. This article describes the typical trajectory of a P4P program, the importance of being involved in program design as early as possible, and the challenges and successes of P4P thus far.

P4P goes a long way back

In 1986, Robert Fulgham wrote an insightful book entitled *All I Really Need to Know I Learned in Kindergarten*.[1] It's hard to argue with the basic premise of that title. When I think back to my early school years, I remember well the reward for achievement: a gold star. And I was intent upon achieving my teacher's goals. Why? For the gold star, of course. That was my first experience with P4P.

Let's fast forward a few decades to focus on more sophisticated versions of the gold star, and consider what we need to know to be ready for P4P in our own practices.

5 critical questions

Although our involvement with P4P in health care has so far been limited, we are rapidly recognizing some of the challenges involved. Questions that must be answered include (but clearly are not limited to) the following:

1. Do P4P programs improve care?
2. How do we define "performance"?
3. How do we define "quality"?
4. How do we measure quality?
5. How do we measure the measures?

Although a Robert Wood Johnson Foundation report issued in November 2005 concluded that P4P programs "can improve both medical care and quality of life by giving health-care providers a financial incentive to seek measurable improvements in the health of their patients,"[2] it may be too soon to make such a statement. According to a comprehensive and heavily documented article from the August 15 issue of *Annals of Internal Medicine*,[3] "ongoing monitoring of incentive programs is critical to determine the effectiveness of financial incentives and their possible unintended effects on quality of care."

Answers are on the way

We should soon be able to begin answering some of these questions, however. According to a major survey from 2005, the number of P4P programs in the United States more than tripled over the previous 2 to 3 years, totaling 115 in 2005,[4] and it is very likely that the rate of increase will accelerate. The 2005 survey also disclosed

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Department of Defense started it

The concept of P4P is not new outside the realm of health care. Besides dominating the education process (remember those gold stars!), it has been around in government and the business world for many years:

- Despite the tremendously bureaucratic federal government "General Schedule" (GS) employment system and rigid pay scales, the Department of Defense authorized a demonstration P4P project as long ago as 1980. It became a model for government merit-based pay.
- Recently the government began taking steps to convert from the GS system to one that will link pay to job performance.[9]
- Many—if not most—businesses use merit raise systems, often associated with a pay-scale model.

Business experts question validity. Just as the P4P model is beginning to creep into health care, questions are being raised about its validity. In 2002, the *McKinsey Quarterly* asked "Has pay for performance had its day?"[10] Business journals questioning its value include a source no less luminous than the Harvard Business School.[11] The arguments suggest that a formal program with defined objectives might have the unintended consequence of stifling both creativity and new ideas.[10] And, as more participants achieve the higher goals, it becomes more costly for the company, necessitating upward adjustment of goals, which might frustrate participants.[11]

P4P a "natural" for big-business health care? Application of P4P principles is in many ways the natural next step as "big business" and health-care models become further intertwined.

some key findings, including the following:

- Sponsors cited "clinical improvement" as the main reason for creating P4P programs.
- ObGyns were the specialty most likely to be included in programs (70%), followed by cardiologists (58%) and endocrinologists (47%).
- The most prevalent measurement was "clinical quality," followed by "efficiency" (sometimes a code word for "costliness").
- There is a trend away from measuring "patient satisfaction" and toward measuring adoption of electronic technology.[4]

Measures that overlap 2 specialties are not necessarily bad

Measuring "clinical improvement" or "quality" is particularly challenging. Outcomes are difficult to measure and influenced by many factors, only some of which are within our clinical control.

Should we use Health Plan Employer Data and Information Set (HEDIS) measures as a proxy for quality, such as rates of cervical or breast cancer screening? We must agree that it's good to screen for breast and cervical cancer. Unfortunately, many HEDIS measures fall into the no-man's-land between obstetrics and gynecology and primary care—especially something like mammogram compliance.

As much as possible, we need to have input into program design, and should always suggest measures that fall more clearly within our domain, over which we have more control. However, measures that overlap 2 specialties are not necessarily bad. We will share the credit even if the primary-care physician (PCP) is the one who gets the patient to go for her mammogram—and the likelihood that the patient will be motivated to do so will be doubled, because both the PCP and the ObGyn will be recommending it.

We also need to recognize that P4P is already a certainty for many of us. That means someone is defining the measures by which we'll be judged—and it might as well be us.

Private payers will have big impact

Although the Center for Medicare and Medicaid Services (CMS) is working with various physician groups and health organizations on several demonstration projects,[5] its programs are complicated and not germane to many ObGyns at this time. We will see far greater impact on our practices from the private-payer P4P programs that are coming.

Most programs start simply

A typical privately sponsored P4P program usually starts off relatively simply and then, upon review (usually annually), is modified as the capabilities of both the sponsor and participants expand. One major insurer (a

national payer) has a program that tracks several "process measures" (as opposed to "outcomes"). These include:

- Breast cancer screening
- Cervical cancer screening
- Chlamydia screening
- Postpartum follow-up

These are all HEDIS measures, and the plan itself is measured through them and other factors by the National Committee on Quality Assurance (NCQA). Accomplishing these goals is good not only for our patients (because they are undergoing appropriate screening), but also for the plan, whose NCQA ratings will improve as a result of improved HEDIS compliance.

The program also measures the extent to which a group adopts technology such as electronic medical records (EMRs), electronic health records, e-prescribing, and an electronic disease registry. This last item can be something as simple as a recall system within the larger practice-management system to ensure that patients with abnormal Pap tests, mammograms, and other lab studies are not lost to follow-up.

First, learn to walk

As in the example above, a program should start with several easy-to-measure indicators, such as processes that are either done or not done, whose performance can be tracked through administrative (billing) data. After some attention is focused on these indicators and as goals are reached, the indicators may continue to be monitored or be put aside for a variety of reasons. Gradually, other, more sophisticated measures will be introduced.

The program should mature as our experience grows and data systems improve so that, ultimately, we look at true indications that quality has improved—better outcomes, hopefully at a lower cost.

Emphasis on generic drugs will save dollars

For many plans, increases in generic pharmacy utilization will be rewarded. Now, the cynics among us might conclude that P4P is really all about saving money for the health plans. Remember, however, that most plans have tiered copays for prescriptions, and the patient herself will save a substantial amount in copays if you can prescribe a generic alternative—particularly in high-volume pharmaceutical areas.

Also realize that, if we want a P4P program to reward participants without taking away from those who don't achieve their goals, the money has to come from somewhere. Savings generated from a successful pharmaceutical program can drive the P4P program and pay for more substantial rewards.

How your patients benefit from P4P

Assuming a program actually gets us to change our behavior in a positive way, it should result in improved quality of care. This entails obvious benefits for our patients, such as when we succeed in getting a woman to obtain a mammogram. Let's say the P4P incentive to increase the rate of mammography leads us to change our office workflow and actually make the mammography appointment for the patient before she leaves our office. This may "cost" us a bit more staff time, but it will help us meet a goal that will increase our return from the P4P program and help the patient get a needed service.

We briefly touched on the reduced cost of generic drugs, which has the potential to save the payer incredible sums of money. But this reduction in cost has benefits for the patient, too, who may appreciate the lower out-of-pocket cost of generic drugs.

My experience: Better postpartum depression, chlamydia screening

Last year, one of our programs included a measure of postpartum depression screening. To meet the goal, we developed a brief worksheet that included the Edinburgh Depression Scale. This worksheet was distributed throughout the practice, and almost everyone used it at the postpartum visit. Our doctors and midwives were

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amazed at the number of cases of even mild to moderate depression that were discovered using this tool, and felt they had truly improved the quality of care by performing this screening more formally.

Chlamydia screening is another example. By implementing it in a more wholesale fashion, screening becomes easier to perform. Value judgments about a patient's lifestyle are no longer necessary, and patients accept the screening as part of a larger program rather than as a by-product of their "high-risk" lifestyle.

The bottom line: If appropriate measures are included, we should be able to change clinical behavior and improve patient care.

Bonus could be bigger than you think

Rewards can be substantial in P4P programs. For example, they might consist of a bonus check delivered to the practice once or twice a year, or enhancement of the fee schedule by a certain percentage for the following year. The bonus check, too, may be based on a percentage calculated on top of total earnings from that payer during the time period measured. The precise enhancement possible is proprietary information for most plans, but generally ranges from 0% to high single digits.

That may not sound like much to you. But let's assume you can earn up to 7%. Let's also assume you have annual collections of $1 million in your practice and a particular payer is responsible for 25% of your revenues. That 7% would total an additional $17,500. If all your payers sponsored P4P programs and you did as well across the board, that would result in more than $70,000 in enhanced revenues—right to your bottom line.

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With a 7% enhancement and $1 million annual collection, you could get a bonus of $70,000

Who's looking out for ObGyns?

Many organizations are focusing on P4P, but the activities of the American College of Obstetricians and Gynecologists (ACOG) are most relevant. ACOG has been developing performance measures and plans to incorporate them into new practice bulletins. So far, 21 measures have been developed and are being beta-tested. Approximately 40 more measures are under consideration. The biggest problem to date: The data needed to evaluate performance are not readily available without chart review.[6]

How data are obtained is a rate-limiting step at this point—and perhaps always will be. Chart reviews are highly inefficient and costly, and often rely on extrapolation of results from a limited sample to the whole universe of charts. Sampling errors may be unavoidable.

Large groups may have a technology advantage if they can afford sophisticated practice-management systems—or even EMRs—that make it easier for them to prove compliance with a P4P program. Smaller groups would face increased costs for "mining" their own data manually, or find it necessary to rely on data developed by the P4P sponsor.

One of ACOG's chief concerns (as well as that of other physician-friendly organizations) is design of a P4P program that can be easily implemented in any size practice.

EMR use remains limited

A recent article at www.amednews.com cites a 2003 survey showing that only about 25% of physicians have access to EMRs.[7] A more recent article from *Health Affairs* puts that figure below 20% and identifies barriers to EMR implementation.[8]

The important point: Until we all use EMRs in our practices, P4P programs must be designed to work within the limitations of our data capabilities.

The Accreditation Association for Ambulatory Health Care's (AAAHC) Institute for Quality Improvement has developed principles/guidelines for P4P (see www.aaahc.org), as has the AMA, with agreement in many of these areas.

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Will anything bad happen if you do not participate?

In an age when "consumer-driven health care" and "transparency" are becoming everyday mantras, a practice must stay ahead of the curve as much as possible and not be left on the platform as the train pulls away. Make no mistake, part of the P4P rewards system in the future will be public recognition, which will help payers drive their members to the "better" doctors. A refusal to participate in a P4P program might initiate a downward spiral from which it may be difficult to recover.

I don't mean to imply that the move to consumer-driven health care is necessarily a bad thing. After all, ObGyns are frequently chosen by patients on the basis of word-of-mouth recommendations. I'm simply saying that, if data about us are going to be available for members to peruse prior to their selection of a provider, we should try to control that data as much as possible. It is vitally important that measures used to qualify us as "high performers" are, first of all, meaningful and, just as important, accurate.

A major risk is that a focus on process goals interferes with our attention to outcomes. What good is it if every patient undergoes cervical cancer screening if we don't properly triage abnormal results? P4P should not distract us from what should be our raison d'être: giving the best quality care we can, leading to the best outcomes.

How can we prepare?

- **We need to help create the yardstick** by which we will be measured, through input into the design of programs as much as possible. For smaller groups, this might mean relying on the clout of ACOG or other medical societies.
- **We must invest in technology.** EMRs are very expensive, but ultimately will be necessary to provide the information we need and to avoid having to rely on the sponsor's data when it comes time to measure our performance. One way to mitigate the up-front cost is to approach EMRs incrementally and begin with "EMR-Lite," eg, using a patient portal through an enhanced Web site and e-prescribing tool. Others might prefer to get the pain over with more quickly. Data and information are important. The more we can access our own data, the better off we'll be.
- **Prepare for the sea change.** We must get ready or face extinction. P4P is part of our future.

And remember, at least in theory, P4P makes sense. If we can accurately measure quality and fairly identify higher-quality providers, we can reward them appropriately. If it is possible to improve quality by driving more providers to meet higher standards, then the program is worthwhile.

Most of us feel that we are at least among "the best" in our practice market area. Here is an opportunity to prove it and earn that gold star! ■

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The author reports no financial relationships relevant to this article.

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Make no mistake: patients will go to the "better" doctors