

MedPAC: Physicians Ready for Pay for Performance

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WASHINGTON — Congress should establish a quality incentive payment policy for Medicare physicians, the Medicare Payment Advisory Commission recommended.

In light of the challenges facing Medicare, “nothing is more important” than distinguishing between providers based on performance, MedPAC Chairman Glenn Hackbarth said at a commission meeting.

“Providers are not all created equal—there’s abundant evidence that some providers do a better job than others. To continue to pay them as if they’re all performing equally well is a tragic situation,” he said.

And that was just one of several of the commission’s recommendations aimed at establishing a pay-for-performance system across health care channels, using information technology in Medicare initiatives to financially reward providers on the basis of quality.

Smaller practices in particular may not be ready to provide the clinical information necessary for a mature pay-for-performance initiative.

At press time, the recommendations were scheduled to appear in MedPAC’s March report to Congress.

“Physicians are ready for a pay-for-performance program,” Karen Milgate, a MedPAC research director said at the meeting.

Those participating in such a program could use various facets of information technology to manage patients, such as registries to track patients and identify when they need certain preventive services, or systems for detecting drug interactions, Ms. Milgate said.

These types of information have the potential to improve important aspects of care, and increase physician ability to assess and report on their care.

“Without information technology, it would be difficult for physicians to keep up with and apply the latest clinical science and appropriately track and follow up with patients,” she said.

“This is true for primary care and especially for patients who have chronic conditions. But [it is] also true for surgeons and other specialists, to ensure follow-up after acute events and coordination with other settings of care,” she commented.

Considering that it is the only information collected on physicians, Ms. Milgate pointed out that claims-based measures could be used to determine whether beneficiaries received appropriate follow-up care.

The claims-based process puts no burden on physicians and research shows it’s widely available for a broad group of beneficiaries and physicians, she said. “How-

ever, the depth of information on each kind of physician is unclear and we do know that claims based measures are not available for every single type of physician.”

Because these actions would redistribute resources that are already in the system, they would not affect spending relative to current law, although they may increase or lower payments for providers, depending on the quality of their care, she indicated.

Nicholas Wolter, M.D., a MedPAC commissioner from Billings, Mont., cautioned that physicians may be reluctant to embrace yet another change that would limit their revenue, after the sustainable growth rate. Pay for performance might be “another irritation, rather than an incentive.”

Are all physicians equally ready for such a system? “I’m not sure that’s true,” he added.

Smaller practices in particular may not

be ready to provide the clinical information necessary for a mature pay-for-performance initiative, Alan Nelson, M.D., a commissioner who represents the American College of Physicians, said in an interview.

“However, the insistence of payers for incentives to promote quality is something that can’t be ignored,” he told this newspaper.

Although a differential payment system that rewards higher quality “is almost

The Sun as an Immune System

Why sun-induced skin lesions make excellent

Medical science has long recognized that exposure to solar radiation in the ultraviolet (UV) range, especially UVA and UVB, results in suppression of the skin’s immune function.¹ This is generally a good thing—failure of this mechanism can result in photodermatoses, such as polymorphic light eruption and chronic actinic dermatitis.² In the case of premalignant and malignant



Immune response modification leads to production of cytokines and chemokines.

skin lesions, however, the immunosuppressant effect is deleterious. Besides immunosuppression, exposure to UV radiation

may also produce a carcinogenic effect. Some patients experience both suppressed skin immune function and UV-induced premalignant and

malignant transformation of skin cells.¹ Fortunately, animal studies suggest these processes can be reversed. Experiments in mice have demonstrated that when skin tumors are transplanted into healthy, unirradiated skin, normal skin immunity is able to overcome these lesions.³

How sun exposure causes immune suppression

Recent sunscreen studies suggest that UVA is important in causing immunosuppression in the skin.⁴ In one indicator of immunosuppression, UV radiation cripples immunity by diminishing the Langerhans cells’ number and function.^{5,6} Langerhans cells exposed to UV in vitro lose the ability to present antigens to T cells.⁵ In the skin, Langerhans cells are inhibited by the release of cytokines, such as IL-10. UV irradiation can also convert normal skin chromophores into agents that are immunosuppressive,

such as the conversion of *trans*-urocanic acid to *cis*-urocanic acid.¹

How sun exposure causes skin cancer

Acute UV damage to keratinocytes usually leads to activation of the tumor-suppressing gene *p53*, which is responsible for induction of DNA repair and apoptosis.¹ When the UV



Chemokines and cytokines attract and activate immune cells at the site.

exposure is chronic, however, errors associated with DNA repair and/or replication can result in mutations in the *p53* gene.

The damage caused is very particular: a chemical bonding of adjacent pyrimidine bases in the form of dimers. These dimers are of 2 main

certainly in our future," Medicare should proceed with caution on this initiative, taking care to not increase the administrative burden—and always being aware of unintended consequences, Dr. Nelson said.

Most of these information technology developments "seem to apply more to primary care physicians than other specialties," observed commissioner William Scanlon, Ph.D., a health policy consultant from Oak Hill, Va. "The question is how we would differentiate the rewards for different specialties even on the structural measures."

He suggested that Congress create a

project to test these rewards on an ongoing basis, to accumulate evidence that it was working effectively among the various specialties.

Mandating use of information technology could accelerate use, but "providers could find such a requirement to be overly burdensome," MedPAC analyst Chantal Worzala said. Such requirements could become appropriate as the health care market develops.

The panel also recommended that prescription claims data from Medicare's Part D program be available for assessing the quality of pharmaceutical and physician care.

"Linking prescription data with physician claims could help identify a broader set of patients with certain conditions, and help determine whether they filled or refilled a prescription and received appropriate pharmaceutical care," Ms. Milgate said.

Financial rewards could also be given to providers who improve outcomes in care for their patients in other settings, such as physicians whose patients do better in hospitals, or home health agencies that manage their patients' care transition to nursing homes, MedPAC analyst Sharon Bee Cheng told commissioners at the meeting. ■

Doctors Seek To Close Health Literacy Gap

BY MARY ELLEN SCHNEIDER
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WASHINGTON — Physicians are experimenting with better ways to communicate with patients with low health literacy, Joanne Schwartzberg, M.D., said at a conference on health literacy sponsored by the American College of Physicians.

"It's right in the lap of every physician," said Dr. Schwartzberg, director of aging and community health at the American Medical Association. "Physicians can't say it's someone else's problem."

Using simple language, distributing patient education materials, speaking slowly, reading instructions aloud, asking patients how they follow instructions at home, using teach-back techniques, and drawing pictures are some of the ways health care providers say they are trying to do a better job of reaching out to patients with low health literacy, Dr. Schwartzberg said.

The AMA has developed a health literacy kit with a video and manual for clinicians. The group has also started a train-the-trainer program. To date, the group has trained 11 teams from state and specialty societies. In 6 months, the first 5 teams have conducted 57 trainings and reached more than 1,500 physicians, she said.

Preliminary results show that after the training, a majority of the physicians changed their communication with patients. For example, many reported that they were more often asking patients to repeat back instructions. "People are trying this," noted Dr. Schwartzberg.

Reaching out to patients with low health literacy is especially important in managing chronic disease because there is a "mismatch" between the capabilities of individuals and the demands of their diseases, said Dean Schillinger, M.D., associate professor of medicine at the University of California, San Francisco.

For example, in examining the interactions between physicians and patients with type 2 diabetes, Dr. Schillinger found that physicians used a lot of medical jargon when providing recommendations or education to patients.

Patients with low health literacy were confused by terms that physicians might expect a person with chronic diabetes to know, such as "glucometer," or by hearing that their weight is "stable."

But simply raising awareness among physicians may not be enough, Dr. Schillinger said. Physicians say they need more systemic support, such as more appropriate educational materials and improved labeling of pill bottles.

More research is still needed on what interventions work, especially if the medical community is going to ask insurers and other payers to offer financial incentives in this area, said David Kindig, M.D., chair of the Institute of Medicine Committee on Health Literacy, which issued a report on the topic earlier this year. ■

munosuppressant ent targets for immune response modifiers

types: pyrimidine pyrimidone photoproducts between adjacent pyrimidine residues, and cyclobutane dimers between adjacent thymine or cytosine residues.¹ In fact, accumulations in the form of single (C → T) or tandem (CC → TT) transitions are known as the "UV signature."⁶ The *p53* mutation in keratinocytes plays a key role in the process of carcinogenesis in the skin. In addition to the *p53* gene, mutations in another tumor-suppressing gene, the *patched* (*PTCH*) gene, seem to be implicated in the formation of skin carcinomas.⁷

How immune modification combats skin lesions

Immune response modifiers promise to play an exciting and interesting role in the destruction of precancerous and cancerous lesions. When applied topically, immune response modifiers activate a newly discovered family of pathogen recognition receptors called

Toll-like receptors. Located on the surface of antigen-presenting cells, such as Langerhans and other dendritic cells, Toll-like receptors are a family of 10 members, each of which recognizes signals of damaged cells or microbes.⁸ Activation of Toll-like receptors leads to production of cytokines and chemokines, such as INF- α , TNF- α , IL-12, MCP-1, and MIP-1 α .^{9,10} The



Immune cells clear precancerous and cancerous lesions.

chemokines attract immune cells to the site of application, and the cytokines cause activation of immune cells. Toll agonists have been found to promote cytokine and chemokine release from dendritic cells that reside in the dermis and the epidermis.⁹ Activation of

immune cells and release of cytokines by these dendritic cells can rally the immune system back into action, overcoming the Langerhans cell deficit.¹¹ Mechanism of action studies with immune response modifiers show posttreatment increases in activated dendritic cell and CD4 T-cell numbers when applied to actinic keratosis or basal cell carcinoma lesions, coincident with the destruction of malignant cells.¹²

Ongoing research demonstrates that immune response modifiers are capable of becoming an integral part of the treatment regimen for actinic keratosis and basal cell carcinoma.

3M Pharmaceuticals

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