

Pay for Performance: Mix the Right Ingredients

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

WASHINGTON — Mix a little money with solid incentives physicians can relate to, and you've got a successful recipe for a pay-for-performance program, Ronald P. Bangasser, M.D., suggested at the annual National Managed Health Care Congress.

Physicians try to deliver the highest level of medical care they can, but most can't keep track of the needs of every patient, said Dr. Bangasser, a family physician and immediate past president of the California Medical Association.

Studies show that 50% of patients don't get what they need in quality of care, he said. "Most patients rate their doctor a four out of five, but they hate the health care system."

That's one reason physician groups need a data-based approach to help reduce

The right types of incentives are important. 'If the physician thinks the measure is not going to improve quality, \$1 million will not change behavior.'

errors and improve care, he continued.

A new program in California has yielded positive results, and is "certainly one way to pay for quality," Dr. Bangasser said.

Backed by a state foundation grant, the statewide Integrated Healthcare Association (IHA) got together with medical groups, health plans, purchasers, and consumer groups several years ago to collaborate on a plan to reduce expenses for physician reporting.

The program was able to achieve this savings "by accumulating all of the health plans together, so physician groups only had one reporting mechanism instead of seven or eight," said Dr. Bangasser, medical director of the wound care department of the Beaver Medical Group L.P., at Redlands (Calif.) Community Hospital. The group participates in the IHA program.

All of the health plans and medical groups had to agree on a common set of measures and a common way to report those measures. The IHA, in turn, acted as a "neutral convener," in coming up with standards for reporting the data, he said.

Technical and steering committees were formed to work with technical experts on proposing measures.

The measures had to be valid and accurate, meaningful to consumers and physicians, and important to public health in California.

"They also had to get harder over time," Dr. Bangasser said.

In the IHA program, physicians get paid not just for performance, but also for performance improvement. "We actually have a calculator [that determines whether] people are improving," he pointed out.

The first payout took place in 2004, based on first-year data from 2003.

Physicians in the program are assessed on three types of measures: clinical, patient experience, and information-technology investment.

First-year results saw little variation among the participating groups on patient experience, although variations were seen among clinical and information-technology measures.

There was room for improvement in

both of these areas, Dr. Bangasser said. Fewer groups participated in IT measures than in the other measures, and of those who tried, "only two-thirds of them got full credit for it. It showed us that we had a huge IT deficit."

Variations occurred in the clinical measures because not all of the groups used a registry-type system—a list that details the specific diagnoses of each patient.

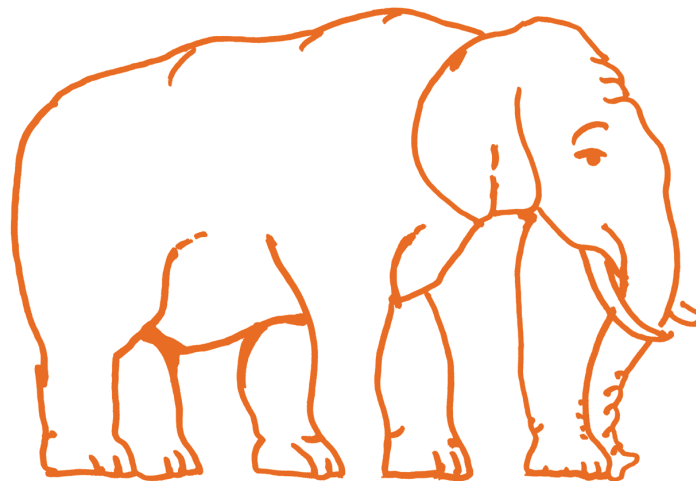
Physicians using a registry can find out if a patient got a certain test or if they

need one, Dr. Bangasser said. To date, groups that use registries "are doing much better on these measures than groups that don't."

One of the biggest improvement areas was in cervical cancer screening, he said. Based on data comparisons between 2002 and 2003—the year the program got started—nearly 150,000 more women were screened for cervical cancer, and 35,000 more women were screened for breast cancer.

What you see ver

The uncertainty of actinic keratosis.



Actinic keratoses (AKs) typically appear as rough, scaly papules and plaques ranging in color from skin-tone to reddish-brown. They range in size from a millimeter to an inch or more in diameter.¹

More than 10 million Americans are known to have them.² They are among the most common conditions seen in clinical dermatology practices. Yet, just what AKs are—or might become—and how best to treat them remains a topic for discussion.

Precursor to skin cancer?

There is growing support for the notion that AKs exist on the same continuum as Bowen's disease and squamous cell carcinoma (SCC). AK and SCC are indistinguishable in terms of cytology. Both contain atypical keratinocytes with loss of polarity, nuclear pleomorphism, disordered maturation, and increased numbers of mitotic figures, many of them atypical and pleomorphic.¹

THE CASE OF THE ELEPHANT
How many legs do you see?

There are variable acanthosis and hyperkeratosis in both. Research has demonstrated

that damage to the *p53* gene found in more than 90% of

SCCs is also present in AKs.³

One recent study showed that 44% of primary lesions of metastatic SCC were contiguous with AKs.⁴ In another, 60% of SCCs developing in a 12-month period arose from clinical AKs.⁵ When reviewed histologically, the relationship of SCCs to AKs appears even stronger: histological evidence of contiguous AKs has been shown in 97% of SCCs arising on sun damaged skin.¹

AKs can regress, remain stable, or enlarge and extend. Once neoplastic cells have grown into the dermis, the AK has in fact become an SCC—with full potential to metastasize.¹ This would place AKs on a continuum that begins with DNA damage and mutation, proceeds through neoplastic transformation and proliferation and the involvement of

3M Pharmaceuticals

© 3M Pharmaceuticals 2005.
Printed in U.S.A. 7/05 AL-9690

An additional 10,000 children got two needed immunizations, and 180,000 more patients were tested for diabetes, he reported.

Although some groups scored fairly high, specialists didn't fare as well. Patients cited access problems to specialists as a specific complaint in the satisfaction surveys, Dr. Bangasser said.

The estimated aggregate payment to physician groups in the IHA program in 2003 was between \$40 million and \$50 million, although some groups thought they didn't get paid properly, Dr. Bangasser said.

There were some concerns about in-

creased utilization and cost of services for groups participating in the program, and what the long-term returns on investment would be.

It was also determined that groups serving large Hispanic or Native American populations should get "extra credit" for having to deal with more diverse, culturally different populations.

Applying the right types of incentives is key, he said.

"If a physician thinks the measure is a good idea, putting a little money behind it will speed quality improvement. However, if the physician thinks the measure is not going to improve quality, \$1 million

will not change behavior," Dr. Bangasser said.

Sometimes, the simplest incentives can produce good results.

Dr. Bangasser mentioned a particularly bad influenza season in 1998, when patients had to wait in long lines to see physicians in his group practice. "I asked all of the doctors if they'd take on two more patients a day. That's a long day, but I gave them two tickets to a movie theater for Christmas."

All but two physicians took on the extra patients. "This meant that over 60 physicians saw an extra 120 patients per day," he said. ■

Recruitment Trends Track Rising Salaries

In medicine, salary offers are going up. The Merritt, Hawkins & Associates 2005 survey on recruitment trends showed steady increases for all of the top 15 recruited specialties in 2005. For example, the average income offered to recruit cardiologists rose from \$292,000 in 2003-2004 to \$320,000 in 2004-2005, whereas the average offer to orthopedic surgeons increased from \$330,000 in 2003-2004 to \$361,000 in 2004-2005.

In primary care, the average income offered to recruit internists rose from \$148,000 in 2001-2002 to \$152,000 in 2003-2004 and crept up to \$161,000 in 2004-2005. For the same years, average income offers for family physicians increased from \$144,000 to \$146,000 to \$150,000.

Geographically, salaries were often lower in the Northeast than in other regions. For internists, the average offering there was \$155,000 but was \$164,000 in all other regions of the country. This trend also was seen in psychiatry, neurosurgery, general surgery, and cardiology. Salary offers for family physicians were slightly higher in the Southeast and Midwest (\$151,000-\$152,000) than in the Northeast and West, where income offers were \$144,000-\$145,000.

There are several reasons for the disparity, Mr. Miller said. "There's a higher rate of physicians per population [in the West and Northeast], so in general, production goals based on volume of patients seen are harder to reach. Also, managed care is minimal in many places in the high-earning states, such as Texas, where HMOs like Kaiser tried but failed to catch on, and where the old fee-for-service model still lives."

—Jennifer Silverman

Reimbursement Plan Questioned

The much talked about "pay-for-performance" style of reimbursement system is still largely untested and is not designed to reap cost savings, "particularly since most of the quality measures it targets are of underuse," Meredith B. Rosenthal, Ph.D., of Harvard School of Public Health, Boston, said during testimony before a subcommittee of the House Committee on Education and the Workforce.

In addition, there is little guidance in the literature for purchasers and health plans to reference when they set out to design their pay-for-performance programs.

"If only a few of the many payers that a provider contracts with are paying for performance, or if each payer focuses on a different measure set, the effects of pay for performance may be dulled." She suggested that Congress fund more research by the Agency for Healthcare Research and Quality to identify approaches that would improve this method's cost-effectiveness and increase the likely gains in quality of care.

—Jennifer Silverman

sus what's there.

deeper structures, and may conclude finally with metastasis and death.¹

Treatment that reveals the need to treat

Given the pervasiveness of AK and the possibility of progression to malignancy, it would seem prudent to treat these lesions with due diligence. Guidelines from the American Academy of Dermatology recommend treatment with either destructive or topical therapy. Therapies that facilitate the treatment of large areas offer the advantage of addressing fields of UV damage as well as lesions that are numerous and less well defined. Among those therapies providing field treatment, topical immune response modifiers offer a further benefit: the ability to reveal and treat subclinical lesions.

Decreased cutaneous immune response has been shown to play a vital role in the transformation of AK into invasive SCC.⁶ Therefore, stimulation of the immune response with an immune response modifier could potentially decrease or halt the transformation of AK into invasive SCC.⁶ This would be especially important if one considers AKs as SCCs *in situ* in their earliest stages.¹

Similarly, induction of a cell-mediated response could theoretically decrease the recurrence rate of AKs in treated areas. Since chronic UV exposure creates widespread damage of the dermis, AK patients likely harbor many foci of damaged skin that are not yet clinically apparent. This may explain the high rate of recurrence with other treatments, which treat only individual lesions that are clinically manifest.

Revising our response

Immune response therapy promises to play an exciting and interesting role in the destruction of precancerous lesions as it provides dermatologists with an opportunity to treat the effects of UV damage at the subclinical stage and to justify a newly proactive approach to AK treatment across the board. Through the use of therapies like an

"Given the pervasiveness of AK and the possibility of progression to malignancy, it would seem prudent to treat these lesions with due diligence."

immune response modifier, dermatology and dermatologists might go so far as to address the gap between teaching sun safety and treating the end result of sun damage, helping the many patients in whom a destructive disease process is at work, but not fully revealed.

References: 1. Cockerell CJ. Pathology and pathobiology of the actinic (solar) keratosis. *Br J Dermatol.* 2003;149(suppl 66):34-36. 2. American Academy of Dermatology. Fact Sheet: Actinic keratosis and skin cancer. Available at: <http://www.aad.org/public/News/DermInfo/ActKerSkCancerFAQ.htm>. Accessed May 17, 2005. 3. Leffell DJ. The scientific basis of skin cancer. *J Am Acad Dermatol.* 2000;42:S18-S22. 4. Dinehart SM, Nelson-Adesokan P, Cockerell C, Russell S, Brown R. Metastatic cutaneous squamous cell carcinoma derived from actinic keratosis. *Cancer.* 1997;79:920-923. 5. Marks R, Rennie G, Selwood TS. Malignant transformation of solar keratoses to squamous cell carcinoma. *Lancet.* 1988;1:795-797. 6. Lebowitz M, Dinehart S, Whiting D, et al. Imiquimod 5% cream for the treatment of actinic keratosis: Results from two phase III, randomized, double-blind, parallel group, vehicle-controlled trials. *J Am Acad Dermatol.* 2004;50:714-721.

3M