Cost Profiling of Physicians Found Inaccurate

BY MARY ANN MOON

Current methods for profiling individual physicians as to whether they provide low-cost or high-cost care are often inaccurate and produce misleading results, according to study findings.

Health plans use cost profiling to limit how many physicians get in-network contracts and to allot bonuses to the physicians whose "resource use" is lower than average. In each case, there must be a method for determining physicians' costs, yet the accuracy of these methods has never been proven, according to John L. Adams, Ph.D., of Rand Corp., Santa Monica, Calif., and his associates.

Dr. Adams and his colleagues assessed the reliability of current methods of cost profiling using claims data from four Massachusetts insurance companies concerning 1.1 million adult patients treated during 2004-2005. A total of 12,789 physicians were included in the study. They were predominantly men who were board certified, had been trained in the United States, and had been in practice for more than 10 years.

The physicians worked in 28 specialties, including cardiology, endocrinology, gastroenterology, and obstetrics and gynecology. Family physicians, general physicians, and internal medicine physicians comprised approximately one-third of the sample.

The investigators estimated the reliability of cost profiles on a scale of 0-1, with 0 representing completely unreliable profiles and 1 representing completely reliable profiles. They then estimated the proportion of physicians in each specialty whose cost performance would be calculated inaccurately.

Overall, only 41% of physicians across all specialties had cost profile scores of 0.70 or greater, a commonly used threshold of acceptable accuracy. Only 47% of internists, 30% of cardiologists, 41% of family or general physicians, 57% of ob.gyns., 59% of gastroenterologists, and 22% of endocrinologists received scores of 0.70.

Overall, only 9% of physicians in the study had scores of 0.90 or greater, indicating optimal accuracy.

The proportion of physicians who were classified as "lower cost" but who were not in fact lower cost ranged from 29% to 67%, depending on the specialty. Fully 39% of family or general physicians were misclassified as "lower-cost" providers when they were not.

These findings indicate that standard methods of cost profiling are highly unreliable, and that many individuals and groups are basing important decisions on inaccuracies (N. Engl. J. Med. 2010;362:1014-21).

The study findings also suggest that using cost profiles that are based on these unreliable methods will not reduce health care spending. ■

Disclosures: *This study was supported by the Department of Labor, the National Institutes of Health, and the Robert Wood Johnson Foundation. The investigators' conflicts of interest included support from the Physicians Advocacy Institute, Commonwealth Fund, and Ingenix Inc.*

MY TAKE

Abandon Flawed Evaluations

The RAND Corporation study verifies the American Medical Association's longstanding contention that there are serious flaws in health insurer programs that attempt to rate physicians based on cost-of-care.

The RAND study shows that physician ratings conducted by insurers can be wrong up to two-thirds of the time for some groups of physicians. Inaccurate information can erode patient confidence and trust in caring physicians, and disrupt patients' longstanding relationships with physicians who have cared for them for years.

Patients should always be able to trust that the information they receive on physicians is valid and reliable, especially when the data are used by insurers to influence or restrict patients' choice of physicians.

Given the potential for irreparable damage to the patient-physician relationship, the AMA calls on the health insurance industry to abandon flawed physician evaluation and ranking programs, and join with the AMA to create constructive programs that produce meaningful data for increasing the quality and efficiency of health care.

J. JAMES ROHACK, M.D., *president of the American Medical Association, reported having no conflicts of interest.*

EHR REPORT

Going Paperless

BY CHRISTOPHER NOTTE, M.D., AND NEIL SKOLNIK, M.D.

As medical practices grow, so does the number of charts occupying space on their shelves. Most physicians look forward to the day when they can dispense with paper charts completely and reclaim precious office space. Unfortunately, the goal of a paperless office is a very difficult one to achieve. It can take years to get there and, even with the best EHR software, the process of adding old data into the system can be arduous.

There are two basic methods to input old paper records. Historical information such as diagnoses, medication lists, and allergies can be manually entered by the physician or staff. More detailed information, such as reports of procedures or correspondence from other physicians, will need to be scanned into the record. Either way, it will take a significant amount of work to enter even a small number of charts. Here are a few things to consider:

Begin by Looking Forward

Typically, it is most beneficial to work forward from the point of installation and ensure that all new patient information is immediately entered into the EHR to avoid creating a paper chart entirely. One way to do this is to "scan forward"—that is, to scan documents received only after the EHR is in place. Such scanned documents can immediately be digitized and attached to the patient's electronic chart. The original can then be shredded instead of adding it to the paper record. By doing so, there will be a single date marking the end of information available on paper. After that date, all staff members will know to look in the EHR to find the data they need.

Take It One Day at a Time

One way to feasibly address the problem of entering old information into the EHR is to do a limited but consistent amount every day. But where to start? Many practices select charts to scan by reviewing the following day's patient schedule. By "preloading" charts, important data are available at the time of an appointment, and the charts of so-called "frequent flyer" patients are usually among the first to be entered. Once the chart has been inputted, it can be archived off-site or properly disposed of.

To Scan or Not to Scan

Patient charts are filled with a tremendous amount of irrelevant information. Amidst the radiology reports, notes, and letters are likely dozens of sticky notes, blank pages and fax cover sheets. For a couple of reasons, it behooves a practice to spend time prepping charts before scanning them.

First, every page that is scanned will need to be indexed for the EHR to properly file it. It would be extremely cumbersome, when searching for an old lab result, to have to wade through dozens of papers at random. Indexing allows all documents to be sorted by type and date, but this process is extremely time-consuming. Each page scanned needs to be individually addressed. To minimize the amount of indexing, a practice may decide to only sort information of a certain age or type. Everything else can be then placed into a general, unsorted electronic file. The most important data would then be easy to find, yet even less valuable documents can be located with a bit of effort if necessary.

The second reason is cost. Many offices choose EHR solutions that are hosted off site. Depending on the nature of the storage agreement, every page scanned into the system may incur an additional charge. In most cases the rate is about a penny a page. One need not take a very long look at the chart rack to realize how quickly the price will add up. Choosing to electronically archive only the most important items can help minimize the economic impact.

When to Say Goodbye to Paper

Fear of unintentionally losing critical patient data is reasonable, and data security should be a primary consideration when designing an electronic storage solution. A well-chosen storage method should alleviate any fears of data loss.

From a malpractice protection perspecive, the length of time the data must be maintained varies from state to state, but is typically about 7 years for adults or 7 years after turning age 18 for minors.

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