Better Outcomes

Medical Homes *from page 1*

funded by Capital District Physicians' Health Plan Inc., a physician-founded network of health plans that covers about 400,000 enrollees in New York and Vermont. Founded in 1984, CDPHP grew out of the physicians' concerns that they were losing their voice in standard staff-model HMOs that were popular at the time. Today, 8 of CDPHP's 15 board members are physicians who have been elected by their peers, according to Brian Morrissey, vice president of strategy and development at the plan.

Although CDPHP's board has authorized spending $1 million to fund the demonstration project, "We realize that's seed money. … The board expects the price tag to rise," Mr. Morrissey said in an interview.

CDPHP is wagering that paying physicians based on outcomes and quality will yield substantial savings. "Our model says that if there is a 2% reduction in unnecessary health care expenses, the project will fund itself," Mr. Morrissey said. Other practice redesign projects that are reaching maturity are starting to yield about a 5%-7% reduction in unnecessary spending. "So that's what we are aiming for," he said. "If we get to 3%, then we are rolling forward with the rest of [the practices in] the network."

During the remainder of this year, CDPHP and the practices, which include Latham (N.Y.) Medical Group and CapitalCare Family Practice of Clifton Park, N.Y., will hammer out details such as the exact rate of compensation per patient and the outcome measures that will serve as the basis for the physician bonuses, Mr. Morrissey said. The goal is to identify measures that will be the most meaningful in terms of improving health outcomes and reducing system costs. All of the measures will likely be drawn from measures already established in the Healthcare Effectiveness Data and Information Set (HEDIS), he said.

Although only about 40% of each of the practice's panel is composed of CDPHP enrollees, CDPHP will pay a bonus based on every patient in the panel. This is to prevent the physicians from having to practice medicine based on the payer, Mr. Morrissey explained. "Because our board is adamant [about finding a way to pay for medical homes], they wanted to move forward. So CDPHP is paying the bonus tab for all patients."

The worst-case scenario is that CDPHP will lose its shirt. But that won't happen, Dr. Leyhane said with confidence. "All the practices [in the pilot] are passionate and so I'm 100% certain it will work." The more worrisome concern is how to package this and export it to other practices.

Dr. Leyhane admits that redesigning one's practice this way "involves a lot of change and effort at a time when most physicians will tell you that they are putting 100% of their effort into keeping their office open. And we are saying that they need to do more?"

All three of the practices in the pilot have established electronic medical record systems and are gearing up to meet participation criteria such as the ability to offer open-access scheduling, e-visits, and group visits. The idea is that e-visits and group visits will boost efficiencies so that physicians can spend more time with patients for whom they can have the largest impact in terms of outcomes.

While these changes are a lot to take on, "I think everyone realizes the desperation of our situation nationally in regard to primary care. The current system of rewards and reimbursement has gone terribly awry. The alternative [to this type of practice redesign] is for primary care to go down the tubes. We'll become an emergency room society, which is much more expensive," Dr. Leyhane said.

What sets this pilot apart from others across the country is the fact that it's making a clean break from the fee-for-service model, Mr. Morrissey said. Every other medical home pilot project out there has entailed putting some bonus money on the table and then hoping for a return. The problem with such an approach is that the numbers have not been enough for anyone to really do much with their practice. As long as practices attempt to provide a medical home within a volume-based fee-for-service practice, he said, "that is not going to save primary care nor is it going to attract medical students." ■

Physicians Urged to Get in the Pay-for-Performance Game

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — Physicians may never embrace pay for performance with open arms, but they need to get in the game. That was the message delivered by policy experts speaking at meeting of annual research meeting of AcademyHealth.

Hospitals have viewed pay for performance "as something that is coming down the pike, and they're getting ready for that," said Melony Sorbero, Ph.D., a researcher with the RAND Corporation.

In recent interviews conducted by RAND as part of studies on existing pay-for-performance programs, hospital staff expressed much less resistance than did physicians.

"Hospitals have an organizational framework, staff, and systems to be able to respond to these programs," said Cheryl Damberg, Ph.D., a senior researcher with RAND.

For hospitals, the question is how many measures are being requested and what the technical requirements are for reporting the data. For physicians, the problem is a fundamental: How will they collect the data in the first place?

"Physicians for the most part lack the infrastructure. Their data systems aren't anywhere near what hospital data systems are," said Dr. Damberg.

However, physicians do have opportunities to get involved with the development of pay-for-performance measures. There are hundreds of pay-for-performance experiments currently engaging physicians, while only about 40 programs are aimed at hospitals, said Dr. Sorbero.

The American Board of Internal Medicine is behind one such effort targeting physicians. The organization recently completed a study to see whether physicians can be ranked based on a combination of chart reviews, patient surveys, and practice system surveys. They assessed the consistency of those data individually and together.

"We want to make sure that the measures that are going into our composites are fair and reliable," said Rebecca Lipner, Ph.D., vice president of psychometrics and research analysis at ABIM.

The study looked solely at the treatment of hypertension, a focus that was key in formulating the patient survey questions, she said.

The questions aren't "the general 'do you like your physician?' or 'do you get good access to care?' They're all about how does the physician give care for your specific disease," said Dr. Lipner.

However, ABIM found that there was wide variation across the sets of measures and, depending on how they were combined, an individual physician's rank could swing by more than three quartiles. For example, a physician could do well based on his chart and systems data, but do poorly on the patient surveys, she said.

One lesson may be that devising a reliable measure of physician performance is not a simple thing to do, Dr. Damberg suggested.

Another may be that physicians need a structure within which these measures become relevant. In that sense, medical homes can be seen as an attempt to give a framework to practice settings outside the hospital, said Dr. Lipner.

"A lot of what we have learned from the hospitals systems is transferring over to that medical home. But it is a big challenge. We have… quite a few physicians in solo practice. They are really by themselves, and we always underestimate how many physicians are working by themselves without an infrastructure, without peer connections," she said. ■

Medicare Advisers Protest Agency Plan to Publish PQRI Information

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — A panel of Medicare advisors warned agency officials against moving forward with a proposal to make public a list of doctors participating in a voluntary federal quality reporting effort.

The Physician Quality Reporting Initiative was created under a provision of 2006 tax relief and offers physicians a 1.5% Medicare bonus for sending data on several quality measures to the Centers for Medicare and Medicaid Services. So far, about 16% of Medicare participating physicians have elected to participate in PQRI, although about half of those who are not participating see fewer than 50 Medicare patients a year, according to agency officials.

"We have had in place for a number of years public reporting of quality information and now cost information for a number of settings, hospitals most prominently, dialysis facilities, nursing homes, and home health agencies," Dr. Barry Straube, CMS chief medical officer, said at a meeting of the Practicing Physicians Advisory Council. "The agency, the [Health and Human Services] department, the White House, [lawmakers], and many consumer advocates and employers would like for us and everyone to start focusing more on physician office public reporting."

Dr. Straube announced at the meeting that the CMS was considering whether to publish the names of physicians who have agreed to participate in the PQRI as well as to indicate whether those physicians were paid the incentive, a proxy for whether they met or exceeded the agency's reporting requirements.

That proposal didn't sit well with several PPAC members.

"I'm concerned that you are taking these PQRI data that were presented to the physician community for one reason and now you're taking that information garnered out of that and you're going to put it on a Web site," said Dr. Tye Ouzounian, an orthopedic surgeon in Tarzana, Calif.

Publishing the names of PQRI participants could create a public perception that physicians who are not on the list are not quality providers, he told Dr. Straube.

The perception might be even worse for those physicians who chose to participate, but were not able to fully comply, said Dr. Fredrica Smith, an internist in Los Alamos, N.M. "It's not that they are not listed as having participated. They are listed as participating and failing, which has horrible implications." A solo practitioner, Dr. Smith said she spent 1-2 hours a week trying to comply with the reporting requirement only to be left confused by them.

CMS officials told the council that they were applying the reporting requirements flexibly and that they expected most physicians who chose to participate to receive the incentive payment.

Despite such assurances, PPAC recommended that the CMS give physicians and their colleagues enough lead time to consider whether they want to participate in the initiative, knowing their participation will be published, before that information is made available to the public.

"If you are going to put [those] data up there, you need to advise the physician community, with ample notice," Dr. Ouzounian said.

Dr. Straube said he understood council members' concerns, but that it was inevitable, given the push for transparency, that such information will some day be made public."I suspect that this is going to happen sometime in the future. I don't see how the physician office setting will not have some need to be publicly accountable." ■