Wanted: Docs to Craft Pay for Performance

CMS says physician input is needed to make programs effective; AMA trustee stresses quality.

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

CHICAGO — Physicians need to help design the pay-for-performance programs that are now being initiated by Medicare and other payers or they may not like the results, Dr. Trent Haywood said at the annual meeting of the American Association of Clinical Endocrinologists.

"What it comes down to … is there's a certain level of fear, a certain uneasiness" about the program among doctors, said Dr. Haywood, who is deputy chief clinical officer at the Centers for Medicare and Medicaid Services. "The thing is for clinicians to work with us and get on board. We don't want to design a program and not have clinician input."

One current pilot program is an oncology project in which physicians are paid to report their use of guidelines and outcome measures.

Medicare currently has several pilot programs under which physician and hospital pay is based in part on patient outcomes and quality of care.

Demonstrations include a project with 10 large multispecialty practices nationwide, and an oncology project in which physicians are paid to report their use of guidelines as well as outcome measures for their patients.

Dr. John Rowe, executive chairman of Aetna, made a similar comment at the Society of Hospital Medicine meeting in Washington.

"My fear is that the pay-for-performance train is leaving the station, and the doctors aren't on it," he said. "When I talk to people who buy Aetna's services [such as large employers], they get it. Corporate America is adopting the concept of pay for performance before the details are worked out, and the details have to be worked out by physicians."

But physicians have reservations about the pay-for-performance concept. Dr. John Nelson, an American Medical Association trustee and panelist at the AACE meeting, said Medicare's pay-for-performance program would be a great opportunity for physicians to serve patients, but only "if it improves quality, if it's voluntary, and if the data are accurate, clinically meaningful, and relevant."

However, another panelist had other ideas. Twila J. Brase, president of the Citizens' Council on Health Care, a St. Paul, Minn., group that advocates competition in health care, said that pay for performance was based on what she called the "faulty premise" of evidence-based medicine. While the original idea behind evidence-based medicine was good, "it is being perverted to allow rationing of care," she said. Because of its insistence on having all physicians practice in the same way, "evidence-based medicine will make every doctor a managed care doctor. It will lead to budget-based care, not customized care."

Rather than participating in pay-for-performance programs, Ms. Brase urged doctors to stop participating in Medicare and private insurance programs and instead have patients pay cash for each visit. She called Medicare and private insurance "the real culprits" in the health care cost spiral.

"Evidence-based medicine isn't about evidence. It's not even about science. It's about control. It's meant to centralize power and control outside the exam room, and if you let pay for performance and evidence-based medicine become the standard way that you do business, the only way you'll make a decent dollar working at your profession is to follow the directives of people who don't know what they're talking about," she said to loud applause.

Dr. Haywood seemed taken aback by Ms. Brase's comments. "This is the first time I've ever been on a panel where someone advocated the abolishment of Medicare and Medicaid," he said. "It's a shock to me."

But he agreed with Ms. Brase that consumers need more information to make better health care choices. "I think we're moving more toward consumers having more decision-making capacity. . . . I do believe we're going to be providing information to consumers so that they can make some of those decisions, and hopefully that leads to better quality."

One audience member wanted to know how CMS would deal with patients who, for one reason or another, don't meet the outcome goals. "How will CMS deal with . . . that 10% of the population who, come hell or high water, will never have a [hemoglobin] A_{1c} of 6.5%, for a variety of reasons?" she said.

Dr. Haywood said that physician input would be helpful in trying to answer that question. In the meantime, according to Dr. Haywood, CMS is considering the idea that "some patients automatically are going to get excluded—excluded for noncompliance or excluded because from the standpoint of that clinician, they've reached the therapeutic goal for a variety of reasons and won't fall into the denominator for that particular measure." ■

Patient Registries May Offer Cheaper Alternative to EHRs

BY MARY ELLEN SCHNEIDER
Senior Writer

PHILADELPHIA — A costly electronic health record system is not necessary to engage in quality improvement and participate in the growing number of pay-for-performance programs, Dr. Rodney Hornbake said at the annual meeting of the American College of Physicians.

Patient registry software is a lower-cost alternative that allows physicians to track their care of patients with chronic diseases.

"It's really an excellent starting place for quality improvement in the ambulatory setting," said Dr. Hornbake, an internist in private practice in Essex, Conn.

Patient registries are one of the best tools for physicians participating in pay-for-performance programs, Dr. Hornbake said. Many electronic health records (EHRs) may not have population-based functionality, and therefore cannot generate simple reports on the physician's performance on certain measures. Most EHR vendors can build interfaces with patient registry software, but that's generally an added cost, he said.

There are a number of patient registry programs available; a comprehensive program can be purchased for less than $1,000 per provider, Dr. Hornbake said. Some are available for free.

For example, Dr. Hornbake tested the Comorbid Disease Management Database (COMMAND) software in his practice. This registry system is available for free from the Mississippi Quality Improvement Organization. And technology-savvy physicians can use programs like Microsoft Access to design their own registries, he said.

Dr. Hornbake tried out COMMAND in his practice to help keep up with the pay-for-performance programs in his local market. One insurer—Anthem Health Plans Inc. of Connecticut—has a program that offers incentives for process and outcomes measures, as well as for the use of health-related information technology, including electronic prescribing, EHRs, and patient registries. The insurer also offers incentives to physicians for generic prescribing, he said.

Dr. Hornbake said that he exported demographic information from his billing system into COMMAND and manually entered the clinical information from patient charts himself. After using the billing system to identify all of the patients who had conditions included in his registry, he had his staff put red stickers on those patient charts.

This flagged the patients for special attention from the staff, he said. For example, patients whose charts had stickers received follow-up calls if they missed an appointment. To keep the registry up to date, every 2 months the staff pulls the charts of all registry patients and Dr. Hornbake updates the system manually. He spends about 1.5 hours entering data on 125 patients, he said.

Dr. Hornbake said that he prefers to enter the information in periodic batches because it helps him to identify any chronic disease patients who have slipped through the cracks.

Even factoring in his time, Dr. Hornbake said that he saw an immediate return on investment with the patient registry system. Unlike implementation of an EHR system, he added, patient registry software tends to fit in easily with the normal workflow of the office.

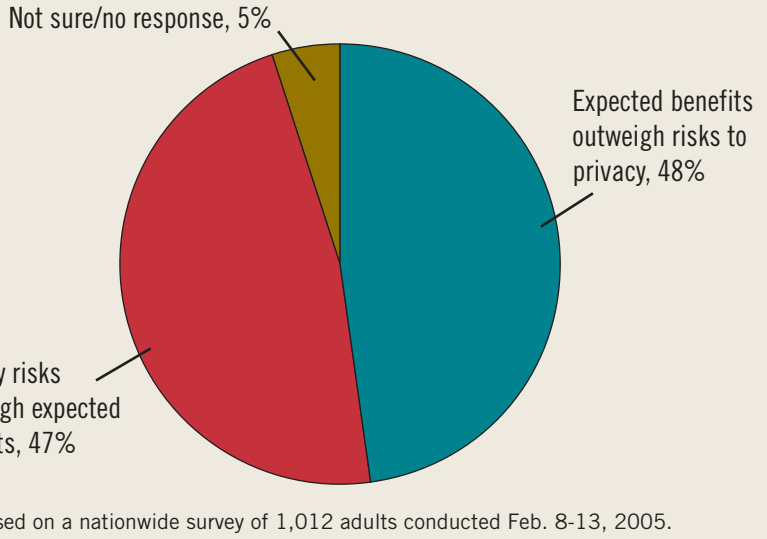
Physicians can also manage their patient care using a paper-based patient registry, he said, but once they begin to track 20 or more measures, a paper system quickly becomes unworkable.

So far, Dr. Hornbake said that he has resisted purchasing an EHR system because he still can't make a financial case for the investment.

He advised physicians to buy or upgrade an EHR system based on its ability to support pay for performance and manage a population of specific patients. Many of the other selling points for an EHR system—that it will eliminate transcription, cut down on needed staff positions, and improve coding—don't hold true for all physicians, he said. ■

DATA WATCH

Public Divided on Electronic Medical Records



Note: Based on a nationwide survey of 1,012 adults conducted Feb. 8-13, 2005.
Source: Harris Interactive

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