Some Smaller Practices To Get Redesign Boost

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The American College of Physicians is testing a new resource that would provide direct assistance to physicians interested in practice redesign.

Starting this month, the ACP's Center for Practice Innovation (CPI) will work with 25-50 small- and medium-sized internal medicine practices to help them prepare for the ever-developing pay-for-performance movement and technology boom, and the complexities of the new recertification process.

"Our belief," said Dr. C. Anderson Hedberg, ACP president, "is that the financial concerns of physicians regarding the implementation and management of the changing practice environment will be addressed through office redesign, attention to quality innovation, enhanced patient satisfaction, and practice growth."

Funding for the center was provided in a 2-year, $996,000 grant from the Physicians' Foundation for Health Systems Excellence (PFHSE). "The grant will enable ACP to provide new practice-level support and to test innovative approaches aimed at changes in practice management, physician education and patient safety/disease management, and patient satisfaction," said Dr. Michael S. Barr, ACP's vice president of practice advocacy and improvement and director of the project.

In an interview, Dr. Barr said the center would be selecting practices from across the country, "probably in regional clusters." Specifically, it wants to target practices of 10 physicians or smaller—practices that don't always have outside support to improve their practice environment.

"We will aim to have a group of practices that are fairly representative of the types of practices in the United States, and will seek to balance the set of practices based on fairly typical demographic factors," he said.

The 2-year project includes an implementation phase, during which the 25-50 practices will be actively engaged in practice redesign efforts, Dr. Barr said. "We're not going into these practices with a specific, cookie cutter model," he said. The idea is to adapt different tools and resources, and put together a "menu" of options for these practices based upon their unique situation. The practices will determine which interventions are right for them.

Success will be measured through data collected for selected clinical measures, as well as patient satisfaction, physician/staff satisfaction, and economic indicators of practice function.

Dr. Barr said the CPI will be urging practices to select clinical measures most appropriate for the populations they serve. The center will encourage practices to use clinical measures endorsed by the Ambulatory Care Quality Alliance. Those measures would allow for "adequate comparisons to be made across practices reporting on the same measures," he said.

These measurements "will help us assess the outcomes for a final report," he said. "Based on the lessons learned, we hope that the activities continue beyond this 2-year project." The CPI plans to convene a steering committee to help guide its progress.

None of the practices will be getting direct monetary assistance from the center, he said. "The assistance will come in the form of on-the-ground consultation, support, giving them tools and services, connection with their peers," and help with recertification.

For now, the project will be limited only to the selected practices, Dr. Barr said. "Unless we are able to obtain additional funding during this 2-year period, it will be difficult to provide the level of assistance to other practices. However, we'll certainly be sharing information along the way through the new CPI Web site." ACP's Practice Management Center will continue to provide the advice and support that it currently offers for practices looking for more resources, he said.

The CPI is aware of the American Board of Internal Medicine's work with its practice improvement modules, Dr. Barr said. As it develops its own interventions, the center will be mindful of these developments in recertification.

Although health information technology won't be the central focus of the center's activities, there's no denying that health IT is a good way for practices to generate these types of quality improvement outcomes, Dr. Barr said.

"Health information technology and performance measurement have the potential to improve the consistency of outpatient medicine. This new approach will require some time for assimilation, but the external pressure for rapid change might cause future shock for established practitioners," commented Dr. William Golden, a professor of medicine and public health at the University of Arkansas, who has also worked on a special liaison panel between the American College of Physicians and the ABIM to develop pathways to recertification. ■

Help Identify Public Health Needs

The Centers for Disease Control and Prevention is seeking public comment on its new "Health Protection Research Guide," which will provide a comprehensive long-range vision of national and global public health needs.

The 60-day comment period ends Jan. 15, 2006. To review the current draft document of the Research Guide and to provide comments, go to www.rsvpbook.com/custom_pages/50942/index.php.

POLICY & PRACTICE

Outlook 2006

Facing yet another year under the threat of lower Medicare payments, internists in 2006 will continue to focus on the developing pay-for-performance initiative, while advocating for funds to support health information technology. Medical liability reform was on the back burner in 2005, but fueled by a promise from Senate Majority Leader Bill Frist (R-Tenn.), it should appear on the table again in 2006.

Pay for Performance

Getting Congress and the federal government to understand the physician's point of view on pay for performance is a goal this year for the American College of Physicians. The ACP, along with other medical societies, is advocating for a consistent data set, such as the 26 quality measures that have been vetted by the Ambulatory Care Quality Alliance. In a document given to Congress, the ACP presented a time line for a pay-for-performance program. The program would be voluntary, but participating physicians would receive a higher payment update. Much of what will affect physician payment this year will be addressed in conference negotiations on the omnibus appropriations bill, which at press time have not been completed. Even if Congress stabilizes payments and provides a 1-year fix, "there still could be a long-term problem" with the sustainable growth rate, Robert B. Doherty, the ACP's senior vice president for governmental affairs and public policy, told INTERNAL MEDICINE NEWS. "We don't know if the conference agreement will include a legislative mandate for [the Centers for Medicare and Medicaid Services] to move forward on pay for performance in 2007" or whether the program would be punitive, he said. Based on current proposed language, physicians could receive an increase for participating in quality reporting, but those who aren't able to participate may get a 2% cut in payments, he said.

Voluntary Reporting Program

Primary care groups are pressing CMS to make changes to its new voluntary reporting program, which has fueled concerns about using unfamiliar G codes to measure physician performance. The ACP in particular wants CMS to agree on a smaller set of measures that are aligned with the Ambulatory Care Quality Alliance measures, Mr. Doherty said. Currently, the agency is calling for 36 measures, "which will load up physicians with too many measures," he said. It's expected that this voluntary program will become the basis for a federal pay-for-performance program as early as 2007. For that reason, "it's really important to get this program right, once dollars are linked to it," he said.

Health Information Technology

The ACP continues to support efforts to help small practices implement electronic health records, and is calling for payment incentives for health information technology. The ACP wants to keep breaking down the barriers to physicians using EHRs, Mr. Doherty said. It's not enough for the college to track how many internists use EHRs—what's more important is finding out how many of these electronic systems function well enough to allow internists to participate in a quality measurement reporting program. One tool to help track this trend is the Certification Commission on Health Information Technology, which was set up by the American Health Information Management Association to create voluntary standards for health information technology. The ACP was involved in the development of this commission on several levels, Mr. Doherty said. "It started out purely as a private sector initiative, but now it has the federal government behind it to develop these standards." The standards, focusing on interoperability and functionality, are expected early this year. "For the first time, physicians will know that there's an independent commission that will be able to tell them whether the system they're purchasing is a quality EHR system, which will greatly ease anxiety," he said. In addition, the ACP is pressing Congress to enact a bill (H.R. 747) that would reimburse physicians who have electronic medical record systems that meet these types of certification standards and who participate in a CMS-approved quality measurement reporting program.

Medicare Drug Changes in 2007

The U.S. Pharmacopeia recently issued draft revisions to the voluntary model guidelines used by Medicare Part D prescription drug plans. The revisions will apply to formularies for 2007. The revised guidelines contain the same number of unique drug categories and classes as the previous version; however, the USP is proposing changes within and across several categories. For example, the document proposes to eliminate the distinction between NSAIDs and cyclo-oxygenase-2 inhibitors and between selective serotonin reuptake inhibitors and serotonin norepinephrine reuptake inhibitors. The document also proposes to add a number of medicines that might be covered either by Medicare Part B or Part D, depending on the setting. The revisions are based on the review of newly approved and discontinued drugs, changes to approved therapeutic uses, new information on the safety and efficacy of drugs, and comments since the first version of the model guidelines was issued in 2004. The 2004 model guidelines were widely used by Medicare prescription drug plans in designing their formularies, USP Vice President William A. Zeruld said at a press briefing. Three of every four formularies used the USP model guidelines in designing plans for 2006, Mr. Zeruld said. USP will submit its final proposal to CMS on Jan. 30.

—Jennifer Lubell