

Effect of Pay for Performance on PC Uncertain

BY MARY ELLEN SCHNEIDER
Senior Writer

PHILADELPHIA — The effect that any future Medicare-run pay-for-performance program would have on primary care physicians is still very much up in the air, experts said at the annual meeting of the American College of Physicians.

Medicare currently has no pay-for-performance programs in effect, and—although the agency has various demonstrations and pilots underway to look at this issue—the real effect of such a program is still a matter of speculation, said Dr. John Tooker, ACP's executive vice president and chief executive officer.

But Dr. Tooker urged physicians to consider participating in what may be a precursor to a Medicare pay-for-performance program: the Physician Voluntary Reporting Program. The initiative, launched earlier this year by officials at the Centers for Medicare and Medicaid Services, asks physicians to report on a core starter set of 16 quality measures. There is no funding attached to the program at this point.

"It's a good way to begin to learn how to do this in your practice," Dr. Tooker

said. "But most importantly, I think it's really a matter of learning to change the culture of a practice."

If done right, pay-for-performance programs could result in higher quality patient care and increased physician and patient satisfaction, said Dr. C. Anderson Hedberg, ACP's immediate past president.

But the ACP is concerned that such programs could also lead to increased paperwork burdens, higher expenses, less revenue, and time taken away from patient care, he said. And there could be unintended consequences for sicker and non-compliant patients. Much will depend on what measures are used, how quickly they are phased in, how data will be collected, the type of public reporting involved, and the incentives applied, he said.

ACP officials aren't the only physicians who have questions about how pay-for-performance programs—whether through Medicare or private insurers—will affect their practices. At the ACP's town hall meeting on the issue, Dr. Emily R. Transue, an internist in a group practice in Seattle, said there is still not a set of consistent and appropriate quality measures that everyone has agreed to use. For example,

she received two reports on her performance from two different companies. In one report she was rated as a high performer, and in the other her quality of care was considered below average. "Clearly there's something that isn't fitting together," she said.

If physicians can't come up with appropriate quality measures, these programs will end

up just being another set of hoops that physicians have to jump through, she said.

Dr. Teresa M. Schaer, a geriatrician at St. Peter's University Hospital in New Brunswick, N.J., said she would like to see measures that are on topics of importance to Medicare beneficiaries, such as counseling about end-of-life planning. When she spends 40 minutes discussing such preferences with a patient who has Parkinson's disease, she would like to see such counseling recognized as high-quality care.

Dr. Barry M. Straube, acting director of the Office of Clinical Standards and Quality at CMS, acknowledged that some of the measures the agency has been focused on may not be relevant to older Medicare patients. Officials at CMS have been discussing how to assess quality care in special populations, he said.

But the ongoing quality work is being done in collaboration with Medicaid and commercial health plans, so for now the focus is on measures that apply to a broad population, Dr. Straube said.

One program that has been a pioneer in this area was formulated by the Bridges to Excellence coalition, which was founded by a number of larger employers and offers incentives to physicians who demonstrate quality care. To date, the program has shown that in communities where incentives are available, there has not been patient dumping, said Francois deBrantes, national coordinator of the program. "That's not



Some of the measures may not be relevant to older Medicare patients, said Dr. Barry M. Straube (right).

how good performance is achieved." In fact, after physicians devoted time to reengineering their practices, they generally sought out more patients, he said.

Officials with the program have also found that the financial incentives are effective, and that the size of the incentive has a direct relationship to whether physicians are willing to go through an expensive and time-consuming overhaul of their practices. Asking a physician to make these changes for \$1,000 a year is an insult, Mr. deBrantes said.

Incentivizing physicians to provide higher quality care has also paid off for payers, he said. They have found that patients who are managed for their chronic conditions have more office visits and fewer hospital stays, which produces an average 10% savings for payers.

But setting up incentive programs is not a small task, Mr. deBrantes said. Because incentives need to be large enough to encourage physicians to make significant practice changes, it's hard for any one employer or health plan to set up rewards programs.

It's also a major undertaking for physicians and their staffs, especially given the cost and complexity of electronic health record systems. (See box.) The transition from a paper-based practice to something more systematic takes about a year and a half with outside help, which, for small practices, is nearly impossible to make the transition without, Mr. deBrantes said. ■

Invest Wisely in Information Technology

One of the barriers to systematically measuring quality for physicians, especially those in small practices, is the cost of electronic health records and other technology.

"Don't waste a lot of time and money on high-tech solutions," advised Dr. Kevin B. Weiss, professor of medicine at Northwestern University, Chicago, and chair of the ACP's performance measurement subcommittee.

Dr. Weiss, who said he considers himself a believer in health information technology, cautioned that many of the first- and second-generation EHRs were not designed for population-based medicine, which is essential for participation in pay-for-performance programs. Instead, the systems were built to mimic paper records and

to work with individual patients.

Consider investing in EHRs that have population-based care functionality, or look into cheaper alternatives, he said. A lower-cost option is to use patient registries, he said. Patient registry software allows physicians to track their management of patients with chronic health conditions and to report on process and outcomes data that may be required by pay-for-performance programs.

One way to get ready for the pay-for-performance movement that does not involve any technology is to get in the habit of having weekly discussions with staff on quality issues, Dr. Weiss said. Physicians can also consider investing in team-oriented continuing medical education courses, he said.

Performance Measurement Could Help Narrow the Racial Care Gap

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PHILADELPHIA — Performance measurement is one way to help eliminate racial disparities in health care, Dr. John Z. Ayanian said at the annual meeting of the American College of Physicians.

Public and private payers must also do their part by maintaining accurate and complete data on race and ethnicity to help monitor disparities, said Dr. Ayanian, associate professor of medicine and health care policy at Harvard Medical School in Boston.

There has been some success in narrowing the racial care gap in areas where measurement is widespread. For example, a study published last year found both overall quality improvement in the use of β -blockers after acute myocardial infarction among Medicare managed-care beneficiaries and a significant narrowing of the

racial gap in treatment. The treatment gap between African American and white beneficiaries had been 12% in 1997 and fell to 0.4% in 2002 (N. Engl. J. Med. 2005;353:692-700).

But there is still work to do, he said. For example, the same study shows that while overall quality improved in cholesterol control for coronary artery disease, the racial disparity is actually increasing in that measure. The study showed that the gap for cholesterol control, defined as LDL cholesterol below 130 mg/dL after discharge, between black and white patients was 13% in 1999, and the gap widened to 16% in 2002.

Lack of communication and trust between minority patients and physicians also are factors in care disparities, Dr. Ayanian said. Many physicians don't recognize the legacy of discrimination in health care, such as the Tuskegee syphilis study, that still fuels mistrust of the health care system among minorities, he said.

A cooperative national study conducted by Dr. Ayanian and his colleagues looked at new patient preferences for renal transplantation among end-stage renal disease patients ages 18 to 54 in Michigan, Alabama, Southern California, and the Washington metropolitan area in 1996-1997.

The researchers found small differences in the patient preferences for the transplant but larger differences in the referral for evaluation. For example, 86% of white men favored transplantation, and 82% were referred for evaluation. However, 81% of black men favored transplantation but only 58% were referred for evaluation (N. Engl. J. Med. 1999;341:1661-9).

In addition, most patients in the study said they agreed with and trusted their physician. But white patients were more likely to trust and agree with physicians than African American patients, and black patients received less information about transplantation. ■