



Assessing Physician Performance: Challenges. Opportunities and Who's Measuring

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Disclosure

- VP and Medical Director, Thomson Reuters, Healthcare
- Will not discuss any products or solutions

Objectives

- At the end of this presentation participants should be able to:
 - Discuss the national performance improvement enterprise
 - Identify the challenges in assessing physician performance
 - Explain a vision for the future
 - Take action to initiate projects to improve physician performance

National Trends

- Triple threat—uninsured, cost escalations and quality chasm
- Progress and improvement is slow
- Solutions hampered by deep political divide on covering the uninsured
- Complex and uncertain approaches to performance improvement
- Uncertainty about how to contain costs

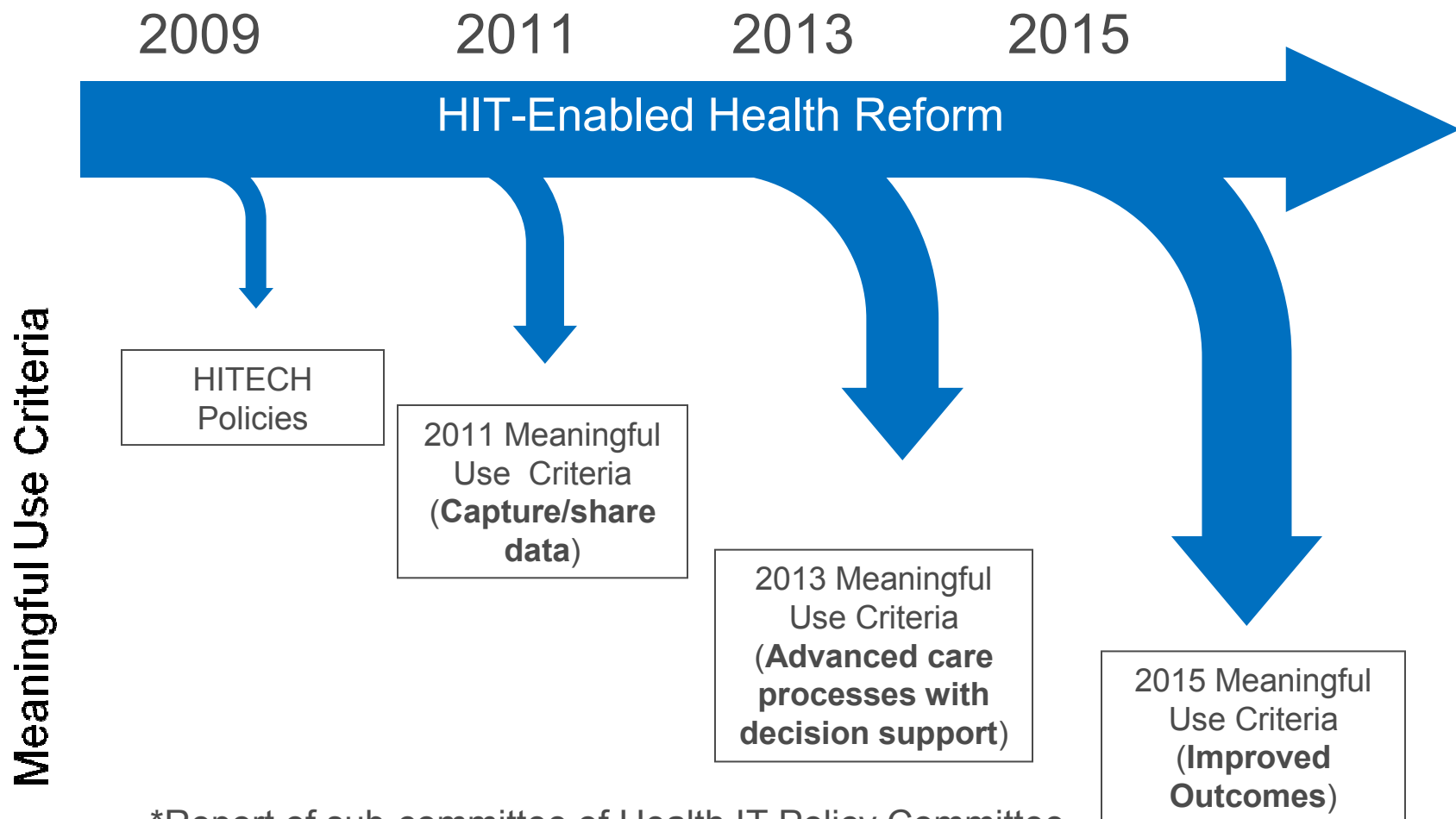
Overarching Commitment Is Needed

- Professionalism
 - A commitment to continued learning
 - The conduct of performance assessment, and
 - To reporting and accountable externally

Physician Assessments: Recent Trends

- Physician Consortium for Performance Improvement (PCPI) develops 150 plus measures
- CMS P4R project (PQRI)
- Multiple private sector initiatives
- Specialty Boards – Part 4 – Maintenance of Certification (MOC)
- Federation of State Medical Boards (FSMB) commit to performance based re-licensure (MOL)
- Interest by the House of Medicine (ACP, NJMS and surgical specialties, ACC, etc.)
- CMS certifies patient registries for use in the PQRI program (August 08)
- ARRA—Meaningful Use and CMS incentive program--\$34B

Meaningful Use is Being Defined and Will Follow an “Ascension Path” Over Time*



*Report of sub-committee of Health IT Policy Committee

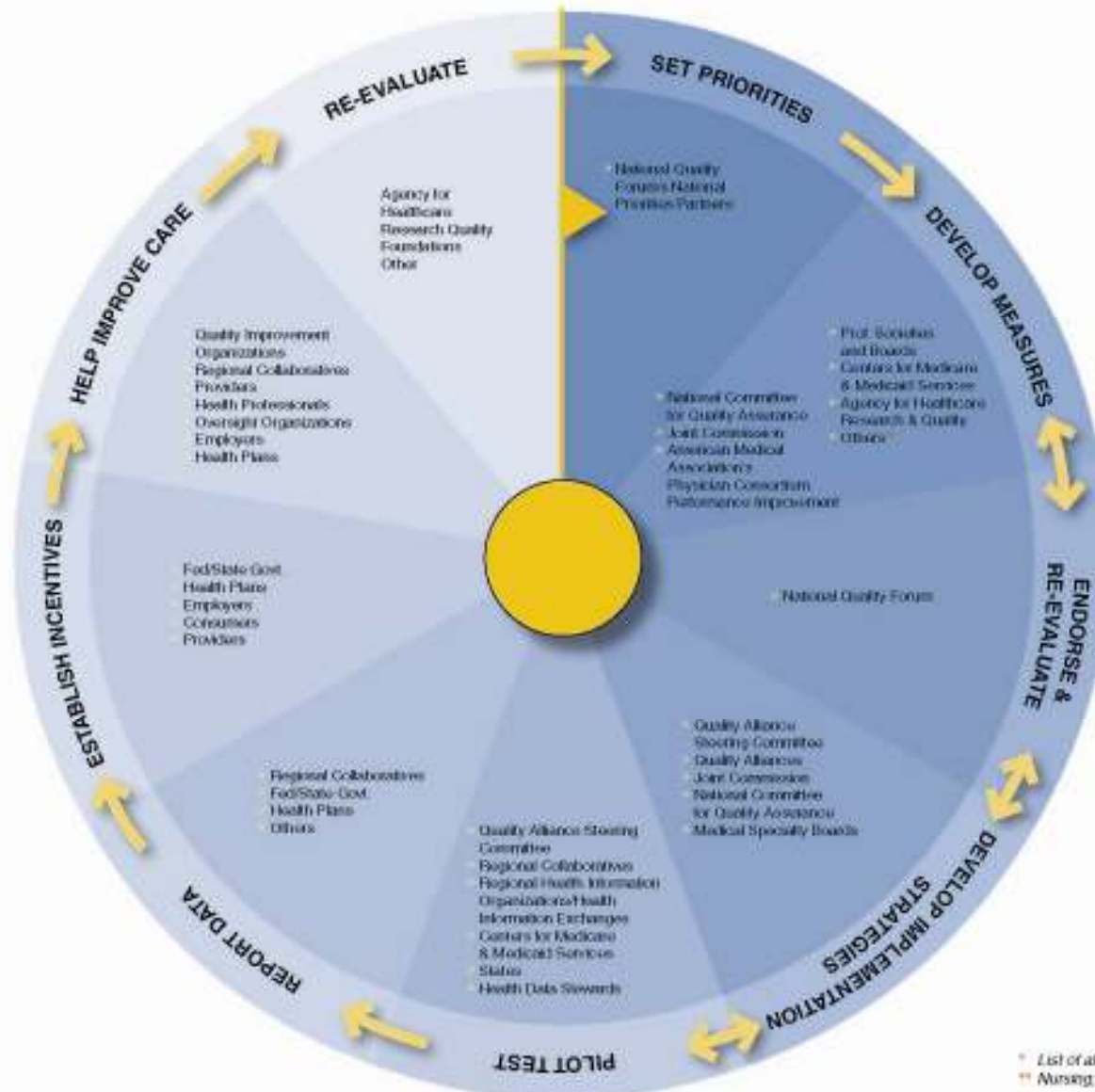
Meaningful Use Incentives by Adoption Year

Meaningful User	2009	2010	2011	2012	2013	2014	2015	2016	Total Incentive
2011			\$ 18,000	\$ 12,000	\$ 8,000	\$ 4,000	\$ 2,000		\$ 44,000
2012				\$ 18,000	\$ 12,000	\$ 8,000	\$ 4,000	\$ 2,000	\$ 44,000
2013					\$ 15,000	\$ 12,000	\$ 8,000	\$ 4,000	\$ 39,000
2014						\$ 12,000	\$ 8,000	\$ 4,000	\$ 24,000
2015 +									\$ Penalties

Health Outcomes Policy Priority	Care Goals	2011 Objectives		2011 Measure		2013 Objectives		2013 Measures	
		Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions				Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions			
		Eligible Providers	Hospitals			Eligible Providers	Hospitals		

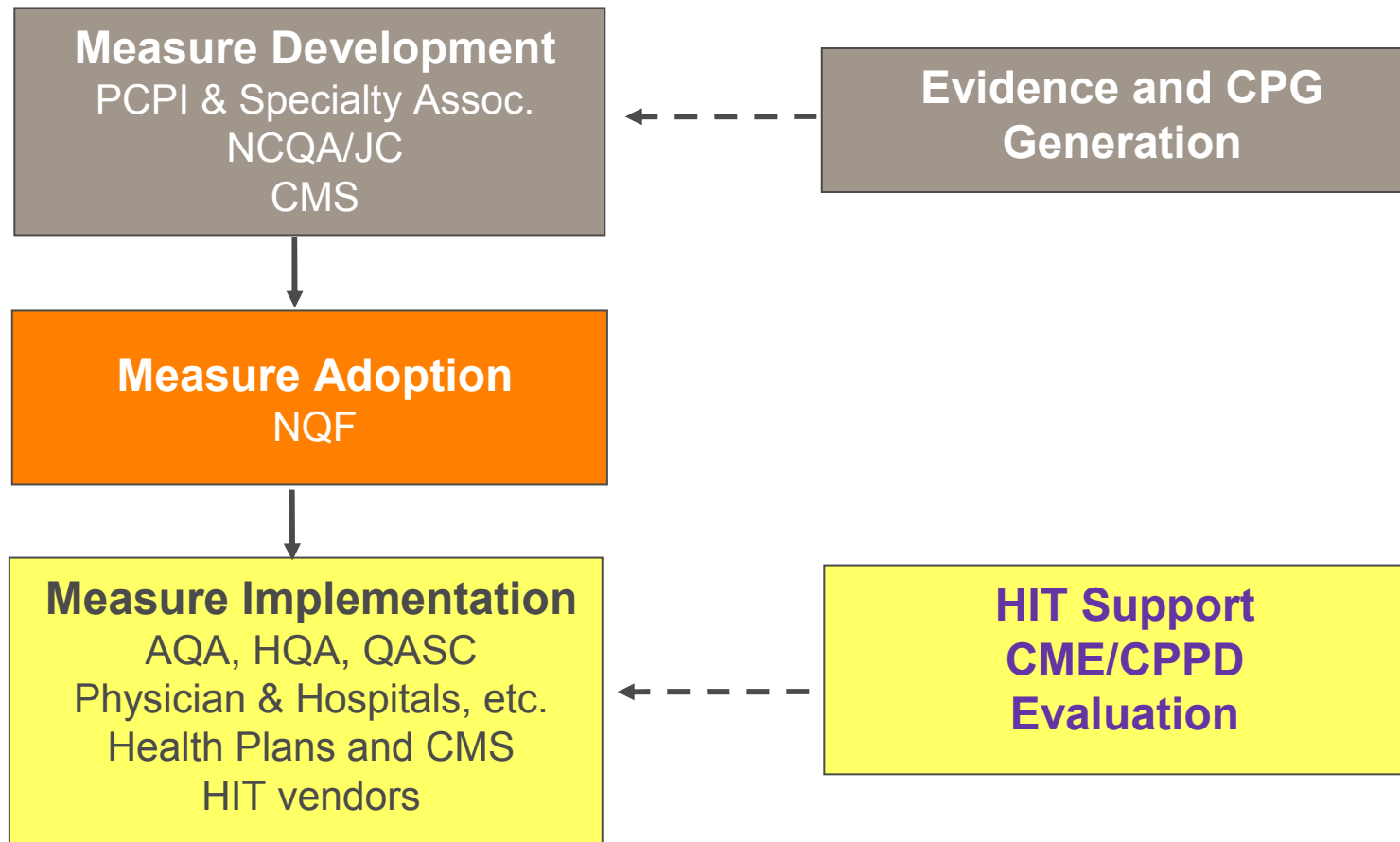
Health Outcomes Policy Priority	Care Goals	Adoption Year 1 Objectives		Adoption Year Measures		Adoption Year 2 Objectives		Adoption Year 2 Measures	
		Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions				Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions			
		Eligible Providers	Hospitals			Eligible Providers	Hospitals		

Steps for Improving Health Care Quality & Value: Who's Making it Happen?



* List of all involved partners available
 ** Nursing, Academic Communities, etc

Performance Measurement and Quality Improvement “System”



Performance Measurement Framework

- A balanced set of quality, cost of care and efficiency metrics
- For quality measures
 - Structural vs. process vs. outcomes vs. patient experience vs. appropriateness
 - Overuse vs. underuse vs. misuse
- IOM aims 6 aims plus
 - Patient experience
 - Composite measures
 - Surveys by colleagues and members of the “team”

Evidence as a Basis for Quality Performance Measures

- Precision of the science – the evidence
- Need to apply EBM to population management vs. individual patients
- Take into account physician professional development and patient preference
- Changing science (and interpretation)
- Need to case mix adjust
- Disease rather than a patient focus
- Problems with clinical practice guideline development

Changing Science (Some Additional Examples)

- Diabetes control
 - Ref: ACCORD and ADVANCE studies, NEJM. Jun 08
- Erythropoietin (ESAs) in cancer and kidney failure patients
 - Ref: FDA Reports. (2007-2008)
- Pneumonia management
 - Ref: Wachter; Ann of Intern Med. Jul 08
- Also the issue of the link between outcomes and intermediate outcomes
 - Ref: Krumholz and Lee; NEJM. Jun 08

Performance Measurement and the “Complex” Patient

- 78 yr. old female-osteoporosis, diabetes, hypertension and COPD
- 10 meds, potentially taken at 7 times during the day, plus in excess of 10 additional instructions
- Physician tasks during a visit-7 types of tasks, including 3 with 4/5 subtasks
- Contradictory guidelines
- Guidelines with varying levels of evidence, no prioritization, no balance, practicality and feasibility not addressed

Patterns of Care and “Assignment of Accountability”

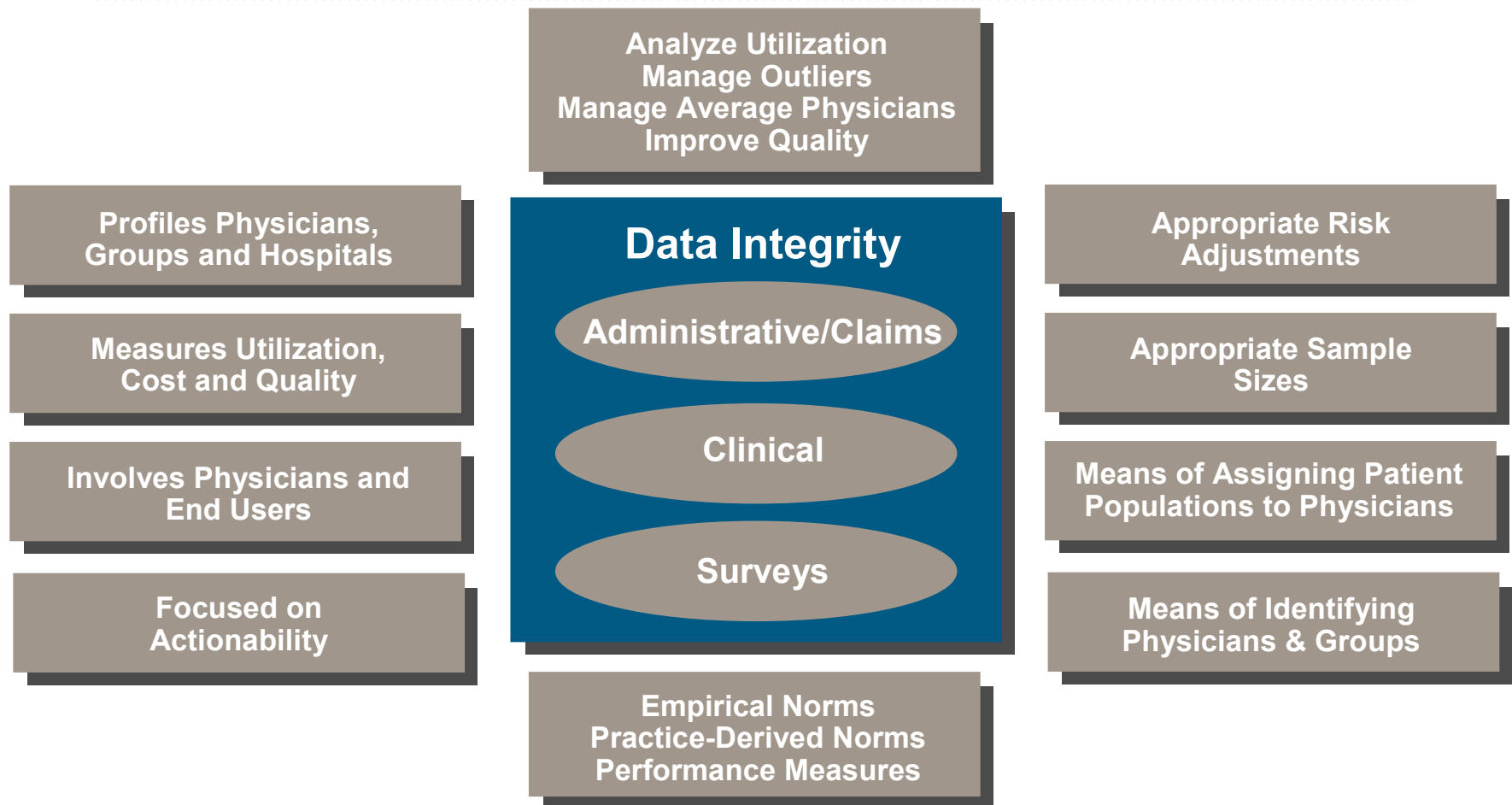
- 66% had a traditional primary care physician, 22% a specialist and 12% a surgeon
- Many had 2 primary care physicians in a calendar year and 33% changed “assigned” physician
- The “assigned” physician billed 53% E and Ms and 35% of total visits (Bach; New Eng J Med March 07)
- For Medicare pts; PCPs need to coordinate with 229 MDs and 117 practices (Pham; Ann. Int Med; Feb 09)
- “System” coordination of care difficult absent CHANGE

Physician Assessment: Provider Profiling: What a Physician Should “Know”

- What the purpose is
- Measurement set being used
- Ease of data collection
- Currency of data
- Frequency of reporting
- Reporting format
- Process for planning, implementation and review
- Balance between public reporting and use for internal performance reporting
- Type and structure of a P4R, P4P or P4Q

P4R-Pay for Results
P4P-Pay for Performance
P4Q-Pay for Quality

Components of a Provider Profiling System



Challenges Assessing Physician Performance

- Measure sets limited in scope, covering limited dimension, disease specific rather than patient focused
- Data collection difficult
- Methodological---evidence limitations, attribution, cell size
- Focus on public reporting rather than improvement
- Team care issue
- Physician recognition of the need limited

Recommendations: National

- Create a national coordination of efforts to improve care and contain costs – need for a rational measurement system
- Clearly distinguish measurement purposes – improvement, public reporting/accountability, patient choice, P4P (split P4P from public reporting) and to drive CPPD
- Implement ARRA and flexibly define “meaningful use”
- Provide funding for evidence creation, guideline development, measurement development, HIT infrastructure needs and for EVALUATION
- Facilitate implementation of the National Priorities Partnership recommendations for national priorities
- Evolve to a new accountability system for physicians and other healthcare professionals
- Conduct public information campaigns to change expectations and behaviors

Recommendations: Local

- Be knowledgeable about national trends
- Leverage national efforts by committing to small local and achievable steps
- Build coalitions and collaborative relationships with employers and patient advocacy groups
- Prepare for the information age
 - All care is predominantly an information exchange
- Prepare for continued change

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