# 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

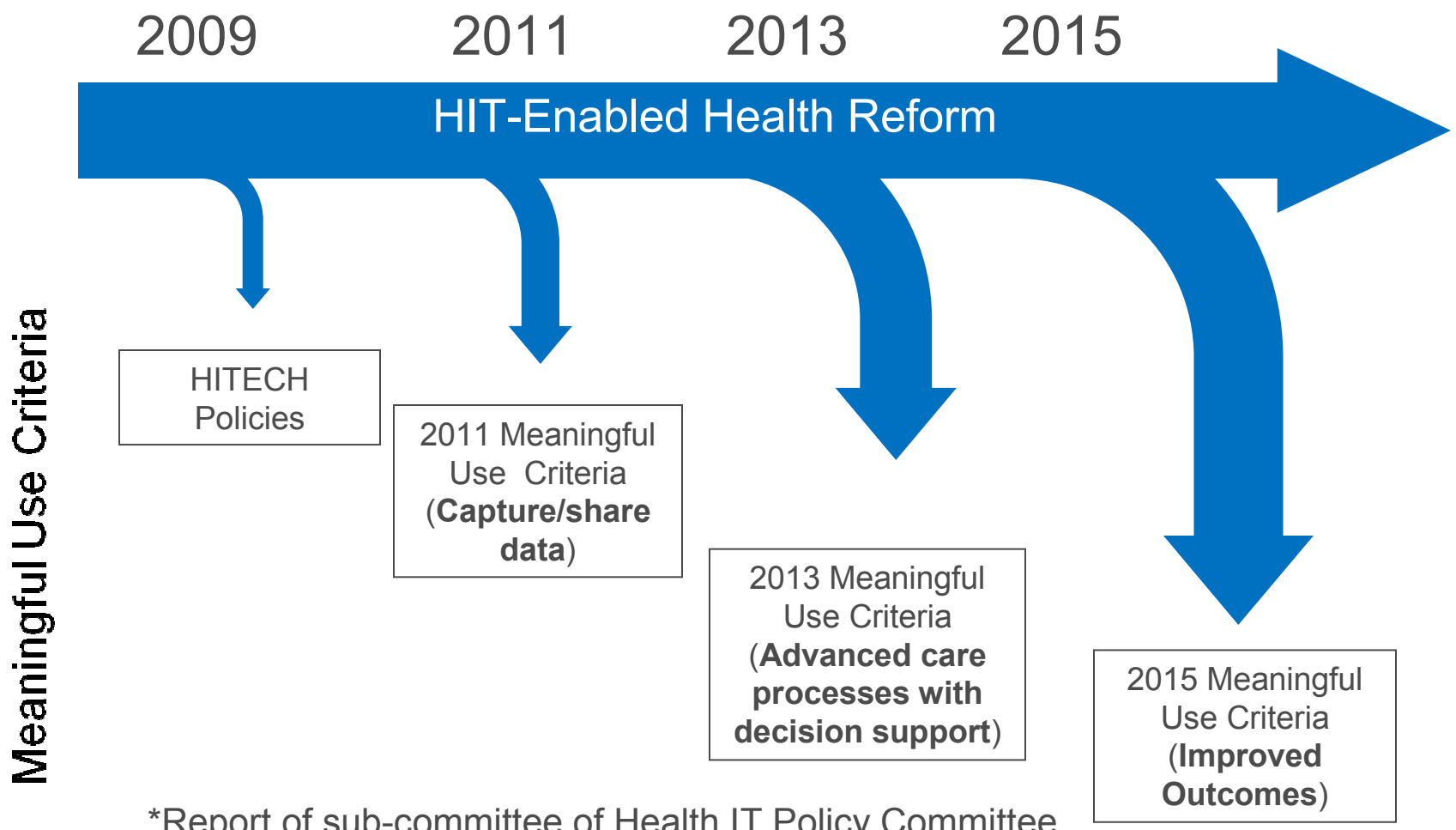
# Overarching Commitment Is Needed

- 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 *Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions* | | 2011[1] Measures | 2013 Objectives *Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions* | | 2013 Measures |
|---|---|---|---|---|---|---|---|
| | | Eligible Providers | Hospitals | | Eligible Providers | Hospitals | |

| Health Outcomes Policy Priority | Care Goals | Adoption Year 1[1] Objectives *Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions* | | Adoption Year Measures | Adoption Year 2 Objectives *Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions* | | Adoption Year 2 Measures |
|---|---|---|---|---|---|---|---|
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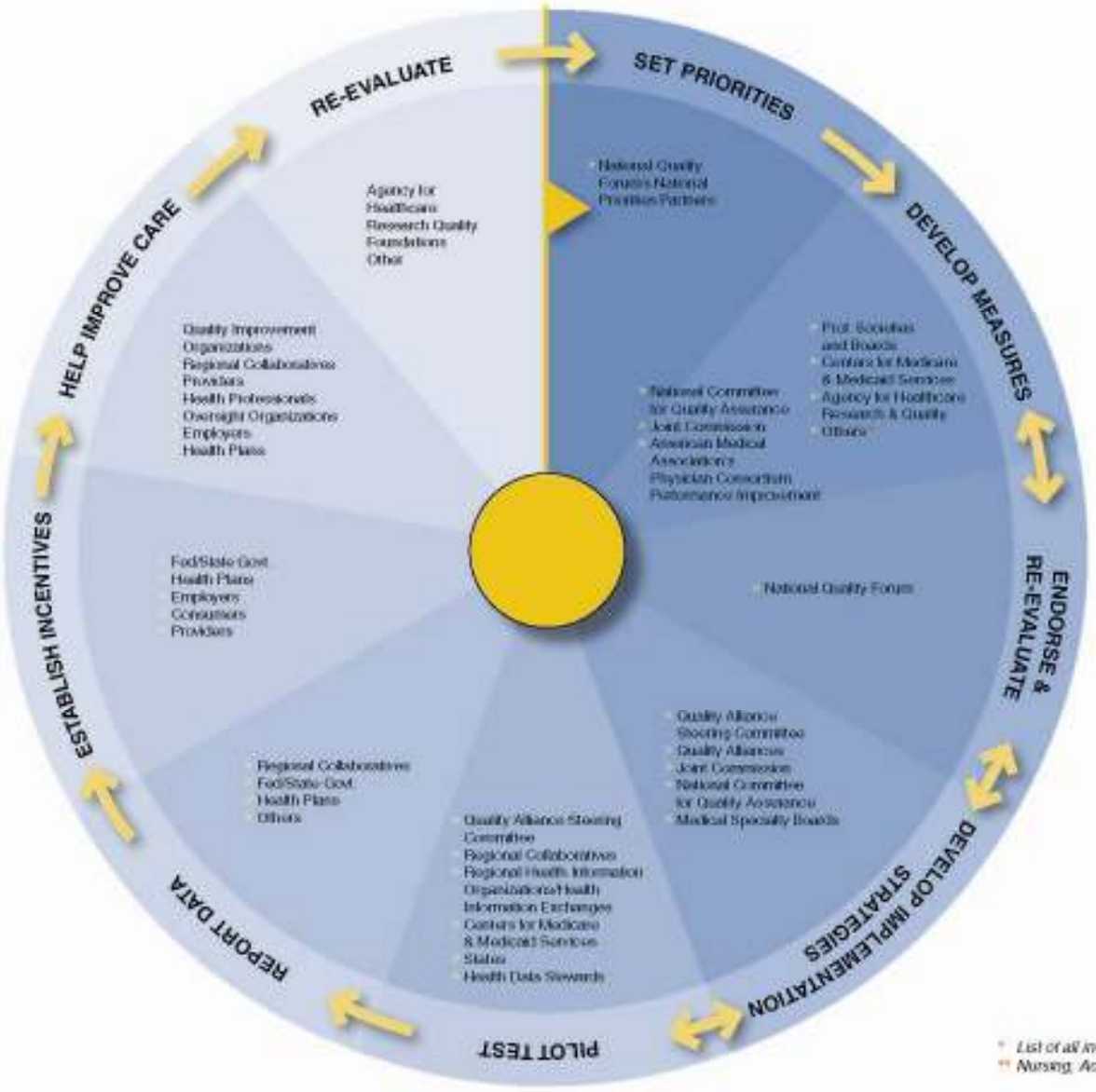
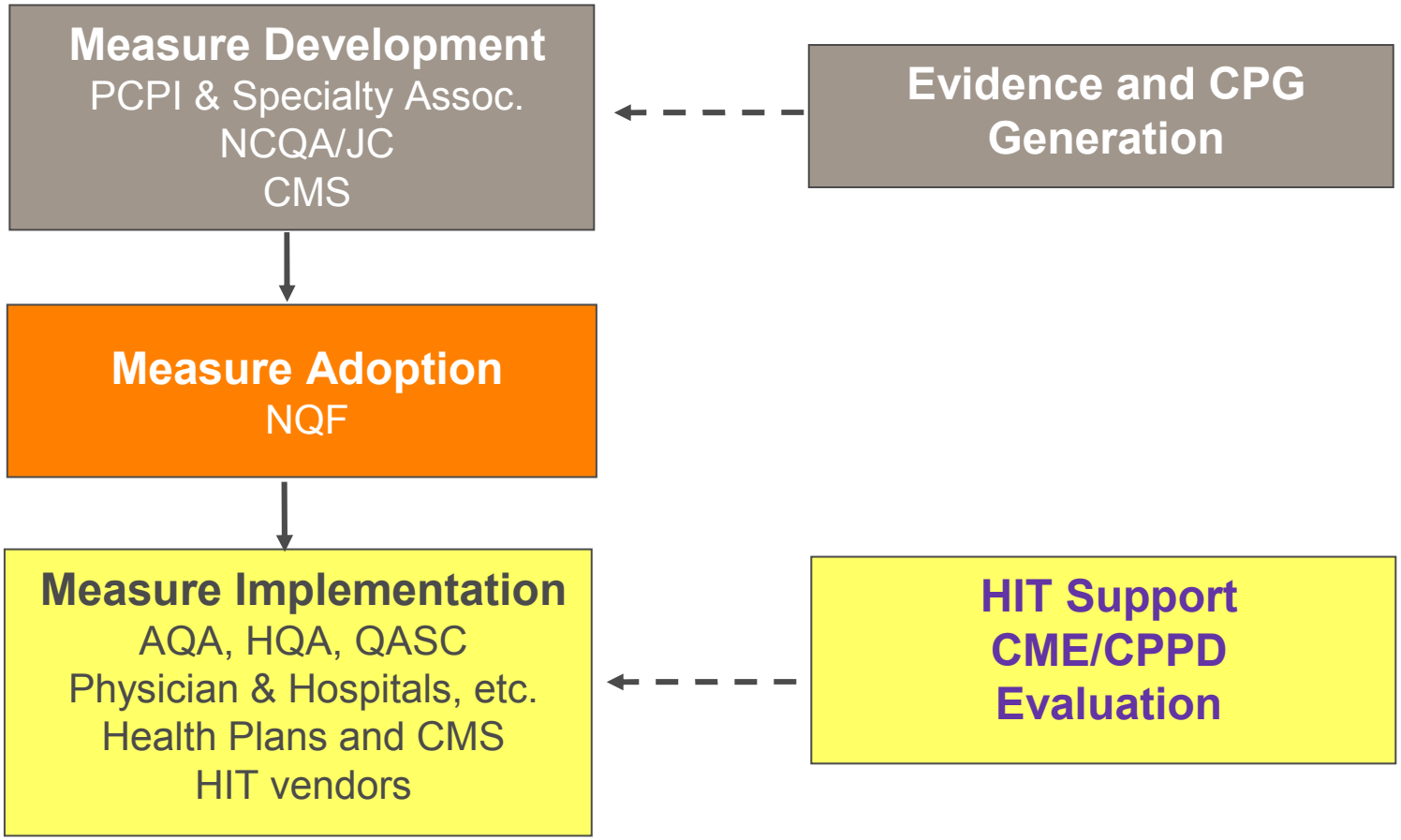
# Steps for Improving Health Care Quality & Value: Who's Making it Happen?




* *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

Ref: Boyd and Wu JAMA 10/Aug/05

# Patterns of Care and "Assignment of Accountability"

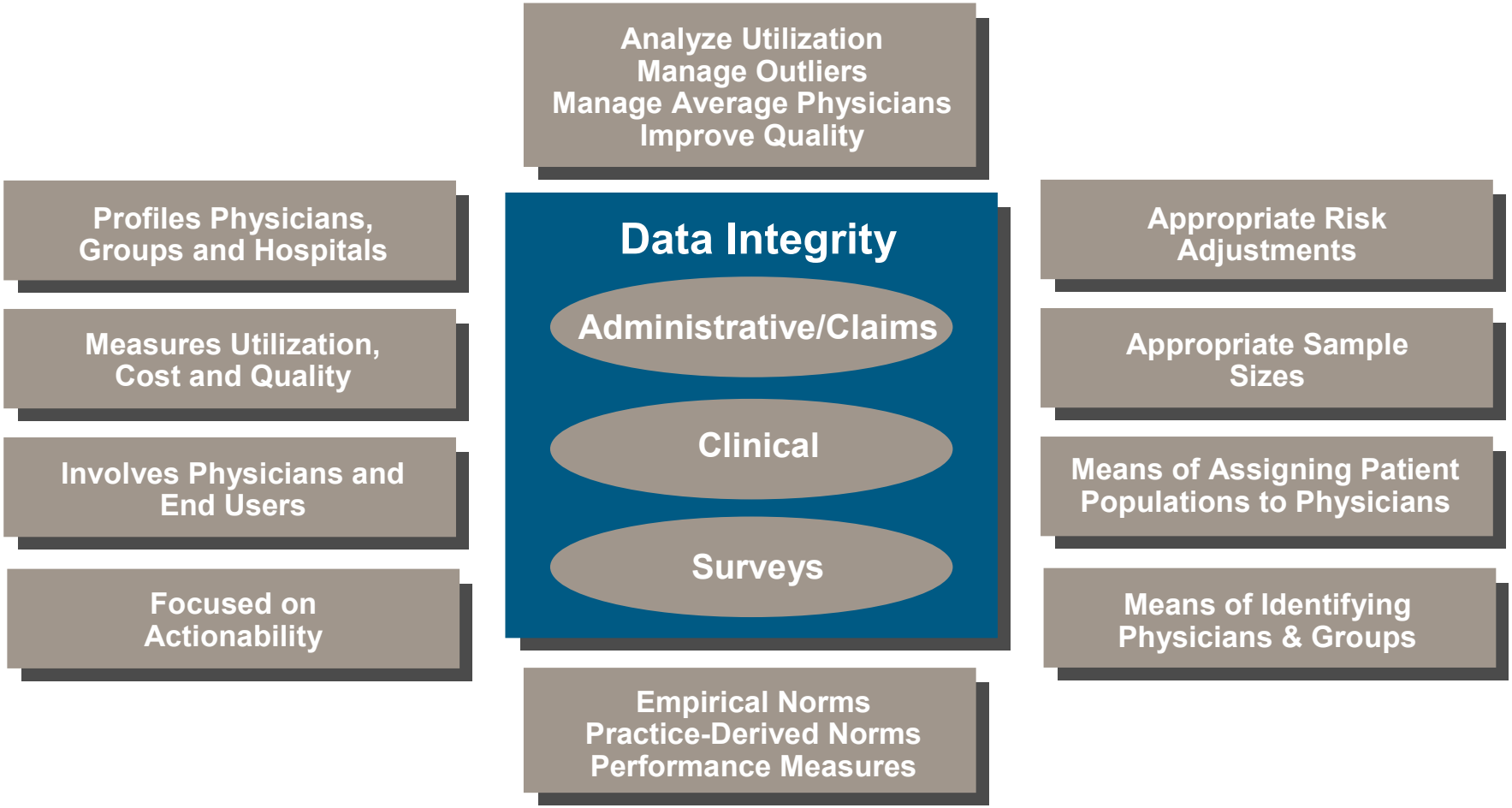
- 66% had a traditional primary care physician, 22% a specialist and 12% a surgeon
- Many had 2 primary care physicians in a calendar year and 33% changed "assigned" physician
- The "assigned" physician billed 53% E and Ms and 35% of total visits ( Bach; New Eng J Med March 07)
- For Medicare pts; PCPs 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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