

2005 Quality Colloquium

August 22, 2005

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Public Reports of Physician Performance: When is it Appropriate or Inappropriate?



The AMA and PFP

- White paper on Pay for Performance
- Principles and Guidelines
- AMA video on PFP:
Pay for Performance: The Good, the Bad and the Ugly

www.ama-assn.org/go/PFP





Preamble: AMA principles for PFP programs

“Physician PFP programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our healthcare system...”

“...Fair, ethical and patient-centered PFP programs link evidence-based performance measures to financial incentives and are in alignment with five AMA principles...”



The five AMA principles

- Ensure quality of care.
- Foster the patient-physician relationship.
- Offer voluntary physician participation.
- Use accurate data and fair reporting.
- Provide fair and equitable program incentives.



Goals


- Informed, empowered consumer.
- Improved quality.
- Excellence rewarded.

The Empowered Consumer?

- The majority of Americans with health insurance have only ONE “option” – the plan their employer chooses.
- All other “choices” pale in the face of this severe restriction.

What Do Consumers Want to Know?

- Competence: Board certified; up-to-date; technical skills; well-regarded by physicians and nurses.
- Caring: Attentive to my anxieties; listens to my concerns.



What Do Consumers Want to Know? (Cont.)

- **Efficient:** No unnecessary tests; does the right test the first time; doesn't waste my time or money.
- **Truthful:** Works with me; explains options.
- **Service provided:** Ease of access; follows up test results; communication; staff attentive.

PERFORMANCE MEASURES

- The foundation of the PFP program.
- Must be Evidence-Based.
- Physician involvement in developing measures.
- Risk-adjusted
 - Process
 - Outcomes



QUALITY MEASURES

- Process measures
- Outcomes measures
- Efficiency measures
- Patient satisfaction

Process Measures

- Prevention: Immunizations; lifestyle advice and counseling (smoking, drug/alcohol use, obesity, exercise)
- Detection: Mammograms, PSA, colonoscopy
- Treatment: MI (ASA, beta blockers); CHF (ACE or ARB Rx)
- Control: DM (HgbA1C, dilated retinal exam)

Outcomes Measures

- Can be tricky
- Sample size
- Risk adjustment
- Accuracy of data



Outcomes Measures (Cont.)

- “Attributable” to right doctor.
- Patient compliance: health literacy; cultural barriers; finances, etc.
- Microsystem of practice.
- Unintended consequences: NY CABG report; “cherry-picking”; worsened disparities.

Efficiency Measures

- No overuse, underuse, misuse.
- No conflict of interest: my health needs should be primary, not subsidiary.
- My time is valuable.
- My money is precious.

The Reality

- “Centers of Excellence” may be “Centers of Low Cost,” with cheapest – but not best – care.





The Reality: Efficiencies

- AMA not opposed to true efficiencies, BUT
- “Efficiency” may be code for cost containment.
- Be sure the program won’t withhold needed care.
- Be sure there’s no discrimination against sicker patients, or incentives to “cherry pick.”



The Reality: Preferred Provider Lists

- United Healthcare debacle in St. Louis



United Healthcare's Physician Performance Program

- Not “Pay for Performance”
- 12 pilots nationwide
- Cost-based
- Created narrow network of physicians
- Divisive to patient-physician relationship

A High Price for Low Cost

- Physicians can control costs by rarely ordering tests or prescribing medications, or never referring you to a specialist.
- Is that really what you want?

Solution: More Objective Performance Measures

- Most are for chronic conditions and primary care.
- Many specialties have none.
- All must be evidence-based.

Objective Performance Measures

- Should be developed collaboratively.
- All stakeholders should weigh in before endorsing (NQF process).
- Role of AMA's Consortium for Performance Improvement.



Objective Performance Measures (Cont.)

- NCQA and others.
- Hospital Quality Alliance (HQA).
- Ambulatory Care Quality Alliance (AQA).
- NQF.

Models of Success

- IHA in California.
- IHA in Western New York.
- Active Health Management.
- Brent James model.

Design

- Practicing physicians should be actively involved in design and implementation.
- Measures should be evidence-based, clinically relevant, statistically valid and reliable.
- Measures should be stable over time, unless the science changes or goals are met.
- Providers should be notified of any changes in methodology and evaluation.
- Methods, including risk adjustment methods should be disclosed and explained.

Data Collection

- Data should include administrative data and medical record abstraction when appropriate.
- Burden and disruption to the practices, hospitals and plans should be minimized.
- Mechanisms to verify and correct reported data should be identified.
- Aggregation for comprehensive assessment should be encouraged.

Reports

- Format should be user-friendly, easily understood and pilot-tested.
- Performance against agreed-upon targets and improvement should be evaluated.
- Relative performance should be displayed, without identifying others.

Reports (Cont.)

- Rewards for physicians should not be based on relative performance.
- Pertinent information should be shared in a timely manner.
- Physicians and hospitals should be able to review performance results before public release.

Physicians Need Their Say

- Physicians should have the right to appeal with regard to any data that is part of the public review process.
- Physician comments should be included with any publicly reported data, to give an accurate and complete picture of their patient care.



Do Public Reports Get Public Use?

- Are Public Reports used by consumers to make health care choices?
- The evidence suggests – not yet.

Public Reporting

- Providing patients with flawed information would undermine the goals of value-based purchasing and violate the oath – first do no harm.





Principles of Reporting to the Public

- Should focus on opportunities to make care safe, timely, effective, efficient, equitable and patient centered (IOM goals) .
- Should include what consumers want and information they need.
- Should be user-friendly.
- Should be continuously improved.

Goals

- Quality improvement
- Informed, empowered consumer
- Rewarding excellence

In Closing

- The AMA will continue in our long-term commitment to improving the quality of care for our patients.
- All of us are partners as we seek to provide quality health care for all.



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Together
we are
stronger.

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GETHER WE ARE STRONGER



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