PHYSICIAN REPORT CARDS AND PAY FOR PERFORMANCE

How Physicians Can Succeed in Quality Measurement and Management Efforts

White Paper

ICLOPS, LLC

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SYNOPSIS: Improving Physicians' Pay for Performance and Report Card Results

Most physicians are unaware that they are on public view in employer or health plan quality "profiles", report cards, and "preferred performance" physician networks, and that their information is easily accessed through web sites and health plan distributions. Measuring physician quality is here. All major payers, including Medicare, are implementing plans to measure clinical performance and tie financial incentives to good quality.

To succeed under Pay for Performance will be difficult for physicians. The emerging measures of quality do not adjust for patient complexity, for specialty care, or for situations where a payer may have a handful of patients in the physician's practice. Physicians who don't participate in Independent Practice Associations (IPAs) or Physician Hospital Organizations (PHOs) that measure and implement plans to improve outcomes (these functions are beyond the capacity of individual practices) are vulnerable to revenue decreases and patient loss.

ICLOPS presents a model that helps physician organizations achieve and demonstrate high clinical performance to ensure Pay for Performance success. ICLOPS has a sophisticated 3-part system to measure and improve physician quality. One part depends on the collection, aggregation, and analysis of data to track patients by condition, and then assess their results. This includes AMA Category II Codes and G-Codes data. However, ICLOPS goes further.

The ICLOPS approach is built on the premise that both the physician and the patient must be equally committed to achieve good outcomes. Physicians must actively engage patients – particularly unmotivated or poor-performing patients, who will have the most impact on physician quality "scores" - in goal-oriented programs to ensure that patients improve.

Once practice data is analyzed, ICLOPS develops a written patient communication program that conveys information from physician to patient. The objectives are to convey the physician's interest in outcomes to the patient; to engage the patient treatment adherence (such as HBA1C tests); to provide tools for patients to track needed care; and to provide a means of patient feedback. ICLOPS handles all parts of the process so that there is no additional work for physicians and no interruption in workflow.

ICLOPS is a company that works with IPAs and PHOs to measure and improve clinical performance, to achieve clinical integration, and to succeed in Pay for Performance contracts. The company is Chicago-based and also has an office in Houston.

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Status of Physician Clinical Performance Measurement

Most physicians are not aware that they are being graded on their clinical performance. They believe that web profiles, physician report cards, and “preferred performance” physician networks are in the planning stage. The fact is that evaluation of physicians’ clinical services is here, and it will affect practice volume and revenues in the very near term.

Employers and payers are frustrated after two decades of attempting to control costs with changes in health care system structure, modifications in benefit plans, and incentives to providers. Despite the previous efforts, the rates of chronic illness, heart disease, and cancer continue to go up. The pace of health care cost increases outstrips every other measure of inflation.

Payers and employers are now turning to quality improvement as a method of cost control. They are establishing Pay for Performance plans that will reward physicians who provide “good quality” and in a budget-neutral environment penalize the others. Measures are being established from many sources to judge clinical outcomes and processes, but the most important are Medicare and the AMA Category II CPT codes.

The practical issue for physicians is not “if” but “how”: how to make their physician report card positive for the practice, and how to be least vulnerable to arbitrary performance ratings.

Several initiatives are noteworthy because they signify collaboration among the players for the first time. The end result will be new, across-the-board measurements that will be a foundation for quality-based reimbursement arrangements. These initiatives typify the trend:

- The National Business Coalition on Health recently selected four of its member organizations as Bridges to Excellence quality demonstration sites for implementation of physician quality measurements and incentives. The coalition has a large membership of companies committed to better managing health benefit plans for employees.

- A group of high-profile Silicon Valley companies, including CISCO, Intel, and Oracle, have announced payment of financial benefits to Independent Practice Associations (IPAs) that demonstrate compliance with quality measurements developed for physicians by the NCQA (National Committee for Quality Assurance). The group plans to award quality scores to

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physicians based on three general sets of criteria: clinical quality (such as the proportion of various preventive screenings), patient satisfaction, and use of technology.

- Six major California health plans have agreed to develop a common quality measurement scheme through the NCQA to avoid variations in reports of individual physician quality. This raises the stakes for physicians by standardizing measurement of physician services. With multiple health plans using a standard measuring stick, the scores will have heavier weight than individual plan grades. The health plans include Blue Cross and Blue Shield plans in California, Aetna, Pacificare (now part of United HealthCare), CIGNA, and HealthNet. The health plans have multi-state presences and are likely to use the same mechanisms in other parts of the country.

- The American Medical Association has agreed to develop over 100 CPT codes to measure patient outcomes and physician quality. The original AMA Category II Codes were the basis for Medicare's recent adoption of a voluntary physician quality reporting system and creation of "G-Codes." The creation of these codes will significantly spur activity by insurers and employers to collect the same data and develop new reimbursement incentives.

- Medicare's announcement of its Pay for Performance initiative on a budget-neutral basis will be the largest single effort to measure and reward physician quality. Even more important has been the response from industry. The NCQA, in commending the Medicare action, stated that there must be collaborative efforts to ensure that there is a "standardized set of national consensus measures" to ensure the "success of performance-based health care."

It is not surprising that employers and payers are embarking on this path. They understand that previous attempts failed because they did nothing to change the way patients actually receive medical care in physician-patient relationships. In general, physicians see patients and provide services in the same way they have done for the last 50 years.

Most physicians provide services to patients episodically. They have held the belief that the responsibility for adherence to treatment is the patient's. In fact, there seems little choice given the growing administrative and clinical demands on physicians to document services.

Employers and payers, the courts, and even the public clearly take a different view. They hold the physician largely responsible for patient outcomes. Judging physician quality is broadly the

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basis for trends in consumer driven health plans, medical malpractice rates, Pay for Performance, and regulatory efforts such as the Federal Trade Commission's clinical integration rulings.

The question is whether the state of physician quality measurement is developed enough to meet the demands required by the market. Can the measures really determine quality of a provider? Is it appropriate to put all the responsibility for quality on the physician? How will scorecards work in an environment in which multiple payers cover patients in an individual practice?

This paper comments on some of the current measures being developed to calculate physician quality and offers a practical model for physicians and their organizations to succeed in the quality benchmarking process.

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Emerging Measurements for Physician Clinical Performance – and Their Flaws

Efforts to measure physician quality are very positive. The emerging measures do much to define patient status and physician processes. Alone, however, they are not sufficient for assessing physician quality. Consider the AMA Category II Codes below, and how a practice may be interpreted with the various results:

AMA Category II Code	Description	Sample Practice – % of ALL Diabetic Patients With this Code	Sample Practice – % of Payer XYZ Diabetic Patients with this Code
3046F	Diabetic patient with most recent hemoglobin A1c level (within the last 12 months) documented is greater than 9%	14%	25%
3046F – 1P	Diabetic patient where there is a medical reason for which physician has documented that testing Hemoglobin A1C level is not advised.	0%	2%
3046F – 2P	Diabetic patient where patient refuses testing for Hemoglobin A1C level	8%	5%
3046F – 3P	Diabetic patient where there is another reason for not testing.	0%	0%
3047F	Diabetic patient with most recent hemoglobin A1c level (within the last 12months) documented as equal to or less than 9%	34%	36%
(None)	Diabetic patients with no Category II Code	44%	32%

Quality measures may not present a clear view of the practice for several reasons, many of which are obvious in the example above. The most basic is the likely number of patients without any codes assigned; since the codes are not required for payment, extra effort will be needed for practices to ensure that physicians actually code the claim. In addition, there will be variances by payers because the complement of patients is different, there will be scores that look high but may reflect more complicated patients, and there will be patients who are diabetics but are not being followed for that condition by the particular physician. This raises a number of flaws inherent in interpreting measures as directly equivalent to physician quality. The most important of these are:

- Stratification of patient risk. Patients with high HBA1C may reflect poor management, or more complex patients due to co-morbidities, genetics, or age. Payers may be tempted to conclude that high HBA1C levels such as 14%, or even 25% of a practice, when compared

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to practices with lower results, reflect poor physician management. The G-Codes and AMA Category II Codes attempt to adjust HBA1C level data to some extent by allowing the physician to add a modifier (i.e., was the test not clinically advised, did the patient refuse, etc.). However, how the additional documentation will adjust the conclusions is not clear. A more significant indicator of quality is the improvement of HBA1C levels over time for the same patients. Calculating this level, however, is very difficult for one payer because it requires tracking of patients over time, data that single payers generally do not have.

- Attribution of patients. Many measures of quality are related to chronic illness, such as diabetes, lipid disorders, hypertension, and heart disease. Patients may be managed by multiple physicians for these conditions. While the Medicare G-codes will allow physicians eventually to declare that another physician is managing an individual patient, this could create additional problems under Pay for Performance. Physicians feeling that they are penalized for high levels of patients with complicated chronic disease may be motivated to shift responsibility for care to avoid financial consequences.[1] This could easily create additional access problems for patients in underserved communities, where the concentration of chronic disease is high.

- Low numbers phenomenon. The adoption of Pay for Performance plans based on individual payers' patients in a practice poses real problems for physicians. Studies show that unless there are at least 40 to 50 patients for each classification being scored, an accurate picture of physician services cannot be derived.[2] This can only be accomplished by aggregating data from multiple payers, or calculating quality measures based on the whole practice, which most payers are intending to pursue in their Pay for Performance systems.

- Incomplete coding. Most practices are challenged just to get ordinary codes input into the system to accomplish a claim. While the need to collect additional quality data is clear, it will take time and extra effort for practices to adopt the new coding. It is unrealistic to assume that physicians will automatically remember these codes without some kind of prompt. Even for practices with electronic clinical records, there will be a need to develop prompts for the codes. Without such prompts, the capture of information will be incomplete.

[1] Werner, Rachel, and Asch, David, Journal of the American Medical Association, March 10, 2005.
[2] Hofer, Timothy, MD, Kaplan, Sherrie, MD, and Greenfield, Sheldon, MD, Diabetes Quality Improvement Project for the U.S. Agency for Health Care Policy and Research, reported in the Journal of the American Medical Association, June 9, 1999.

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Payers are understandably eager to implement quality measures quickly. A mad scramble to adopt Pay for Performance reimbursement is beginning to happen. Payers argue that patients are searching for physician scorecards. Long before the most recent measures were introduced, for example, Blue Cross of California announced financial incentives with the support of the Pacific Business Group on Health, claiming that "Recent surveys among medical groups in California have shown that physicians who receive rewards for superior performance related to clinical care and patient satisfaction are more satisfied with their work and are better appreciated by their patients."[3]

The most recent information released by NCQA indicates that the measurements are being interpreted as complete quality indicators. In its recent response to the development of G-Codes, the organization makes these statements:

> "For any health plan, knowing which of your doctors and hospitals provide great care, and using that information to manage the health of your members, is responsibility number one," said NCQA President Margaret E. O'Kane. "These standards provide plans with tools to determine which doctors and hospitals perform at a high level, to reward and encourage them through incentives, and to steer patients to the highest-quality practices and facilities."
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> Plans seeking distinction in *Physician and Hospital Quality* must demonstrate that they use measures of quality and efficiency for in-network hospitals and physicians, based on a set of widely accepted performance measures and valid methodologies. Plans must also make use of clinical performance results to improve patient care—through product design, public reporting, and by noting high-quality providers in online directories and setting realistic quality goals based upon performance data.[4]

When tying physician quality measurement to financial incentives, there is a danger of creating undesired consequences. Recall the backlash against HMOs because of the perception that patients were denied access to needed care, or against the fee-for-service payment system for surgeries because of motivating unnecessary surgeries. This can only be corrected by addressing the issues of risk adjustment, patient attribution, and payer-only numbers.

Regardless of these flaws, however, it is very unlikely that the trend toward adoption of these measures as quality standards will stop for a "fairness" adjustment. The stakes are too high, the participants too eager to find a solution to cost control. Therefore, it will be up to physicians and to physician organizations to find a way of managing and improving their performance results within the context of these efforts. ICLOPS presents a model for achieving this that helps physician organizations achieve and demonstrate high clinical performance, as well as present patient risk information that can be used to mitigate unfair Pay for Performance reimbursement.

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[3] Quote from Jeff Kamil, MD in Press Release, Blue Cross of California, July 10, 2001.
[4] NCQA Website, www.ncqa.org, April 2006.

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Making Quality Measurement Work: The Role of Patient Communications

Options for succeeding in the emerging quality measurement schemes are not obvious. Most practices lack the tools to calculate their own quality measurements. Or, they assume that the measures will show them to advantage, which is not often the case. Physicians in general are unaware of their patient counts or visits, or the level of chronic disease in their practices, and rely on their memories or primitive trigger systems to follow up on patients. ICLOPS has found that fully 25-30% of chronically ill patients do not adhere to visit standards recommended for their conditions. It is unlikely that these patients will fare better in other treatment adherence measures.

Even practices with electronic medical records largely use them only for handling information in individual patient visits; very few practices are using the data in those systems to manage patient populations or to address patient satisfaction. Even with good data, the tack of arguing with every payer and employer over adjustment of measurements because of patient risk or other issues is not practical; there are too many payers and far too many outlets for reporting physician scorecards. A single physician, or even an organization, will not be able to keep track of all the information about his/her quality that is published, encased in network preferences and financial incentives, or distributed directly to employees.

A better approach for dealing with the emerging measures and Pay for Performance plans is for physicians to aggressively adopt quality projects that will guarantee a positive physician profile. This makes sense from both business and patient care standpoints. Practices that make a long-term effort to monitor and improve health outcomes for their patients will succeed under the new measures. In addition to measurement, these organizations will have to take on the responsibility of actually intervening in patient care, to demonstrate that every possible effort is being made to meet standards.

Realistically, physicians will need to participate in larger organizations to effect a quality management effort. Only IPAs or PHOs and very large physician groups are in a position to address the issues raised by third party measurement of quality and financial incentives - and only then if they negotiate fee-for-service contracts on behalf of their physician membership. Physicians who do not participate in these organizations are at risk – and especially vulnerable are the small, private independent practices, and those in IPAs that have chosen not to pursue a clinical integration strategy.

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In the third party efforts of assessing physician quality listed previously, there are three key aspects that must be addressed by physicians:

- Clinical performance, as contained in the quality criteria embedded in AMA Category II Codes and G-Codes;
- Patient satisfaction;
- Use of technology to assist in management of patient care.

ICLOPS believes that the best way to do this is to involve the patient. The patient is the ultimate arbiter of quality. Employers and payers are thrusting information about physicians to patients, and the patients need to be assured that their physicians are committed and engaged.

With the emphasis in cost control shifting to physicians, it is easy to forget that patients make the majority of decisions about managing their health – and, the patient-physician relationship is one of the strongest factors in influencing those decisions. The reason that disease management programs have disappointing results is that they take patients out of the physician-patient setting and direct their activities independently, causing both the primary physician and the patient to disengage.

Physician-patient communication is key in producing good outcomes, higher levels of confidence, and higher patient satisfaction. Early studies in the 1960's revealed that physician-patient communication was significantly related to treatment adherence, positive outcomes, and higher patient satisfaction.[5] A 2003 published study of quality of life for rectal cancer patients revealed that cancer patients who experienced poor communications with their physicians had physical, social, and emotional difficulties that resulted in a poorer quality of life.[6]

Patients are more knowledgeable about their care than some suspect, and they are desirous of maintaining continuity with their physicians. In a recent large Robert Wood Johnson Foundation-funded study of patients about their care, reports on physician quality were remarkably consistent across patients in assessing individual physicians.[7] Other recent data corroborates the finding that patients will choose technical proficiency over interpersonal skills in

[5] Korsch, BM, Gozzi EK, Francis V. "Gaps in doctor-patient communication: I. Doctor-patient interaction and patient satisfaction." Pediatrics 42; 855, 1968; and Kaplan SH, Greenfield S and Ware JE. "Assessing the effects of physician-patient interactions on the outcomes of chronic disease." Med. Care 27:S110, 1989.
[6] Kerr, J., Engel, J., Schlesinger-Raab, A, Sauer, H., Holzel, D. "Doctor-Patient Communication: Results of a 4-yer Study in Rectal Cancer Patients," Dis Colon Rectum, 46(8):1038-46, 2003.
[7] Safran, D., et al. "Measuring Patients' Experiences with Individual Primary Care Physicians: Results of a Statewide Demonstration Project," Journal of General Internal Medicine, January 2005.

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selecting a physician.[8] Recent information reveals that patients may not necessarily react to payers' information about their physicians, however. Although they are more likely to positively respond to getting such information, it is interesting that the study also concluded that loyalty to their physicians may actually increase if they receive information about physician incentives.[9]

Various research studies on medication and treatment adherence, which positively affect outcomes, show the obvious: patients are critical to decision-making on their health care.

Using the physician quality measures inherent in the AMA Category II and G-Codes as a guide, one can design mechanisms to involve patients in a curriculum of care. At issue are patients who are not highly motivated, for these are the ones who are most likely to show poor clinical results. How is this best done? The most important mechanisms are post-visit, written patient communications.

Because of the time limits of the physician office visit, where most interaction occurs, written patient communications are advantageous for two reasons: (1) to supplement the events and discussions that take place during an office visit without taxing additional physician time, and (2) to provide a mechanism to involve the patient past the visit. Especially with patients first diagnosed with chronic disease, or where the condition is not well managed, the patient may need additional time to contemplate the issues and absorb the treatment requirements. Post-visit communication provides a mechanism for patients to re-engage, understand the physician's plan, and agree to a process of care. The patient is also prepared for a planned visit.

Written communications that also require some action on the part of the patient – filling out and returning information for the next visit, visiting a web site (with a log in), completing a survey – are significant for their ability to both involve the patient *and* provide a mechanism for further data analysis (e.g., tracking of patients who completed web site survey).

ICLOPS recommends these basic features of written patient communications:

- They extend over the long term, and are designed to engage patients in a continuous process of commitment to specific health care goals;

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[8] Fung CH, Elliott MN, Hays RD, Kahn KL, Kanouse DE, McGlynn EA, Spranca MD, Shekelle PG. Patients' Preferences for Technical versus Interpersonal Quality When Selecting a Primary Care Physician, HSR: Health Services Research, 2005.
[9] Pearson, S., et. al., "A trial of disclosing physician's financial incentives for patients," Archives of Internal Medicine, 166: 623-628, March 2006.

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- Targeted and personalized correspondence to patients focus on individual adherence or health issues, rather than generic newsletters;
- Content that empowers patients, improves the efficiency of the office visit, and enhances the quality of service offered by the physician;

Patient communications are a way of managing the quality measurement process, patient satisfaction, and the quality scores. Engaging the patient is the key to making the quality process work for the benefit of both the patient and the physician. ICLOPS' model for the quality process is an example of how this can be easily accomplished.

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The ICLOPS Circle: A Model for Measuring and Managing Quality

The ICLOPS system to measure and improve physician quality is a sophisticated 3-part system. One part of the system depends on the collection, aggregation, and analysis of data to track patients by condition, and then assess their results. This includes all of the features of measurement previously discussed, such as the collection of AMA Category II Codes and G-Codes. However, the ICLOPS system goes much further.

The ICLOPS system is built on the premise that both the physician and the patient must be equally involved to achieve good outcomes, and that the physician-patient relationship is the primary vehicle to better care management. Therefore ICLOPS works to properly measure physician quality, engage patients in the process of care, and prompt physicians to work with those patients to achieve results. The ICLOPS process works in this way:

- Data aggregation and analysis. ICLOPS extracts and aggregates practice data from physician practice management systems for analysis. By identifying patients by condition, age, gender, and history, ICLOPS is able to generate analyses that compare results by physicians. G-Codes or AMA Category II Codes are collected in the process, allowing ICLOPS to evaluate not only physician use of the codes but to analyze the same data that payers will use.

  One significant feature of ICLOPS services is the aggregation of data. Because ICLOPS clients are primarily IPAs, PHOs, or large physician groups, it is possible to track patients from primary to specialty care and to identify procedures not performed in the primary care setting. If laboratory data is available as well, it is possible to ensure that patients have received appropriate tests.

- Patient status determination. ICLOPS identifies patients who have not been seen and categorizes these patients by duration since last visit. This is important in determining responsibility for patient care and for tracking visits of individual patients against standards set for patients with chronic disease. Some of the issues that are raised in this process are:
  - Patients with chronic disease who have not been seen in over 24 months. They may have quit the practice, or are just seeing specialty physicians for the chronic condition.

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- Patients with serious conditions who are out of compliance with visit norms, routine tests, or comprehensive visits. They must be brought back into the office to ensure adherence with standards of care.

The final step in this process is the creation of patient registries for conditions being tracked in performance measurement, such as diabetes and hypertension. These registries are used for both measurement and patient communications. ICLOPS works with practices to verify patient registries. This process is also used for determining patient attribution.

- Patient Communications. Patient communications are a critical part of ICLOPS services. ICLOPS creates letters under the physician's electronic signature that incorporate practice letterhead and are customized to patient names, gender, diagnoses, and status. These are sent to patients to convey standards of care and to request that the patient come into the office for certain tests and services. The ICLOPS communication package also includes requests that patients provide information on issues they have with medical adherence, such as not understanding the value of the treatment or problems in accessing it.

- Point-of-service prompts are created for physicians and placed in patient charts by the practice. These prompts are check-offs for physicians during the visit, and quality audit codes are incorporated into these prompts (such as Category II codes). The prompts are customized and vary over time; they are tied to the patient's condition and quality initiatives of the IPA. The prompts serve as triggers for physicians to ask the patient about medical adherence, perform or document certain services, and submit the quality codes.

ICLOPS works with IPAs and PHOs to implement quality projects. These organizations, while some are still in transition from their previous role as HMO intermediaries, are growing into entities that will be very important to physicians. Physicians, especially those in independent practices, do not have the resources to measure and monitor quality or to develop quality improvement processes on their own.

The result of ICLOPS processes is a constantly renewing process of measurement, patient engagement, and quality improvement. The philosophy is that patients who believe that their doctors are committed to helping them meet goals, and know that their progress is being tracked, are more accountable.

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Summary: The Future of Physician Quality Management

One of the major byproducts of current quality measurement efforts is the quantification of patient results by physician. For the first time, data is becoming available and used to determine the impact of physician management on care. Whether or not the picture of an individual physician is accurate or not – and measures can never provide a fully accurate account - the future is one in which data will be used to assess physician quality.

Initially, only the most sophisticated patients and employers will be able to access and understand the quality profile of a physician. That is certain to change. Physicians face a real risk of damage to their professional reputations if they do not take the trend seriously.

Physicians who embrace the quality measurement movement will find opportunities. They will improve their reputations, provide more and better services, and build profitable practices. However, they need support. Unless a practice is very large, the resources required to measure, monitor, and intervene in health care are too much for individual practices to handle. Furthermore, it makes more sense to operate in conjunction with specialists and ancillary services where quality is likewise monitored.

ICLOPS proposes these tenets for consideration among physicians:

- Physician organizations such as IPAs and PHOs are a good vehicle for quality management. However, these organizations must be willing to be vigorous and tenacious in organizing these efforts. Strong physician leadership is essential.
- Quality measurement is only the beginning. Many organizations try to "start slow" and get physicians used to looking at and sharing data. The time is too short. Organizations should establish a long term and dynamic program, using "interventions" as well as measurement. Physicians will accept changes if they understand the imperative.
- Patients must be involved in the process. This is an asset rather than a complication. Patients are looking for direction and help from their physician; meeting this need will create a positive response in patient satisfaction and treatment adherence. But the effort needs to be broad-based, public, and "beyond the norm". That's why patient communications are such an excellent vehicle for demonstrating good concern and follow-up.

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