Pay for Performance: The Right Ingredients

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WASHINGTON — Mix a little money with solid incentives physicians can relate to, and you've got a successful recipe for a pay-for-performance program, Ronald P. Bangasser, M.D., said at the annual National Managed Health Care Congress.

Physicians try to deliver the highest level of medical care they can, but most can't keep track of the needs of every patient, said Dr. Bangasser, a family physician and immediate past president of the California Medical Association.

Studies show that 50% of patients don't get what they need in quality of care, he said. "Most patients rate their doctor a four out of five, but they hate the health care system."

That's one reason physician groups need a data-based approach to help reduce errors and improve care, he continued. A new program in California has yielded positive results, and is "certainly one way to pay for quality," Dr. Bangasser said.

Applying the right types of incentives is important. 'If the physician thinks the measure is not going to improve quality, $1 million will not change behavior.'

Backed by a state foundation grant, the statewide Integrated Healthcare Association (IHA) got together with medical groups, health plans, purchasers, and consumer groups several years ago to collaborate on a plan to reduce expenses for physician reporting.

The program was able to achieve this savings "by accumulating all of the health plans together, so physician groups only had one reporting mechanism instead of seven or eight," said Dr. Bangasser, medical director of the wound care department of the Beaver Medical Group L.P., at Redlands (Calif.) Community Hospital. The group participates in the IHA program.

All of the health plans and medical groups had to agree on a common set of measures and a common way to report those measures. The IHA in turn acted as a "neutral convener," in coming up with standards for reporting the data, he said.

Technical and steering committees were formed to work with technical experts on proposing measures.

The measures had to be valid and accurate, meaningful to consumers and physicians, and important to public health in California. "They also had to get harder over time," Dr. Bangasser said. In the IHA program, physicians get paid not just for performance, but also for performance improvement. "We actually have a calculator [that determines whether] people are improving."

The first payout took place in 2004, based on first-year data from 2003.

Physicians are assessed on three types of measures: clinical, patient experience, and information-technology investment.

First-year results saw little variation among the participating groups on patient experience, although variations were seen among clinical and IT measures.

There was room for improvement in both of these areas, Dr. Bangasser said. Fewer groups participated in IT measures than in the other measures, and of those who tried, "only two-thirds of them got full credit for it. It showed us that we had a huge IT deficit."

Variations occurred in the clinical measures because not all of the groups used a registry-type system—a list that details the specific diagnoses of each patient. Physicians using a registry can find out if a patient got a certain test or if they need one, Dr. Bangasser said. To date, groups that use registries "are doing much better on these measures than groups that don't."

One of the biggest improvement areas was in cervical cancer screening, he said. Based on data comparisons between 2002 and 2003—the year the program got started—nearly 150,000 more women were screened for cervical cancer, and 35,000 more women were screened for breast cancer.

An additional 10,000 children got two needed immunizations, and 180,000 more patients were tested for diabetes.

Although some groups scored fairly high, specialists didn't fare as well. Patients cited access problems to specialists as a specific complaint in the satisfaction surveys, Dr. Bangasser said.

The estimated aggregate payment to physician groups in the IHA program in 2003 was between $40 million and $50 million, although some groups thought they didn't get paid properly, Dr. Bangasser said. There were some concerns about increased utilization and cost of services for groups participating in the program, and what the long-term returns on investment would be. It was also determined that groups serving large Hispanic or Native American populations should get "extra credit" for having to deal with more diverse, culturally different populations.

Applying the right types of incentives is key, he said. "If a physician thinks the measure is a good idea, putting a little money behind it will speed quality improvement. However, if the physician thinks the measure is not going to improve quality, $1 million will not change behavior."

Sometimes, the simplest incentives can produce good results.

Dr. Bangasser mentioned a particularly bad influenza season in 1998, when patients had to wait in long lines to see physicians in his group practice. "I asked all of the doctors if they'd take on two more patients a day. That's a long day, but I gave them two tickets to a movie theater for Christmas."

All but two physicians took on the extra patients. "This meant that over 60 physicians saw an extra 120 patients per day," he said. ■

POLICY & PRACTICE

Declining Mental Illness Stigma

A mental illness diagnosis does not result in the fear or shame that it used to, according to a recent survey by the American Psychiatric Association. Nearly 90% of the 1,000 adults surveyed said that people with mental illness could live healthy lives, and 80% said mental health treatment was effective. In addition, 70% said seeing a psychiatrist was a sign of strength, according to the APA. Despite those encouraging signs, however, there were also some disturbing results, the association noted in a statement. For instance, 20% of respondents said they would not see a psychiatrist under any circumstances, and 57% said they were not concerned that they themselves or a family member might ever having to deal with a mental illness.

Mental Health Coverage Trends

The Mental Health Parity Act of 1996 has resulted in some gains in employee mental health coverage, but inequities remain, according to a report from the U.S. Department of Labor. Since the passage of the act, which requires employers to equalize dollar benefits for mental health and physical health coverage, the incidence of employees in medical plans that impose more restrictive dollar limits on inpatient mental health care coverage has decreased from 41% in 1997 to 7% in 2002. However, employees in plans that contain tighter restrictions on the number of days of inpatient mental health care compared with inpatient medical and surgical care—a disparity allowed under the law—rose from 61% to 77% in the same period. Differences in substance abuse coverage also remained, with only 8% of employees who had coverage for alcoholism treatment receiving the same coverage for that condition as for other conditions in 2002.

Depression and Marijuana Use

The evidence for a link between marijuana use and depression is getting stronger, according to the White House Office for National Drug Control Policy. "There certainly are people who self medicate, but the danger we're talking about is the growing evidence that use itself . . . may be triggering and may be worsening the onset of mental health problems," ONDCP Director John Walters said at a Washington press conference. "Now, would some of those people have mental health problems anyway? That's entirely possible. But it's also entirely possible that some of these people may not subsequently show these mental health problems, and the evidence suggests that the use of marijuana may trigger the onset of problems that would not otherwise be there." According to the office's National Survey on Drug Use and Health, among persons aged 18 years or older, those who first used marijuana before age 12 were twice as likely to have serious mental illness in the past year as those were who first used marijuana at age 18 or older.

AMA: Ban Booze Ads at NCAA Events

The American Medical Association has asked the National Collegiate Athletic Association to eliminate alcohol advertising associated with NCAA events. "The prevalence of alcohol advertising in college sports sends a damaging message about the core values of the NCAA and higher education," AMA President-elect J. Edward Hill, M.D., said in a statement. "Allowing aggressive alcohol advertising during its events only encourages underage consumption of alcohol." In a national poll sponsored by the AMA, 62% of adults said the NCAA should reverse its policy and not allow beer companies to advertise during college sporting events. NCAA spokesman Erik Christianson said that the association already limits alcohol advertisements to 60 seconds per hour of any broadcast NCAA event. In addition, Mr. Christianson noted that the NCAA executive committee was already planning to discuss the idea of banning the advertisements completely at an upcoming meeting, in response to a request from one of its divisions.

Ads Influence Prescribing

Direct-to-consumer advertisements appear to have an impact on physician prescribing practices, reported Richard L. Kravitz, M.D., of the University of California, Davis (JAMA 2005;293:1995-2002). A total of 152 family physicians and general internists were recruited from solo and group practices and health maintenance organizations to participate in the study, which focused on advertising for prescription antidepressants. Standardized patients were randomly assigned to make 298 unannounced visits, presenting either with major depression or adjustment disorder with depressed mood. When the patients with depression made a general request for an antidepressant, only 3% of the physicians prescribed paroxetine (Paxil). However, when they asked for the prescription by name, 27% were given a prescription for Paxil.

E-Prescribing Standards

Medicare should adopt a program-wide system of uniform national electronic prescribing standards for its new prescription drug benefit, according to the Pharmaceutical Care Management Association (PCMA). A uniform national standard is needed to maximize the participation of private plans in the Part D benefit and to help reduce regional variations in health care delivery and outcomes, PCMA said in comments to the Centers for Medicare and Medicaid Services on its proposed rule for Medicare e-prescribing standards. "PCMA believes that Medicare e-prescribing holds the potential to transform the health care delivery system," PCMA President Mark Merritt said in a statement. "Regrettably, a 50-state patchwork approach would increase costs, decrease efficiency, and severely undermine the promise of e-prescribing."

—Joyce Frieden