

Pay for Performance: The Right Ingredients

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

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



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DR. BANGASSER

new program in California has yielded positive results, and is "certainly one way to pay for quality," Dr. Bangasser said.

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 areas, Dr. Bangasser said. Fewer groups participated in IT measures than in the other measures, and of those who tried, only two-thirds got full credit for it.

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 were screened for breast cancer.

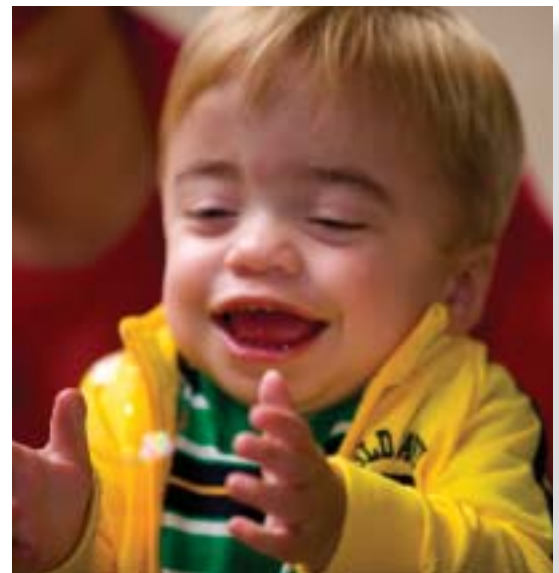
An additional 10,000 children got two needed immunizations, and 180,000 more patients were tested for diabetes.

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

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

Early diagnosis is critical

Treatment options may give hope to children with MPS I



Jarrett presented with the following signs and symptoms:

- Chronic rhinitis
- Recurrent otitis media
- Umbilical hernia
- Coarse facial features

A suspicious cluster of signs and symptoms?

An urgent referral to a metabolic or genetic specialist is what your MPS I patients need most ...

For children like Jarrett, every day may make a difference. Early diagnosis and treatment are essential to help children avoid some of the debilitating effects of MPS I, which, if left untreated, can lead to significant morbidity and mortality.

Your recognition of an unusual sign or symptom, or a cluster of more common signs and symptoms, may make the difference. If you suspect MPS I, request an urgent referral.

genzyme

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 mea-

sure 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. ■

Physician Disclosure of Errors Is Still a Mixed Bag

BY KATHLEEN LOUDEN
Contributing Writer

CHICAGO — Four percent of primary care physicians and third-year medical students surveyed in a regional study reported that they made errors resulting in a patient's death but did not disclose them to their institution, Lauris C. Kaldjian, M.D., said at the combined annual meeting of

the Central Society for Clinical Research and the Midwestern section of the American Federation for Medical Research.

Dr. Kaldjian surveyed faculty, residents, and third-year medical students in the departments of internal medicine, family medicine, and pediatrics at two medical schools and three hospitals in the Midwest and Northeast. The 538 responses were weighted more heavily toward residents and students than faculty members.

Of respondents, 17% did not disclose to their institution medical errors that prolonged the course of treatment or caused discomfort, and 12% did not disclose to the patient. Still, more primary care physicians and students voluntarily disclosed medical errors than those who did not, said Dr. Kaldjian, a bioethicist at the University of Iowa. Of the respondents, 27% revealed to the patient a medical error that prolonged therapy, and 18% disclosed such a mistake to their institutions.

The study was designed to develop a comprehensive taxonomy of the factors that influence voluntary disclosure of errors by physicians and to use the taxonomy in a cross-sectional survey of primary care physicians. The survey asked about factors that facilitate voluntary disclosure in four domains: a sense of responsibility to the patient, oneself, the medical profession, and the community. It also solicited reasons that impede disclosure of errors in four domains: attitudinal barriers, uncertainties, helplessness, and fears and anxiety.

These eight domains included 59 factors that either facilitate disclosure, such as the belief that telling patients about mistakes increases their trust in the physician, or hinder disclosure—for example, fear of legal liability.

"This study is trying to get at the deepest motivations and barriers that come into our minds and even our hearts when it comes to talking to patients about medical errors," said Dr. Kaldjian, whose work was funded by the Robert Wood Johnson Foundation. "The issue of disclosure of errors has come to the fore in recent years because of the patient safety movement."

Among fears, the most common reason survey respondents did not disclose a medical error was fear of a negative reaction from the patient or family (88%).

"You hear certain experts in the field saying the more candid we are, the less likely we'll get sued," he said. "Among the people we surveyed, it certainly is not the consensus of what would happen."

Women in the study were more inclined than men to disclose their errors to patients. Faculty members appeared more willing than trainees to disclose errors to their patients but not as willing to disclose to their colleagues.

Dr. Kaldjian did not break down medical errors other than those that prolonged therapy or caused discomfort and those that caused death, he told this newspaper. He is continuing to interpret the data.

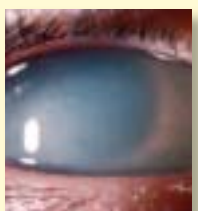
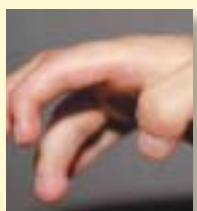
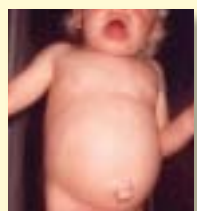
The taxonomy he developed may assist in the design of systems for reporting medical errors and might be helpful for educational interventions. ■

Mucopolysaccharidosis I (MPS I) – a lysosomal storage disorder

Jarrett was diagnosed with MPS I, a relatively uncommon yet rapidly progressive and often life-threatening lysosomal storage disorder. Now, with early detection, an urgent referral, and treatment options, children like Jarrett may have a more positive prognosis, and may avoid serious problems associated with disease progression.

Signs and symptoms of MPS I – identifiable, but not always obvious

Look for telltale clusters of signs and symptoms, which may begin to present as early as infancy.



- Macrosomia (in infancy)
- Recurrent otitis media
- Hepatosplenomegaly
- Hearing loss
- Hernia (inguinal/umbilical)

- Facial dysmorphism (coarse features)
- Corneal clouding
- Chronic rhinitis
- Communicating hydrocephalus (severe form)

- Joint stiffness and skeletal deformities
- Developmental delay (severe form)
- Valvular heart disease
- Obstructive airway disease

Learn more about identifying signs and symptoms of MPS I by visiting www.MPSIDISEASE.com or by contacting Genzyme Corporation at **800-745-4447, option 2.**



Make the call

Make the urgent referral that may make the difference for children with MPS I