Assessing Individual Physician Performance By Managed Care Organizations

American College of Physicians–American Society of Internal Medicine
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# Assessing Individual Physician Performance

By Managed Care Organizations

## Table of Contents

- Executive Summary ...........................................1
- Introduction ....................................................3
- Current Environment ..........................................4
- Group Practice Performance Evaluation Sample .............6
- Do These Systems Really Measure Quality? ..................6
- Recommendations .............................................8
  - Effective Approaches to Assessing Physician Performance ....8
  - Key Concepts for Maximum Positive Impact on Quality of Care .9
- Criticisms of Physician Assessment Systems ..................14
- Data Sources, Collection, and Analysis .......................16
- Conclusion ......................................................17
- Endnotes .........................................................18
Executive Summary

Mechanisms that offer financial incentives to manage health care resources should also encourage quality. Across the country, managed care organizations (MCOs) and physician groups are experimenting with internal performance assessment systems that identify problems and inefficiencies and encourage quality improvement. Increasingly, MCOs use the physician performance information garnered from these systems to set compensation, recredential physicians, and provide information on quality of care to consumers.

This white paper provides practical recommendations on the responsible and effective development, use, and dissemination of physician performance information to encourage continuous quality improvement within MCOs.

The American College of Physicians–American Society of Internal Medicine (ACP–ASIM) believes that performance assessment systems can change the incentives in the health care system to favor quality of care and patient satisfaction, as well as manage utilization and cost. However, it is important to properly balance the incentives in such systems among the various aspects of care and to use them appropriately to make sure that the highest priority is providing quality health care to patients. After an extensive review of literature on quality monitoring and improvement, and on the advice of practicing physicians familiar with quality issues, ACP–ASIM has concluded that certain approaches to performance assessment and improvement are more effective than others in changing medical practice in a positive manner.

ACP–ASIM has identified nine principles that it believes are key to a successful, internal, individual physician performance assessment program. ACP–ASIM recommends that MCOs use these principles when developing and implementing internal performance assessment and improvement programs:

1. The primary focus of internal physician performance assessment systems should be to improve quality.
2. The success of any performance measurement system will depend in great measure on the cooperative relationship between the MCO and physicians. MCOs should consult with practicing physicians in developing and refining performance measures and should make these criteria or measures available to physicians. Also, practicing physicians should be involved in all aspects of the development, implementation, and evaluation of physician performance data.
3. Internal physician assessment and improvement systems should be non-punitive and confidential in monitoring and improving quality. MCOs should provide educational feedback on a timely and routine basis in the form of user-friendly reports with explanations of methodology to facilitate review by physicians. Unless regulatory or patient safety requirements are in jeopardy, plans should focus on opportunity for practice adaptation.
4. Physician performance assessment programs should provide physicians with nonjudgmental, comparative clinical performance information derived from population-based data analysis and adjusted quality measurements to promote internal quality improvement.
5. MCOs should adjust physician performance profiles appropriately for such elements as case mix, severity of illness, age and sex of patients, size of a physician’s panel, number of comorbid conditions, and other features of a physician’s practice and patient population that may influence the results. MCOs must give physicians the opportunity to review their profiles for accuracy and to request adjustments for particular characteristics of the patients they serve, before the MCO takes any adverse action. Adjustments should be based on sound scientific evidence.

6. If a physician does not have adequate control over an element of medical care used to assess performance, that element should not be considered when measuring quality of care.

7. MCOs should not release internal physician performance profiles or evaluations to the public on a physician-specific basis. They should release aggregate performance data instead, without physician-specific identifiers.

8. Physician performance may be evaluated in a number of areas, including clinical quality of care, utilization, access and service, cooperation with the MCO’s quality improvement efforts, and patient satisfaction. ACP–ASIM believes that all these measures affect quality of care to some extent and it is appropriate to include these kinds of measures in performance assessment systems.

9. ACP–ASIM believes that patient satisfaction results and measurement of clinical practice and disease-specific patient outcomes should be given equivalent weight when evaluating physician performance.
Introduction

Managed Care Organizations (MCOs) often use internal performance assessment systems that reward physicians not only for performance on process and quality of care measures, but also for patient satisfaction, access and service, cost and utilization, practice growth, adherence to the managed care ‘philosophy,’ and board certification criteria. MCOs often use the resulting physician performance profiles to encourage quality improvement, determine physician compensation, and to make recredentialing decisions.

Many are concerned that these systems may focus only on cost and patient satisfaction, and ignore quality of medical care. A recent study noted that although the private sector is becoming more sophisticated at measuring quality, the impetus behind this interest is pressure to contain costs. Another study found that managed care plans still consider price and patient satisfaction the two most important factors for successful marketplace competition. (1) Evidence has shown that patients’ decisions are based upon price and satisfaction; however, it is important for the physician community to educate those patients about quality and why it is so important.

A primary driver of all quality, profiling, and cost containment initiatives leading, in some cases, to ‘physician profiling,’ is frequently the ‘purchaser’ of health care. These purchasers can be businesses, government, or even individuals. When the party paying for the service takes the lead, they frequently confuse whether cost or quality should come first and don’t take the practicing physician view into account.

ACP–ASIM’s goal in this paper is to present practical recommendations on how responsible, fair, and effective physician performance information can be developed, used, and disseminated in the managed care environment. This paper addresses many questions, including:

• Do performance assessment systems really measure quality?
• What performance measures are appropriate for assessing physician performance and how should they be weighed?
• How should managed care organizations approach performance assessment and improvement activities, and what are the essential components of an effective quality improvement program?
• How can managed care organizations enhance the credibility of performance information for physicians?
• What are the current criticisms of physician performance assessment systems?
• What is the appropriate way to publicly release performance assessment information?
Current Environment

Forces such as fierce competition within the managed care industry, efforts to control the costs of health care, and dramatic changes in the organization and delivery of health services are shaping the health care system in the United States while at the same time, raising concern over its quality. By focusing on the accreditation and quality of care in MCOs or health care facilities and on performance of individual physicians, the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are actively involved in developing physician profiling. Collaboration among these organizations, along with the American Medical Association (AMA), was announced in June 1998, creating the Performance Measurement Coordinating Council (PMCC). Based on sound scientific methodologies that effectively balance medical and business objectives, the Council develops and coordinates performance measurement activities that efficiently meet the needs of physicians and health care delivery organizations.

In general, physician profiling involves the collection and analysis of data on practitioners’ patients from databases. Measures of care or outcomes are then compared with a population of providers, groups, facilities, or national standards regarding quality of care resource utilization and cost. (2) Physicians increasingly find that MCOs are monitoring their individual practice patterns and style, and using this information in recredentialing and in setting payment levels. By focusing on in-depth provider data, MCOs can influence physician practices to be more efficient while still maintaining acceptable levels of quality of care. (3) There is also a “West Coast” model of physician profiling where physician groups are contracted by health plans that delegate the profiling function to that particular physician group.

Concerns over the quality of care have increased emphasis on quality measurement, and have resulted in the development of “report card” performance evaluations of individual physicians, group practices, and health plans. (4) “Report card” performance evaluations allow individual physicians, physician groups, and sometimes consumers to view a comparison of outcomes relating to quality of care, resource utilization, or cost. “Managed care organizations use profiling as part of physician incentive payment plans or to make decisions about which physicians the organization wishes to have participate in its network, while hospitals use physician resource profiling to reduce variation in practice patterns and the mean (average) resources used.” (5) Those reports made available to the public provide consumers “with a valuable tool to make more informed health care decisions and provides information that can assist with choosing a doctor or deciding which medical group to join.” (6)

One specific plan only shares individual profiling data with their physicians because they have found that “what consumers view as important in physicians is very different from what health care professionals view as important.” (7) However, as more MCOs make their profiling information available on the Internet, some physicians are beginning to feel exposed.

One managed care organization’s profile program uses medical and pharmacy claims data to provide physicians (only) with information about how well their practice patterns follow clinically important, established medical practice guidelines. The program is not used to penalize physicians, but to improve patient care by sharing clinically relevant information about delivery of care.
This organization’s profile program can determine the rate which participating physicians are prescribing beta blocker drugs for survivors of heart attacks and the rate which patients with diabetes are getting HgA1c or Glycosylated Hemoglobin tests, for example. (8)

As mentioned earlier, some organizations make public their profile findings, as is the case of one California-based system. (See Group Practice Performance Evaluation Sample, following page) Their report establishes information on provider group performance in selected areas of clinical, service, and administrative quality. The scores of all participating medical groups are converted to percentiles, which show how one medical group compares to another. A “Best Practice” designation is given to a particular medical group which scores in the top 10 percentile in any given category. However, specific indicators, such as patient non-compliance or unavailable or inaccurate data will not necessarily reflect true performance.

The organization described in the above paragraph believes the information provided allows consumers to make more informed decisions about choosing or changing health care providers. Collection of the data used is mostly obtained electronically from contracted medical groups, IPAs, and hospitals, while service quality data is collected through member surveys, phone calls, and correspondence. The “report card” is not only distributed to plan members, providers, employers, brokers, and consultants, but available to the general public via the Internet as well.
Do These Systems Really Measure Quality?

ACP–ASIM supports the following Institute of Medicine (IOM) definition of quality of care:

Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. (1)

In this era of cost containment and concerns about inefficiency, many people are talking about the need to assure “quality” of medical care. But do the performance assessment programs proliferating in the managed care industry really measure quality? For example, is it quality or a way to minimize emergency room charges while getting more work out of a physician when physicians receive bonuses for having more than 50 office hours per week? Is it quality when plans reward physicians for doing more procedures in the office rather than demonstrating excellence in performing them? Or is it simply a method of minimizing referrals? (9) Is patient satisfaction—which some physicians argue is seldom critical to clinical outcome—an appropriate performance measure? Do other measures—often used by MCOs to address issues such as cost control, utilization reduction, access, market expansion, and cooperation with the MCO—have anything to do with quality? Such measures appear to focus primarily on getting physicians to practice in ways that are healthy for the MCOs bottom line, not necessarily for quality of care.

Defining and measuring quality of care is a difficult task, because “quality” can mean very different things to physicians and MCOs. The Employee Benefit Research Institute sums up this problem with the statement: “Quality is a multidimensional concept: it can be viewed narrowly (as clinical effectiveness) or broadly (as all attributes of medical care that patients value).” (1) In attempting to manage health care costs and to allocate health care resources, MCOs are using untried measures to evaluate physician performance. It is often unclear what relationship, if any, these measures have to quality of health care.

For optimal patient care, however, ACP–ASIM believes that there should be a balance between clinical quality, cost control, access, patient satisfaction, and the MCO’s business concerns. For example, too much emphasis on utilization and cost measures may lead to underutilization and diminished quality. With an overemphasis on patient satisfaction, the physician may respond too readily to patient demands for high-priced services, even when a less expensive service or no service may be more effective. Also, MCOs might focus too much on lowering premium prices, since price has been shown by many studies to be consumers’ number one reason for selecting a plan. Again, a strong focus on lowering premiums may come at the price of diminished quality and underutilization.

Deciding how to balance the disparate elements of quality is one of the most controversial tasks in developing a measurement system. As noted in a current study, “Even if individuals agree on the disparate attributes of care that determine its quality, they may disagree about the relative importance of each attribute.” (1) Given the current pressure in the private sector to reduce health care costs and the financial incentives under capitation to underutilize services, it is important to make sure that quality of care should not be underemphasized.
MCOs should not use performance measures to assess individual physician performance unless the care they measure is attributed to the physician, not to environmental or other factors. An *American Medical News* article, “Grading the Report Cards,” warned that the managed care industry’s increased interest and skill in monitoring physicians may lead to physicians being graded unfairly on things that are beyond their control. (10) For example, patient compliance may have as much to do with mammography rates as the physician’s performance. These things are useful for evaluating systems of care, but not necessarily individuals.

To select appropriate quality measures and to develop an appropriate balance between the various elements of quality, MCOs should consult with their enrolled physicians on the appropriate weights to be assigned to measures of clinical skills, patient outcomes, patient satisfaction, and other elements that may be included in a program for assessing physician performance.

QNet, ACP–ASIM’s Physicians’ Quality Network, is designed to assist physicians in incorporating best practices and implementing office-based quality-improvement projects in clinical settings. A best practice is an intervention for a specific clinical state found to be maximally effective in improving health outcomes through scientific research. QNet aims to bridge the gap between research and clinical practice. (11)

A study by QNet involved five clinical conditions based on criteria such as prevalence, well-established evidence-based treatment norms, ease of documentation, and improved patient outcomes linked to best practices. These conditions were asthma, adult-onset diabetes mellitus, warfarin therapy for anticoagulation, congestive heart failure, and cholesterol risk factor identification. (11)

Physician volunteers completed a questionnaire for each patient with the specified condition; in addition, participants used the comment section to explain, clarify, and document the circumstances that influenced clinical decisions. It was found that most physicians followed best practices, yet based on participants’ comments, best practices are not applicable to all patients. ACP–ASIM’s research provides the first documentation of why clinical practice may legitimately diverge from the findings of randomized controlled trials (RCTs). (11)

ACP–ASIM found the major reasons for physicians not adhering to best practices to be patient noncompliance, timing issues, and noncontinuity of care. Since some of these reasons point to the patient as the sole agent of control, they clearly define the limits of physician influence on optimal patient outcome. ACP–ASIM believes that any effective quality improvement exercise needs to differentiate between and target specifically those factors under the control of the physician and those under the control of the patient. (11)
Recommendations

Effective Approaches To Assessing Physician Performance

The ultimate objective of any performance assessment program is to translate performance information into action. Feedback of performance data has been successful in improving physician performance, especially if it is associated with other interventions. (12) Feedback can have an effect on practice performance in two ways: as a regulatory “stick” to identify and punish “bad apples,” or as a positive incentive to stimulate physicians to review and change their patterns of care. Experts believe that a health plan’s approach greatly affects the impact its activities will have on changing physician behavior.

The punitive, bad-apple approach improves health plan performance by identifying and eliminating poor performers who fall below a certain acceptable level. This approach is likely to have less impact on a health plan’s performance for several reasons. First, it focuses on outliers, by definition a small percentage of the population, leaving the majority of physicians unaffected. Second, the punitive approach sets up an adversarial relationship between the physician and the plan, making the physician less likely to cooperate in any effort to change behavior. Most experts in the field of quality improvement agree that cooperation is key to successfully changing physician behavior.

Another approach that many MCOs are taking is to develop a highly quantitative score card, primarily so that purchasers can choose low-cost, adequate-quality providers (or alternatively, high-quality providers). This approach also may have limited impact on medical practice. According to the above American Medical News article, quality may suffer if plans place too much weight on the aspects of care that are reported while ignoring other aspects that may be more central to quality as was discussed earlier in this paper. (13)

The most effective approach to profiling may be the one outlined by the Medicare Payment Advisory Commission (MedPAC, formerly the Physician Payment Review Commission [PPRC]) in one of its annual reports to Congress:

Although payers, consumers, and credentialing bodies can take action on profiling results—using them to choose “good providers” and to sanction “bad apples”—this alone will probably do little to make American health care more appropriate and cost-effective overall. To play a role in achieving that goal, profiles will need to focus on providers as the agents of change, developing profiles and systems that will stimulate them to review and improve their patterns of practice. (14)

This non-punitive approach, often called the quality management approach, uses positive incentives and works when participating physicians are highly involved. It primarily focuses on encouraging continuous quality improvement. Several organizations have incorporated this philosophy into their quality oversight programs, among them the federal Peer Review Organization (PRO) program, the National Committee for Quality Assurance (NCQA), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
Key Concepts for Maximum Positive Impact on Quality of Care

ACP–ASIM has identified the following key elements for a performance assessment program to have the maximum positive impact on quality of care:

1. The primary focus of internal physician performance assessment systems should be to improve quality.

   Studies show that feedback is more successful when the objective is to improve quality of care rather than to decrease cost or utilization. (12) Physicians, as patient advocates, are less likely to cooperate if the primary objective of an internal performance measurement system is cost savings or utilization management. For this reason, some researchers have suggested that internal measurement systems will influence physician practices more if their primary focus is quality, not cost. (12) This approach assumes that since there is inefficiency and unnecessary care in the system, improving quality will lead to lower costs and greater efficiency.

2. The success of any performance assessment system will depend in great measure on the cooperative relationship between the MCO and physicians. MCOs should consult with practicing physicians in developing and refining performance measures and should make these criteria or measures available to physicians. Also, practicing physicians should be involved in all aspects of the development, implementation, and evaluation of physician performance data.

   Distrust and disbelief in the accuracy and significance of performance data is often the physician’s first response when presented with practice pattern data. Physicians are more likely to accept performance measures as good and valid if they know that practicing physicians were involved in developing quality standards, and if they can check the validity of the methodology used to develop the data. Keeping performance criteria in a “black box”—as was often done in the past in fear that physicians would game the system—only heightens physician distrust.

   Most quality-improvement experts agree that physicians must believe in a program for performance data to have significant impact on practice. Participation is the best way to achieve physician trust. Logically, physicians are more likely to feel that the feedback process is fair if they know practicing physicians have had input into it, and less likely to feel that it is being imposed on them by a bureaucracy. Lack of involvement in developing quality definitions used by MCOs, as well as how those measures are implemented, is a source of considerable frustration for internists.

   Putting performance reports in the hands of groups of physicians can be an effective stimulus to action. The Maine Medical Assessment Foundation—a respected, independent, quality improvement foundation—advocates a collegial, educational, and confidential approach. Physicians form a core group of professionals who are educated about the need for quality improvement, who understand the data supporting that contention, and who carry credibility with their peers, thus enabling them to effectively influence their colleagues changing practice behavior. (15) The foundation has enjoyed considerable success with its community-based, study-group model of quality improvement.

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3. Internal physician assessment and improvement systems should be non-punitive and confidential in monitoring and improving quality. MCOs should provide educational feedback on a timely and routine basis in the form of user-friendly reports with explanations of methodology to facilitate review by physicians. Unless regulatory or patient safety requirements are in jeopardy, plans should focus on opportunity for practice adaptation.

One way of gaining physician trust and support is to make internal physician assessment and improvement systems non-punitive. Punitive approaches, such as the pre-1993 PRO program, are expensive and largely ineffective. As noted earlier, punitive approaches only affect a small portion of the population and this threatening approach puts physicians on the defensive, making them less likely to admit they need to change their practice or use performance data to improve. On the other hand, positive incentives, such as educational feedback or rewards, encourage the entire cohort of physicians to improve. (12)

Complete confidentiality is key to gaining physicians’ trust and support. Physicians will be more willing to discuss performance issues in an open and frank manner if they know that the information is confidential. If they believe that performance information could potentially embarrass them, they will not be as willing to participate in improvement activities.

Performance data have more impact when used as a positive incentive to help physicians review and improve their own patterns of practice. This can be done by framing the purpose as educational feedback, rather than punitive. Physicians are more likely to use performance data if they feel that the MCO is working with them to improve their performance. For example, it is useful for the MCO to support physician use of performance data by providing educational assistance.

It also is important that physicians receive comparisons of their performance with that of their peers on a routine basis, so they can see over time how they are doing. To convince physicians that the feedback is educational and that the MCO wants to help them improve, the MCO should allow the physician a reasonable amount of time to adapt his or her practice before any adverse action is taken. By the same token, the time between the end of the measurement period and the presentation of the information should be minimal, so that the information is applicable to the physician’s current practice.

4. Physician performance assessment programs should provide physicians with nonjudgmental, comparative clinical performance information derived from population-based data analysis and adjusted quality measurements to promote internal quality improvement.

Since appropriate provision of medical care is often a matter of degree, it makes sense to present comparative performance data in a nonjudgmental and non-threatening manner. Various studies have shown that physicians are uncomfortable as outliers and will act on comparative performance information if it is provided to them. Adjusting quality measures for illness severity and other practice characteristics is key to convincing physicians that their practice is truly out of line with that of their peers in similar practices with similar patients, and that need to take corrective action.
5. MCOs should adjust physician performance profiles appropriately for such elements as case mix, severity of illness, age and sex of patients, size of a physician’s panel, number of comorbid conditions, and other features of a physician’s practice and patient population that may influence the results. MCOs must give physicians the opportunity to review their profiles for accuracy and to request adjustments for particular characteristics of the patients they serve before the MCO takes any adverse action. Adjustments should be based on sound scientific evidence.

Since practice and patient factors can have a substantial effect on utilization and outcome rates, it is important that plans properly adjust physician profile results to account for differences in physician practices and patient population. Physicians must also have the opportunity to review the collected profile data, enabling them to ensure the accuracy of the data. Physicians are unlikely otherwise to accept performance data as valid.

The literature indicates that adjusting profile data for sex, age, and case-mix can make a significant difference in profile results. A study shows that the referral rate for certain physicians initially identified as outliers decreased 24 percent when the profile data were adjusted for patient age and sex. Three-fourths of the physicians still identified as outliers when the data were adjusted for age and sex were no longer identified as outliers when the data were further adjusted for case-mix. (16) Another study noted that even a simple case-mix adjustment analysis will improve the accuracy of individual physician profiles considerably, thus increasing the impact the profile has on physician behavior. (17)

ACP–ASIM recognizes that such adjusters are still under development. A MedPAC study of managed care plans found that risk adjustment is common but limited. Of the plans surveyed, 51 percent were risk-adjusted profiles for patient mix or health status. Adjustments for age and sex or other demographic variables are most common. One-quarter of the plans adjust profiles for patient health status by eliminating data for outliers, catastrophic cases, or specific diagnoses or comorbidities. Other common health status adjusters include severity of illness, type of benefits, size of patient panel, provider specialty, and the percentage of outliers. (13)

ACP–ASIM believes one way of getting around the current limitations of adjusters is to give physicians the opportunity to review their profiles for accuracy, and request further adjustments to account for particular characteristics of the patients they serve before the plan takes any adverse action. In many cases, individual physician profiles may be made more accurate by adjusting for readily identifiable factors such as outliers, catastrophic cases, or specific diagnoses or comorbidities.

6. If a physician does not have adequate control over an element of medical care used to assess performance, that element should not be considered when measuring quality of care.
According to the MedPAC study, only 51 percent of the plans surveyed said they could attribute results to individuals “reasonably well.” (13) For this reason, when making credentialing and payment determinations, plans should be careful to measure only those elements of care that are directly under the individual physician’s control. To do otherwise is unfair and inaccurate.

7. MCOs should not release internal physician performance profiles or evaluations to the public on a physician-specific basis. They should release aggregate performance data instead, without physician-specific identifiers.

Some consumer advocates believe that releasing physician performance data will protect the public from poor-quality practitioners. They also suggest that making such data public will stimulate providers to improve their performance. Again, ACP–ASIM believes that physician-specific data should be strictly confidential. First, physicians are likely to view any release of performance information to the public as a serious breach of confidentiality. Almost certainly, it would have a chilling effect on their willingness to participate in quality improvement projects. Second, many medical researchers now say that consumers are not interested in the kinds of physician data that MCOs gather for internal assessment and improvement; they are interested instead in information about access to care and how others feel about a MCO. They don’t find profiling data useful. (18) Third, until adequate severity adjustments are made to physician performance data, public release of this information could result in physicians with sicker patients being unfairly labeled as “over-utilizers” or having poorer outcomes.

The release of aggregate data about the MCO without physician-specific identifiers may be useful for a number of reasons, including health plan accountability, population-based quality improvement studies, and tracking the effect of new health care delivery systems on patient care.

8. Physician performance may be evaluated in a number of areas, including clinical quality of care, utilization, access and service, cooperation with the MCOs’ quality improvement efforts, and patient satisfaction. ACP–ASIM believes that all these measures affect quality of care to some extent and it is appropriate to include these kinds of measures in performance assessment systems.
For example, ACP–ASIM recognizes that access and economic concerns—such as appropriate utilization of health care services—are important attributes of care that should be considered when assessing quality. Patients need to have access to care and be able to afford it. Patient satisfaction with the care provided by a physician also may be directly related to the likelihood of achieving desired health outcomes, and therefore should be a key element in a total program that assesses physician performance. Plans have a legitimate need to set measures for their own business purposes. This is necessary for managing medical care and limited resources in the most effective and cost-efficient manner possible. ACP–ASIM recognizes that MCOs have the right to set performance standards and to use them as one element in assessing physician performance. For example, plans may hold physicians responsible for office hours, number of office procedures provided, and cooperation with the health plan.

9. ACP–ASIM believes that patient satisfaction results, measurement of clinical practice, and disease-specific patient outcomes should be given equivalent weight when evaluating physician performance.

For example, due to regulatory and purchaser requirements, MCOs almost always use board certification as the determining factor when selecting a physician. Board certification is also a HEDIS-required measurement and in some states, required for expansion of network. However, there are other valid measures of a physician’s quality of care. As much emphasis must be given to patient satisfaction, an important element in the delivery of care, as is given to the direct assessment of a physician's clinical skills. Patient evaluations don't always reflect a physician’s abilities; patient satisfaction may be based on factors that are beyond the physician’s control (e.g., whether or not the patient wanted to be enrolled in the plan or was assigned to it or if a patient refused treatment). A physician’s communication skills and attentiveness toward his or her patients also play key roles in determining patient satisfaction.
The Massachusetts Medical Society's 1999 “Principles for Profiling Physician Performance” states, “Physicians criticisms of current profiling activities stem from (1) potentially adverse effects of pressures to restrict services on the quality of care; (2) burdens created by uncoordinated and redundant requests for data; (3) reports based on variable and often poor quality data; and (4) inadequate risk-adjustment of results.”

Criticisms include:

• the incomplete picture of health care provided by clinical indicators that are measured
• excessive reliance on administrative databases
• incentives created for “upcoding” or other expedient steps to improve measured performance
• failure to audit results adequately
• premature release of inaccurate or misleading information
• ambiguous and confusing public releases of information
• absent or inadequate adjustment of results for differences in case-mix and severity of illness

Other major problems include reports that are used to restrict services or to penalize physicians whose practice patterns represent “high cost outliers,” the duplication of effort required when physicians are asked to submit data to multiple insurers, health plans, or regulatory agencies, and data quality problems that compromise the validity of results. Unfortunately, efforts to measure and improve the quality of clinical care have been secondary to the efforts of managed care organizations to control health care costs. (4)

Some believe physician profiles only show the ugly side. It has been said that profiling is a “tool-weapon that managed care organizations employ to cut out doctors who don’t play by the corporate rules. It’s a ruse to force doctors to provide cheaper care and accept lower fees.” (19) Others say, “Until the source data are expanded, the methodologies evolve, and the analysts are willing to go beyond big-picture comparisons, some good doctors will continue to be penalized, and some inappropriately cheap doctors will continue to be rewarded.” (20)

On the other hand, some say profiling information from managed care organizations can strengthen a physician’s bargaining power with health plans, broaden one’s patient base, and uncover inefficiencies in a practice. Even a profile that paints a physician as an outlier in a specific area may, when explored, yield new information that can win concessions from the sponsoring health plan. (21) Others say a smart physician or group can use a flattering performance assessment as a marketing tool to capture managed care contracts and advantageously negotiate reimbursement rates.
Data Sources, Collection, and Analysis

Data Sources

Data sources for physician profiling include medical records, electronic medical records, clinical information systems, patient surveys, and administrative and claims data. The importance for data sources to meet explicit standards of accuracy and completeness in order to support valid results or comparisons is critical. Depending on the performance measure being evaluated and its uniform availability in the practice settings being evaluated, each data source’s strengths and weaknesses must be carefully assessed before a data source is chosen.

Medical record reviews are essential to the measurement of many clinical processes and most clinical outcomes, but quite labor intensive. One must remember that the completeness, accuracy, and legibility of medical records vary widely in different clinical settings. Electronic medical records and clinical information systems can provide reliable and inexpensive sources of data for examining outcomes and processes. Systems that can integrate information from medical records, chemistry and bacteriology laboratories, radiology and pharmacy are especially important, however, very few health care settings have installed effective systems. (4)

Patient surveys are a good source of information from patients regarding relief of symptoms, quality of life, satisfaction with the care received, and overall relationships with providers. Claims data can be used to identify some types of clinical complications, while most HEDIS measures and most profiling for costs and resource-use patterns also depend on administrative or claims data. The scarcity of clinical information needed for adequate risk-adjustment, variable accuracy, completeness of data, coding errors, and the potential for biased estimates of performance from upcoding of diagnoses are all major shortfalls of this type of source data. (4)

Data Collection and Analysis

Experts agree that data collection should be performed by skilled, objective persons. Data collection protocols should be both as objective and explicit as possible. Fully trained individuals should conduct analyses, using techniques that are suitable to the objectives of the study and its database. Analyses should emphasize time trends in performance or comparisons among physicians or practices. Methods of analysis must be described in sufficient detail and be readily available.
Conclusion

The managed care industry is becoming increasingly interested in measuring and evaluating the quality of its medical care to identify areas for improvement. More health plans are using physician performance information to set compensation, recredential physicians, and provide information on quality of care to consumers. This paper has outlined practical recommendations on how to develop, use, and disseminate physician performance information.

Many have raised concerns about the goals and the implementation of performance assessment programs. ACP–ASIM believes these programs, if properly carried out, can provide incentives to improve quality of care and patient satisfaction, while also controlling health care costs. Managed care plans need to assess the goals of these programs carefully, to make sure their highest priority is to provide quality health care to their patients. ACP–ASIM believes that, for optimal care, performance assessment programs should achieve a balance between the various aspects of quality—including clinical effectiveness, cost, and utilization—and patient satisfaction.

ACP–ASIM believes that some approaches to performance assessment are more effective than others. Specifically, ACP–ASIM believes that the most effective internal performance assessment systems are:

- confidential;
- non-punitive;
- reward positive behavior;
- focus primarily on clinical effectiveness and patient satisfaction rather than cost;
- provide regular educational feedback and assistance;
- use appropriate and properly adjusted performance measures; and
- incorporate a high level of physician involvement in all aspects of development, implementation, and evaluation.

ACP–ASIM believes that plans may use performance information in making decisions about bonus payments or recredentialing individual physicians for participation in the health plan, provided that the information is consistent with these principles.
Endnotes
