

MANAGED CARE OUTLOOK

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Physician confidence promotes pay-for-performance compliance

Rewards must be commensurate with the efforts required to receive the rewards

BY EMAD RIZK, MD

Paying physicians for performance is one of managed care's hottest trends. According to recent figures from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), about 100 active pay-for-performance (P4P) programs are operating across the country. Because most of these programs are in relatively early stages of development, the best approaches to building successful P4P programs are far from clear.

Good advice is available, such as the JCAHO "Principles for the Construct of Pay-For-Performance Programs," published in November 2004. For example, JCAHO advises that programs should start by aligning rewards with high-quality, safe care, and that they work best with a combination of financial and non-financial incentives.

If physicians are not on board, you don't have a program. All the sophisticated technology and brilliant marketing in the world cannot ensure provider buy-in if a program is not properly introduced, credible beyond all question and carefully managed.

Here are a few guidelines for ensuring physician acceptance:

Build the program on performance data with which providers are intimately familiar. One Pennsylvania plan profiled its providers and reported metrics to them for several years before introducing its P4P program. That gave the physicians a chance to grapple with their data and become comfortable with how they were being evaluated before the stakes got higher.

Solicit physician input. Listen to physicians' opinions about the program, and don't discount their criticisms as simply reflexive push-

back. Refine the program as necessary. A small health plan in northern California launched a very successful program by sending physicians and nurse ambassadors into physicians' offices to explain the program over lunch and report feedback to the plan.

Make sure your metrics are credible. Be sure that your metrics are quantifiable, evidence-based, clinically valid and based on clean data.

Apply clinical and regional context to your data. If you can organize your data and report scores in the context of geographic region, population density, type of practice, relative risk or other relevant groupings, you will counter the common complaint of "my patients are sicker than those of my peers" and also help physicians see how their practice patterns deviate from the norm.

Seek out alliances with other organizations to create common performance metrics. As increasing numbers of organizations begin implementing P4P programs, the burden on physicians will become onerous if each plan has a distinct set of metrics. Reach out to other plans in your region to collaborate on performance metrics. Perhaps the trickiest question of all is what types of incentives work best. To many physicians, relief from certain administrative burdens, for example, is as precious as greater compensation.

Several plans have found that publishing scores to all physicians in the program can be far more effective than financial rewards. One Massachusetts plan that published its providers' scores on the Web found that it was the physicians, far more than the members, who were visiting the site most often.

It comes down to doing your homework. Learn from others and apply it to your unique physician community. Design a program that eliminates potential barriers to acceptance, and couple that with incentives that convince physicians that change is best for them as well as their patients. MHE

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