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EDITORIAL

Federal P4P Results Raise Questions

When evaluating pay for performance (P4P) programs, it's important to consider the source. It's not unusual for proponents of P4P to promote these programs by saying they produce remarkable results. Opponents of P4P, meanwhile, readily point out the flaws.

Last month, the federal Centers for Medicare & Medicaid Services (CMS) reported that its demonstration project involving P4P for 10 large physician groups was a success. And, by many measures, this statement is true. But, only two of the 10 groups received any financial performance incentive. All participating physician groups improved the clinical management of diabetes patients in the first year of the three-year Medicare Physician Group Practice Demonstration, CMS said.

By itself, this result is significant because diabetes is becoming a crisis in this country and many physicians are swamped trying to manage patients with diabetes efficiently. But the 10 groups that participated in the CMS P4P project had to invest resources in making improvements to care for these patients and only two groups got financial rewards. In other words, the amount of money most groups saved in improving care didn't qualify them to share in P4P payment rewards. Nine of 10 groups had some savings.

Regina Herzlinger, PhD, professor of business administration at Harvard Business School, has not been favorable toward P4P. In her most recent book, *Who Killed HealthCare: America's $2 Trillion Medical Problem—and the Consumer-Driven Cure* (McGraw Hill, 2007), she writes, "Congress is now practicing medicine. Its pay-for-performance initiatives enable governments to tell health care providers how to practice medicine. The higher the performance, the higher we pay. The health care system lacks metrics of performance. Despite its name, P4P does not pay for performance—the attainment of improved care at a reasonable price. Instead, it pays for conformance—the adherence to a government-dictated recipe for the provision of health care. The government pays for adherence to its recipes for the process of delivering health care rather than for outcomes."

As Herzlinger correctly points out, there are two kinds of metrics: process measures and outcomes measures. Most P4P programs currently use process metrics as in counting the percentage of quality indicators a physician or group achieves. What matters to patients are outcomes metrics, such as morbidity and mortality, patients' adherence to therapy, and patients' understanding and control of their disease.

While P4P is in its early stages of development, most programs focus on process measures. The goal is to develop P4P programs that focus on outcomes. Then we will have pay for performance that makes a significant difference in terms of improved care and better health for patients.

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High Revascularization Rates Found in Markets with Cardiac Hospitals

Some cardiologists have developed specialty cardiac hospitals to gain greater control over patient care and to help them improve practice efficiency in an era of rising costs and declining reimbursements. Opponents of such specialty hospitals, however, assert that hospital ownership creates incentives for physicians that do not always ensure optimal care or the best resource use.

Researchers examined the concern that specialty hospitals promote overutilization of health care procedures in a study published in the *Journal of the American Medical Association* on March 7 (JAMA. 2007;297:962-8). In this study, the researchers found that rates of cardiac revascularization procedures, such as coronary artery bypass graft (CABG) and angioplasty, or percutaneous coronary intervention (PCI), were higher in health care markets with new cardiac hospitals than rates found in other markets.

Examining the Data

"The United States has experienced a rapid proliferation of physician-owned specialty hospitals, particularly in the fields of cardiology and orthopedic surgery," says Brahmajee Nallamothu, MD, MPH, an interventional cardiologist at the University of Michigan Hospitals, in Ann Arbor. Nallamothu is also an assistant professor at the University of Michigan Medical School and lead author of the study.

"Even though these facilities represent a relatively small part of the U.S. health care system, their growing numbers and the competitive implications for general hospitals has prompted considerable policy discussion," he says. "At the same time, there has been little empiric data to illuminate the actual impact of these specialty hospitals on the health care system."

The arguments in favor of specialty hospitals can be compelling. Proponents believe that these hospitals offer higher quality of care for patients and greater efficiency for physicians. Hospitals with specialized nurses, equipment, and procedures can focus on and develop expertise in the care of certain conditions, they argue. Physicians working at such facilities could have fewer complications and infections and achieve better outcomes. In fact, research has linked high procedure volume with higher quality, particularly in cardiology.

"Certain types of patients have complicated conditions and require particular expertise," Nallamothu confirms. "Research studies have suggested that these hospitals can achieve excellent outcomes of procedures such as CABG and PCI. These hospitals might also be better at managing cardiac-related disorders such as acute myocardial infarction (AMI) and heart failure."

Another aspect of care that makes specialty hospitals appealing is that they return some control over patient care to physicians, Nallamothu says. "Many cardiologists working within a larger hospital or health care system feel frustrated by a lack of control over how services are provided," he adds. "Investing in a facility gives cardiologists a meaningful role in care delivery by allowing them to purchase new technologies and more easily implement processes they believe will improve care."

Process Improvement

Clearly, other benefits accrue to specialty hospital physicians beyond the control of care. In particular, physicians who have an ownership interest in a specialty hospital can collect fees for their own professional services as well as share in any profit generated from the facility fees paid to the organization that operates the facility.

Physicians also might be able to add more patients to their practices thanks to the efficiencies that specialty hospital care offers. Patients often find specialty center care appealing and so the physicians who use these facilities might receive more referrals than physicians who are not associated with such facilities.

"In fact, the strongest data on specialty hospital benefits (even stronger than the outcome data) relates to patient satisfaction with care," Nallamothu comments. "These hospitals tend to be very patient-centered, with amenities and services that are particular to the patient's condition. Overall, patients tend to

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Research suggests that specialty hospitals can achieve excellent outcomes for CABG and PCI, and cardiac-related disorders such as acute myocardial infarction (AMI) and heart failure.

(Continued from page 3)

be very pleased with the care they get at a specialty hospital."

Despite these benefits, concerns about specialty hospitals exist. One concern is whether physicians choose patients appropriately for treatment at these hospitals. "Physicians have to be careful that they consider a patient's full spectrum of medical needs prior to sending them to a specialty hospital for treatment," Nallamothu observes. "For example, certain cardiac patients have multiple comorbidities, necessitating other specialty care that is best accessed in a general hospital."

Furthermore, opponents of specialty hospitals have accused physicians at these hospitals of cherry-picking the most profitable patients for care. "Critics argue that specialty hospitals are choosing to treat the healthiest patients, who are at low risk for complications that would require extra care and extend the hospital stay," Nallamothu says. Shorter stays translate to a higher net income to hospitals under the diagnosis-related groups (DRG) system of reimbursement. "This leaves the general hospitals to take care of the sicker and more expensive patients," he explains.

Practice Patterns

Another concern is that specialty hospital ownership can influence a physician's patterns of care. In particular, opponents charge that specialty hospitals lead to overuse of resources. "Critics claim that specialty hospitals promote the use of more invasive procedures, subjecting patients to unnecessary care." Nallamothu points out. The consequences can include risk to patient health as well as higher health care costs. "Stated simply, physicians get paid more with each additional service they provide to a patient. Specialty hospitals may add to that financial incentive because physicians are earning even more money for each additional service because they are also able to share in the facility fees."

Of course, specialty hospital ownership may affect practice patterns not only because of the financial relationship, but simply by virtue of offering greater access to certain services. "Physicians who start these hospitals believe in the value of what they do," Nallamothu asserts. "Cardiologists who open cardiac hospitals argue that these procedures enhance care. Furthermore, a cardiac hospital is structured and equipped to provide this care efficiently, enabling physicians to more readily offer these services."

What's more, Nallamothu adds, there is considerable discussion regarding what constitutes a specialty hospital. "In the framework of our study, we defined a specialty hospital as a stand-alone facility with physician ownership," he explains. "These hospitals are unique and separate from other institutions. So, for example, we did not include heart centers that were affiliated with larger general hospitals. We focused on this particular group of hospitals because this is the group that CMS and other regulators

Study Has Implications for Cardiologists

Concern about over-utilization of services in specialty hospitals prompted Congress to impose an 18-month moratorium on physician self-referrals to certain new specialty hospitals when it passed the Medicare Prescription Drug Improvement and Modernization Act of 2003. The moratorium has since been lifted, and on Aug. 8, 2006, the federal Centers for Medicare & Medicaid Services (CMS) released a report on specialty hospital referrals. The report, *Final Report and Strategic and Implementing Plan*, mandated that certain specialty hospitals disclose physician ownership and compensation. Federal officials said periodic reporting requirements eventually will extend to all hospitals.

"Up until this time, it was not necessary for hospitals to fully disclose the financial relationship between the facility and individual investors," says Brahmajee Nallamothu, MD, MPH, an interventional cardiologist at the University of Michigan Hospitals, in Ann Arbor. "Therefore, the extent of a physician's financial interest in a specialty hospital was unclear. Some specialty hospitals are owned by a small group of physicians, while others are owned by many in conjunction with a private corporation. If a physician is one of a handful of owners, his or her return on patient care provided by that facility is going to be much greater than that of a physician with less personal investment. And that return has the potential to impact on an individual physician's practice patterns."

The CMS report noted that federal officials intend to scrutinize physician investments for disproportionate returns, to define specialty hospitals' obligations with respect to emergency care, and to start a demonstration project to promote coordination and cost-savings among physicians and general hospitals through gainsharing.

"CMS recognizes that specialty hospitals can offer some important benefits for patients," Nallamothu says. "But a system is needed to prevent or minimize the potential for incentives that lead to overutilization and cream-skimming. CMS is taking an important first step by asking for transparency of financial relationships. Longer-term goals, such as adjusting payments so that providers are more favorably reimbursed for high-risk patients, are important but may be challenging to implement."

—DJN

are most interested in, and that general hospitals are most threatened by."

Nallamothu and his colleagues examined CMS data on Medicare beneficiaries nationwide who underwent revascularization between 1995 and 2003. "Each health care market has a certain rate of revascularization within its population," he explains. "After a specialty hospital opened, we wanted to determine if this rate changed, and how it changed relative to other markets without specialty hospitals."

CABG and PCI

The researchers found that while revascularization rates were increasing in all markets, rates rose more rapidly in markets where new specialty hospitals opened. Total revascularization rates in markets in which a new cardiac hospital opened increased by 19.2%, compared with 6.5% in markets in which a new cardiac program was opened at a general hospital and 7.4% in markets with no new program.

PCI rates in markets in which a new cardiac hospital opened increased by 34.6%, compared with an increase of about 23% in other markets. CABG rates in markets in which a new cardiac hospital opened decreased by 3.9%, compared with a decrease of 18.9% in markets in which a new cardiac program was opened at a general hospital and a decrease of 18.3% in markets with no new program. This finding was consistent with the other findings from the study that indicated a greater use of revascularization procedures in specialty hospital markets.

"Nationally, CABG rates have been declining, likely due to the increase in PCI," Nallamothu notes. "But this decline was significantly lower in the markets where specialty hospitals opened."

The administrative data did not reveal potentially critical nuances that would have highlighted the clinical indications justifying each procedure, Nallamothu acknowledges. "However, we did consider a rough marker for treatment: the presence of acute myocardial infarction (AMI) when the PCI was performed," he says. Clinical trial evidence strongly supports the use of PCI in patients with AMI. In contrast, the indication for PCI is often less clear in patients in whom an AMI is not present.

Comparing Similar Rates

The researchers found that changes in rates of PCI in patients with AMI were not significantly different across markets during the study period. "Cardiologists are more likely to perform PCI in patients with AMI at similar rates across different communities," says Nallamothu. "There may be less variation here because of all the clinical evidence in support of the procedure in these cases."

However, the rates of PCI in patients without AMI rose almost twice as fast in markets with new specialty hospitals as they did in other markets. "Most of the differences between markets in PCI rates occurred in patients who had no AMI, the group of patients for whom the benefits of PCI are less clear," Nallamothu states. "This suggests a potential of over-utilization of the procedure."

The study results give cardiologists new data to determine how to assess the affect of cardiac hospital utilization on patient care. "There is no clear evidence that higher rates of utilization of revascularization in certain markets necessarily translate to better outcomes," Nallamothu says.

Of course, physicians should always consider non-invasive approaches when the clinical evidence supports such approaches, Nallamothu adds. "All cardiologists (whether they are specialty hospital owners or not) should be cautious when recommending patients for a CABG or PCI," he says. "For example, in patients with stable coronary artery disease, especially with disease limited to one or two vessels, current evidence supports attempts at maximal medical therapy first and reserving PCI for those who fail." Traditional agents, such as beta blockers, nitrates, calcium channel blockers, and statins, can, along with risk factor modification, help many patients adequately manage their conditions.

Of course, physicians should confirm the quality of care at any hospital before referring patients. An institution's status as a specialty hospital is no guarantee of a certain level of quality, Nallamothu comments. "Just as in the case of general hospitals, not all specialty hospitals are the same," he adds. "Specialty hospitals are very much the product of the people who are creating and investing in them, and quality can vary."

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 8).

"All cardiologists should be cautious when they are recommending patients for a CABG or PCI. For example, in patients with stable coronary artery disease, especially with disease limited to one or two vessels, current evidence supports attempts at maximal medical therapy first and reserving PCI for those who fail."

—Brahmajee Nallamothu, MD, MPH, University of Michigan Hospitals

How to Recruit and Retain Specialists

Recruiting physicians is a major undertaking for any medical practice, whether the practice is looking to grow through the addition of an associate, or seeking to fill an open position. With the nation's diminishing pool of physicians, recruiting takes longer than it did in years past and often requires intensive search activities. Even with professional assistance, the process can take a significant amount of time away from clinical and other administrative responsibilities.

Since there's a heavy investment of time and resources, it's little wonder that practices also hope to retain the individuals currently on staff. And because turnover is costly, it's important that practices retain qualified and productive physicians.

Taking Deliberate Steps

For groups seeking to recruit and retain staff, the two strategies are closely linked. Good physician retention rates lead from good recruiting practices, says Ronald Watson, of Medical Search Consultants Unlimited of Cleveland. "Getting the right individual into your practice makes the difference between having that person be happy and productive, or having that person leave a few months down the road," he adds.

Practices should start recruiting with a deliberation about the qualifications of an ideal candidate. It's useful to determine what the practice requires in an associate, including the type of training expected and the type of personality that will fit well with the group. Weigh the needs of the practice, and clearly define the position's requirements.

But be reasonable, and remember to base the job description on factors that make sense. Many practices have unrealistic expectations about training qualifications, says Michael Broxterman, of Pinnacle Health Group in Atlanta. "You can't always find a candidate who is as specifically trained as a client would like," he says. "In a smaller town, for example, the parameters have to be a little more open. You may not be able to get a sports medicine specialist. So instead you'll have to look for a general orthopedic surgeon. In a small community, a physician can't survive on sports medicine, so you have to start with a generalist in orthopedics and balance that practice with the sports medicine cases that might come in."

The size of the area the practice serves also can affect the number of candidates a practice can recruit. "It's definitely a numbers game," Broxterman says. "Among physicians, some 75% want to practice in a town with a population of 200,000 or more. Figures like that mean only a small percentage of physicians will even consider a smaller community."

Community size affects other factors, including compensation. "Everyone in physician recruiting knows that you have to pay a physician more to go to a small town than to a bigger town, even though in the bigger town, you're going to have higher expenses," says Broxterman. That means that the compensation offer must be attractive. A practice also should weigh community market conditions including the average physician income in the area, population growth or decline, and patient mix (such as the rate of Medicare and Medicaid beneficiaries among all patients).

Start With Networking

Once a practice has made a realistic assessment of its needs, it can begin the search. Networking is a good place to start. "It's a simple and very effective way to recruit," Broxterman says of networking. He suggests that the practice's physicians ask colleagues whom they know who might be interested in a position or partnership. Many practices also find it worthwhile to advertise in trade journals and newspapers, especially large city papers.

Direct mail also may be effective, but it's an intricate undertaking that can be daunting for the inexperienced. In addition to designing and printing the direct marketing piece, a practice may have to contact a mailing or packaging firm. Mailing to a good targeted list is paramount, so practices should choose a list house licensed by the American Medical Association to buy and sell segmented mailing lists for specialized candidate searches.

Another option is to collaborate with a local hospital recruiting or human resources office. Many hospitals recruit on behalf of communi-

"Getting the right individual into your practice makes the difference between having that person be happy and productive, or having that person leave a few months down the road," says Ronald Watson, Medical Search Consultants Unlimited in Cleveland.

ty-based medical practices, and others will contribute preliminary help in marketing the community and the practice opportunity to prospective candidates.

"There's been an interesting transition over the last five years, with many hospitals hiring in-house recruiters," says Watson. Understand, however, that hospital recruiting offices often have a broad scope of responsibilities, and might juggle recruiting duties along with human resources functions. In addition, hospitals that own or manage free-standing medical groups may compete with a practice's recruiting efforts.

Using Recruiting Firms

It's not uncommon for both hospital recruiting offices and medical practices to seek the help of physician recruiting firms. While charges for such services can range from $15,000 to $25,000 or more, a good firm will handle everything from finding suitable candidates to negotiating compensation packages.

Practices hire recruiting firms for many reasons. Efficiency seems to be the primary advantage of working with recruiters, since such organizations have access to search resources and can focus fully on the assignment. "I can reach more physicians than an individual group is able to, and I have the time to devote to the task," says Rob Rector of the Pinnacle Health Group. "I'm not taking care of patients and I don't have to attend committee meetings with other physicians or members of the practice staff. This is my full-time function." What's more, some physicians may lack the expertise needed to recruit efficiently or conduct an appropriate interview, Rector says.

Recruiters also may be more focused on getting results. "Many practices think they can bring a candidate in for an interview and take the tack that 'if they like us, they like us,'" he says. "That's not realistic in today's market. So recruiters are brought in because the process is about getting someone to sign the contract, and that makes a lot of physicians uncomfortable."

An Objective Negotiator

That same discomfort can affect employment offers. Therefore, recruiting professionals serve as an impartial third party during sensitive negotiations. "I'm bringing them together, but I have a degree of objectivity, and I can be a buffer," Rector comments. "Candidates will tell me things they don't want to tell my clients, and my clients will tell me things they don't want to tell the candidates. Since there's a potential employer-employee relationship, it's better coming from me."

Whether a practice makes an offer directly or through a third party, the key is to have the physician feel wanted, Watson says. When you want a candidate, show him you want him. Don't be afraid to say, 'Come on board,' " Watson says.

—Reported and written by Judith Reppucci in Cotuit, Mass. More information on physician practice strategies is available on our Web site (see page 8).

Clear Steps Needed for Successful Partnership

Few factors influence physician turnover more than partnership issues, say recruiting professionals. When a new physician joins a practice, the hiring physicians should make sure to establish clear parameters for becoming a partner. While there's often reluctance on the part of the established group to set an explicit formula, it's only fair that new associates understand partnership qualifications. And any changes to such terms are bound to create conflict, resulting in dissatisfaction and turnover.

Most candidates join a practice with full expectations of being a partner, says Rob Rector of the Pinnacle Health Group, a recruiting firm in Atlanta. "That's the accepted standard. Most physicians feel, 'I'm going to come in and work doing what I'm supposed to do, but I want to be a full partner and I want the benefits of being a full partner.' Being a junior partner is not an option."

But such expectations may be more difficult to reconcile when growth estimates are overly optimistic, comments Ronald Watson, of Medical Search Consultants Unlimited of Cleveland. "Sometimes a group will think the potential is there to grow a practice, but the opportunity just isn't what you thought it was," Watson explains. "When new associates aren't making the money they want to make and the practice isn't growing the way they thought it would, they lose interest. I get calls all the time, saying, 'This didn't pan out. I've got to get out of here and go somewhere where I can make money.'"

Such circumstances are not always the result of errors or miscommunication, Watson adds. Even statistics that seem to indicate a need for additional specialists may be wrong. "There's really no way to prevent these things from happening from time to time," he says. "When physicians make a move, a lot of it is based on potential or on what you think is going to happen. And you can't always look into the future. You work hard, you do your best, but there's no guarantee."

—JR

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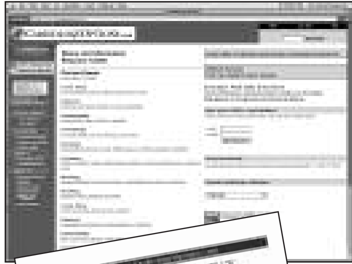

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