

Paying for population health care: The link between reimbursement models and quality health care

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The Department of Family Medicine at the University of Wisconsin is beginning to look at the issue of paying for performance within its physician faculty compensation formula in a different way. The concept of paying for quality performance over the traditional model of compensation that pays for “activity” as measured by patient visits, charges, and/or “RVUs” (relative value units) is gaining momentum as the industry looks at the incredible amount of money we invest in our health care system, while concerns about errors and poor outcomes grow.

The Institute of Medicine’s reports “To Err is Human” and “Crossing the Quality Chasm” underscore the need for radical change in how we provide care in this country. Aligning financial incentives with desired outcomes is a natural place to start this evolution, or perhaps revolution. For the first time ever, the Department of Family Medicine has implemented a compensation plan that links 10% of physician faculty pay to quality measures. While a good first step, it has been made very difficult by incomplete data sets, variable phy-

sician acceptance, limited funding resources, and our own inexperience with this process. The litmus test for data that physicians expect and deserve includes: that the data truly measures quality of care, that it is linked to the physician being measured, that the physician has some control over the outcomes, and that it is accurate and reproducible over time. Without an effective electronic health record (we are just beginning to implement our system) and advanced data systems support, this is a daunting task for any medical group.

What are the forces that are coming together to encourage this revolution? Health Maintenance Organizations along with traditional insurers, employers, government agencies (Medicare), and integrated health care systems are recognizing their aligned missions, values, and need for change. The previously mentioned reports by the Institute of Medicine outlining the deficiencies in our health care delivery systems have become a rallying cry for change. All involved are beginning to recognize that we need to move from a traditional episodic disease care model to one that emphasizes population health improvement. Those paying the bills and those providing the care are starting to understand that if we continue to rely on the best efforts of individual physicians caring for one patient, during one visit, that

we will continue to be frustrated with poor outcomes and dissatisfied patients and providers. The concept of defining teams of clinicians and allied health professionals working in an integrated system, supported by complete data systems and promoting healthy populations, is being embraced.

The challenge is finding a way to institute change while the present system is moving full speed ahead. Stopping the traditional flow of dollars (which is promoting more of the same activity) in midstream will be both necessary and the challenge. Who will take the risk and who will invest in such change?

I would propose that large integrated health care systems, along with their financial partners, begin to pilot projects that focus on changing the entire funding model that pays for physician activity. Until physicians are freed up to think and behave differently while caring for patients, we cannot expect to see much change.

The groups responsible for paying the bills for our present system of care are already implementing programs aligned with these concepts. There are already many examples of pay for performance schemes cropping up throughout our industry and nation. While well intended, many are ill conceived and will lead to increased physician dissatisfaction and an unhealthy focus on specific and sometimes question-

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able outcomes while missing the bigger picture. In the worst case scenario, such schemes will result in gaming of the system by physicians. This will be the inevitable result of efforts that are merely nibbling at the edges of the problem, without addressing the systems and infrastructure that support physician's daily practices. The typical primary care clinician is like a juggler with 5 balls in the air at any one time. Many "pay for performance" schemes simply throw another, more valuable, ball in the air hoping the clinician can now juggle 6. A dropped ball or 2, or worse, is inevitable.

Instead, larger integrated systems of care need to begin to address these issues and invest in demonstration projects in which physicians are guaranteed a good base salary linked to local and national benchmarks, regardless of how many office visits, RVUs or procedures they perform. In addition, incentives beyond this base salary must be linked to mutually agreed on outcomes felt to be indicators of quality health promotion and care. Immunization rates, hemoglobin A1C levels, LDL levels, and blood pressure control may be

examples of indicators measured. Other supported activity might include team leading, reviewing of data sets, e-mail to patients, and leading group patient visits. Achievement of set goals, along with being an active team leader, would result in additional compensation dollars for clinicians.

During initial pilots, ongoing measures of the traditional parameters of work such as visits and RVU generation would occur. In addition, measures of utilization of resources by the patients through office visits, hospitalizations, ER visits, and use of pharmaceuticals would be compared to historical data. A picture of the effects of a change in reimbursement will emerge.

Demonstration projects will require an infrastructure and staffing above and beyond what would be considered in a traditional care model. Additional investment will be necessary to provide the extra data support and pay for time needed by clinicians to lead this effort. Health educators and other allied health professionals will be integral to this process. Whether new models of care will or should require more resources is not pres-

ently clear. While there may not be any additional funds within our present system, a potential resource to finance increased cost will be found in dollars saved for HMOs, traditional insurers, hospitals, employers, and other partners secondary to improved outcomes, decreased utilization, decreased waste, and improved patient satisfaction and loyalty.

Ultimately the investment for this experiment, perhaps initially only affordable to larger systems, will reap information and tools that can be incorporated by smaller practices and even the solo practitioner.

The future of our health care system is dependent on identifying improved models of primary care delivery. Status quo reliance on secondary, tertiary, and even quaternary care systems to mend and heal already sick patients cannot continue. It is up to primary care physicians to redefine their role within our broader health care systems in promoting and maintaining health. Linking financial incentives to these new models will be a necessary, though not sufficient first step.

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