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Should Doctors Be Penalized for Patient Outcomes?

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Ways to Help Improve Outcomes

As physician payment begins to shift to value-based payments, the measures of quality care will slowly move from processes to outcomes.

That's a relief for some doctors who have never liked reporting process measures and instead wanted to be judged by their outcomes. But outcomes also present a new burden: You'll be held accountable for patients who don't improve because they aren't following the treatment plan you recommended.

"Most doctors don't mind being judged on their quality of care," says Kevin Campbell, MD, a cardiologist at the University of North Carolina. "But if the physician has done everything right for the patient and the patient is nonadherent, should that reflect poorly on the clinician?"

The answer from some adherence experts is "yes," although that answer is disputed by many physicians. Assuring patients' adherence is as much a part of being a good doctor as drawing up a successful treatment plan, says Stephen Wilkins, MPH, a former hospital executive who runs Mind The Gap Academy, a San Jose, California, group that seeks to improve outcomes through better physician/patient engagement.

Even when patients decide not to follow the treatment plan, Wilkins thinks physicians should bear some financial responsibility for the resultant poor outcome. "Physicians should be checking prescription fill and refill rates, or taking similar measures," he says.

Many physicians have strong feelings against this type of sentiment. Their view is that patients should bear a large degree of responsibility for their own health and health-related decisions. Why should a doctor pay the price if a patient continues to drink too much, continue smoking, or gorge on french fries? Others, though, feel that with today's apps and electronic communications, it has become less burdensome for doctors to urge patients toward better outcomes.

The Move Toward Outcome Measures

Being held accountable for outcomes is still fairly rare, but it's becoming an important ingredient in quality assessments.

Medicare's Physician Quality Reporting System (PQRS) requires doctors to report process measures—for example, the percentage of patients with coronary artery disease for whom the physician has prescribed aspirin or clopidogrel.

Already, PQRS allows physicians to select from a small number of outcome measures (eg, the percentage of patients who require intubation after coronary artery bypass graft surgery), but they are not required to do so.

Next year, however, thanks to the Medicare Access and CHIP Reauthorization Act (MACRA), PQRS will be replaced by the quality performance (QP) category of the Merit-Based Incentive Payment System (MIPS). Under MIPS QP measures, which start in January 2017, physicians will have to choose one quality measure out of a total of six measures to report.

Furthermore, MACRA anticipates that physicians will eventually assume financial risk for lowering costs and assuring quality. These arrangements include shared savings in accountable care organizations (ACOs), bundled payments, and episodes of care.

All of these programs will rely on better patient adherence, which can be daunting for many physicians. According to a 2005 meta-analysis,[1] nonadherence rates can exceed 40%.

Steps to Improve Adherence

Experts agree that getting patients to follow through on medical and health regimes is the best way to improve outcomes. Four experts who approach adherence from different directions—a patient advocate, a hospital leader, an academic physician, and a private practice physician—have recommended some key approaches to help improve outcomes. These may work for you:

Provide patients with reminders. These range from phone calls to email reminders to digital reminders on pill box lids. But Wilkins says reminders address only forgetful patients, who account for 25% of nonadherence. Even a friendly call from an assistant may not affect an intentionally nonadherent patient, he says.

Simplify dosing. Reducing the number of times patients must take a drug—and, if possible, the total number of medications they must take—has been shown to improve adherence. A Cochrane review[2] found that this approach increased adherence by 8% to 19.6% (depending on the study).

Get patients involved in decision-making. Many nonadherent patients decide not to take their drugs owing to perceived side effects, and then they don't tell you about it. One way to tackle this problem is to help patients get more involved in choosing the therapy and understanding the side effects through handouts, videos, and other material used as decision aids.

A program at Massachusetts General Hospital in Boston uses this approach. "Previsit use of decision aids promotes richer discussions and allows for more efficient use of the appointment time," says Leigh Simmons, MD, medical director of the program. In a survey, clinicians at the hospital said they thought this approach improved quality of care, she says.

Help patients accept high medication costs. Patients often don't want to pay for a drug because they think it's less important to their lives than other activities they pay for. Dr Simmons says that decision aids and discussions with patients can help patients understand why the drug is important.

Improve the patient interaction. Some doctors can improve outcomes by changing the way in which they interact with patients, says Anthony Jerant, MD, family physician at UC Davis. Dr Jerant has developed SEE IT (Self-Efficacy Enhancing Interviewing Techniques), an interviewing method that is meant to boost patients' confidence in managing chronic disease symptoms. "The goal is to empower and motivate patients," he says.

Adherence Techniques Can Be Simple

Effective adherence techniques don't have to be as complex as many experts are recommending, says Steven R. Feldman, MD, a dermatologist in Winston-Salem, North Carolina. Although he doesn't believe adherence can ever reach 100%, he says that he has enhanced his own adherence rates by taking the following steps:

Make adherence your responsibility. "Your basic assumption should be that patients won't follow the treatment unless you make the effort to get them to do so," he says.

Build patients' trust. This is done in many little ways, such as having plenty of parking, a clean waiting room, and a polite staff, and by personally dealing with patients in a respectful, unhurried manner.

Select treatments that patients will actually use. For example, "greasy ointments may be the preferred treatment, but if patients don't like them, you're going to need to give them something else," he says. For many conditions, there are usually other treatments that are basically just as good.

Prepare patients for side effects. If a medicine is going to sting, "I tell patients that's a sign that it's working," Dr Feldman says. "So when they feel the sting, they see it as a positive experience—'It's working.'"

Ask patients to check back in 3 days. If patients are asked to contact the doctor very soon after they get the prescription, they are motivated to immediately start using it, he says. And once they use it, they'll start seeing positive results and that will motivate them to continue use. When several weeks have elapsed, patients will be less likely to start the medication, he says.

Dr Feldman insists that his techniques don't take any extra time, even during the office visit. If they did take extra time, he believes most doctors wouldn't want to use them, because they simply don't have the time to add even a minute or two to the office visit.

He thinks paying attention to adherence is an essential physician skill, comparable to diagnosis and selecting a treatment plan. "If you make the right diagnosis and select an effective treatment plan, it doesn't mean anything if the patient doesn't follow it," he says.

Aiming for Better Outcomes in Diabetes and Oncology

Focusing on improved outcomes entails different work for different groups of patients. For diabetes, a chronic condition, a patient's motivation may ebb and flow over time.

The chronic care model, which is often used for diabetes patients, is meant to improve patient adherence, according to Kevin M. Pantalone, DO, an endocrinologist at the Cleveland Clinic.

"If the patient gets a headache a few days after starting a new medication, he or she may stop taking the drug and not let the doctor know," he says. "Under the chronic care model, nurse coordinators contact patients after the visit to make sure they're starting the med and

that it's working well." This team care approach enables a physician to stay on top of the patient's adherence and lets the physician recommend a different treatment, or work with the patient to encourage them to be active in their own treatment.

Dr Pantalone doesn't think that meeting the single outcome measure for diabetes care under MIPS QP and other Medicare quality programs would be highly difficult. The measure requires physicians to report the percentage of their patients who have an A1c value of less than 9%, but he says the goal for individual patients with diabetes is set much lower, at less than 7%. That allows doctors "some wiggle room" in meeting MIPS standards, Dr Pantalone says.

Oncology Also Moves Toward Measuring Outcomes

Cancer care and payment, as with many other specialties, is moving toward measuring outcomes. In July, 195 practices joined the Oncology Care Model, a 5-year demonstration program that makes oncologists responsible for the effectiveness and efficiency of oncology care. Physician practices are engaged in payment models that include financial and performance responsibility for episodes of care involving chemotherapy administration to patients with cancer. The Centers for Medicare & Medicaid Services provides a $160 monthly management fee for each patient, which can be used to pay nurse coordinators to improve adherence. Like the ACO program, participating doctors with high quality scores who save money during a 6-month episode of care can also get extra payments.

Oncologists are beginning to embrace this payment concept, says Stephen Grubbs, MD, vice president of clinical affairs at the American Society of Clinical Oncology. "Initially there was some resistance among members, but I think they have come to understand that change is coming," he says.

Dr Grubbs counsels that when outcomes are measured, providing accurate coding using the International Classification of Diseases, 10th edition, becomes crucial. "To establish your risk and to be graded at the correct level of severity, you need to be putting in the right comorbidity codes," he says.

References

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