

**THE AMERICAN COLLEGE OF PHYSICIANS POLICY PAPER:  
THE ROLE OF PERFORMANCE ASSESSMENT IN A REFORMED HEALTH CARE SYSTEM**

**THE AMERICAN GERIATRICS SOCIETY • COMMENTS • 8/26/11**

The American Geriatrics Society (AGS) is the nation's largest association of geriatrics healthcare professionals, with nearly 6,000 members. We, and our members, are dedicated to improving the health, independence and quality of life of older people through initiatives in clinical practice, professional and public education, research, and public policy advocacy.

We appreciate the opportunity to comment on your policy paper, "The Role of Performance Assessment in a Reformed Health Care System," as AGS has actively been thinking about ways in which we can reform our current payment system to improve quality of care and lower costs. We believe that your document is a very cogent and comprehensive policy statement and agree with the majority of points outlined. As AGS's constituent population includes that of the frail, multi-comorbid elderly, we have outlined below, several comments which further address the needs of this population through the paper's parameters of the "triple aim" of improved patient experience, better population health, and overall reductions in per-capita health care spending.

**OVERALL COMMENTS ON:**

**Changes to our Payment System**

AGS agrees with ACP that the present payment methodologies incent the wrong approach to care so moving toward compensation for the right outcomes makes sense. AGS feels it is important to discuss the need for payment systems to support transitions of the delivery system and to properly pay for services that are currently not paid for, such as care coordination, team care, and non-face-to-face time. We believe that the kind of high-quality care provided by geriatricians and other primary care providers requires that Medicare changes how it pays for services. We need innovative models for financing care that pay for value, not volume. These innovative models should create systems that incent and provide coordinated, patient-centered care -- the kind of care which is most likely to result in savings or, at minimum, reduced growth. This means properly compensating providers for the type of care provided and for the value added by improving functional outcomes and reducing the number of hospitalizations and unnecessary tests and procedures that are performed on patients. It also means increasing Medicare's investment in the development of performance standards, metrics and measurement methodologies as well as establishing additional incentives to use electronic health records and data collection tools.

**The Need for Quality Measures**

With the multi-morbid geriatrics population in mind, AGS believes it is of great importance to clearly define quality measures which address those whom are vulnerable and/or frail and that efficiency should always be the leading priority in terms of quality measurement. We believe there should more focus on process measures with emphasis on care coordination, safe transitions, co-management with home care, and specialty care.

We also believe that such measures should:

- Account for comorbidities and assess the aspects of health that are common to these types of patients (e.g., cognitive status, inability to perform activities of daily living, and pain.).

- Be constructed so that providers are rewarded for providing treatment that improves the quality of life, particularly where the treatment goal for a given patient is not to prolong life, but to ensure stability and comfort.
- Be evidence-based and clinically relevant, and valid for the unique needs of this older population.
- Account for patient and family preferences and caregiver and patient burden.
- Address patient safety, particularly regarding overuse or underuse of health care.

In that regard, AGS recommends:

- A system that promotes quality improvement under Medicare must address the care of Medicare beneficiaries who have multiple chronic conditions, advanced disease, are frail, or have cognitive and physical functional limitations in addition to those beneficiaries who are healthy or without functional limitation.
- Structure, process and clinical outcomes measures must be valid and relevant for the unique care needs of frail or vulnerable older adults. These measures should be evidence-based, clinically relevant, have clear association with improved outcomes of care, and be applicable to all patients whose care they assess.
- Quality improvement and physician performance improvement policies must take into account the current ability of different types of practices to provide comprehensive care and to promote (and reward) improvement of the care provided by those practices. Large multi-specialty physician groups often have more resources for quality and performance improvement processes than smaller physician practices, yet most Medicare providers operate in small physician practices.
- Investment in research regarding quality indicators for the elderly population and patients with complex chronic conditions is critical.

#### **SPECIFIC COMMENTS ON POSITIONS:**

(**Suggested additions in red and bold**; *Comments in blue and Italics*)

#### **Introduction; Lines 68-72**

To effectively change the current fragmented, reactive health care landscape to one that fosters provider collaboration, patient engagement, and preventive care, stakeholders would need to adopt a “pay-for-improved-population outcomes” mindset that attends to population health outcomes rather than just the performance of individual physicians and other clinicians. *In the current environment, we are looking at public reporting that is focused at the individual or institutional level in terms of how quality is being reported. We would suggest that ACP take a strong stand on the need to have more fully implemented and tested quality measures before publically reporting results for individuals or institutions.*

#### **Position 1; Lines 92-95**

The primary goal of programs that link payments to performance assessment must be to promote continuously improving quality care across the health care delivery system while evolving towards providing incentives to improve population health. **Incentives should also promote and fund Continuous Quality Improvement in health care, including efficiency.**

#### **Position 2**

Line 158; Potential rewards should be:

Reflective of the cost and other resources needed to participate in a P4P program; **including the cost to measure and design improvements which will take, for example, system supports and program management.**

Line 166-169; Potential rewards should be:

Designed to encourage physicians and health care systems to care for vulnerable patients with complex health care needs, reflect the level of care required, and avoid adverse, unintended consequences resulting from P4P program implementation. ***AGS supports this but would also like to add that there should be performance incentives/ measures that recognize the nature of how to safely and appropriately care for and make shared decisions with frail elders that reflect patients' choices and values. Like ACP, AGS is concerned that we not design an incentive-based system that leads to individual clinicians abandoning the care of the frailest because the quality measurements in place are not aligned with the needs of this population.***

**Position 10; Lines 228-230**

Such a strategy should also lead to determination of a single core measure set to provide data for benchmarking and ongoing quality improvement. AGS has concerns about creating a single core measure set that would work for a frail elder geriatrics practice. ***With the multi-morbid geriatric population in mind, AGS believes that due to the complex nature of care for this population quality measurement must expand beyond one set and should also do more than measure singular, core outcomes of care. It should lead to improvements in the care processes that take into account vulnerable elders, who are more likely than other populations to experience adverse outcomes such as falls, line infections, and delirium.***

**Position 14; Lines 277-282**

Performance measure developers must incorporate socioeconomic status adjustments or other variables to ensure vulnerable patients receive the care they need. Programs that link payment to assessment of performance must monitor participants to identify and address unintended consequences, such as exacerbation of racial and ethnic health disparities. This may be achieved by including incentives to care for underserved or complex-needs patients, **including frail minority and poor elders**, in such programs

**Position 17; Lines 307-310**

The results of programs to link payments to assessment of performance should not be used against physicians in health plan credentialing, licensure, and certification. Such programs must have defined security measures to prevent the unauthorized release of physician ratings and patient data. ***AGS believes that this section needs clarification. Collectively, we should be moving to an alignment of performance measures so as to not unduly burden clinicians or institutions with multiple reporting requirements. In an aligned quality measurement system, individual clinicians would be tracking performance across platforms and all players (certifying bodies, payers, and licensing bodies) would have access to the same data. This has been well-articulated by certifying Boards who, under ACA, are now positioned to partner with CMS on the Physician Quality Reporting System.***

**Position 18; Lines 335-336**

A Medicare value-based purchasing program should meet the principles outlined in the paper. ***AGS believes that ACP needs to articulate what the potential negative consequences are if these principles are not met.***