Pay-for-Performance Principles that Ensure the Promotion of Patient Centered Care— An Ethics Manifesto

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This paper, written by Lois Snyder, JD, and Richard L. Neubauer, MD, FACP, was developed by the American College of Physicians (ACP) Ethics, Professionalism and Human Rights Committee. Members of the Ethics, Professionalism and Human Rights Committee were Frederick E. Turton, MD, FACP (Chair); Richard A. Hranac, MD, FACP (Vice Chair); Neil J. Farber, MD, FACP; Virginia L. Hood, MD, MPH, FACP; Allen S. Keller, MD; Diane E. Meier, MD, FACP; Paul S. Mueller, MD, MPH, FACP; Richard L. Neubauer, MD, FACP; Mahmoud Sharaf, MD; and Peter A. Ubel, MD. This paper was approved by the ACP Board of Regents on October 29, 2006.

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Position Paper
by Lois Snyder, JD, and Richard L. Neubauer, MD, FACP for the
American College of Physicians Ethics, Professionalism and Human Rights Committee*

Abstract
Pay-for-performance programs are growing, but little evidence exists on their effectiveness or on their potential unintended consequences and effects on the patient-physician relationship. Pay-for-performance has the potential to help improve the quality of care, if it can be aligned with the goals of medical professionalism. Initiatives that provide incentives for a few specific elements of a single disease/condition, however, may neglect the complexity of care for the whole patient, especially the elderly patient with multiple chronic conditions. Such programs could also result in the de-selection of patients, "playing to the measures" rather than focusing on the patient as a whole, and misalignment of perceptions between physicians and patients. The primary focus of the quality movement in health care should neither be on "pay for," nor "performance" based on limited measures, but rather on the patient. ACP hopes to move the pay-for-performance debate forward with a patient centered focus—one that puts the needs and interests of the patient first—as these programs evolve.

Introduction

Quality of care varies across all health care systems,[1] and the "gap" between evidence based guidelines and clinical care in this country has received considerable attention in recent years. One recent study suggested that Americans receive only about 55% of recommended health care.[2]

Quality improvement efforts that focus primarily on education have met with limited success. Many initiatives are now attempting to measure the clinical "performance" of physicians and health care facilities. Combine that performance measurement with financial incentives to bring about clinician and systems change, and the result is pay-for-performance (P4P) programs that aim to improve quality in health care —and hope to lower cost.

The linking of physician reimbursement to measures of clinical performance is growing in popularity among payors, including the federal government. It is also controversial. While a body of literature is developing on the anticipated positive results that such programs may yield, and we applaud innovations that improve care, little evidence exists on the effectiveness of such programs[3, 4] and a number of potential consequences remain largely unexplored.

Every payment system creates incentives and potential conflicts of interest, such as the incentives in fee-for-service payment to increase care or the incentives under capitation to do less

rather than more. No matter what the practice environment—including the development of P4P programs-- clinicians must seek to ensure that the provision of a medically appropriate level of care takes precedence over financial considerations imposed by the physician's own practice or financial arrangements.[5, 6]

Additional ACP position papers explore public policy, reimbursement and other issues raised by P4P.[7,8] The purpose of this paper is to examine the ethics implications of P4P and to discuss P4P's potential unintended consequences and impact on professionalism and ethics, especially for the patient-physician relationship.

As a group of professionals dedicated to the care and best interests of patients, the American College of Physicians (ACP) believes the P4P movements can offer a unique opportunity to positively change health care. But the emphasis of programs needs to be not only on how health care professionals, payors and policy makers view quality, but how patients view quality in medicine. In addition, we are concerned about the potential for unanticipated adverse consequences of using a limited set of parameters to assess quality tied to physician compensation,[9] especially if this is grafted onto the current system rather than instituted as part of reforms that encourage robust comprehensive care of the patient.

ACP is concerned about how this debate is being framed, and the very language of "pay-for-performance." P4P initiatives that provide incentives for a few specific elements of a single disease/condition may neglect the complexity of care for the whole patient, especially the elderly patient with multiple chronic conditions.[10, 11] In addition, it is unclear that current efforts will enhance the patient-physician relationship and address patient views of measures of quality, which include access to and continuity of care with trusted physicians;[12] effective communications and empathy; adequate time for office visits;[13] coordination of treatment across all providers and settings; decision-making about whether and how to accept treatment recommendations; and the role of the family in care. On the other hand, P4P has potential to help improve the quality of care, if it can be aligned with the goals of medical professionalism and applied more generally to all facets of and specialties in health care.

In order to address the needs of the patient as a whole, the primary focus of the quality movement in health care should neither be on "pay for," nor "performance" based on limited measures, but rather on the patient. Care and the evaluation of it should center on the relationships, medical home[14, 15]and systems necessary to the delivery of high quality medical care to patients. The Institute of Medicine defines high quality care as being safe, effective, efficient, patient-centered, timely and equitable.[16] The Centers for Medicare & Medicaid Services add that such care is personalized, oriented toward prevention and based on evidence of benefits and cost for each particular patient.[17] Any program that focuses on quality should specify clear definitions of what is meant by that term and the metrics that will be used to monitor and evaluate it. In addition, programs must be tested for effectiveness and validity, and assessed for potential unintended consequences.

Physicians have had, and continue to have, a professional duty to provide high quality care.[5, 18] P4P sets up a potential conflict between the physician's duty to the patient and a competing interest in achieving a performance measure—whether the measure is a priority for that patient

or not. ACP suggests the following ethics principles to help guide the pay-for-performance movement.

Ethics Principles Relevant to Pay-for-Performance

P4P programs should:

- Recognize and support the physician's duty to act in the best interests of the patient, and the individual and collective ethical responsibilities of physicians. Any incentives to physicians must align with physician professional responsibilities.

- Promote high quality evidence-based health care and the physician's ability to provide it in the context of a strong patient-physician relationship based on trust, effective communications, adequate visit time and continuity of care over time. Definitions of quality should specifically include a statement about the value of the patient-physician relationship and measurement sets should include metrics associated with the patient-physician relationship, communications, respecting values, patient preferences and goals, and others focused on ethics.

- Support patient decision-making about, and patient experience with, care.

- Facilitate and encourage collaboration and coordination among members of the health care team and across health care settings.

- Respect confidentiality and patient privacy, especially in data collection and analysis activities.

- Address the goals and treatment of varied patient populations, especially those with complex, chronic, multiple conditions, not just single disease/condition approaches to care based on narrow processes or outcome measures.

- Disclose to patients, in an understandable manner, quality processes and any potential conflicts of interest and financial or other arrangements that may influence care.

- Not limit access to care or lead to "deselection" or risk selection of patients or categories of patients.

- Recognize the potential for unintended consequences such as deselection of patients or limitations in access to care, and develop processes to prevent them.

- Recognize that as P4P evolves, the ethical principles of beneficence (to promote good and act in the patient's best interest); nonmaleficence (the duty to do no harm) and respect for patient autonomy, and considerations of justice, should be adhered to.

Physicians should:

- Be conscious of all potential influences on clinical judgment. Actions must be guided by patient best interests and appropriate utilization, not by other factors.

- Ensure their judgments reflect the best clinical evidence and literature, including data on the clinical effectiveness and cost of care of different clinical approaches, in applying clinical judgment personalized to each patient.

- Engage in and be advocates for continuous quality improvement in health care and be held accountable for patient-centered quality of care.

- Advocate for and participate in programs that do not lead to discrimination against a class or category of patients.

- Seek to ensure that the medically appropriate level of care takes primacy over financial considerations imposed by the physician's own practice or financial arrangements.

Potential Ethical Pitfalls and Unintended Consequences of Pay-for-Performance Programs

While not all potential pitfalls can be anticipated, it is worthwhile to start early in the establishment of pay-for-performance programs to consider issues with ethics implications and possible unintended consequences that might result from such programs as they are currently conceived.

- Deselection of patients

    - P4P programs should not create incentives that lead to discrimination against a class or category of patients, such as elderly patients with multiple chronic medical problems or patients with low health literacy. Incentives in a system structured to measure a physician's performance on specified clinical measures can potentially encourage physicians to modify their performance scores by dropping patients who negatively affect the physician's profile. Such a result violates ethical principles and needs to be specifically addressed in the design of such programs.

    - Incentives should encourage care of the sickest and most vulnerable patients. However, programs may discourage individual physicians from accepting challenging patients who may need care and services the most. Society should not accept approaches to health care that do the least for the patients who need care the most, or that do not address barriers to care such as language or health literacy issues.

- "Playing to the measure" or "gaming the system" rather than focusing on the patient

    - Comprehensive, appropriate care is not served by an environment in which care is judged based on limited measures that do not account for multiple complex chronic conditions, counseling and communications needs of patients, patient experience, continuity of care and other factors that are not as readily quantifiable as, for example, a lab result. All measures must sustain and enhance appropriate patient care and the patient-physician relationship.[19]

    - Performance measures should be meaningful for the patient, physician and the community and should therefore include not just clinical outcomes, but structural and process measures.

- Misalignment of perceptions between patients and physicians

    - As physician reimbursement is linked to specific process or outcome measures of performance, the potential exists for the patient to view the clinical encounter very differently than the physician and the payor. Patient goals for care—such as for effective communications and coordination of care across providers and settings—must be part of the P4P program.

    - Physicians must keep the best interests of patients paramount, and align their recommendations to respect the values and goals of the patient. In one recent poll, more than half of adult patients said they declined a treatment or test, or to fill a prescription, because they believed it to be unnecessary care or care that was too aggressive.[20] And this is before widespread adoption of P4P.

- Potential for increasing unnecessary care and medical costs

    - Physicians have an ethical obligation to practice effective and efficient health care, using resources responsibly and helping to ensure resources are equitably available. P4P programs that take a one size fits all approach to quality could encourage unnecessary care and an increase in overall costs within the medical system.

<u>Conclusions</u>

P4P programs may have the potential to increase overall quality of care when aligned with the ethical obligations of the physician to deliver the best quality care to her or his patient. However, the phrase "pay-for-performance" and initial plans for P4P do not provide assurances that such alignment will occur. Current incentives that could result in de-selection of patients, "playing to the measures" rather than focusing on the patient as a whole, misalignment of perceptions between physicians and patients, and increased unnecessary care and costs, have the potential to harm access to care, continuity of care, patient-physician relationships, and care for those patients with complex chronic conditions.

By framing the discussion of P4P in terms of ethics and professionalism, both in the context of the individual patient and for society, ACP hopes to move the debate forward with a patient centered focus—one that puts the needs and interests of the patient first—as P4P programs evolve.

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