Data's Motivating Power

Analytics can be a tool for constructively engaging physicians in health systems' transition to value

By Robert W. Pryor, M.D., and Matthew J. Lambert III, M.D.

Physician engagement in value-based care is an increasingly critical issue for health care boards. Many organizations are focusing on financial incentives to encourage physicians to move the needle toward value, but remuneration is a blunt tool and only one among many that can influence physicians practicing today.

At the heart of what most physicians seek is to do what's best for the patient, as desired by the patient, through the provision of high-quality clinical care that achieves the best-possible outcomes. Boards ultimately are responsible for the quality of care delivered in their health care organizations, so providing clinicians with accurate and actionable data about quality and outcomes performance should be front and center on board radar screens.

Data and analytics that get to the heart of performance improvement opportunities are no longer nice-to-have tools; rather, they underpin an organization's ability to achieve high-value care.

Peer comparisons

For most hospitals and health systems, unwarranted variation in care is a significant source of suboptimal patient outcomes and unnecessarily high costs. Such variation is present in clinical practice when there is a gap between a desired best practice and an existing practice. Physicians who receive reliable data with evidence of unwarranted variation in their own care — whether related to quality, outcomes or cost — most often need no further inducement to bring their practices in line with their colleagues'.

All practicing physicians need to be offered information that lets them know how their colleagues practice and how their own practices compare. Peer comparisons are not new. Available now through Medicare's Physician Compare program and other report card databases on a more limited basis, such data will be broadly available to the public through the peer comparisons embedded in the Medicare Access and CHIP Reauthorization Act. Passed with bipartisan support in 2015, MACRA makes sweeping changes to how Medicare pays for physician services — moving payment aggressively from volume to value.

Starting with Medicare physician fee schedule payments in 2019, Medicare reform under MACRA puts providers at risk for not improving value. At the outset, the Centers for Medicare & Medicaid Services expects that approximately 90 percent of clinicians who bill under Medicare Part B and are not subject to MACRA exclusions will go into the Merit-based Incentive Payment System program. (For more information, visit qpp.cms.gov.) Physicians will receive a composite score from 0 to 100 based on their performance on measures related to quality, resource use, advancing care information and clinical practice improvement activities.

For 2019 payments, performance on six quality measures or on a specialty subset of measures, with at least one outcome measure or high-priority measure (e.g., patient safety, appropriate use), will constitute 60 percent of the score's weighting for providers participating in MIPS but not Advanced Alternative Payment Models. The latter have different quality reporting and weighting requirements.

Medicare bonus or penalty payments will be tied to providers' scores, reflecting performance relative to their peers. Physicians should be keenly aware that their comparative performance will be up on the web for use by consumers and others by 2019.

Relevant data

Organizations should work with their employed and affiliated physicians to identify the metrics most suitable to the organization's and physicians' care delivery and payment goals under MACRA. Physician leaders should be involved in designing meaningful peer comparisons, including comparisons among colleagues within a group, and benchmarking among similar types of groups.

Analyses that assure accurate attribution of the data by physician or group, exclude outliers, and are risk- and severity-adjusted are the most useful for showing where quality outcomes and/or costs differ significantly by physician or other care provider. This apples-to-apples analysis produces actionable

IMAGE FROM ILLUSTRATION SOURCE

data that can be used to eliminate or decrease performance gaps.

Whether physicians are employed or in private practice and affiliated, high-quality patient care is their common goal. Providing relevant data at a high level of accuracy, clarity and attribution helps align physicians around this goal. Most physicians don't want to be on the negative end of quality and efficiency scales; peer performance is a powerful motivator for improvement. A data-driven approach successfully engages physicians in achieving success at reducing care variation.

For example, in "Using Data and Analytics to Improve Clinical and Financial Performance" (*Leadership* magazine, fall 2016, Healthcare Financial Management Association), Walter W. Morrissey, Robert W. Pryor and Anand Krishnaswamy discuss how one health system focused on reducing unwarranted variation in knee and hip joint replacements to optimize care under CMS' joint replacement bundled payment program. Using powerful analytic tools with embedded national benchmark data, the system identified its best-performing hospital based on measures including a risk-adjusted patient safety index, postoperative infections and other measures.

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Drilling down by individually named physicians in system hospitals, the system's analysts also identified the best-performing operating physician for knee replacement among his peers. The system's chartered clinical improvement team then studied the clinical practices of this top physician to learn the means by which he was able to achieve exceptional results. Through this, clinicians and executives were able to identify underperforming practices and areas in need of attention with other physicians.

The design of physician peer comparison programs requires considering a number of factors, including whether the information is blinded or unblinded, the scope of the reference group, individual versus group comparisons and other issues. Boards and leadership teams should ensure that they are actively involved in engaging physicians in two-way communication and consultation about how to use data and analytics to improve clinical performance and accelerate the transition to value-based care. **T**

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