

# Engaging Physicians and Leveraging Professionalism

## A Key to Success for Quality Measurement and Improvement

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**I**NCREASING COSTS AND GROWING EVIDENCE OF GAPS IN quality have led to a health care environment emphasizing accountability to purchasers and patients. Physicians and hospitals are expected to demonstrate the value of the services they provide by measuring the quality of care, reporting to payers, and increasing public transparency. Patients and payers increasingly expect public input in the formation and evaluation of medical evidence and the inclusion of patient experience and clinical outcomes when evaluating quality of care.

Trends over the past decades have contributed to strengthening this context for medical care. One is the expanding science of health care quality and the ability to develop meaningful measures of clinical quality, safety, and patient experience. The second is increasing awareness of the importance of quality improvement science and high-reliability organizations as learned from other industries.<sup>1</sup> Organizations such as the Institute for Healthcare Improvement have applied the science of quality research from other industries to health care. This transformational thinking has led health care to use industrial engineering models to reduce or eliminate defects in process, increase reliability, and reduce waste. The third trend has been the increasing adoption of electronic health records, stimulated by the creation of the meaningful-use incentive program. The proliferation of quality measures in this context have increased attention to accountability and led to the formation of the National Quality Forum (NQF) to encourage consistency and endorse measures being used to improve quality. This background highlights the importance of the need for insurance payers to actively engage physicians and other clinicians and to leverage professionalism in quality programs.

### Maintenance of Certification

The medical profession is responding to these same realities and is increasingly aware of its own responsibility to demonstrate value and improve quality. For the profession, this awareness resulted in advancing the concept of Maintenance of Certification (MOC) through the Ameri-

can Board of Medical Specialties. For nearly a century, specialty board certification had been a mark of distinction and a way of differentiating the competencies of specific medical specialties. For most physicians, this meant passing an examination of knowledge at the end of training after which certification remained valid for the rest of their life. In the 1970s, a few proactive specialties limited the validity of certificates so that to remain board certified, physicians would have to recertify periodically (eg, every 6-10 years). By 2002, all 24 specialty boards had agreed to the necessity for periodic recertification.<sup>2</sup> The number of grandfathered physicians not required to recertify has decreased over time and is the minority in major specialties. For instance, among all physicians who are currently board certified by the American Board of Internal Medicine, approximately 23% of those younger than 70 years are not required to and have chosen not to recertify. In addition, the percentage of physicians who have never been board certified is declining.

The move toward recertification was in response both to the ever-changing nature of medicine and the primacy of public accountability within their ethical framework of professionalism. In response, the boards developed a consistent framework for MOC, which in addition to demonstrating up-to-date knowledge in a specific field, also included actual assessment of performance consistent with measurement, accountability, and quality improvement science. This movement had momentum and extended to physicians within the osteopathic specialty framework.

### Beginning to Pay for Quality

With the proliferation of quality measurements and reporting, reward systems emerged. The reporting systems led to report card-type reports on physicians using the measures available. Insurance companies began to use models of pay for performance that had been tested in the United Kingdom. The Centers for Medicare & Medicaid Services (CMS) began developing this idea, called value-based purchasing, outlining the need to move from fee-for-service payment to

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purchasing based on value. The CMS completed its hospital value-based purchasing report to Congress in 2007, which became 1 of the first value-based purchasing programs.<sup>3</sup> The CMS started the physician quality reporting program in 2007, which has evolved over time, and rewards physicians for reporting approved quality measures such as blood pressure measurement and control, cholesterol measurement and control, and many process of care measures. As a result, physicians were increasingly expected to report certain quality measures to payers other than CMS and separately to their specialty boards for board certification.

### CMS and Physician Quality

Despite the rapid changes in specialty certification and quality-related payment programs in the past 5 to 10 years, there is an increasing concern that the results of pay-for-reporting and pay-for-performance programs and public reporting have not driven health system change as quickly as desired. Quality improvement has occurred in select areas, but the pace and scale of improvement need to increase. Importantly, smaller physician groups and solo practitioners have had lower successful reporting rates.<sup>4</sup> The relatively small payments outlined in congressional statute did not typically offset the additional work that went into collecting and transmitting this information.

Therefore, CMS reviewed the major physician program, the Physician Quality Reporting System, in 2011. The aims of the review were to align measures with the National Quality Strategy<sup>5</sup> released by the Department of Health and Human Services outlining national goals, ease the burden of reporting to reach a goal of the majority of physicians in the United States participating by 2013, strategically engage the physician community in improving the program over time, and focus on measures with maximum effect on achieving the National Quality Strategy goals of better health, better care, and reduced costs through improvement. The review also focused on how to leverage other collection mechanisms, such as registries and specialty quality measurement efforts, to increase participation in the Physician Quality Reporting System. In addition, the review focused on aligning reporting requirements, including leveraging the electronic health record incentive program so a physician could ultimately report once to receive credit for multiple programs.

This review resulted in implemented changes that focused on measure alignment and engaging the clinician community in the stage 2 meaningful use rule proposed in early 2012 and in the CMS physician fee schedule rule proposed in July 2012. These changes are the beginning of implementing this longer-term strategy. The stakes of quality and cost measures for physicians were raised further by the congressional mandate for CMS to implement a physician value modifier that will adjust payments to all physicians by 2017 based on performance.

### MOC, Clinician Engagement, and CMS

Physician engagement in MOC has been better than expected, even though its requirements in many specialties are greater than many payer programs. Many physicians have reported quality data through the boards for several reasons: board certification remains a valuable professional credential, increasingly valued not only by physicians but by employers, patients, and potential patients. In addition, the process of certification is familiar to physicians and includes aspects such as evaluation of knowledge and comprehensive and clinically relevant quality measures that return data back in a timely fashion and require improvement as part of the process. Maintenance of certification is often required for privileging with the clear aim to improve quality rather than simply to increase payment. The comprehensiveness of the MOC approach makes sense to physicians and is consistent with the clinical flow of their practice.

These observations suggest that closer alignment for physicians who choose to use their MOC-related assessments with CMS programs for quality reporting and value-based purchasing could lead to more meaningful information available to consumers, as well as greater opportunities for meaningful quality improvement as a result. The CMS is engaging with the specialty boards to make this vision a reality over time. Participation in MOC would still be voluntary but for physicians who participate, they might reap additional benefits in terms of participation and quality reporting that meets CMS requirements. This is part of a broader strategy in which CMS aims to engage clinicians of all types in quality measurement and improvement through specialty and professional societies. A fully integrated system of data collection and data reporting to both payers and specialty boards is possible. Although much work remains, collectively leveraging professionalism and continuous learning are needed to improve the health system.

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