6. Measuring physician practice, difficult as it is, is progressing in both countries. Both qualitative and quantitative methods are required to understand practices, and routine data from practices are essential. Standards for information systems are being established more slowly in the United States. To be sufficient, primary care information systems must be able to aggregate data necessary to measure performance and incorporate ordering principles (classification) and terminology capable of creating and analyzing episodes of care as they occur in primary care.

It would be advantageous for key US organizations devoted to optimizing primary care to sustain for the foreseeable future exchanges with other countries to enable the United States to see itself more clearly, import innovations of relevance, and elude avoidable mistakes. While there is much to learn in many countries, UK-US exchanges present immediate opportunities with particularly great relevance. It is not as if there is little to learn from one another. Rather it is how much can be learned that can find prompt application in the redesign of primary care that is underway.

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SHAPING THE FUTURE OF PAY-FOR-PERFORMANCE PROGRAMS

Whether it's driven by private insurers or the federal government, pay-for-performance (P4P), a concept that offers health care providers payment for meeting certain performance measures, is here to stay. Recognizing the potential impact P4P will have on family physicians, the American Academy of Family Physicians is working to ensure that family physicians are involved in shaping the future of P4P.

"Pay-for-performance is an incentive to *prove* the quality of care we already provide and to *improve* our care," says AAFP Board Chair Mary Frank, MD, of Mill Valley, Calif. "Think of it first as quality improvement and then as positive financial recognition."

"It's here, it's going to stay, and it's going to change the way we practice," Ron Bangasser, MD, says of P4P. A family physician in Redlands, Calif, Bangasser is a member of the National Committee for Quality Assurance's Committee on Performance Measurement. He's also past president of the California Medical Association.

Bangasser speaks to groups all over the country about pay-for-performance. He estimates that between 100 and 120 P4P programs — overseen by the federal government or private insurers — currently operate across the country. "There are tens of millions of patients covered under these programs now, and soon there are going to be hundreds of millions," says Bangasser.

An example of these programs is Integrated Healthcare Association, a nonprofit, California-based entity, which has a P4P program that will pay out a total of $88 million to 235 California medical groups, including Bangasser's, in 2005. These types of programs appear to have boosted the quality of care in the California market. According to Bangasser, a comparison of health care data between 2002 and 2003 reveals that:

- Nearly 150,000 more women received cervical cancer screening
- 35,000 more women received breast cancer screening
- An additional 10,000 children got 2 needed immunizations and
- 18,000 more people received a diabetes test.

P4P Opportunities

"I'm constantly fishing for P4P programs of various kinds," says Robert Fortini, clinical operations manager at Community Care Physicians in Albany, NY. Fortini and the physicians at the multispecialty group practice he oversees embrace P4P programs because they translate into better patient care. "It's been pretty well demonstrated over the last 10 years that quality and improvement strategies result in decreased cost and improved patient outcomes," says Fortini. "The bottom line is that reducing the risk of medical errors — and these are just strategies to do that — is the right thing to do."

Fortini's group, Community Care, has 35 individual practices and 191 clinicians — many of them FPs — practicing in the Capital District of upstate New York. The group participates in the P4P program of the Bridges to Excellence coalition, a not-for-profit group established by employers, providers and health care plans. Bridges to Excellence works to improve health care quality through rewards and incentives that encourage providers to deliver optimal care and patients to seek evidence-based care and self-manage their conditions.

"Right now I have 8 practices — 43 physicians — that have realized the maximum reward potential for the first year," says Fortini, adding that everyone agreed to put the money against the bottom line to offset the cost of either implementing or maintaining electronic health record systems in their practices.

The time and effort expended at the front end (setting up registries, collecting data and reporting data) is balanced by the fact that in the end, participating clinicians not only realize monetary payoffs but also quality improvement in their practices, says Fortini. "That money can be used to support electronic systems that further facilitate quality care and efficient practice."

In January, CMS jumped on the P4P bandwagon when it announced a 3-year Physician Group Practice initiative that is intended to demonstrate the viability of P4P in 10 large, multispecialty physician practices.

Another pilot program, the Medicare Chronic Care Improvement Program, includes the 3-year Mississippi Chronic Care Collaborative, which will test the value of chronic care management for 20,000 Medicare patients in the state. Among its goals is to implement a P4P system using recommendations from a physician incentives workgroup on performance measures and methodology, target values, and eligibility for participation.

Paying for P4P Programs

"It's not the amount of money so much as good measures and a little bit of money," says Bangasser. "If I don't believe the measures are worth it, I ain't gonna play. And the payouts have to be from new money. It can't be money taken away from all of us or some of us as a stick; it has to be all carrot."

AAFP's policy on P4P also insists on new money: "P4P incentive programs should utilize new money funded by using a portion of the projected health plan savings. There should be no reduction in existing fees paid to physicians as a result of implementing a P4P program."

Funding for P4P programs is key to their success. Many family physicians fear that incentive payments for some mean that others will have their payments cut. Even policy-makers are beginning to recognize that how these programs are funded is critical. Samuel Nussbaum, MD, chief medical officer for WellPoint, a national medical health plan company, and Jack Ebeler, chief executive officer of the Alliance of Community Health Plans, recently joined together to recommend an infusion of new money into any pay-for-performance system. On September 8, the 2 testified before the Medicare Payment Advisory Commission that family physicians and their primary care colleagues should receive a 5% to 10% incentive payment for meeting quality standards under any Medicare pay-for-performance program approved by Congress.

The section on physician services in MedPAC's March 2005 report to Congress recommended a 2.7% increase in physician payment for 2006. A section of the report on strategies to improve care also called for establishing a pay-for-performance system that would be budget-neutral. Such an approach would effectively reduce all physicians' payments by a certain percentage and then would create a fund from which incentives would be distributed to those who met quality standards.

MedPAC's recommendations, if implemented, would hamper a successful outcome, Nussbaum told MedPAC. Payment reductions to establish an incentive fund would discourage physicians from investing in health information technology, he said. And incentives of only 1% to 2% would not be enough to encourage physicians to improve care.

Family Physician Involvement

It's critical to have family physicians involved in the planning when incentives for a P4P program are developed. Part of why California's Integrated Healthcare Association program works for family physicians is that FPs helped put the program together, says Frank. "We need to be involved in discussions with employers or regional insurers about P4P. Lots of times, the family doctor is the reality test."

Frank encourages family physicians to be aware

that P4P will affect their future. "Some of our members aren't clued in that it's coming, even though it's already here," says Frank. "CMS demo projects are already under way. And P4P is a major direction employers and insurers are considering."

At press time, Congress was grappling with budget problems arising out of Hurricane Katrina and appeared likely not to take up legislation including P4P this year. However, bills containing pay-for-performance and health information technology provisions, including the Medicare Value-Based Purchasing for Physicians' Services Act, HR 3617, and the Wired for Health Care Quality Act, S 1418, still are likely to come up next year if they are not tackled this year.

AAFP News Department

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2005 PISACANO SCHOLARS

The Pisacano Leadership Foundation, the philanthropic arm of the American Board of Family Medicine (ABFM), recently selected its 2005 Pisacano Scholars. These 5 medical students follow in the footsteps of 53 scholar alumni who are practicing physicians and 13 current scholars who are enrolled in family medicine residency programs across the country. The Pisacano Leadership Foundation was created in 1990 by the ABFM in tribute to its founder and first Executive Director, Nicholas J. Pisacano, MD (1924-1990). Each Pisacano Scholar has demonstrated the highest level of leadership, academic achievement, communication skills, community service, and character and integrity.

Bridget Harrison, a 2005 Pisacano Scholar, is a fourth-year medical student at the University of California-San Francisco (UCSF). She is also completing her masters in public health at the University of California, Berkeley. Bridget graduated summa cum laude with a bachelor of science in physics from the College of William and Mary. At William and Mary, she was also a member of Phi Beta Kappa, Mortar Board and ODK Honor Societies. Bridget was one of 20 students chosen nationally for the *USA Today* College All-Academic First Team.

After graduating from William and Mary, Bridget taught middle and high school math and science to underserved students for 3 years. While teaching, she restarted and advised a chapter of the Mathematics, Engineering and Science Achievement (MESA) for underrepresented students and coached students to multiple awards at annual MESA fairs.

As a medical student, Bridget has continued her academic excellence and community service. She served as copresident of the UCSF chapter of the American Medical Student Association and helped organize events in support of universal health insurance. She also codesigned and cocoordinated a new health policy elective course at UCSF. During her family medicine clerkship, Bridget codeveloped a community project that involved visiting physicians' offices, completing mailings to county physicians, walking precincts, and writing op-ed and letter-to-editor pieces in support of "Measure Q". "Measure Q" was a local ballot proposal to raise money for the county's financially ailing sole public hospital, which serves an underserved agricultural field worker population. Bridget plans to practice family medicine in a public clinic in an urban underserved community and hopes to incorporate health policy advocacy and international volunteer work into her career.

Kristen Kelly, a 2005 Pisacano Scholar, is a fourth-year medical student at the University of California San Francisco (UCSF). She received a fellowship from the University of California Berkeley to complete her master's in public health over the past year. Kristen graduated with distinction from the University of Virginia with a double major in Spanish and Middle East Studies. As a Virginia Scholar, she received a 4-year scholarship from the State of Virginia based on demonstrated academics and leadership during high school. She was named an Echols Scholar, an award given to approximately 8.5% of the incoming class.

Following graduation from Virginia, Kristen worked for 2 years as a business analyst and associate consultant for a consulting group in Washington, DC. She then took a leave of absence for 3 months to volunteer at an orphanage in Honduras, taking care of disabled children. Kristen decided to extend her stay in Honduras, where she eventually took on the job of Administrative Director for a year until the orphanage could find a permanent administrator.

Kristen has continued her academic achievements and community service as a medical student. She has received a number of scholarships, including a Dean's Scholarship from UCSF. She spent 6 months of her third year participating in "Model Fresno," a UCSF core clinical training program that emphasizes primary care, working with medically underserved and ethnically diverse populations, and community health. She focused on community health during her MPH program, and concurrently worked to improve teaching about commu-