

PHYSICIAN ACCOUNTABILITY FOR PHYSICIAN COMPETENCE

SUMMARY

What will healthcare in the United States be like in the year 2020? And how should physician competence be evaluated and measured within the context of a future US healthcare system?

The Physician Accountability for Physician Competence (PAPC) initiative is a national, multi-stakeholder effort to develop a valid, uniform system for measuring and evaluating a physician's competence over his or her career. Representatives from approximately 40 organizations are participating in this initiative, bringing to the dialogue the diverse views of stakeholders such as the profession, the academic community, certifying and licensing boards, payers, accrediting agencies, insurers, and the public.

A series of invitational summits have been coordinated by the Federation of State Medical Boards to facilitate discussion about how the medical regulatory community will measure, evaluate and provide information to the public about a physician's competence throughout his or her career. The first summit in March 2005 focused on developing various scenarios describing the US health care system in 2020 (attachment 1). This exercise helped participants envision the health care environment in which physician competence must be assessed. The second summit in December 2005 produced a draft definition of physician competence, a draft outline for a document describing "good medical practice", and a beginning conceptualization of a National Alliance for Physician Competence. During the third summit in June 2006, participants continued to develop the good medical practice document, created a basic plan for an Alliance, and proposed concepts for a portfolio tool that could be used by physicians both to provide information about their competence to the public as well as to reflect upon their performance.

A fourth summit is planned for January 2007.

Background

On March 24 – 25, 2005, a group of leaders drawn from a broad cross section of healthcare came together for two days in Fort Worth, Texas, for the first Physician Accountability for Physician Competence Summit. The focus of this summit was to begin a dialogue about the future of physician self-regulation by exploring the context within which physicians will be expected to demonstrate accountability in the year 2020.

This first meeting focused on identifying and prioritizing the trends and developments that are influencing the healthcare delivery system in the United States and then using this information to develop scenarios about what that system might look like in 2020. The scenarios were intended to be used during subsequent meetings as the context within which to explore solutions to the question "*how does the healthcare community evaluate and measure physician competence over the career of the physician?*"

To encourage as broad a dialogue as possible about this issue, summit participants were asked to solicit feedback from their respective organizations on the scenarios' plausibility and possible implications on their organizations' constituencies.

A second summit took place in Chicago on December 8 – 9, 2005. The goal of the second meeting was to continue exploring how physician competence should be measured and

evaluated in the future, using the scenarios and the feedback received from various stakeholder groups as the context for that discussion.

Participants explored many possible options for how physician competence might be measured and evaluated in each of the five future states. At the conclusion of the meeting, the group had developed the following:

1. a draft definition of competence;
2. a draft table of contents for a document describing the behaviors and values one would expect of a competent physician;
3. drafts of several models of regulatory systems to stimulate further conversation about measuring and evaluating physician competence in 2020; and
4. a timeline and task list for activities that needed to occur over the next 12 to 16 months.

The group also endorsed the notion of creating a “national alliance” of organizations focused and aligned around the goal of ensuring physician competence.

During a third summit on June 28 – 29, 2006 in Philadelphia, participants began writing content for the “good medical practice” document and developed more fully the concept of a National Alliance. Discussions about the relationship between maintenance of licensure and maintenance of certification and about how to engage the practicing community and the public in this effort were also initiated. It was evident by the end of the meeting that a shift in “ownership” for the initiative occurred as participants proactively began to identify and tackle issues and challenges that will need to be resolved if the vision of having a uniform, meaningful system for assuring the continuing competence of physicians is to be realized. An even more illustrative indicator of the shift were the generous pledges by participants to a request for financial and human resources to keep the national dialogue moving forward over the next 12 months.

Next Steps

Since the June 2006 meeting, a group of volunteers has continued working on the “Good Medical Practice” document. A first draft will be available for discussion and feedback at the January 2007 meeting. A draft proposal for the National Alliance for Physician Competence has been distributed for discussion by participating organizations’ governing boards. The proposal includes a mission and purpose statement, possible governance structures, descriptions of pilot projects that could be pursued in support of measuring physician competence, and a proposed business plan. Feedback will be incorporated into a final proposal that will be distributed following the January 2007 meeting. A communications strategy to engage practicing physicians and the public in this effort is also being developed and will be a point of discussion at the next summit.

ATTACHMENT 1

The Scenarios

The five scenarios contained in the following pages were developed at the March 2005 Physician Accountability for Physician Competence summit and subsequently refined into stories that can stand alone when read by people who did not attend the session. These scenarios are not intended for wide distribution, nor to be seen as final in any way. Brief descriptions of each are provided below.

The first scenario, **Techno Community Alliance**, depicts a healthcare system where information technology provides a platform for the provision of safe and effective health care. The healthcare community voluntarily collaborates to develop standards for the collection of data and for how those data are used to hold practitioners accountable for demonstrating competence. Data are collected and stored in a national database, and national standards for performance are developed.

The second scenario, **Data Cacophony**, depicts a world where the healthcare community is unwilling to collaborate. Public demand for change in the way healthcare is delivered generates much discussion but little coordinated response. Chaos emerges.

The third scenario, **The Federal Tarbaby**, depicts a world where federal oversight of all aspects of the healthcare system is in effect by 2020.

The fourth scenario, **Brave New World**, is an attempt by the group to develop a wildcard scenario that is completely different, bringing in emerging technologies and completely different thinking about how patients will interact with the healthcare community.

In the **happyhealthcare.com** scenario, skyrocketing healthcare costs combine with increased public dissatisfaction with the system to prompt dramatic change in who controls the healthcare dollars. Patients become true consumers of healthcare services, basing buying decisions on value and cost. In response, the healthcare community turns to continuous quality improvement as the basis for how they deliver care.

Scenario 1: Techno Community Alliance

2005-2010

The US healthcare system is besieged by escalating costs, public dissatisfaction, decreasing labor pools, and misaligned incentives encouraging over-utilization of procedures.

Providers become increasingly disgruntled because payers are implementing pay for performance measures as a means of lowering costs and improving quality. Each payer had its own set of measurement criteria, and the administrative work involved with collecting the data necessary to meet the varied requirements are increasingly burdensome and overwhelming. Few providers are willing to invest in electronic medical records in part because of the expense involved but mostly because there are no assurances that IT systems would be interoperable and that the investments will pay off financially.

The federal government intervenes by developing standards for an IT infrastructure that would allow health professionals to share data electronically. The initiative receives positive public reaction but has mixed results within the healthcare community, due in part to provider concerns about lack of funding and mandates. Little progress is made in developing standards for performance measurement.

Recognizing that interoperability could be possible by 2020, a consortium of the health care community – health care professionals, hospitals, insurers, educators, regulatory bodies, peer review organizations, and professional associations – meet and agree to collaborate to develop national standards for measuring practitioner performance. After many months of dialogue, the group releases standards for performance measurement that are applicable across professions. The standards are predicated on development of a central data repository containing millions of cases that would facilitate a number of improvements in quality. It is proposed that the database be controlled by the consortium; however, public concerns about transparency and public accountability prompt significant debate about this recommendation. The provider community prevails but only after agreeing to report to a federally appointed public oversight agency.

2010-2015: Healthcare costs continue to increase, and physician and nursing workforce shortages coupled with an aging population continue to negatively impact public access to care. Demand for more affordable healthcare choices spurs insurers to begin reimbursing non-traditional healthcare services, such as telehealth services or services provided by non-physicians or alternative medicine providers. Businesses and insurers begin to outsource healthcare services to countries like India, which offers state of the art facilities and US trained health professionals at a fraction of the cost in the US. Use of telehealth services increases, with many of the telehealth providers located outside the US.

Budget deficits, the rising costs of health care and the aging of America take their toll on Medicare, as the system appears to be headed for insolvency. State-based Medicaid programs also face crippling budget cuts. The percentage of Americans who are uninsured increases annually. Bowing to public pressure, Congress introduces legislation that would create a national healthcare system; the public is generally supportive of the bill but businesses and special interest groups prevail and the initiative is narrowly defeated.

Meanwhile, acceptance of the consortium's performance measurement standards slowly gains ground, particularly among multi-state payers and healthcare systems. These progressive healthcare systems are using the standards to measure the performance of healthcare teams

rather than individual practitioners. Use of EMRs is also slowly increasing, although an effort by the federal government to mandate their use is blocked by the provider community in part due to the mandate being unfunded. However, the Center for Medicare and Medicaid implements such requirements of its participants.

2015-2020:

CMS' mandated use of EMRs, coupled with the influx of newly educated, techno-savvy healthcare professionals, and reduced costs in hardware and software, results in exponential growth in the use of EMRs. Providers are capturing performance data using EMRs and transmitting the data to the central repository. The data are used by the healthcare community and the government to develop standards of care, disease management profiles and to perform outcome analysis. Trend analysis across graduate and undergraduate education for physicians, nurses and allied health personnel are available to the government and the public. Assessment tools are developed to evaluate the performance of the healthcare system. All data are available to the public for use in selecting providers.

By 2020, patients are using health smart cards that contain their medical history and which can be updated from their providers' health networks via the internet. Patient care is managed using evidence-based protocols, and EMRs are used at the point of care. Significant advances in patient safety are gaining ground, as hospitals and healthcare institutions employ technology such as optic scanning to confirm patient identity or electronic prescription and order entry systems that are integrated with EMRs.

Medical advances resulting from genomics and nanotechnology are less costly and are increasingly available to all patients, not just to the affluent. Healthcare providers use computers to help identify possible diagnoses and suggested methods of treatment based on patient data entered. Patients have immediate access to their own individual health information as well as provider performance. Pay for performance is the norm.

Scenario 2: Data Cacophony 2020

2005-2010

It is 2005, and the medical delivery system is under tremendous pressure to improve the quality and safety of care being provided to the American public. Costs are skyrocketing, there has been little improvement in the rate of medical errors occurring, and both patients and practitioners are becoming increasingly frustrated and disillusioned.

Information technologies such as electronic health records (EHRs) are cited as offering opportunities both to significantly reduce costs and improve quality. However, providers are reluctant to implement EHRs because they are expensive and no standards are in place to ensure interoperability across systems. Provider groups, licensing boards, the health professions, federal and state governments, and the payer community can not agree on either basic IT standards or data sets necessary to develop such standards.

Growing budget deficits, fueled in part by escalating healthcare costs, force states and the federal government to cut back in funding for social programs. Although the government is encouraging the use of EHRs, neither private insurers nor federal or state governments have the funds to significantly support investment in them. With no indications that interoperability will be a reality any time soon, EHR use declines and in fact falls well short of predictions.

2010-2015: Insurers and employers attempt to deal with cost increases by shifting the burden to patients. Incentives aimed at encouraging patients to take more responsibility for their health are implemented. Patients become better educated about the “real” costs of healthcare and the limited value received for dollars spent. More and more patients opt for health savings accounts, and public interest in personal health records spikes.

Put in the position of having to “value shop”, patients ask for performance data on healthcare providers but the lack of uniformity in standards for quality comparisons make access to meaningful information impossible. Frustrated at having to pay high prices for care they perceive as unsatisfactory, patients increasingly turn to non-physician providers who provide healthcare services for less money. They also turn to the internet, where health care entrepreneurs are offering low cost medical care via the internet. They also increasingly turn to the international community for healthcare services, which offer state of the art facilities and US trained doctors at a fraction of the costs for similar services in the US. Entrepreneurs find ways to capitalize on the public’s search for more accessible healthcare by using the internet as a means of providing services. There is little control over the quality of care being provided to patients.

An increasingly competitive market, coupled with a frustrated public and little agreement on what constitutes quality medicine, results in an erosion of trust between patients and their providers. Legislators respond by implementing more regulatory interventions, resulting in even more punitive and complex accreditation and licensure processes.

2015-2020: As the public becomes more value-conscious, it increasingly recognizes the importance of early intervention. Research into genomics and nanotechnology begin paying off with the development of new diagnostics and therapies that allow patients to anticipate what diseases they are susceptible to. Patients begin to see reductions in health expenses in exchange for improved health practices. However, these incentives, while intended to give patients greater personal control over their risks, in fact increases the divide between the

wealthy and low-income, since the latter group lacks education, access to technology, and the money to take advantage of new diagnostics and therapies. In addition, patients experience decreased access to care resulting from a growing shortage of health professionals coupled with the changing healthcare needs of the US population brought on by the “graying of America.”

Healthcare organizations are collecting performance data on their network providers but the environment is so unfriendly that no one is willing to collaborate on establishing national standards, making it impossible to conduct meaningful research regarding the validity of performance measurement schemes. Attempts by various providers to make data available for quality improvement purposes are frustrated by privacy concerns and the legal profession’s demand that any data be fully discoverable for the purposes of litigation. In several areas of the nation, instances of manipulation of data to increase market share begin to surface. In many of these instances, this manipulation of data actually was responsible for worsening rather than improving care.

This toxic state leaves a serious trust vacuum between patients and the entire healthcare community over the quality of American healthcare. By 2020, multiple data sets, many conflicting, are required at each patient encounter. Numerous entities including CMS, specialty boards, state licensing boards, and payers have so many different standards that there is no way to validate even the basic definition of quality of care or physician competence.

As a result, quality improvement stagnates, costs continue to rise; the profession remains fragmented and continues to lose the trust of the public.

Scenario 3: The Federal Tarbaby

2005-2009: Elected leadership at both the state and federal level feel increased public pressure to deal with a number of domestic crises, including sky-rocketing healthcare costs and increasing numbers of individuals who are uninsured, continued threats of terrorism, continued loss of jobs to international markets, and a faltering economy.

Seeking ways to reduce spending on healthcare, the government develops a blueprint for how patient data systems could be structured and connected to allow for improved data sharing. Negotiations with provider communities around their concerns regarding funding and privacy take place in an attempt to gain buy-in to the government's patient data blueprint. The parties reach agreement on trade-offs, the most important being if the providers agree to voluntarily participate in a reporting system the government will make changes to the system to reduce inefficiencies.

An epidemic of medical errors prompts an immediate and harsh public call for greater patient safety. The federal government steps in to establish a system of total reporting with the analysis of data being made available by the government to the public via the internet. As part of this process, Congress passes legislation that abolishes the current tort system and replaces it with a no-fault system similar to Australia's.

Bolstered by public calls for greater patient safety, the federal government mandates the use of electronic records to improve disease management and reduce medical errors. Providers struggle to find the dollars necessary to install such systems and integrate them into their practices.

Concurrently, the amount of dollars spent on alternative medicine by US citizens continues to increase, fueling opinions that the public sees no value in the existing delivery system. Taking advantage of this, payers (both government and private) offer incentives to patients that encourage disease prevention. Providers lobby payers to change the reimbursement system to reward disease prevention.

By 2009 a tremendous amount of provider performance data has been reported to a national database and there is a push to mandate use of practice guidelines nationally.

2010-2015: The economy goes into a tailspin. Corporate America pushes the burden of health care costs to employees, resulting in an increasing number of uninsured Americans. A call for universal coverage generates the political will to develop it. The difference this time around is that the government already has the data it needs. A multi-stakeholder committee is formed in which the public, the government and the profession collaborate to develop a plan for universal healthcare coverage. Many aspects of the current system would be nationalized, including oversight of accreditation and licensure.

The coalition is fragile, dependent upon each party trusting the other. However, it holds together and produces a plan that all stakeholders can support. The plan calls for the creation of a national office of secretary of health to oversee the elements of the new federal health plan. A "Medicare for all" system emerges that guarantees minimum coverage for all Americans, but the option to purchase private insurance in the open market is also retained. The system encourages preventative health, relies on the national standards developed through years of data collection to drive disease management, and depends heavily on non-physician providers

to triage primary care needs of patients. The role of physicians changes from independent practitioner to team leader.

This new model for reimbursing care results in the forging of new alliances within the healthcare community, and a coalition of medical organizations representing all the health professions is formed.

By 2020, regional integrated delivery systems are responsible for monitoring the competency of practitioners and providing standards by which teams of health professionals are evaluated. These systems employ virtually all the health professions and use information systems to manage performance and monitor competence.

Care is less expensive and more readily available for everyone, but only those who can afford the private health insurance are ultimately assured of receiving high quality care.

Scenario 4: Brave New World: Healthcare in the year 2020

Bill Smith logs on to mydoc.com, types in his symptoms and is immediately directed to a nurse practitioner who is on-call in India. Comparing Mr. Smith's symptoms against a set of clinical guidelines recently released by the International Alliance of Certified Internet Practitioners, the nurse directs Mr. Smith to go to the Health Depot two blocks from his house for some diagnostic work. There are Health Depots on every corner, much like convenience stores. Mr. Smith arrives at the Health Depot, approaches a self-serve health kiosk, inserts his personal health record security card, enters his biographical data and is assigned a processing number. He puts his finger into an opening on the kiosk and has blood drawn for a blood test, then walks to the next room, enters his processing number in an automated x-ray machine and gets a chest x-ray.

Before he leaves, he directs the Health Depot automated teller to transmit the results of his tests to the nurse practitioner in India. Within an hour the nurse in India has reviewed the results and, based on Bill's expressed symptoms, he recommends Bill see his local physician. He sets up an appointment with Bill's physician, then before moving onto the next patient inquiry, transmits the results of the tests and a summary of his interaction with Mr. Smith to Bill's physician.

When Mr. Smith arrives at his local physician's office, he gives his personal health record to the physician's nurse, who inserts the card into the office's electronic health record system to update Bill's office record. His physician has already reviewed the data sent to her by the physician in India. Bill's physician tells him that the data, blood test, chest x-ray, etc shows that Bill has a cancer and is a candidate for a new treatment using nanotechnology. The physician pulls up a website that lists the different Centers of Excellence around the world where Bill can go for his surgery. Each profile on the list includes performance data for the specific cancer that Bill has. Bill picks a center, and his doctor makes the arrangements for Bill.

Two days before Bill is to be admitted to the Center for surgery, he pulls up the hospital's website and prints off his pre-authorization and admission verification forms. Upon arriving at the hospital, he inserts his personal health record into the registration kiosk, enters his pre-authorization number, and completes check-in. He is then shown to his room, and within two hours has had a conference with the treatment team that will be handling his case. His surgery takes place the next day, and he is discharged from the hospital the following morning.

Two days after returning home, Bill is contacted via email by the hospital asking him to complete a patient satisfaction survey. The survey asks questions about his overall experience with the Center, including the interaction with and care provided by his treatment team. His responses are incorporated into a report that is reviewed weekly by the Center's multi-disciplinary Quality Improvement Team, which makes recommendations for improving care and provides data for posting to the Center's website.

Two weeks later Bill meets with his primary care physician, surgical team and insurance provider via web conference to check on Bill's progress and to map out next steps in his treatment.

Scenario 5: Happyhealthcare.com

In an effort to bring spiraling healthcare costs into control, employers and insurers begin using health savings accounts as a means of shifting healthcare costs to patients and encouraging patients to be more responsible for both their health as well as for dollars they spend on healthcare. As patients become more comfortable with the increased responsibility, they begin demanding better resources – like personal health records and better provider comparison data – for use in making decisions about their healthcare needs. Portable health insurance becomes the norm, and patients that were once completely oblivious to the cost of healthcare become very shrewd shoppers for value-driven care.

Faced with such dramatic shifts in how healthcare dollars and decisions were being managed, providers respond by collaborating to redesign the delivery system using continuous quality improvement as the foundation for change. This collaboration is aided when the federal government publishes national standards for information technology as a means of facilitating better data collection and sharing.

Federally funded regional partnerships between providers, patients and employers are formed to develop and manage performance data collection for use in accreditation, credentialing, licensure and public education. Performance standards are developed and implemented at a regional level and monitored nationally by the federal government for significant variances across pre-determined public health indicators. Reports are used by the regional collaborations to make improvements to care.

Healthcare remains a market-driven industry, with both traditional and non-traditional providers competing for patients' healthcare dollars. While this model benefits the majority of Americans, it also results in a greater divide between the haves and have-nots.

As patients become more knowledgeable consumers of healthcare, they increasingly demand more public investment in health prevention, disease management, and stronger incentives for research and development to meet public health goals. A whole industry of watch-dogs, product testing and consumer reporting companies develop to support patients in their new role as healthcare decision makers and payers.

Teaching institutions benefit from the reformed delivery system because they can track and measure their students more efficiently across the continuum of practice. Public calls for more and better applied research are possible because of the available performance data, and providers benefit from more customized lifelong learning offerings.

Licensing boards begin holding practitioners accountable for outcomes in patient care, rather than for meeting minimum standards. With the help of the provider community, practitioners whose patient outcomes are in question are identified early and receive appropriate intervention and remediation; liability insurance providers agree to cover this practice because it reduces the risk of malpractice suits. The public is not initially supportive of this shift, fearing it is an attempt by providers to "protect their own" in the face of change, but through education, research and most importantly, improved patient care, public trust increases.

There is a level of provider attrition because some practitioners don't measure up to agreed-upon performance standards. However, the emphasis on continuous quality improvement and collaboration between the health professions facilitates systems-based practice and team-based

care, so that attrition is manageable. Because of the reliability of the data, there is also better risk management.

Initially, these changes prompt a push-back from the health professions – and in particular the physician community. Many long-time practitioners, perceiving a loss of control and autonomy, resent the philosophical premises upon which continuous quality improvement and consumer driven care are predicated. In particular, the notion of being compared against one's peers is perceived as very threatening. These perceptions, while not enough to prevent the revolution from occurring, does hamper progress.