MANAGED CARE: PROVIDER PROFILING

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The Physician Payment Review Commission has examined the potential of profiling physician practice patterns within the context of cost containment and quality assurance. Profiling has the capacity to provide information about service use, quality of care, and costs. It uses epidemiological methods to document practice patterns and to compare the practice patterns of different providers. Profiling can be used to characterize the
practice of an individual practitioner, a group of practitioners, a health care organization (e.g., hospital, HMO) or all the practitioners and institutions in a community. The practitioner/provider profile is expressed as a rate: some measure of service utilization, outcome, or costs aggregated over time for a defined population of patients under the provider’s care.

The norm used to compare the profile of a practitioner or other provider (e.g., hospital) may be either practice-based (a rate derived from practice patterns of similar providers) or standards-based (e.g., practice guidelines). When standards-based norms are available for comparative purposes, they are generally preferable to practice-based norms because the latter may not necessarily reflect appropriate cost-effective care.

It is important when using profiles for comparative purposes to be sure that the functions of the practitioners are similar. For example, it is not particularly useful to compare a consultant cardiologist with a family practitioner in terms of their use of cardiovascular diagnostic procedures. In some cases, the specialty of the physician can serve as a proxy for the mix of patients and their problems cared for by a particular physician.

Profiles should be designed to generate some type of action that can improve the quality of care or moderate cost increases without compromising quality of care. Three characteristics of profiles make them particularly useful in conveying information about medical practice that can be applied to achieve these goals: (1) profiles described patterns of practice rather than individual episodes of care; (2) profiles will be non-intrusive when the information can be obtained from claims data, hospital discharge data, or other administrative records; and (3) profiles can be used to compare a practice to a norm, thus enabling actions to be considered when profiles deviate from the norm.

The Physician Payment Review Commission has been particularly interested in the application of profiling in three areas: quality improvement, assessment of physician performance, and utilization review.

Quality Improvement: Profiling can play an important role in quality improvement, including the identification of problem areas where there are large variations in outcomes (e.g., mortality, functional status) for particular procedures (e.g., coronary artery bypass graft surgery) and the identification of aspects of the process of care that could be changed to improve outcomes. In some cases, detailed studies of the process of care will be needed to assist practitioners in determining how the profiling information can be used most appropriately for feedback and discussion to understand the reasons for the deficiencies and to improve performance.

Assessment of Physician Performance: An important application of profiling will be in the identification of practitioners, organizations, or communities that do not meet accepted standards of care. In some cases, deviation from the norms may be appropriate, but this would require more detailed investigation. Profiling can be used to evaluate both overuse and underuse of appropriate services.

Utilization Review: Profiling is already being used widely in utilization review. Profiling can focus on outliers and on improving median performance. In the case of outliers the profile identifies those physicians who deviate substantially from the norm. The initial approach to modifying the behavior of outliers is through feedback to the physician and case-by-case review. Although this use of profiling is more efficient and less intrusive than case-by-case review alone, it does not affect the practice of most physicians and thus can have little effect on care overall.

More promising than detecting outliers is the potential for profiling to improve the performance of the average physician. The effective application of profiling for this purpose requires the availability of practice guidelines that can be used for the norm for comparative purposes. When standards-based norms and practice guidelines are not available, it may be possible to bring together the physicians in a hospital or a community to review profiling results and to make judgments about what they believe to be appropriate practice in their community.

Sound profiling depends on the availability of data that is appropriate for that purpose. While the availability of large claims databases and advances in the technology with which to evaluate them have led to rapid increases in the use of profiling, these are not adequate. The Physician Payment Review Commission believes that profiling would be improved if databases were available that provided: (1) information to identify similar providers or to account for important differences across providers, such as differences in patient case mix; (2) adequate numbers of observations; and (3) clinically meaningful indicators of the process or outcomes of care and its costs. In addition, utilization and outcome rates that reflect appropriate cost-effective care are needed. The database needs to be constructed to provide physician and institutions with information that they can act on individually and collectively to improve the process and outcomes of care.
Perhaps the most critical step that is needed to make profiling broadly useful is the development of data that can be used to characterize—accurately and reliably—relevant aspects of both the provider and the patient. To make comparisons most useful, profiles must be able to compare the practice patterns of similar types of providers who care for similar patient populations. Data are needed to identify physician specialty and the relevant patient characteristics, such as diagnosis or condition, including severity. The data also needs to distinguish the referring physician from the physician who provides the care. Medicare claims files currently include this information, but the codes used to describe physician specialty and patient condition/diagnosis are not used or interpreted uniformly. Administrative databases of many private payers frequently do not include this essential information. It would not be difficult to make the changes needed to permit claims data to be used much more effectively for profiling.

While relatively simple changes can facilitate the use of profiling for utilization review, this may not be the case where more sophisticated comparability adjustments are required. Comparison of morbidity and mortality rates following particular procedures are more difficult because a variety of patient variables—some known and some unknown—may affect outcomes. The development of new computerized databases of clinical care may make such information easier to collect and analyze.

In order to get information on the frequency of services provided by a particular practitioner, it is necessary to develop comprehensive databases covering all patients for whom a physician provides care. This could be achieved by a single payer system as in Canadian provinces or by linking data sets across payers, particularly if they were required to collect comparable data. For some procedures, it will be necessary to gather data from groups of physicians (e.g. hospital staff, community) rather than profiling rates of individual physicians.

To profile physicians in terms of the quality of care provided will require data on clinically meaningful aspects of the process and outcomes of care. In this case, the choice of indicators is critical if the profiles are to serve their intended purpose. Unfortunately, relevant process and outcome indicators are seldom accurately and reliably recorded in available databases. In many cases, claims data do not contain information about many relevant aspects of the process of care (e.g. medication, preventive services) that are not included within the scope of a benefit package. In addition, post-operative visits may not be included because they are part of a global payment for surgical services. Many of the most meaningful patient outcome measures, such as functional status or patient satisfaction, are not included. While medical records should be an excellent source of relevant information, their usefulness is often limited by problems with completeness, accuracy, and retrievability.

The commission believes that condition-specific encounter forms may be a useful means to obtain accurate, reliable, and relevant information about the process of care. Such forms could be developed to monitor compliance with essential components of the process of care included in specific practice guidelines.

The commission also believes that cost-effectiveness must be an essential component in comparing the performance of one practitioner or institution with another. The comparative rates can be obtained in the future by comparing profiles of physicians who care for patients with particular conditions using practice guidelines that reflect appropriate, cost-effective care. Unlike the Agency for Health Care Policy and Research, the entity designated by Congress to facilitate the development of practice guidelines, the commission believes that these should deal with both the appropriateness of care and its cost-effectiveness.

The use of profiling for its most constructive purpose—to improve the quality and cost-effectiveness of medical care—requires the linkage of practice guidelines with profiling and the development of an infrastructure at the local level to support and utilize these methods. It is evident that just the publication of practice guidelines has little impact on medical practice. By contrast, feedback of profiling results to physicians has been shown to improve their performance. The commission believes that the profiling organization should also function as a convener, bringing physicians together to interact as a group in interpreting profiling results and designing a course of action to improve the quality of care. This process can increase the credibility of the effort among physicians and can help stimulate them to change their practices.

In conclusion, profiling can be an important tool to improve the quality and cost-effectiveness of care, particularly when combined with practice guidelines by practitioners to review and improve the patterns of practice. The alternative to this kind of self management and regulation by physicians is the expansion of existing external controls, which is likely to be more costly and less effective in the long term.