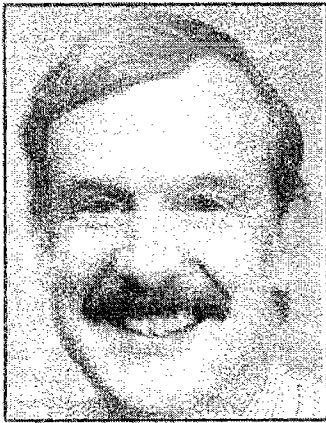


**Eric Holmboe, M.D.**

# Internal Medicine Board Adds Practice Improvement Modules



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**PND: What is the Comprehensive Care Practice Improvement Module (PIM)?**

**EH:** The practice improvement module is a web-based tool that helps physicians to assess their performance in practice. There are a variety of PIMs, each of which is condition-specific for things like diabetes, asthma, hypertension and the like, and there are three main data components

to a PIM. The first is a medical record audit that the physician or a member of the physician's staff completes on 10 to 25 patients, depending on the module, which goes through guideline- and evidence-based quality measures for that particular condition. For example, in diabetes it would ask what the patient's most recent hemoglobin A1c was, what their blood pressure is, what's their cholesterol level and LDL, did they get a foot exam, eye exam, etc. Another piece of the PIM is a patient survey, using either the Web or paper. The third portion is a practice system survey to assess how work processes are configured in the physician's office, what sort of information systems they have, how they activate patients to care for their chronic illness. Once all three of those data components are completed, they are analyzed here at the board and a report is returned

*Continued on page 12*

# Practice Improvement Modules

Continued from page 1

to the physician via the Web on how they did with regard to their chart audit, the patient survey results, and what they reported for their system survey. The physician then reviews those results and picks two to five areas that they would like to work on for their quality improvement activity, and they give us an idea when they would like to remeasure. We encourage them to do something along the lines of a Plan, Do, Study, Act (PDSA) Cycle, and we have them report back to us how things went by using an impact statement.

**PND: How does this PIM program differ from the American Board of Internal Medicine's maintenance of certification (MOC) program?**

**EH:** These practice improvement modules modify and enhance the MOC program. It's actually a big change because, prior to January 1<sup>st</sup> of 2006, there wasn't a requirement to do any sort of evaluation of your practice performance. You could complete five knowledge modules, take the exam and become recertified. The PIMs that were available previously were voluntary. Even introducing the PIMs, which is about six or seven years ago now, was also a major shift for the board. Up until that time the board had never gotten involved with practice assessment activities; everything had been knowledge-based. The overall participation rate for both generalists and specialists is around 87 percent, or around 8,000 physicians a year.

**PND: What specialties and subspecialties may apply?**

**EH:** Basically, it's open to all internists. Obviously, not all PIMs apply to each specialty. For example, diabetes would work well for endocrinologists and anybody who provides primary care. Hypertension would work for general internists and nephrologists. We do have some subspecialty PIMs, for example one for gastroenterologists that looks at the quality of procedural care in colonoscopy. We have two that relate to infections – HIV and Hepatitis C – so infectious disease specialists can do either of those and gastroenterologists who do liver disease could do the Hepatitis C module. There are now about 10 to 11 chronic disease, disease-specific or pre-

vention-specific modules. We also have several surveys that look specifically at patient experience based on the Consumer Assessment of Health Plan survey (CAHPS) developed by the Agency for Healthcare Research and Quality (AHRQ). Work has been done in the last year and a half adapting that survey for use at the physician level: there's a module for primary care physicians, one for specialists, and we are launching a new module that looks at the quality of peer-to-peer interaction and communication, which is a very good one for any subspecialist who does consultative-type practice.

**PND: How much does it cost a physician to participate?**

**EH:** The cost to the physician is a single \$1145 fee to enroll in the entire maintenance of certification program, which includes access to self evaluation program modules that are designed to help you keep up with medical knowledge. Another aspect included in the fee is the secure exam, which you have to pass once every 10 years. Lastly is the evaluation of performance and practice, which these PIMs are a part of, and which you also have to do at least once in a 10-year period. You can use as many of the modules and products as you wish during that 10-year period, while the knowledge modules and the PIMs also come with CME credit – the PIMs are 20 hours of CME credit.

**PND: What data systems are required by physicians to participate?**

**EH:** We used to use a CD-based product, but now everything is Web-based. So as long as you can get to our server through Internet access, you can do the module. Physicians get a report back that gives the summary statistics for all the patient charts that they entered in through the Web.

**PND: How is physician data validated?**

**EH:** We hold the right to selectively audit. We have sent medical record abstractors in to do a parallel independent audit and found the data is actually quite accurate. For the purposes of recertification, if you complete the entire module and implement a quality improvement plan, you get credit; there isn't a pass/fail standard right now. For pay-for-performance, obviously, you have to meet a threshold. For the NCQA program, they actually do the office audit if they feel there's any ques-

tion about the validity of the data. Their work has also found that physician reports are actually reliable and valid. They have not found a problem with people trying to cheat or game the system.

**PND: What guidance is there for physicians to design quality improvement programs in response to what they learn from the PIM?**

**EH:** There are educational links within these modules, various medical society improvement tools to help them, but as far as hands-on, that's probably one thing the PIMs probably don't do well. We try to encourage them to link up with their local medical society, quality improvement organizations, etc. to help them hands-on if they're really struggling. We do have a helpline here at the board if they call and have a question about their PIM.

**PND: How frequently would a practice participate in this module?**

**EH:** At the current time, the requirement is just once in 10 years for recertification. However, they have to get a total of 100 points over the ten-year period. Twenty points has to come from a practice improvement-type process and 20 points has to be medical knowledge. That leaves 60 points to be flexible however people want to do it. You could do a second practice improvement module to meet the remainder of your requirement, and we do see physicians doing that. We've also had interest from other entities such as health plans who would like to facilitate physician use of these PIMs on a more regular basis and give them some form of credit. Although nothing has been formalized yet, there have been several discussions about how that might be done.

**PND: Can physicians receive the pay-for-performance bonuses for their participation in PIMs?**

**EH:** That would depend on the pay-for-performance programs. We have worked hard to interface with organizations to make these products meet their standards and to help facilitate data transfer for the physician. Bridges to Excellence approached us about whether or not our practice improvement module might be a useful vehicle for their kind of program. Bridges to Excellence is a program of the Leapfrog Group, which is a coalition of employers trying to promote quality in

markets where they have large employer presence. Because PIMs use medical record data, they felt that was stronger than using just claims-based data because a medical record allows you to get at aspects of care that you can't capture using just claims. We currently have one program under way; if physicians who do our diabetes practice improvement module are in a market that has pay-for-performance in the Bridges to Excellence Program, our board can transfer their data to the National Committee for Quality Assurance for recognition in that program if they meet their criteria. I believe this program is currently being piloted in Massachusetts and the Capital region of New York. We are developing another PIM product, currently called comprehensive care, that is attempting to look across more than one condition within a practice and will be pilot tested this summer. If it meets the reliability and feasibility requirements of Bridges to Excellence, we hope that some time next fall it would also be available for physicians to use in the program. A number of health plans have also been interested in partnering with Bridges to Excellence. We also have been approached by several health plans about using PIMs for incentive programs, for example, giving physician participants a "gold star" or higher designation within their program. Blue Cross Blue Shield Nebraska is rolling out a program in which a physician can receive a \$100 payment for completing the PIM on a yearly basis.

**PND: How would this PIM approach help Pennsylvania physicians get paid extra for their performance?**

**EH:** We've had discussions with the national Blue Cross Blue Shield Association, and with UnitedHealth Group about potentially working with the PIMs. Those discussions are ongoing, and there's nothing definitive at this time. Remember, we do not run pay-for-performance programs at the board, and we don't determine payment or set the criteria. The board's main function is to set professional standards for a number of competencies. We provide the kind of science to help entities define what they want to do with their pay-for-performance programs, and we've got a nice vehicle that physicians can use to participate in them. One of the reasons we got involved in the pay-for-performance area was to help reduce redundancy for physicians who are collecting this data as part of their maintenance of certification.

**PND: What sort of participation and feedback have you gotten about the PIM?**

**EH:** The majority of people who have done these PIMs have found them to be quite helpful in bringing about change in their practice. Part of the challenge is that physicians now are inundated with quality improvement and pay-for-performance programs, and yet they were never in their training programs taught those skills. The PIM is a good technology to get started in quality improvement. In a diabetes study we did in Connecticut about a year and a half ago, physicians really found the chart audit and patient survey valuable, which surprised us a bit, given some of the past history of patient surveys. A lot of physicians use that information, particularly around education and communication with patients, as part of their quality improvement plan. We've also looked at the first 150 users of our preventive cardiology PIM and 75 to 80 percent of them have found it to be a valuable experience. They've actually instituted changes in their practice that have helped them to deliver better care. }