

Philadelphia Medicine



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AMA principles and guidelines for pay-for-performance programs

The AMA document provides five overriding principles with which fair and ethical PFP programs should be in alignment. The guidelines document identifies specific PFP structures and practices which can be used to assess the quality of individual PFP programs.

These two documents were prepared by the Board/Council Task Force on Pay-for-Performance that included a member from each AMA Council (except the Council on Constitution and Bylaws) and five Board of Trustees members. The Task Force was Chaired by John H. Armstrong, MD. The Task Force submitted its recommendations to the Board of Trustees which approved both documents.

For further information or questions about these two documents, please contact Steve Ellwing at 312-464-4367.

Principles for Pay-for-Performance Programs

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our healthcare system. Fair and ethical PFP programs are patient-centered and link evidence-

based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

1. Ensure quality of care: Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.
2. Foster the patient/physician relationship: Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
3. Offer voluntary physician participation: Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the eco-

Please see AMA principles on page 3

Former Philadelphia Health Commissioner Dr. Walter Tsou elected president of American Public Health Association

Practicing physicians should become involved in such public health issues as seatbelt use and gun control, says Dr. Walter Tsou, president of APHA and PCMS member. Trouble is, he acknowledges, while doctors go into medicine for the right reason—i.e. to help people through science—they're mostly short of time and energy by the end of a day of practice. Dr Tsou, an enthusiast of a universal healthcare delivery system, believes that such a system would deal with the issue of the uninsured and would also reduce the amount of litigation in healthcare. Dr. Tsou's editorial on the major issues confronting public health appears on page 2 of this issue of *Philadelphia Medicine*—DW

PCMS News

Volunteers Needed—NBC 10 Fit Fest

The Philadelphia County Medical Society will again sponsor the "Ask the Doctor" booth at the NBC 10 Fit Fest event, and we would like you to help us by volunteering one hour of your time, or as much time as you can give us.

Physicians will meet with the public and discuss health matters in general. We are asking physicians, residents and medical students to help man the booth on Saturday, April 9, from 10:00 AM to 5:00 PM, and on Sunday, April 10, from 10:00 AM to 4:00 PM.

The Fit Fest is free to the public and designed to capture the attention of tens of thousands of health-conscious consumers and offers dancing, cycling, aerobics, health screenings, jazzercise, rock climbing and much more! We expect more than 50,000 people from the Philadelphia area. To volunteer, call: 215- 563-5343 Ext. 113.

Docs On Call

Watch our volunteer physician members "live" on Thursday April 7, 2005, on Channel 10, NBC as we participate in our second live community call-in program.

NBC 10 is once again sponsoring our award-winning program in which the consumer phones in to speak with our physician volunteers. We thank those physicians that have volunteered for this event. Many of our members will be interviewed live that night, and the special event will be broadcast during and after the early evening news starting at 4:00 PM.

Many classified advertisements are placed on the PCMS Website. These may help you in your practice of medicine.

We encourage you to visit www.philamedsoc.org and click on "Classified Ads."

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Guest Editorial

Public health priorities: access, universality, disparities

By Walter Tsou, MD



When most of us attended medical school, public health was a vague ethereal subject—not really medicine and not really understood. Issues on society and medicine, healthcare for the poor, or the role of health departments seemed remote and inconsequential.

Today, it is impossible to practice medicine without being acutely aware of the social and political context in which healthcare is financed and delivered. Virtually everything we do in healthcare is dependent on the conditions, rules and regulations that govern practice.

And all of these factors create the foundation upon which we build our healthcare system—in short, our public health infrastructure. The American Public Health Association has three major priorities: public health infrastructure, access to care and eliminating health disparities. Let's consider each of them.

What is this public health infrastructure? I define it as the workforce, buildings, equipment, laboratory, surveillance systems and organizational structure needed to protect the public and promote health. Within this we should recognize that physicians are only part of the public health infrastructure, albeit a very important part. But we do not practice in a vacuum and valuing every part of this infrastructure is paramount.

Access to care should be an issue that organized medicine devotes its full resources and weight behind. While we talk about how high malpractice premiums are driving doctors out of practice and worsening access to care, our remedy is to cap noneconomic damages.

Interestingly, if we devoted our full efforts on creating a universal healthcare system through something like national health insurance, all future

healthcare costs would be removed from malpractice suits, saving billions in jury settlements. Canadian physicians, for example, pay anywhere from one-half to one-tenth of what we pay for malpractice insurance and are not sued for future healthcare costs, saving millions in premiums. The real solution to the malpractice crisis in America is universal healthcare for all Americans.

That our healthcare non-system treats people with such wide disparity should disturb every physician. We ration by ability to pay, and minorities

Doctors are burned out and too many would not recommend our noble profession to our children. It is time to change this. Maybe, just maybe, with a little more public health in how we practice.

and the uninsured disproportionately get worse care. Between 2000-2002 in Philadelphia, the average black infant mortality rate was 14.3 deaths/1000 live births versus 6.8 for white babies. Why should a black baby's chance of living to his/her first birthday be less than half of a white baby in a city with the medical resources of Philadelphia?

The public admires the medical profession, but they don't love us. Too often we are seen as insular and not interested in broader social issues. And we don't love ourselves either. Doctors are burned out and too many would not recommend our noble profession to our children. It is time to change this. Maybe, just maybe, with a little more public health in how we practice.

Dr. Tsou is president of the American Public Health Association.

www.philamedsoc.org

Safety for older drivers is a public health issue

Motor vehicle injuries are the leading cause of injury-related deaths among 65- to 74-year olds and are the second leading cause (after falls) among 75- to 84-year olds. Compared with other drivers, older drivers have a higher fatality rate per mile driven than any other age group except drivers under the age of 25.

On the basis of estimated annual travel, the fatality rate for drivers 85 and older is nine times higher than the rate for drivers 25 to 69 years old.

There are two reasons for this excess in fatalities. First, drivers 75 years and older are involved in significantly more motor vehicle crashes per mile driven than middle-aged drivers. Second, older drivers are considerably more fragile.

Fragility begins to increase at ages 60 to 64 and increases steadily with advancing age. By age 80, male and female drivers are 4 and 3.1 times more likely, respectively, than 20-year olds to die as a result of a motor vehicle crash.

In the year 2000, 37,409 Americans died in motor vehicle crashes. Of this number, 6,643 were people aged 65 years and older. This population represented 13% of the total US population but accounted for 18% of all traffic fatalities.

As the older population in this country continues to grow, drivers alone aged 65 and older are expected to account for 16% of all crashes and 25%

of all fatal crashes.

Fact: Although many older drivers self-regulate their driving behavior, this is not enough to keep crash rates down.

Fact: The majority of older Americans rely on driving for transportation.

Fact: The crash rate for older drivers is related to physical and mental changes associated with aging.

Fact: Physicians can influence their patients decision to modify or retire from driving. They can also help their patients maintain safe driving skills.

Although most older drivers believe that they should be the ones to make the final decision about driving, they also agree that their physician should advise them.

In a series of focus groups conducted with older adults who had retired from driving within the last five years, all agreed that the physician should talk to older adults about driving if there was a need.

As one panelist stated, when the doctor says you cant drive anymore, that's definite. But when you decide for yourself, there might be questions. While family advice alone had limited influence on the participants, most agreed that if their physician advised them to stop and their family concurred, then they would certainly stop.

Physicians help their older patients maintain safe mobility in two ways. By

providing effective treatment and preventive health care, physicians enable their patients to preserve their functional abilities later in life, prolonging their driving years. Also, better baseline health protects against serious injuries and speeds the recovery process in the event of a crash.

In addition, physicians can play a more active role in preventing motor vehicle crashes by assessing their patients for medical fitness to drive and recommending safe driving behaviors, driver rehabilitation, or driving limitations as needed.

In many cases, physicians can help their patients stay on the road longer by identifying and managing medical obstacles to safe driving, such as vision problems or arthritis.

There is a crucial need for this latter intervention. To date, there has been little organized effort in the medical community to help older adults improve or maintain their driving skills.

Research and clinical reviews on the assessment of older drivers have traditionally focused on screening methods to identify unsafe drivers and restrict older drivers.

Physicians are in a position to identify patients at increased risk for unsafe driving or self-imposed driving cessation due to functional impairments, and treat underlying medical causes to help their patients drive safely as long as possible.

The above is an extract from the web site of the National Highway Traffic Safety Administration. You may read the entire article at www.nhtsa.gov.

AMA principles from page 1

- conomic viability of nonparticipating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers.
4. Use accurate data and fair reporting: Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.
 5. Provide fair and equitable program

incentives: Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

Guidelines for pay-for-performance programs can be found on the PCMS website: www.philamedsoc.org.

Place your ad in the PCMS website

The PCMS website accepts typical classified ads. We also advertise upcoming events, such as CME programs and seminars.

Call 215-563-5343, ext. 102 for more information.

pcms people

Stephen L. Schwartz, MD, has recently been appointed to the Montgomery County Mental Health/Mental Retardation Board for a term expiring December 31, 2007.



Change of address?
Phone 215-563-5343, Ext. 102 with any change of address, phone, fax number or e-mail address.

PCMS people wanted!
Your colleagues would like to know what you're up to. Send news about academic or other appointments, achievements, awards, promotions, etc. to:
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Philadelphia, PA 19130

**The Philadelphia County Medical Society
Board of Directors
cordially invites you to attend
The President's Ball and Awards Night**

**Joyann A. Kroser, MD
will be installed as the Society's 144th President**

**Friday, June 3, 2005
Philadelphia Country Club
Gladwyne, PA**

**Reception: 6:30 PM
Program, Dinner and Dancing: 7:00 PM**

Guests invited • Black tie preferred

Cost: \$95 per person • residents and students \$50

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