

Characteristics of patient panels appear associated with quality ratings of primary care physicians

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Patients panels (used to rate the quality of care of physicians) with greater proportions of underinsured, minority and non-English speaking patients were associated with lower physician quality rankings, according to a study in the September 8 issue of *JAMA*.

Physicians have increasingly become the focus of quality performance measurement. Many health care systems now use physician clinical performance assessment as part of their re-credentialing process, and public reporting programs have become widely adopted approaches to influence clinician performance. "These programs use performance incentives including cash payments and public reports to motivate clinicians, practice groups, and health care systems to achieve specific health care quality goals," according to background information in the article.

The authors add that an assumption underlying physician clinical performance assessment is that the measures represent physician performance. "However, the same physician may have higher or lower measured quality scores depending on the panel of patients he or she manages. The association of patient panel characteristics with physician quality scores could lead to inaccurate physician clinical performance rankings that could have implications on how [physicians](#) are rewarded and on how resources are allocated within health care systems."

Clemens S. Hong, M.D., M.P.H., of Harvard University and Massachusetts General Hospital, Boston, and colleagues conducted a study to examine whether patient panel characteristics are independently associated with changes in a physician's relative quality ranking. The study included data from 125,303 adult patients who had visited any of the 9 hospital-affiliated practices or 4 community health centers between January 2003 and December 2005 (162 [primary care physicians](#) in one physician organization linked by a common electronic medical record system in Eastern Massachusetts). The researchers used the data to determine changes in physician quality ranking based on an aggregate of Health Plan Employer and Data Information Set (HEDIS) measures after adjusting for practice site, visit frequency, and patient panel characteristics.

The researchers found that based on unadjusted composite quality rankings, patients of top tertile (one-third) physicians compared with patients of bottom tertile physicians were older (51.1 years vs. 46.6 years), had a higher number of co-existing illnesses, made more frequent primary care practice visits, and were less often female.

"Because older patients with more comorbidities are often seen more frequently, they may have stronger relationships with their physicians, and physicians caring for such patients may have more opportunities to complete process measures," the authors note.

The proportion of minority patients (13.7 percent vs. 25.6 percent), non-English-speaking patients (3.2 percent vs. 10.2 percent), and patients with Medicaid coverage or without insurance (9.6 percent vs. 17.2 percent) was significantly lower in the top vs. bottom tertile, respectively, of primary care physicians. Patients of top vs. bottom tertile primary care physicians also lived in neighborhoods with higher median (midpoint) household incomes and higher high school graduation rates.

The researchers add that after accounting for practice site and visit frequency differences, adjusting for patient panel factors resulted in a relative average change in physician rankings of 7.6 percentiles per primary care physician, with more than one-third (36 percent) of primary care physicians (59/162) reclassified into different quality tertiles.

"To the extent that health systems reward physicians for higher measured quality of care, lack of adjustment for patient panel characteristics may penalize physicians for taking care of more vulnerable patients, incentivize physicians to select patients to improve their quality scores, and result in the misallocation of resources away from physicians taking care of more vulnerable populations. Conversely, adjustment for patient panel characteristics may remove the incentive to improve care or may inappropriately reward lower-quality physicians caring for more vulnerable patients. Efforts to improve quality of care must address both fairness of physician clinical performance assessment and the design of incentive schemes to both provide equitable distribution of resources and reduce disparities in care for vulnerable patients," the authors conclude.

More information: *JAMA*. 2010;304[10]:1107-1113.

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