they cannot be rewarded for investing in their practices to provide high-quality care.

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Financial Disclosures: Dr Roland contributed to the development of the pay-for-performance scheme described in this letter, but has no financial interest in its development or implementation.

1. Boyd CM, Darer J, Boult C, Fried LP, Boult L, Wu AW. Clinical practice guidelines and quality of care for older patients with multiple comorbid diseases: implications for pay for performance. *JAMA*. 2005;294:716-724.
2. Roland M. Linking physician pay to quality of care: a major experiment in the UK. *N Engl J Med*. 2004;351:1448-1454.
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To the Editor: In their Special Communication, Dr Boyd and colleagues[1] argue that strict adherence to CPGs for populations with multiple comorbid diseases could have detrimental effects, a problem that could be exacerbated by linking pay to CPG adherence. However, CPGs could be used to establish a clinically relevant payment system. The current fee-for-service system does not reflect the evidence-based resource requirements to appropriately manage diseases. A payment system shaped by CPGs could base payments on evidence-based, clinically appropriate resources, thus creating an immediate incentive to reduce both overuse and underuse.

Such a payment model is being designed by Bridges to Excellence,[2] a multistakeholder group. In this model, physicians and payers would agree on the selection of specific CPGs; initially, patients with multiple complex conditions would be excluded. The payment amount would be based on resources required to deliver the services recommended in the chosen CPG. Physicians who are contracted to be paid this way would be offered an explicit reduction in current payer-imposed administrative burdens. However, they would have an explicit performance incentive to use the most effective and efficient pathway to treat patients. The primary shortcomings described by Boyd et al would be avoided because the physician would not be micromanaged or directed to adhere to one CPG over another (or multiple CPGs simultaneously). A CPG-based payment model that incorporated appropriate clinical flexibility, combined with a balanced scorecard to evaluate and reward performance on critical parameters of care including cost, could produce better outcomes and higher physician and patient satisfaction. Moreover, just as pay-for-performance has intensified interest in the development of tools to measure quality, a CPG-based reimbursement system should accelerate improvements in the CPGs themselves.

It is important to make it easier to bring more evidence-based care to the patient, taking into account the complexities and specific clinical and social needs of each individual. Today's CPGs might not be ideally suited to that task, but using CPGs to establish payments for simple conditions could pave the way for change that will also positively affect the patients with more complex cases.

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Financial Disclosures: None reported.

1. Boyd CM, Darer J, Boult C, Fried LP, Boult L, Wu AW. Clinical practice guidelines and quality of care for older patients with multiple comorbid diseases: implications for pay for performance. *JAMA*. 2005;294:716-724.
2. Bridges to Excellence Web site. Available at: http://www.bridgestoexcellence.org. Accessibility verified November 11, 2005.

In Reply: We thank Dr Hager and Ms Michael for reminding us that a physician's referral is required for Medicare to cover medical nutrition counseling. Although such consultations have the potential to simplify the nutritional recommendations contained in multiple CPGs, they also require additional health care visits for the patient. More problematic is the limited amount of evidence about the changing nutritional needs of older patients, which has led the American Diabetes Association CPG to state that "nutrition recommendations for older adults with diabetes must be extrapolated from what is known from the general population."[1]

We look forward to the results of the current experiment in the United Kingdom linking a physician's pay to quality of care, described by Dr Roland,[2] and hope that the results will be applicable to older patients with multiple comorbid diseases. However, we are concerned that when performance indicators are calculated, these patients can be excluded from both the numerator and the denominator for various reasons, thereby excluding them from the results of the study.

We agree with Mr de Brantes and colleagues that creative payment schemes may induce greater adherence to selected recommendations for patients with relatively simple needs. The exclusion from these schemes of those patients with "multiple complex conditions," however, still ignores the plight of the most vulnerable (and the most expensive) patients with the hope that they too may somehow be positively affected in the future. For this hope to become reality, standards will need to be developed that address high-quality complex care for patients, provide pragmatic methods