

CREATING THE STRONGEST
POSSIBLE INCENTIVE WITH
PAY FOR PERFORMANCE:
IMPLICATIONS FOR PAYMENT
STRATEGIES

Aggressive Internal Compensation in Route
to QI

PAY FOR PERFORMANCE SUMMIT

SAN FRANCISCO, 3/24/11

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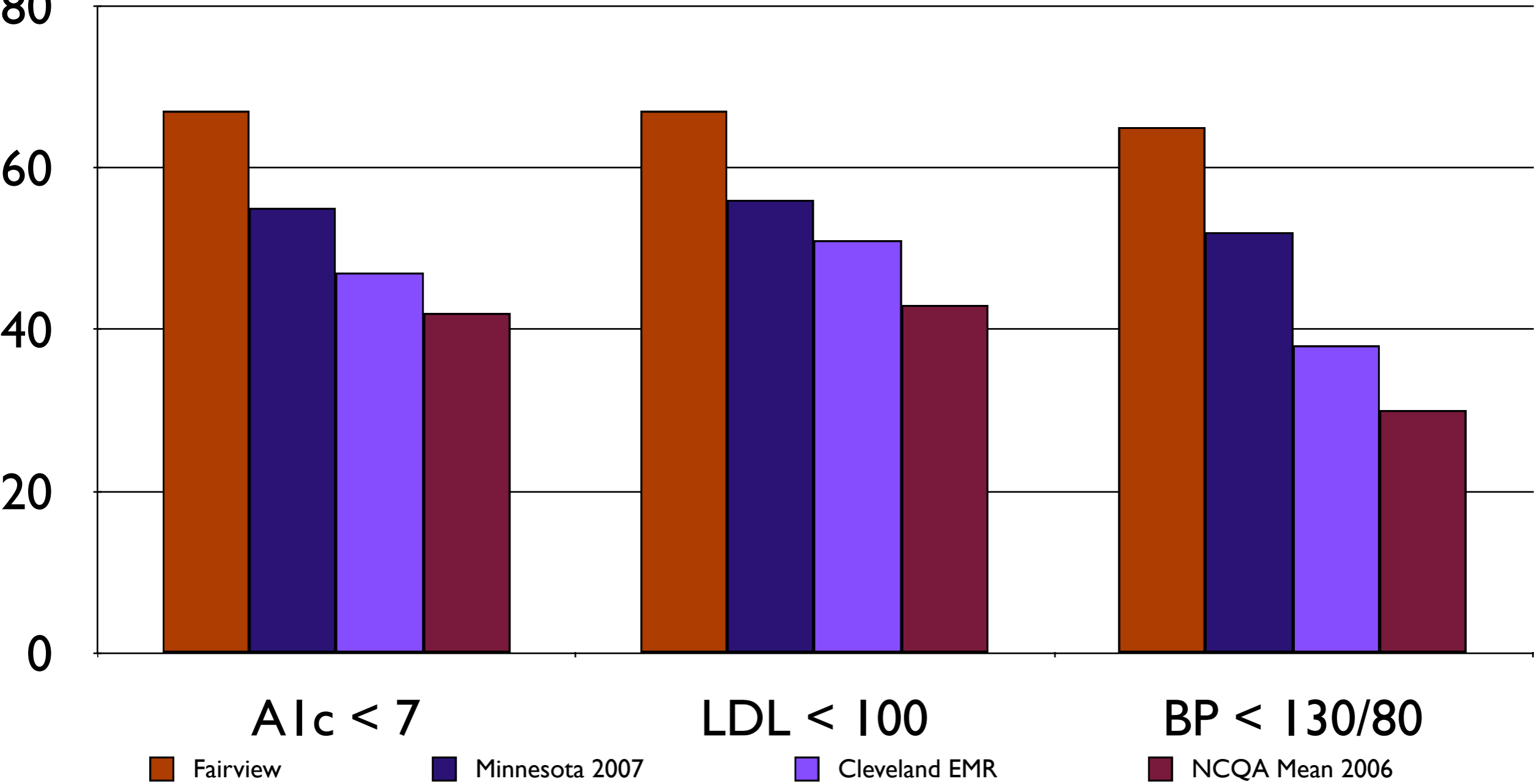
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Although it makes my wife quite
sad.....

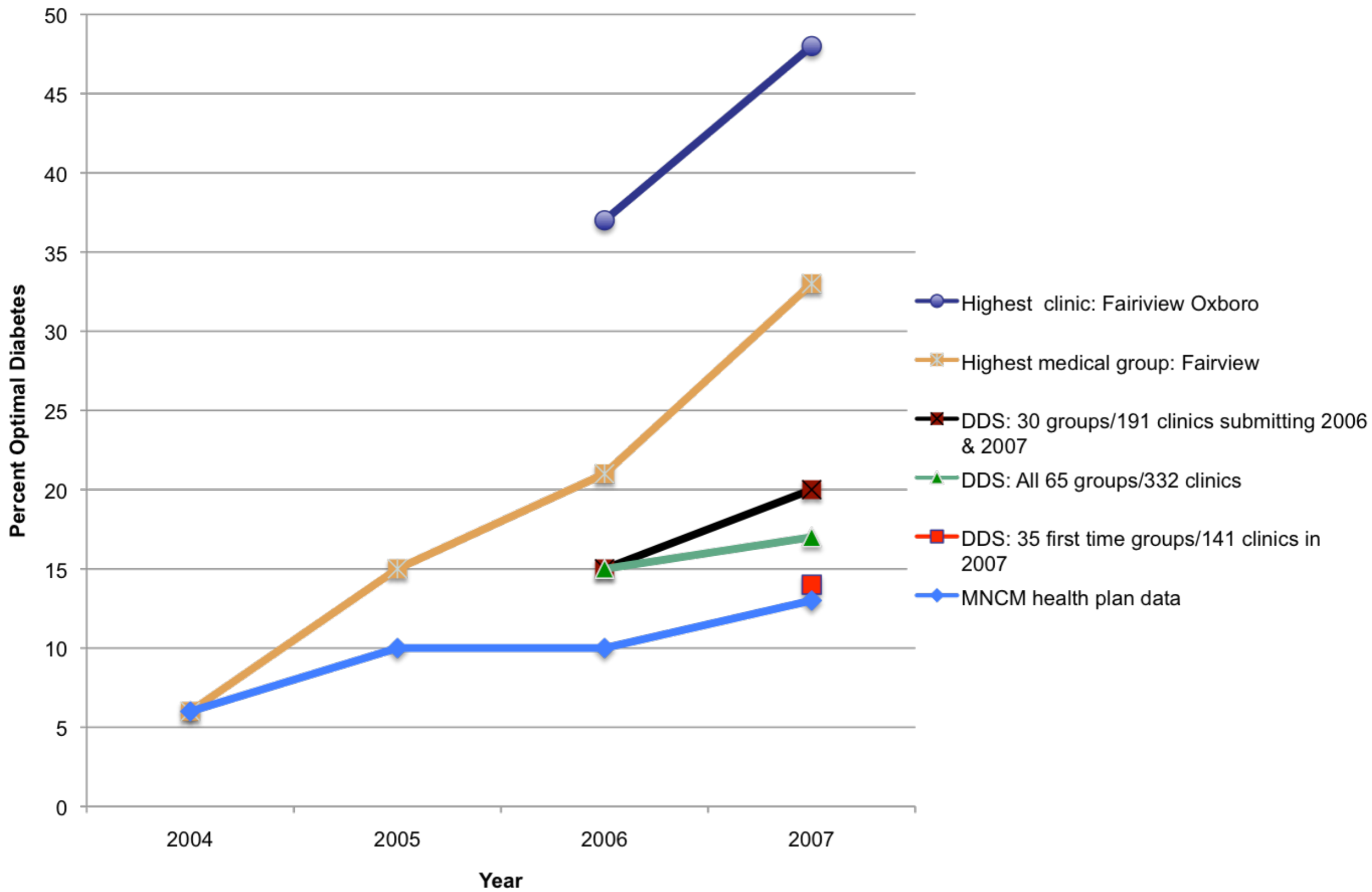
I have no significant financial
conflicts to disclose

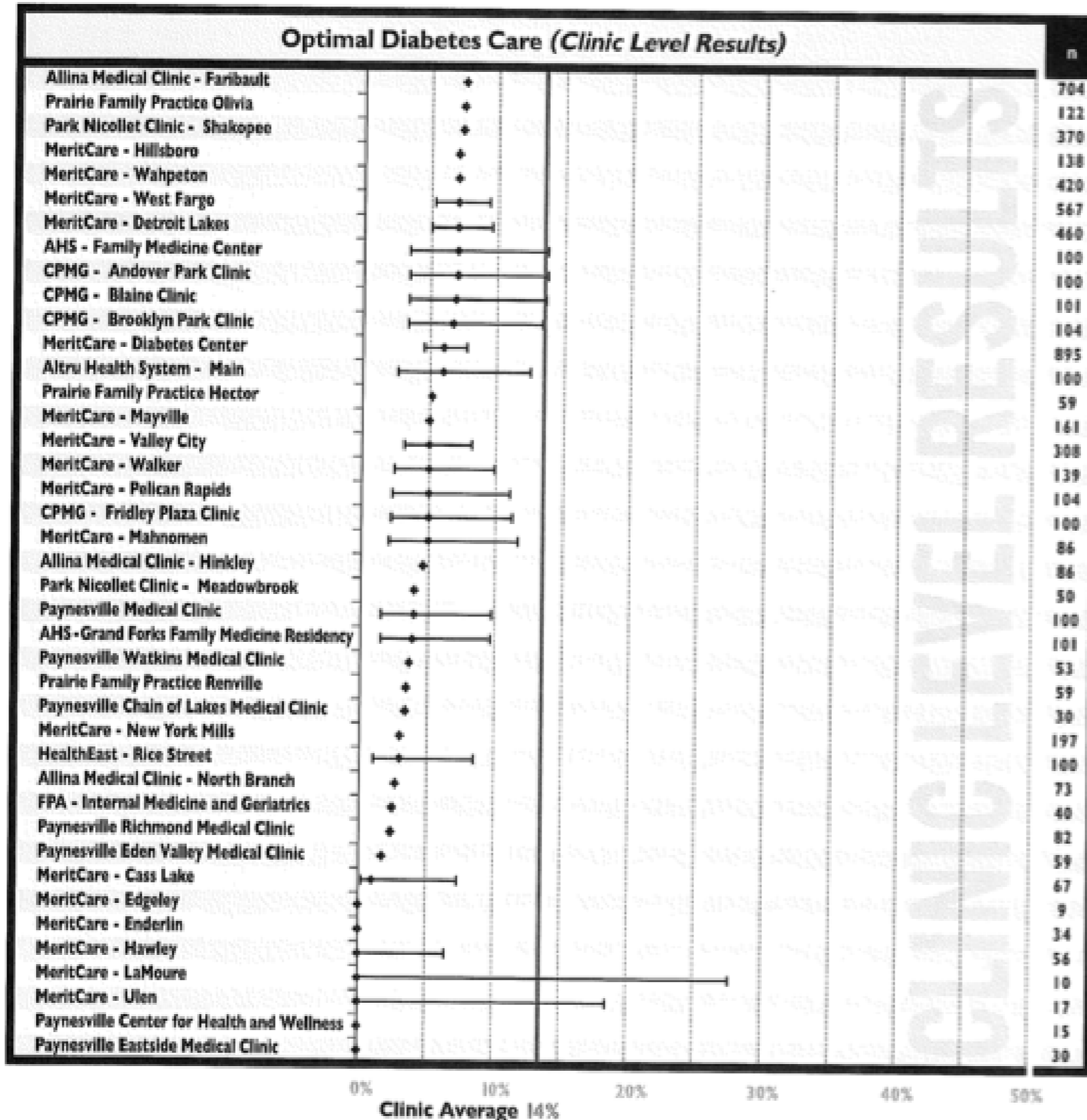
- Former VP of Quality @ Fairview Health Services
- Board of Directors MNMCM (unpaid position)
- Currently with Bershow Consulting, LLC (contracts with Cedars-Sinai, HHS, Quality Quest in Illinois & Stratis [the QIO in MN])

2007 Diabetes Performance (%)

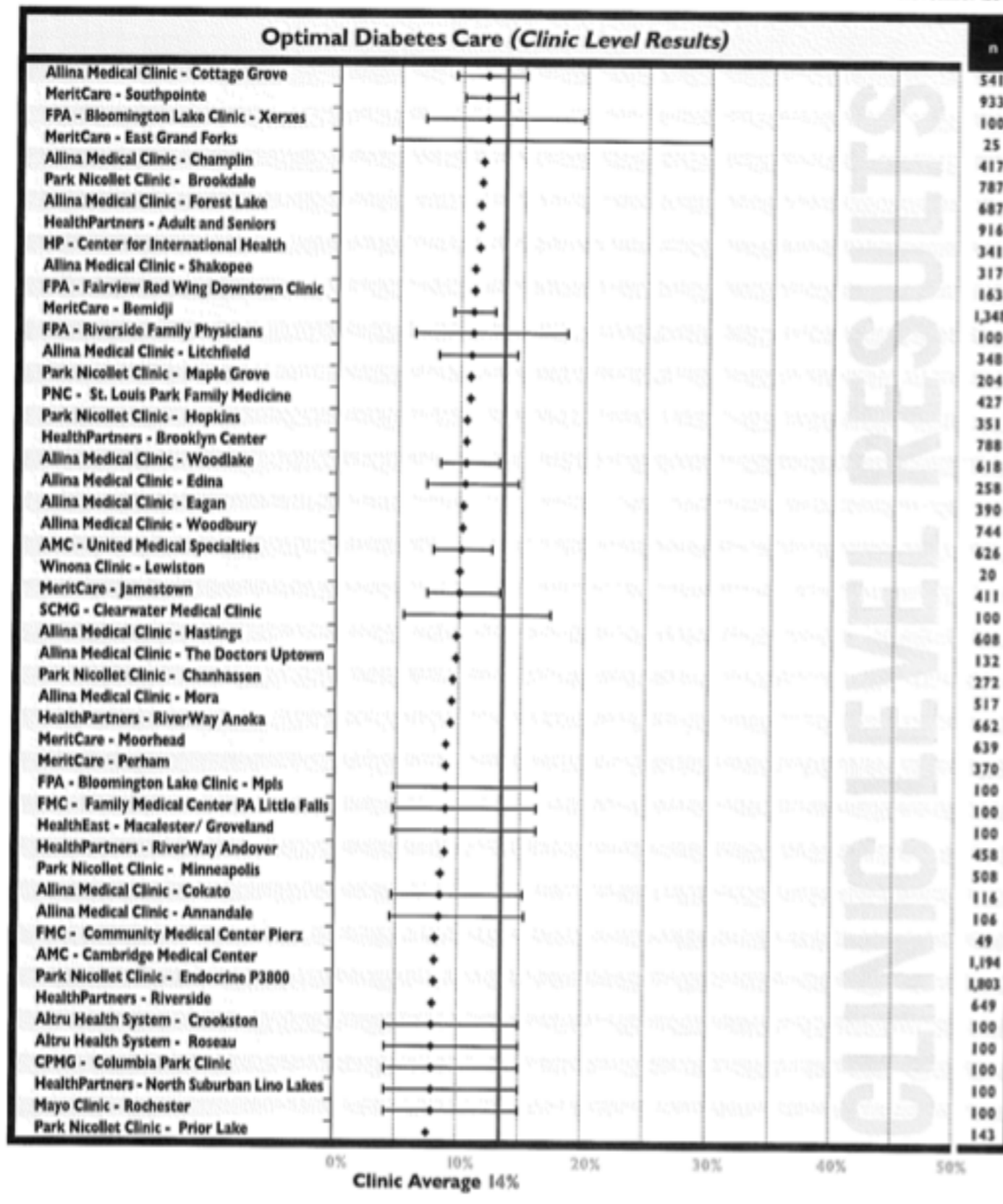


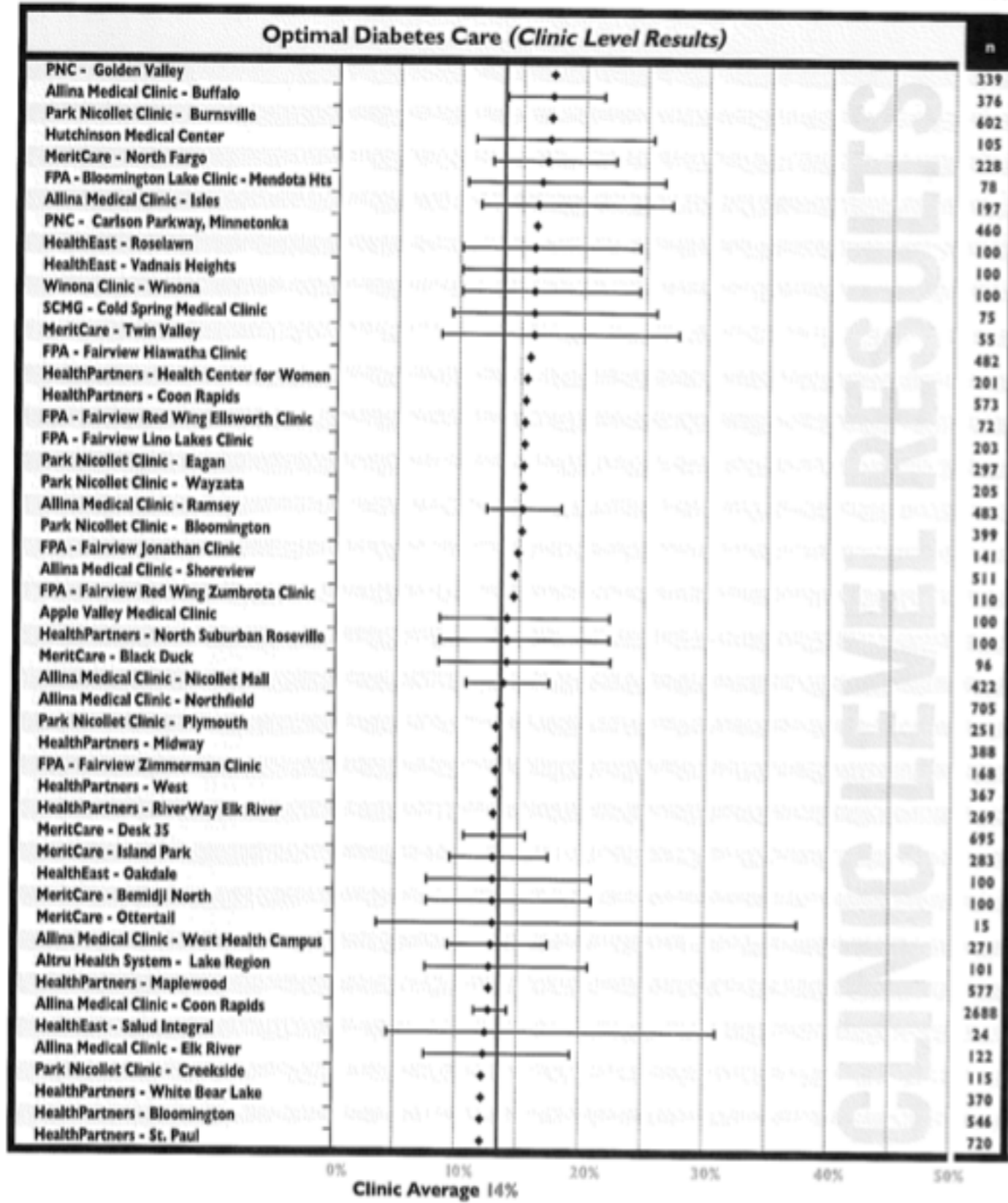
Optimal Diabetes Scores



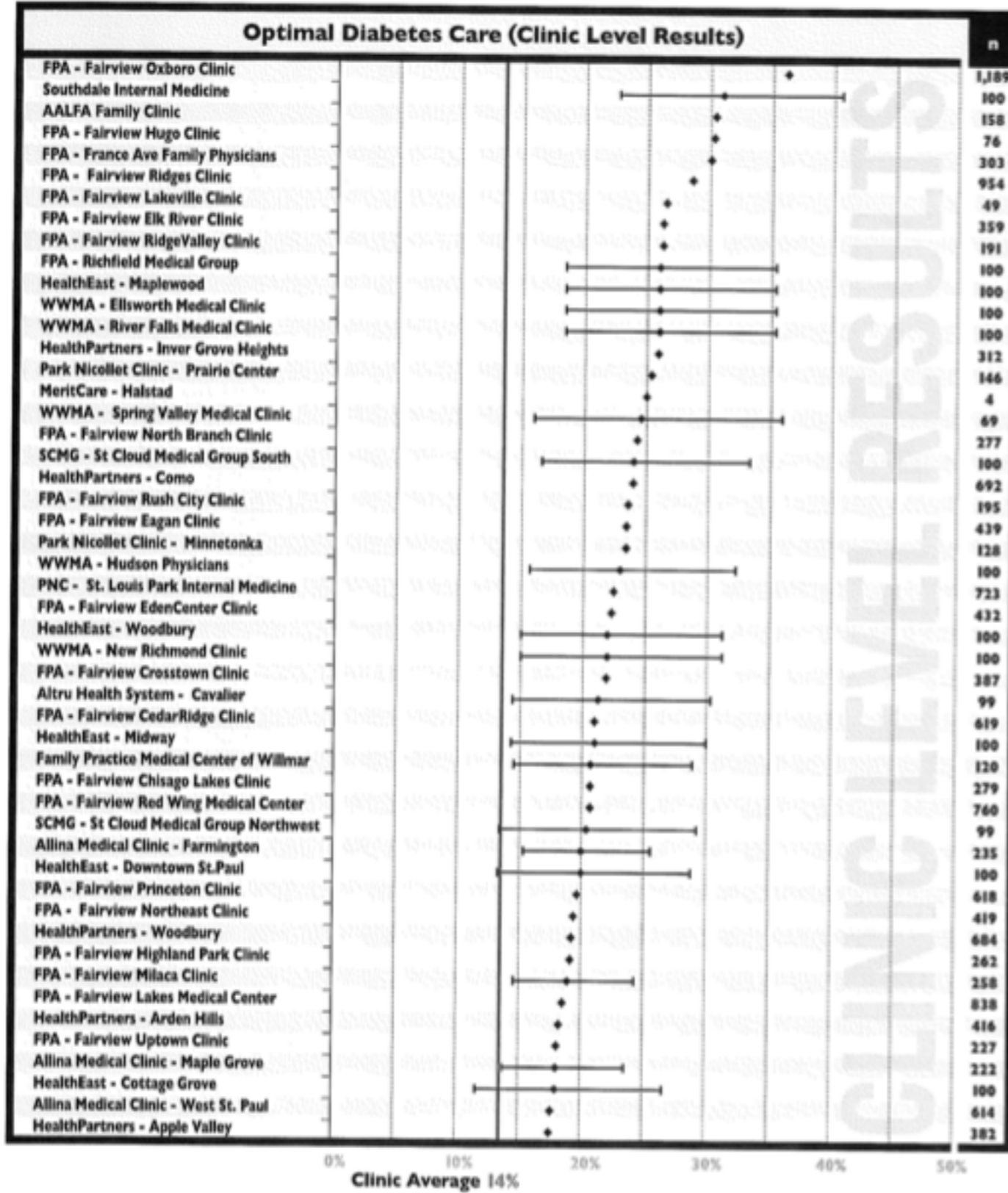


CLINIC LEVEL RESULTS





CLINIC LEVEL RESULTS







Timeline - Building Capabilities

Volume

Value

Fee-for-Service

Shared Savings

Episode Payment

Partial Capitation

Global Payment



Care Delivery Innovation

Medical Home

Network Development

Fairview Population

Population Health

Epic Inpatient Install

Direct Contract Capabilities

Integrated Business Intelligence

Medical Group Reorganization

Care Packages

Physician Compensation

Accountable Care Organization

Payer Contracting Methodologies

Virtual Care Expansion



Care Model Innovation Compensation Model

- The model is designed to assist in delivering greater value by aligning provider incentives to Triple Aim goals of:
 - Exceptional clinical care
 - Exceptional patient experience
 - Decreased cost of care

New Compensation Model

- Primary care provider compensation will be attractive
- Compensation aligned with Fairview strategic goals
- Provide a competitive advantage that is fair for the work primary care does, so....
- Recruitment and retention goals achieved

New Compensation Model

- Compensation model in alignment with care model innovation (CMI)
 - Care for populations
 - Incorporate innovations such as team based care (CDE's/MTM/C3PO), nurse based HTN clinics, telemedicine, virtual visits, group visits, etc. without penalizing doctors for shifting their way of practicing

CMI Compensation Pilot Assumptions

- A provider performing at median/target on **all** measures will be compensated market median compensation prorated to FTE.
- ~ 50% upside salary boost is possible
- Whenever possible, external benchmarks will be used.
- Salaries will be recalculated quarterly.
- Specialties involved: Family Medicine, Internal Medicine, Pediatrics, IM/Peds, Nurse Practitioners and Physician Assistants

Rewarding for Outcomes: Elements of CMI Compensation Plan

Performance Measures	Payout Percent	Outcomes based on	Measures based on	Payout Range
Quality	40%	Team	External benchmarks	0% to 150%
Patient Experience	10%	Team	Moving from internal to external	50% to 150%
Cost of Care	10%	Team	Internal benchmarks	50% to 150%
Productivity	40%	Team – 10% Individual - 30%	Internal benchmarks	50% to 150%

Quality – Weighted Metrics Based on Team Outcomes at the Clinic/Department Level

FP/IM/MedPeds	Pediatrics
• Ischemic Vascular Disease – 30%	• Childhood Immunizations – 30%
Diabetes –30%	• Asthma –30%
• Cancer Screening – 15%	Chlamydia –25%
• Depression – 15%	• Otitis Media – 1 st line – 15%
• Asthma – 10%	Fifth measure currently in development– possible ADHD

Additional Metrics

- **Patient Experience** – currently using FPA Survey, but moving to CG-CAHPS in 2011
- **Cost of Care**
 - Appropriateness of High-Tech Diagnostic Imaging
 - Follow up within 72 hours of significant health event
 - More robust metrics as data available
- **Productivity**
 - “Clinical Activities”
 - Panel Size x complexity fudge factor

CMI Compensation Model Implementation

- Four sites have been compensated on the pilot model since 8/10
- Modifications have been implemented in the plan design for both immediate and future implementation based on physician feedback
- Remaining primary care sites will transition to the new model 4/11

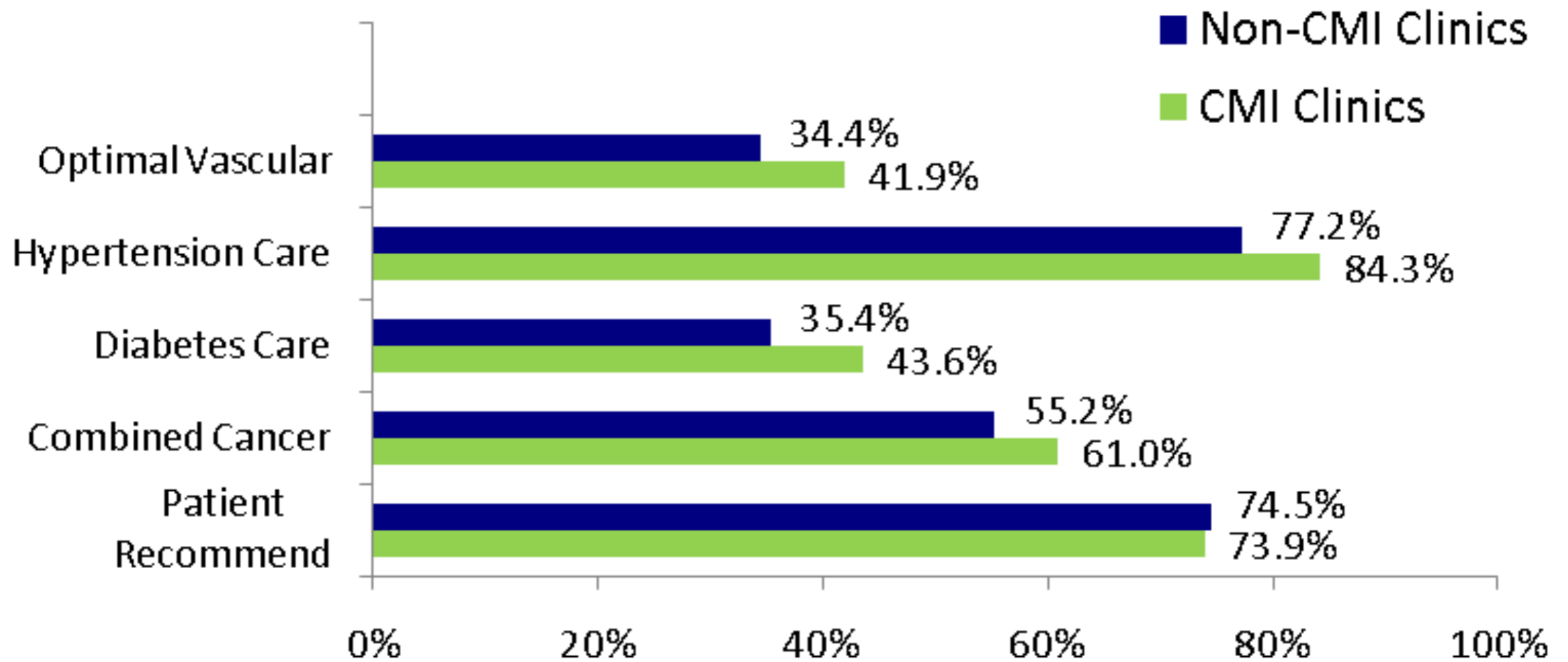
Most Recent Model Revisions

- 1/1/11: Production measure moved from Unique Patients Served to Clinical Activities (CA), measured over a rolling 12 months
- Procedures such as DEXA and EKG reads added to CA measure
- 10/1/11: Will move from FPA patient experience survey to CG-CAHPS
- 1/1/12: Addition of 5th quality measure for Pediatrics
- Timing TBD: depression quality metric will be revised to meet new MNCM definition

Provider Comp Change Distribution Table (Estimate August 2010)

% Compensation Change from Current	# of providers
-50%+	0
-40% to -49%	0
-30% to -39%	4
-20% to -29%	4
-10% to -19%	20
0% to -9%	32
0% to 9%	41
10% to 19%	39
20% to 29%	21
30% to 39%	13
40% to 49%	7
50% +	9

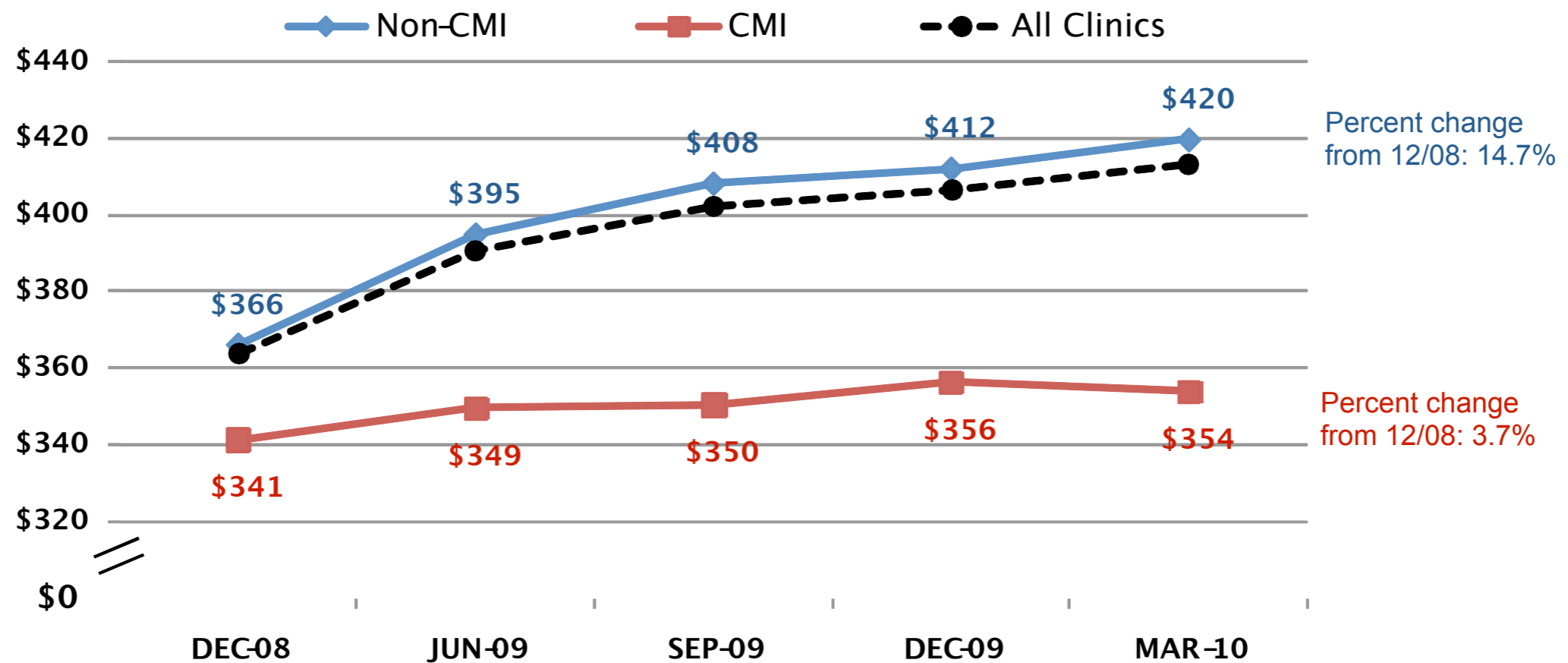
CMI Clinic Comparison 2010 scores thru September



Demonstrating Outcomes: Bending the Cost Curve

Paid Claims Per Member Per Month for Fairview-Attributed Members

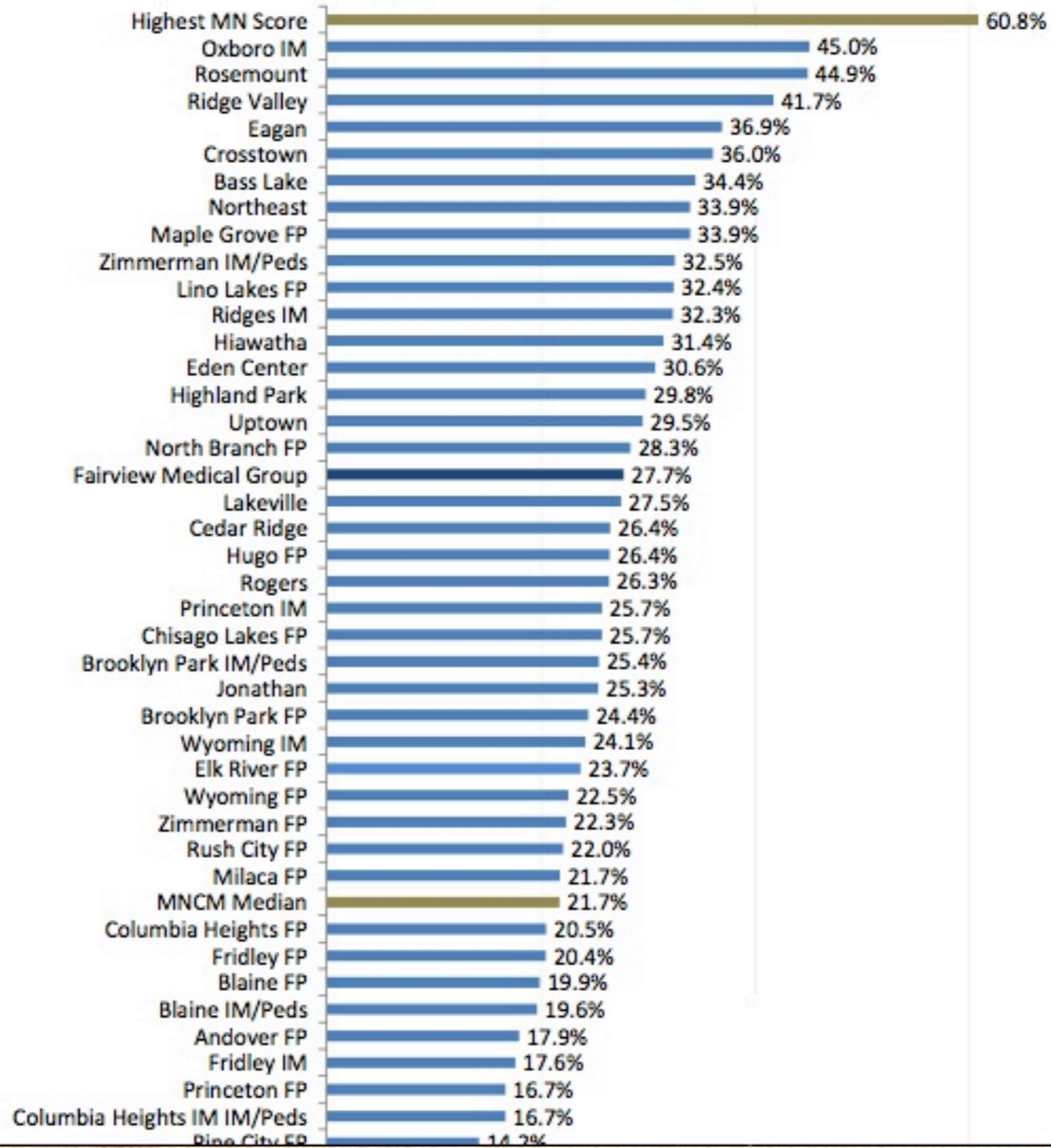
Weighted Average by Member Months, Includes Pharmacy
CMI Clinics: Eagan, Hiawatha, Northeast, Rosemont



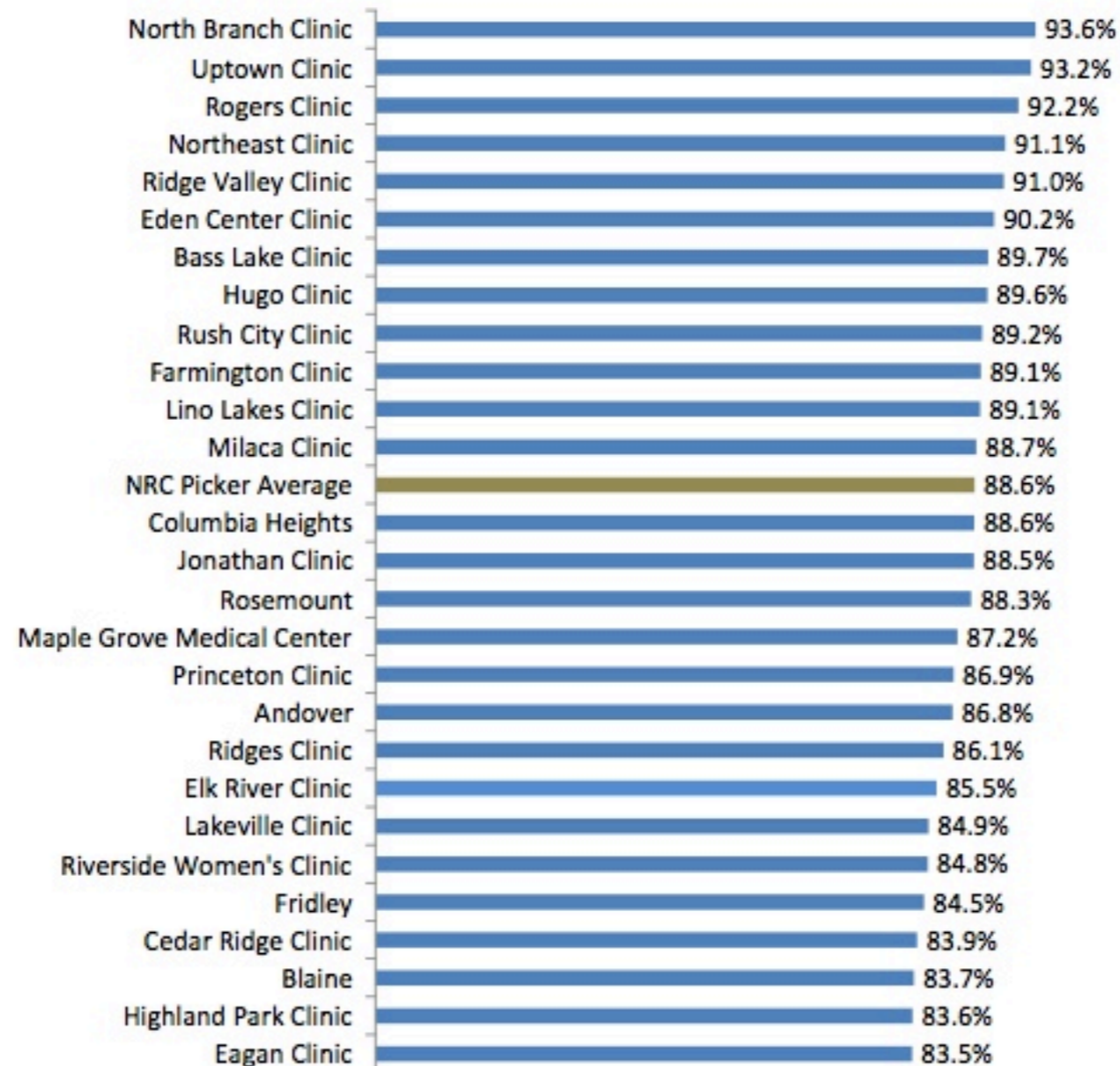
Clinic data excludes selected specialty primary care clinics (less than 2% of the Member Months in the data)

Fairview Medical Group Diabetes Care

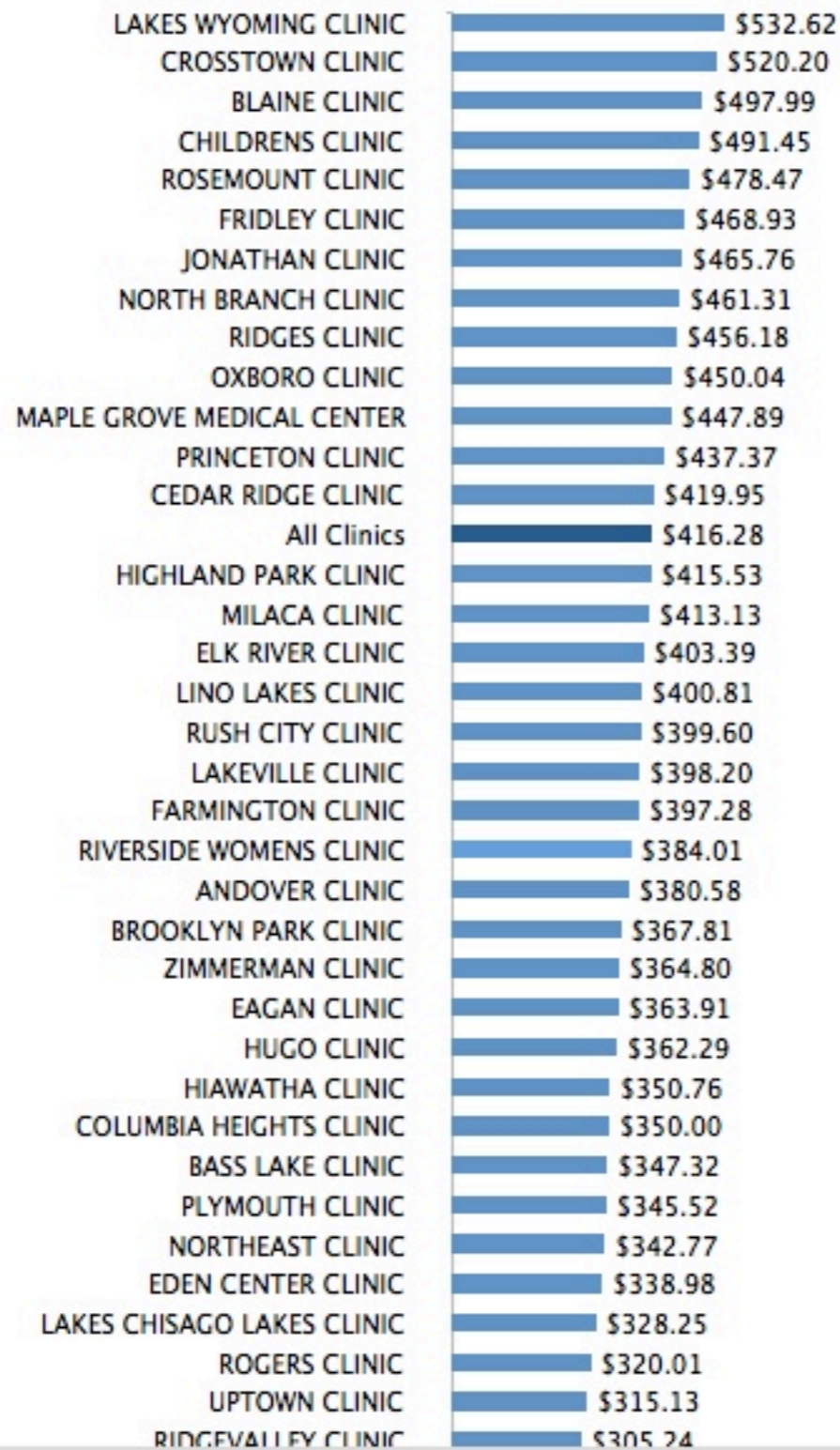
**% of Patients that Received Appropriate Care
July 1, 2009 to June 30, 2010**



**Fairview Medical Group
Clinic Patient Satisfaction--CG CAHPS
Would you Recommend - % Top Box
Q2 2010 (n = 6,153)**

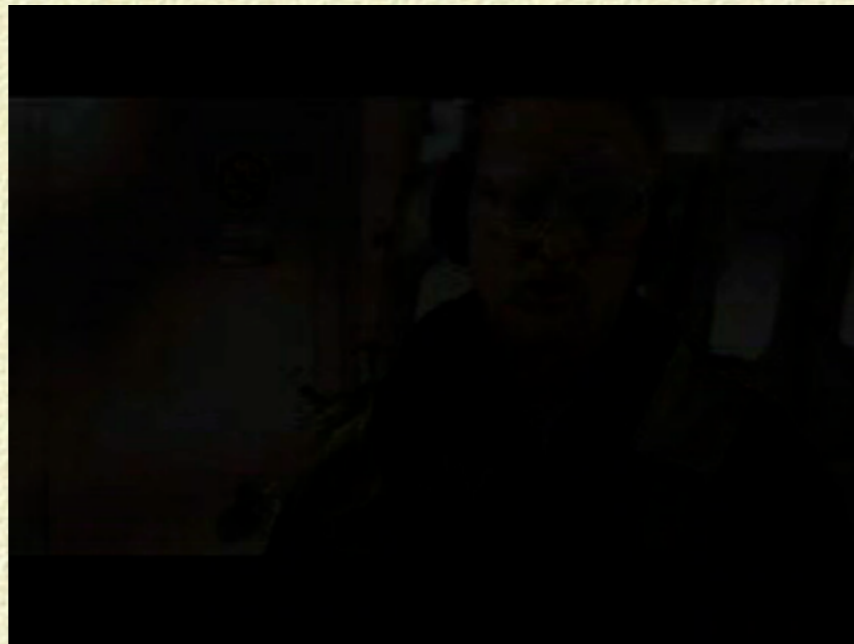


Total Cost of Care (PMPM) (Adjusted for Severity of Patients) 2009



Will this be good, bad or ugly?

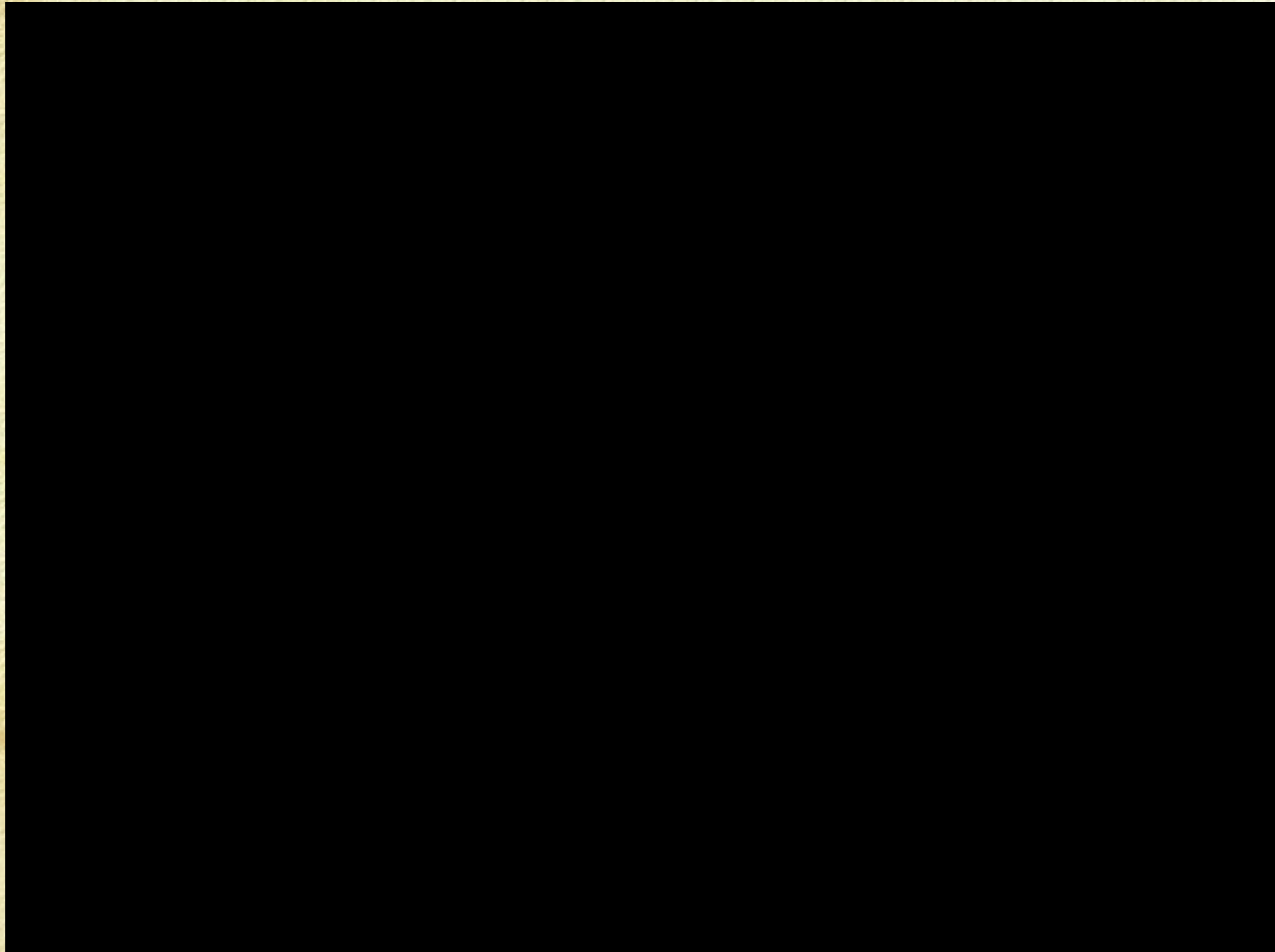
How will this all work out?



In leaving you, my advice is:

- Aim high & you will wind up in high places
- Aim low and you'll be disappointed even if you hit your goals
- Those who say it can't be done should get out of the way of those who are already doing it!

How to identify and prevent whiney doctors:



THANK YOU!

QUESTIONS?

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Please call or write if questions