Disease Management & Pay-for-Performance:

Is it just about the money?

June 22, 2005

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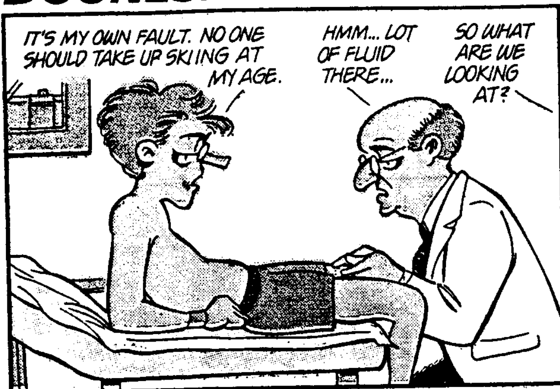
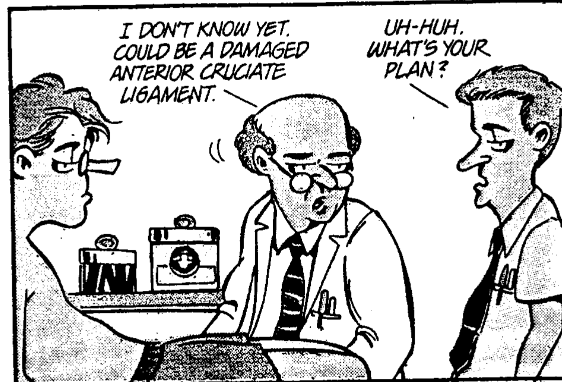
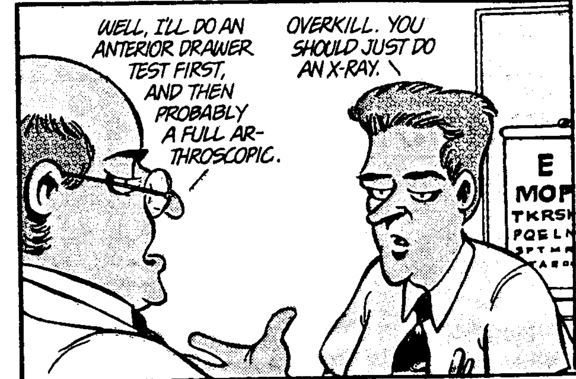
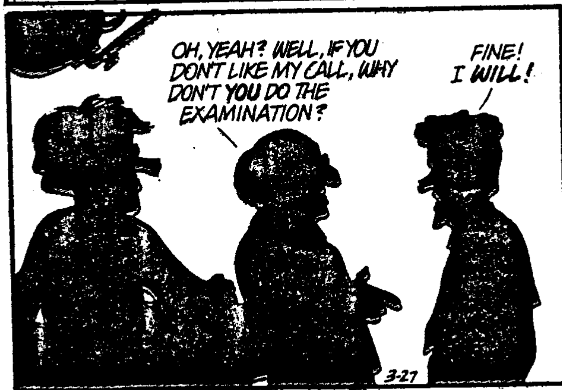
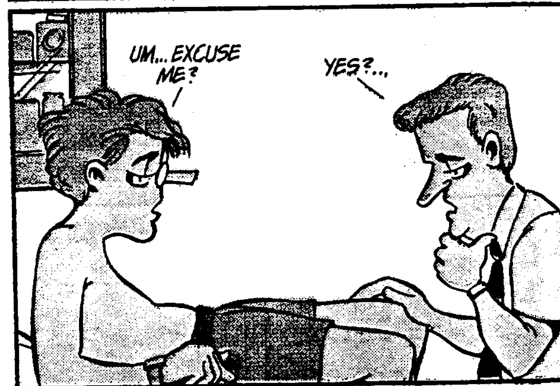
BY GARRY TRUDEAU

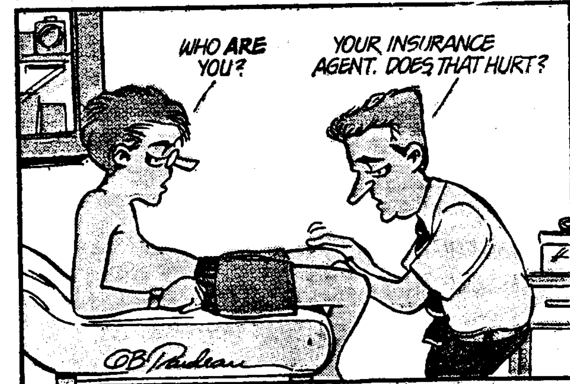












Gaining Physician Buy-In for Disease Management Initiatives

Harry L. Leider

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Disease Management & Health Outcomes, Dec. 6th, 1999

DM P4P Experience

Client	Outcomes
XLHealth	1,400 physicians and 10,000 patients enrolled in Texas BIPA program for CHF and diabetes
XLHealth	Now implementing P4P program for providers in New York region for HIP DM program
McKesson	Provided consulting support for design of new P4P programs
CardioContinuum (Kansas City)	Designed, implemented, a multi-center P4P program across 5 major cardiology sites
CardioContinuum (Boston)	Designed and implemented a P4P program for a large provider network affiliated with dominant IDS

Real World Experience in P4P

CardioContinuum

- Low and high density provider groups
- Medicare and Medicaid
- PCPs and specialists
  - Kansas City
  - Boston

XL Health

- Across the entire state of Texas (mostly “low density” groups)
- Medicare – mostly low income (BIPA)
- Highly successful launch of BIPA project – partially due to strong physician support

Specific Issues We Must Address

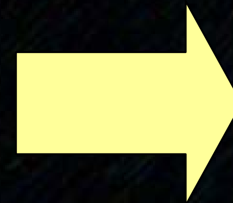
1. How a P4P model can be used to positively impact physician performance
   - Following EBM/Guidelines
   - Collaboration with DM program
2. Some specifics about an actual “reward model”
3. Other strategies and supports that must accompany the reward model
4. Scalability
   – Of a suggested reward model

Typical Key P4P Challenges in DM

1. Short time line for development and implementation
2. Low density of patients with most PCPs
   - Validity of many clinical metrics will be weak*
3. Skepticism regarding P4P from providers
   - Managed care “backlash”
4. Low recognition of specific DM programs by providers (based on our survey in 3 states)
5. Need to minimize IT/data complexity
   1. Data collection, cleaning, analysis, reporting
6. Need to maintain ROI to meet contractual requirements and business goals

Validity of Clinical Metrics and Low "Density" per Provider (<20 pts)

- Data is not statistically significant
- Case-mix arguments ("2 of my 5 patients are sicker")
- Provider shifting (multiple PCPs -"not really my pts")
- Not enough patients to drive a change in clinical processes ("I can't win")



Physicians believe that P4P model is not valid

What would success look like?

In our view, the goal of a P4P program is really to <u>increase physician engagement</u> to drive improved clinical and financial outcomes….

Physicians can "turbo-charge" DM outcomes across three domains….

Why Physician "Engagement" Improves Outcomes

80%	Number of patients identified	Physicians can identify additional patients with a targeted disease
X		
70%	Number of patients enrolled	Physicians can encourage patients to enroll and other physicians to participate
X		
60%	Effectiveness of Clinical Care	Physicians must be willing to modify medical regimens to preventing admissions

↓

34% Reduction in costs on a *population basis*

What would success look like? Your program is:

- Elegantly simple and intuitive (so physicians understand and support it)
- Highly scalable, generalizable, and reliable
- Can be developed in an iterative manner
- Is not costly, complex, or time-consuming to implement
- Innovative
- Significantly enhances clinical and financial outcomes by:
  1. Increases identification of eligible members
  2. Increases enrollment of targeted members into the DM programs
  3. Increase the willingness to modify medical and support regimens (according to well established guidelines) to reduce hospital admissions

Strategy: Incent Physicians

Models for Incenting Physicians

- Compensation
  - capitation, bonuses, risk pools, FFS
- Profiling of performance
- Recognition
- Leadership opportunities
- Penalties/sanctions: economic credentialing
- Equity Participation

Strategy: Incent Physicians

Advantages

- physicians respond to incentives (if enough $)
- quick to *implement*
- ownership of practices not required

Disadvantages

- "you get what you incent"
- no perfect comp. model
  - 6 mo. to years to *develop*
  - easy to incent productivity and low utilization, difficult to measure/incent quality
- incentives don't show how to improve performance

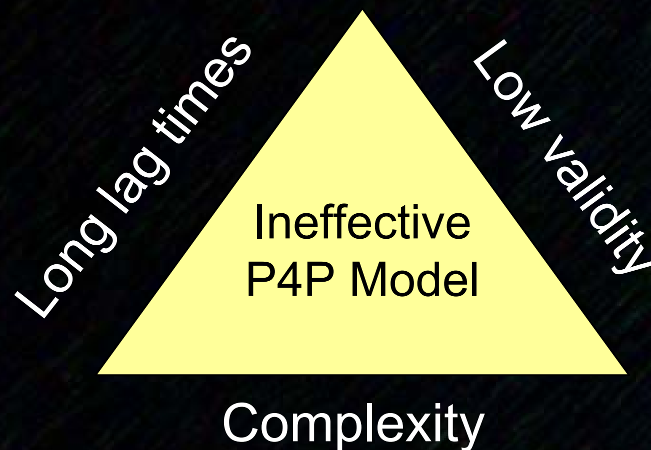
Our Physician Engagement Model:
(a.k.a. "The herding cats model")

1. Clinical Leadership – address WHY providers should support the DM program (that it enhances quality of care) This is the first driver of success!!
2. Effective Incentives (P4P) – reward providers for taking the time to work to support the program and optimize medical regimens
3. Tools for Improving Performance – provide the resources that make it "easy" for providers to succeed and participate

Our View of an Effective P4P Model

We need to avoid the "Bermuda triangle" of P4P:

1. A complex compensation model
   - Confusing to providers (they will ignore it)
   - Difficult to administer (IT and data analysis issues)
2. A model that has limited validity due to low patient volume per physician (especially early on when "density" is always low)
3. A model that has long lag times between provider behavior, data collection, reporting on results and the bonus payment



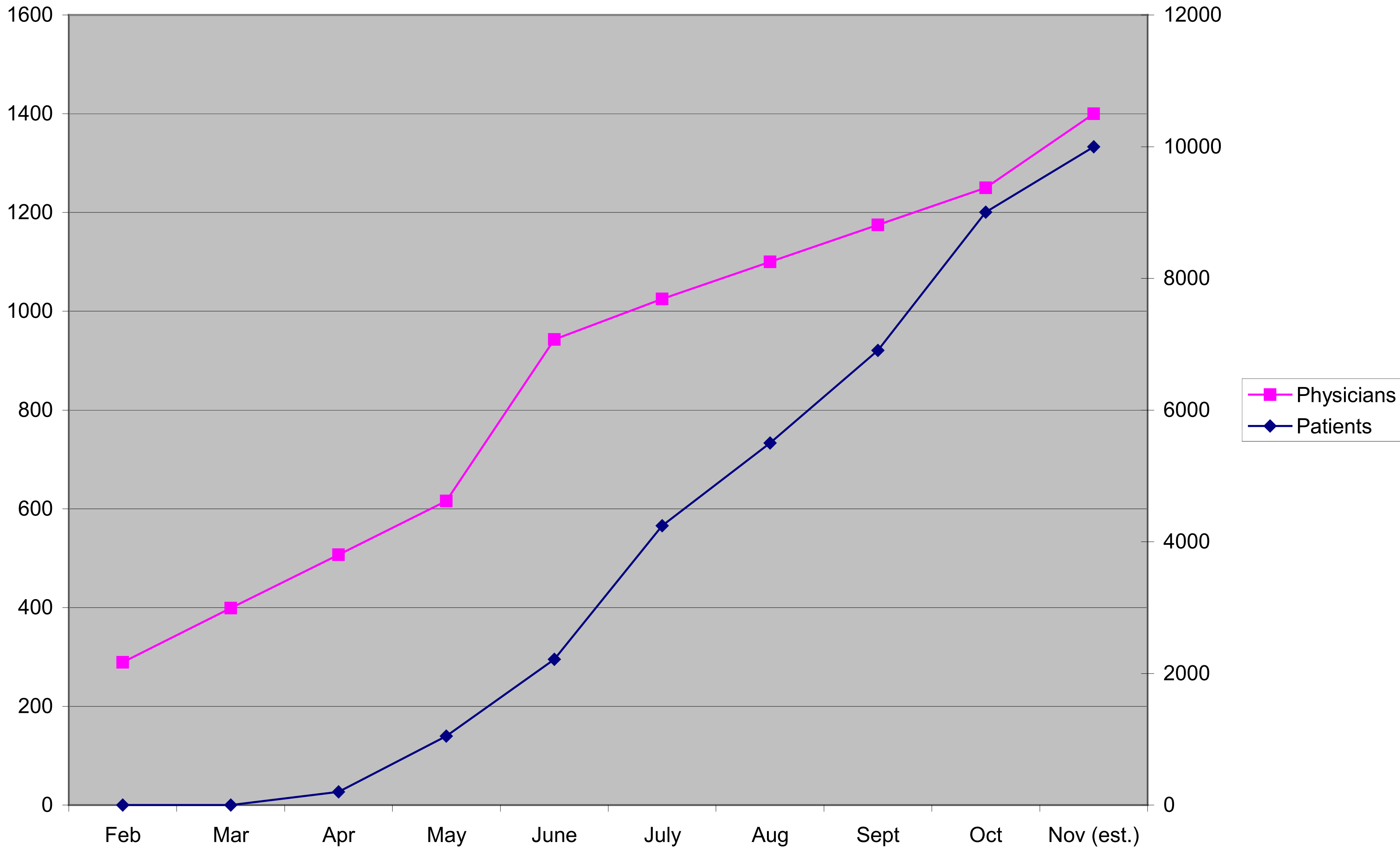
Our View of a Effective P4P Model

Basic Principles & Design

- Avoid the “Bermuda Triangle” by initially paying for provider participation
- Participation = help with patient identification, enrollment, and simple care management functions (e.g. reviewing med profile)
- The P4P model should function like a FFS payment model – office managers will understand it and support it
- Participation “metrics” should be simple and measure (no need for claims analysis or run-out)
- As providers “participate” and develop trust in the program and volume increases , introduce simple, widely accepted clinical metrics that can be measured
  - For example: % of enrolled diabetic patients on ACE/ARB therapy

This "Construct" Overcomes the Key Challenges to Your P4P program

- Short time line for program launch
  - Simplicity of model is compatible with its rapid introduction
- Low density of patients with most PCPs (validity issue)
  - Paying for participation has strong "face validity" and minimal measurement problems. Clinical metrics added when density increases
- Skepticism regarding P4P from providers
  - Rapid FFS-type payments coupled with a Provider Relations strategy will overcome skepticism
- Low recognition of DM programs by providers
  - Success of this model is not dependent on program recognition as qualifying behaviors are simple ("if you play you get paid")
- Need to minimize IT/data complexity
  - No need for complex claims data analyses or risk adjustment methodology
- Maintain ROI to meet contractual requirements & business goals
  - Since the model is simple (not data intensive) it will not be costly to administer


XLHealth BIPA Enrollment Summary
1600
1400
1200
1000
800
600
400
200
0
12000
10000
8000
6000
4000
2000
0
Feb
Mar
Apr
May
June
July
Aug
Sept
Oct
Nov (est.)
Physicians
Patients

Why Physician "Engagement" Improves Outcomes

80% | Number of patients identified
X
70% | Number of patients enrolled
X
60% | Effectiveness of Clinical Care

Physicians can identify additional patients with a targeted disease

Physicians can encourage patients to enroll and other physicians to participate

Physicians must be willing to modify medical regimens to preventing admissions

34% Reduction in costs on a *population basis*

The Economics of a Model

- **$1.0 Million funding**
- **20,000 beneficiaries (60% enrollment) with all DM conditions = 12,000 enrollees**
- **1,800 PCPs**
  - **7 patients per PCP (average)**
- **$555 per PCP per year total incentive** ($300 after tax!)

Conclusions

- Not enough money to pay for “passive eligibility” (P4P for all pts. and providers)
- Focus funds on active enrollment and simple clinical and care management “behaviors”
- Even so, physicians will need to believe it’s the right thing to do!

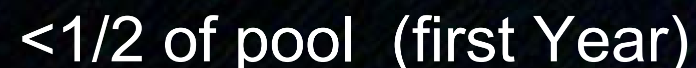
A “Menu” of Performance Metrics

Participation

- Sharing of data for patient identification
- Enabling program to use practice letterhead
- # of patients actively enrolled
- # of care plans reviewed
- Active collaboration with care managers
- Reviewing lists of potential enrollees to validate “clinical eligibility”

Clinical Processes

- Reviewing a “medication profile” that includes national guidelines
- Submitting key lab values to the DM program
- Simple clinical actions on enrolled patients*
  - Diabetics on aspirin
  - CHF pts. on a beta-blocker
  - Asthma patients with an “Action Plan”
  - CAD patients on ACE inhibitor



Clinical Leadership: A Necessary Element for P4P

- Providers are inherently skeptical about all new care management programs and compensation models
- Creation of a P4P or incentive program is a necessary, but not sufficient condition to engage physicians (remember the "Herding Cats" model)
- Providers must be educated on the merits of a DM program
- A Provider Services Strategy provides education on:
  - Why the program enhances quality of care (this is critical)
  - What is expected of providers
  - How their patients will benefit
  - How they will maintain control of patient management
  - How they can benefit economically

13 Lessons Learned "From the Front…"

1. Physicians are more receptive to "concept of DM" than they are to "enrolling themselves" – concept of a formal contract is a major barrier to participation
   - Physicians responded well to education of the benefits and expectations of the program
   - Use clinical outcomes to promote the program to physicians.

2. Approach physicians as though this is a Medicare or Medicaid benefit that is centered around their patient – a "done deal"
   - Being able to show physicians a list of their eligible patients immediately engages them in the program

3. Physician champions can't be identified using demographics – must be selected and cultivated individually

Lessons Learned (cont.)

4. Plan on a 6 month recruitment / educational effort
   - Mid-course corrections are a key to success
   - Plan for appropriate lead times for collateral development
   - Set realistic targets that can be worked to and obtained
5. Key partnerships are essential
   - State Medical Society
   - Local Medical Societies
   - State Medicaid offices
   - Others
6. Medical society/association relationships have high impact and high ROI – but also require high maintenance
7. Each state must be approached individually – same goes for separate markets within that state
8. A physician call center is necessary and valuable – 1200 incoming calls, 700 outbound calls in the BIPA project

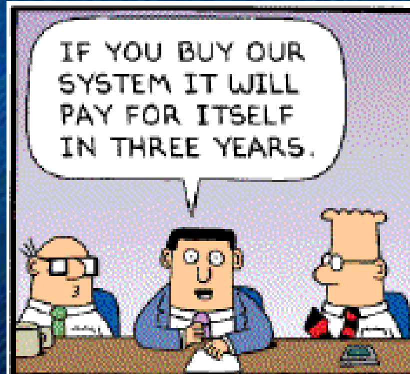
Lessons Learned (cont.)

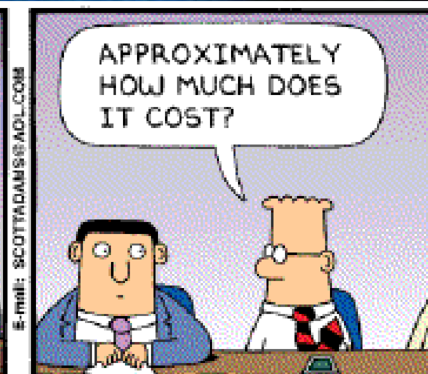
9. Don't rely on physician groups to mine their practice data – get data from Medicaid or Medicare
10. When physician-related issues arise, quickly get ahead of them
11. Physicians won't cooperate with the program just because of participation fees – however, once they are working with you, they expect those fees.
12. Collect and share outcomes data early and often
    - Physicians are all born in Missouri (Show Me!)
    - The lag between the behavior (e.g. enrolling a member in the program or reviewing a medication profile), the sharing of data and the reward must be short for the P4P program to succeed!
13. A patient/program video was a great success

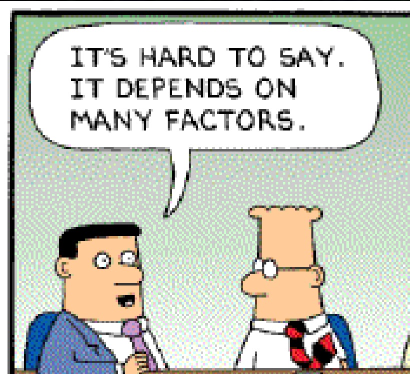
Summary

1. **Engaging provider to support DM programs can improve outcomes**
2. **An effective incentive model is a necessary - but not sufficient condition to achieve this**
   - **Avoid the P4P Bermuda Triangle….** (high complexity, poor clinical validity and long lag times)
3. **Remember the "Herding Cats Model"**
   - **Strong clinical leadership**
   - **Effective incentives that reward effort**
   - **Tools to help physicians improve performance**

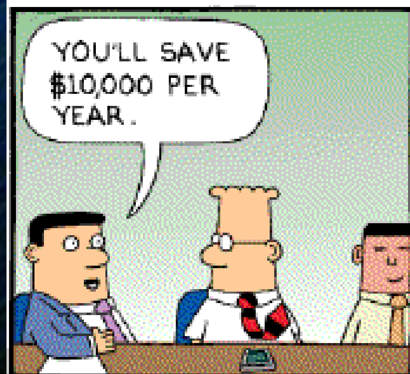
It's not all about the money…….


IF YOU BUY OUR SYSTEM IT WILL PAY FOR ITSELF IN THREE YEARS.

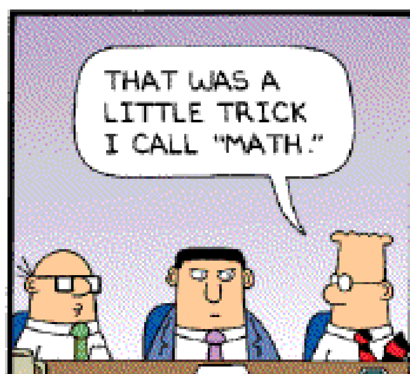

APPROXIMATELY HOW MUCH DOES IT COST?


IT'S HARD TO SAY. IT DEPENDS ON MANY FACTORS.

FINE. JUST TELL ME HOW MUCH MONEY IT WILL SAVE ANNUALLY.


YOU'LL SAVE $10,000 PER YEAR.

WELL THEN, IF IT PAYS FOR ITSELF IN THREE YEARS, IT MUST COST ABOUT $30,000.


THAT WAS A LITTLE TRICK I CALL "MATH."

OOPS. NOW I'M NOT EMOTION-ALLY INVESTED.
YOUR VENDOR TAUNTAGE IS QUITE EXCELLENT TODAY.

Discussion and Next Steps

XLHealth
Inform. Empower. Excel.