Reengineered Care in Reengineered Practices: The Impact of Pay-for-Performance on Medical Practice

November 28th 2007

Agenda & Faculty

Introduction
Francois de Brantes, CEO, Bridges to Excellence

Results of Empirical Studies: BTE's findings in MA and MN
Edison Machado, Jr., MD, MBA, National Accounts Manager, Bridges to Excellence

Results of Reengineered Care: Views from the field
Harry S. Miller, MD, Four Seasons Pediatrics, NY
Jennifer Lail, MD, Chapel Hill Pediatrics, NC
Barry Bershow, MD, Fairview Health Services, MN
Laurel Trujillo, MD, Palo Alto Medical Foundation, CA

Practice Reengineering: The next frontier - The Medical Home
Greg Pawlson, MD, MPH, Executive Vice President, NCQA

Practice Reengineering: A multi-strategic approach
A. John Blair, III, MD, President, Taconic IPA, Inc.

BTE Mission

Bridges to Excellence is a not-for-profit organization developed by employers, physicians, health care services researchers, and other industry experts with a mission to create significant leaps in the quality of care by recognizing and rewarding health care providers who demonstrate that they have implemented comprehensive solutions in the management of patients and deliver safe, timely, effective, efficient, equitable and patient-centered care.

What are we holding physicians accountable for today in our programs

Systems and processes – Physician Office Link (AR, CA, DC/MD, MA, ME, NY, NC)

Diabetes care – Diabetes Care Link (AR, CO, GA, KY, MA, ME, MN, NC, NJ, NY, OH, WA)

Cardiac/Stroke care – Cardiac Care Link (AR, CO, MA, MN, NY, NC)

Back care – Spine Care Link

BTE implementations typically emphasize a focus on results (e.g. DCL), or results in addition to systems and processes (e.g. POL + DCL/CCL)

What have we learned to-date in "P4P"?

Incentives work and can lead to practice reengineering, and practices need help to reengineer – which is why we're working closely with QIOs

Better quality can cost less, and you need to focus on the right measures – which is why we focus on quasi outcomes

Self-assessment of performance leads to focused quality improvement, and it's resource-intensive to pull charts – which is why we encourage use of HIT

Three-year study shows adopters AND users of HIT can be top performers

- BTE-POL-recognized physicians have lower ($579 v. $695 -- $116 in savings) average episode costs across all episodes and patients than a comparison group. The average savings per patient is $245 per year (2.11 episodes * $116)
- POL-recognized physicians also show lower variation in total episode costs
- POL-recognized physicians have better quality scores and lower variation in those scores than the comparison group

Primary Care Providers	Recognized	Comparison
Avg episodes/patient	2.11	2.22
Std deviation	1.74	1.88
Min	1	1
Max	25	30
Avg repriced cost / episode	$579	$695
Std deviation	$1,967	$2,441

POL Study Group	Recognized	Comparison
- Cervical Cancer Screening	**89%**	**85%**
Std Dev	8%	10%
- HbA1c testing	**87%**	**82%**
Std Dev	11%	13%
- Lipid panel: CHD 382: CHD_ lipid_PQP	**90%**	**86%**
Std Dev	8%	12%
- Lipid panel: Hypertension 12: HTN_lipid panel_PQ	**44%**	**44%**
Std Dev	15%	17%

Source: Mercer, 2007

Physician Practice Testimonials

Massachusetts Practices

Edison Machado, Jr., MD, MBA

Study Objectives

Explore BTE programs' impact on the relationship between care transformation, improved patient care, and decreased health expenditures

Goals:

1. Investigate the link between BTE program participation and subsequent practice transformation
2. Investigate the role BTE incentives play in the practice re-engineering process

Methods

Study Design: retrospective, qualitative interview

Data Collection:

- 14 practices participated
- Practices varied by location, practice size, and specialty though predominantly: small, suburban, primary care practices of about 5-7 physicians, with predominance of patients covered by private insurance
- Identified Medical Directors and Quality Improvement individuals
- Pre-interview screener survey
- Face-to-face interviews (~1 hour): Aug-Oct 2007

Methods

Pre-Interview Screener Survey

- Background information
- BTE care processes: pre and post participation

On-Site Interview

- Awareness and participation in P4P programs including BTE
- Motivation for participation in BTE
- Care process improvement experience
- Processes and tools to support improved quality care
- Barriers to success
- Impact of P4P incentives, particularly Bridges to Excellence (BTE)
- Future plans and challenges

Practice Transformation Results

- **Participation process catalyzed improvement**
  - Educate practices on the existence of processes
  - Evaluate current processes
  - Prioritize goals
  - Speed up timetable to implement some goals, and move towards EMR
  - Validated those who had already implemented goals.
- **Drives "chain reaction" of care process change and quality improvement effort**
  - Implementation of EMR
  - Tracking all outside labs, tests, and referrals
  - Monitoring/follow up with patients with chronic illnesses
  - quality improvement committee formed
- **Rewards monies tend to end up in practice bucket**
  - Fund practice-wide efforts (administration, quality department)
  - Offset application/participation process, EMR adoption
- **Obstacles Remain**
  - Effort required for change is not always appreciated by staff
  - Differences in participants interpretation of the standards/benchmarks
  - Sustaining positive changes is difficult

Lessons Learned

- **Financial incentives are a strong motivator:** but must remain consistent to promote sustainable change
- **Rewards provide a strong catalyst for transforming care processes:** when rewards are high
- **Practices actively make process improvements in what they perceive to be a P4P environment**
- **Transformation process is financially difficult for practices**: and while rewards help, they were perceived to be too small to alone sustain most practice improvements
- **P4P is one piece of the puzzle:** In most cases practice staff recognize BTE as one of many motivators driving their practice transformation
- **P4P quality goals set the standard so keep them high:** It promotes a culture of progress and continuous improvement
- **Financial and Resources limit participation:** Application process is cumbersome and is expensive on face value and to execute

Bridges to Excellence Minnesota

Best Practices Study

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buyers health care action group
BHCAG

clear point
health

Study funded by GlaxoSmithKline

Study Objectives

- **Goal:** examine the impact of BHCAG's pay-for-performance (P4P) initiative in diabetes

- Specifically, objectives were to compare rewarded and unrewarded medical groups with regards to:
  - Practice characteristics
  - Differences between 2004 and present

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Methods

- Study Design: retrospective, qualitative interview
- Data Collection:
  - Reviewed background on 54 practice groups
  - Matched 9 rewarded groups and 9 unrewarded groups by location, practice size, specialty
  - Identified Medical Directors and Quality Improvement individuals
  - Web-based screener survey
  - Face-to-face interviews (~1 hour): Sept-Oct 2006

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Methods

- Screener Survey
  - Web-based
  - Background information
- Interview Guide
  - Awareness and pursuit of ICSI Optimal Diabetes Care Guidelines - Revised
  - Diabetes care management approaches
  - EMR and registries to support diabetes care management
  - Processes and tools to support improved diabetes care
  - Performance measurement practices
  - Barriers to success
  - Impact of P4P incentives, particularly Bridges to Excellence (BTE)
  - Future plans and challenges

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Reward vs. Non-Reward

- Rewarded medical groups more likely to:
  - **Actively** pursue goals
  - Have **CDEs**
  - Report in an **unblinded** fashion
- Electronic Medical Record (EMR) = Disruption
- **Tools** and **processes**
  - from standing lab orders to EMR prompts – to aid providers in managing diabetic patients
- **Rewarded** groups looking to increase **patient engagement**
  - attention to coaching and case management, personal care plans and recall systems – as well as **EMR** implementation
- **Non-rewarded** groups looking to improve diabetes **education**, increase **standardization** of practices and create **recall** systems

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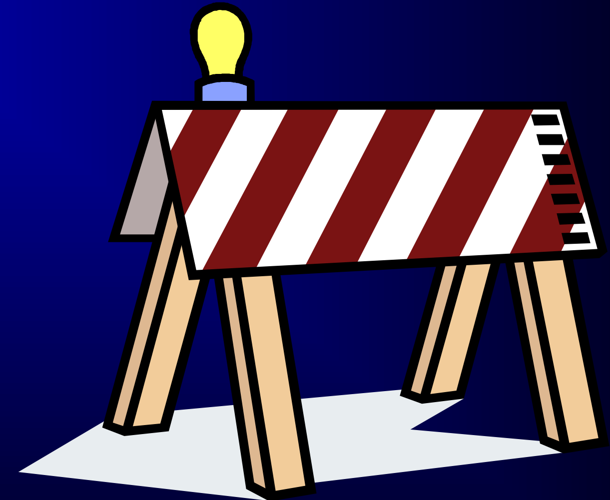
Barriers to Success

Medical groups listed the following as barriers they face in successfully managing diabetic patients:

- Medication cost and adherence
- Balancing costs vs. goal attainment
- Patients who refuse to quit smoking
- Aspirin use for patients on other anticoagulants
- Patients who do not come in for appointments
- Adapting to changing goals (including measurement levels and rates)
- Initial resistance from physicians



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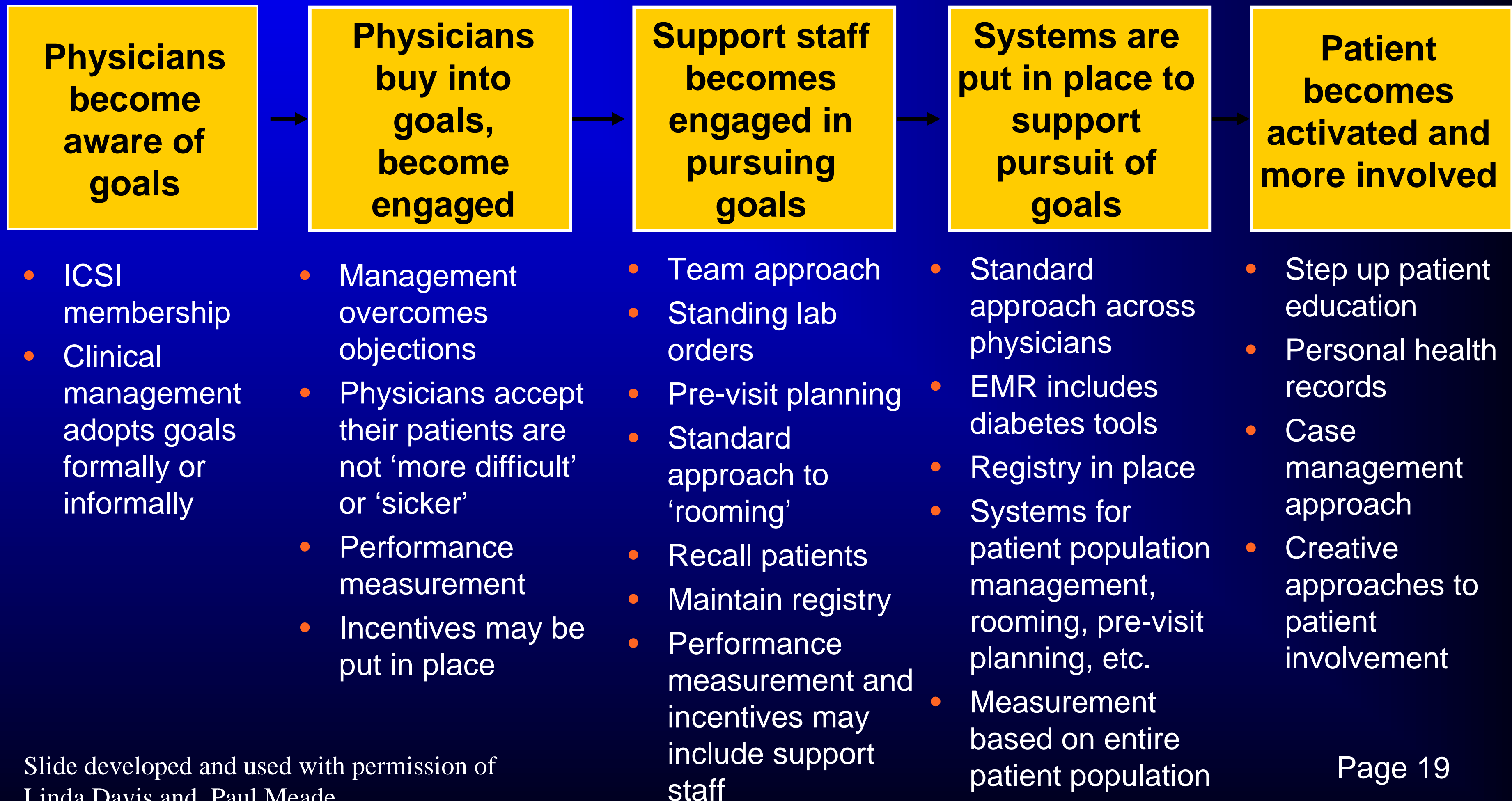
Evolutionary Process

Most medical groups are moving through an evolutionary process with varying levels of success in changing their management of diabetic patients:



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BTE Success in a Small Practice

Harry S. Miller, MD
Four Seasons Pediatrics

BTE Success in a small practice

- Practice of 3 pediatricians in suburban upstate New York
- 90% Commercial 10% Medicaid
- Contact from BTE
  - Mailing Outlined Rewards and program
  - Lunch Meeting
  - Practice interest in using technology to improve care delivery, but cost prohibitive
  - BTE stimulated cost benefit analysis

Challenges faced/Lessons Learned

- Cost
  - Utilize current resources to meet standards
    - Structure of program allowed maximum rewards in 1st year
    - Rewards were applied to purchase of an EMR
      - Re-tooled to meet higher standards
- Re-defined processes at least 3 times
  - Reapplied to achieve maximum rewards
- Staff resistance to change
  - Feedback, meetings, communication

What does BTE mean to Four Seasons Pediatrics and the patients we treat?

- Re-define office flow to take advantage of the EMR
- Improved efficiency
  - Charts not misplaced
  - Follow up for recommended treatments
    - Referrals, lab tests, preventive visits
- Chronic Disease
  - Identification, set standards
  - Incorporate into templates for consistent collection of history, exam, testing, treatment plan and education
  - Alert trigger built into template for patient recall
- Insurer profiles have improved in almost every measure
  - Getting recommended testing, HEDIS scores, lead tests, asthma control, improving generic prescribing

Practice Promotion

- Many insurers promote certification on their websites/directories
- NCQA brochures kept in waiting room
- Patient & Practice testimonial to air in December on MSMoney.com
- Certification aids in insurer contracting

What does P4P mean to our practice?

- Rewards & recognizes the significant work and investment
- Fits our commitment to high quality care
- Could not have started an EMR without BTE
- 16 years in practice, 1st year of BTE was the hardest, 2nd was most enjoyable
- P4P is a key element to recognize practices that proactively invest in systems
  - Using these systems matches what should be happening to what is happening

Quality Improvement at Chapel Hill Pediatrics

Jennifer Lail, MD

Chapel Hill Pediatrics

Our Who and Why of QI

- Suburban Private Practice, 2 offices, self-owned
- Duke University and University of NC Medical Centers within 15 miles
- 11 MD providers, 6 F.T.E.
- 85% Managed Care
- 7.1% Private Pay
- 7.9% Medicaid + SCHIP
- >30 year history of collaboration with both medical centers
- Office hours 365 days/year
- Evening/weekend office hours
- Nighttime Nurse triage and daytime advice nurses
- Birth to age 21

Our Challenges

“System Changes? I have patients to see!”

- Time and Money for Innovation
- Documentation of our Processes
- MD acceptance of change (“late adopters”)
- Staff turnover
- Sustainability (financial and energy)
- Spread of changes

Benefits to All

Clinicians

- Planned care increases efficiency/communication
- Reduced ED utilization
- Improved MD coding
- Streamlined referral process/specialist links
- More new patients
- More use and documentation of practice parameters for conditions

Families

- 84% -"Not difficult" to access specialist
- 98%-Response for phone help or advice
- 93%- Small or no problem to obtain special services
- *"makes my visit more useful and efficient",*
- *"less reviewing, more looking forward"*
- *"you have answers in your pockets!"*

P4P- Value beyond Dollars?

- Impact of Recognition to Patients/Colleagues remain unclear
- Standards and Protocols important as practice grows
- Recognition rewards “behind-the-scenes” work
- Oversight by payers is in our future
- Financial rewards permit ongoing QI efforts

P4P Drives Quality Improvement in Large Integrated System

Barry Bershow, M.D.
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Fairview Health Services
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FAIRVIEW

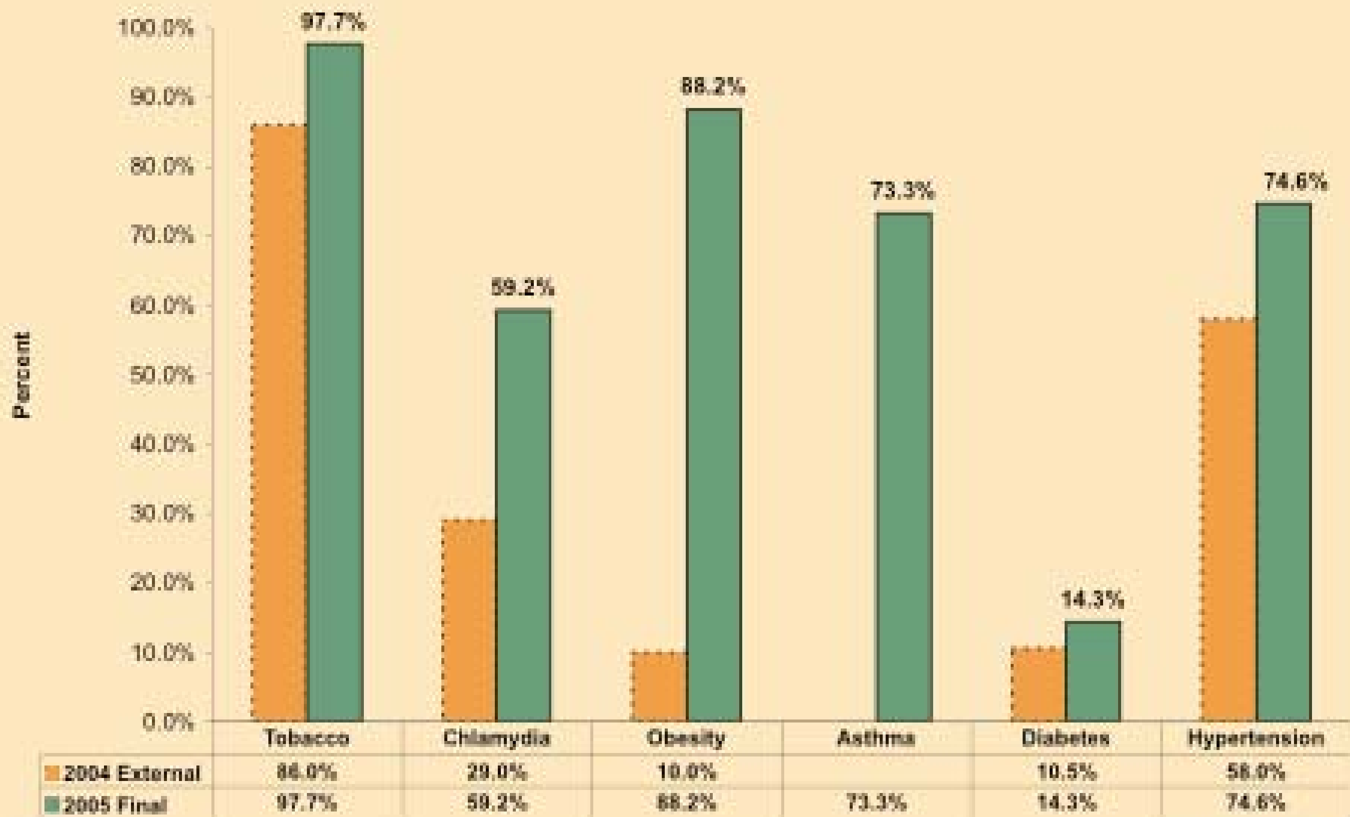
Fairview Health Services

- *20,000 Employers*
- *7 Hospitals*
- *31 Primary care clinics- 300 physicians*
- *28 Specialty clinics*
- *24 Institute for Athletic Medicine locations*
- *5 Urgent care centers*
- *5 Fairview Hand Center locations*
- *8 Orthotics & prosthetics clinics*
- *8 Fairview Counseling Centers*
- *20 Senior housing facilities*
- *5 long-term care facilities*
- *24 Retail pharmacies*

BTE & other P4P programs redirect organizational culture

- 2004- Fairview below average in state for diabetes outcomes as reported by Minnesota Community Measurement
- 2005- average
- 2006- above average, but “in the pack”
- 2007- BTE in place. FV now #1 in state. Named as “setting the benchmark in MN for DM care

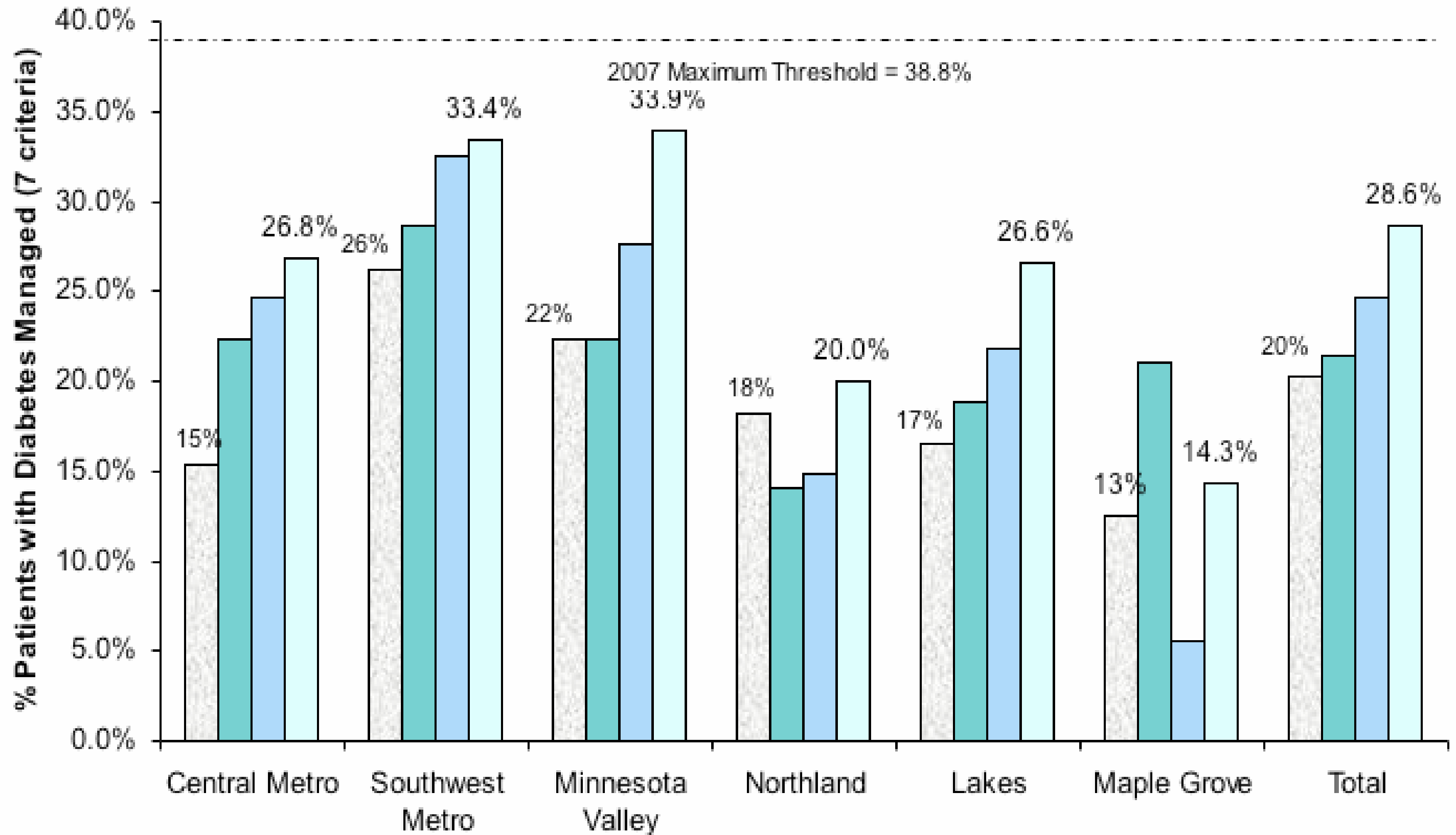
Overall Fairview Clinics (5 Care System) 2005 Quality Initiative Results

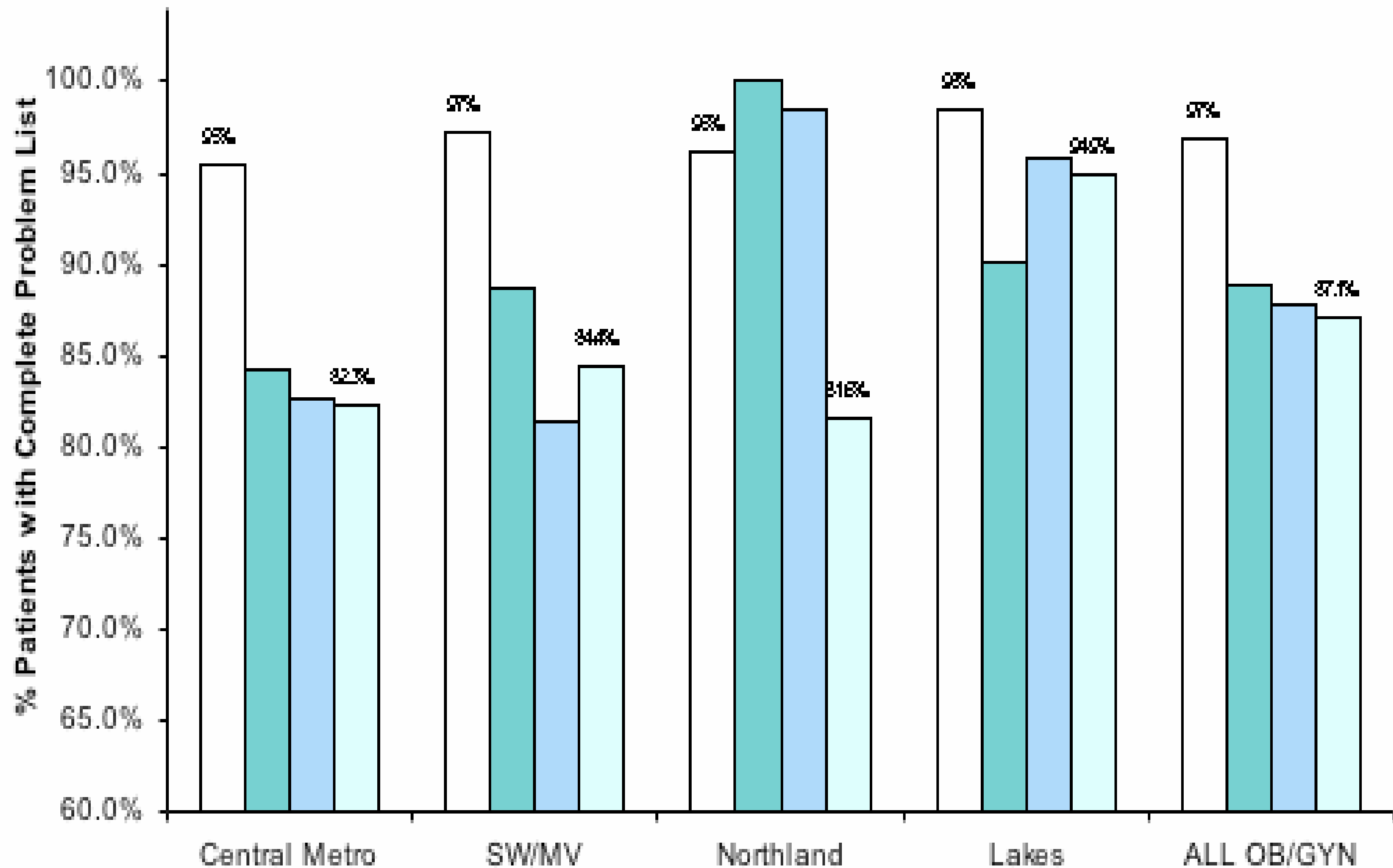


	Tobacco	Chlamydia	Obesity	Asthma	Diabetes	Hypertension
2004 External	86.0%	29.0%	10.0%		10.5%	58.0%
2005 Final	97.7%	59.2%	88.2%	73.3%	14.3%	74.6%

FAIRVIEW

FAIRVIEW

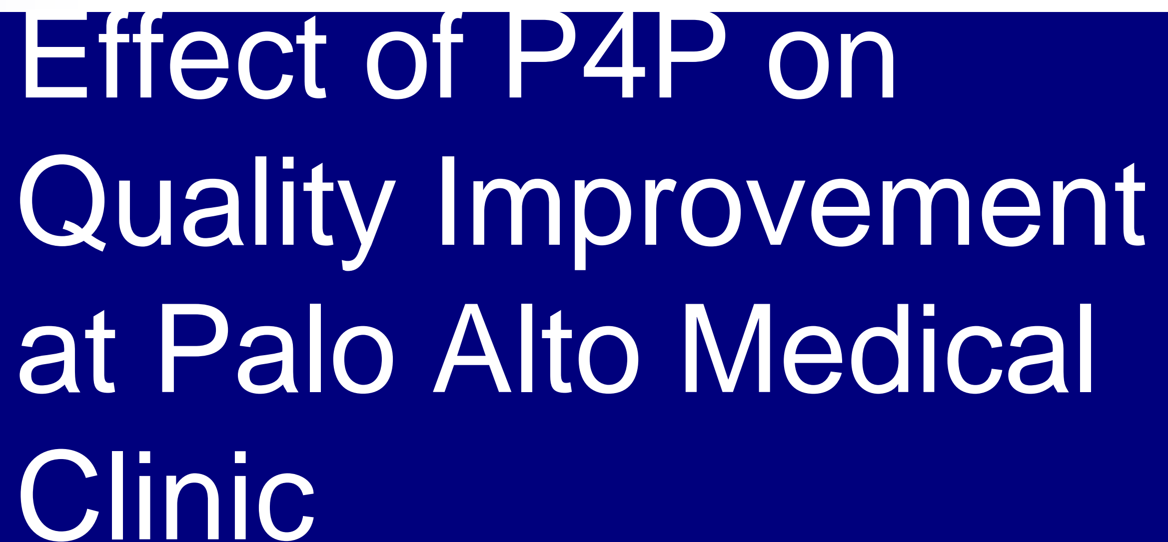

Fairview Ambulatory Clinical Quality Initiative Results
Diabetes Management
2006
2007 1Q
2007 2Q
2007 3Q
% Patients with Diabetes Managed (7 criteria)
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
2007 Maximum Threshold = 38.8%
15%
26.8%
26%
33.4%
22%
33.9%
18%
20.0%
17%
26.6%
13%
14.3%
20%
28.6%
Central Metro
Southwest Metro
Minnesota Valley
Northland
Lakes
Maple Grove
Total



FAIRVIEW

P4P/BTE Lessons

- P4P is a powerful tool in producing improved quality outcomes
- Ongoing P4P continues to improve patient results
- Withdrawal of P4P leads to erosion of gains
- Rewards programs redirect conversation towards what really matters.



Effect of P4P on Quality Improvement at Palo Alto Medical Clinic

Laurel Trujillo, MD
Medical Director, Clinical Quality Data and Reporting

- Multi-specialty Medical Group
- 9 outpatient locations in San Francisco Bay area
- 380 MDs, caring for over 300,000 patients
- Fully functional EMR since 1999

Actively Measuring Outpatient Quality at MD Level

- Unblinded quality metrics published quarterly on intranet at MD level since 2002
- Number of metrics has gradually expanded
  - Preventive Care: Pap smear, Chlamydia screening, Colon Cancer screening, MMR and Varicella immunizations in 2 year olds, % of patients where BMI can be calculated, etc
  - Chronic Disease: Asthma on Long-Term Controller, CHF patients taking ACE/ARB, CHF pts taking Beta Blockers, Warfarin patients with INR check within 28 days, 7 Diabetes metrics (HbA1c, LDL, BP, foot exam), etc

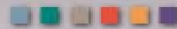
Pay for Performance Initiatives

- Participated in Integrated Healthcare Associations Pay for Performance Statewide Initiative since 2002
  - Total more than $2 million over past 4 years
- 2006 Silicon Valley Health Information Technology P4P
  - Completed NCQA's Physician Practice Connection Tool and received BTE certification
  - Received $137,000 from SV HIT P4P for 2006 performance
- MD Level P4P started in 2007
  - Current research study on effect of quarterly vs. annual MD Incentive payments on metric improvement
  - Maximum payment of $5000 per year each to Primary Care MDs

P4P Effects On Quality Improvement

- Increased visibility of quality of care
  - Clear that improving quality is now one of primary strategies for future competitiveness of organization
  - Interest in incorporating quality measurement at all meetings
- Increased organizational support for Quality Improvement projects
  - Have hosted QI trainings featuring leading national speakers
- MD level P4P really engaged MDs
  - Dramatic increase in questions from MDs about existing quality measurements and how they can improve
- Future
  - Need to develop medical and surgical specialty metrics
  - Efficiency Metrics that focus on variations in practice

Extending the Work of Bridges to Excellence The Patient Centered Medical Home a key to Physician Practice “Buy-In”



Greg Pawlson, MD, MPH
Executive Vice President

Physician Practice Connection®
Testing and Current Use

Recognition Program Rewards

Pay rewards and/or applications fees to recognized MDs

BTE (AR, CO, GA, KY, OH)

Anthem (VA)

Blue Care Network (MI)

BCBS (NC)

BCBS (SC)

Companion Health Plan

CareFirst (DC-MD-VA)

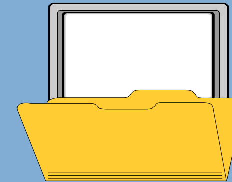
CareFirst (FL)

Silicon Valley (CA)

Taconic IPA (NY)

Distinction in Provider Directory

1. **Aetna**
2. **BCBS Delaware**
3. **CareFirst**
4. **CIGNA**
5. **GeoAccess**
6. **HealthAmerica**
7. **Humana**
8. **Lumenos**
9. **Medical Mutual (OH)**
10. **MVP Healthcare**
11. **United**
12. **CDPHP**
13. **BCBS Association**



Help practices with data collection

BTE (GA, KY, OH)

Novant Health (NC)

North Carolina Healthcare System

United (4 areas)

Use for network entry

Aetna, CIGNA, United

Recognition Process
PPC and Physician Office Link (BTE)

- **NCQA Recognition is based on:**
  - Responses in Web-based Survey Tool
  - Supporting documentation attached to Survey Tool
- **Each element specifies type of documentation**
- **Recognized practice sites – 273 (as of 11/07)**
- **Physicians practicing at recognized sites – 3490**
- **Characteristics of PPC recognized practices**
  - **Practice Size**
    - Median number of physicians – 6
    - Number of solo practitioner sites – 70
  - **Practice Specialties**
    - 57% - Primary Care
    - 19% - Pediatrics
    - 9% - Cardiology
    - 2% - OB-GYN
    - 13% - Multi-specialty

Study of Validity: Accuracy of Self-Report

- Tested accuracy of self-reports of practice systems using on site audit as "gold" standard
  - Varies by domain, by staff position, and by medical group
  - The predictive value of a positive report of a practice system is generally high.
  - Overall agreement with the on-site audit ranges from high (clinical information systems, quality improvement) to low (care management, population management).
- Several factors may explain lack of agreement
  - Variable implementation of systems across sites and conditions
  - Variations in staff members' exposure to systems
  - Lack of familiarity with systems

Conclusion: Need Audit or Documentation

Studies of Correlation of PPC with Clinical Performance and Patient Experience

- Preliminary results from Minnesota (California and Massachusetts in prep)
  - Overall PPC score, and sub-scores have positive correlation with higher clinical performance on most measures (diabetes, CV, asthma)
  - Overall PPC score does NOT appear to correlate with patient experiences of care
  - Presence or absence of EMR per se, correlates ONLY WEAKLY with clinical measures
  - However, practices with *fully functional* EMR's achieve highest scores on PPC

Conclusions

- Assessment of systems is feasible though challenging
- In pay-for-performance applications, review of documentation or on-site audit needed to verify some systems as well as implementation across practice sites
- Educating physicians and practice staff about systems is high priority
- More research on relationship of systems to quality and patient experiences is needed

Patient Centered Medical Home the Concept

The Patient Centered Medical Home Defined

ACP, AAFP, AAP, AOA joint statement – April 2007

- ***Personal physician*** **–** each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- ***Physician directed medical practice*** **–** the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- ***Whole person orientation*** **–** the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- ***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Brief History of Medical Home

- 1980-present: The American Academy of Pediatrics defined the medical home concepts related to caring for children with special needs
- 2000-present: AAFP and ACP have developed and extended the concept to include care for all patients with chronic illness (ACP-advanced medical home, AAFP-Personal Medical Home) and patient centeredness
- 2006-07- AAFP, AAP, ACP and AOA (with input from NCQA) develop common definition of "patient centered medical home" (PCMH) and link PCMH to reform of payment for physicians.

Recent Work on Medical Home

- **12/06–CMS medical home demonstration project included in TRSCA legislation**
- **2007–Rapid uptake by health plans, employers and consumers**
  - AAFP, AAP, ACP AOA and NCQA agree on draft common tool for "qualifying" medical homes
  - Creation of Patient Centered Primary Care Collaborative by ERISA Employers group to advocate for implementation of PCMH projects
  - Interest from private payers
    - PCP shortage
    - Controlling costs

Linkage of PCMH to Reimbursement
A Suggested Model

Pay for Performance
Quality, Resource Use and Patient Experience

Fee Schedule for Visits/Procedures

Payment per Patient for Qualified Medical Homes
(services not normally reimbursed)

To use PCMH as basis of payment reform-we need an accurate and valid way to "qualify practices"

- AAFP and ACP participated in the development of NCQA's Physician Practice Connections (PPC)
- Proposed using PPC as a starting point for a "qualifying" tool

Linking the PPC to the PCMH

Content of PPC-PCMH-Wagner CCM

	What's Included? (Infrastructure)	How Much Used? (Extent)	What Functions? (Implementation)	Evidence and Scoring (Verification)
Delivery System Design				
Clinical Information Systems				
Decision Support				
Self-Management Support				
Community Support				

PPC

Patient Centered Medical Home

Wagner CCM

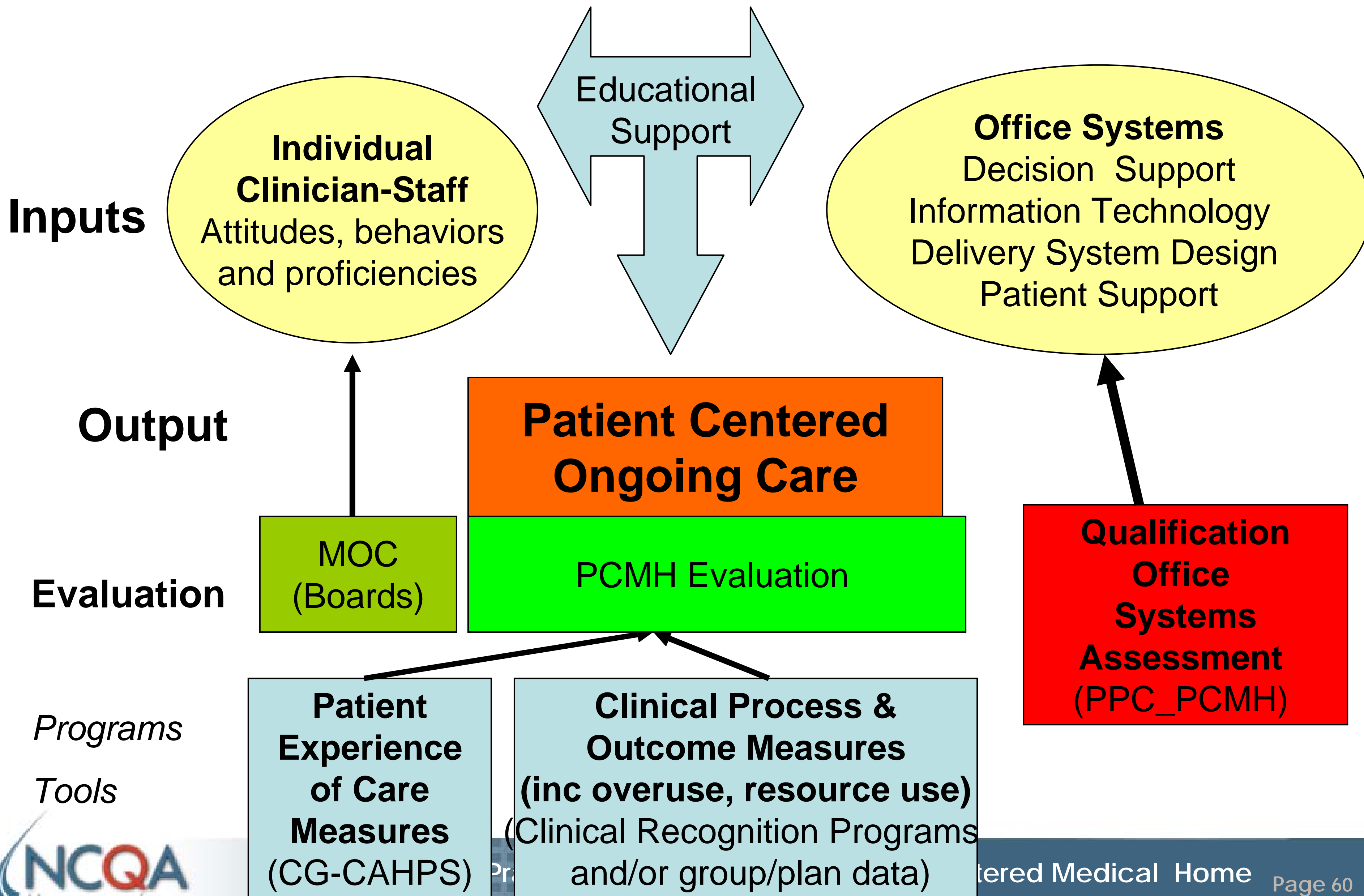
Progress to Date

- **Modification of existing PPC tool with input from ACP, AAFP,AAP and AOA**
  - Critical attributes of PCMH (completed)
  - Review and modification of current PPC tool to use for "qualification" of PCMH by ACP, AAFP, AAP, AOA (PCC_PCMH now endorsed by all four groups)
  - New PPC_PCMH version due out January 2008
- **Engagement of practicing physicians, health plans, employers and consumers**
  - Numerous presentations by ACP et al-and others
  - Emergence of Patient Centered Primary Care Coalition (PC_PCC)

Proposed Implementation of PCMH

- Regional sponsors (plan, coalition, employer group)
- Agreement on core elements of PCMH
  - Affidavit or attestation of core principle of PMCH (as defined by AAP, AAFP, AAP, AOA)
  - Valid, reliable tool to "qualify" practices as PCMH's (PPC)
  - Identification of reliable and valid clinical process and/or outcome, resource use and patient experience of care survey (CG-CAHPS) to evaluate impact of PCMH
- Agreement (via PC-PCC) by five major national plans on collaboration on one or more multi-payer, regional demonstration projects
- Substantial interest by Congress (both Senate and House-both parties) in expansion of CMS PCMH demonstration project passed in December 06

Implementing and Evaluating PCMH-Proposed Model



Next Steps

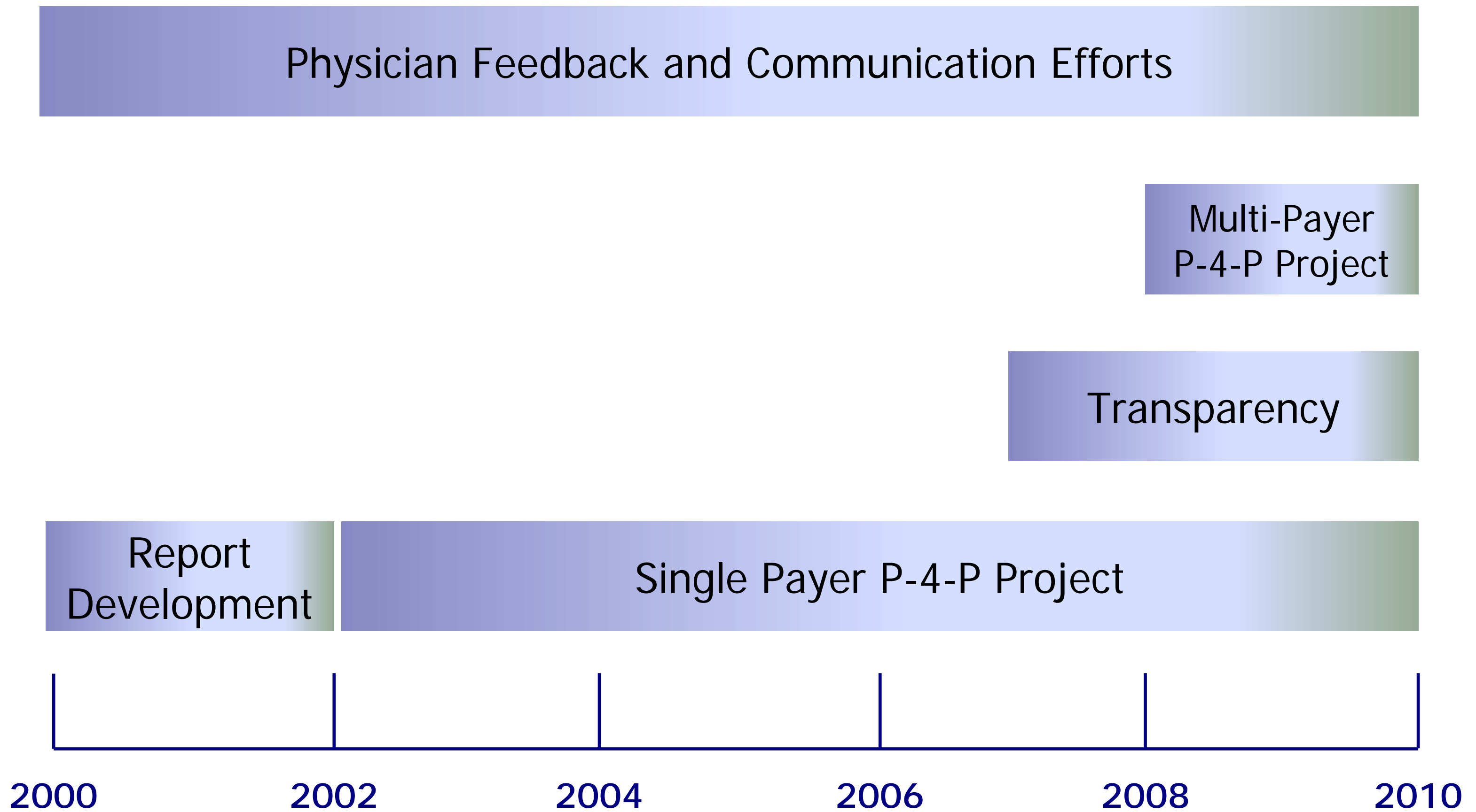
- **Identification and implementation of private sector pilot projects**
  - Multiple regions have indicated intent (RI, Pa, Ma, Me, NY (Taconic and NY city) and others
  - Support for evaluation of key pilots -Commonwealth
- **CMS awarded contract to Mathematica Policy with subs to NCQA and CHSC to assist CMS in defining Medicare PCMH demo**
- **CMS and states exploring implementation in Medicaid and State Employee benefits programs**
  - Legislation passed in Washington and Louisiana
  - Pending in several other states

A. John Blair, III, MD
President, Taconic IPA

Evolution

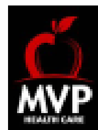
- Claims data
- Structural incentives
  - IT adoption and usage
  - NCQA/POL
- Clinical data

Claims Based Incentives



Physician Reports

TaconicIPA



Physician Quality Report - Family/General Practice

Physician: PRIMARY CARE PHYSICIAN

PQR Region: MVP IPA REGION

Avg Panel: <149

Normalized PQR Score (Range 0 - 1.49): 1.02

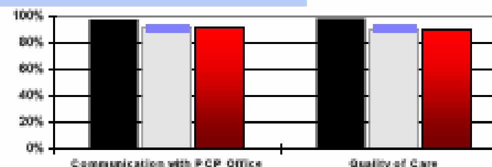
PQR Score Sub-Categories (Range 0 - 2)
Med. Record: 2.00 Disease Mgmt: 0.50
Preventive: 1.50

Member Satisfaction and Access

Quality and Communication

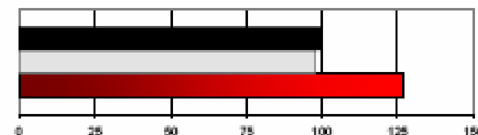
Scores are obtained from questions asked on the Member Satisfaction with PCP Survey which is administered by Eliza Corporation. A complete copy of your survey and explanation of survey methodology is included with this mailing.

Change from 2005: Communication +7.5
Change from 2005: Quality of Care +3.3



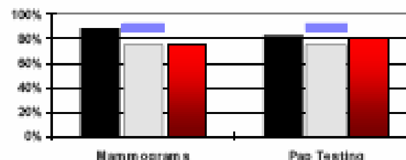
Emergency Room Utilization

The number of ER Urgent/Non-Emergent services accessed by your panel members during the reporting year, reported as a rate/000 members. These services can generally be provided in the office setting. The goal is fewer than 91 such visits per 1000. Region and HMO rates are specialty specific.



Quality of Care

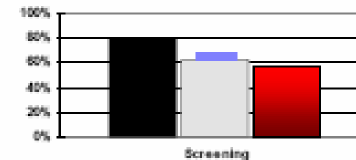
Women's Health



Mammograms: The percentage of your female members between the ages of 52-69 who had a mammogram in the reporting year or the year prior.
Pap testing: The percentage of your female members between the ages of 21-64 who had a pap test in the reporting year or the two years prior.

Change from 2005: Mammograms -6.5
Change from 2005: Pap Testing -9.0

Colorectal Cancer Screening



Percentage of enrolled members 50-80 years of age who have had screening for CRC: flexible sigmoidoscopy during the last 5 years, DCBE during the last 5 years, or colonoscopy during the last 10 years.

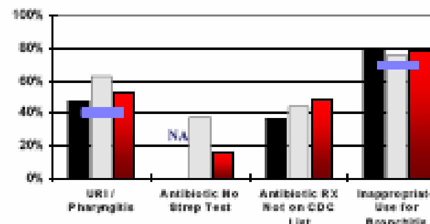
Antibiotic Use

URI/Pharyngitis: Percentage of members in your panel who were treated with an antibiotic for Tonsillitis, Adenoiditis or Pharyngitis without surgery.

Antibiotic No Strep Test: The only condition included that warrants antibiotic treatment is strep pharyngitis. We are not able to report on the results of strep tests, but can report if such a test was performed.

Antibiotic RX Not on CDC List: Percentage of antibiotics prescribed not from the CDC recommended list.

Inappropriate Use for Bronchitis: Percentage of antibiotics dispensed within three days after a diagnosis of acute bronchitis.
A lower rate represents better performance.



Change from 2005: Acute URI/Pharyngitis +4.1

Physician Score *Region Mean* *HMO Mean* *HMO Goal*

Single Payer P-4-P

TIPA Family Practice
2006 Pay for Performance Program
Dr. Example
MVP ID: XXXX

Average Panel Size 2005 289

Pay for Quality P4Q (see other side for P4T)

CRITERIA	HMO Mean	HMO Goal	Payment Level	Measure Definition	Your Score	$ Earned
BASIC						
*Open Panel		Open	$0.10	Panel open to new MVP members	Y	$0.10
*Weekend/Evening availability		3	$0.10	Hours outside of 8:30-5:00 Mon-Fri available for routine appointments	Y	$0.10
COMPREHENSIVE (>149 Members)						
Diabetic Care HbA1c Control < 7	48.9%	60.0%	$0.05/ 0.10	Percentage of the PCP's patients with diabetes, whose A1c was less than 7.0.	20.0%	$0.00
Diabetic Care LDL Control < 100	45.1%	60.0%	$0.05/ 0.10	Percentage of the PCP's patients with diabetes, whose LDL-C was less than 100.	20.0%	$0.00
Well Teen Risky Behavior	75.5%	80.0%	$0.05/ 0.10	Percentage of PCP's patients, age 14-18, where there is medical record documentation present that alcohol or drug screening was performed at least once in past 2 years.	100.0%	$0.10
Well Teen BMI	10.3%	50.0%	$0.05/ 0.10	Percentage of PCP's patients, age 14-18, where there is medical record documentation present that a BMI measurement was done.	0.0%	$0.00
Antibiotic RX URI/Pharyngitis	47.2%	Less than 40.0%	$0.05/ 0.10	Percentage of episodes of URI/pharyngitis, during which an antibiotic was prescribed and filled. Since bacterial infection is infrequent, the goal is to reduce antibiotic use.	**	$0.00
Asthma Medication Management	88.8%	100.0%	$0.05/ 0.10	Percentage of PCP's patients with asthma, who filled a prescription for more than one SABA in a 6 month period, and were also on a long-term controller medication.***	**	$0.00
Member Satisfaction Quality of Care Communication with PCP Office	86.9% 85.3%	90.0% 90.0%	$0.05/ 0.10	Percentages regarding Overall Quality of Care and Communication with PCP Office are obtained from questions asked on the Member Satisfaction with PCP Survey which is administered by FactFinders.	92.5% 89.5%	$0.10 $0.05
ER Utilization: Family Practice Urgent/nonemergent (HMO)	123.1 enc/000	91 enc/000	$0.05/ 0.10	The number of PCP's panel members accessing ER services for conditions that would generally be treated in the office setting, reported as a rate/000 members. HMO mean is specialty specific.	248.0	$0.00
COMPREHENSIVE (>249 Members)						
Resource Consumption Index	0.75-0.89 1.01-1.10	0.90 - 1.00	$0.10/ 0.20	Comprehensive risk adjusted measure of utilization of medical services	**	$0.00

The reporting period ends 6/30/05 for all measures.

** Indicates there were not enough members to qualify for the measure/payment

***Note: To give credit for those who are not using excessive SABA and are on a long-term controller, these members are added into both the numerator and denominator.

Total payout per member per month (capped at $.80)	$0.45
Total member months (January 2005 - December 2005)	3,233
Total P4Q Payout	**$1,454.85**
Total Possible P4Q Payout:	**$2,586.40**

Amount a physician would have received if that physician had scored well enough to receive the maximum payment ($.80 pmpm).

Transparency

Taconic IPA

Family Practice - IPA XXX Performance Metrics

Met credentialing standards ★

Met or Exceeded Average ★★

Met or Exceeded Goal ★★★

	NCQA Recognition	Taking New Patients	Evening or Weekend Hours	Patient use of ER for Non Emergencies (Lower is Better)	Diabetes HbA1C < 7%	Diabetes LDL < 100 mg/dL	Asthma Medication Management	Adolescent Body Mass Index (BMI)	Drug or Alcohol Screening	Antibiotic use for URI/ Pharyngitis (Lower is Better)
MVP Average:				127 /000	54%	46%	90%	33%	83%	53%
MVP Goal:		Yes	Yes	91 /000	60%	60%	100%	50%	90%	40%
Medical Group		Y	N	★★						★★
Medical Group		Y	N	★★	★	★★★	★★★	★	★	★★
Medical Group		Y	N	★★	★	★				
Medical Group		Y	N	★	★	★★	★★★	★	★★★	
Medical Group		N	N	★	★★★	★★★	★★★	★★★	★★★	★★
Medical Group		Y	N	★	★★★	★★	★	★★★	★★★	
Medical Group		Y	N	★★	★★★	★★★	★★★	★	★★★	
Medical Group		Y	N	★★	★★★	★		★	★★★	★★
Medical Group		N	N	★	★★★	★★	★★	★	★★★	★
Medical Group		Y	Y	★★	★★★	★★★	★	★	★	★★
Medical Group	Practice Connections	Y	Y	★	★★★	★★★	★★	★	★★★	★★
Medical Group		Y	Y	★★	★★★	★	★★★			★
Medical Group		Y	Y	★★	★★★	★★	★	★	★	★
Medical Group		Y	Y	★	★	★★★	★	★	★★★	★★
Medical Group		Y	N	★	★	★★★	★★★	★★	★★★	★
Medical Group		Y	Y	★	★	★★	★	★	★★	★★
Medical Group		Y	N	★★	★	★★★	★★★	★★★	★★★	★★
Medical Group		Y	Y	★★	★★★	★★★	★	★★★	★★★	

NCQA Recognition: Physician Practice Connections (PPC) is NCQA's nationwide recognition program for physician practices that use information systematically to enhance the quality of patient care.

It is important to MVP that the data presented accurately represents the performance of each practice. As a result, we only include those practices with at least 250 members. Even with this requirement, there may be other factors such as the prevalence of a given condition within each practice's population, or other variations in the patient mix of each practice, that can impact the reported performance.

Multi-Payer Reports

New York Multi-Payer Data Reporting Project

Provider-Specific Report

Provider Name: Paul Springs **License Number:** 000003

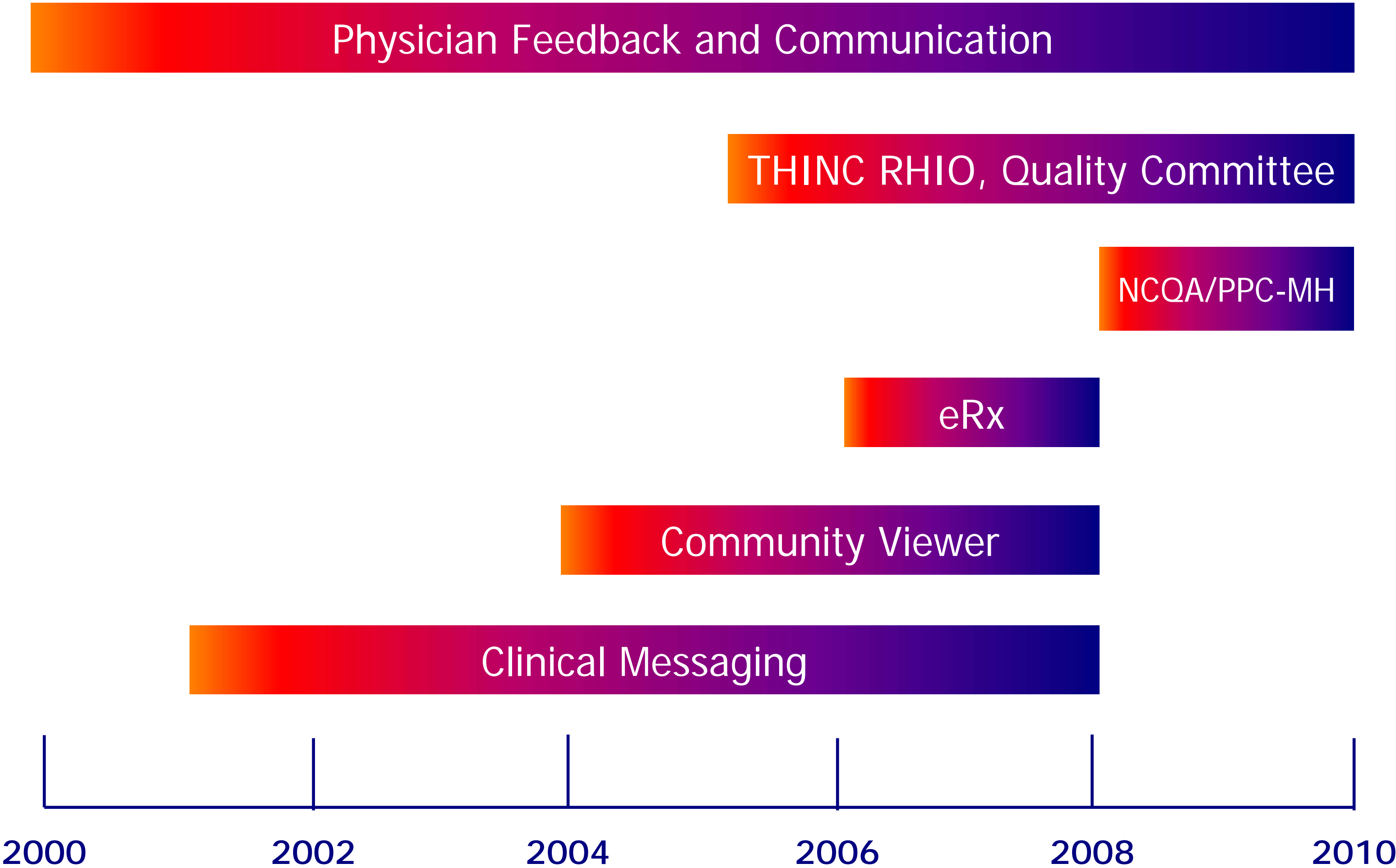
Address: 133 CENTRAL PARK W NEW YORK NY 10023

Measures	Your Results[1]			Project Results[4]			Benchmark	
	Numerator	Denominator	Rate	Numerator	Denominator	Rate	NYC Average[3]	National Average[4]
Breast Cancer Screening	35	56	62.5%	26,192	39,734	65.9%	71.0%	73.4%
Cervical Cancer Screening	89	115	77.4%	72,028	89,511	80.5%	79.0%	80.9%
Colorectal Cancer Screening	83	172	48.3%	56,585	101,964	55.5%	n/a	49.0%
Comprehensive Diabetes Care - HbA1c Tested	44	52	84.6%	13,762	17,337	79.4%	86.0%	92.5%
Comprehensive Diabetes Care - LDL-C Screening Performed	49	52	94.2%	15,834	17,337	91.3%	95.0%	94.9%
Comprehensive Diabetes Care - Nephropathy monitored	29	52	55.8%	9,325	17,337	53.8%	60.0%	65.5%

Physician Feedback & Communication

- Medical Council
  - PCP
  - Specialty
  - Clinical leadership
  - Strong quality focus
- Initial report feedback
  - Individual
  - Group
- Monthly Newsletter
- Physician comment period prior to incentive payments

Structural Incentives



NCQA Physician Practice Connections

- Access / Communication
- Patient tracking / Registries
- Care management
- Self management support
- Electronic prescribing
- Test tracking
- Referral tracking
- Performance reporting & improvement
- Interoperability

THINC RHIO, Quality Committee

- Activities
  - Determine performance measures
  - Promote standards
    - HIE
    - Measure metrics
  - Coordinate payment incentives
- Committee Composition
  - Physicians
  - Hospitals
  - Health plans
  - Quality measures experts

2008 Incentive Pilot

- FFS Base
- Structural Incentive
  - PPC-MH
- Process/Outcome Measure Incentives
  - Claims Data
  - Multi-payer Aggregation
- Clinical Measures
  - CMS/AMA/NCQA/EHRVA Collaborative
  - TCNY Project
  - HL-7 Project

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