Enhancing Quality: Incentivizing Providers

The National Pay for Performance Summit
February 7, 2006

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San Francisco, CA
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Informed Decision Making Tools for Purchasing and Selecting Healthcare Services

Agenda

- National Context for Physician and Hospitals
- Measurement and P4P Strategies and Programs
- What to Measure, How to Measure
- Actionable Reporting
- Provider Engagement
- Public Reporting of Quality
- Predictions and Critical Success Factors

Impact of Trends on Employers and Plans

National Overview

Employers

- Need to Manage Cost
- Encouraging Consumer Engagement
- Demand for Information for Informed Purchasing
- Interest in Transparency
- Performance-based Purchasing
- Shorter Term Horizons - “Aim-fire-ready”

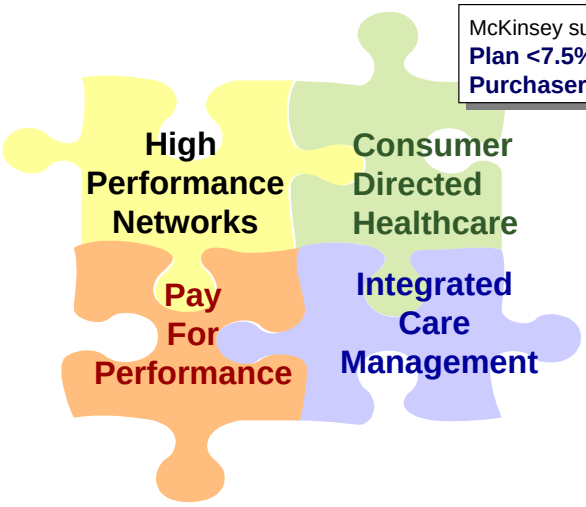
Health Plans

- Need to Manage Trends and Practice Variation
- Need to Maintain Networks
- Quality Calling for Provider Engagement
- Using Evidenced-based Performance Measures
- Developing CDH Products
- Transparency Requires Acceptance
- Longer Term Horizon - “ Crawl-walk-run”

Responses to Health Care Trends

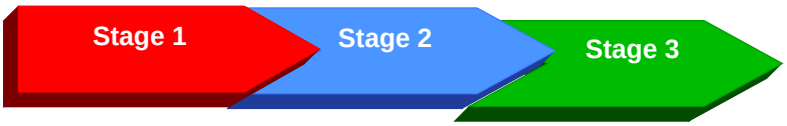
Market Responses

McKinsey suggests savings of:
Plan <7.5%-14%
Purchaser <12.5%-22%



Evolution of P4P Program Designs

National P4P Overview



	Stage 1	Stage 2	Stage 3
Features	• PCP HEDIS measure • Hospital measures • Minimal consumer reporting • HMO product line • Withhold or Bonus based payouts	• PCP + Facility measures, 1-2 Specialties • Balanced Scorecard • EB quality and affordability measures • HMO, PPO, CDH • Tiered fee schedules	• PCP, Specialist + Facility • Balanced Scorecard • Shared savings for funding • Integrate with DM • Actionable MD info - alerts, registries, reminders • All products, ASO
Benefits	• Informational • Low impact on cost • Preventive care • Existing data sets	• Static consumer report cards • Safety and medication errors • Provider IT investment • Collection of non-claims data (lab values, etc.)	• Dynamic consumer report cards (Provider ID) • Demonstrable ROI • Sophisticated clinical info • Point of care data integration

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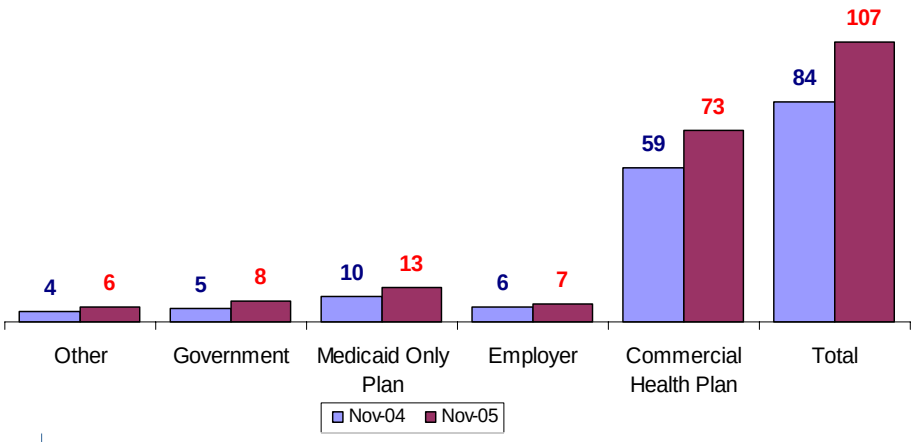
Med Vantage Survey of P4P Programs

National P4P Overview



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Types P4P Programs

National P4P Overview

	2003 n = 34	2004 n = 78	2005 n = 82
PCPs	32 **94%**	73 **94%**	78 **95%**
Specialists	13 **38%**	33 **42%**	43 **52%**
Hospitals	8 **24%**	17 **27%**	30 **37%**

National P4P Overview

Reasons for Implementing P4P Programs

Decision Making Criteria*	Mean 2004	Mean 2005
Improved clinical outcomes	8.3	7.9
Market differentiation, positive image	6.6	6.6
Alignment with other initiatives	7.2	6.4
Reducing medical errors/improving safety	6.6	5.9
Improved medical loss ratio, lower cost	5.9	5.9
Need for better data collection and reporting	6.2	5.4
Employer pressures	6.2	5.0
Regulatory or accrediting body	4.1	3.8

1 = NOT important, 9 = VERY important.

National P4P Overview

Recommendations for New P4P Programs

Recommendation	Responses	%
Involve providers early in the design	61	74%
Use well-established/co-authored measures	52	63%
Be willing to make changes over time	40	49%
Pilot the P4P measures/reports first	26	32%
Use transparency/public reports as incentive	15	18%
Be clear where your own ROI will be	8	10%
Other	7	9%

n = 82

National P4P Overview

Anticipated Changes in P4P Program

Anticipated Change	Responses	%
Change the performance domains/weights	55	67%
Tie P4P to DM, tiering, benefit design changes	48	59%
Collaborate with others (e.g. employers, plans)	38	46%
Develop a public performance report	35	43%
Expand program to other products (PPO, ASO)	33	40%
Expand program from PCP to specialty	33	40%
Expand program to additional specialties	29	35%
Expand program to include hospitals	22	27%
Other	17	21%

n = 82

2005 Physician P4P Domains

National P4P Overview

	2003 Survey n = 34	2004 Survey n = 50	2005 Survey n = 76
Clinical	89%	94%	91%
Patient Satisfaction	79%	56%	37%
Efficiency/Utilization	57%	46%	50%
IT/Infrastructure	39%	54%	42%
Administrative	54%	40%	25%
Other	32%	22%	26%
Patient Safety	n/a	n/a	12%

NOTE: in 2003 and 2004 both hospital and physician P4P programs were included in this question

Sources of Physician Performance Measures

National P4P Overview

Source	Responses	%
HEDIS	68	87%
Internally developed efficiency measures	36	46%
Internally developed clinical measures	35	45%
Patient surveys	25	32%
National Quality Forum	19	24%
Bridges to Excellence	18	23%
AMA Consortium or Specialty Societies	13	17%
CMS	12	15%
AQA Starter Set	11	14%

n = 78

National P4P Overview

2005 Physician P4P: Average Weights for Domains

Clinical	**52%**
Efficiency/Utilization	**35%**
IT/Infrastructure	**26%**
Patient Satisfaction	**22%**
Administrative	**15%**
Patient Safety	**15%**
Other	**28%**

National P4P Overview

2005 Hospital P4P Domains

Performance Domain	# of Responses	%
Clinical quality (process or outcomes)	30	100%
Patient safety / medical error reduction	23	77%
Efficiency/utilization	15	50%
Patient satisfaction / experience / perceptions	10	33%
IT or infrastructure development	8	27%
Community service	2	7%
Administrative	5	17%
Other	2	7%

n = 30

Sources of 2005 Hospital Measures

National P4P Overview

Sources	Responses	%*
The Leapfrog Group	24	80%
Joint Commission	23	77%
Federal CMS	23	77%
National Quality Forum	21	70%
AHRQ	17	57%
Internally developed efficiency measures	13	43%
Patient surveys	12	40%
Self-reported compliance by hospitals	9	30%
Internally developed clinical measures	8	27%
HEDIS	5	17%
AMA Consortium or Specialty Societies	5	17%
Other	3	10%

n = 30

National P4P Overview

2005 Hospital P4P: Average Weights of Domains

Clinical	48%
Patient Safety	34%
Efficiency/Utilization	30%
IT/Infrastructure	13%
Patient Satisfaction	12%
Administrative	10%

n = 30

Building a Performance Scorecard

1. Indentify Prevelent Conditions
2. Apply Evidenced-based Measures to High Impact Conditions
3. Document Sources, Grade of Evidence)
4. Translate guideline into measure specification
5. Establish rules & test reliability
6. Review provider compliance rates and test accuracy at patient level
7. Perform statistical analysis
8. Validate results
9. Develop actionable reporting

Principles of Measure Development

1. Measures that are Quantifiable, Feasible, Evidence-based
2. Comparable and Within Scope for Providers in Specialty
3. Statistically Reliable with Sufficient Sample Size and Reproducible
4. Potential for Impact on Cost Trends and Outcomes
5. Reported with Patient Detail for Process Improvement
6. Developed in Partnership with Physician Community

Sources: 1) Duke Rohe, MD, MD Anderson, Houston, TX, 2) Dr. Nicholas Bonvicino, Medical Director, Horizon BCBS, 3) Principles for Profiling Physician Performance, Massachusetts Medical Society, 1999

Move Towards National Standards

Measure Selection

Marketing -EBM Measures Dataset

MED-VANTAGE EBM CROSSWALK LISTING

MED-VANTAGE EBM CROSSWALK LISTING

MV Ref #	Clinical Measures	Measure Description	Condition	Data Source	HEDIS	NQF	AMA	ACC/AHA	DOQIT/CMS	AHRQ	RAND	ACS	CMS 2005 PIP	REFERENCES
	Cardiovascular/Renal													
1	Total Lipid Profile during preventive health visit; or problem oriented visit	CV preventive screening during problem or well adult visit	CV preventive screening-average risk	Admin				Δ	Δ					NCEP, 2002
2	Baseline lipid profile in those over 35 and/or with high risk CV factors (obesity, Hx of AMI, HTN, diabetes, etc)	CV preventive screening	CV preventive screening - high risk; AMI HX; Diabetes, HTN, Diabetes, Metabolic Syn; Obesity	Admin	Δ	Δ	Δ	Δ	Δ			Δ	Δ	ACC/AHA, NCEP, 2002
3	Stress testing recommended either at preventive health visit or problem oriented visit for men over 45 and women 55 plus with 2 or more CAD high risk factors	AMI Risk Prevention in CAD	CAD	Admin				Δ						ACC, 2002; ACC, 2003; Am Heart J 2005;149:539-53
4	Statin Therapy for patients with elevated lipid panel	AMI Risk Prevention in CAD; statin tx	AMI ;CAD;	Admin		Δ	Δ	Δ	Δ	Δ	Δ	Δ	Δ	ACC/AHA, 2002
5	Beta-Blocker Therapy for patients with history of AMI or post-AMI admission	recurrent AMI Risk Prevention in CAD/AMI; beta blocker tx	AMI	Admin	Δ		Δ	Δ	Δ	Δ	Δ		Δ	ACC/AHA, 2002
6	Initiation of ACEI in post AMI and CAD; Consider chronic therapy for all other patients with coronary or other vascular disease unless contraindicated	recurrent AMI/CHF/risk reduction; ACEI tx	AMI/CHF	Admin		Δ	Δ	Δ	Δ	Δ	Δ	Δ		HOPE Study, 2000; ACC/AHA, 2002; Scottish Intercollegiate Guidelines Network (SIGN), 2000
7	Use of aspirin and/or Plavix antiplatelet therapy in patients post PCTA	DVTPE risk reduction in AMI-patient safety	AMI/PTCA	Admin				Δ					Δ	ACC/AHA, 2000; 2002; JAMA, 2004; BMJ 2005
8	Diuretic as first line drug in treating HTN	HTN drugs tx	HTN	Admin				Δ			Δ			NCEP, 2003; JNC 7, 2003; NHLBI/NIH

Types of Performance Feedback / Reports

Reporting

Type of Feedback/Report	Responses	%*
Periodic report cards - paper	59	76%
Provider meetings	52	67%
Patient registry lists	40	51%
Educational materials	38	49%
Patient reminders	34	44%
Periodic report cards – web based	24	31%
Clinical alerts	20	26%
Reporting at time of patient eligibility	3	4%
Other	9	12%

n = 78

Totals may exceed 100% because multiple answers were tabulated.

Key Performance Indicator Report for Cardiologist

Data & Measurement

Domain	Clinical KPI Measures	Eligible Patients	Total Received Services	Rate	Peer Avg.	Provider Percentile
Coronary Artery Disease	Beta Blocker Compliance – % of Patients after MI on Beta Blocker	**113**	**79**	**69.9%**	**83.6%**	**75th**
	Continued ACEI Therapy after MI	**117**	**79**	**67.5%**	**79.5%**	**65th**
	LDL Test for CAD Population	**115**	**85**	**73.9%**	**78.4%**	**50th**
Total		**597**	**431**	**72.2%**	**83.1%**	**77th**

Scoring Physician Performance

Scoring

Method of Scoring Physician Performance	Responses	%
Performance above an absolute threshold	37	47%
Relative ranking to peer group – each measure	34	44%
Relative ranking to peer group – total score	21	27%
Relative ranking to peer group – efficiency index	9	12%
Relative improvement over previous reporting period	9	12%
Some combination of the above	27	35%
Other	12	15%

n = 78

Major Reporting and Data Constraints

Challenges

Reporting/Data Constraints	Responses	%
Small numbers problem	49	63%
Timeliness of the data	46	59%
Accuracy of the data	40	51%
Availability of lab data	39	50%
Assigning patients to doctors	25	32%
Need to use chart data	24	31%
Sharing/exchange of data with MDs	22	28%
Risk adjustment	21	27%
Availability of pharmacy data	18	23%
Defining a phys. practice/group	16	21%
Auditing the data	16	21%

n = 78

Potential Impact of Moving Quickly

Challenges

THE WALL STREET JOURNAL Tuesday, March 29, 2006

"Doctors Rap UnitedHealthcare For Its New Evaluation Program"

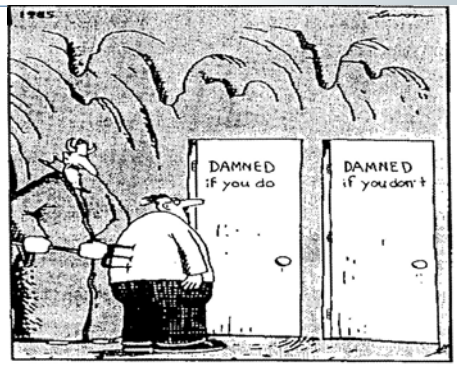
By Sarah Rubenstein

ST. LOUIS POST-DISPATCH Sunday, February 13, 2005

"Health insurance program aimed at efficiency brings confusion, outrage"

By Judith Vandewater

When The Choices Look Like This . . ….Do This……

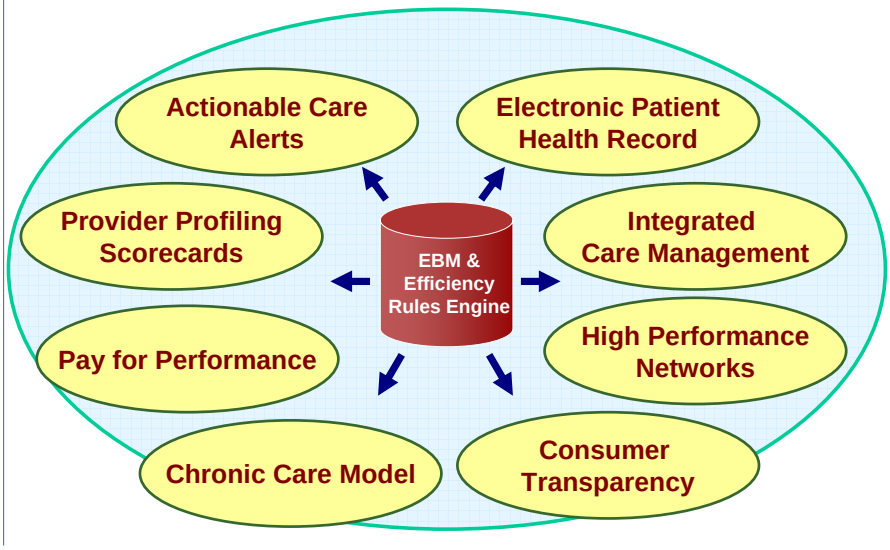


"C'mon, c'mon - It's either one or the other."

Do the right thing.
It will gratify some…
and astonish the rest."

Mark Twain

Health Plans Now Leverage EBM Metrics Across the Enterprise



Data in Physician Workflow

Reporting

MD Site

EMR/Patient Registry

Scores
Patient Registry
Patient Health Record
Education Materials
Care Alerts

HEALTHPLAN

Enterprise Access for Management Decision Making

Web Enabled Connectivity

Chart intake, patient hand-outs, E-Rx, EBM Compliance

Medical Chart, Lab Results, Rx
MD Care Plan
Health Risk Survey
Exceptions

Rules Engine + Decision Support

Plan EDW

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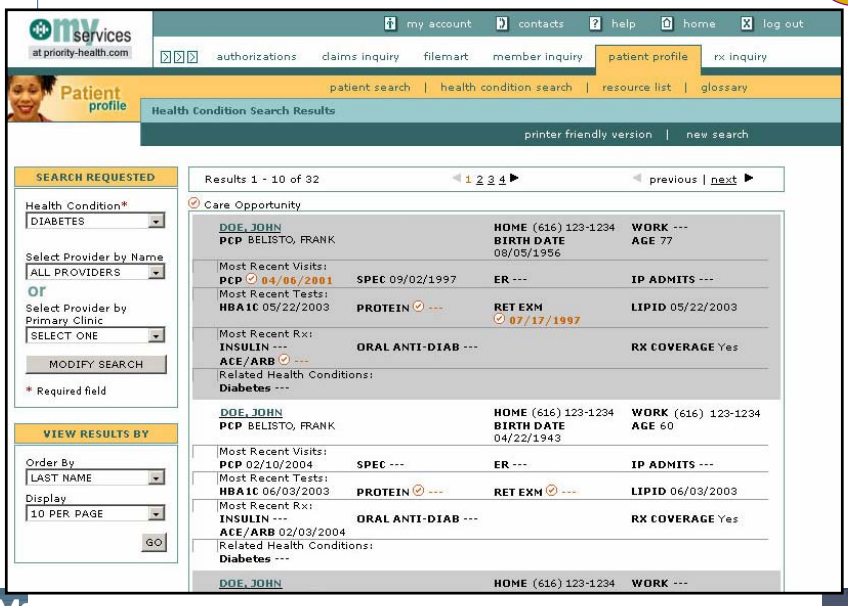
Actionable Physician Scorecard

Reporting



ACP Definition of Provider Engagement

- **Physician "co-authoring"**
- **Data and Measures**
- **EBM based, broadly accepted, clinically relevant**
  - **Physician direct control**
  - **Statistical reliability, sufficient sample size, risk adjustment**
  - **Data collection must not impose higher administrative costs**
- **Information and Process that Fosters Improvement**

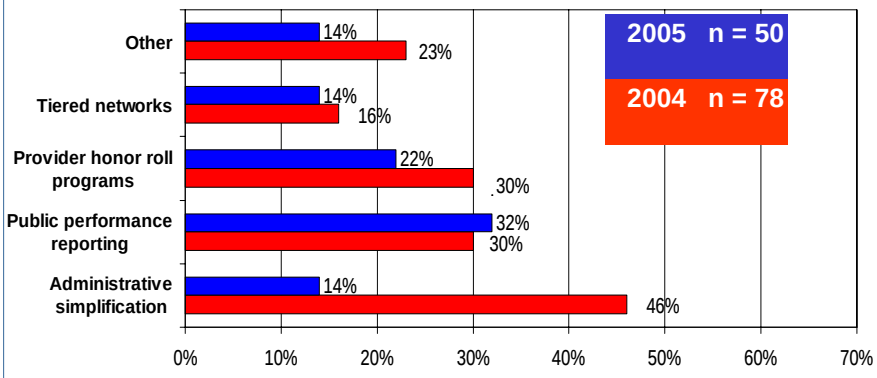
Source: The Use of Performance Measurements to Improve Physician Quality of Care, A Position Paper, American College of Physicians, April 2004

Provider Advisory Council Role and Timeline

Meeting Dates	Key Tasks and Topics
Phase 1 Meetings	• Program goals, guiding principles (CQI vs. tournament) • Overview of Advisory Council role as "co-author" • Proposed performance categories and weighting • Overall program roadmap (evolution of program over time) • Review and address physician concerns
Phase 2 Meetings	• Review baseline quality report results • Refine selection of measures • Review reporting and scoring methodology • Review proposed correction process for MDs • Review and address physician concerns
Phase 3 Meetings	• Finalize reporting and scoring methodology • Finalize measure selection • Finalize program design • Finalize communication for other specialty colleagues • Continuing role of Advisory Council

Physician P4P: Non-Financial Incentives

National P4P Overview



2005 n = 46

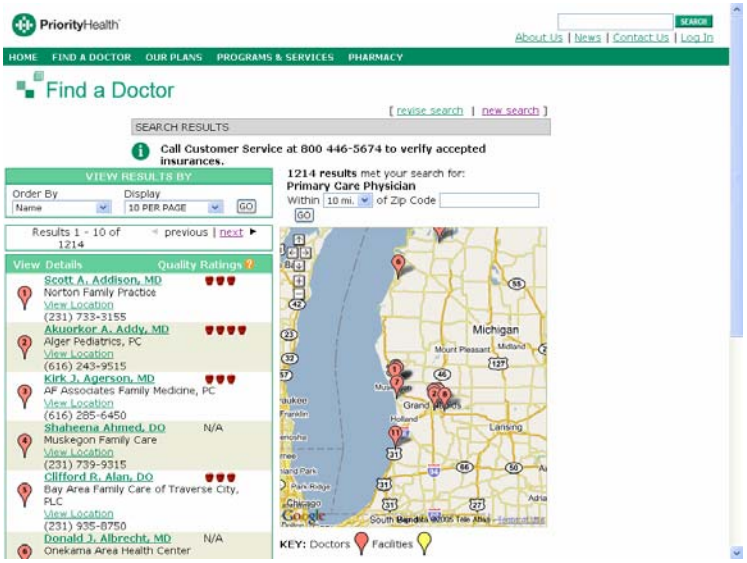
Totals exceed 100% because multiple answers were tabulated..

What Next?...
Uniform Provider and Member Views

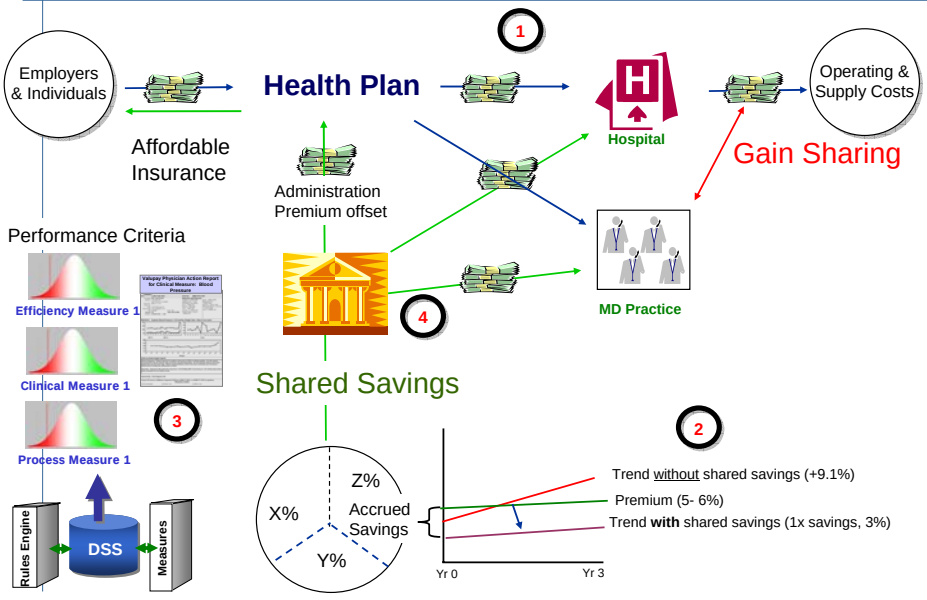
Member

Provider

Public Reporting



Emergence of Shared Savings Models



Key Trends and Issues Ahead in P4P

- **Commitment to IT adoption**
- **Getting "actionable information" to physicians**
- **Public scorecards on quality, efficiency, and IT**
- **Integration of P4P and DM**
- **Growth in *consumer* incentives**
- **Continuing role of CMS**
- **'Budget neutral" P4P**
- **Continued push for standard ambulatory measures**
- **The emergence of "shared savings" models**

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Maine Health Management Coalition: Office Systems Survey and Reporting

Self-Reported Survey on Physician Office Systems:

- Electronic Medical Records
- Patient Registries
- Decision Support (evidence-based guidelines – shared with patients)
- Electronic Prescribing
- Risk Factor Assessment
- Self Management Support

Healthcare information you can trust
Maine Health Management Coalition · *www.mhmc.info*

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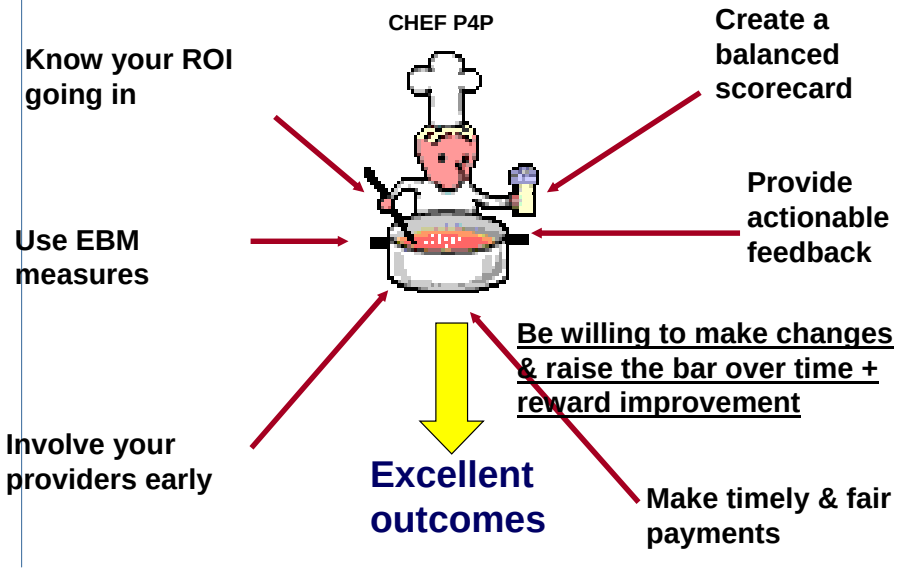
The Key Ingredients for P4P Success?



Adapted from slide by Bruce Taffel, MD BCBST

For More Information…

I thought those guys would never stop talking

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