National Pay-for-Performance Summit

Session on Multi-Stakeholder Views of P4P

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The American Health Quality Association (AHQA)

- AHQA is a 501(c)(6) national trade association, founded in 1973, which lobbies Congress and executive branch agencies.

- We work in partnership with Congress, the Administration and key stakeholders including:
  - AMA, ACP, AAFP, ACEP, AHA, FAH, MedPAC, NQF, BTE, HIMSS, eHI, AAHSA, AHCA, etc.

Summary

- Conceptual Framework for viewing P4P
  - Evidence
- Framework Applied:
  - Bridges To Excellence
- Stakeholder role in P4P:
  - Quality Improvement Organizations (QIOs)
- Future Issues related to P4P
  - Data sources, EMR adoption, HIE

Evidence Supporting P4P

- Few comprehensive studies exist on P4P
- Only 3 demonstrate that P4P leads to improved quality – all single measure efforts
- *Early Experience with Pay-for-Performance: From Concept to Practice*
  - Rosenthal, Frank, Zhonghe, Epstein – Published in JAMA Oct. 12th, 2005
  - Volume 294, No. 14

Rosenthal et al JAMA Study:

- PacifiCare Health Systems in California:
  - Public Reporting since 1998
  - Began P4P in 2003
- PacifiCare in Washington and Oregon:
  - Public Reporting since 1998
  - No P4P
- PacifiCare established performance targets on 10 measures

Rosenthal et al JAMA Study:

- PacifiCare providers eligible for quarterly bonus of $0.23 PMPM for each performance target met
  - Potential Dollars: Physician Group with 10K plan members that reached one target would receive approx. $6900/quarter, or $27,600/year
  - Approx. 5% of plan payment

Rosenthal et al JAMA Study:

- Complete pre and post data available on 3 targeted quality measures:
    1. Cervical Cancer screening
    2. Mammography
    3. HbA1c Testing
- No significant differences in quality for Mammography or HbA1c
- 3.6% improvement in CA over WA/OR in cervical cancer screening

Rosenthal et al Findings:

- Low performers improved the most;
  - high performers improved the least; maintained status quo
- Researchers surprised that low performers improved as much as they did
  - Chances of receiving bonus low
  - Saw P4P program as sign of the future?
- Lesson: Pay for improvement AND for meeting targets

Rosenthal et al Findings:

- Why didn't this P4P program yield higher quality gains across all three measures?
  - Need to pay for performance and improvement
  - Financial rewards too low? (5%)
  - Only one payer, accounting for 15% of the average group's revenue
  - Study spanned 5 quarters: Did providers have enough time to invest in required infrastructure?
  - Money alone is not enough.
    - Need: technical assistance, reporting, incent consumers to choose quality, and P4P

Findings Applied: Bridges To Excellence (BTE)

- Active in 5 markets
- 16,000 participating physicians
- 1600 (10%) are recognized
- 1275 (8%) have been rewarded ($$)
- $4.76 million in rewards paid to date

BTE: Issue: Percent of Revenue

- PacifiCare rewards represented 5% of average medical group revenue
- BTE Similar:
  - Covered patients range >1% -- 15%.
    - Average 5%

Issue: Pay for Targets vs. Improvement

- BTE primarily pays for targets
  - Diabetes and Cardiac Care programs
  - Physician Office Link more incremental over 3 yrs.
- BTE Rationale:
  - Targets are achievable; represent good care vs. excellent care
  - Payers hesitant to pay bonuses for below average care
  - Design Issues with Improvement
    - Improvement over what? How much improvement? Relative vs Absolute?

Issues: Incentivizing Consumers & Public Reporting

- Activated consumers play important role
  - But lack of evidence regarding effective incentives in ambulatory care
  - Some evidence for plan choices based on quality ratings, and hospital choice based on co-pay
- Plans licensing BTE may utilize differential co-pays, but not officially part of BTE.
- BTE publishes names of recognized physicians and info on quality

Issue: Technical Assistance

- One lesson from BTE: Small practices need help re-engineering
- BTE does not provide technical assistance in Diabetes or Cardiac Care
- BTE does, in some states, link to assistance for Physician Office Link
  - Quality Improvement Organizations (QIOs)

Issue: Outcomes Data

- BTE not designed to collect data on improvement over baseline.
  - Providing right care 75% of time is target.
  - Contrast with RAND study – 55% currently
- Many of the BTE physicians had much of the infrastructure in place already
- BUT: data shows these "high performers" continue to improve over time
- Lessons:
  1. To inform national efforts, design of P4P should examine issue of engaging low performers.
  2. To broaden impact of P4P, must increase payer use of P4P to increase % of revenue impacted.

Stakeholder: QIOs and P4P

- #1 role: Help providers perform well:
  - Provide needed assistance with improving quality
  - Help physicians adopt and use the technology infrastructure for practice transformation
  - Engage and assist providers who see significant numbers of underserved patients

QIOs: A National Infrastructure for Quality Improvement

- Private, independent, mostly not for profit organizations, in every state and territory.
- Have three-year, performance-based contracts with Medicare.
- Work with nursing homes, home health agencies, hospitals, physician offices, pharmacies and MA & PDP plans to measurably improve care for beneficiaries
  - QIO quality improvement projects are voluntary
- QIO program represents largest coordinated federal investment in QI -- $4.17 per beneficiary per year ($0.35 PMPM) for 8th SOW.

Do physicians need assistance?

"Unless substantial support is given, physicians will not be able to configure their systems, train for their use, integrate them into their workflow, and support the transition of their staff. In other words, if left alone, most physicians will fail at CPR [computerized patient record] implementation."

-David Brailer, MD, PhD

CHcF, 2003.

Role of QIOs in HIT:

Work with at least 5% of adult primary care practices in 3 domains:

1. Adoption of HIT systems
   - EHR, Registry, e-prescribing, e-labs
2. Care Process & Workflow Redesign
   - for care management, patient self-management and efficiency
3. Reporting of clinical quality data
   - to data warehouse for QI

What QIOs Will NOT Do:

- Provide financial support
  - But do provide “consulting” services for free
- Recommend a specific vendor
  - But will provide considerations to help physicians narrow down their options
- Offer programming or other technical support, perform the installation, write interfaces, etc.
  - But will consult on planning for implementation, workflow and systems configuration to lay the groundwork for care management and QI
- Provide “help desk” support to troubleshoot technical problems
  - Will help troubleshoot workflow issues, quality issues, etc.

HIT Systems Adoption

- Readiness: Help prepare practices
- Planning for implementation
- Considerations for vendor selection
- Guidance on functionality and interoperability considerations
- Information on contract (key points)
- Hardware considerations

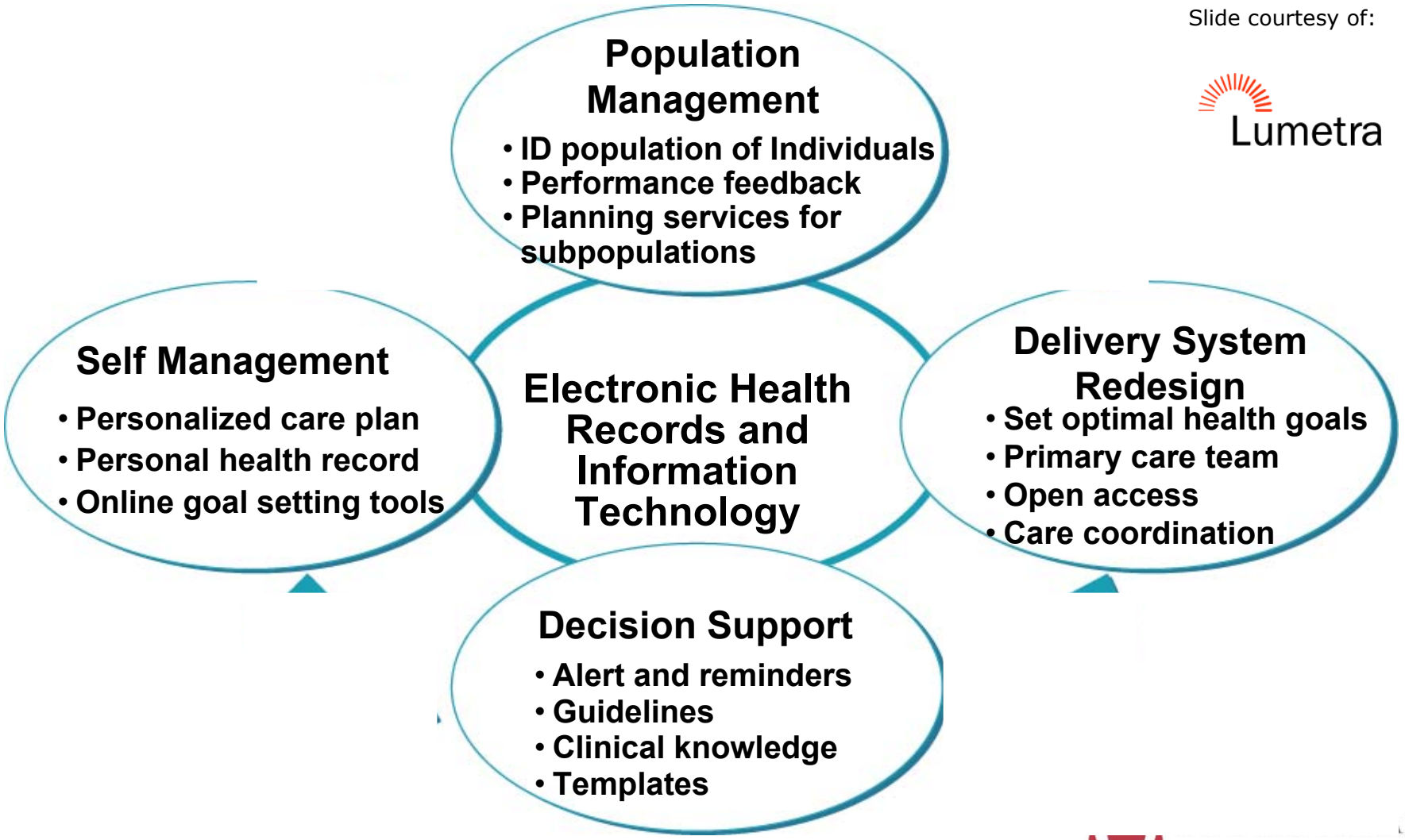
Care Process Redesign

- Assessing current processes
- Mapping workflow
- Guidance on improving chronic care management and preventive care
- HIT functionality
  - Alerts and reminders, decision support, etc.
- Assistance with care management:
  - Group visits, open access scheduling, regular analysis of quality data, etc.

Care Management

Slide courtesy of:

Lumetra



Reporting Data

- From EHR or Registry to Data Warehouse
- DOQ Measures:
  - CAD, HTN, CHF, DM, Preventive Care
- QIO provides practice-specific report on measures
- Identify further changes to improve quality

Quality Improvement

- QIO will help practices understand practice-specific reports on care quality
- Based on data, implement changes to improve quality:
  - Further care process changes
    - Group Visits
    - Open Access Scheduling
    - Patient-specific care plans
    - Activating additional features of EHR
- Continue cycle as needed

Advantages of QIO-BTE Partnership

- Same role in BTE as in future national P4P initiatives:
  - Small practices get help they need but can't afford
  - Payers like link to quality reporting
  - Process of transformation witnessed and supported
  - Avoids "electrifying paper"
  - Helps build data collection infrastructure

Beyond P4P

- Data key for P4P
- Data *quality* is a key issue:
  - Claims data is insufficient, but government will use it
  - Better alternative is data from EMR
- Drive EMR adoption now to prepare for both P4P and H IE
- Health Information Exchange (HIE)
  - Mobilizing information across settings and providers in communities across the country

Health Information Exchange

Health Information Exchange

- HIE likely to help providers:
  - coordinate care
  - improve care
  - reduce costs
  - increase efficiency
- …AND perform better on quality measures
- Which should equal more rewards

Conclusions

- Pay for Performance is coming
  - Over 100 programs in private sector today; National in 5 yrs?
- How it happens just as important as when it happens
  - Need more study & evidence to inform design
- Get beyond the money - P4P must include:
    - Technical assistance – QIOs can help
    - Public reporting & incentivized consumers
    - Engage and incentivize lower performing providers
- Health Information Exchange can help improve quality as well – will benefit P4P
- Get ahead of the curve – healthcare providers need to adopt HIT now.

For More Information:

- List of QIOs to contact for state-specific information: http://www.ahqa.org

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