MedStar Health

Employer and Health Plan P4P Programs – Bridges to Excellence: *A Physician's Perspective*

National P4P Summit

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Peter Basch, MD
Medical Director, eHealth
MedStar Health

Overview

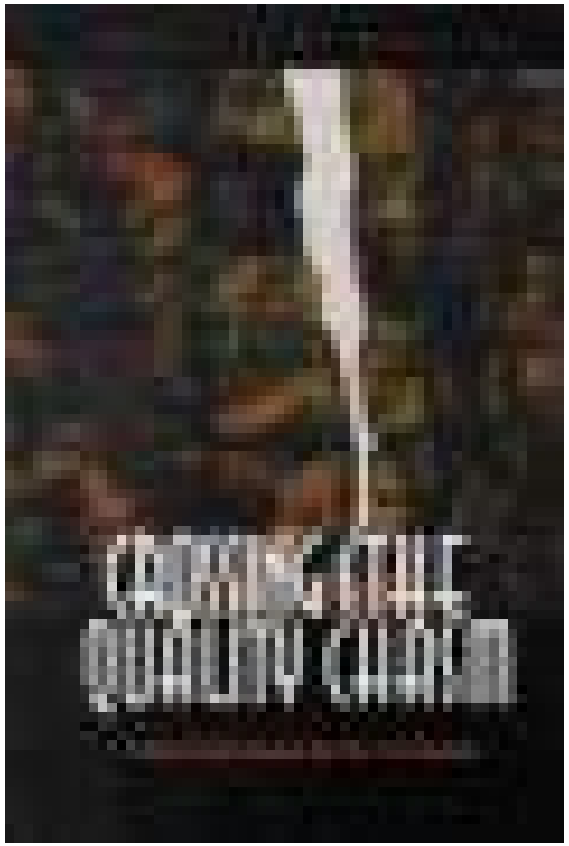
- **Why bother?**

  Defining the "quality" problem and the P4P solution to obtain physician buy-in

- **Bridges to Excellence meets Washington Primary Care Physicians**
- **Barriers to / unintended consequences of P4P**
  - **Patient**
  - **Physician**
  - **Payer**

The chasm…

- Informational medicine is suffering
  - Suboptimal quality
  - Too many errors
- Not compelling to MDs
  - "My practice is fine"
  - "What do you expect from a 7-minute office visit?"



…is growing deeper and wider

New definition of quality includes

- Decreasing unwanted variability
- Decreasing the time from "bench-to-bedside"
- Increasing (or perhaps resuming) care coordination
- Reducing / eliminating disparities in care
- Proactive population and disease management
- Shifting focus from episodic to longitudinal care
- Making health information more mobile and shareable
- Increasing involvement of the patient
- Acknowledging the necessity of reporting / transparency
- Efficiency measures
- Patient satisfaction

And what was once considered good care…

- Reactive episodic visits
- “Top-of-mind” decisions
- Paper-based ad hoc prescribing
- Non-interactive documentation
- No news = good news

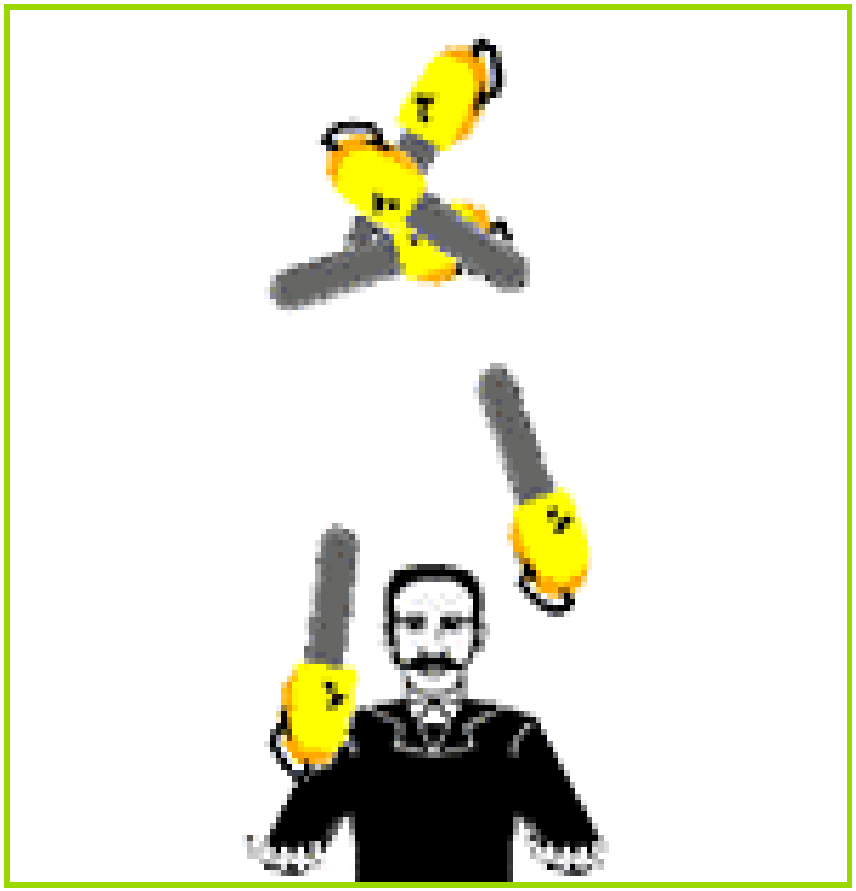
…is no longer

- Reactive episodic visits
- "Top-of-mind" decisions
- Paper-based ad hoc prescribing
- Non-interactive documentation
- No news = good news

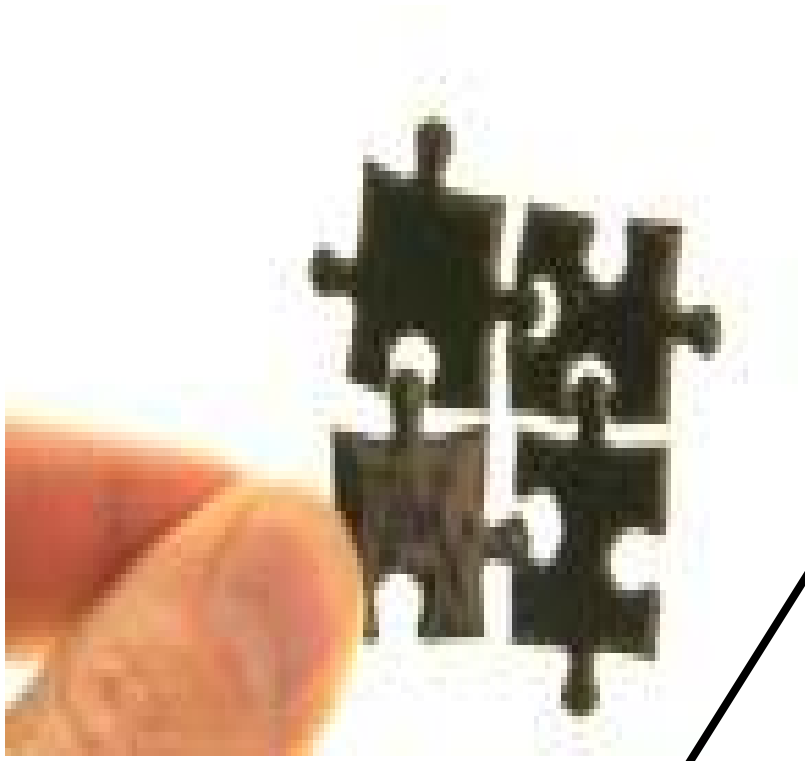
- **Reactive and proactive care**
- **Embedded CDSS / guidelines**
- **Knowledge-based medication management (eRx)**
- **Interactive documentation**
- **Orders loop management**

Particularly when…

- Caring for patients with
  - Chronic disease
  - Multiple disorders
- Attempting to follow complex guidelines in a time-efficient manner
- Coordinating complex medication regimens
- Collecting / reporting quality data to Medicare, QIOs, payers



The solution consists of…



Bridges to Excellence

Aligning financial incentives to:

- Encourage learning / practicing new skill sets
  - Proactive care
  - Collaboration
- Encourage incremental process change / redesign
- Encourage HIT investment and optimal use
- Create a sustainable business case for information management and quality

Washington Primary Care Physicians – then,

1995

- 4-person general IM
- Two offices
  - Capitol Hill (Washington, DC)
  - PG County (Maryland)
- 12 support staff
- Demographics
  - 20% Medicare
  - <1% Medicaid
  - 75% Insured (non-Medicare/Medicaid)
  - ~4% self-pay
- Drowning in paper
- Struggling to survive with declining reimbursements / increasing responsibilities
- Decision made to get an EMR

Washington Primary Care Physicians – then, and now

1995

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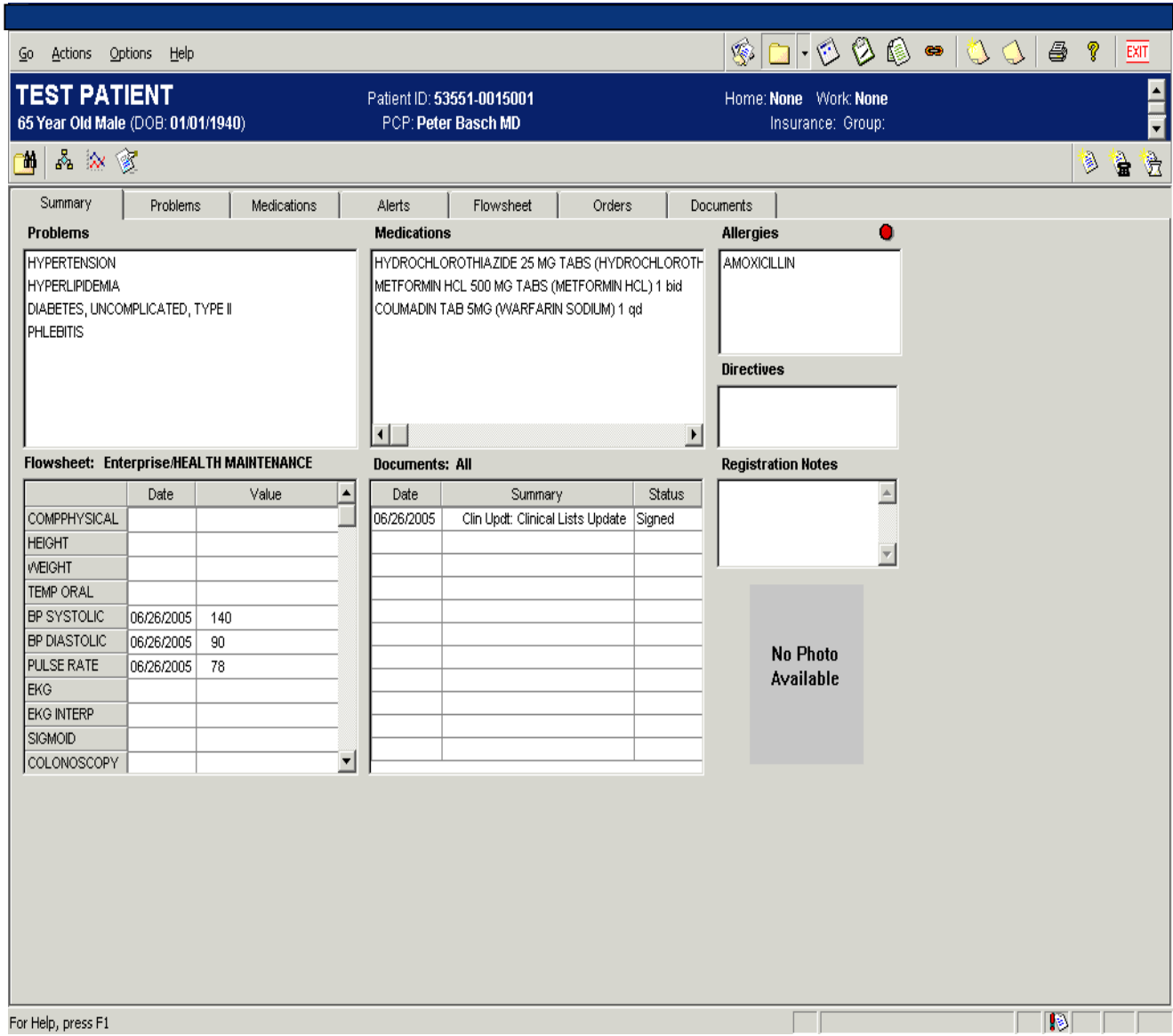
2005

- 6-person general IM
- One office
  - Capitol Hill (Washington, DC)
- 12 support staff
- Demographics
  - 20% Medicare
  - <1% Medicaid
  - 75% Insured (non-Medicare/Medicaid)
  - ~4% self-pay
- Drowning in information
- Surviving
- All enabled by an EMR

And after 8 years

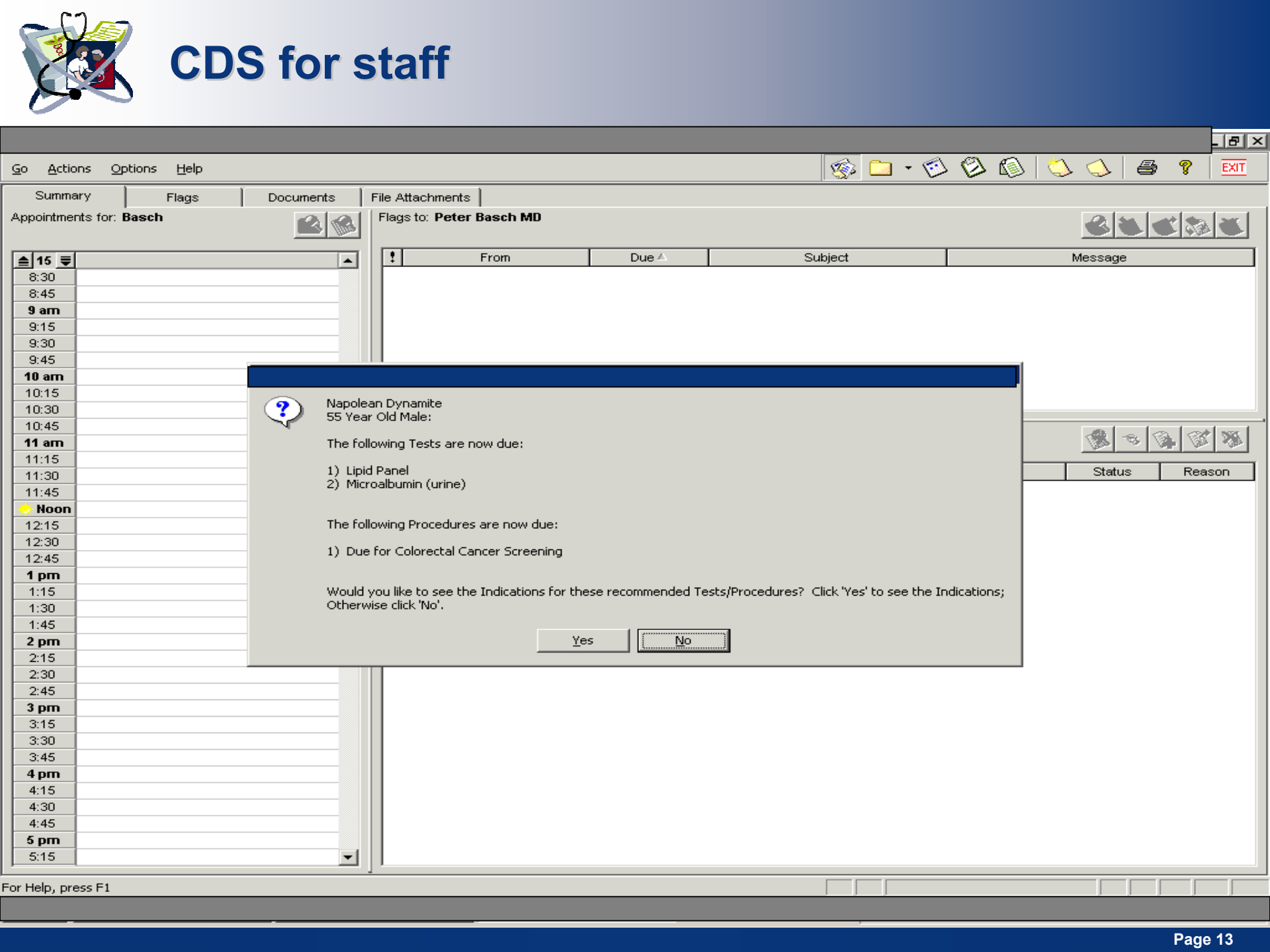
- "Successful" implementation
- No improvement in MD productivity
- Decent improvement in efficiency
- No transcription expenses
- Better communication with patients
- Quality improving, but nowhere near where it could be



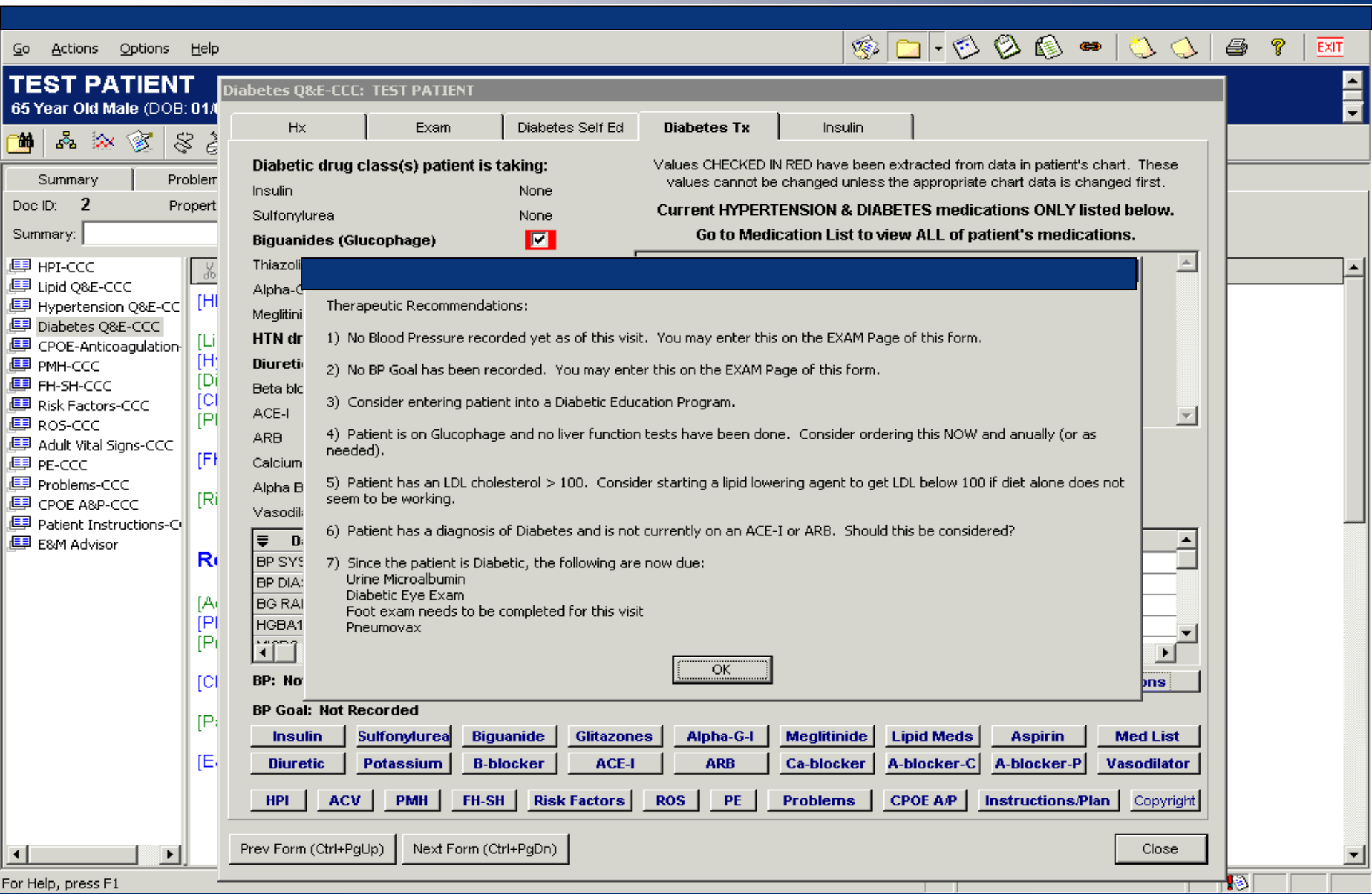
An opportunity emerges

- CareFirst adopts a pilot of the BTE program
- CareFirst is willing to enroll a few practices that already have EMRs, but are not using them optimally for practice improvement
- Our business case for quality
  - Up to $100,000/yr for 3 years
  - Not to maintain the status quo
- I buy some additional software and plan for process redesign

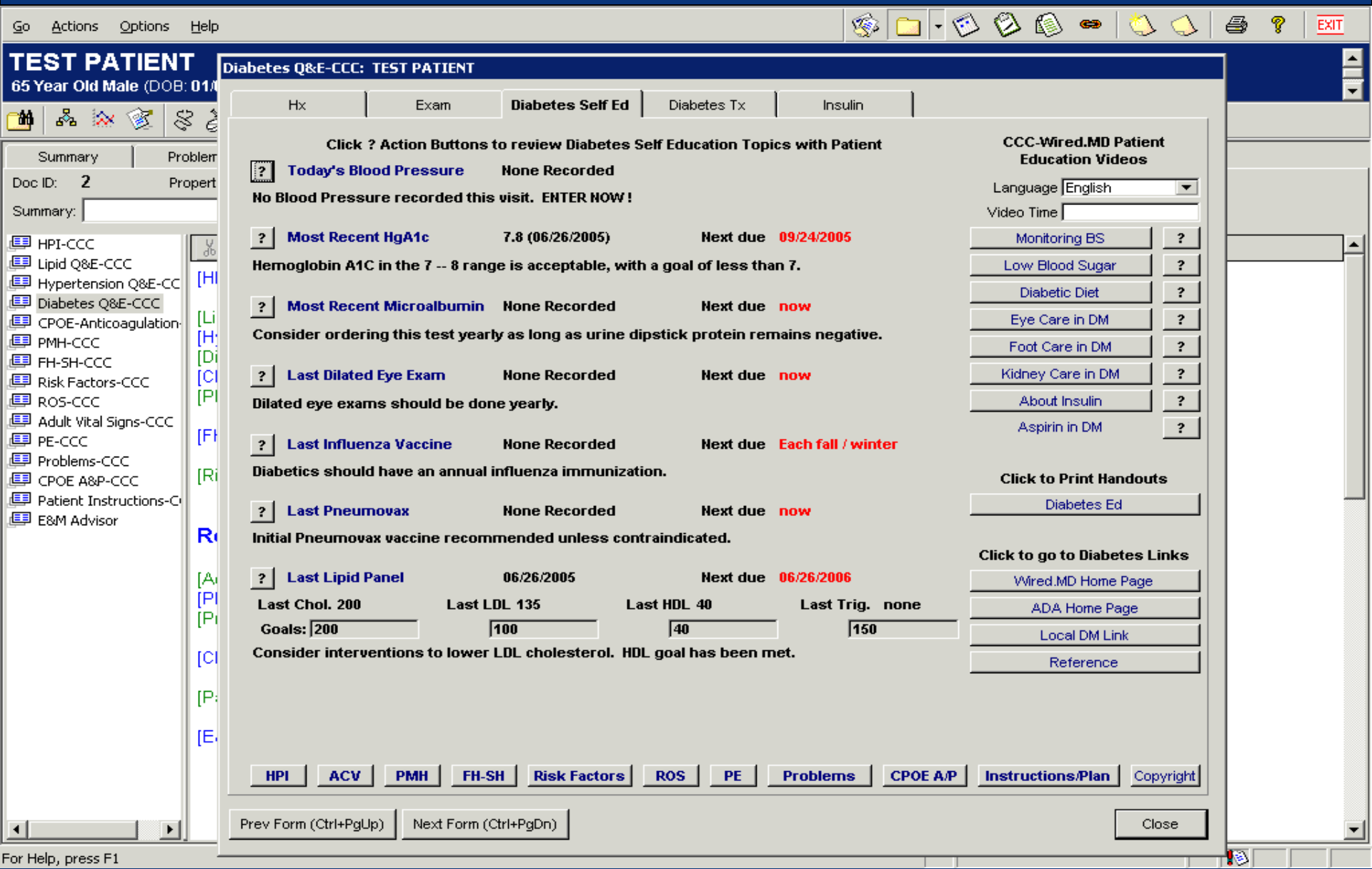
CDS for staff



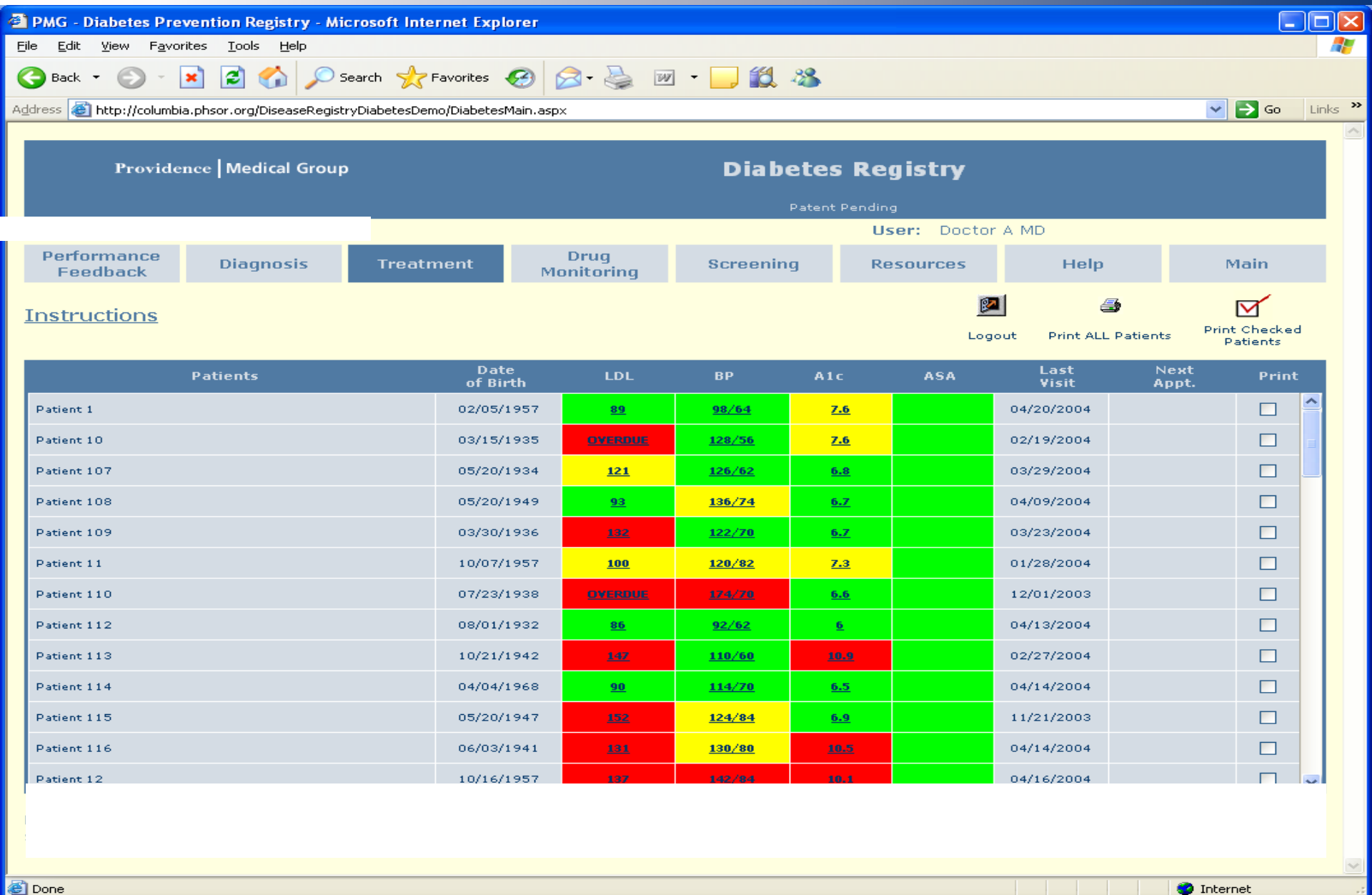
CDS for providers



CDS for patients

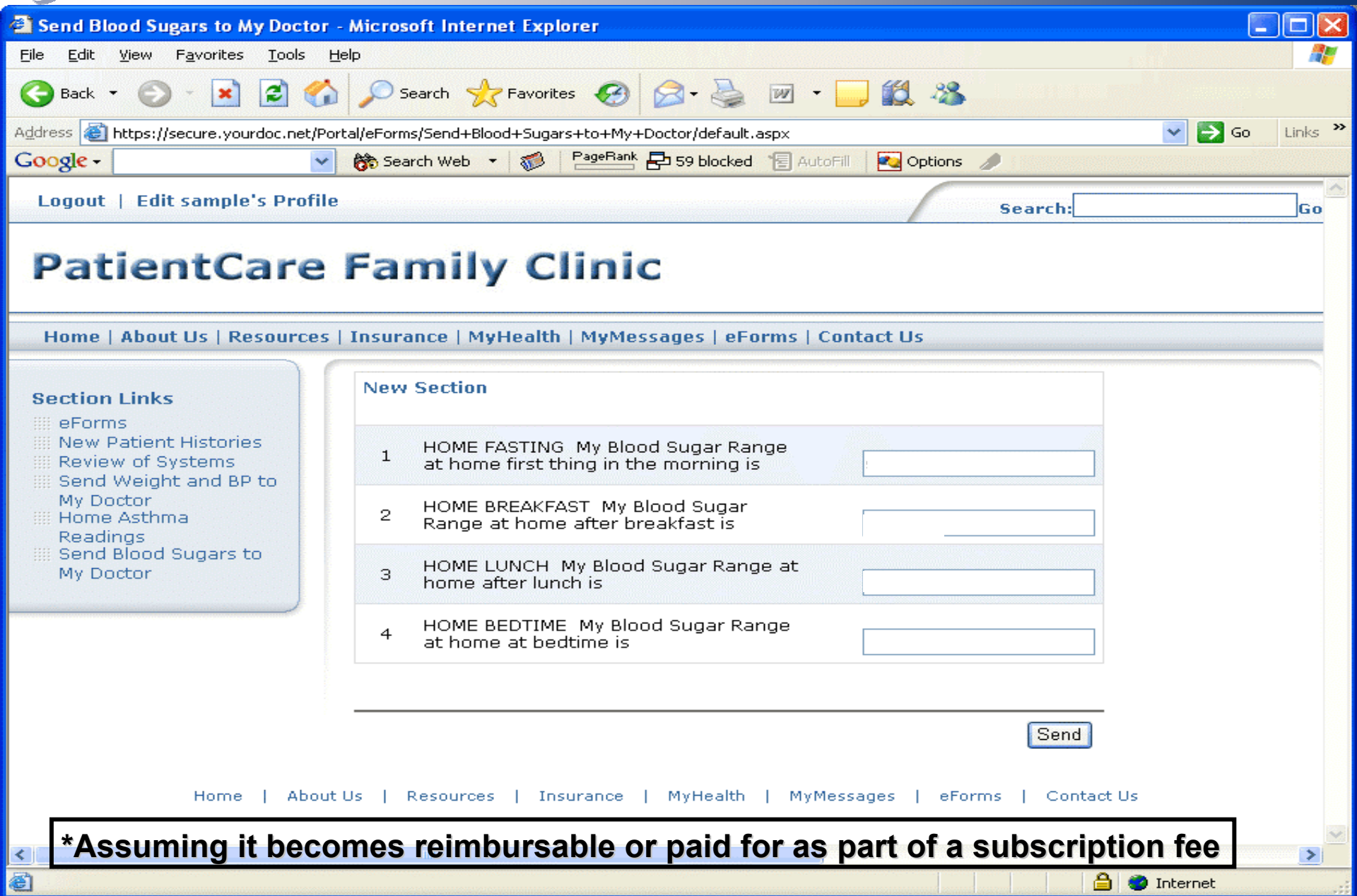


CDS between visits



Patients	Date of Birth	LDL	BP	A1c	ASA	Last Visit	Next Appt.	Print
Patient 1	02/05/1957	89	98/64	7.6		04/20/2004		☐
Patient 10	03/15/1935	OVERDUE	128/56	7.6		02/19/2004		☐
Patient 107	05/20/1934	121	126/62	6.8		03/29/2004		☐
Patient 108	05/20/1949	93	136/74	6.7		04/09/2004		☐
Patient 109	03/30/1936	132	122/70	6.7		03/23/2004		☐
Patient 11	10/07/1957	100	120/82	7.3		01/28/2004		☐
Patient 110	07/23/1938	OVERDUE	174/70	6.6		12/01/2003		☐
Patient 112	08/01/1932	86	92/62	6		04/13/2004		☐
Patient 113	10/21/1942	147	110/60	10.9		02/27/2004		☐
Patient 114	04/04/1968	90	114/70	6.5		04/14/2004		☐
Patient 115	05/20/1947	152	124/84	6.9		11/21/2003		☐
Patient 116	06/03/1941	131	130/80	10.5		04/14/2004		☐
Patient 12	10/16/1957	137	142/84	10.1		04/16/2004		☐

Plans to integrate eCare*



***Assuming it becomes reimbursable or paid for as part of a subscription fee**

Potential problems with P4P

- For patients
  - Cherry picking
  - Patient dumping
  - The return of medical paternalism
- For physicians
  - Mistrust of data
  - “Shell game” with dollars
  - Further deprofessionalization
- For payers
  - Measurement mania clouds common sense

Summary

- **Defining the quality problem and P4P solution appropriately is essential for physician buy-in**

  Labeling practice as "bad" is not effective

- **P4P should incent the outcomes we wish to see, and should not be so narrow that we see nothing else**
  - **BTE is an excellent start, however…**
  - **Still need long-term solution that create a sustainable business case for information management and quality**
    - **Makes advanced EMR purchase a wise investment**
    - **Makes it more likely that the EMR will be used to support system level change / transformation**
- **Moving towards P4P is not without risk, but if done thoughtfully, is far less risky than continuing our current payment system**