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“Physicians and Physician Organizations: The Engine of P4P”

Review of California P4P History and Experience

History

- Statewide collaborative program
- 2000: Stakeholder discussions started
- 2002: Testing year
  - IHA received CHCF Rewarding Results Grant
- 2003: First measurement year
- 2004: First reporting and payment year
- 2007: Fifth measurement year;
  fourth reporting and payment year

Goal of P4P

To create a compelling set of incentives that will drive breakthrough improvements in clinical quality and the patient experience through:

- √ Common set of measures
- √ A public scorecard
- √ Health plan payments

Plans and Medical Groups – Who's Playing?

Health Plans*

- Aetna
- Blue Cross
- Blue Shield
- Western Health Advantage (2004)
- Health Net
- PacifiCare
- CIGNA

Medical Groups/IPAs

228 groups / 40,000 physicians

12 million HMO commercial enrollees

* Kaiser Medical Groups participate in the public scorecard

Program Governance

- Steering Committee – determine strategy, set policy
- Planning Committee – overall program direction
- Technical Committees – develop measure set
- IHA – facilitates governance/project management
- Sub-contractors
  - ✓ NCQA/DDD – data collection and aggregation
  - ✓ NCQA/PBGH – technical support
  - ✓ Medstat – efficiency measurement

Multi-stakeholders "own" the program

Organizing Principles

- Measures must be valid, accurate, meaningful to consumers, important to public health in CA, economical to collect (admin. data), stable, and get harder over time
- New measures are tested and put out for stakeholder comment prior to adoption
- Data collection is electronic only (no chart review)
- Data from all participating health plans is aggregated to create a total patient population for each physician group
- Reporting and payment at physician group level
- Financial incentives are paid directly by health plans to physician groups

Measurement Domain Weighting

	MY 2003	MY 2004	MY 2005-06*	MY 2007
Clinical	50%	40%	50%	50%
Patient Experience	40%	40%	30%	30%
IT Adoption	10%	20%	20%	
IT-Enabled Systemness				20%
Efficiency				TBD

* Starting in MY 2006, measures of absolute performance and improvement are included for payment

MY 2007 Clinical Measures

- **Preventive Care**
  - ✓ Breast Cancer Screening
  - ✓ Cervical Cancer Screening
  - ✓ Childhood Immunizations
  - ✓ Chlamydia Screening
  - ✓ Colorectal Cancer Screening
- **Acute Care**
  - ✓ Treatment for Children with Upper Respiratory Infection
- **Chronic Disease Care**
  - ✓ Appropriate Meds for Persons with Asthma
  - ✓ Diabetes: HbA1c Testing & Poor Control
  - ✓ Cholesterol Management: LDL Screening & Control (<130 and <100)
  - ✓ Nephropathy Monitoring for Diabetics
  - ~~✓ Obesity Counseling~~

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MY 2007 Patient Experience Measures

No changes from MY 2006:

- Communication with Doctor
- Overall Ratings of Care
- Care Coordination
- Specialty Care
- Timely Access to Care

MY 2007 IT-Enabled "Systemness" Domain

- Incorporates two current IT Domain measures and Physician Incentive Bonus
  - Data Integration for Population Management
  - Electronic Clinical Decision Support at the Point of Care
  - Physician Measurement and Reporting

- Adds two new measurement areas:
  - Care Management
    - Coordination with practitioners, chronic care management, continuity of care after hospitalization
  - Access and Communication
    - Having standards and monitoring results

Proposed MY 2007 Efficiency Domain

- Consider cost / resource use alongside quality
- Compare across physician groups the total resources used to treat :

  1) an episode of care, and

  2) a specific patient population over a specific period of time

- Risk-adjusted for disease severity and patient complexity

Proposed MY 2007 Efficiency Measures

1. Overall Group Efficiency
   - Episode and population based methodologies
2. Efficiency by Clinical Area: specific areas TBD
   - high variation
   - account for significant portion of overall costs
   - areas that can be reliably measured
3. Generic Prescribing
   - Using cost and number of scripts

Strategic Measure Selection Criteria

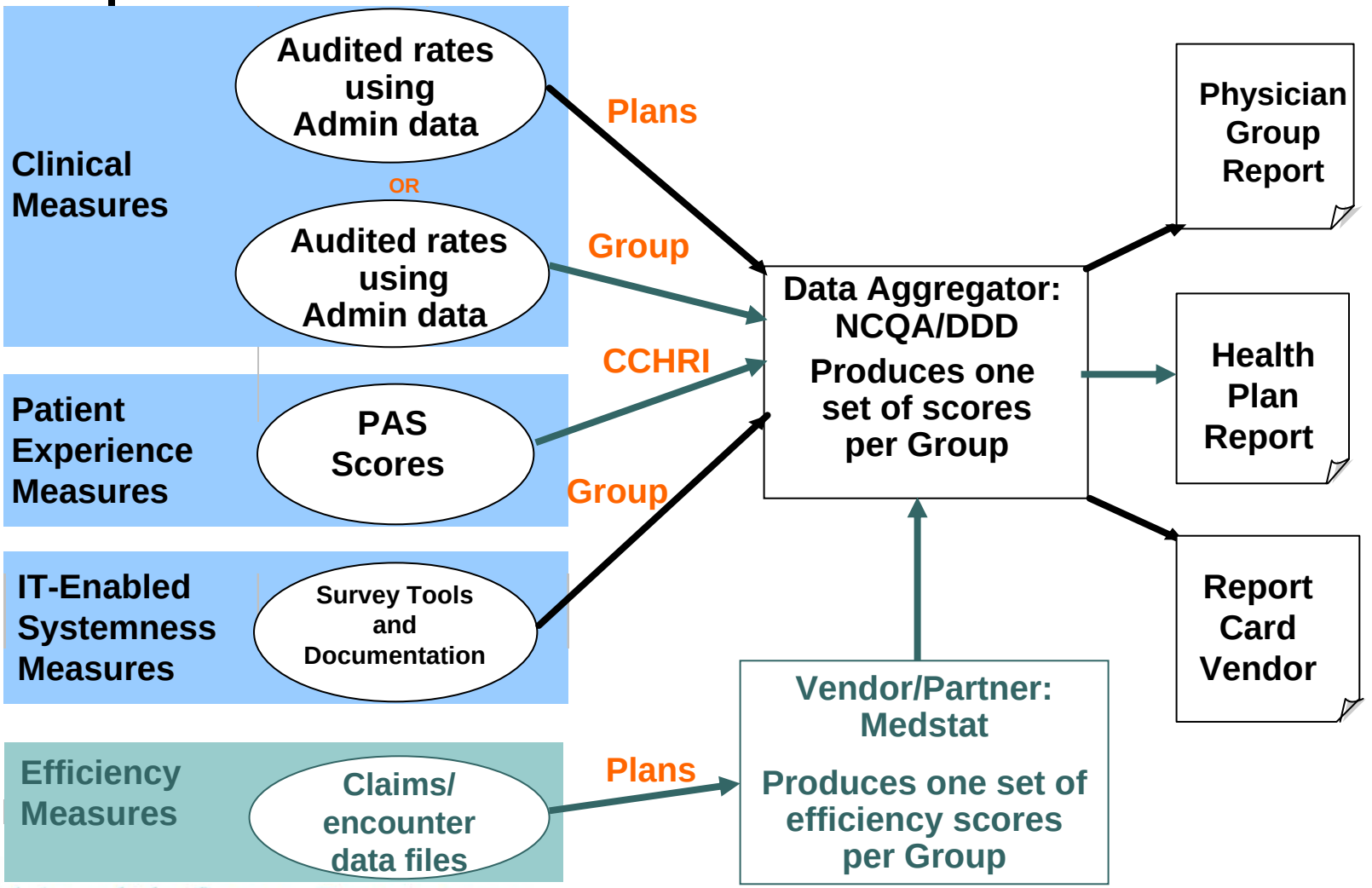
Include measures that are:

- Aligned with national measures (where feasible)
- Clinically relevant
- Affect a significant number of people
- Scientifically sound
- Feasible to collect using electronic data
- Impacted by physician groups and health plans
- Capable of showing improvement over time
- Important to California consumers

2007 P4P Testing Measures

1. Appropriate Use of Rescue Inhalers
2. Potentially Avoidable Hospitalizations
3. Evidence-Based Cervical Cancer Screening of Average Risk, Asymptomatic Women
4. Childhood Immunization Status – Hepatitis A
5. Appropriate Testing for Children with Pharyngitis
6. Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis
7. Use of Imaging Studies for Low Back Pain
8. Annual Monitoring for Patients on Persistent Medications
9. Diabetes Care – HbA1c Good Control

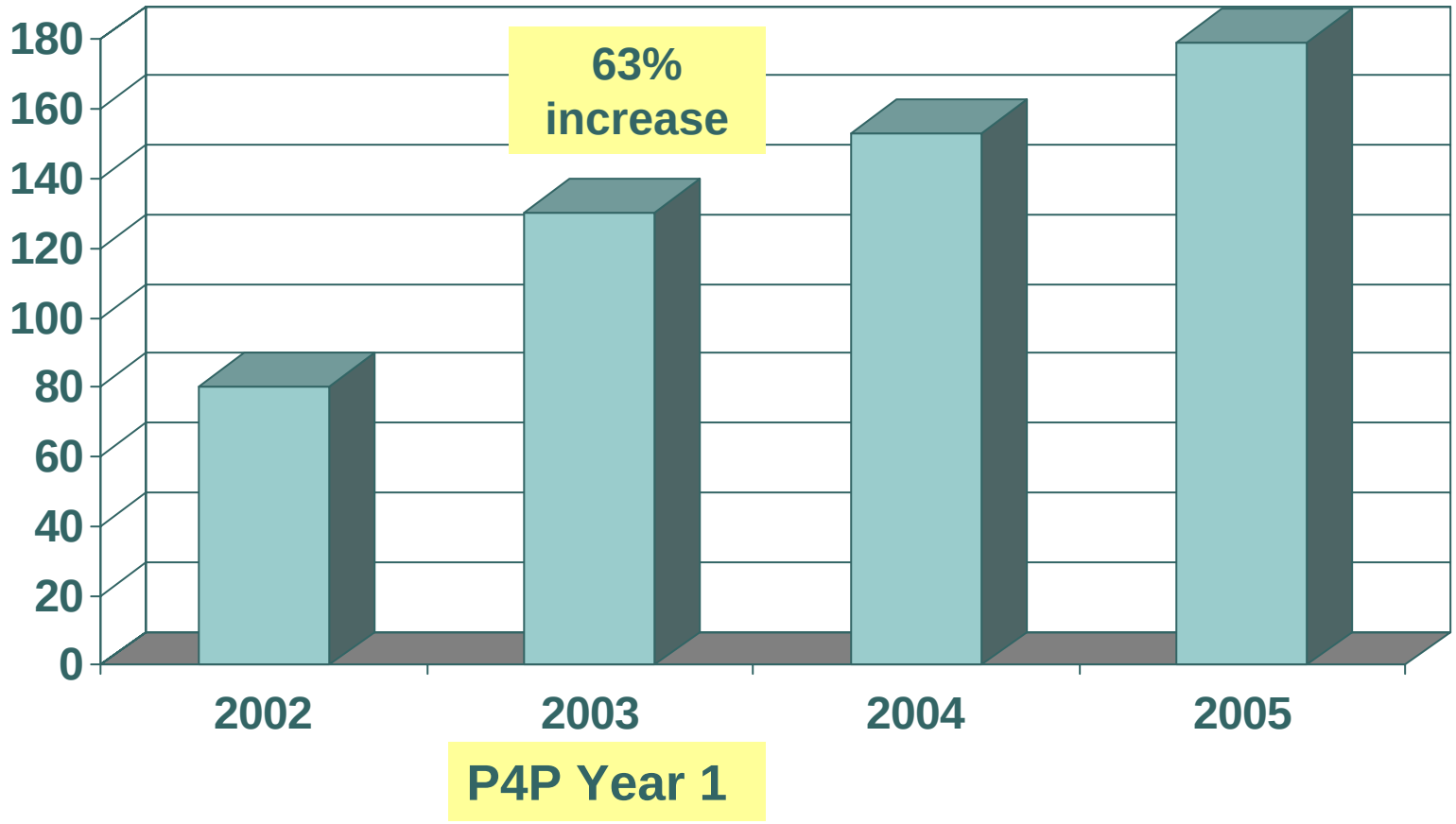
Data Collection & Aggregation



Overview of Program Results

- Year over year improvement across all measure domains and measures
- Single public report card through state agency (OPA) in 2004/2005 and self-published in 2006
- Incentive payments total over $140 million for measurement years (MY) 2003-2005
- Physician groups highly engaged and generally supportive

Results:
Increased CAS Participation



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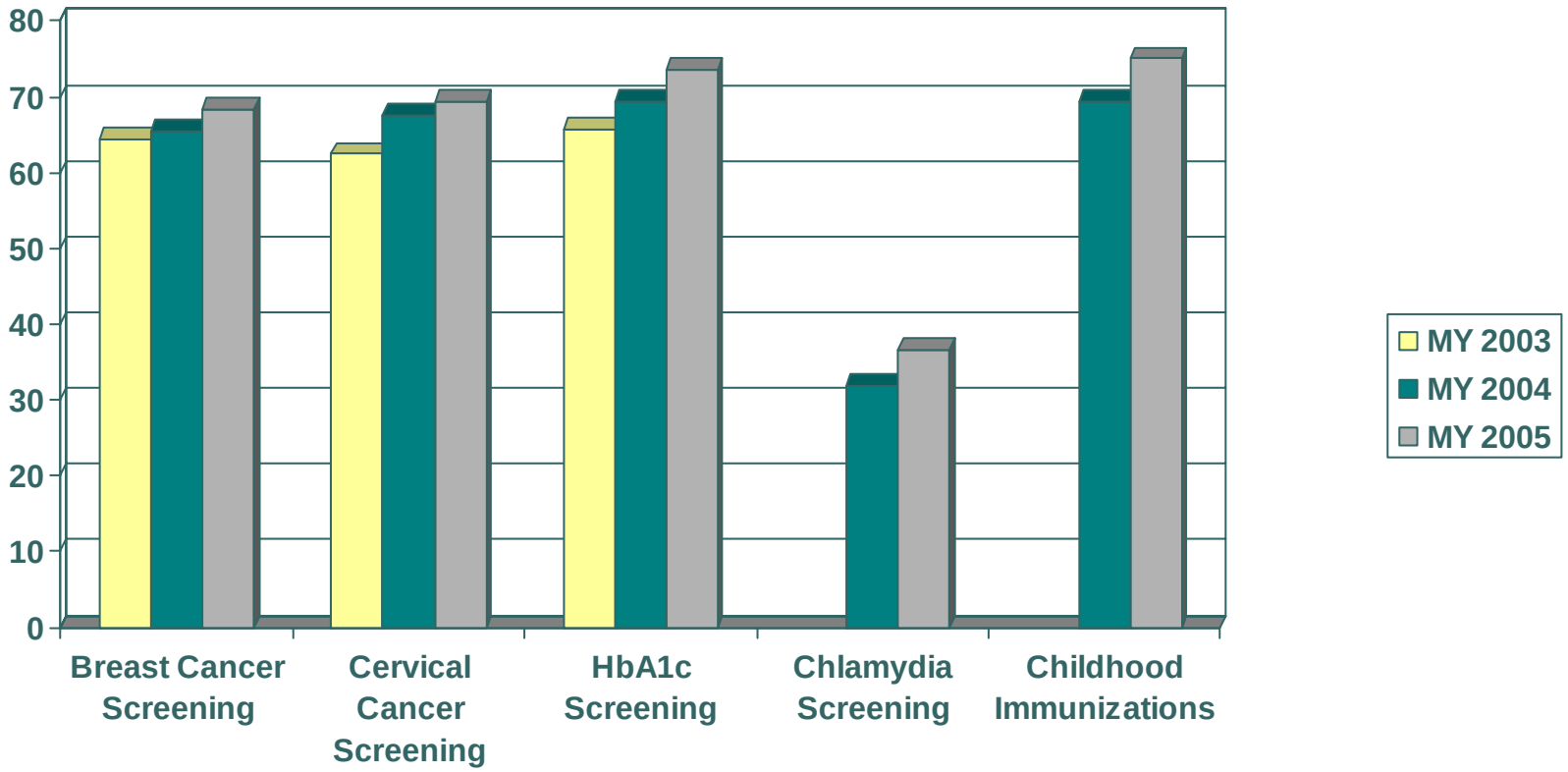
Clinical Results MY 2003-2005



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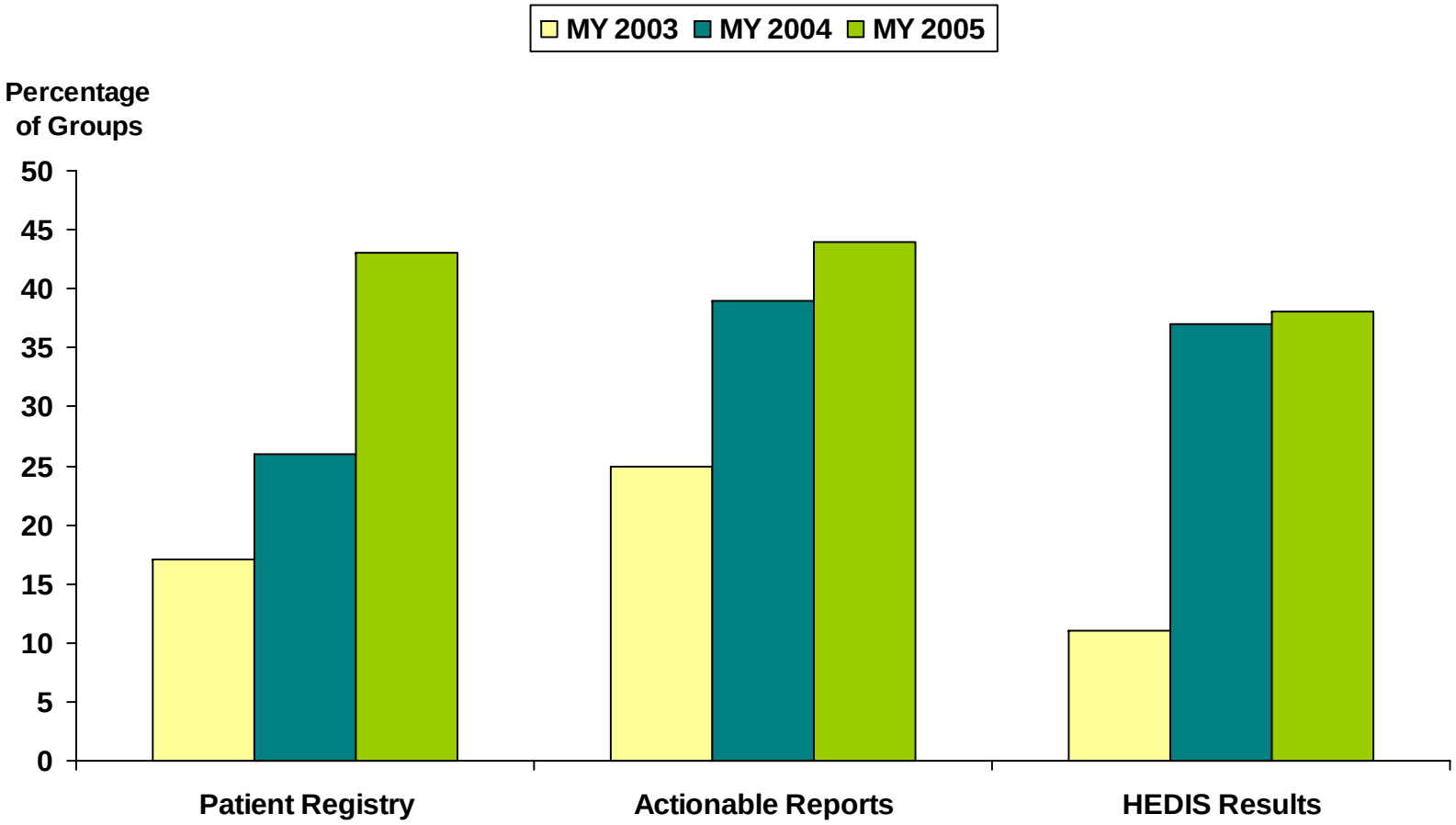
IT Measure 1:
Integration of Clinical Electronic Data



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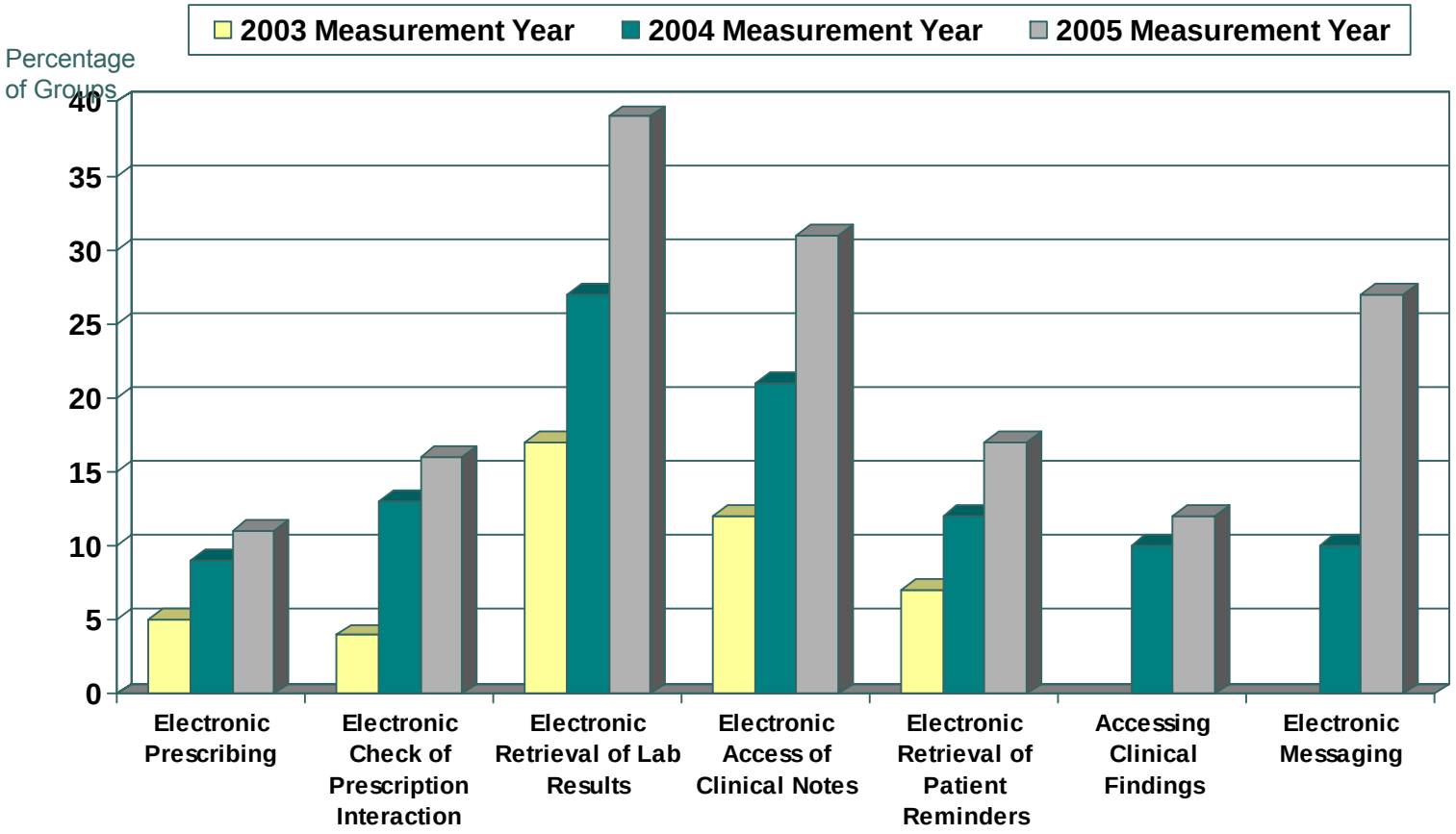
IT Measure 2: Point-of-Care Technology



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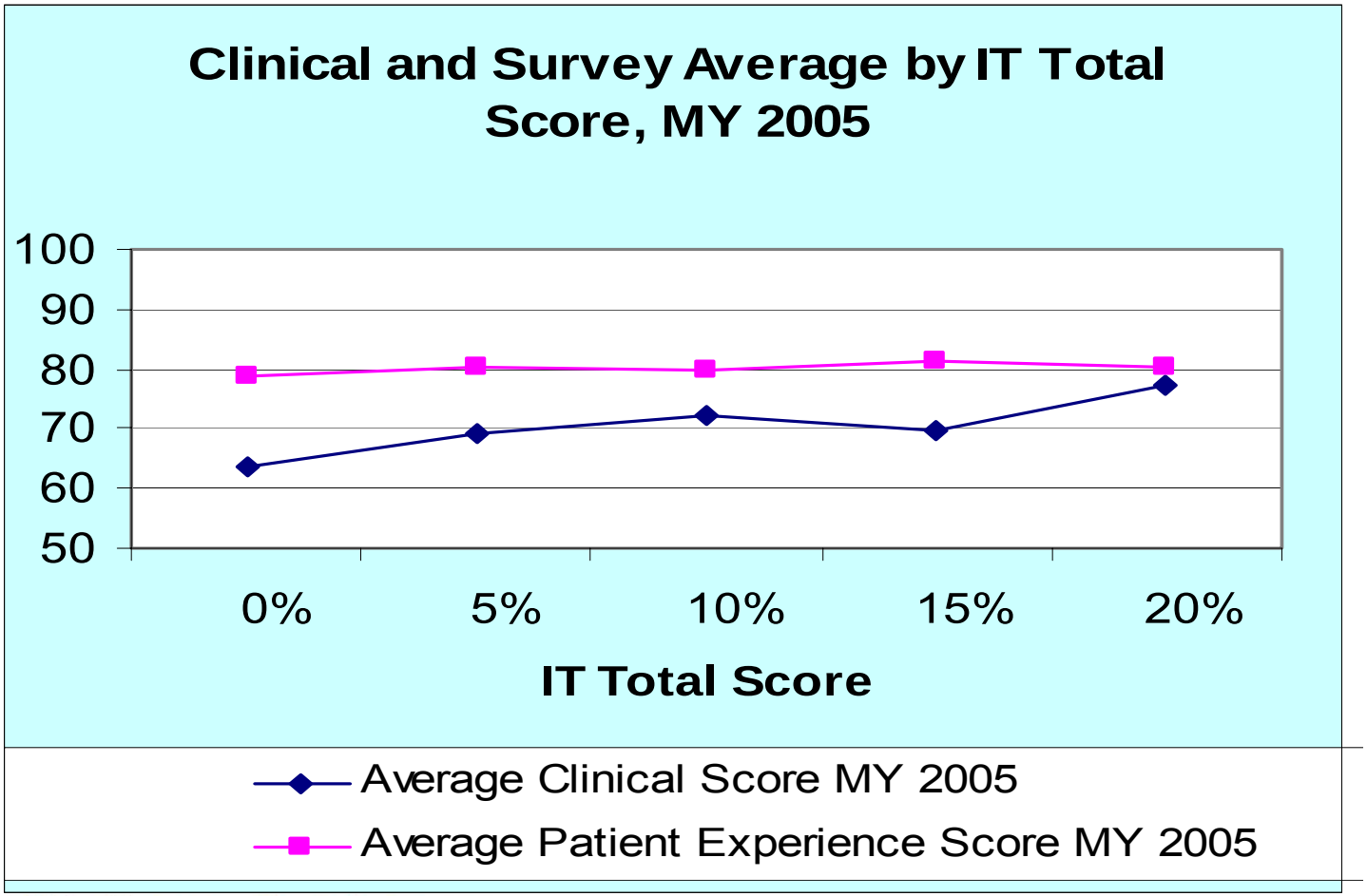
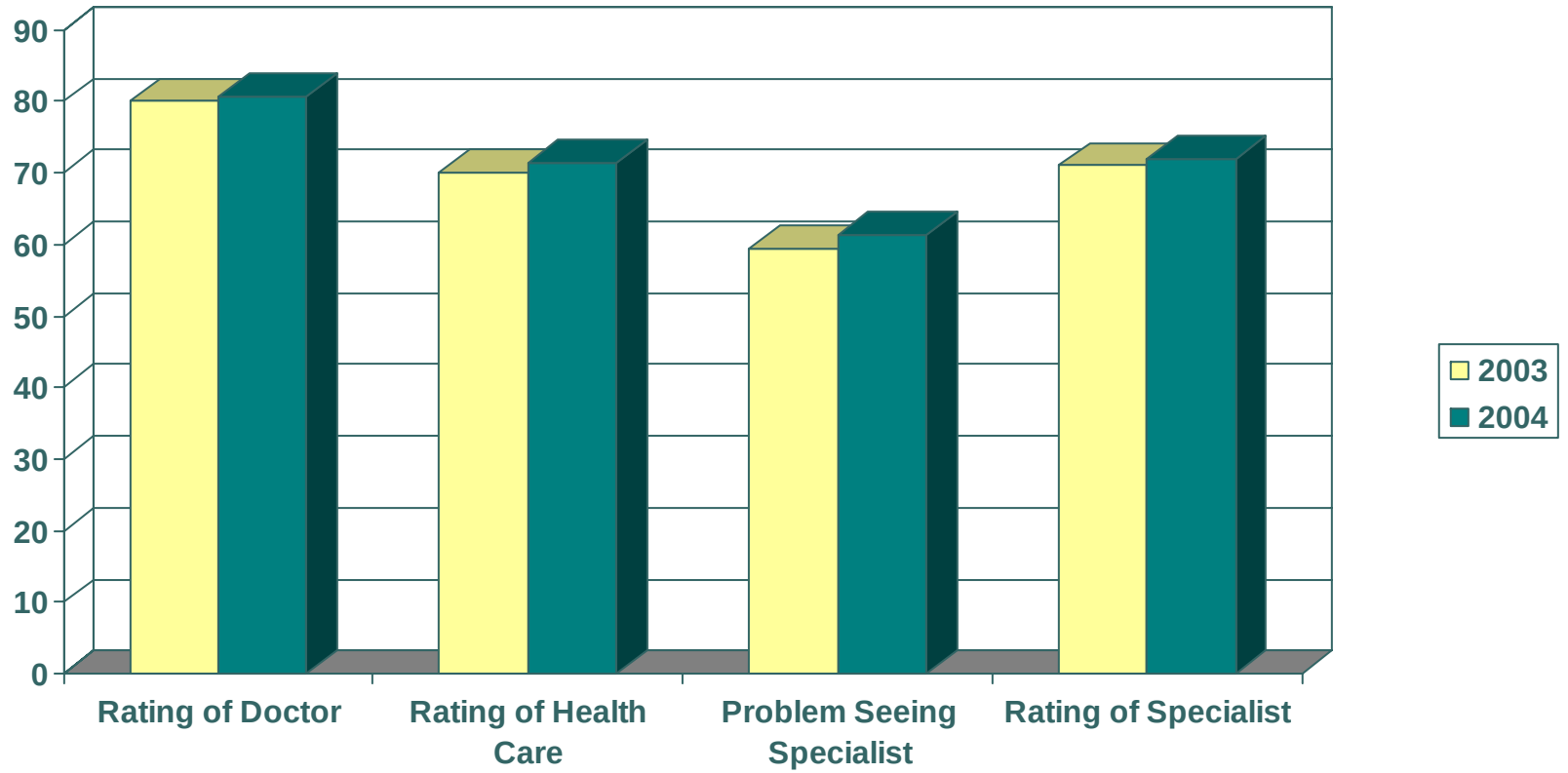
Correlation Between IT and Other P4P Domains



Patient Experience Improved



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Patient Experience Improvement is Broad

Patient Experience Measure Improvements from 2003 to 2004

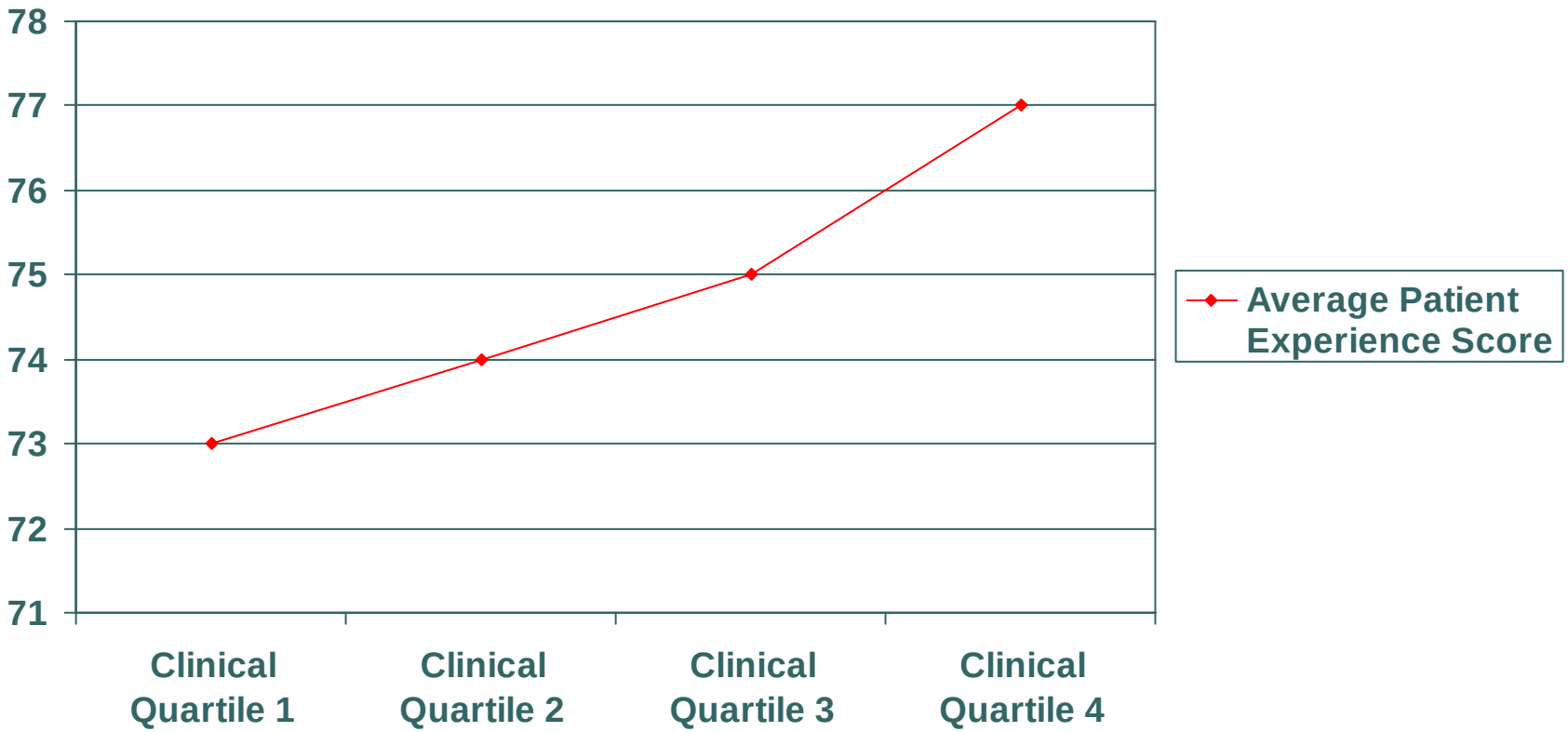
Measure	Number of Groups	Number of Groups Improving	Pct of Groups Improving	Average Change
Patient Experience				
Survey Average	108	71	65.7	1.2
Rating of Doctor	115	62	53.9	0.5
Rating of All Care from Group	115	73	63.5	1.4
Specialist Problems	109	64	58.7	2.2
Rating of Specialist	108	63	58.3	0.8

Patient Experience: Another View

Improvements for groups participating in P4P from the start

Patient Experience Measure (n=106 groups)	2005 vs. 2003 Performance Change (% points)
Rating of Doctor	2.7
Rating of All Care from Group	4.9
Rating of Specialist	3.0
Problem Seeing Specialist	5.0

Correlation Between Clinical Performance and Patient Satisfaction



IHA Report Card

iha.ncqa.org/reportcard

OPA Report Card

www.opa.ca.gov

Balancing Stakeholder Needs

- Purchasers want more measures to provide meaningful information to consumers
- Physician Groups want more money to support QI efforts and want to focus on a few measures at a time
- Health plans can't justify paying significantly more for basically the same measures year after year

Physician Group Feedback

- Public reporting is viewed favorably
- Public reporting is strong motivation to perform
- Physician Groups believe the measures are reasonable
- Physician Groups are comfortable being held accountable for measures

Collected from Physician Group leadership interviews conducted by RAND and UC Berkeley

Physician Group Feedback

- P4P has inspired significant efforts to collect relevant data
- After Year 1, some groups reported a negative ROI on investments vs. incentive payments
- Lack of transparency on payment methods is confusing to Groups and creates distrust

Collected from Physician Group leadership interviews conducted by RAND and UC Berkeley

Lessons Learned

#1: Building and maintaining trust

- Neutral convener and transparency in all aspect of the program
- Governance and communication includes all stakeholders
- Independent third party (NCQA) handles data collection

#2: Securing Physician Group Participation

- Uniform measurement set used by all plans
- Significant, incentive payments by health plans
- Public reporting

Lessons Learned

#3: Securing Health Plan Participation

- Measure set must evolve
- Efficiency measurement essential

#4: Data Collection and Aggregation

- Facilitate data exchange between groups and plans
- Aggregated data is more powerful and more credible

Key Issues Ahead

- Increase incentive payments
- Develop and expand measure set
  - Incorporate outcomes and specialty care
  - Apply risk adjustment
  - Add efficiency measurement
- Include Medicare Advantage and Medi-Cal

One Physician's Perspective on the Power of P4P (P5)

National P4P Perspective

- 107 P4P programs exist in the U.S. today with 55M patients (Med Vantage, Inc. 2005 survey)
- CMS has launched multiple P4P demonstration projects
- Principles and standards for P4P by AMA, JACHO, AAFP and many other organizations
- P4P is growing internationally

Examples of Experimentation and Success Abound

- British P4P
- Massachusetts Quality Initiative
- Indianapolis Health Information Exchange
- Exchange
  - Puget Sound
  - Minneapolis
  - Wisconsin
- CMS pilots with
  - Hospital Updates
  - Premier
  - Group Practice Demos
  - Physician Voluntary Reporting

A boost from Presidential Executive Order

- Transparency in Pricing
- Transparency in Quality
- Adoption of HIT

Physician Pride

- Recognition Awards in
  - Diabetes
  - Heart Stroke
  - Back Pain and Oncology (future)

Advantages of Coordinated Care Networks

- Literature Support
- Higher use of
  - Registries
  - HIT
  - Care Management
  - Disease Management
- Higher Quality and Satisfaction Scores

Goals of Idealized System

- IOM goals – STEEEP
- Personal Responsibility – Patient P4P
- Transparency
- Care Coordination (not buyer beware)
- Trusted Advisor

Usually said:

P4P Not The Answer

(or part of the answer)

But perhaps:

P4P is the Answer

(but not for the reasons we think)

- Coordinated Patient-Centered Care Provides Superior Results

  e.g. Intermountain, Mayo, Harvard Pilgrim, HCP, Kaiser Permanente

  How can P4P incentive systems create real and virtual coordinated Patient-Centered Care Systems?

- Carefully Crafted P4P incentives creates more than P4P

  In order to succeed in a P4P system, organizations and individuals must enter a learning environment.

Here is what can be learned:

- A culture of cooperation
- Information standardization, accuracy, collection and sharing
- Incentives for automation, registries, population health
- Interfacing Skills
- Networking Skills

- Shared Responsibility Skills
- Shared Risk/Reward Skills
- Pride in Reported Results
- Transparency Phobia Dissipates
- Customer Relations Skills
- Branding Skills
- Risk Adjustment Skills
- Pt. Communication/Adherence/Compliance

Shifting measures over time leads to:

An Organizational Culture of Quality

P4P

It’s time to stop crawling and start Running