A Health Systems Experience with P4P in Ambulatory Clinics

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Minnesota Environment

- Minnesota Community Measurement (MNCM)
- Bridges to Excellence (different model)
- Institute for Clinical Systems Improvement (ICSI)
- Multiple payer P4P plans
- State task force (Q-Care)

Summer Vision Camp

- **Our Vision:**

  You will know us for our continuum of health care, our responsiveness and our setting national standards for clinical excellence, innovation and safety

Positive Perfect Storm

Ascending physician leadership, MNCM, increasing dollars from health plans, and the expanding and maturing Epic installation, made the time right to try a move towards incenting "doing the right thing", and away from incenting "just doing."

Concept 2005 Plan

- **Why had previous quality incentives been less successful than hoped?**

Concept 2005 Plan

Past initiatives, even when successful, raised performance in that one area, but left all other areas unimproved/status quo. Yet to take a pool of $ and divide it into seven initiatives meant each one was such a small slice, it really wasn't worth the work effort to deal with the harder initiatives.

Steps in the Process:

- **Fairview Board of Directors and administration to commit to pumping in a large dollar amount, and pool potential incentive payments from health plans to create a critical mass of money that would be hard to ignore.**
- **Board divorces incentive payments from financial performance.**
- **Care systems no longer need to hit certain budget thresholds to qualify for reward.**

Get docs to but into:

- **Quality was important (not “crap”)**
- **This wasn’t an administration plan to take away potential bonus money**
- **These were obtainable goals**

Docs need to buy into:

- **Standardization & reduction in variations, both in terms of "what" *(is an AAP useful?, is it worthwhile to drive A1Cs <7.0?)* as well as "how" *(data must be entered in discreet data fields, not floating loosely in their charting notes, ASA must be one of 4 NDC codes we chose, asthma Dx must be one of eight fake codes we built, etc.)***

Many would say that we shouldn’t have to incent physicians to do the right thing. It is their job, plus they have sworn an oath to always keep the patient's interest at the top of their priority list.

The reality is, in this era of financial pressures, we concentrate on what is being measured and rewarded.

- **Some felt we should limit our scope (it is easier to focus attention units on a smaller group of projects). However, we were being measured on many fronts, so needed to brainstorm how to bring the entire scope of care up. We didn't want to look good in a few areas and bad in many others.**

  It wouldn't be a good public image.
  It wouldn't be good care for our patients

We knew we had the right balance because:

- **Administration hated** it for representing an easy, large pay out to physicians, unbudgeted, and unfunded by any revenue stream.
- **Physicians hated** it because the thresholds were impossible targets, and this was an administration plan to withhold their rightful incentive bonus.

The Initiatives:

- **Diabetes** - 20% on the “all five” of optimal care
- **Asthma** - 75 % on controller meds & an AAP on file
- **HTN** - 70% of hypertensive patients ≤ 140/90
- **BMI** - 90% of patients screened for obesity
- **Tobacco use** - 95% of patients screened for use or passive exposure
- **Chlamydia** - 85% of sexually active patients (13-26)
- screened

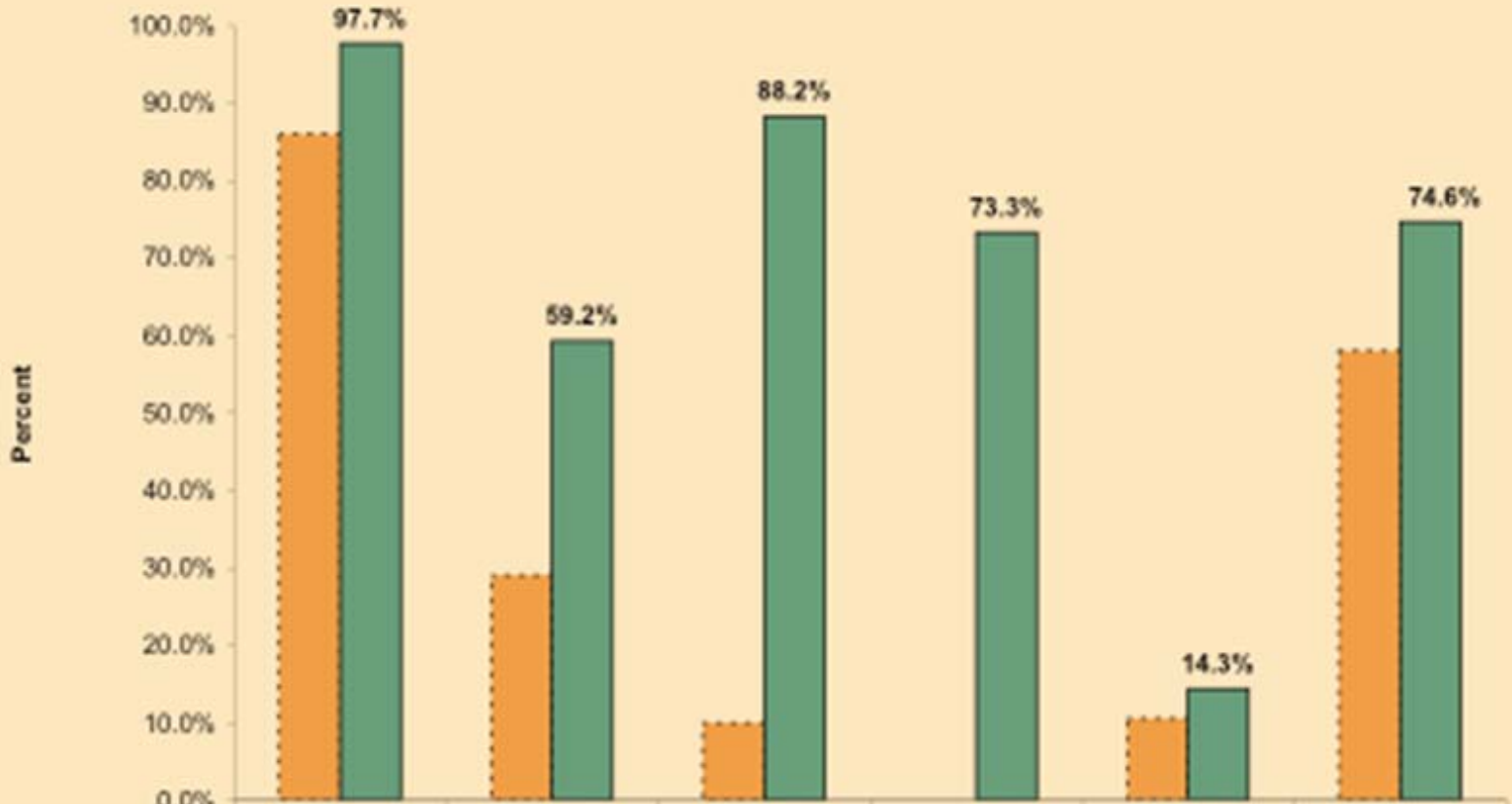
Shortfalls of program

- We may have set standards too high
- Reports were more difficult to write than first appreciated, so lack of early feedback delayed improvement efforts

The follow up

- We actually may not have set the standards high enough.
- Next year measures added for problem list maintenance, vascular disease, otitis Rx, immunizations, depression & cancer screening

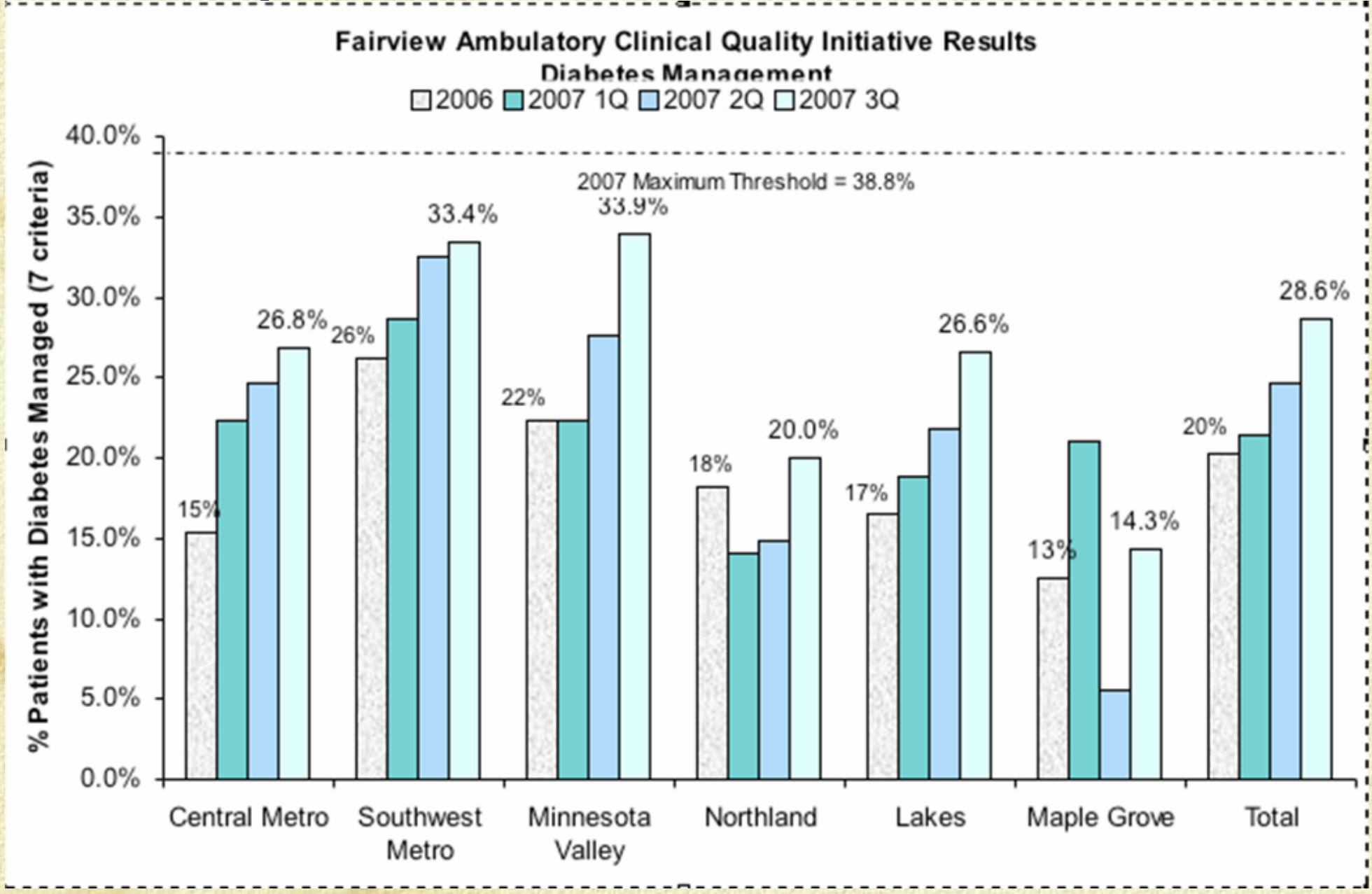
Overall Fairview Clinics (5 Care System)
2005 Quality Initiative Results



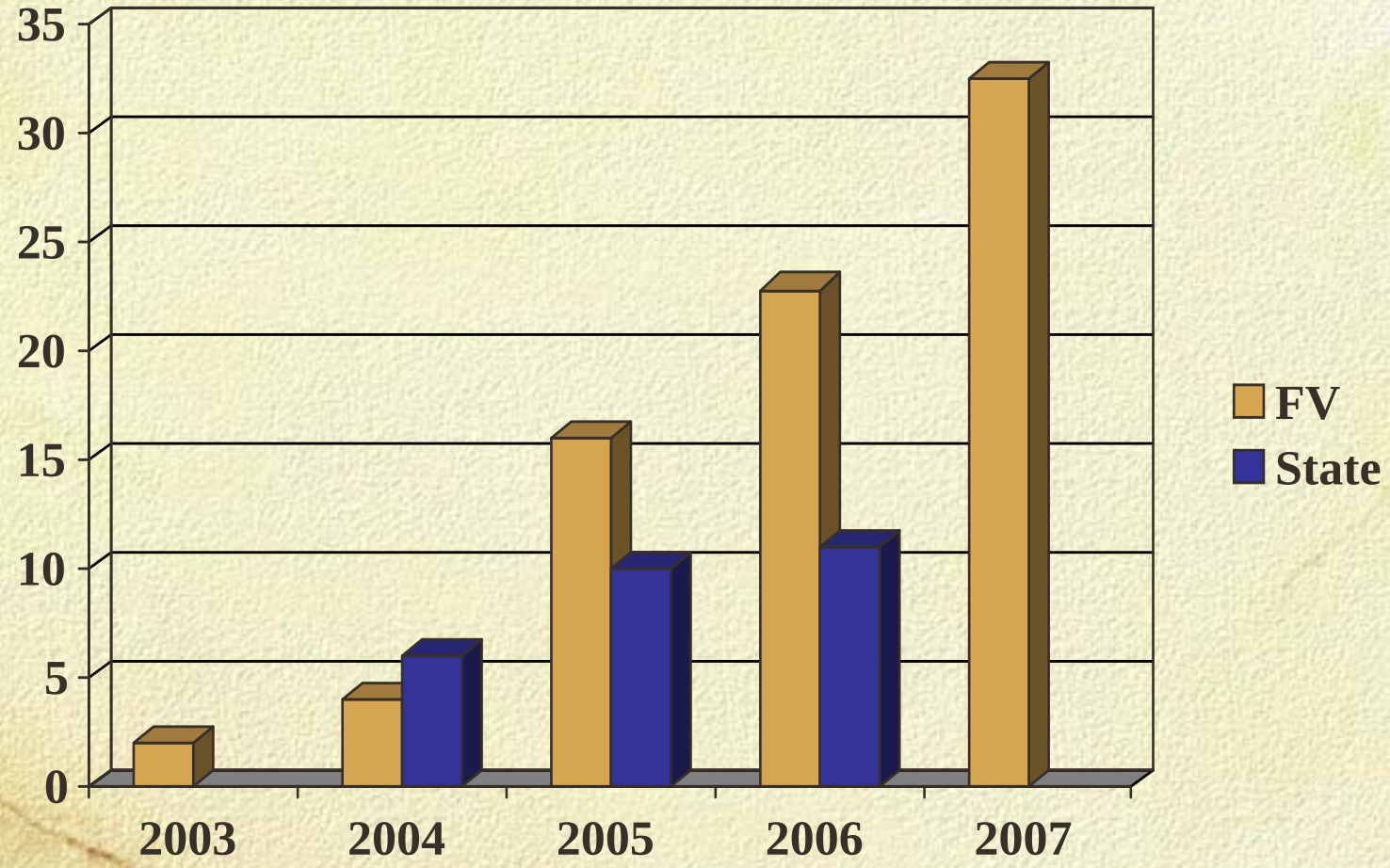
	Tobacco	Chlamydia	Obesity	Asthma	Diabetes	Hypertension
2004 External	86.0%	29.0%	10.0%		10.5%	58.0%
2005 Final	97.7%	59.2%	88.2%	73.3%	14.3%	74.6%

P4P

Experience since 2005



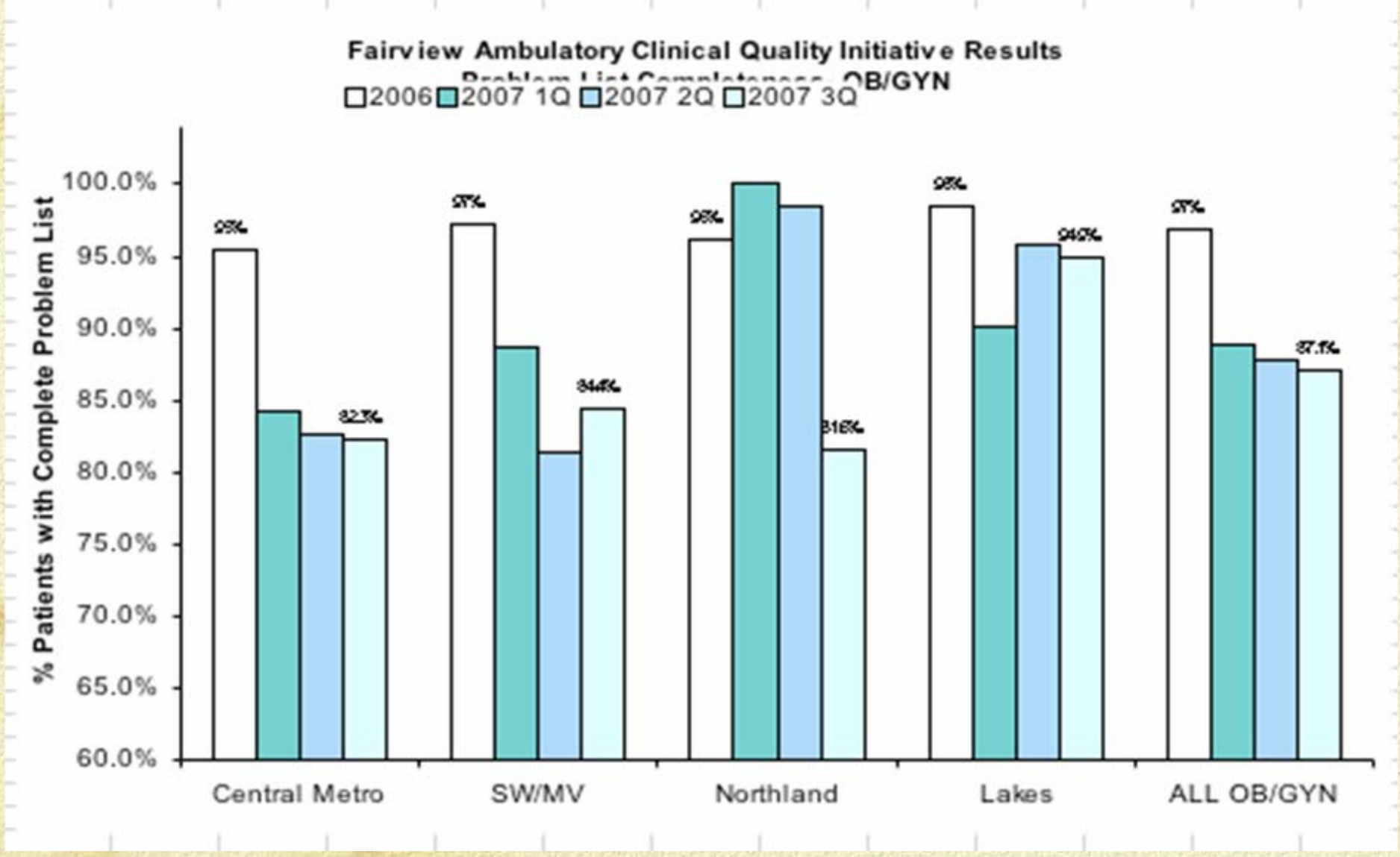
FV outpaces state improvement in DM



~~FV in top four in state for~~ vascular care

- We are now working on 14 different initiatives, and paying on a pre-determined set of three for each specialty (1/3, 1/3, 1/3)

Does P4P work “too well?”



Project future needs

- Redesign of care delivery model (medical home, pay for chronic Dz management, pay more for outcomes [& less for “just doing”]) to make this a sustainable model
- Decouple MD salary reimbursement from a production model

Thanks for your attention!
~~Looking for your feedback~~
& questions……

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