Aligning Hospital and Physician P4P – The Q-HIP^{SM}/QP-3^{SM} Model

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A Concerted Effort

"…Because the rewards are based on shared performance, the program is intended to create incentives for competing physician groups to work together with hospital administration in a cooperative manner to achieve continuous quality improvement."

Congressional Testimony of John Brush, MD, American College of Cardiology July 27, 2006

Anthem's Quality Evolution

Quality-In-Sights®: Hospital Incentive Program (Q-HIP℠)

- *Partnership developed in collaboration with the American College of Cardiology and the Society of Thoracic Surgeons*

Quality Physician Performance Program (Q-P3℠)

- *Sister program to Q-HIP℠ designed to align incentives*

Q-HIP^{SM} - Aligning with National Performance Based Incentive Principles

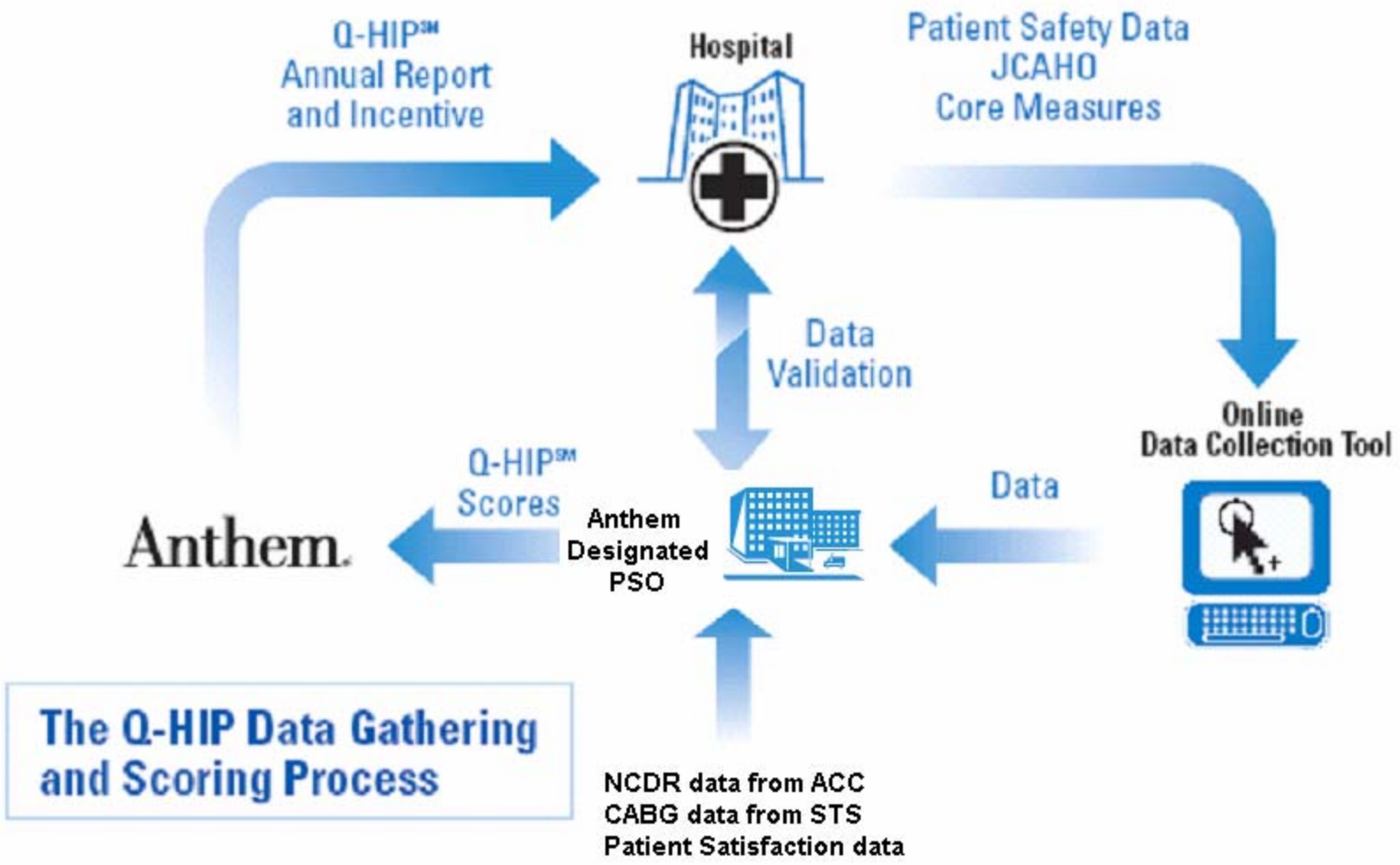
Q-HIP^{SM} :

- **Is voluntary**
- **Consistently applies nationally vetted and recognized evidence based indicators**
- **Aligns reimbursement with the practice of high quality and safe health care for all consumers**
- **Is transparent with external validation and auditing of data**
- **Based on all-payer data**

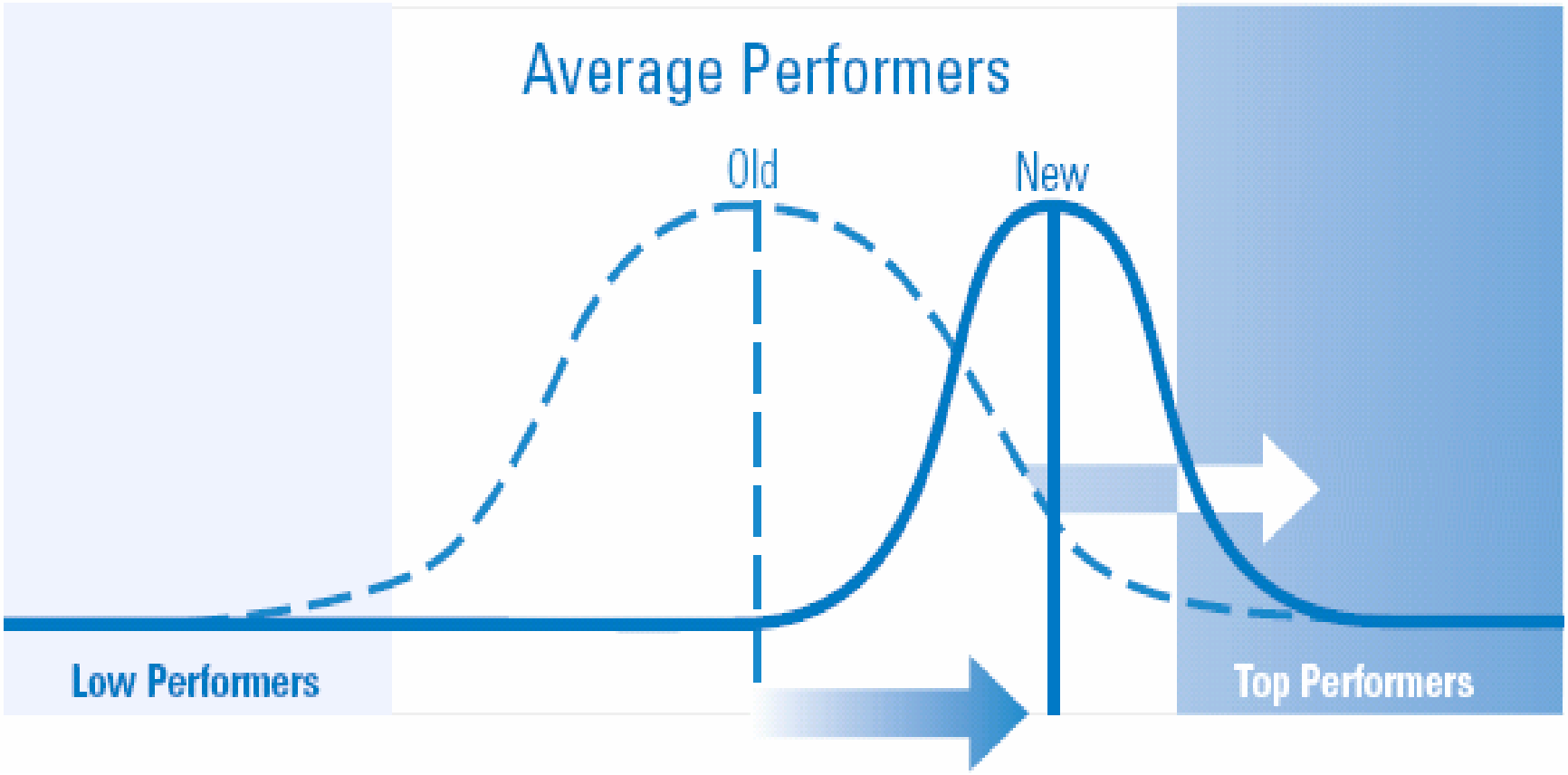
The Q-HIP℠ Patient Safety Organization (PSO)

- **Third-party organization specializing in healthcare quality improvement and patient safety**
- **Provides an unbiased evaluation of Q-HIP℠ submissions and produces final performance scorecards**
- **Reviews material on a real-time basis and provides ongoing feedback to participating hospitals**
- **Caretaker of all Q-HIP data**

Q-HIP^{SM} – A Collaborative Effort



Quality-In-Sights® Hospital Incentive Goal



ACC-NCDR & STS National Database

- **No additional costs on top of regular registry membership – simple consent form allows data release**
  - **ACC-NCDR: $3,195**
  - **STS Database: $2,850**
- **Data comes directly from registries – no additional data entry by hospitals or physicians**

Scorecard Components

Patient Safety Section
(25% of total Q-HIP℠ Score)

- JCAHO Hospital National Patient Safety Goals
- Computerized Physician Order Entry (CPOE) System
- ICU Physician Staffing (IPS) Standards
- NQF Recommended Safe Practices
- Rapid Response Teams
- Patient Safety and Quality Improvement Measures

Member Satisfaction Section
(15% of Total Q-HIP℠ Score)

- Patient Satisfaction Survey
- Hospital-Based Physician Contracting

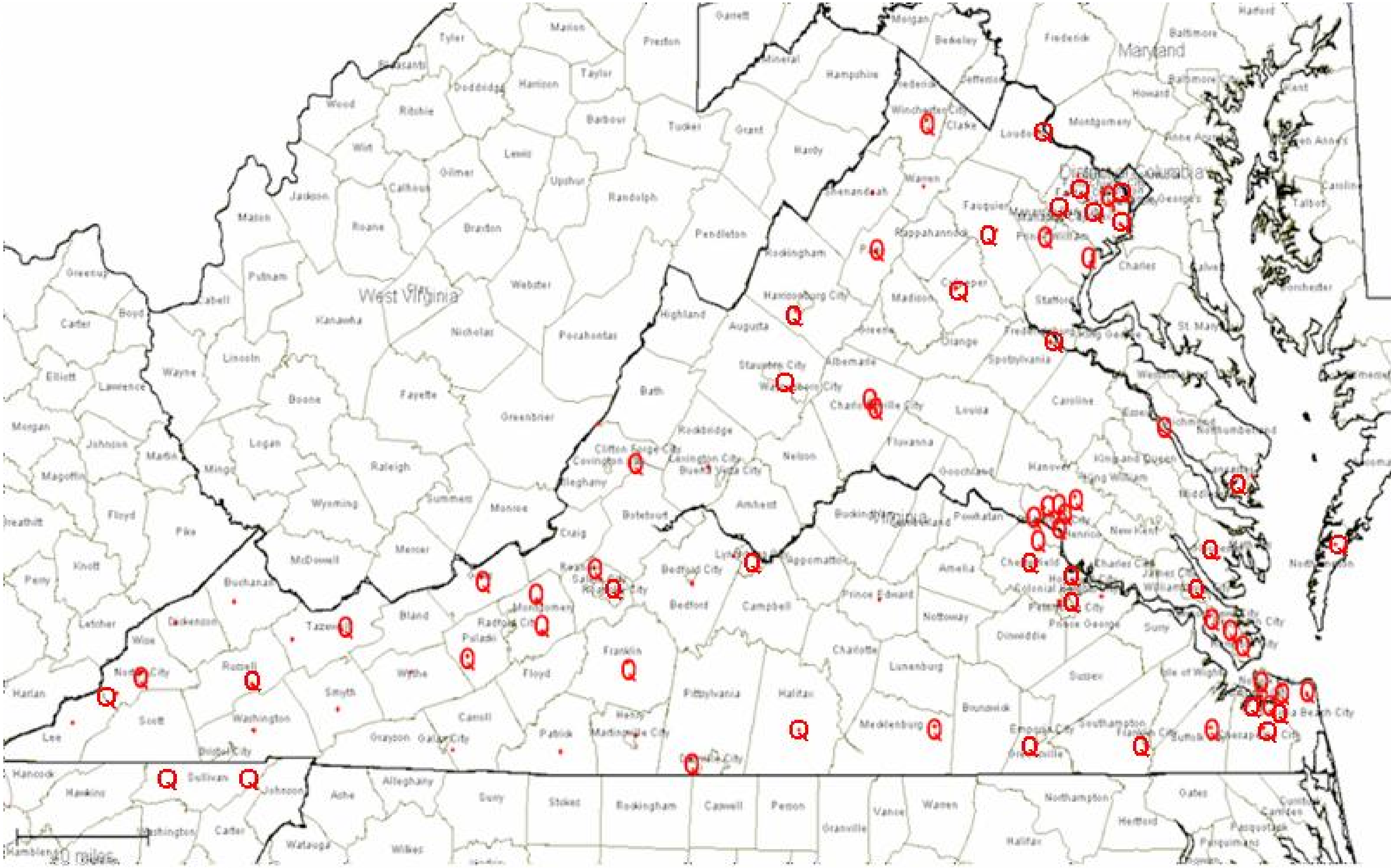
Patient Health Outcomes Section (60% of total Q-HIP℠ Score)

ACC-NCDR Section
- 7 ACC-NCDR Indicators for Cardiac Catheterization and PCI

JCAHO National Hospital Quality Measures
- Acute Myocardial Infarction (AMI) Indicators
- Heart Failure (HF) Indicators
- Pneumonia (PN) Indicators
- Surgical Care Improvement Project (SCIP)
- Pregnancy Related

CABG Indicators
- 5 STS Coronary Artery Bypass Graft (CABG) Measures

Q-HIP^SM Hospitals in Virginia



Q-HIP^{SM} in Virginia

- **65 hospitals participating in Q-HIP^{SM} in Virginia**
- **>95% of Anthem inpatient admissions in the Commonwealth of Virginia**
- **Rural, local and tertiary care hospitals**
- **Measurement period runs July-June; started in 2003**
- **Outside Virginia:**
  - **Northeast Region (ME, NH, CT): 32 hospitals**
  - **Georgia: 21 hospitals**
  - **New York: Pilot/Rollout Phase**
  - **California: Pilot/Rollout Phase**

Q-HIP℠ Model Adoption in WellPoint States

Encouraging Developments

- **Multiple hospitals report Q-HIP^{SM} scores to their boards of directors annually.**
- **A number of hospitals include Q-HIP^{SM} scores as part of their own internal corporate performance reporting**
- **A major academic medical center ties Q-HIP^{SM} scores to front-line staff salary bonuses**

Provider Perspectives

"This is a win-win situation in my mind. As health care providers, we always strive to do the right thing for our patients. The reality is this sometimes costs more in terms of putting in place new structures and processes to support a better way of delivering services."

Ron Clark, MD, Chief Medical Officer, VCU Health System

"We perceive Q-HIP to be a successful program that positively contributes to successful outcomes for our most important people—our patients. Ultimately, that is why we exist."

Larry Fitzgerald, Chief Financial Officer, University of Virginia Health System

Q-HIP^{SM} – Why it Works

- **No "Black Box" – measurement methodology, metric specifications all transparent to participants**
- **Third party administrator – unbiased evaluation by the PSO**
- **Collaboration is critical (success is directly proportional to involvement of key personnel)**
- **Financial incentives can lead to a higher organizational prioritization**
- **Alignment of physician and hospital goals focuses efforts**
- **Adoption of national quality metrics**

Communicate, Collaborate, and Build Consensus!

Q-P3SM Program

- **Q-P3SM is Anthem's performance based incentive program (Pay-for-Performance) for physicians**
- **Opportunity to reward high quality performance**
- **Collaborated with the American College of Cardiology and the Society of Thoracic Surgeons**
- **Researched published guidelines, medical society recommendations and evidence-based clinical indicators**
- **Programs implemented in 2006**

The Q-P3^{SM} Market Share Approach

- Results determined based on all group facilities – scores are weighted by indicator based on market share at each facility

Indicator	Hospital A (60% market share)			Hospital B (40% market share)		
	Result	Score	Weighted Score	Result	Score	Weighted Score
Indicator A	2.2%	10.00	**6.00**	3.0%	0.00	**0.00**
Indicator B	95%	15.00	**9.00**	84%	7.50	**3.00**
Indicator C	54%	5.00	**3.00**	66%	10.00	**4.00**
Total	N/A	30.00	**18.00**	N/A	17.50	**7.00**

- In the example above, the score for each indicator at each hospital is multiplied by the group's % market share at that facility.
- The total weighted scores for each facility are then combined to produce the final score of 25.00.

The Benefit of a Shared Approach

- **Physician groups can't rely on one hospital's exceptional performance and hospitals don't benefit from any one group practice**

- **Best Practice sharing is facilitated by physician involvement at various hospitals**

- **"Competing" physician practices are given incentive to work together to achieve common goals**

Provider Perspectives

"Hospitals, physicians and health plans must work together to provide high-quality care to patients. Anthem has taken a leadership role in promoting and supporting true hospital/physician quality alliances in Virginia and its Q-HIP and Q-P3 programs are using pay-for-performance programs to provide incentives for participation and for achieving consensus-based performance thresholds designed to improve the quality of care for patients."

Jeff Rich, M.D., Chairman STS Taskforce on Pay for Performance

Q-P3SM - Cardiology

- **Voluntary Program – participating physicians account for 83% of market share**
- **Based on an all-payer data base except for the pharmacy measure**
- **Mirrors QHIP indicators to align incentives**
- **Final Scorecard results are based on hospital market share**
- **Rewards are based on excellence**

Q-P3SM Cardiology Scorecard Components

JC AMI Section
• Aspirin at arrival
• Aspiring prescribed at discharge
• ACEI/ARB for LVSD
• Beta blocker at arrival
• Beta blocker at discharge
• Smoking cessation advice
JC HF Section
• LVF assessment
• ACEI/ARB for LVSD
• Discharge Instructions
• Smoking cessation advice

ACC-NCDR Section
• Rate of serious complications – diagnostic caths
• Door to balloon time for primary PCI <=90 min
• Door to balloon time for primary PCI <=120 min
• % of patients receiving Thienopyridine
• % of patients receiving statin or substitute at discharge
• Rate of serious complications - PCI
• Risk-adjusted mortality rate - PCI
Bonus Section
• Generic Dispensing - Statins

Q-P3SM - Cardiac Surgery

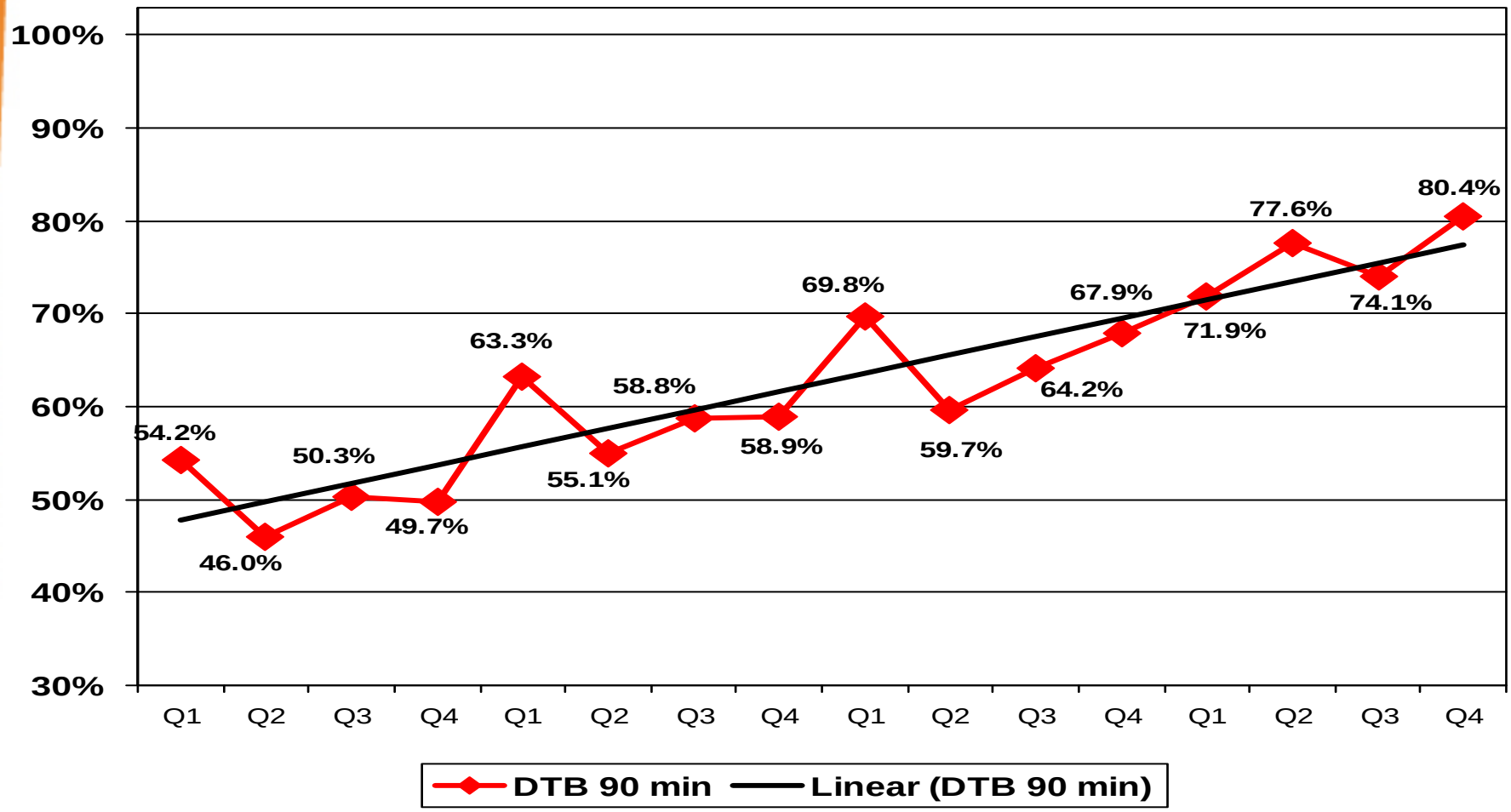
- **Voluntary Program – participating physicians account for 100%* of market share**
- **Based on an all-payer data base from the Society of Thoracic Surgery**
- **Mirrors QHIP indicators to align incentives**
- **Developed in collaboration with Virginia cardiac surgeons - Virginia Cardiac Surgery Quality Initiative**

Q-P3SM Cardiac Scorecard Components

STS Clinical Indicators
• CABG Operative Mortality Rate – Risk-adjusted
• Surgical Re-exploration – Risk-adjusted
• Prolonged Intubation – Risk-adjusted
• Pre-Operative Beta Blockade
• IMA Use
STS Discharge Medications
• Anti-platelet
• Beta Blocker
• Anti-Lipid
Point of Care Usage
• Increased Transactions

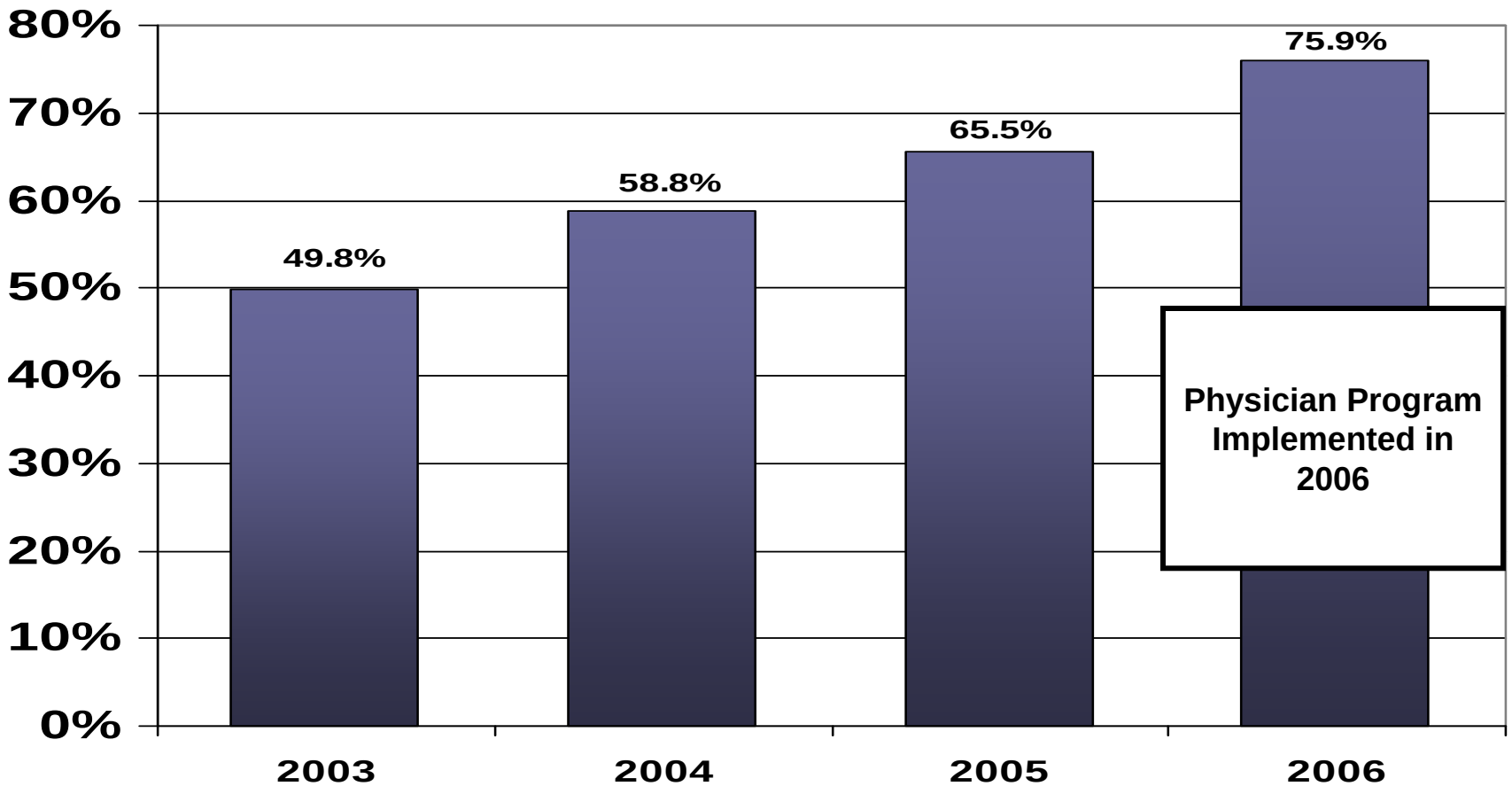
Outcomes

Original 8: DTB 90 min or less (Quarterly)



*data is from original 8 cardiac care hospitals that supplied four full years of comparative data (07/2003-06/2007)

Original 8: DTB 90 min or less (Annual)



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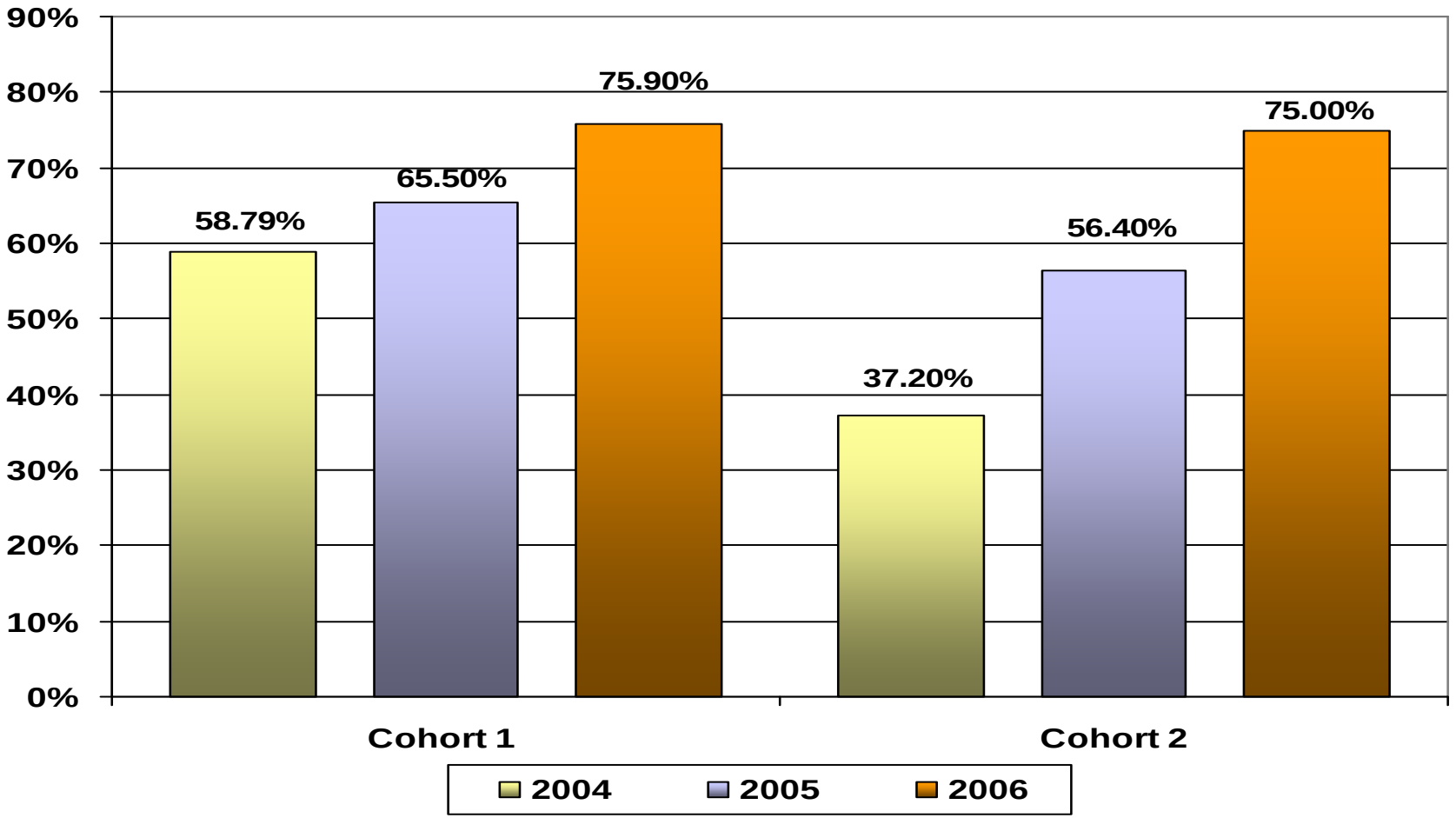
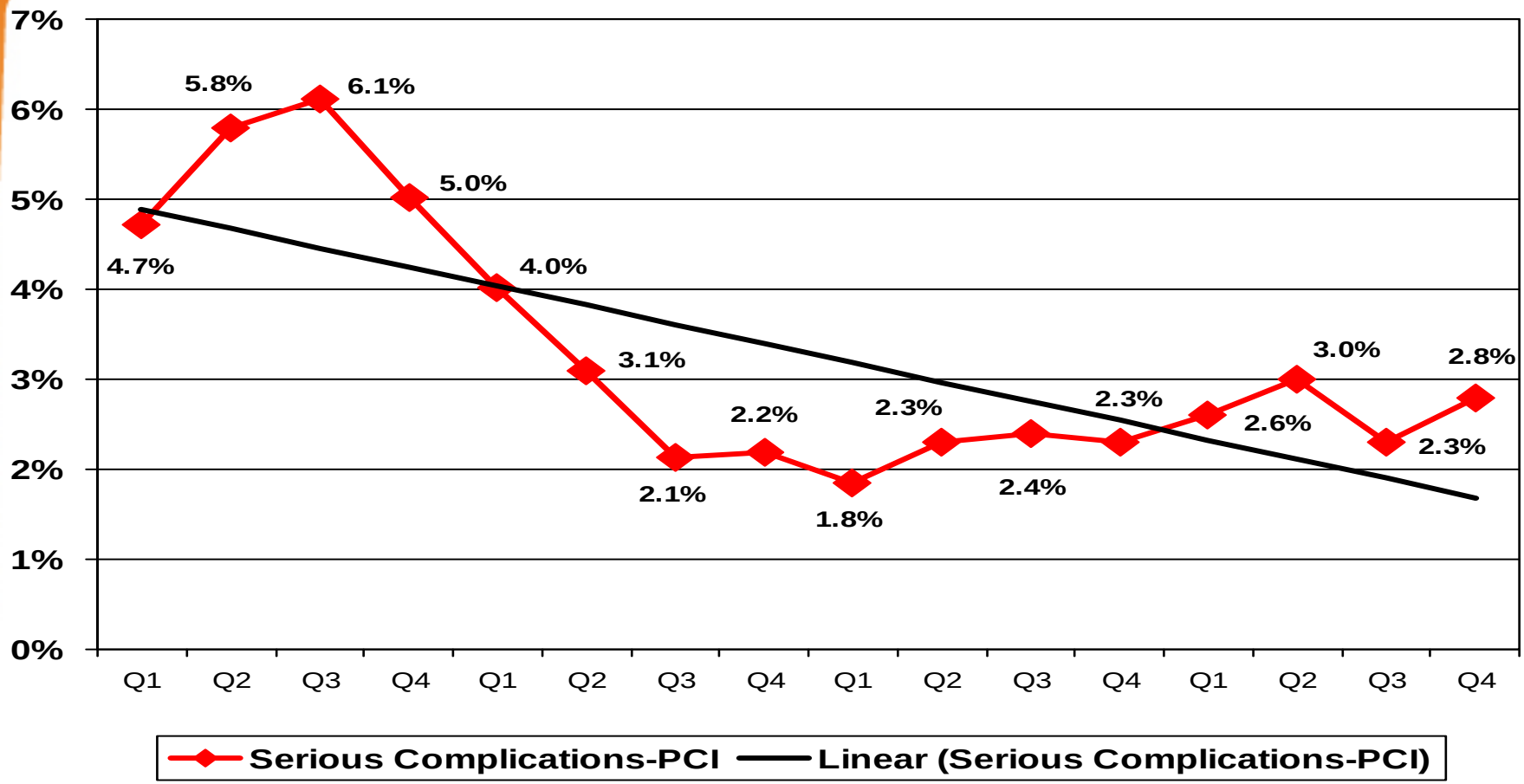
Cohorts: DTB 90 min or less (Annual)



*Cohort 1: cardiac care hospitals that joined during Q-HIP 2003 (8 hospitals)
Cohort 2: cardiac care hospitals that joined during Q-HIP 2004 (6 hospitals)

Original 8: Serious Comp - PCI (Quarterly)



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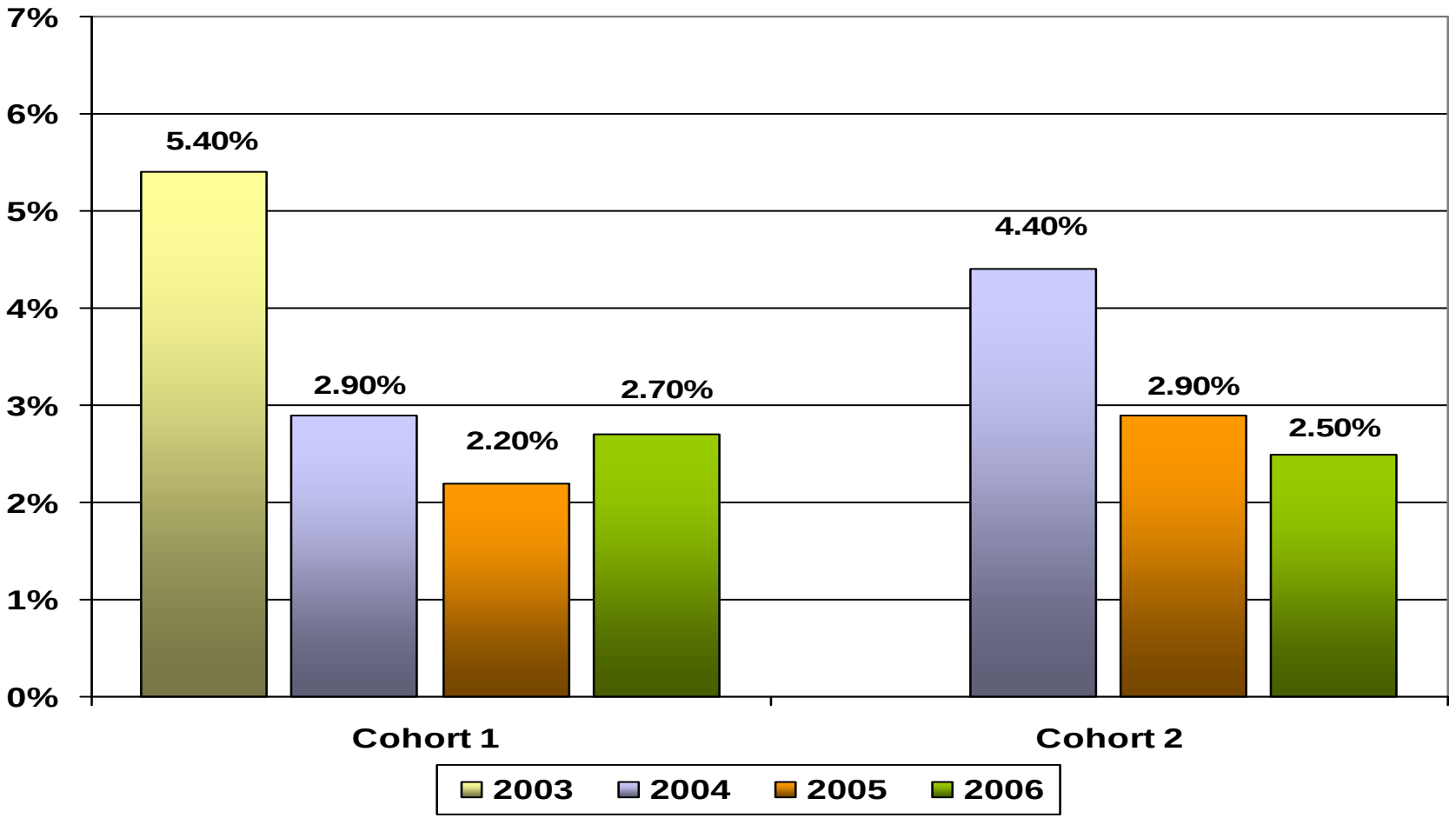

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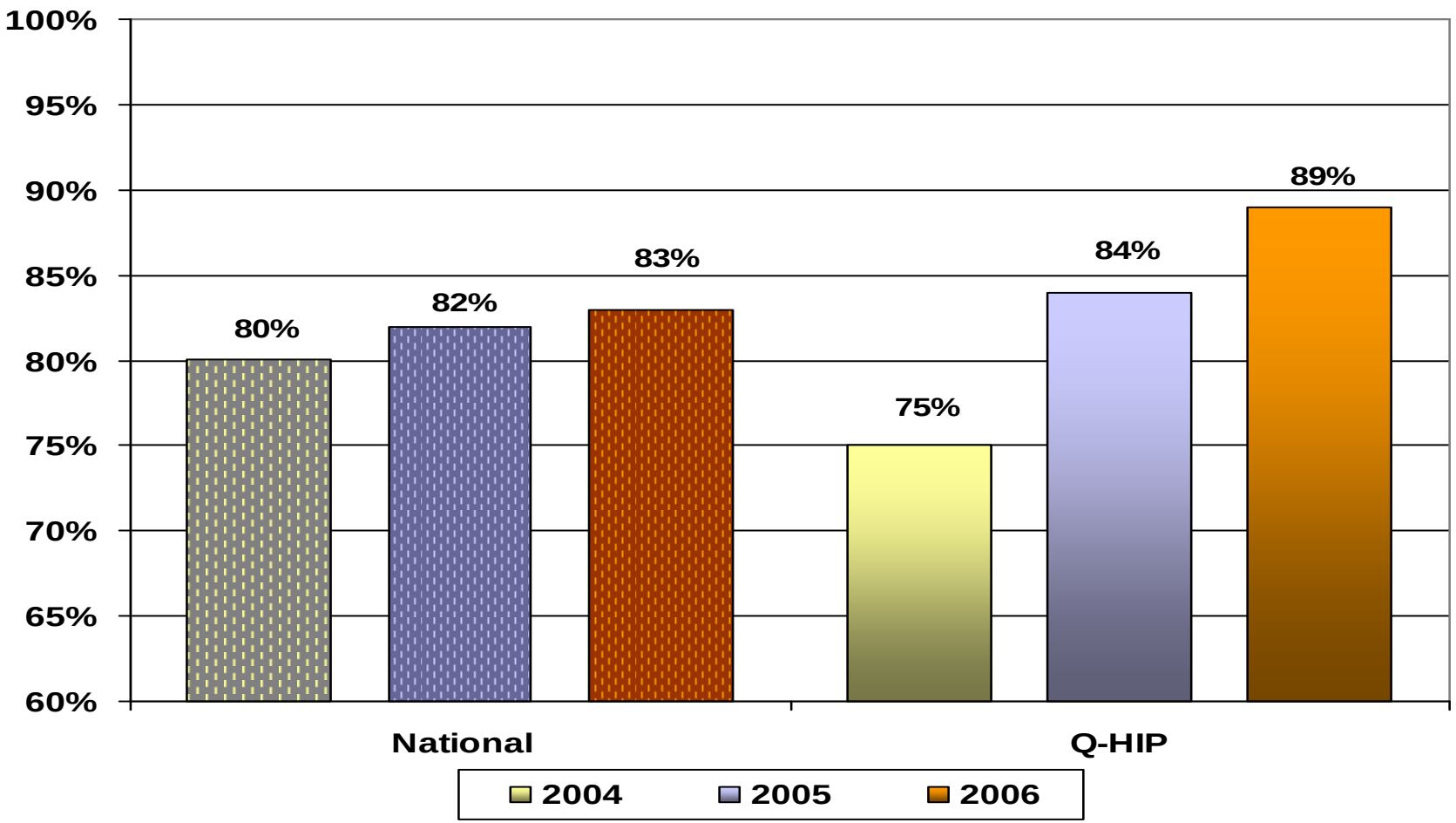
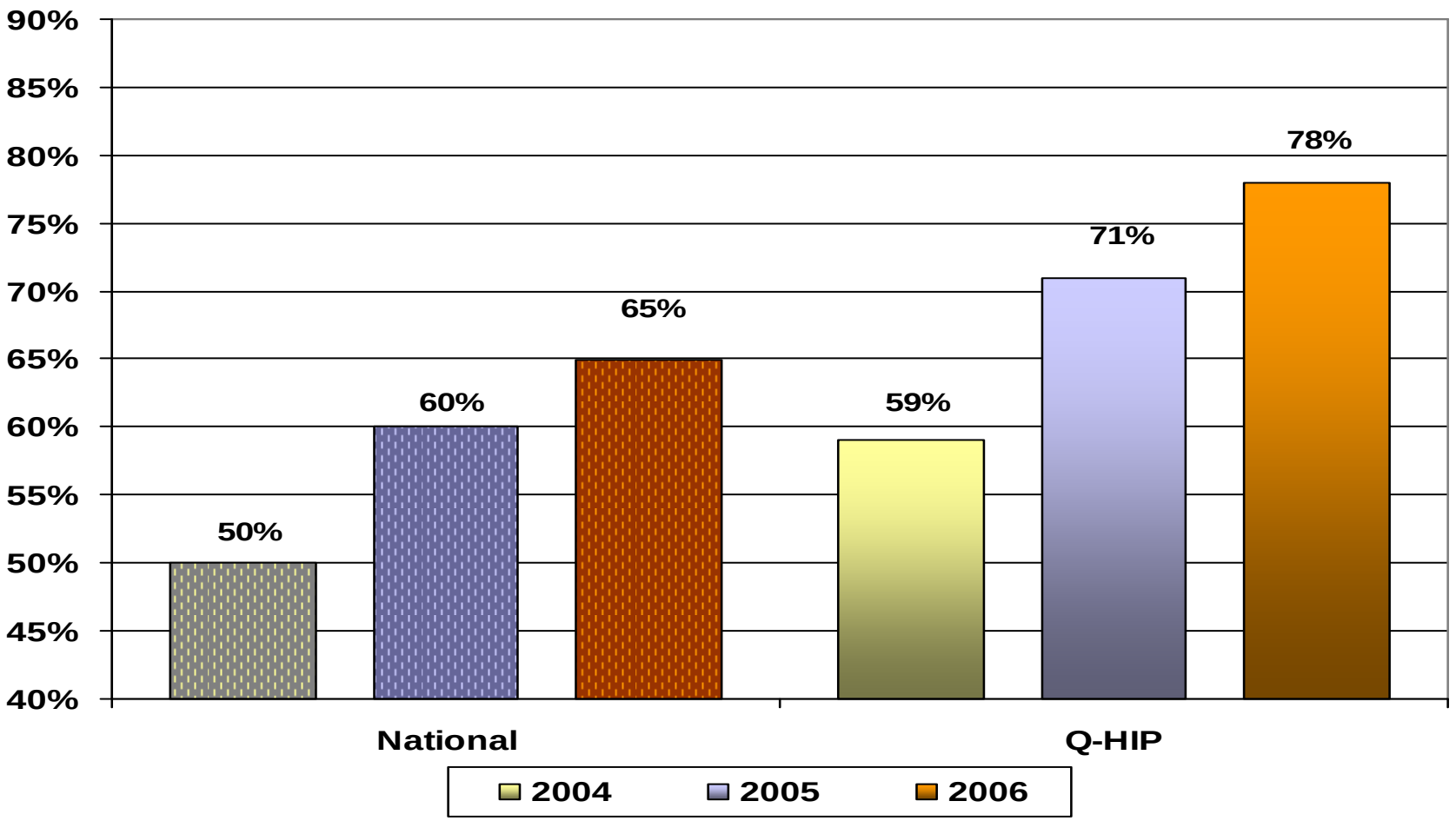
ACE/ARB for LVSD: Q-HIP^{SM} vs National



- Q-HIP: average for the 39 facilities that submitted data for Q-HIP 2004-2006
- National: national average (source – Hospital Compare). Note 2006 data one quarter behind (2Q06-1Q07)

Discharge Instructions: Q-HIP^{SM} vs National



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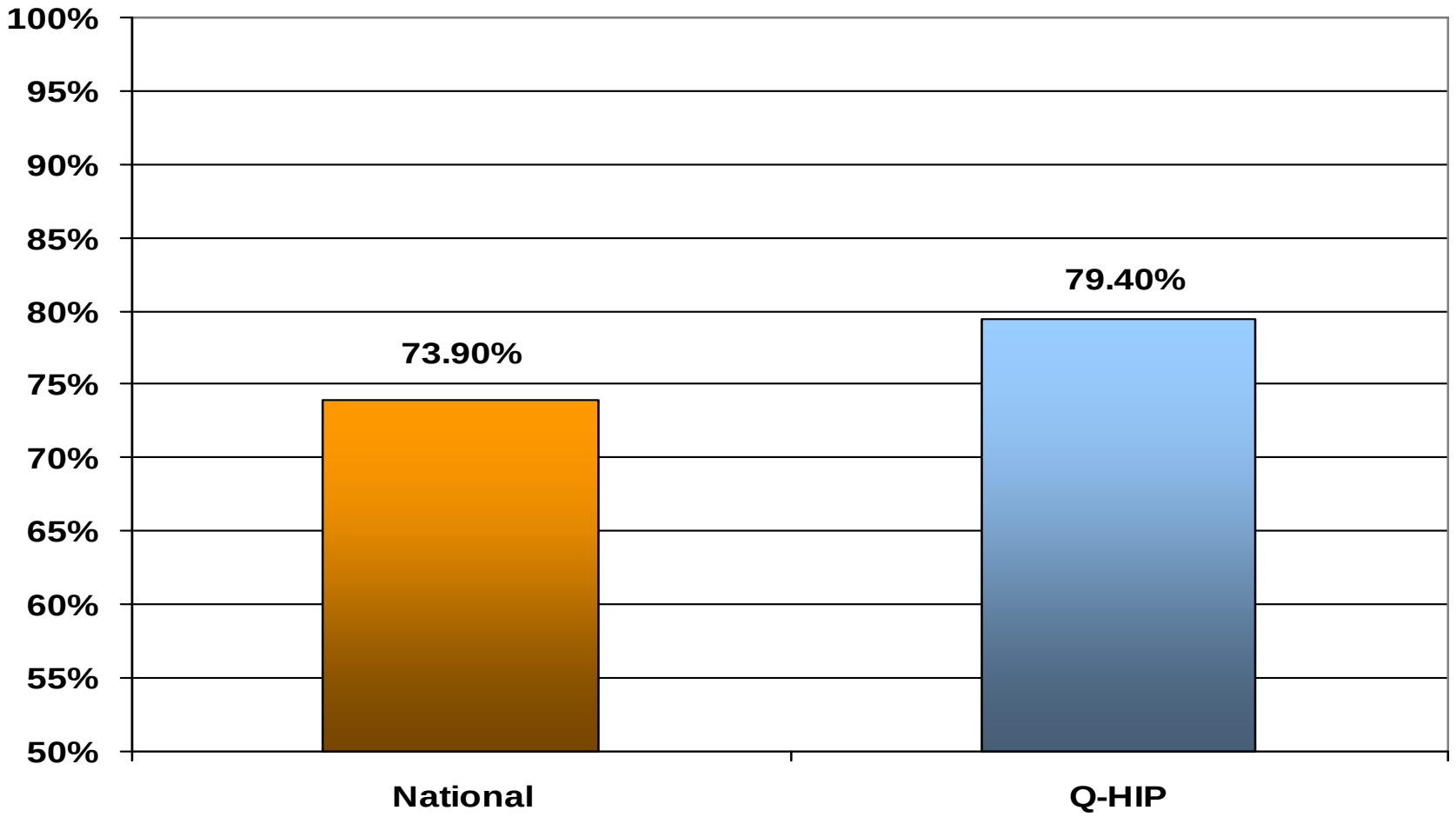
Pre-Op Beta Blockade: Q-HIP vs National



*Q-HIP: average for the 13 facilities that submitted data for 2006 National: national average during 2006 (source – STS National Registry).

ROI Challenges

- Varying base reimbursement methods
- Wide ranging starting reimbursement levels
- Physician programs still new – outcomes analysis just beginning
- Care must be taken to recognize external forces and identify unique “change”
- Not all indicators are “created equal”

Summary

- Marketplace is looking for a solution
- A demonstrated impact on quality of care for cardiology
- Feeds into hospital transparency efforts
- Drives alignment between hospitals and cardiac specialists
- Win-Win solution for providers, members and employers

Questions?