Measuring the Value of Health Centers in the Emerging Pay for Performance Environment

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Origin of Pay for Performance

One Definition:

“ An effort by healthcare payors to contain rising healthcare costs through incentives derived from quantifying the relative value of services offered by medical providers.”

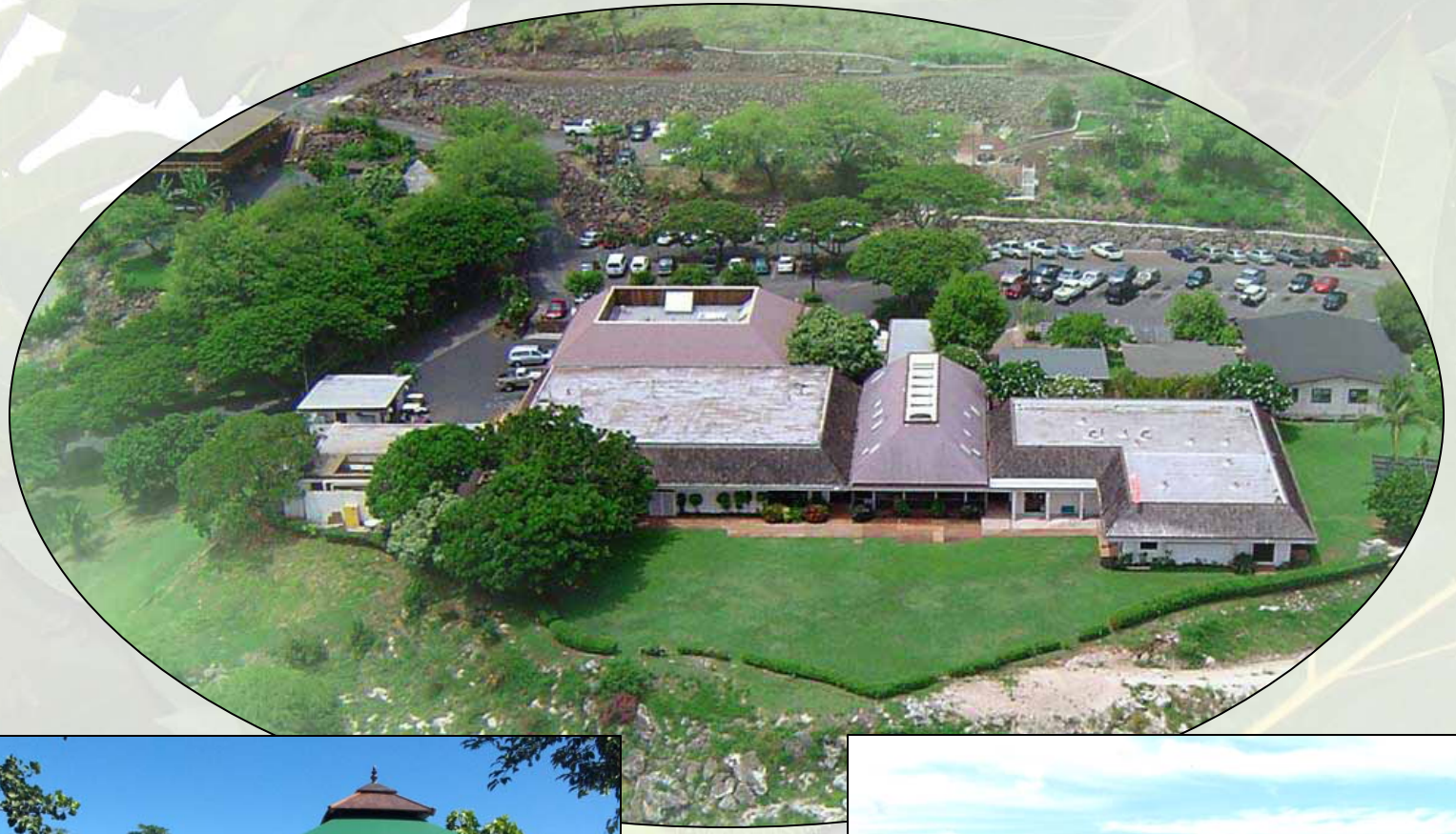
QUESTION

Will we be fairly valued?

- Few models consider population characteristics
- Health Centers often don’t get to participate in measure selection
- Most models measure medical process not healthcare process

A Typical Community Health Center in Hawaii

- A federally qualified Health Center serving 25,000 predominately low income Native Hawaiian residents through 125,000 clinical visits annually
- Clinical services include primary medical care, specialty medicine, dental, behavioral health, substance abuse treatment, and 24 hour emergency medical care
- Population extremely high risk/high cost
  - Two-thirds live below federal poverty level
  - Estimated 30% of adult population used methamphetamines in last year
  - Early onset of chronic disease with multiple co-morbidities very prevalent



How are we Performing?

Perinatal Characteristics

- 743 Health Center Patients entered prenatal care in 2006
- 660 present with at least 1 risk factor
- 185 are teenagers
- 503 are single
- 183 currently or recently using illegal substances

Outcome: hospital stay & post partum outcomes

Outcomes: Average compared to total Hawaii population

How do we score: A B C D F

Obesity Characteristics

BMI Study Based on 7/2003 to 6/2004 average height and weight data collected in practice mgmt. System and EMR for patients aged 18+	# Patients	Average BMI	BMI 30-34	BMI 35+
All population	15574	31.4	2072	2984
			21%	31%
Top 5 Ethnicity Groups				
Hawaiian/Part Hawaiian	6890	33.2	1020	1681
			23%	38%
Caucasian	3345	29.9	423	462
			21%	23%
Filipino	1887	27.4	194	168
			16%	14%
Samoan	981	37.0	116	356
			19%	59%
Japanese	585	27.8	62	47
			19%	14%

Process Measure: % of morbidly obese offered and receiving weight retention services.

Standard: Does it matter the volume of patients needing services in determining whether population characteristics matter?

From Medical Home to an Integrated Healthcare Home

A Hierarchy of Need

LEVEL	WORKING NAME	INDICATED FOR POPULATION CHARACTERISTICS	MODEL OF CARE
I	Medical Home	Up to 5% of population living in poverty	• Accessible provider of care (reach by phone/weekend access) • Chronic Disease Management • Office practice well organized and on time • Screening for medical conditions
II	Healthcare Home	Up to 25% of population living in poverty	• Broader scope of enabling (facilitating) services (transportation, translation, etc.) • Screening for risk includes behavioral, substance abuse, obesity • Continuum of care with behavioral, substance and dietary services • Sliding fee considerations to reduce financial barrier
III	Integrated Healthcare Home	Over 50% of population living in poverty	• Enabling and other non-revenue services codified and tracked • Integration with cultural traditional practices • Job development and training integrated into practice • Emphasis on healing community and economic development • HIT strategically integrated with MCO •Active vote by patients in planning and evaluation of services

Job Training and Economic Development Incorporated Into an Integrated Healthcare Home in Hawaii

- The Health Academy (Entry level Health Career Training)
- Graduated Competencies
- Bringing Integrated Professional Training to Community Health Center Setting

What % of our payroll gets diffused as buying power into the low income community we serve?

Value Measurement is a good thing for Community Health Centers

Proving the value of what we provide to payors should be a fundamental building block of Health Center development!

- History of Value Measurement at one Health Center
  - -UDS concerns
  - -Capitation/Managed Care Concerns – Plans use claims data
  - -The Report Card
- Health Centers are well positioned for P4P
  - -We have measured value for a long time
  - -We inherently provide good value
  - -We are use to adjusting to change

Transitioning our Corporate Culture
A Report Card Measuring Access and Quality

No.	Objective	Jun-05	Jun-06	2006 Score	2006 Grade
A1	350 high risk women will be provided case management services.	522	505	144.29%	A
A2	A risk assessment will be completed on 100% of prenatal patients.	80%	73%	73.00%	C
A3	Reduce low birth weight incidence to 5% or less of live births. Reduce very low birth weights to 1% or less of live births.	5.8%/2.5%	6.5/0.6%	98/100%	A
A4	60% of pregnant women who use tobacco, alcohol and other substances will receive a referral to assist in abstinence throughout pregnancy. (2006: Measure is only those who were offered services-100%).	33.30%	89.00%	89.00%	B
A5	90% will consent to HIV screening	99.50%	99.50%	110.56%	A
A6	70% of pregnant women will enter prenatal care in their first trimester.	62%	65%	92.86%	A
A7	Less than 10% of pregnant women will enter prenatal care in their 3rd trimester.	7.20%	6.00%	104.44%	A
B1	85% of OB patients will return for the postpartum exam.	95%	93%	109.41%	A
B2	95% of newborns will return within 4 weeks of birth for their first newborn visit.	94%	96%	101.05%	A
C1	At least 95% active CHC 2 & 6 y.o. children will be in compliance with their immunizations.	89/89%	89/86%	92.11%	A
D1	Improve performance of growth, development & exposure screenings in active CHC 0-6 y.o. children to at least 80% compliance annually.	74%	69%	86.25%	B
D2	90% of children 0-6 y.o. will have height & weight taken at time of well child exam. *(2005: ht/wt counted at any time of the year)*	79%	74%	82.22%	B

A Report Card Measuring Access and Quality

No.	Objective	Jun-05	Jun-06	2006 Score	2006 Grade
D3	75% of children 0-6 y.o. will have a hemogram by 15 months of age.	80%	76%	101.33%	A
D4	75% of children 4-6 y.o. will be screened for hypertension.	99.40%	97.00%	129.33%	A
E1	75% of active CHC 13-18 y.o. will be screened for smoking risk factors during a physical exam.	62%	65%	86.67%	B
E2	80% of active CHC users 13-18 years old will be up to date on their Hepatitis B immunization.	90%	86%	107.50%	A
E3	80% of active CHC users 13-18 years old will be up to date on their Td immunization.	74%	80%	100.00%	A
F1	Smoking status will be recorded on 70% of the adult population.	73%	70%	100.00%	A
F2	Fasting lipid panels will be obtained for at least 80% of all males 35-65 yo, females 45-65 yo every five years.	83%	81%	101.25%	A
F3	90% of all individuals diagnosed with Congestive Heart Failure will be on an ace inhibitor, unless contraindicated.	66.67%	62.50%	69.44%	D
F4	50% of patients with a BMI over 35 will have weight reduction services offered and documented.	24%	29%	58.00%	F
G1	80% of individuals diagnosed with diabetes will have documented dilated retinal exams annually.	46%	41%	51.25%	F
G2	80% of adults > 45 yo will be screened for diabetes at least every two years.	40%	43%	53.75%	F
G3	50% of children between 9 and 19 years of age with 2 or more risk factors for diabetes/pre-diabetes will be screened annually.	**New Measure** 31%	11%	22.00%	F
G4	90% of diabetics will have 2 Hb A1c measures at least 3 mos apart within 1 year.	65%	64%	71.11%	C
G5	70% of individuals with diabetes will have self management goals.	63%	61%	87.14%	B
G6	Average HbA1C values will be less than 7.0% in 75% of individuals diagnosed with diabetes *(Changed in 2003 from <8% to <7%).*	28%	24%	32.00%	F

A Report Card Measuring Access and Quality

No.	Objective	Jun-05	Jun-06	2006 Score	2006 Grade
G7	75% of women delivered diagnosed with diabetes prior to or during gestation, will have a HbA1c of less than 6.0 at delivery.	**New Measure** 77%	67%	89.33%	B
H1	50% of individuals 2 years and older diagnosed with mild persistent to severe asthma will be prescribed with an anti-inflammatory agent.	67.00%	84.00%	168.00%	A
I1	95% of women18-35 years will be screened annually and women 36-65 years screened every 2 years for cervical cancer through a pap smear. *(2004 data run over 3 yr period)*	62%/44%	61/58%	62.63%	D
I2	100% of abnormal pap results will result in notification to the patient within 2 weeks of receiving results. (Abnormal pap consists of any pap results in the following categories: ASCUS, ASCUS Reactive, ASCUS/SIL, SIL, LGSIL, or HGSIL).	90%	90%	90.00%	A
I3	100% of abnormal pap results will have a follow up appointment scheduled.	98%	100%	100.00%	A
I4	75% of women, 40-49 yo in the past 2 years and 50+ yo within the year will receive a mammogram. *(2004 data run over 3 yr period)*	47%/40%	43/36%	52.67%	F
I5	50% of adult males 50 yo and older will have an annual fecal occult blood screening *(measured if this was offered via chart audit; changed from digital rectal to FOB)*.	1.50%	6.10%	12.20%	F
J1	Improve pneumovax & flu immunization rates for this cohort to at least 75%. *(2004 data run over 2 yrs for flu and 11 yrs for pneumovax)*	73%/36%	72/68%	93.33%	A
K1	90% of health center assigned managed care patients will be assigned or choose a PCP/team.	76%	80%	88.89%	B
L1	50% of women 15 years and older will be screened for domestic violence.	22%	22%	44.00%	F
M1	90% of women 15-35 years old whose PCP is with WCCHC and who had pap smears will be tested for chlamydia annually.	90%	86%	95.56%	A

Health Centers – Common Sense Regarding Adverse Selection

Some say population characteristics should not affect process measurement outcomes in P4P

- Do you reach out to high risk patients?
- Do you serve the uninsured and provide Medicaid Outstationing services?
- Do you have WIC, Behavioral Health & Substance Abuse Services?

If you answered "yes" to any of the above, chances are population characteristics matter.

How can population characteristics be factored into P4P Models

- **Measure individual provider and team improvement**
- **Various risk adjustments**

or

- **Study performance of populations with multiple co-morbidities**

(Health Centers will do well here)

Adoption of HIT

OBSERVATIONS:

- EHR and P4P linkage
- Train and Support Locally
- Customize for FQHC
- Network Data Hubs
  (Multiple EHR Systems can talk)

However, we are disadvantaged by the lack of capital.

So Payors should incentivize the adoption of HIT:

- Health plans should offer differentials for EHR based reporting
- Payors should facilitate HIT adoption
  - Exempt P4P bonus payments from PPS wraparound
  - Adoption of HIT should trigger PPS Change of Scope
  - Cost reporting should capture HIT costs
- HRSA should expand demonstrative program grants for CHC's

A Health Center Driven P4P Demonstration Project is Urgently Needed

- Measures broader value of what we do – beyond medical process and towards integrated healthcare home
- FQHC's participate as partners in selection of measures
- Importance of working with health plans sensitive to health center environment

The Pacific Innovation Collaborative

- 9 Health Centers
- 2 Medicaid Health Plans
- 3 Data Hubs
- 3 stages
  - Pay for Reporting
  - Pay for Performance
  - Pay for Savings

Federally Qualified Health Centers

- **HAWAII:** Kalihi-Palama Health Center, Waianae Coast Comprehensive Health Center, and Waimanalo Health Center
- **WASHINGTON:** Country Doctor Community Health Centers; Puget Sound Neighborhood Health Centers; International Community Health Services; Community Health Centers of King County; Family Health Centers; and Yakima Neighborhood Health Services

Health Insurance Plans

- **HAWAII:** AlohaCare
- **WASHINGTON:** Community Health Plan of Washington

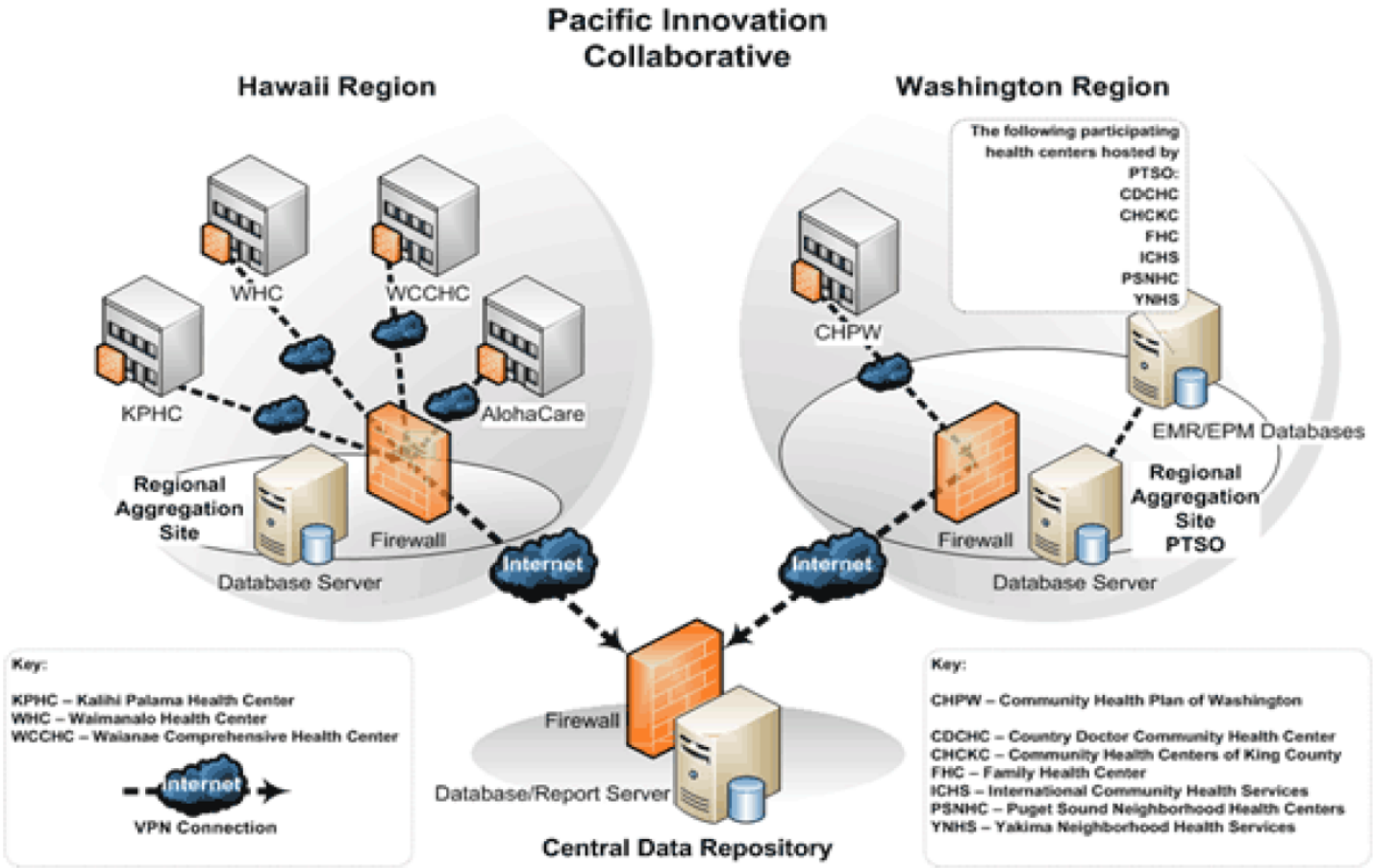
Data Repositories

- **AAPCHO, PTSO of Washington, Waianae Coast Comprehensive Health Center Hawaii Patient Accounting Services**

Pacific Innovation Collaborative Data Network

Technology

Figure III.D.1 – Data aggregation flow in the Pacific Innovation Collaborative



The Cooperative Selection of Measures

Measure	Baseline	Yr 1	Yr 2	Yr 3	Source	Process or Outcome	Impact of Innovation
1. % by age 2 years, with 4 DTaP, 3 OPV/IPV, 1XMMR, 3XHepB, 3XHib (and Varicella)	X	X	X	X	CHC	Process	Effectiveness & Safety, Risk Management, & Quality
2. % of patients with either Type 1 or Type 2 Diabetes whose HBA1c is > 9	X	X	X	X	CHC	Outcome	Effectiveness & Efficiency
2a. % of diabetic patients with a behavioral health (mental health or substance) diagnosis whose HBA1c is > 9			X	X	CHC	Outcome	Effectiveness
3a. % of pts < 7yo who had a primary care visit within the last 12 months	X	X	X	X	Health Plan	Process	Effectiveness & Timeliness
3b. % of pts > 6 yo who had a primary care visit within the last 24 months	X	X	X	X	Health Plan	Process	Effectiveness & Timeliness
3c. Third next available appt			X	X	CHC	Process	Effectiveness & Timeliness
4a. % of patients seen in ER with low complexity problems	X	X	X	X	Health Plan	Process	Effectiveness
4b. % of patients seen in ER who f/u with primary care.				X	Health Plan	Process	Effectiveness
5. % of pts with well child visits: a) In first 15 months; b) At 3-6 years; c) At 12-21 years	X	X	X	X	Health Plan	Process	Effectiveness
6. % of patients on whom early notification of pregnancy was made to the Health Plan.			X	X	CHC & Health Plan	Process	Timeliness & Efficiency

The AAPCHO Enabling Services Accountability Project

- Standardizes, Codifies and Tracks Enabling Services at multiple Health Centers
- Will correlate enabling services with selected outcomes
    - Adequate Child Immunizations
    - Poor Access to Diabetes Care
    - Appropriate Medication for children
    - Adequate prenatal care
    - Obesity Outcomes

Potential Benefits of CHC P4P Pilot Project

- Research
- Link to Enabling Services
- Defend our Mission and Role
- Increase Revenue
- Improve Management Tools
- Build a Network

Conclusion

1. Measuring performance and incentivizing performance is a good thing
2. Population characteristics must be considered and process measures are not inherently risk neutral
3. We need to evaluate and fund new models for measuring the performance of medical (healthcare) homes in high poverty communities

WARNING!

Outreaching to the Homeless could affect your P4P Score

If measured fairly, however, P4P could demonstrate your effectiveness