

Innovations in the Measurement and Payment of Care

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Francois de Brantes
CEO, Bridges To Excellence

Innovations in quality measurement

- Continuous measurement and scoring to create frequent feedback mechanisms to physicians
- Blended scorecards that use process and intermediate outcome measures, single and composite measures
- Weighting of measures and domains that are case-mix adjusted
- Allowances for practices with high percentages of Medicaid and self-pay patients

We are leveraging HIT investments to facilitate measurement

- Gather provider-level clinical quality measures from users of electronic data repositories (i.e. eCIV, EPIC, NextGen, and GE)
- Some providers will use aggregators (e.g. GE's MOC)
- BTE uses three different assessors:
 - IPRO
 - Community Measurement
 - Masspro
- With provider consent, share data with payers for incentive programs

How it's working in Cincinnati

Physician Results Portal = Aligning Forces for Quality

There are a few critical values in a patient's record that impact many measures

Continued Grid With Indicators	MEASURE	DOMAIN SOURCE										Measure Status	
		Age	Sex	Language	Religion	DOB	DOB	DOB	DOB	DOB	DOB		
Medication	...	*	*	*	*	*	*	*	*	*	*	*	...
...	...	*	*	*	*	*	*	*	*	*	*	*	...

Example of scoring the quality of Diabetes care with EMR data

Diabetes Care Link	Possible Points	Actual Points	% of Patients	Weighted Score	Total
Diabetes Care Link	100	88.63	88.63%	39.62	39.62
...

The majority of the points are focused on reducing poor control and, secondarily, optimizing control. For every next patient that is well managed, the physician gets additional points.

Composite measures look at well the physician is doing across measures for any patient

Diabetes Care Link	Possible Points	Actual Points	% of Patients	Weighted Score	Total
Diabetes Care Link	100	88.63	88.63%	39.62	39.62
...

Points on composites of measures are much tougher to achieve, which means that the rewards would have to be greater to motivate high performance on that scale.

We can (and should) adjust for practices with mainly Medicaid/Self-pay patients

The Better Health Greater Cleveland effort shows about a 15% difference in outcome scores between Medicaid/Self-pay patients compared to Medicare/Commercial. Over time, the adjustment should decrease.

Physician (or practice) scorecard

Diabetes Care Link	Possible Points	Actual Points	% of Patients	Weighted Score	Total
Diabetes Care Link	100	88.63	88.63%	39.62	39.62
...

Every applicable Care Link is applied to the appropriate patients. Each Care Link score is re-weighted to reflect case mix.

Continuous scoring applies at all levels of the Scorecard

- To qualify for rewards a practice must achieve a minimum of 50 points overall
- The physician can improve performance at any time by:
 - Improving the care for the next patient that comes in
 - Getting help from some colleagues in managing patients with bad scores
- Between 50 and 90, the practice should earn an increasing % of the incentives offers. Above 90, the practice should get 100% of available incentives
 - At 70.91, the practice would get 52.27% of the incentives ((70.91 - 50)/(90-40))

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Most experts are calling for payment reform to be focused on episodes

Payment Mode	Core Incentive	Organizational Effect	Consumer Shopping Effect
Fee For Service	Increase volume	Favors fragmentation	Can only shop for individual services
Capitation	Decrease volume	Favors consolidation	Can only shop for "systems"
Episode	Decrease volume with episode, increase volume of episodes	Favors some consolidation at the disease/procedure level	Can shop for "care packages" - relevant price transparency

Episodes can be used to cover about 80% of all care, and so it cannot be a full replacement model. We will still need FFS.

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A new flavor for episodes: Evidence-informed Case Rates

- Developed by "sister" company, not for profit Prometheus Payment with grants from Commonwealth and RWJ
- Modeled inpatient procedures, chronic medical conditions, acute events and outpatient procedures
- Core concept is to split cost variation caused by population factors (e.g. prevalence of cancer or heart disease) from variation caused by "care defects" (e.g. hospitalizations for patients with hypertension or hospital acquired infections). We call the latter Potentially Avoidable Complications

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Across these six chronic conditions PACs account for 40% of every \$

Potentially Avoidable Complications for chronic conditions ECRs are mostly comprised of hospitalizations (except for CAD). And the majority of the hospitalizations are caused by flare ups from the condition or are a result of poor management of the patient (e.g. stroke for patients with hypertension).

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Glide path to payment reform

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The deployment of the model depends on the readiness of the market

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ECR-based bonus tied to BTE CareLinks

- Hypothetical physician panel of 1500 patients with 500 chronically ill, distributed as follows

	COPD	Asthma	HTN	Diabetes	CHF	Total
% of all Chronics	9.4%	5.8%	49.2%	32.8%	2.9%	100.0%
# of Patients	47	29	246	164	14	500
Average PACs	\$2,742	\$412	\$586	\$5,100	\$15,421	
Total Opportunity	\$128,874	\$11,948	\$144,156	\$836,400	\$215,894	\$1,337,272

- Total potential quality dividend from practice is over \$1.3MM
- Actual dividend will be equal to \$1.3MM less PACs incurred during year

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Example of an incentive payment

- Total PAC savings opportunity was \$1,337,272
- Assume that actual PACs are \$1MM
- Total potential incentive is \$337,272
- Physician quality score is 70.91
- That qualifies the physician for 52.27% of incentives
- Actual incentive paid is \$176,292

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What does this mean for physicians, payers and patients?

- Physicians can receive significant incentives for delivering high quality care and decreasing PACs
- Payers and purchasers don't have to find "new money" ... it's already there being spent in potentially avoidable complications
- The patients are getting better care, the physicians are financing their "Medical Home", the payers and purchasers are redirecting money where it belongs...and lowering total costs along the way

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