Case Studies in P4P

Preconference II

March 9th 2009

Agenda

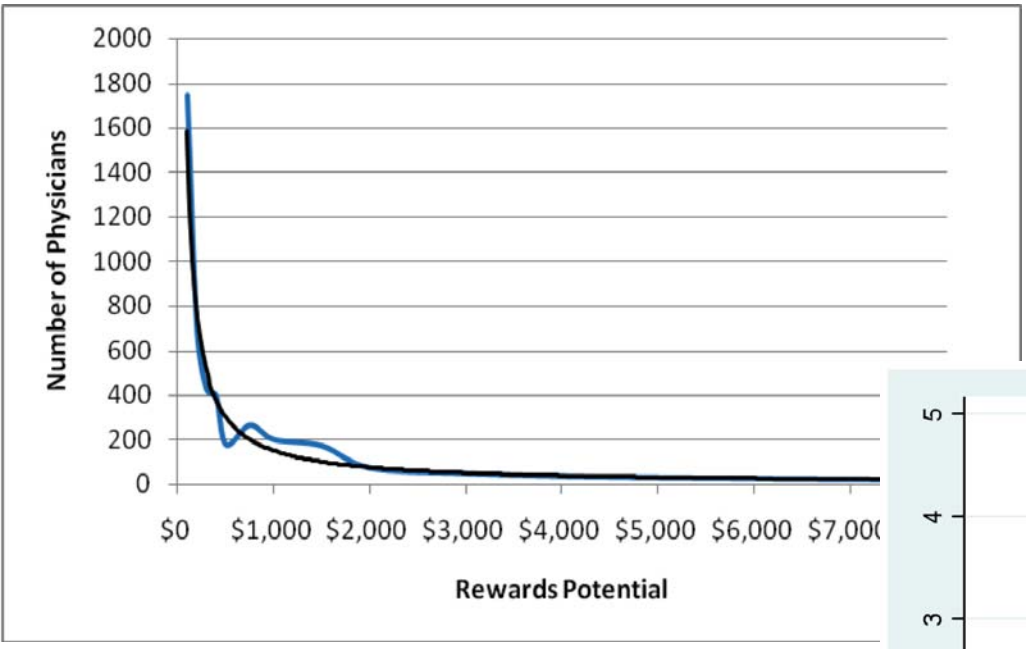
8:00 a.m.	**BTE: Evidence to-date on Program Effectiveness:** Francois de Brantes - Chief Executive Officer, Bridges to Excellence, Newtown, CT
8:30 a.m.	**Balancing the National and the Regional: Aetna and Wellpoint** Elysa P. Ferrara **-** Director, National Provider Quality Performance Programs, Aetna, Hartford, CT Catherine MacLean**,** MD, PhD **-** Medical Director, WellPoint Thousand Oaks, CA
9:15 a.m.	**Baking it in: CDPHP and BCBS North Carolina** Bruce Nash, MD, MBA - Senior Vice President/Chief Medical Officer, Capital District Physicians' Health Plan (CDPHP), Albany, NY Larry Fox **-** Director, Network Quality, Blue Cross and Blue Shield of NC, Durham, NC
10:00 a.m.	**Break**
10:15 a.m.	**Employers Catalyzing Change: CBGH and CHT** Donna Marshall - Executive Director, Colorado Business Group on Health, Denver, CO Laura Linn **-** Project Director, Center for Health Transformation (CHT), Atlanta, GA
11:00 a.m.	**Aligning Forces for Change: Cincinnati AF4Q and NYC TCNY** Craig Brammer - Senior Research Associate, University of Cincinnati Department of Public Health Sciences, Director, Cincinnati Aligning Forces for Quality, Cincinnati, OH Sarah Shih **-** Director of Healthcare Quality Information, Primary Care Information Project, Health Care Access and Improvement, NYC Department of Health and Mental Hygiene, New York, NY
11:45 a.m.	**Questions & Answers**
12:00 p.m.	**Pre-conference Adjournment**

Evidence to-date

Francois de Brantes

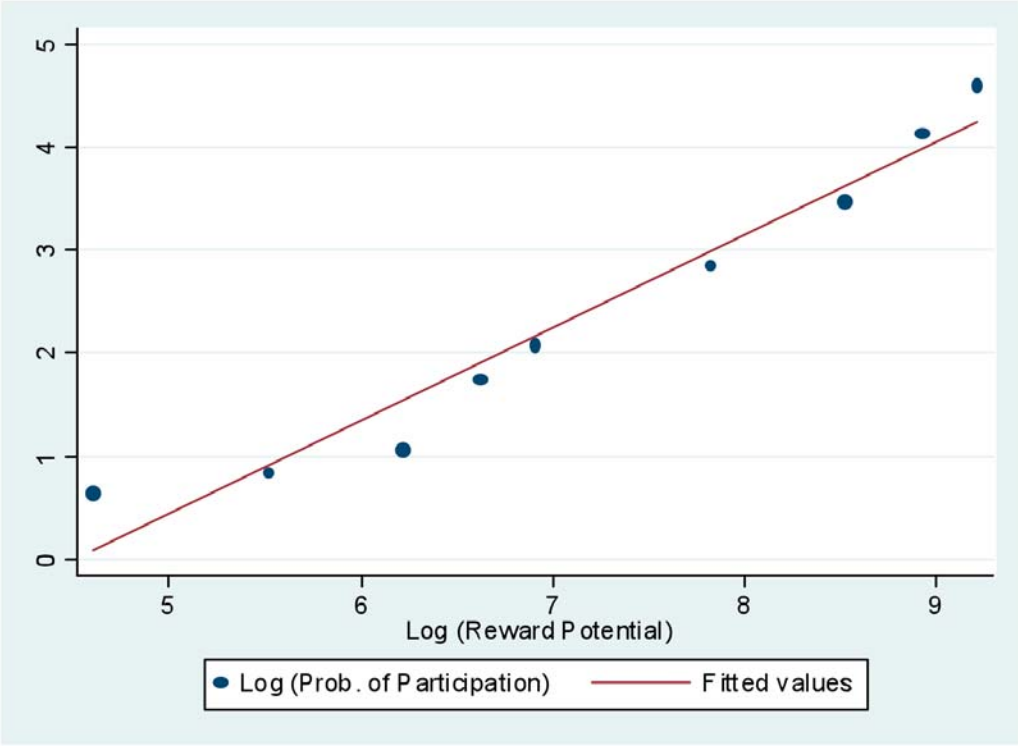
CEO, Bridges To Excellence

Money matters (AJMC, Spring 2009)



The amount of rewards at stake is directly correlated to the likelihood that a physician will participate in the effort. The larger the amount, the greater the likelihood.

Payers have a Pareto-shaped distribution of patients across practices. Most practices will have very small rewards potential, some will have high rewards potential.



Reengineered practices perform better (AJMC, October 2008)

Specialty	POL Recognized	POL Comparison Group	Difference between recognized and comparison physicians	DCL Recognized	DCL Comparison Group	Difference between recognized and comparison physicians
Primary Care Providers						
Avg episodes/patient	2.09	2.22	-0.14	2.61	2.44	0.17
95% C.I.	(2.08 - 2.09)	(2.22 - 2.23)	(-0.15 - -0.13)	(2.58 - 2.64)	(2.44 - 2.45)	(0.14 - 0.20)
Number of episodes	191,527	1,114,334		25,080	577,278	
Avg standardized resource use / episode	$570	$700	-$130	$623	$649	-$26
95% C.I.	($561 - $579)	($697 - $703)	(-$140 - -$119)	($602 - $643)	($645 - $653)	(-$47 - -$5)

Recognized PCPs have lower cost of care than no-recognized peers
The episode count per patient was lower (good thing)
The resource use was higher for E&M, but lower where it counts – hospitalizations

So where do we go from here?

- Balance the local, regional and national
  - Keep measures consistent and don't confuse physicians
- Understand that if you go it alone, you're likely to only be successful with the practices who are in the high rewards tail of your practice distribution
- Focus on intermediate outcomes as much as possible
- Increasingly tie quality performance to reductions in avoidable hospitalizations

Balancing the National and the Regional

- **Catherine McLean, MD, PhD** – Medical Director, Wellpoint
- **Elysa Ferrara** – Director of Provider Quality and Performance Programs, Aetna

National and Local Programs in Quality Assessment

Catherine MacLean, MD, PhD

Staff VP, Provider Performance

WellPoint

IHA Conference

March 8, 2009

The case for national consistency

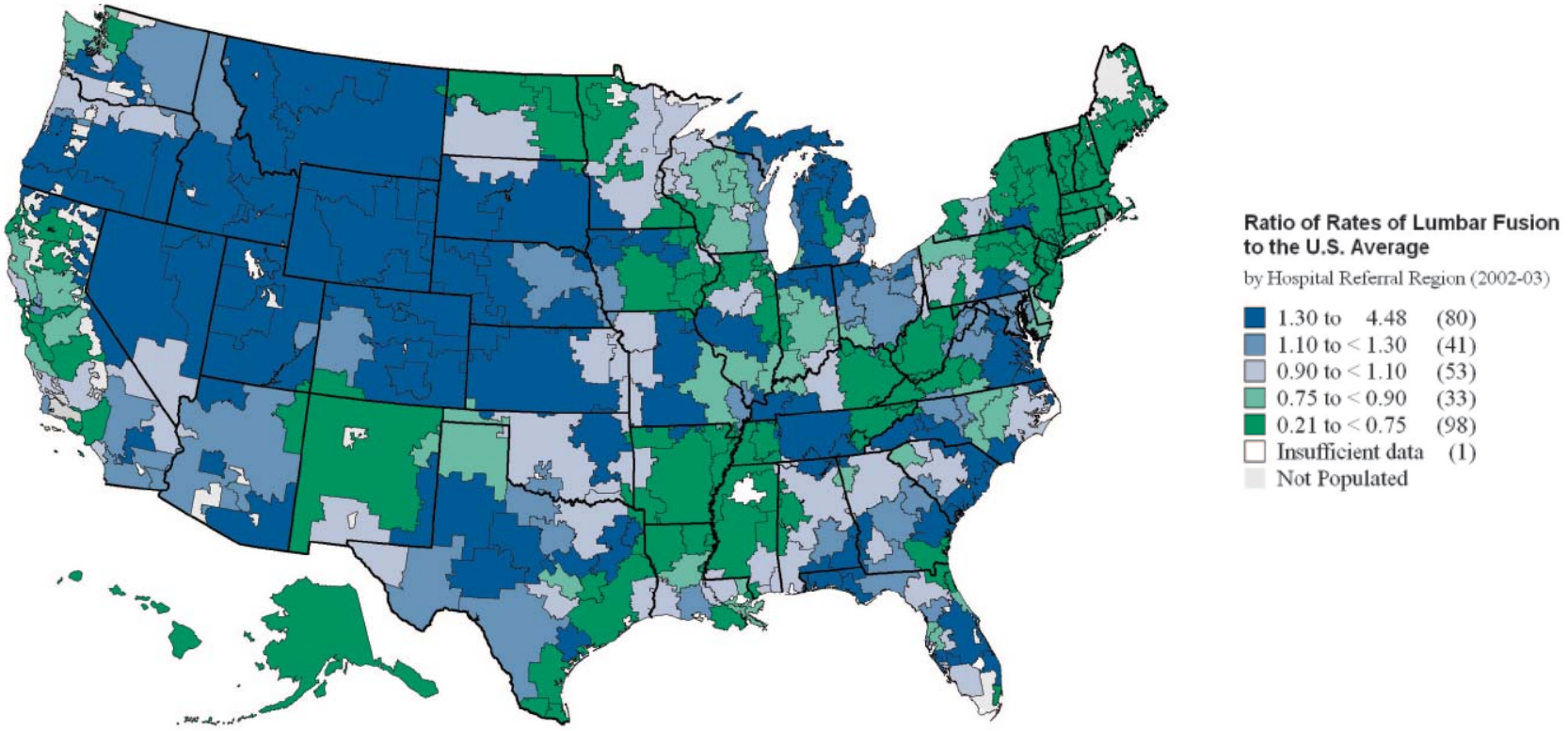
- **Targeted efforts by many stakeholders more likely to drive change**
- **Common measures across assessors would increase relevance to providers**
- **Administrative efficiencies**
  - Employers
  - Plans
  - Providers

The case for locally targeted programs

- **Medicine is practiced locally**
- **Regional variation in**
  - Health
  - Community resources
  - Utilization of services
  - Quality
- **National priorities may not align with local priorities**

Utilization varies by region

Lumbar fusion, Medicare enrollees 2002-2003



Rates varied by a factor of more than 20, from 0.2 per 1000 enrollees to 4.6.

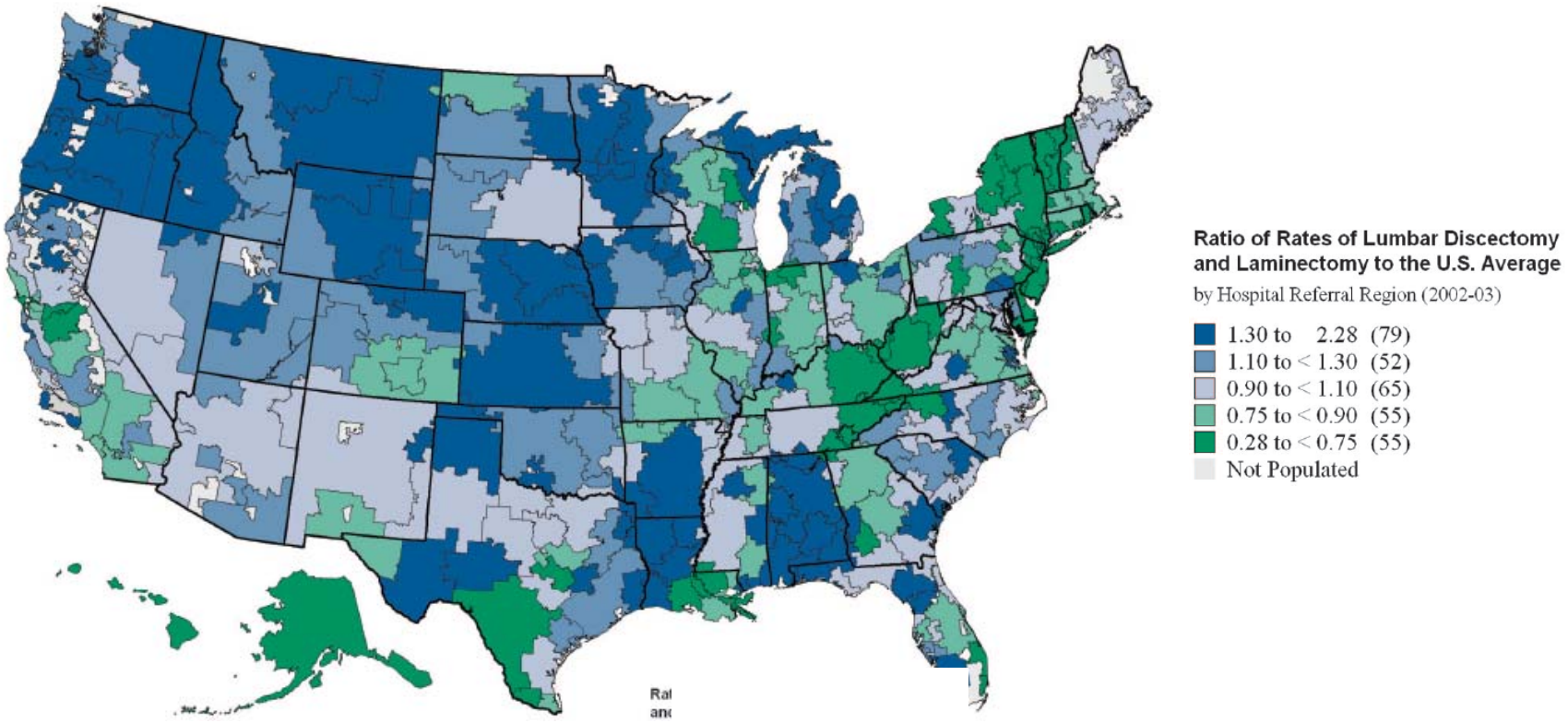
Rates of lumbar fusion were highest in the hospital referral regions of: Idaho Falls, ID (4.6); Missoula, MT (3.0); Mason City, IA (3.0); Bradenton, FL (2.9); and Casper, WY (2.7).

Regions with rates substantially lower than the national average of 1.0 procedure per 1000 enrollees included: Bangor, ME (0.2); Covington, KY (0.3); Terre Haute, IN (0.3); Grand Forks, ND (0.3); and Newark, NJ (0.4).

Weinstein JN, et al. Spine 2006;31:2707-2714

Utilization varies by region and procedure

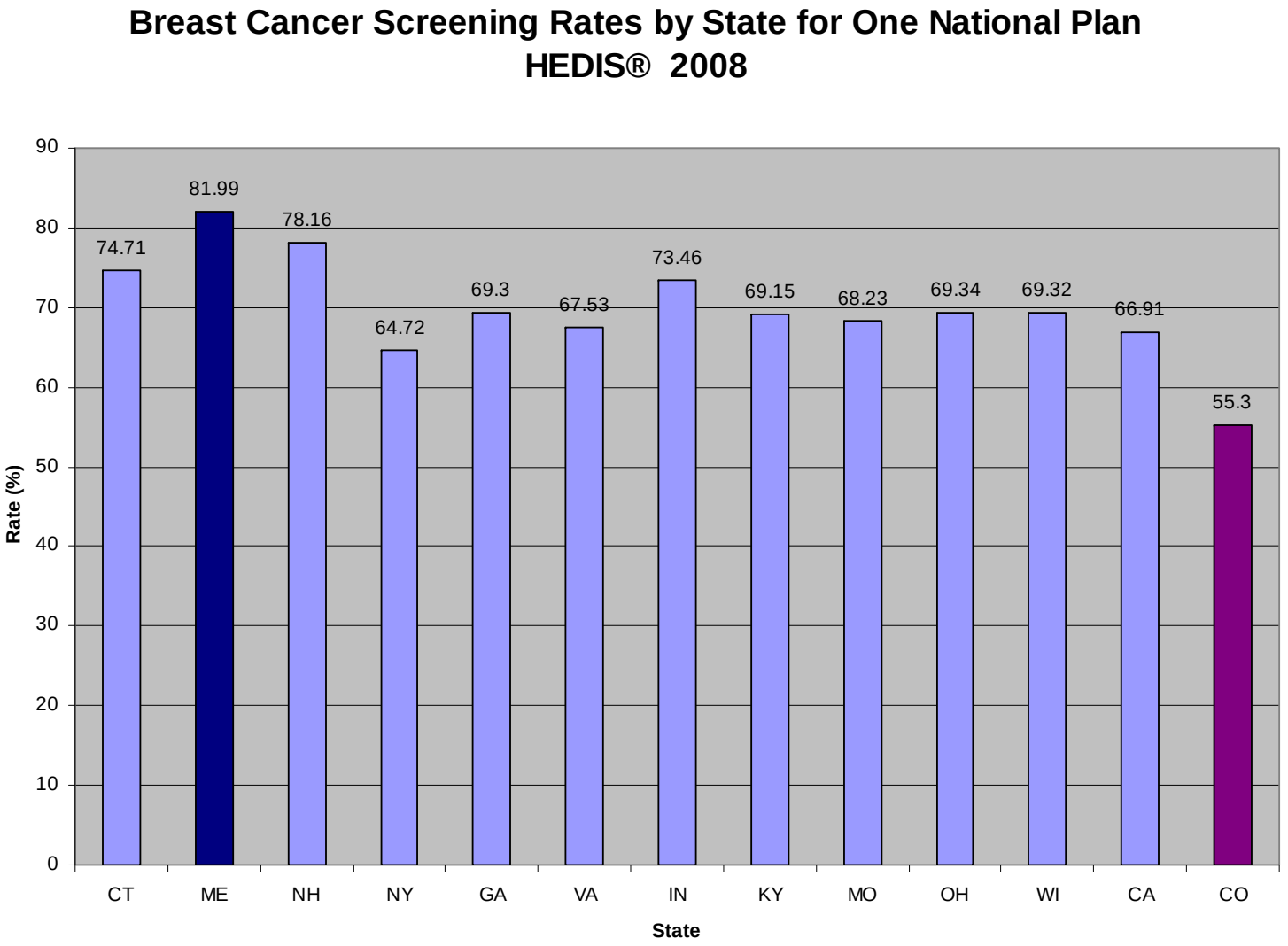
Lumbar discectomy and laminectomy, Medicare enrollees 2002-2003



In 79 hospital referral regions, rates of lumbar discectomy and laminectomy were at least 30% higher than the US average of 2.1 per 1000 Medicare enrollees. In 55 hospital referral regions, rates were more than 25% lower than the national average.

Weinstein JN, et al. Spine 2006;31:2707-2714

Performance Varies by State



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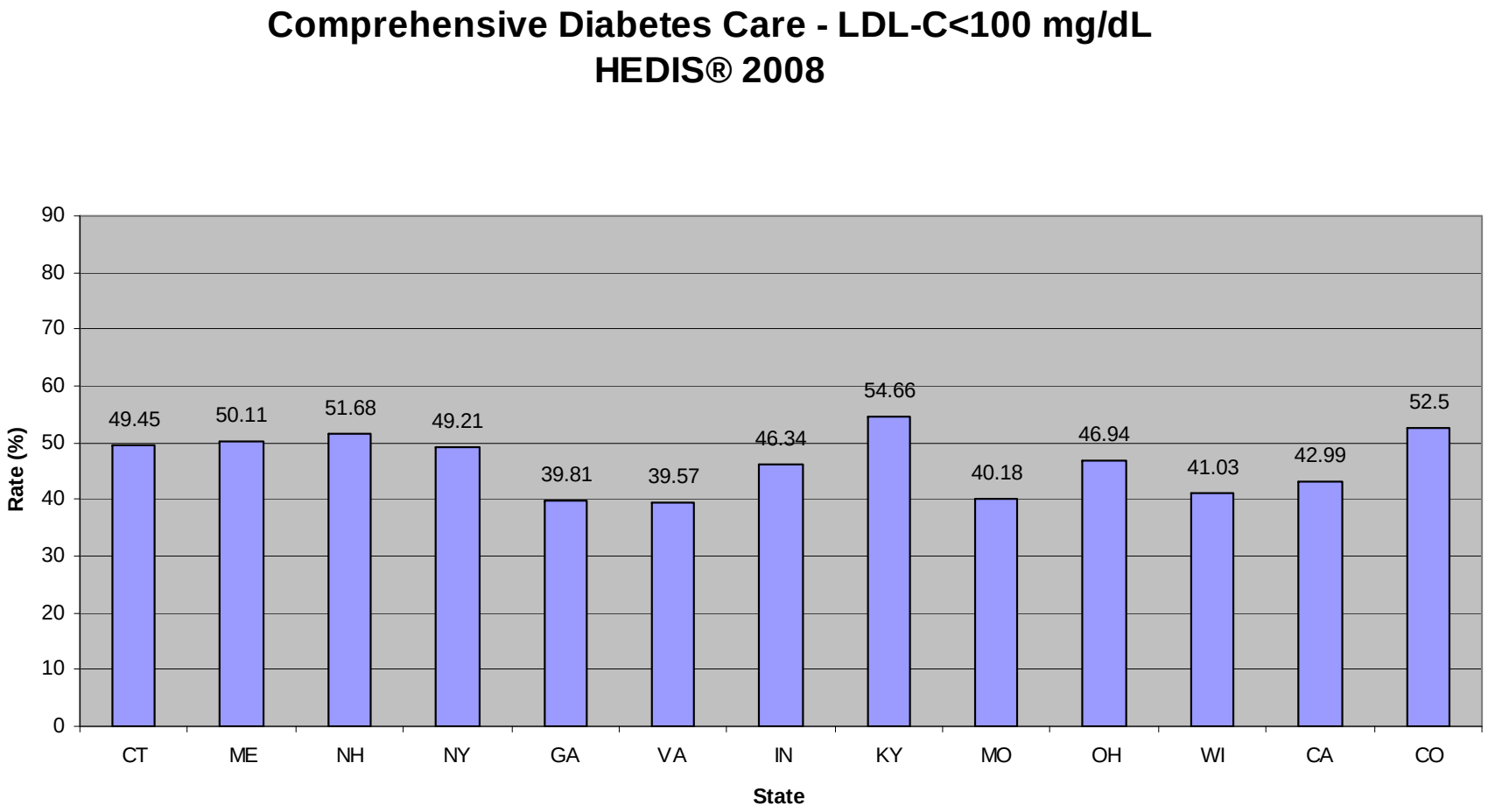
Variance Depends on Measure



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Performance for one national health plan

Sources of inconsistency of performance measurement

- **Measures**
- **Measure specifications**
  - Attribution
  - Time period
  - Diagnostic, procedure and pharmacy codes
- **Units of analysis**
  - Provider
    - Group
    - Individual
  - Health Plan
    - Within
      - Lines of business
        - Commercial
          - HMO
          - PPO
        - Medicare
        - Medicaid
      - Programs
    - Across

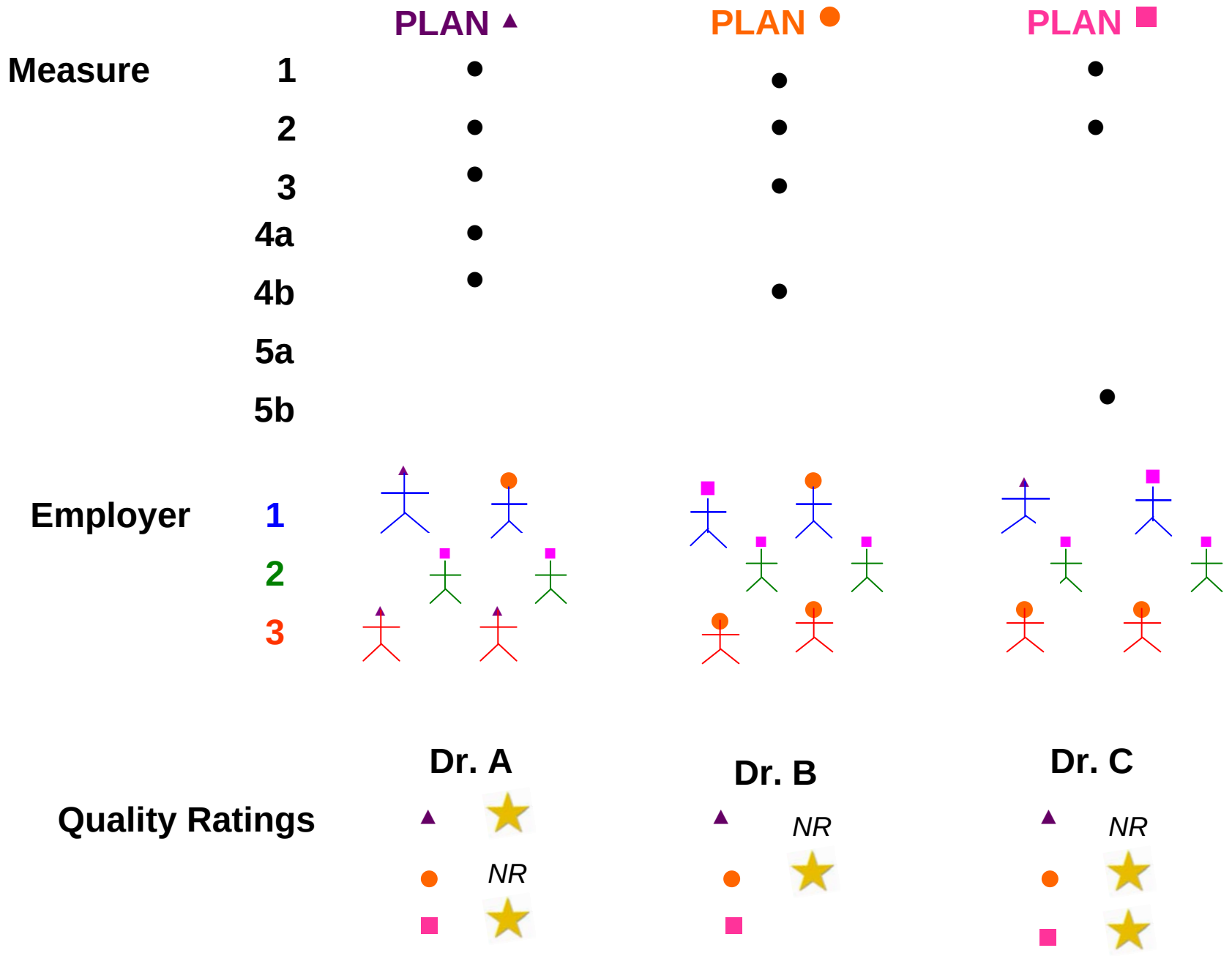
Sources of inconsistency of performance measurement

- **Thresholds**
  - Relative
  - Absolute
- **Statistical methods**
  - Previously no standard
  - NCQA PHQ standards
    - n=30

      or
    - 90% CI

      or
    - Reliability = 0.7
- **Reporting**
  - Individual measures
  - Composite scores

THE RESULT


PLAN
PLAN
PLAN
Measure
1
2
3
4a
4b
5a
5b
Employer
1
2
3
Quality Ratings
Dr. A
Dr. B
Dr. C
NR
NR
NR

National measurement programs

- **NCQA HEDIS measurement and accreditation**
- **NCQA Provider Recognition Programs**
- **BTE Provider Recognition Programs**
- **CMS Hospital Compare**
- **TJC measurement and accreditation**
- **Health plan programs**

Nationally consistent measurement

- **STS registry**
- **ACC NCDR**
- **ABIM PIMs**
- **AAFP METRICS**
- **AAP eQIPP**

Regional performance measurement programs

- **IHA HMO collaborative – CA**
- **California Physician Performance Initiative (CPPI)**
- **THNC RHIO – NY**
- **Quality Health First of Indiana**

Characteristics of national and regional programs

National Programs

- **Same measures across nation**
- **All-payer data, generally for small portion of a practice**
- **Promoted by national organizations**
  - Providers may not be aware or interested

Regional Programs

- **Same measures within region**
- **All-payer data, generally for large portion of a practice**
- **Developed by local organizations**
  - Providers enlisted and engaged

Different measures across different programs

Aligning national and regional programs

- **Define a set of measures that are relevant nationally *and* locally**
- **Define standards for data collection, measure specifications. aggregation, statistical methods and reporting**
- **Develop mechanisms to facilitate collection and use of data for all patients in a practice**

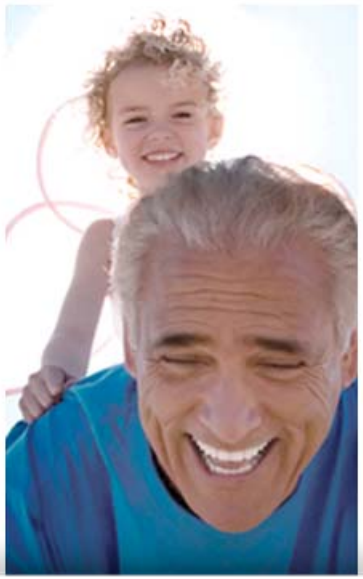
Questions?

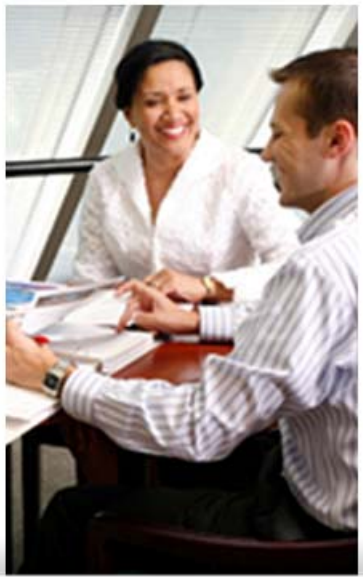
Baking it in to plan-based Regional Initiatives

- **Larry Fox** – Director, Network Quality, BCBS NC
- **Bruce Nash, MD, MBA** – SVP & CMO, Capital District Physicians' Health Plan

Blue Cross Blue Shield of North Carolina/State Health Plan Bridges to Excellence Pilot

Presented to: National Pay for Performance Summit
By: Larry M. Fox
March 9, 2009

About BCBSNC

- Headquarters in Chapel Hill, NC with close to 5,000 employees
- Services all 100 counties in NC
- Founded in 1933
- Current membership exceeds 3.7 million
- Recognized for several national awards as a top employer
  - 2007 and 2008: Top 100 Best Companies by Working Mother magazine
  - 2006-2008: National Business Group on Health Best Employer for Healthy Lifestyles
  - 2008: 25 Noteworthy Companies by Diversity, Inc.

Blue Cross Blue Shield (BCBSNC)/NC State Health Plan (SHP) – Bridges to Excellence Pilot

BTE Background (www.bridgestoexcellence.com)

- A not-for-profit organization - Board includes GE, Ford, IBM, National Business Coalition on Health, The Leapfrog Group, HealthPartners, Partners Community HC
- Program partners include NCQA, Medstat, WebMD, HealthGrades, National Business Coalition on Health
- Founded 6 years ago to create significant advances in healthcare quality by:
  - **Providing tools, information and support** to consumers of healthcare services
  - **Conducting research** on existing healthcare provider reimbursement models, and
  - **Developing reimbursement models** to recognize healthcare providers who demonstrate they have implemented comprehensive solutions to manage patients and deliver safe, timely, effective, equitable and patient-centered care based on adherence to quality guidelines and outcomes achievement.

BTE Implementation Models

- Three models of implementation (in general categories):
  - Implementation directly by employer (generally one that self-funds their health care for employees)
  - Implementation by the employer's health plan administrator on behalf of a specific employer (or group of employers – collaborative model)
  - **Implementation by health plan for their members (crosses many different employers)**

BCBSNC/SHP – Bridges to Excellence Pilot

BCBSNC/SHP BTE Pilot Objectives

- To initiate a physician reward program to encourage the delivery of evidence-based practices and the adoption of clinical healthcare information systems that achieve measurably better member health outcomes, leads to long-term medical cost savings and improves overall affordability.

BCBSNC/SHP – Bridges to Excellence Pilot

BCBSNC/SHP Pilot Description

- Financial rewards, in addition to normal fee reimbursements are being paid to selected BTE Pilot physicians in return for achieving one or more of three NCQA certifications.
- Rewards paid for BCBSNC attributed underwritten and ASO members in addition to attributed SHP employees
- Three-year pilot with three components:
  - **Physician Office Link (POL)** – using NCQA metrics, physician office sites earn financial rewards for implementation of information systems, member education and specific processes for care management to reduce errors and increase quality
  - **Diabetes Care Link (DCL)** - earn financial rewards by achieving NCQA recognition for high performance in diabetes care
  - **Cardiac Care Link (CCL)** - earn financial rewards by achieving NCQA recognition for high performance in cardiac care

(continued)

BCBSNC/SHP – Bridges to Excellence Pilot

BTE Performance Dimensions

➢**POL (Physician Office Link)***

Clinical Information Systems	Patient Education and Support	Care Management
Patient Registries	Educational Resources	Disease Management
Electronic Rx and Test ordering systems	Referrals for Risk Factors and Chronic Conditions	Reductions in ACSC Admits
Electronic Health Records	Quality Measurement and Improvement	Care Coordination of High-Risk Conditions

*Corresponds with NCQA's Physician Practice Connections

BCBSNC/SHP – Bridges to Excellence Pilot

POL – PMPY Rewards (All BCBSNC Members Seen in 12 mo.)

Year	Basic **Caps/Yr:** **$15k/MD** **$90k/Location**	Intermediate **Caps/Yr:** **$20k/MD** **$120k/Location**	Advanced **Caps/Yr:** **$25k/MD** **$150k/Location**
1	**$20**	**$30**	**$50**
2	**$15**	**$30**	**$50**
3	**$10**	**$30**	**$50**

BRIDGES to Excellence
Rewarding Quality across the Healthcare System
PHYSICIAN OFFICE LINK

BCBSNC/SHP – Bridges to Excellence Pilot

CCL (Cardiac Care Link)* – Performance and Reward

	CCL Measures	Year	PMPY Reward **(Cardiac/Stroke Members)**
Basic **Caps/Year:** **$15k/MD** **$90k/Location**	• **Blood Pressure Tested and 75% <145/90 or <140/95** • **LDL Controlled (<100mg/dl)** • **Also, Lipid Panel, Aspirin Use, Smoking Cessation Advice**	**1** **2** **3**	**$70** **$60** **$50**
Advanced **Caps/Year:** **$25k/MD** **$150k/Location**	**Basic, Plus:** • **Blood Pressure Tested and 75% <140/90**	**1** **2** **3**	**$120** **$120** **$120**

*Corresponds to NCQA's Heart Stroke Recognition Program

BRIDGES to Excellence
Rewarding Quality across the Healthcare System
CARDIAC CARE LINK

BCBSNC/SHP – Bridges to Excellence Pilot

- **DCL (Diabetes Care Link)* – Performance and Rewards**

	DCL Measures	PMPY Reward **(Diabetic Members)**
Caps/Year: **$15k/MD** **$90k/Location**	**Tested and Controlled:** HbA1Cs LDLs Blood Pressure **Exams for Eye, Foot and Urine**	**$70**

*Corresponds to NCQA's Diabetes Physician Recognition Program

BRIDGES to Excellence
Rewarding Quality across the Healthcare System
DIABETES CARE LINK

BCBSNC/SHP – Bridges to Excellence Pilot

Pilot Description

- Rewards based on BCBSNC/SHP members with a claim for an office visit in preceding year
- First reward payout – April ’07 with bi-annual payouts concluding April ‘09
- NCQA fees reimbursed for successful practices
- Recognition in provider directories, websites

BCBSNC/SHP – Bridges to Excellence Pilot

Pilot Description

- Invited all Primary Care Physicians (PCPs), Endocrinologists and Cardiologists with identified BCBSNC members
- From applicants, select a geographically dispersed representation of practices representing BCBSNC/SHP attribution of ~45,000 members
- On-site assistance provided for Pilot practices with NCQA trained BCBSNC staff
- Practices offered resources of e-Prescribing project

(continued)

BCBSNC/SHP – Bridges to Excellence Pilot

Physician Selection

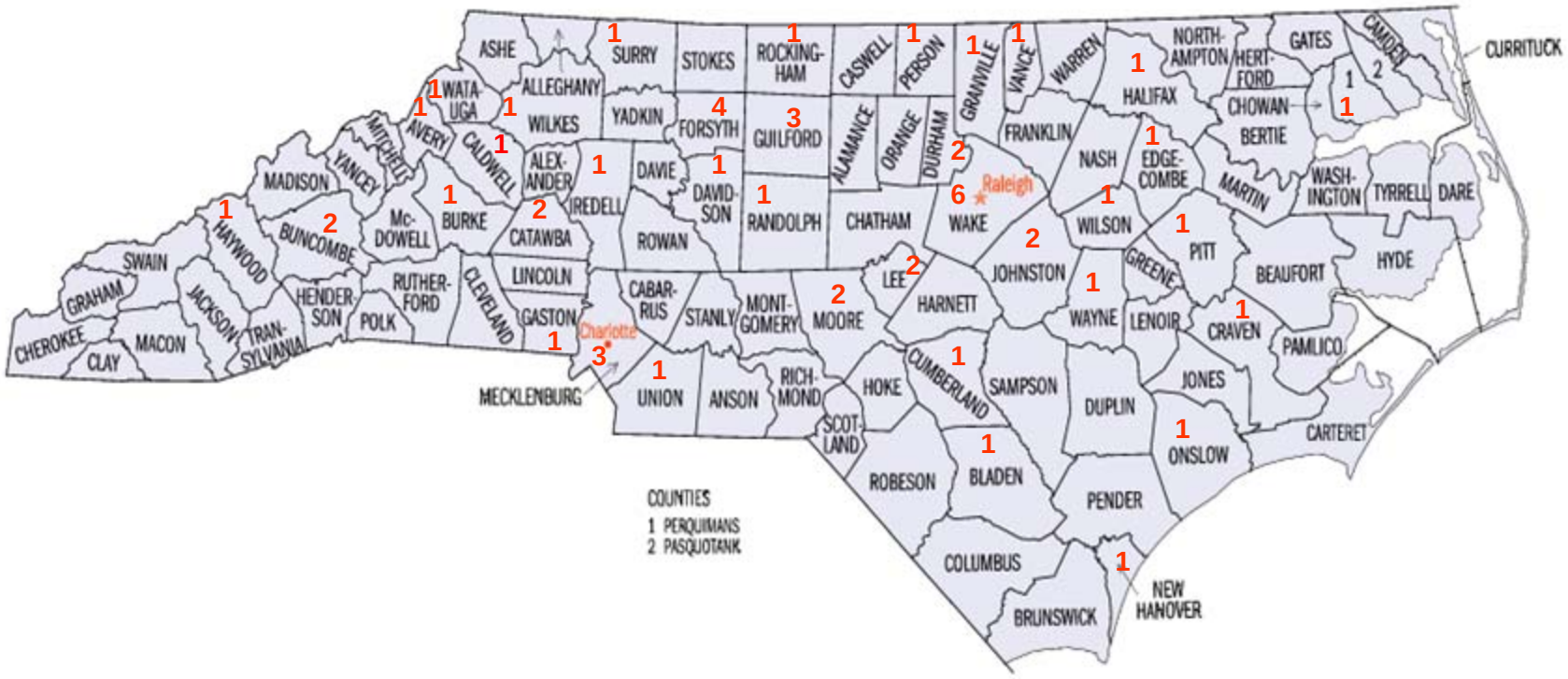
- Widely publicized solicitation to apply via letter and website
- Screening criteria for eligibility:
  - Complete online application submitted by deadline
  - One practice location per large health system/medical group
  - A positive record regarding Special Investigations, Credentialing, etc.
  - Medical Director review
  - Geographic coverage within the state
  - Budget constraints

What was Involved – Cont.

- 6000 letters mailed to eligible network physicians to recruit them to the program
- 572 applications loaded into database, matched with attribution numbers, and reviewed for inclusion in program
- 250+ invited into program – close follow-up to get agreements signed for participation
- Reward payments sent to practices, congratulatory letters to each physician, and letters to practices reminding them of ability to have BCBSNC reimburse for NCQA application fees once recognized by NCQA
- Participation of key stakeholders – SHP, NCMS, NCAFP, Network Mgmt, NCMGM

BCBSNC/SHP – Bridges to Excellence Pilot

NC Practices Accepted In Pilot

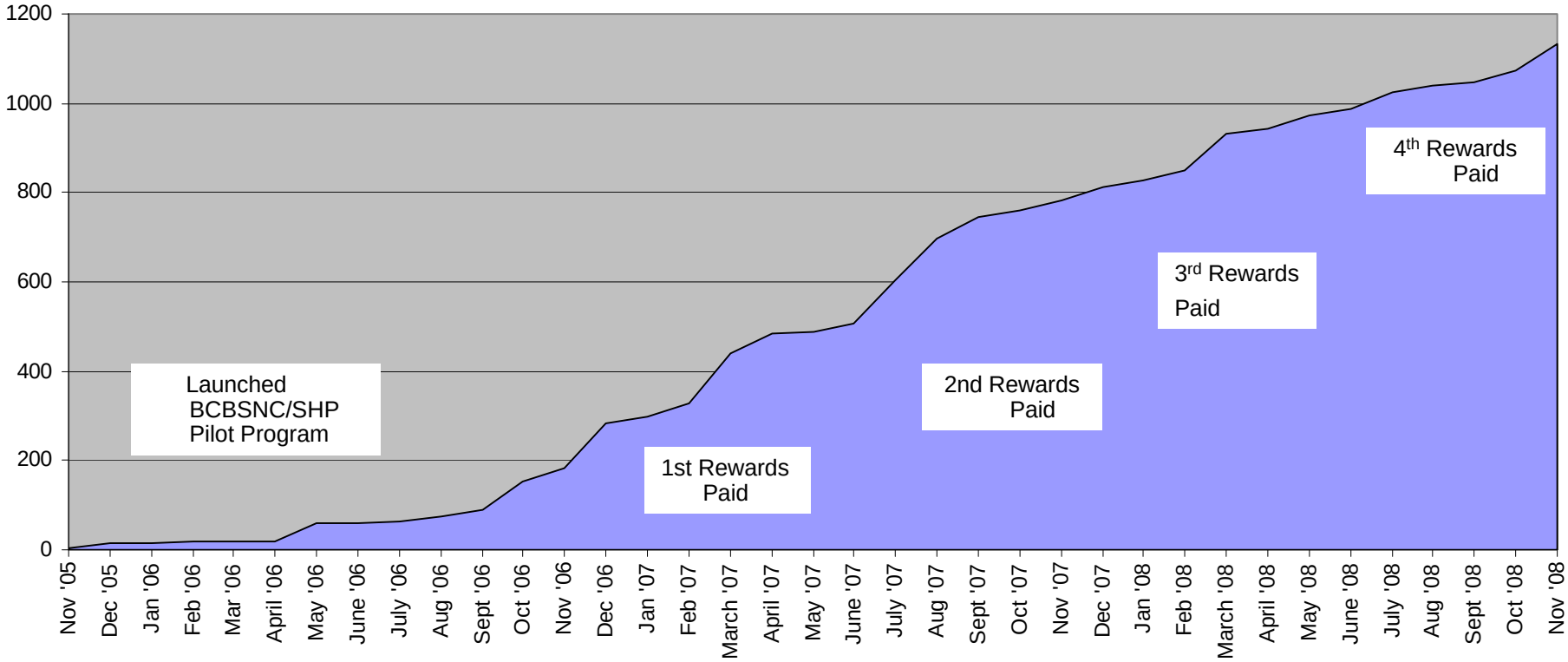


55 Practices
37 Counties

Key Accomplishments (as of 2/1/09)

- Paid out total rewards of over $3,000,000 to providers in recognition of their efforts
- Increased # of PPC (POL) physician recognitions in BCBSNC/SHP Pilot from 0 to 100
  - Total NC recognized providers 7/1/06 = 0
  - Total NC recognized providers 1/1/09 = 189
- Increased # of HSRP (CCL) physician recognitions in BCBSNC/SHP Pilot from 10 to 94
  - Total NC recognized providers 7/1/06 = 53
  - Total NC recognized providers 1/1/09 = 450
- Increased # of DPRP (DCL) physician recognitions in BCBSNC/SHP Pilot 19 to 67
  - Total NC recognized providers 7/1/06 = 81
  - Total NC recognized providers 1/1/09 = 525

Total NCQA Recognitions in NC (as of 11/30/2008)



What was involved:

- BCBSNC Quality Management Consultants (QMC's) trained by NCQA to provide support to practices
- Countless hours spent by QMC's helping practices with the NCQA abstraction tools, reviewing charts as examples for practices, demonstrating quality improvement practices, sharing learnings from other practices, etc.
- Monthly (or more often) meetings with NCQA and QMC's about details of the program, leveraging more support from NCQA for practices, getting questions answered on behalf of practices

Key Challenges

- Some practices were not aware of what they had agreed to do… required more handholding through the process; some decided not to continue with the program – less than 10% ultimately did not get recognized
- Practice physician turnover resulted in confusion: Contracts specified that if MD was not on application there would be no rewards paid in pilot for that MD or for any new physicians added to the practice (needed to assure more accurate estimate of BCBSNC and SHP liability for rewards)
- Calculation of reward caps added complexity to process

Key Challenges – Cont.

- NCQA review process in some instances exceeded the “outer limits” estimate of 60 days we were provided particularly in the early stages of the project; delayed feed of data compressed time frame for getting checks processed
- Errors in NCQA recognition data created issues: some were caught prior to checks being issued, others were caught later and required issue of additional checks
- Transition of BCBSNC staff increased complexity of information transfer/continuity with project

BCBSNC internal program evaluation:

- Clinical results for disease specific program indicate that NCQA recognized docs perform better on BP<130/80 in diabetes – newest NCQA/HEDIS quality measure – otherwise NC physician performance very good; no demonstrated cost savings
- Episode of care costs for physicians recognized in Physician Practice Connection are lower than those for non-recognized physicians, whether we include only episodes for diabetes, CAD, HTN, and asthma OR all episodes that physician is responsible for
- Savings provide a basis for possible additional Primary Care recognition programs

What's Next?

- Last payment for Pilot program to be sent in April 2009
- BCBSNC internal evaluation of pilot is currently being completed with some high level preliminary findings available
- Roll-out of a more comprehensive program in 4Q 2009
  - Clinical Quality
  - Administrative Efficiency
  - Patient Experience with Care

THANK YOU!

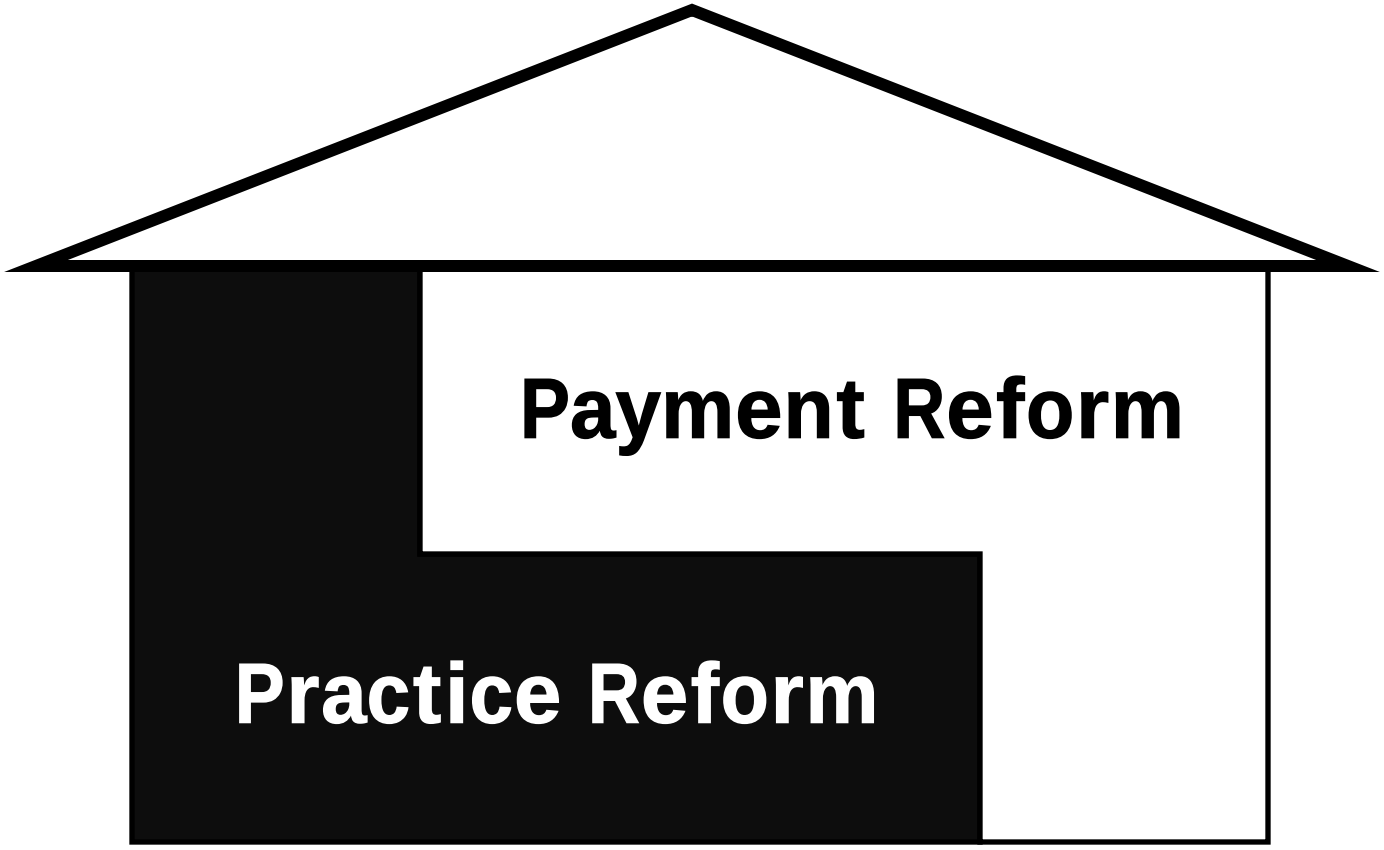
The Medical Home Project

Building the Patient-Centered Practice

Bruce Nash, MD, MBA
Senior VP / Chief Medical Officer
Capital District Physicians' Health Plan, Inc.

March 9, 2009

CDPHP Pilot



Resources

- **TransforMed**
- **Payment Reform**
  - DxCG/Verisk: Arlene Ash, PhD ; Randy Ellis PhD (Boston University)
  - Ingenix: Dogu Celebi, MD, MPH
  - Bridges to Excellence: Francois de Brantes, MBA
- **Evaluation**
  - Allan Goroll, MD (Massachusetts General Hospital)
  - David Bates, MD (Brigham & Women's Hospital)

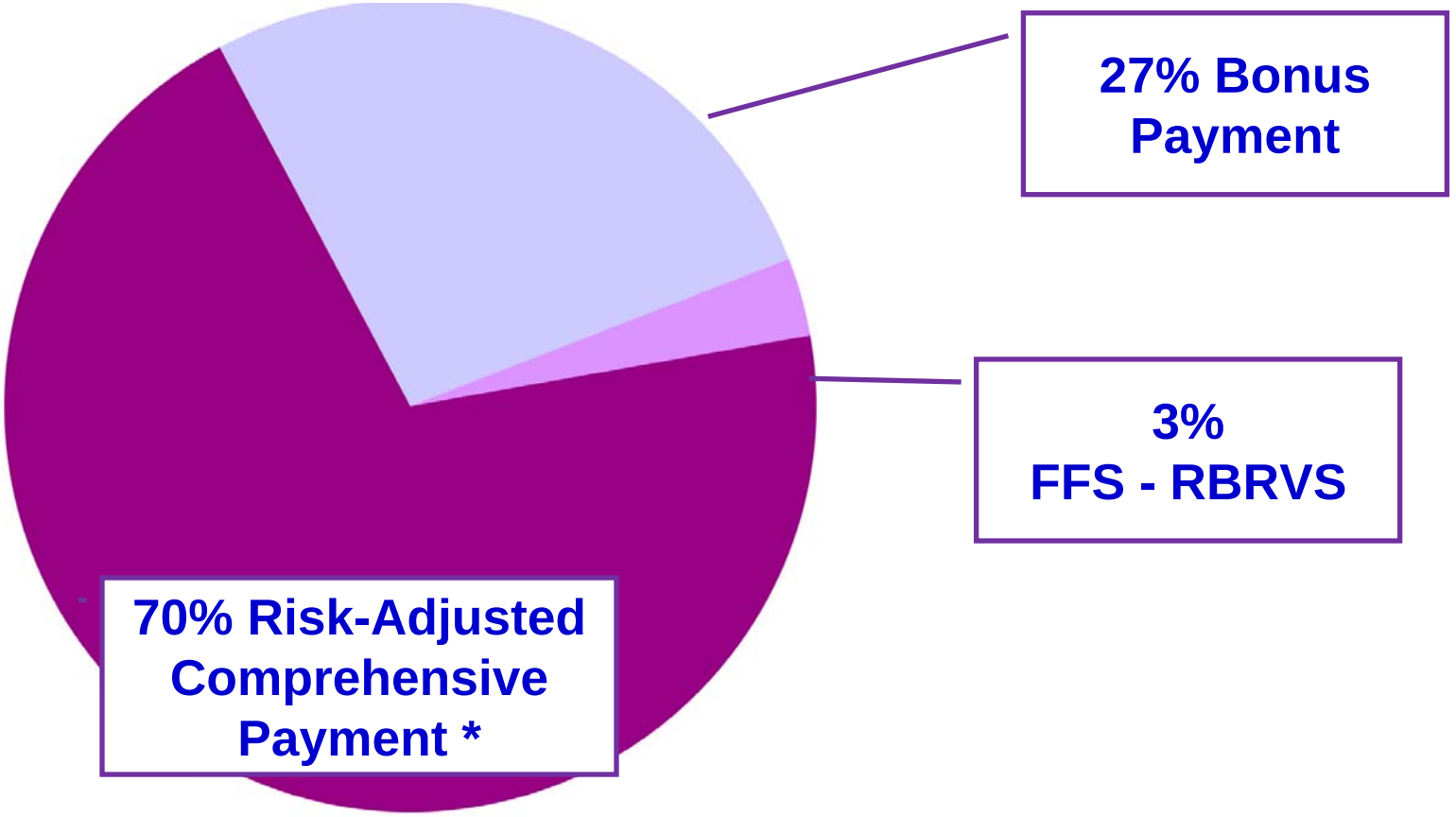
Payment Reform

Payment Reform

- Comprehensive payment for comprehensive care
- Align financial incentives
- Create an opportunity to significantly increase primary care physician income (35 – 50%)

Goroll AH, Berenson RA, Schoenbaum SC, Gardner LB. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. J Gen Intern Med 2007; 22:410-5.

Payment Reform – CDPHP Pilot



Targeted at improving base reimbursement approximately $35,000 to reflect increased costs of implementing and operating a medical home.

Pilot Practice Opportunity

- Per physician with average panel size/risk
  - $35K – base payment increase to cover Medical Home expenses
  - $50K – bonus potential
- Performance will be reported at the individual physician level and the practice
- All payments will be made at the practice level

Risk Adjusted Comprehensive Base Payment

Primary Care Activity Level Model

- DxCG/Verisk developed a risk-adjustment model (PCAL) for the CDPHP Medical Home project.

- A risk-adjusted base capitation payment linked to the expected level of activity needed to provide optimal primary care for a physician's patient panel.

Risk Adjusted Comprehensive Base Payment

- Two components of the formula
  - PCAL = Primary Care Activity Level
  - CF = Conversion Factor

- PMPM = PCAL x CF

CDPHP Panel Attribution

- We will be using the Ingenix “imputation” logic for CDPHP patient attribution.
- Patients who have not been seen within the past 24 months will not be included.
- We will not be using HMO assignment.

Bonus Payment Model

Bonus Model Components

- Satisfaction / Access
- Effectiveness (Quality)
- Efficiency (Cost)

Challenge of Bonus Measure Design

To identify those metrics upon which to base a bonus payment which are strongly correlated to lesser costs and the maintenance or improvement of quality

Bonus Program

- $50K potential per physician with average patient panel.
- A minimum performance of satisfaction/access is a threshold requirement for any bonus eligibility.
- Effectiveness (BTE) will determine available bonus.
- Risk adjusted efficiency measurement (Ingenix) will determine distribution.
- Measurement and payment will be at the practice level, however, data for individual physician performance will also be reported.

Effectiveness

- To ensure that the quality of health care delivery is at least maintained or preferably enhanced under this payment model.
- Measures of:
  - Population Health
  - Acute Disease Management
  - Chronic Disease Management
- Bridges to Excellence tool set

Clinical areas of measurement

- Population health
- Hypertension
- Diabetes
- CHF
- CAD
- Asthma
- COPD
- Back Pain
- IVD/Stroke

Some measures are cross-cutting:

- **BP**
- **LDL**
- **Use of diuretics**
- **Smoking cessation**

Example

Doctor Jones	Possible Points Care Link	Actual Points Care Link	% of Patients	Weighted Score	Total
Population Health	100	91.05	40.0%	36.42	70.91
Hypertension Care Link	100	68.65	15.0%	10.30	
Cardiac Care Link	100	74.91	7.5%	5.62	
Diabetes Care Link	100	68.80	15.0%	10.32	
Heart Failure Care Link	100	59.71	2.5%	1.49	
Asthma Care Link	100	33.79	20.0%	6.76	

Doctor Jones	Possible Points Care Link	Measure	Num/Den Result	Measure	Actual Points Care Link
Diabetes Care Link	100				68.80
Clinical Measures					
Poor control measures					
HgBA1c Control		15	10.74%	13.39	
Blood Pressure Control		15	20.13%	11.98	
LDL Control		10	33.33%	6.67	
Superior control measures					
HgBA1c Superior Control		10	23.08%	2.31	
Blood Pressure Superior Control		10	41.03%	4.10	
LDL Superior Control		10	61.54%	6.15	
Process measures					
Ophthomalogic Exam		10	60.26%	6.03	
Nephropathy Assessment		5	95.92%	4.80	
Podiatry Exam		5	76.83%	3.84	
Smoking Status and Cessation Advice and Treatment		10	95.35%	9.53	

Available Bonus

- On an Effectiveness scale of 100, a physician needs to score a minimum of 50 in order to qualify for a bonus.
- Assuming average size physician panel, every point over 50 will qualify for a bonus of $1,250 per point. Physician with a score >=90 will receive the maximum bonus amount.

Example: For a physician with effectiveness score of 71:

(Effectiveness score – 50) x $1,250 = Available Bonus Amount

(71-50) x $1,250 = $26,250

Efficiency

- To ensure that bonus payments are associated with aggregate cost savings to allow for a sustainable payment model
- Claims based measurement
- Ingenix tools

Efficiency will be measured along three dimensions

A. Utilization Based

B. Population Based

C. Episode Based

A. Utilization-Based

1. Hospitalization rates (inpatient admissions per 1000 patients)
    - Hospitalization rates will be calculated only for Ambulatory Care Sensitive Conditions.

Ambulatory Care Sensitive Conditions

Epileptic convulsions

Severe ear, nose, and throat infections

Chronic obstructive pulmonary disease

Bacterial pneumonia

Asthma

Congestive heart failure

Hypertension

Angina

Cellulitis

Diabetes "A"

Hypoglycemia

Gastroenteritis

Kidney/urinary infection

Dehydration - volume depletion

Iron deficiency anemia

Pelvic inflammatory disease

A. Utilization-Based (continued)

2. Emergency Room Rates (ER visit rate per 1000 members)

Exclusions:

- ER visits with an eventual admission
- Trauma
- Random events
  - Acute
  - High intensity/severe (cancer, etc.)

B. Population-Based

Population-based efficiency will be measured in three categories ($PMPM costs by type of service.)

1. Specialty care and outpatient
   - Includes all specialties
   - Includes all non - radiology, non - lab outpatient costs
   - Excludes inpatient, surgical centers, and ER costs
2. Radiology
   - All professional and facility radiology costs
   - Excludes inpatient radiology costs
3. Pharmacy
   - Pharmacy costs associated with pharmacy benefit

C. Episode-Based

All medical costs associated with a given medical condition, adjusted for differences in case-mix

Selection criteria:

- Clinical significance
  - High prevalence
  - High incidence
- Economic significance
- Sensitive/amenable to primary care, i.e., actionable
- Demonstrated variations in cost/utilization of care

C. Episode-Based (continued)

Episodes for selected medical conditions (cost per episode)

- Diabetes, asthma, CAD, CHF, sinusitis, GERD, hypertension, and low back pain

The same three types of services as population-based measures:

1. Specialty care and outpatient
2. Pharmacy
3. Radiology

Summary of Efficiency Metrics

A. Utilization-based
- Inpatient hospital admissions (selected)
- Emergency room encounters (selected)

B. Population-based
- Specialty care and outpatient
- Pharmacy
- Radiology

C. Episode-based
- Specialty care and outpatient
- Pharmacy
- Radiology

Efficiency Example
Ingenix Index

	Index
A. Utilization	
• Inpatient hospital admissions (selected)	1.50
• Emergency room encounters (selected)	0.90
B. Population-Based	
• Specialty care and other outpatient hospital	1.20
• Pharmacy	0.90
• Radiology	1.35
C. Episode-Based	
• Specialty care and other outpatient hospital	1.35
• Pharmacy	0.85
• Radiology	0.95

Efficiency Example Weightings

	Weight	Index
A. Utilization		
• Inpatient hospital admissions (selected)	5%	1.50
• Emergency room encounters (selected)	5%	0.90
B. Population-Based		
• Specialty care and other outpatient hospital	35%	1.20
• Pharmacy	15%	0.90
• Radiology	10%	1.35
C. Episode-Based		
• Specialty care and other outpatient hospital	15%	1.35
• Pharmacy	10%	0.85
• Radiology	5%	0.95

Efficiency Example
Composite

		Weight	Index	Composite
• Population-Based				
	• Specialty care and other outpatient hospital	35%	1.20	0.420
	• Pharmacy	15%	0.90	0.135
	• Radiology	10%	1.35	0.135
• Episode-Based				
	• Specialty care and other outpatient hospital	15%	1.35	0.202
	• Pharmacy	10%	0.85	0.085
	• Radiology	5%	0.95	0.048
• Utilization				
	• Inpatient hospital admissions (selected)	5%	1.50	0.075
	• Emergency room encounters (selected)	5%	0.90	0.045
	Composite Total	**1.145**		

Ranking

- Each physician's Composite Efficiency Score will be ranked relative to the peer group
- Ranking determines the payout of the available bonus

Bonus Distribution – Efficiency

- Each practice's Composite Efficiency Score will be ranked relative to their peer group of primary care physicians in the Capital District
  - If a practice is below the 60th percentile (Efficiency Threshold), the practice will not be eligible for any bonus.
  - If a practice ranked between 60th and 90th percentile, each additional percentile point is worth 2.5% of the available bonus.
  - If a practice is above 90th, the practice will receive 100% of the available bonus.

Bonus Distribution Summary

(for average panel size)

- **Create the Bonus Opportunity**
  - Effectiveness Score
    - 0 – 50 = No opportunity
    - 51 – 90 = $1,250 per point above 50
    - > 90 = $50,000 opportunity
- **Distribute the Bonus Opportunity**
  - Efficiency Ranking
    - 0 – 60th = No distribution
    - 61st to 90th = 2.5% per percentile above 60th
    - > 90th = $50,000

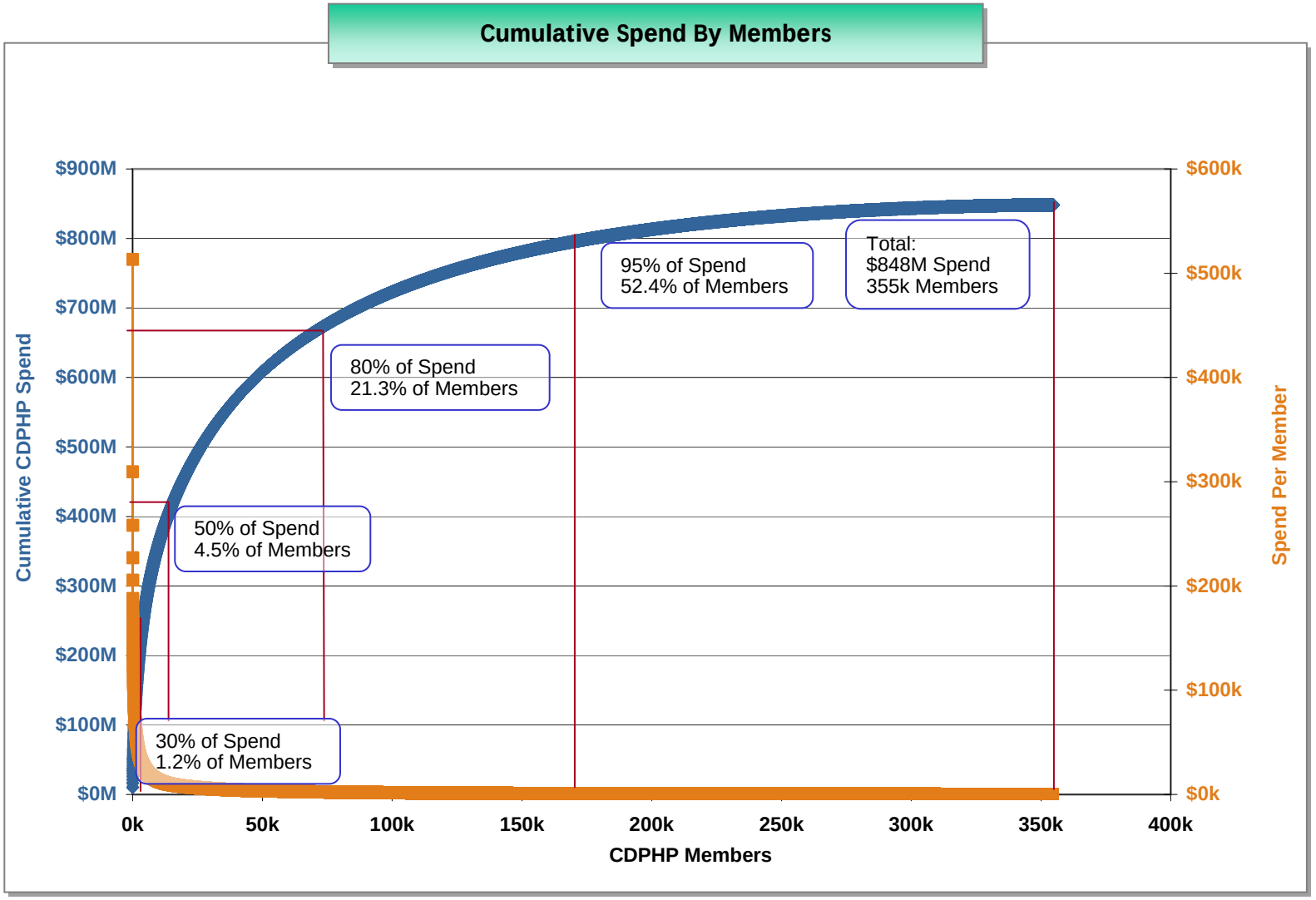
Illustration of Bonus Program Scenarios

Practice	Average Effectiveness Score	Available Bonus amount per MD	Average Efficiency ranking	Bonus Per physician	Total Practice Bonus
A (10 MDs)	92	$50,000	45th	$0	$0
B (5 MDs)	45	$0	92nd	$0	$0
C (4 MDs)	94	$50,000	85th	(85-60) x 2.5% = 62.5% of $50,000 or $31,250	$125,000

Pilot Hypothesis

Is the aggregate savings associated with better health outcomes and lower utilization sufficient to fund the enhanced compensation to a primary care physician as well as provide a surplus to the plan?

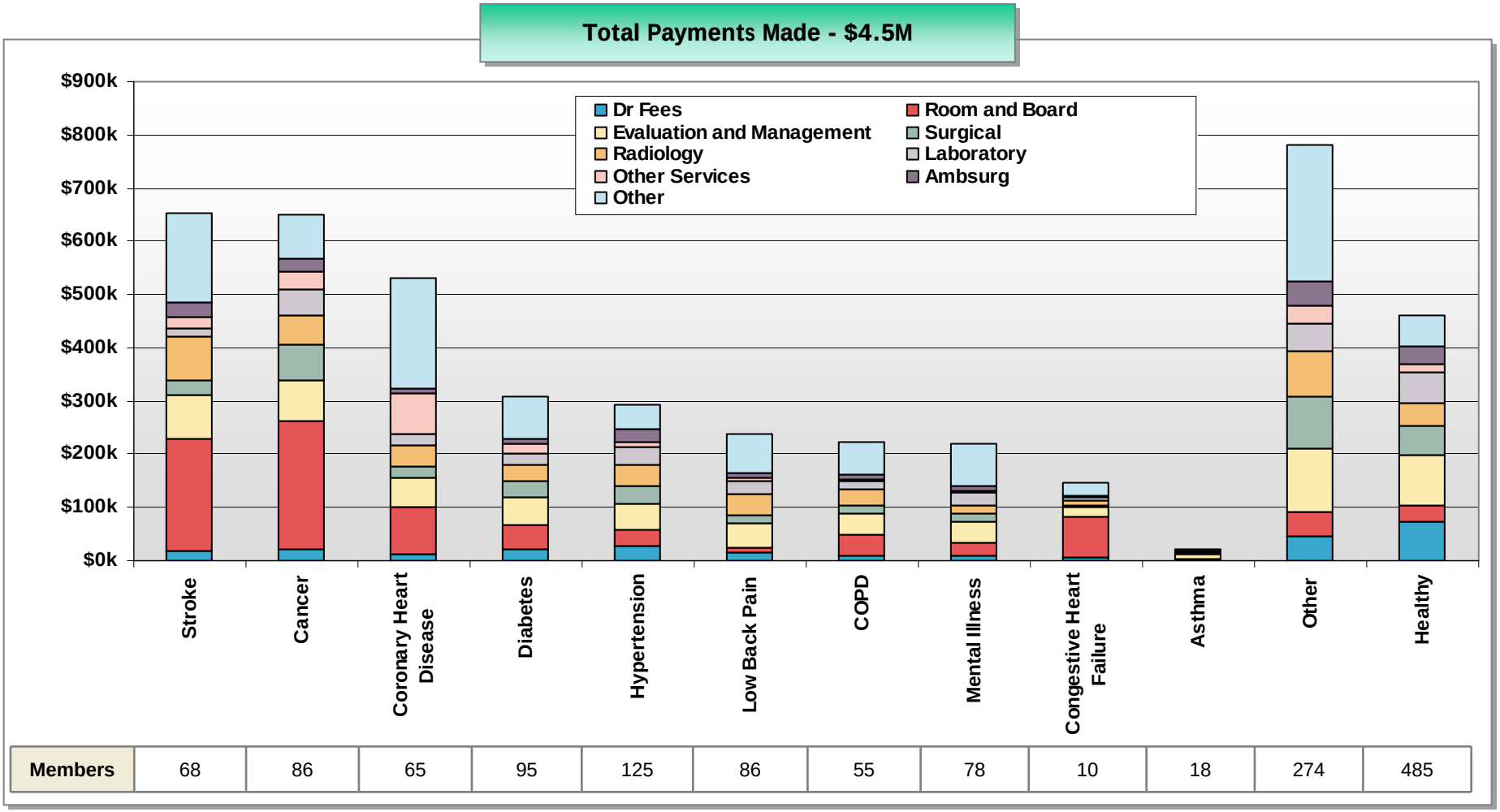
Cumulative Member Spend



Note: Data does not include LabCorp or pharma spend

Sources: 2006 CDPHP Medical Claims, ChapterHouse Analysis

While Only Accounting for 6% of Total Spend, $4.5M Was Spent on Doctor X's Patients



Notes:

1. Does not include LabCorp or pharma spend
2. Shows total spend for any member who visited doctor during 2006

Sources: 2006 CDPHP claims data; ChapterHouse Analysis

Pilot Economics

In our payment model, < 2% of total health care expense for a primary care physician's practice would need to be saved to support an increased payment opportunity of $85,000 per physician.

Times Unio

Friday, December 31, 2010

Primary Care Saved

Three local physician practices, Capital Care Clifton Park, Community Care Schodack and Latham Med, along with insurer CDPHP have successfully created an innovative and sustainable model for the reimbursement of primary care physicians. This has led to an immediate resurgence in the interest in primary care medicine as a career for medical students.

Amazingly, this was accomplished while demonstrating better health outcomes and market leading satisfaction scores for patients, employers and physicians.

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Questions?

BREAK

Catalyzing Change

- **Laura Linn** – Project Director, Center for Health Transformation
- **Donna Marshall** – Executive Director, CO Business Group on Health

EMPLOYERS CATALYZING CHANGE

Laura Linn RN, MN

Project Director

Center for Health Transformation

www.healthtransformation.net

Founded in 2003 by Speaker of the House Newt Gingrich, the Center for Health Transformation is a collaboration of leaders dedicated to the creation of a 21st Century Intelligent Health System that saves lives and saves money.

Mission

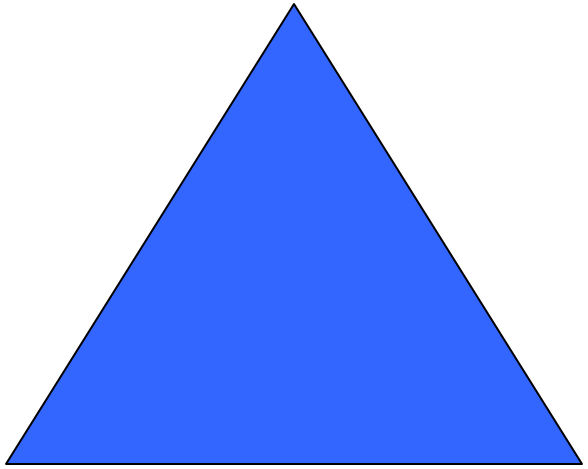
The Center for Health Transformation's mission is to grow a movement that will accelerate the adoption of transformational health solutions and policies that create better health and more choices at lower cost.

We accomplish this by:

- Acting as a catalyst to accelerate transformational change
- Identifying better solutions that provide more choices, better health and lower cost
- Sharing those solutions with the widest array of opinion leaders and decision makers to accelerate their adoption by the system
- Helping create, advance and improve the public policies that will accelerate the transformation
- Training and building a collaboration of leaders

21st Century Model of Health and Healthcare Transformation

Individual-Centered – Incentive - Psychology- Empowerment - Information



Prevention - Early Detection- Self Management – Best Practices

IT- Quality - Expert Systems

A 21st Century Intelligent Health System Requires Transforming 4 Boxes:

4. Financing to Enable 300,000,000-Payor Insurance System

3. Effective, Efficient and Productive Health Delivery System

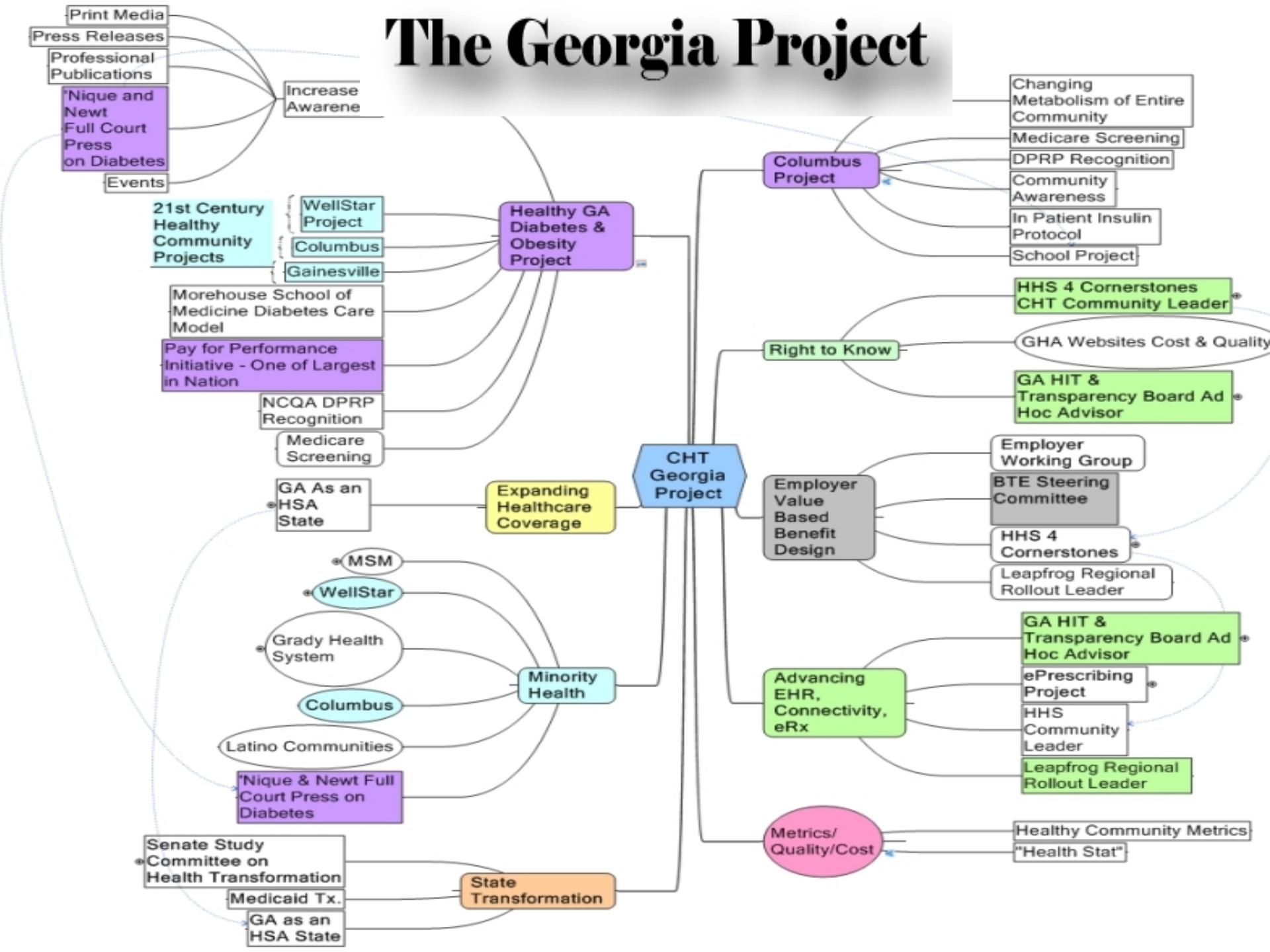
2. Maximize Cultural and Societal Patterns for a Healthy Community

1. Individual Rights, Responsibilities and Expectation of Behavior

Vision and Mission of Project

- The purpose of the Georgia Project is to:
  - Create a model to replicate in other states
  - Involve Georgia members in creating solutions and policies
  - Generate/monitor projects to test solutions

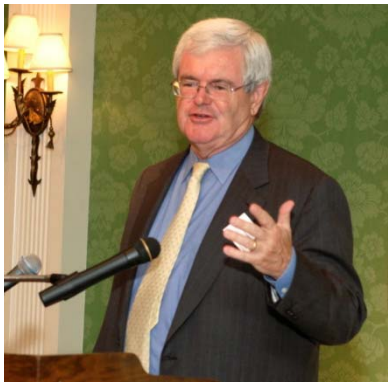
The Georgia Project



Healthy Georgia Diabetes & Obesity Project kick-off at Governor's Mansion in September of 2005

Georgia Governor Sonny Perdue

Dr. David Satcher



CHT Founder, Newt Gingrich

Georgia Diabetes & Obesity Project

- BTE major initiative of the Project
  - Led by UPS, BellSouth [AT&T], and Southern Company

F THURSDAY, JULY 28, 2005
******
The Atlanta Journal-Constitution
ajc Business

Big employers lead way to boost diabetes care

By ANDY MILLER
jamiller@ajc.com

UPS and BellSouth are leading a corporate charge in Georgia to pay bonuses to doctors to improve care for patients with diabetes.

Giving physicians extra money to achieve medical-quality goals -- called pay for performance -- is a small but growing trend in health care. The Georgia initiative, though, aims to be broad-based, involving a large group of employers, the state's major health insurers and possibly Georgia's government-run health care programs.

Dale Whitney, corporate health care manager for Sandy Springs-based UPS, said Wednesday that the Georgia diabetes effort is based on similar incentive programs in Cincinnati and Louisville, Ky. Participating doctors in those cities are not only delivering better care to people with diabetes, but the cost of that care is about 15 percent less expensive than that of other physicians, he said. That's because more money is spent on outpatient services and early treatment, and less on hospitalization and emergency room use.

"We want to change the way health care is practiced, so it's better quality and more affordable," Whitney said.

➤ Please see DIABETES, F4

Diabetes: Plan would make good care pay

➤ Continued from F1

He said UPS and BellSouth have committed to the diabetes pay-for-performance project, called Bridges to Excellence, and that more than 20 other Georgia employers, including Home Depot, have shown strong interest. If successful, the employers could extend their focus to other diseases, such as heart disease, he said. Doctors could earn thousands of dollars extra a year by joining the Bridges program, Whitney said.

Former House Speaker Newt Gingrich, whose Center for Health Transformation is helping organize the Georgia diabetes program, said all major health insurers in the state say they want to participate.

He added that talks have been held with Gov. Sonny Perdue about how it could be extended statewide, including to the insurance plans covering state workers and the poor and disabled.

Nationally, doctor incentive programs have gained momentum amid a general push to improve the quality of American medicine. The trend is driven largely by employers.

Major health insurers want to participate, said former House Speaker **Newt Gingrich.**

Medicare, the federal program covering 42 million Americans, is considering broad use of pay for performance.

Most programs reward the best-performing doctors, while other programs penalize poor quality.

Incentive bonuses to meet quality goals get a mixed reaction from doctors, with many being apprehensive about them, said Dr. William Bornstein, an endocrinologist and chief quality officer with Emory Healthcare.

Pay for performance could work well with diabetes care, he said, because doctors could use the extra money to buy information technology to help them monitor patients better.

Diabetes is a disease in which the body does not produce or properly use insulin, a hormone that is needed to convert sugar, starches and other food into energy needed for daily life. An estimated 18 million Americans have diabetes and another 41 million are pre-diabetic, a condition that will likely become diabetes without appropriate preventive treatment. Obesity is a significant risk factor in developing diabetes.

The economic cost of diabetes in 2002 was $132 billion -- $92 billion in direct medical costs and $40 billion in indirect costs, such as lost workdays and productivity.

Diabetes prevalence in Georgia has increased by more than 50 percent in the last decade. About 7 percent of Georgia's adult population has been diagnosed with diabetes. Diabetes rates are higher among minorities.

Resistance to the program "has evaporated, and did very quickly" in Louisville.
DALE WHITNEY
UPS health care manager

Whitney of UPS said the diabetes project is expected to begin in January. It's voluntary for doctors. A physician could get $80 extra per diabetes patient per year, with an annual maximum of $20,000 for each doctor.

"We had some resistance from the medical society in Louisville," Whitney said. "That has evaporated, and did very quickly."

Dr. Elizabeth Ofili, a professor and director of the Clinical Research Center at Morehouse School of Medicine, said Atlanta physicians are now asking how to join the diabetes program.

ATLANTA BUSINESS CHRONICLE
HEALTH-CARE QUARTERLY
April 21-27, 2006
Industry Focus
Section C

WELLNESS WATCHDOGS
Coaches like Will Prater are not just for sports anymore.
13C

Diabetes' costly toll

Insurance companies and employers search for a way to stem the flow

By Martin Sinderman
CONTRIBUTING WRITER

Diabetes is an ailment that afflicts an ever-increasing proportion of the nation's population, costing businesses billions in direct health-care costs and decreased productivity.

More than 20 million people nationwide — close to 500,000 in Georgia — suffer from the disease, which is the country's sixth-leading cause of death, causing more deaths a year than pneumonia or the flu.

Treating the millions with diabetes carries a stag-

Diabetes by the numbers

20.8 million – Number of U.S. diabetics
14.6 million – Number of U.S. diagnosed diabetics

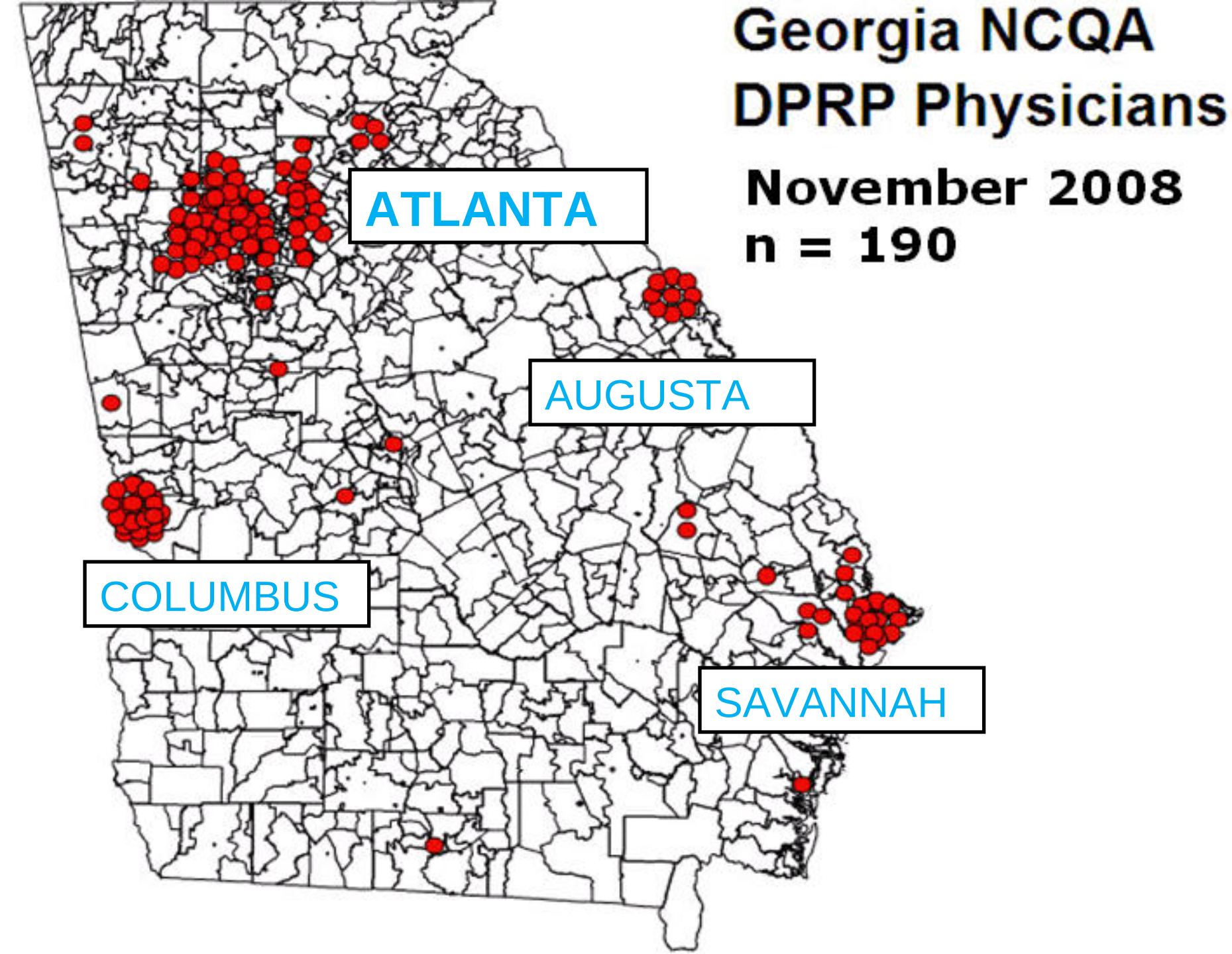
Participating Employers

- Atlanta Gas Light
- AT&T
- ChoicePoint
- Cingular
- Georgia Ports Authority
- GE
- Gulfstream Aerospace
- IBM
- International Paper
- Marriott International
- State of Georgia
- Southern Company
- Savannah Business Group:
  - Atlantic Wood Industries
  - Bradley Dixie Companies
  - Chatham Steel Corporation
  - City of Savannah
  - Colonial Group
  - Critz, Inc.
  - Fuji Vegetable Oil
  - Georgia Emergency Associates
  - Interstate Paper
  - J C Bamford Excavators Ltd
  - The Landings Club
- Synovus
- UPS
- WellStar Health System *
- Xerox

* Participating as Provider and Employer

Participating Health Plans

- Aetna
- Blue Cross Blue Shield of Georgia
- CIGNA
- Humana
- Kaiser Permanente
- United Healthcare


Georgia NCQA
DPRP Physicians
November 2008
n = 190
ATLANTA
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COLUMBUS
SAVANNAH

ATLANTA BUSINESS CHRONICLE www.atlantabusinesschronicle.com January 5-11, 2007 • Page 9A

News Briefs

Delta reports loss for November 2006

Delta Air Lines Inc. said it lost $49 million in November, or $12 million if the costs of its bankruptcy reorganization are excluded.

The airline (Pink Sheets: DALRQ) had a net loss of $181 million in November 2005.

Delta's operating income for the month was $52 million, an improvement of $159 million over November 2005.

The airline had $3.8 billion in cash, cash equivalents and short-term investments as of Nov. 30, of which $2.7 billion was unrestricted.

Delta said its operating income of $52 million includes a $31 million negative impact of fuel hedges.

Delta disclosed the numbers in its monthly operating report for November 2006, filed with the U.S. Bankruptcy Court for the Southern District of New York.

Delta is attempting to restructure and emerge from bankruptcy in the spring. However, **US Airways Group Inc.** is trying to acquire Delta in a hostile takeover.

"November's results continue the momentum that will deliver a nearly $2 billion year-over-year improvement in Delta's net income excluding reorganization items for 2006," said Edward H. Bastian, Delta's executive vice president and chief financial officer. "These results reflect the strength of our business plan and further underscore our confidence to emerge from bankruptcy as a strong, standalone company in the spring of 2007."

Pilgrim's Pride buys 89% of Gold Kist

Pilgrim's Pride Corp. said it has completed its initial offer to acquire all of the outstanding shares of **Gold Kist Inc.**, and expects to complete the transaction in early January.

In the initial round, Pilgrim's Pride (NYSE: PPC) acquired a total of 45,343,812 shares of Gold Kist common stock, or about 89 percent of Gold Kist's outstanding shares (Nasdaq: GKIS), for $21 a share.

A second offering period will run through Jan. 5.

The resulting company will be the nation's largest chicken producer.

"The completion of this tender offer is a significant milestone for Pilgrim's Pride," said O.B. Goolsby Jr., Pilgrim's Pride president and CEO. "We look forward to beginning 2007 as a much stronger company, with industry-leading market share, a broad and growing customer base and a balanced portfolio of fresh chicken and value-added products."

The transaction was unanimously approved by the boards of directors of both Pilgrim's Pride and Gold Kist.

It has a total equity value of about $1.1 billion, plus the assumption or refinancing of about $144 million of Gold Kist's debt.

Times Square

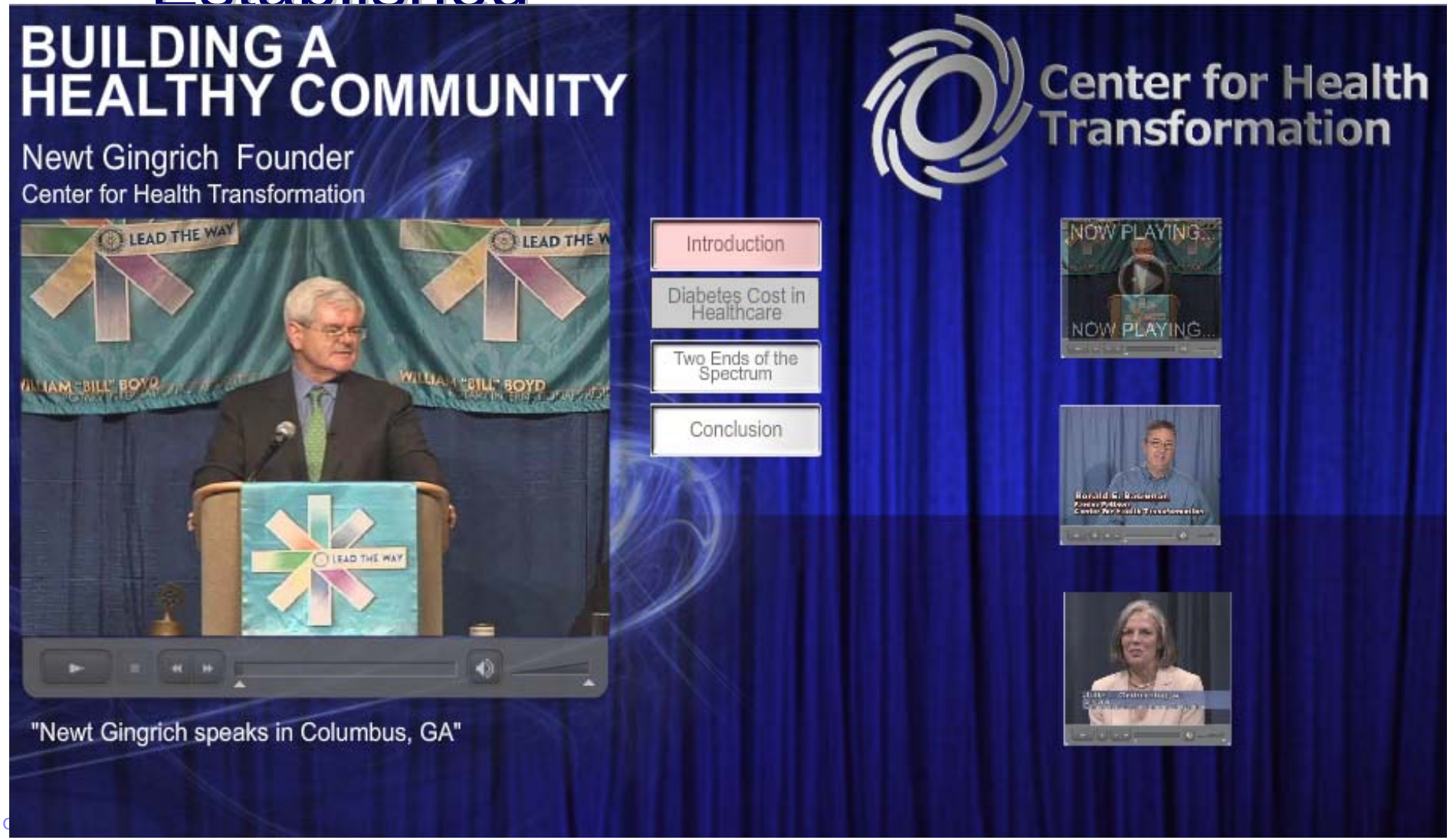
CHT's Georgia Project Leads to Increase In Physicians Recognized for Providing Best Standards of Care for Diabetes

Rewards paid to date

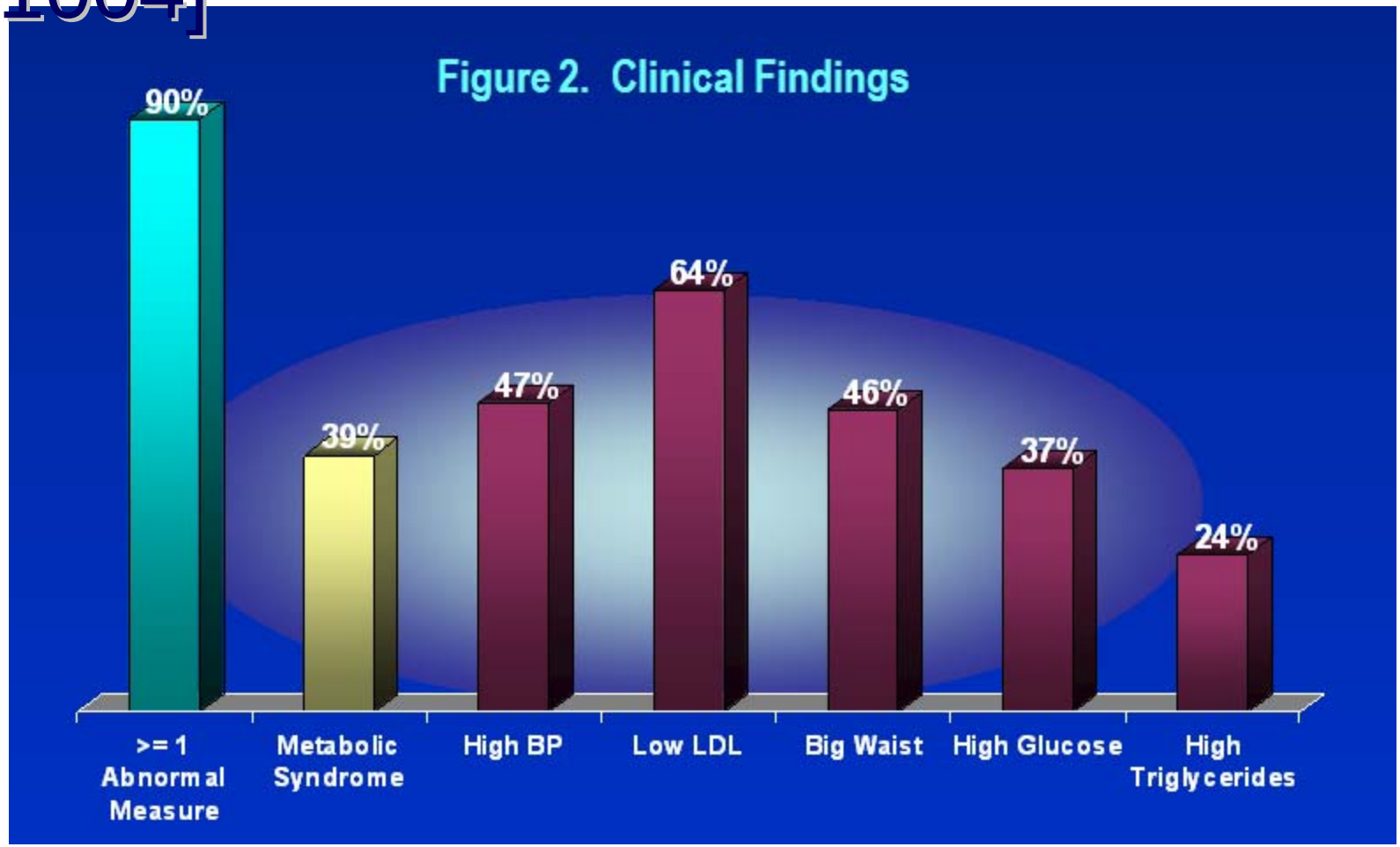
Date Paid	# of Docs rewarded	Total Reward Amt
4Q07	44	$74,420
1Q08	34	$99,735
2Q08	14	$28,365
3Q08	28	$32,269
4Q08	42	$86,000

- 4,000 physicians eligible for incentives
- Almost 200 physicians recognized to date
- 11% of patients are receiving care from a recognized physician

Employer Working Group Established



Employee Screening Project [n = 1004]



Community Based DPRP Project

- Of 81 physician providers, 61 participated in the process.
- Of these, 59 (83%) had chart reviews submitted to NCQA
- 47 (66.2%) were accorded recognition.

Employers Solutions Lab

2009 Goals

- Launch Community Project on Heart Health - Heart/Stroke Module
- Continue to Expand the Employer Solutions Lab
- Focus the Employer Group on Quality
  - Leapfrog
  - BTE

2009 Goals

- Employer Opportunities
  - Internal
    - Wellness
    - Prevention
  - External
    - Community Wellness
    - Hospital Quality
    - Physician Quality
    - Transparency

Lessons Learned

- Focus on the Community
- Distribute incentives close to the behavior
- Small physician practices are a challenge
- Once you build the collaboration change accelerates
- Engage the hospital as both provider and employer

For More Information

Laura Linn RN, MN

Project Director

llinn@gingrichgroup.com

404-201-7904

Colorado's Bridges to Excellence Program

EMPLOYERS CATALYZING CHANGE

Donna Marshall, MBA

Executive Director

Colorado Business Group on Health

March, 2009

Colorado Business Group on Health

- Member organization
- Established in 1996
- Mission: The mission of the Colorado Business Group on Health is to advance the purchaser role to accelerate c… effective, high quality healthcare.
- Vision: Purchasers—united, motivated, and focused on health care value and quality.

One of over 70 coalitions in the U.S.; a proud member of the National Business Coalition on Health

National Business Coalition on Health

Colorado Business Group on Health

Purchasers:

- Boards of Education Self Funded Trusts
- Boulder Valley School District
- City of Colorado Springs
- Colorado College
- Colorado Public Employees' Retirement Association
- Colorado Springs School District #11
- Colorado Springs Utilities
- Poudre School District
- State of Colorado
- TIAA-Cref
- University of Colorado

Associations:

- Colorado Education Association
- Denver Metro Chamber of Commerce
- Rocky Mountain Healthcare Coalition
- South Metro Chamber of Commerce

Affiliates:

- 21 Affiliates

Info@CBGHealth.org

www.coloradoHEALTHonline.org

Influencing Gridlock in Colorado

- **Purchasers — *Not Buying Right:* *Value Based Purchasing/ Influencing the Marketplace/ Using BTE***
- **Plans — *Not Letting Provider Value Show Through to Consumers:* *CBGH Asks Plans to use BTE as a Standard***
- **Providers — *Not Seeing Business Case for Reengineering:* *Leapfrog, Health Matters, BTE***
- **Consumers/Patients — *Not Yet Into Value Purchasing:* *Give them real data***

Colorado's Bridges to Excellence Program

- CBGH is one of four coalitions selected to receive technical assistance from NBCH in 2005
- Diabetic care link program implemented January 2006
- Eight employers, 2 health plans in the Colorado Springs, 50k lives

Starting the Colorado's BTE Program

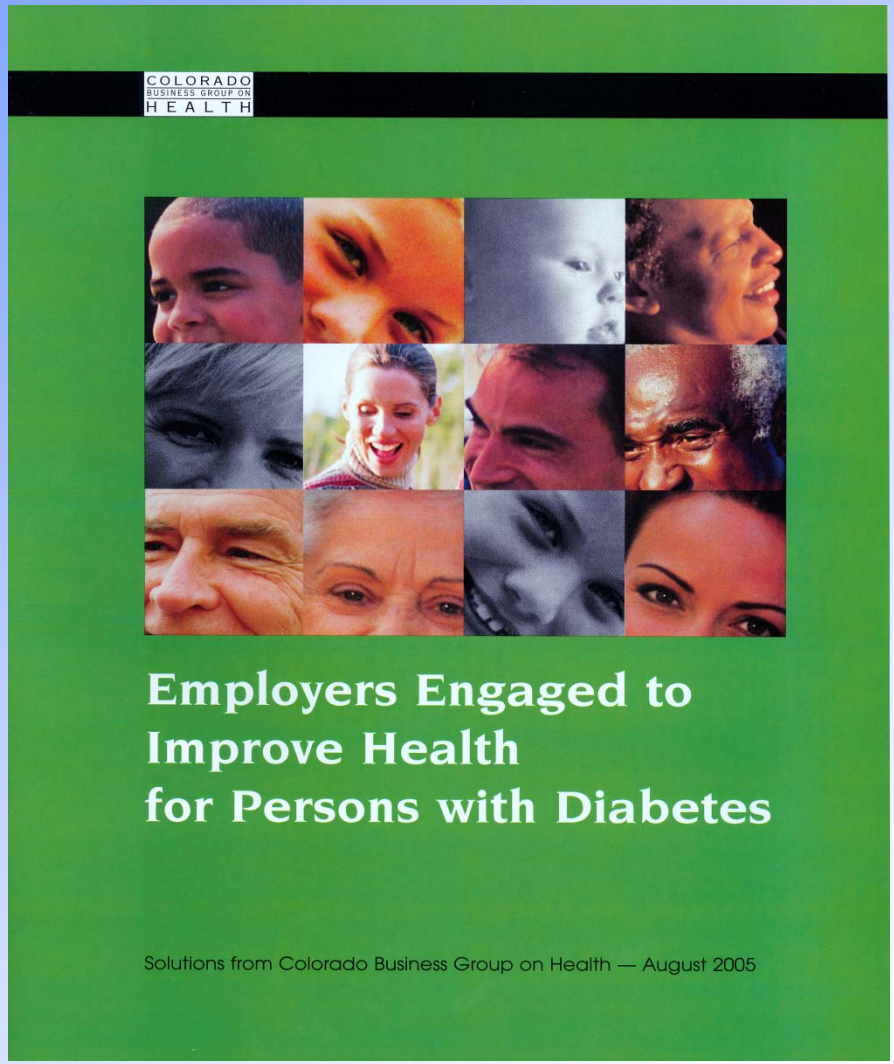
How did we start this program?

Setting the stage with **employer** participants.

The Diabetes Workgroup studied:

- prevalence,
- cost data,
- RAND study on lack of guideline adherence,
- benefit design (Pitney Bowes model),
- systems redesign (Asheville model), and
- employee incentives.

Sharing Best Practices



Starting the Colorado's BTE Program

What did employers expect from this program?

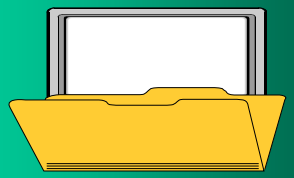
The employer participants wanted:

- better informed employees,
- reduced direct costs,
- improved rates of absenteeism and better productivity.

So, what are employers doing?

- benefit design (Pitney Bowes model),
- systems redesign (Asheville model),
- employee incentives, and
- change physician behavior through BTE

Changing Physician Behavior



Help practices with data collection

Data collection support (CBGH)

Registry support by CBGH and the El Paso Co Medical Society

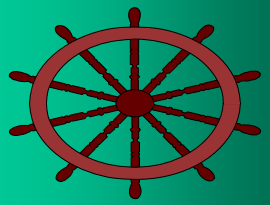
Pay rewards to recognized MDs

Display Recognition Status

1. Colorado Employers

2. Colorado Health Plans

3. Health Matters Quality Report



Actively steer patients to recognized MDs

Use for network entry, or tiering

Has been contemplated in Colorado

BRIDGES to Excellence
Rewarding Quality across the Healthcare System

Starting the Colorado's BTE Program

Setting the stage with **physician** participants:

Endorsement by the El Paso County Medical Society and Mountain View Medical, the second largest physician's group in the area

Articles in the Colorado Medical Society magazine

Lots of meetings…

Original Participants in Colorado Springs, 2006

- City of Colorado Springs
- Colorado College
- Colorado Springs School District #11
- Colorado Springs Utilities
- El Paso County
- Intel
- Memorial Health System
- Penrose-St. Francis Hospital

Colorado's Bridges to Excellence Program

Five health plans signed contracts:

- Anthem (2007: have since dropped the program)
- CIGNA (2007)
- Great West (2006)
- Rocky Mountain Health Plans (2006; has now added cardiac rewards in 2008)
- United (2007)

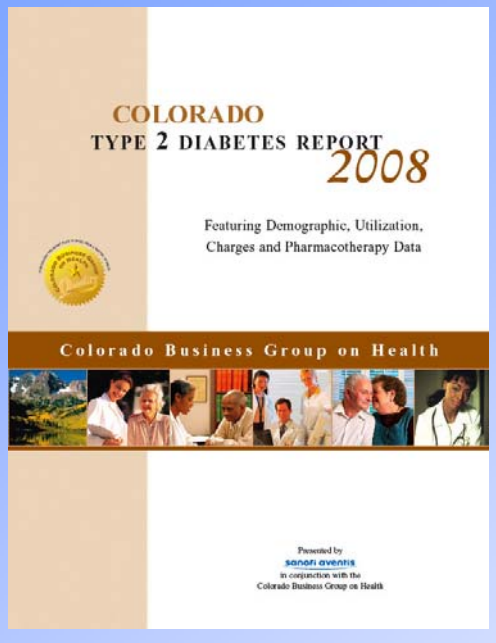
Questions/Issues to Grow Program in 2008

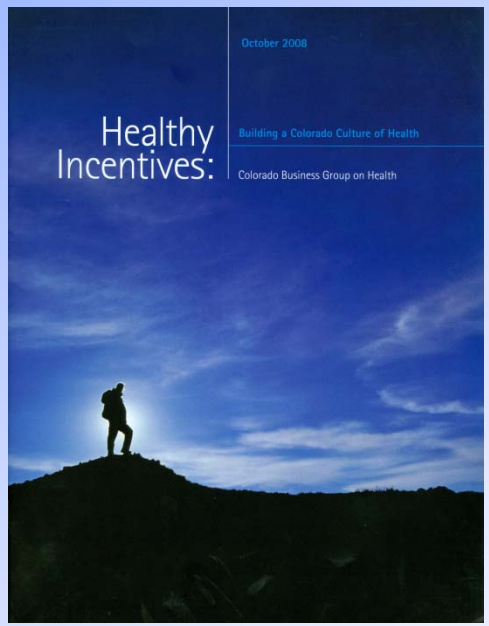
- What resources do potential project members need in order to expand the program?
- What resources do potential project members need "to sell" the program to internal stakeholders
  - ROI calculators? or,
  - Speakers? or,
  - Other presentations?
- Who is "in"?
- What factors should we consider for implementation this year?

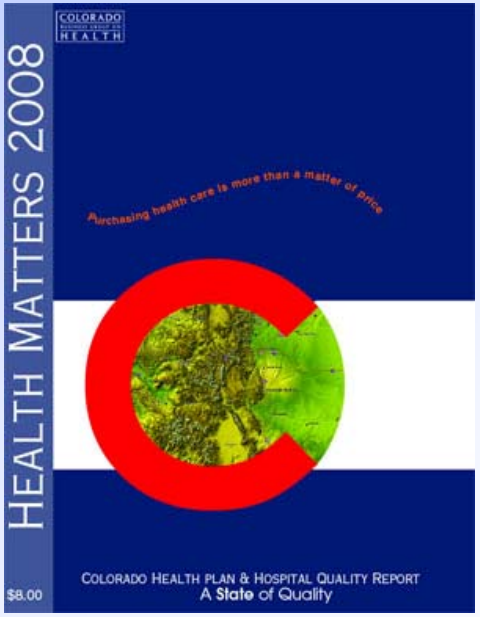
Expansion of the program in 2008? Yes!

- Employers voted to expand their diabetes program to include cardiovascular BTE in 2008, and expand geographically to the front range region
- Employers:
  - City of Colorado Springs
  - Colorado Public Employees' Retirement Association
  - Colorado Springs School District #11
  - Colorado Springs Utilities
  - Memorial Health System
  - Penrose-St. Francis Hospital
  - State of Colorado
  - University of Colorado (2009)

Publications: Keep Information Flowing

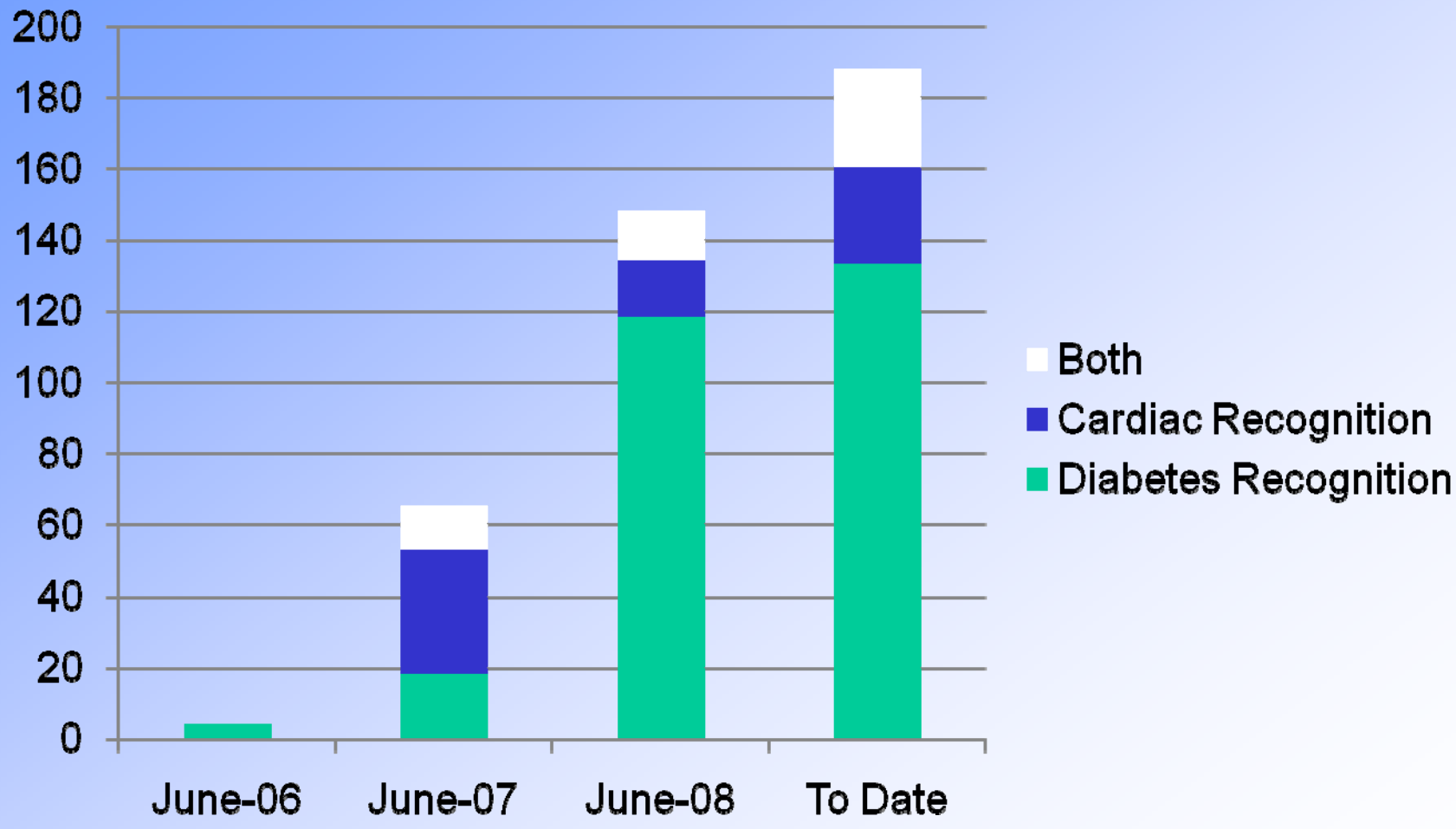






BTE Newsletters: latest issue, Sept. 2008

Have Physicians Been Recognized?



Financial Rewards for Recognized Physicians

In 2006, $0 in rewards were earned.

In 2007, $14,700 was paid.

In the first half of 2008, over $21,000 was paid.

In the second half of 2008, over $18,000 will be paid.

How Many Patients See Recognized Physicians?

	Recognized Physicians, Duplicated Count	Total Patients for these Physicians	Total Patients Possible	Percent of Patients Seeing Recognized Physicians
Participant				
1	14	25	236	10.6%
2	15	30	275	10.9%
3	15	48	287	16.7%
4	16	29	175	16.6%
5	14	39	244	16.0%
6	10	10	54	18.5%
7	16	49	357	13.7%
8	3	3	21	14.3%
9	7	11	59	18.6%
TOTALS	110	244	1708	14.3%

From January 2007 through December 2008/ Unduplicated count of physicians = 87

BTE lessons learned

- Incentives work and can lead to practice reengineering, but practices need help
- Better quality and recognition can occur, but you need to focus on the right measures
- Self-assessment of performance leads to focused quality improvement
- Employers and plans need to band together to create enough critical mass to impact physician behavior

Summary - BTE is a Win-Win Collaboration

- **For Employers**: Better outcomes, lower cost
- **For Providers**: Better outcomes, $ rewards opportunity, recognition among peers
- **For Health Plans**: More transparency, better provider value
- **For Consumers**: Better outcomes, better educated, lower out-of-pocket expense
- **For Society**: A beginning to transform the way healthcare is purchased, delivered and consumed. A beginning towards building a 21st century healthcare system

The Institute of Medicine-- 1999

The Committee's Conclusion

"The American health care delivery system is in need of fundamental change. The current care systems cannot do the job. Trying harder will not work. Changing systems of care will. "

For more information:

Donna Marshall
Colorado Business Group on Health
303-922-0939
Donna.Marshall@cbghealth.org

Questions?

Aligning Local Forces for Change

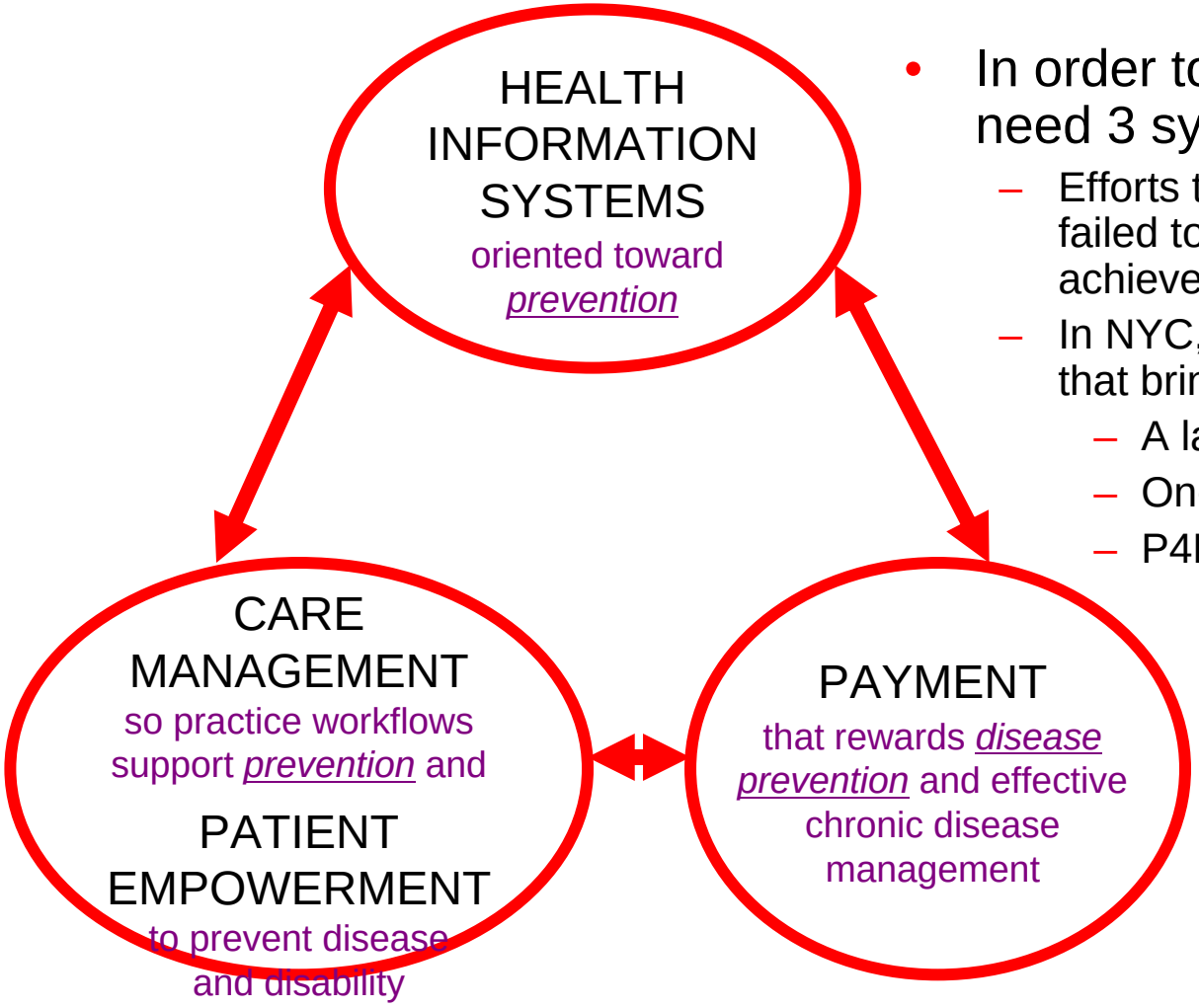
- **Sarah Shih** – Director of Healthcare Quality Information, Primary Care Information Project, NYC DOH MH
- **Craig Brammer** – Senior Research Associate, University of Cincinnati Department of Public Health Sciences; Director, Cincinnati Aligning Forces for Quality

NYC Health eHearts Pilot Recognition and Rewards

Rewarding and recognizing providers for delivering excellent heart health

Sarah Shih, MPH
Director of Healthcare Quality Information
Primary Care Information Project
March 9, 2009

Health Care that Maximizes Health



- In order to restructure health care need 3 synergistic changes
  - Efforts to implement each separately have failed to improve care substantially or achieve scale
  - In NYC, we are creating a local model that brings all three together
    - A large EHR-enabled network ($20M)
    - On-site practice redesign TA ($4M)
    - P4P pilot based on outcomes ($6M)

Remaining Priority Gaps:

*Panel Management
*Patient engagement

ROBIN HOOD
TARGETING POVERTY IN NEW YORK CITY

NYC Primary Care Information Project

- Public Health perspective
  - Public funding—Public benefit expected
- Largest Community EHR project in Nation
  - Diverse primary care practice settings
  - Rapid implementation cycles
  - High levels of utilization of full-featured EHR

- What have we learned?

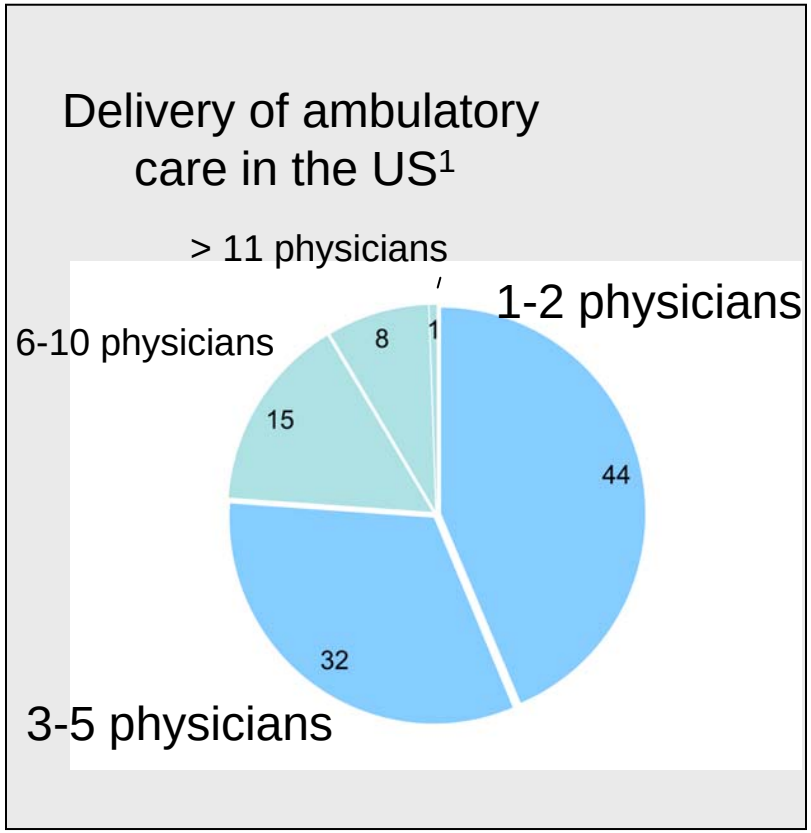
How Can We Get Value From HIT?

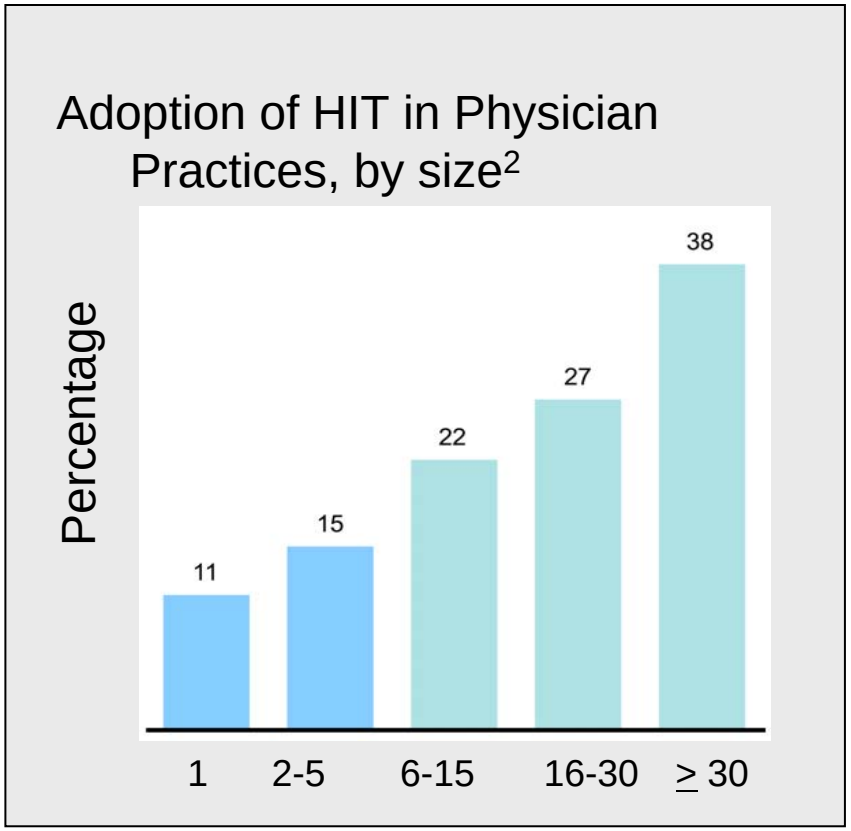
(and avoid wasting a lot of money for no public benefit)

1. **Ensure that EHRs are implemented where they will do the most good**
2. **Ensure that EHRs focus on prevention**
3. **Facilitate EHR adoption**
4. **Ensure exchange of vital information**
5. **Support distributed data networks**
6. **Design incentives to protect health and reduce disparities**
7. **Foster a new workforce for prevention in primary care**

Ensure that EHRs are implemented where they will do the most good

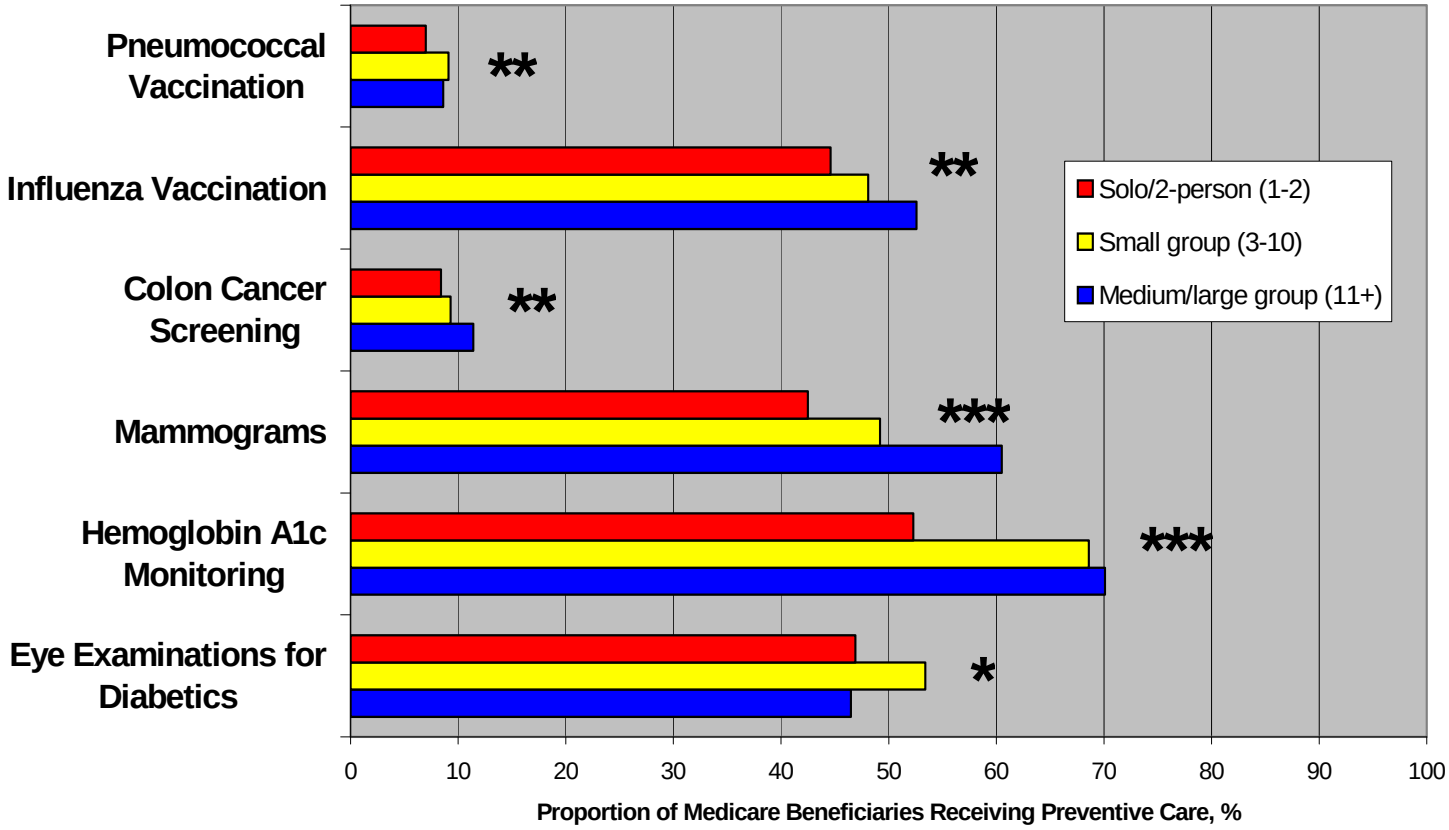
- Must include outpatient and primary care, solo and small practices, safety-net providers





Small Practices:
Most Room For Improvement

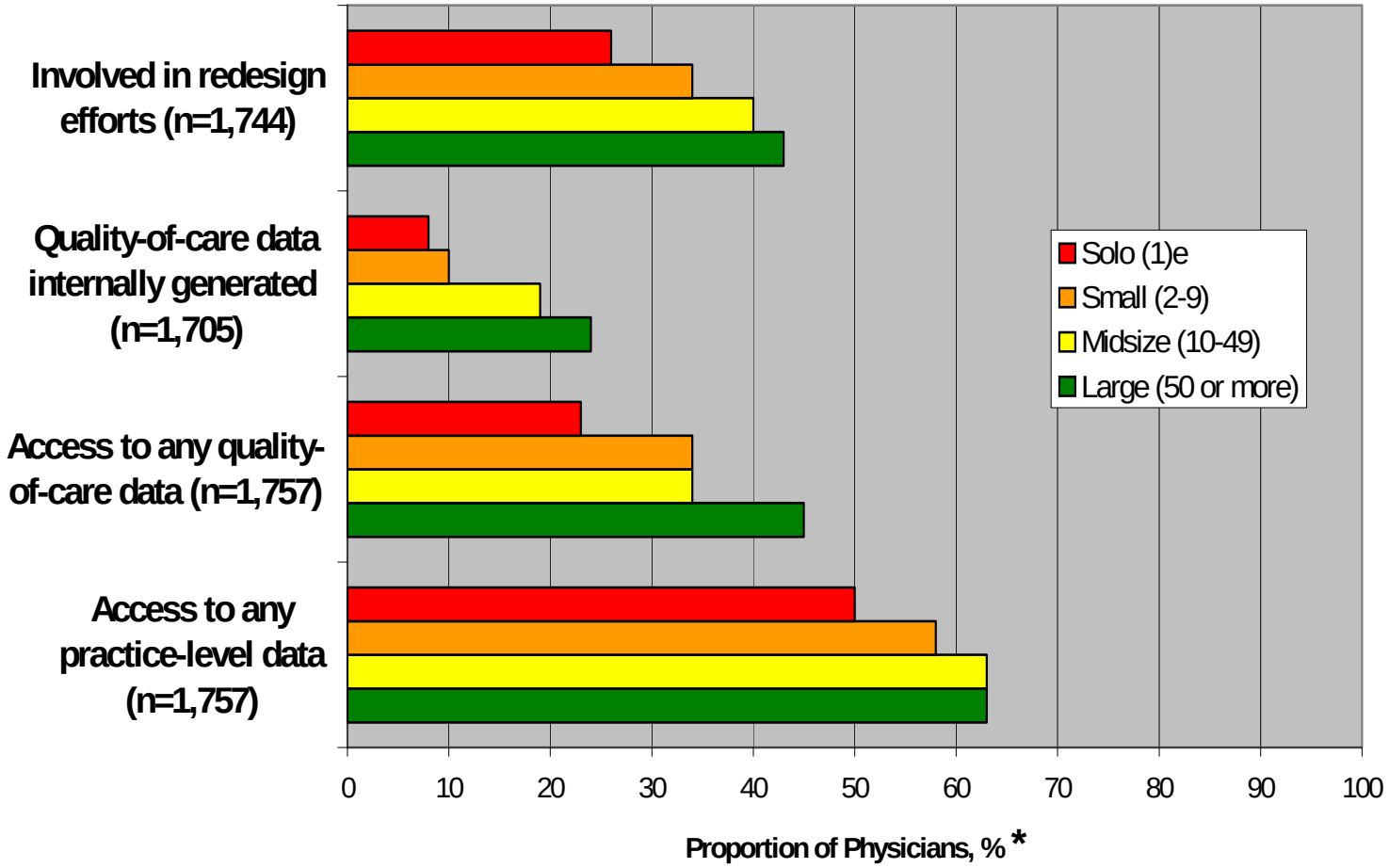
Proportion of Medicare Beneficiaries Receiving Recommended Preventive Services, by Practice Size



*** P<.05 ** P<.01 *** P<.001**

Pham HH, Schrag D, Hargraves JL, Bach PB. Delivery of Preventive Services to Older Adults by Primary Care Physicians. *JAMA.* 2005; 294:473-481.

Fewest Quality Improvement Tools



* Model controls for practice size, years in practice, hours a week in direct patient care, salary status, physician type (primary care vs. specialist), certification status in specialty, and use of EMR.

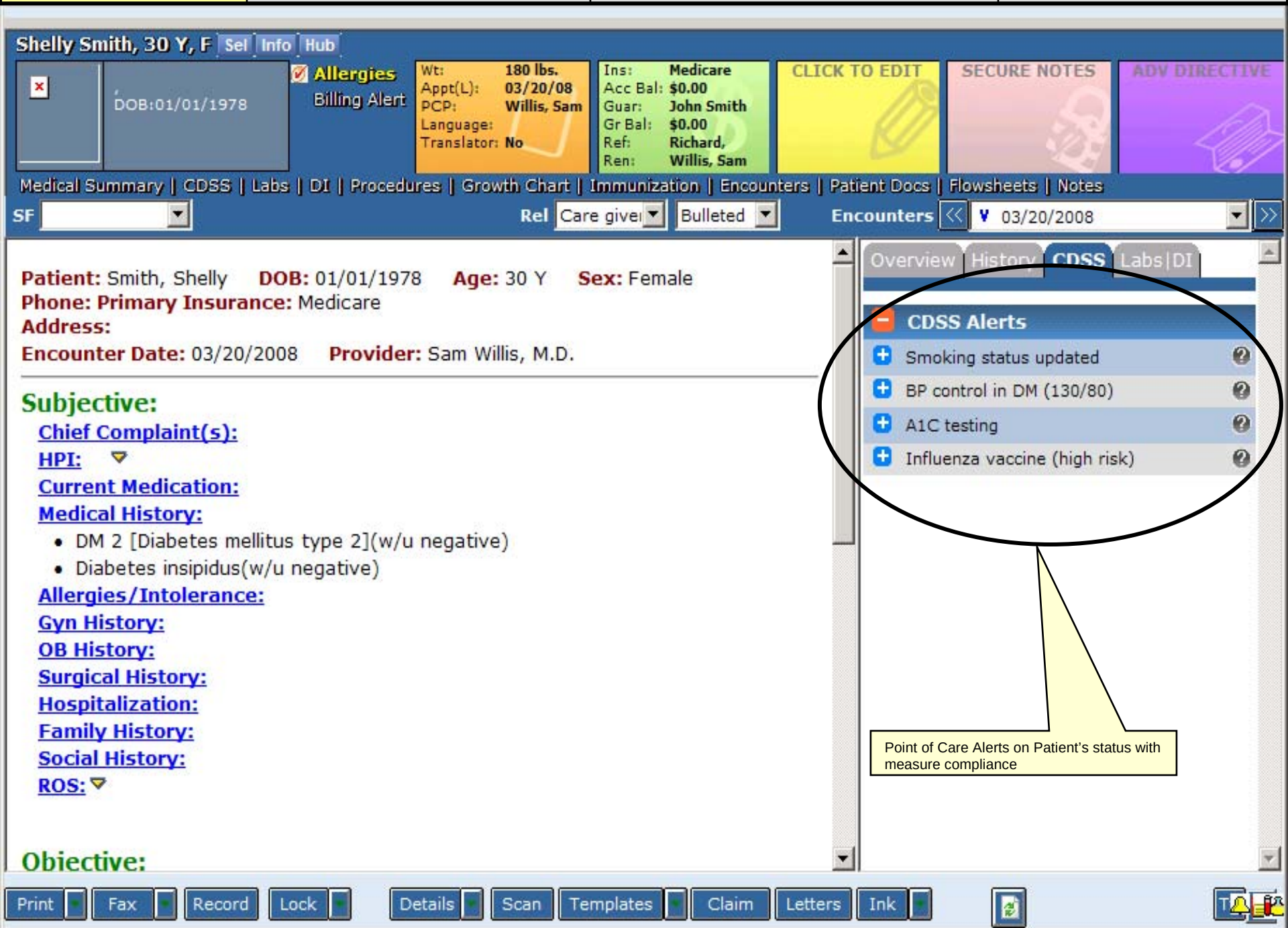
Audet AMJ, Doty MM, Shamasdin J, Schoenbaum SC. Measure, Learn, And Improve: Physicians' Involvement In Quality Improvement. *Health Affairs.* 2005; 24: 843-853.

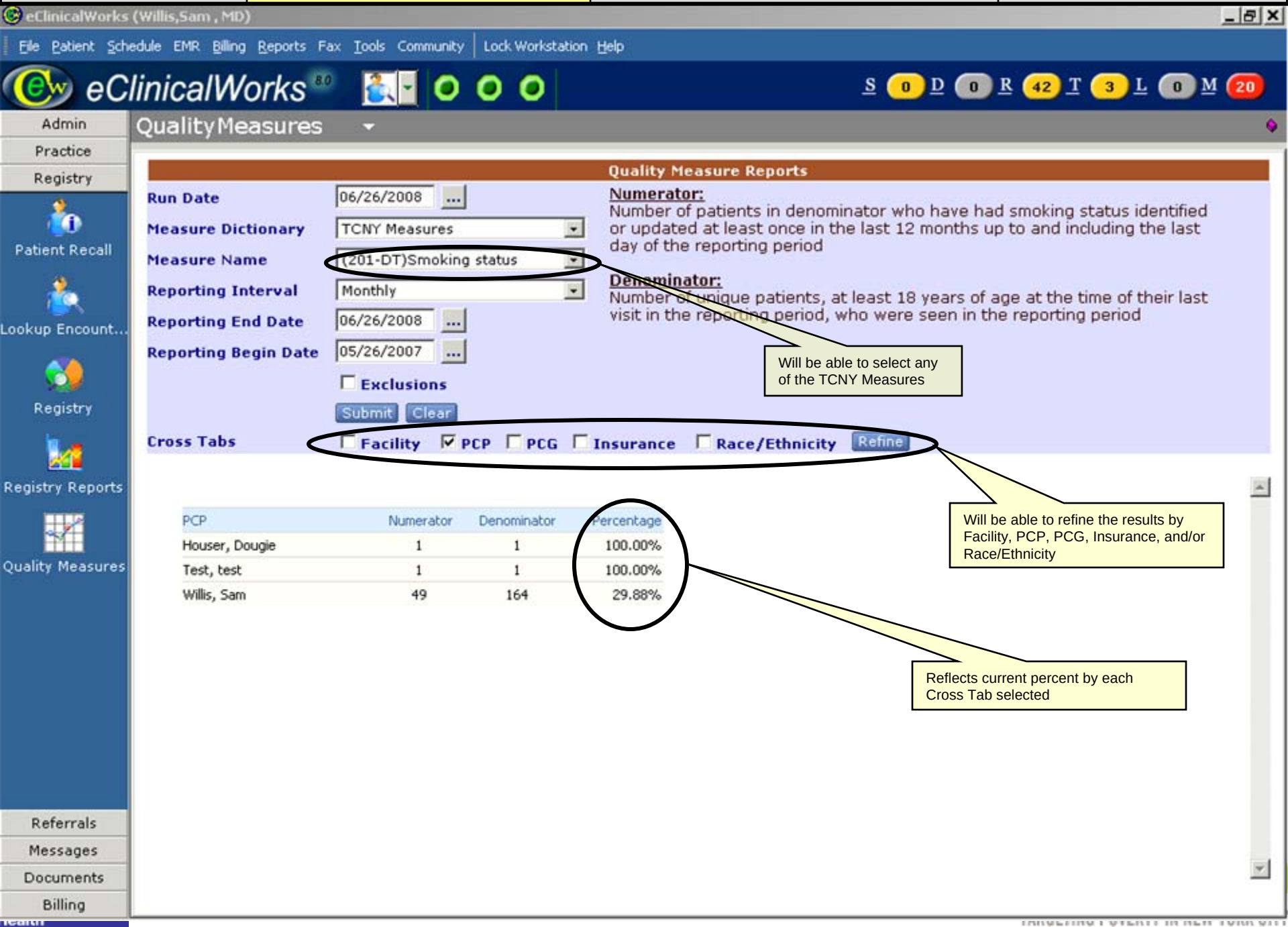
8 Key Features of the TCNY Build

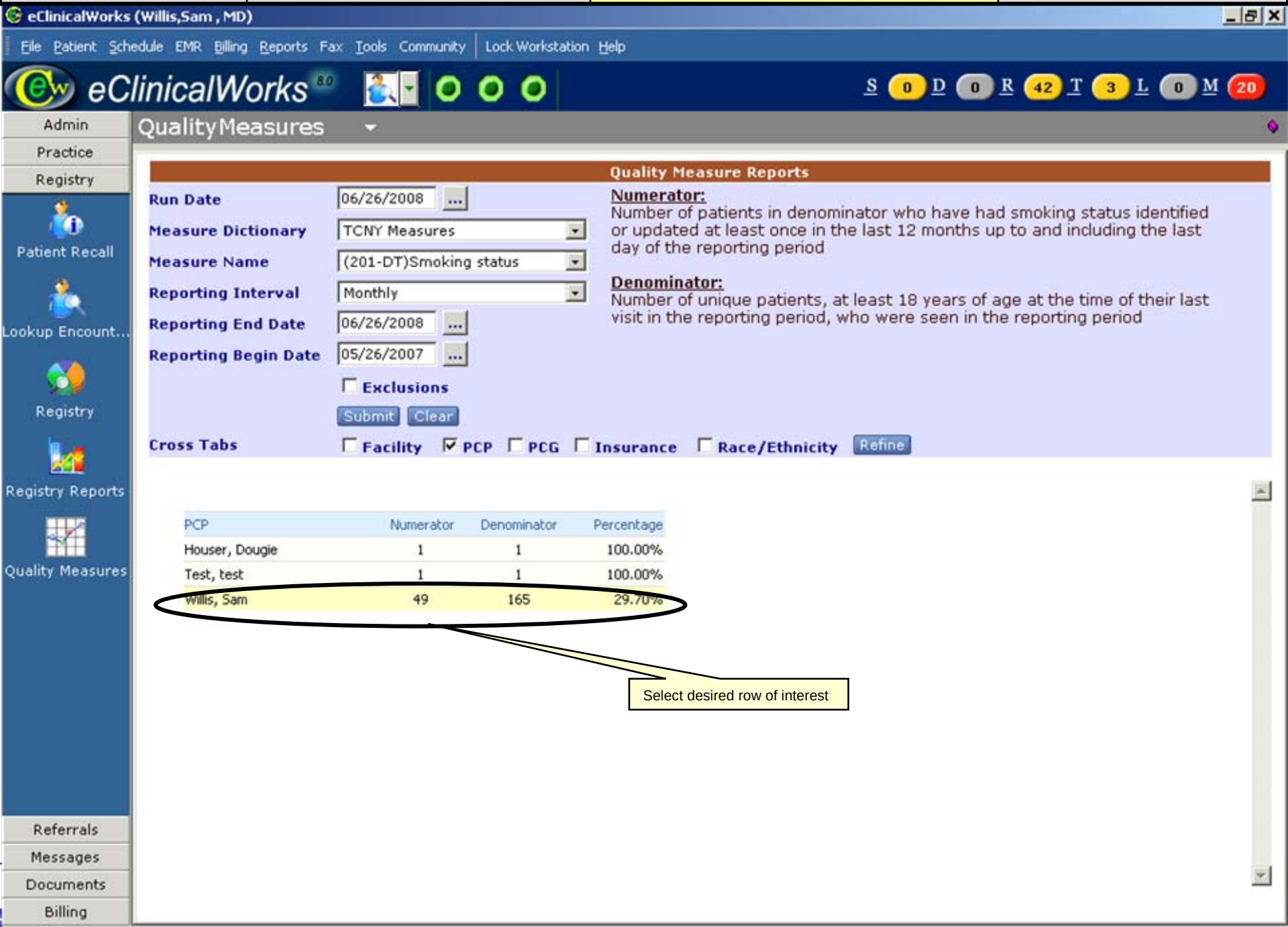
1. **MEASURE REPORTS**
   Side-by-side provider comparisons of performance on quality measures
2. **ENHANCED REGISTRY**
   Identifies patients by structured data (e.g., diagnoses, drugs, labs, demographics)
3. **AUTOMATIC VISUAL ALERTS**
   Highlights abnormal vitals
4. **CDSS**
   Automatically displays preventive service alerts that are suppressed when addressed
5. **QUICK ORDERS**
   One-click ordering of recommended preventive services
6. **COMPREHENSIVE ORDER SETS**
   Displays best practice recommendations (e.g., for meds, labs, patient education)
7. **eMedNY**
   With patient consent, displays 90-day history of all Rxs filled by Medicaid patients
8. **CIR and School Health**
   Sends information to City Immunization Registry and generates school health forms

New EHR Functionality

- The following slides display the interfaces available for providers at the point of care
  - Clinical Decision Support System (CDSS)
  - Quality Reporting Tool
  - Numerator/Denominator
  - Patient Lists


Shelly Smith, 30 Y, F Sel Info Hub
DOB:01/01/1978
Allergies
Billing Alert
Wt: 180 lbs.
Appt(L): 03/20/08
PCP: Willis, Sam
Language:
Translator: No
Ins: Medicare
Acc Bal: $0.00
Guar: John Smith
Gr Bal: $0.00
Ref: Richard,
Ren: Willis, Sam
CLICK TO EDIT
SECURE NOTES
ADV DIRECTIVE
Medical Summary | CDSS | Labs | DI | Procedures | Growth Chart | Immunization | Encounters | Patient Docs | Flowsheets | Notes
SF
Rel Care giver
Bulleted
Encounters 03/20/2008
Patient: Smith, Shelly DOB: 01/01/1978 Age: 30 Y Sex: Female
Phone: Primary Insurance: Medicare
Address:
Encounter Date: 03/20/2008 Provider: Sam Willis, M.D.
Subjective:
Chief Complaint(s):
HPI:
Current Medication:
Medical History:
DM 2 [Diabetes mellitus type 2](w/u negative)
Diabetes insipidus(w/u negative)
Allergies/Intolerance:
Gyn History:
OB History:
Surgical History:
Hospitalization:
Family History:
Social History:
ROS:
Objective:
Overview History CDSS Labs|DI
CDSS Alerts
Smoking status updated
BP control in DM (130/80)
A1C testing
Influenza vaccine (high risk)
Point of Care Alerts on Patient's status with measure compliance
Print Fax Record Lock Details Scan Templates Claim Letters Ink


eClinicalWorks (Willis,Sam , MD)
File Patient Schedule EMR Billing Reports Fax Tools Community Lock Workstation Help
eClinicalWorks
S 0 D 0 R 42 T 3 L 0 M 20
Admin
Practice
Registry
Patient Recall
Lookup Encount...
Registry
Registry Reports
Quality Measures
Referrals
Messages
Documents
Billing
Quality Measures
Quality Measure Reports
Run Date 06/26/2008
Measure Dictionary TCNY Measures
Measure Name (201-DT)Smoking status
Reporting Interval Monthly
Reporting End Date 06/26/2008
Reporting Begin Date 05/26/2007
Exclusions
Submit Clear
Numerator:
Number of patients in denominator who have had smoking status identified or updated at least once in the last 12 months up to and including the last day of the reporting period
Denominator:
Number of unique patients, at least 18 years of age at the time of their last visit in the reporting period, who were seen in the reporting period
Cross Tabs Facility PCP PCG Insurance Race/Ethnicity Refine
PCP Numerator Denominator Percentage
Houser, Dougie 1 1 100.00%
Test, test 1 1 100.00%
Willis, Sam 49 164 29.88%
Will be able to select any of the TCNY Measures
Will be able to refine the results by Facility, PCP, PCG, Insurance, and/or Race/Ethnicity
Reflects current percent by each Cross Tab selected


eClinicalWorks (Willis,Sam , MD)
File Patient Schedule EMR Billing Reports Fax Tools Community Lock Workstation Help
eClinicalWorks 8.0
S 0 D 0 R 42 T 3 L 0 M 20
Admin
Practice
Registry
Patient Recall
Lookup Encount...
Registry
Registry Reports
Quality Measures
Referrals
Messages
Documents
Billing
Quality Measures
Quality Measure Reports
Run Date 06/26/2008
Measure Dictionary TCNY Measures
Measure Name (201-DT)Smoking status
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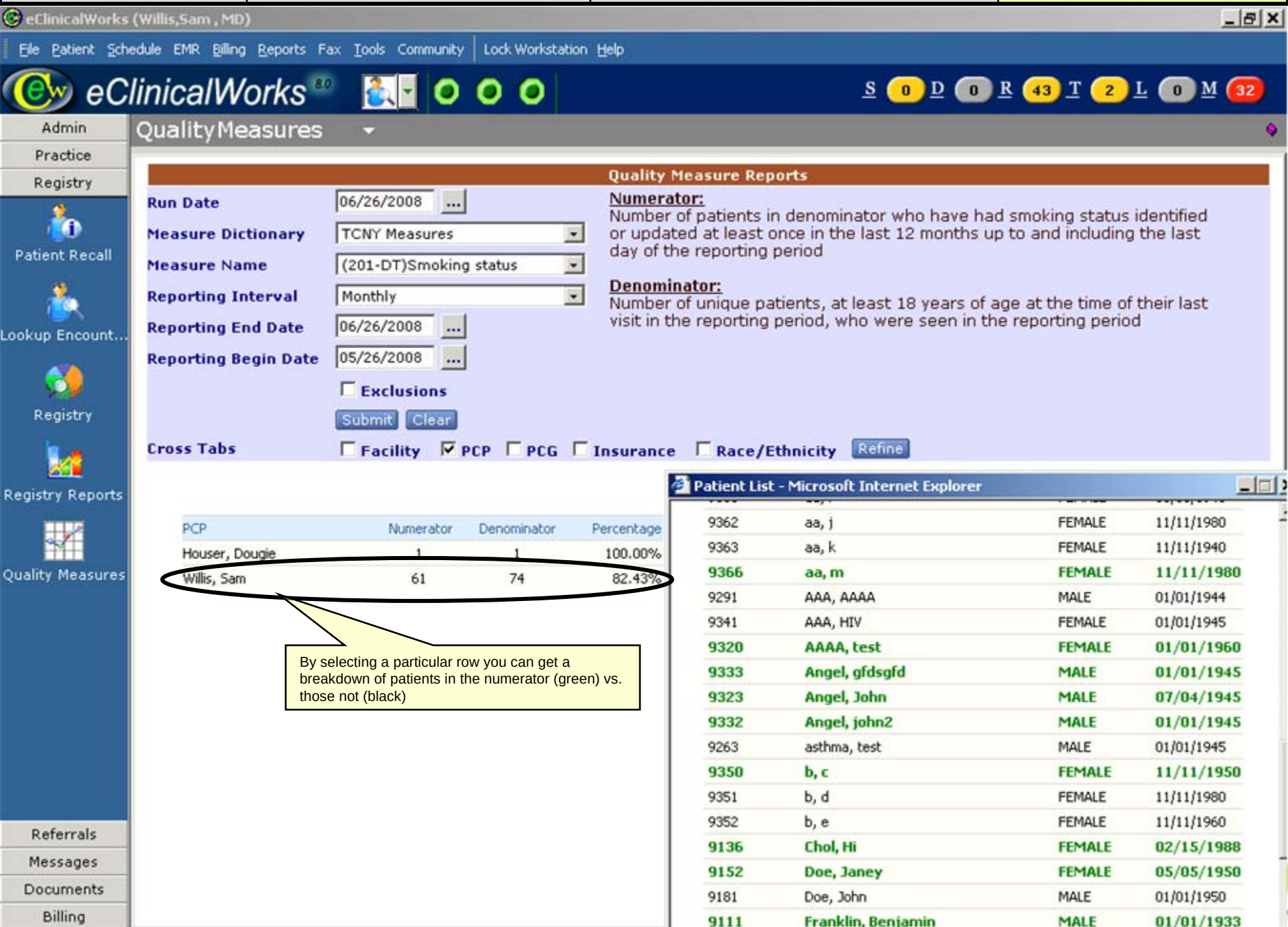
Number of unique patients, at least 18 years of age at the time of their last visit in the reporting period, who were seen in the reporting period
Cross Tabs Facility PCP PCG Insurance Race/Ethnicity Refine
PCP Numerator Denominator Percentage
Houser, Dougie 1 1 100.00%
Test, test 1 1 100.00%
Willis, Sam 49 165 29.70%
Select desired row of interest


eClinicalWorks (Willis,Sam , MD)
File Patient Schedule EMR Billing Reports Fax Tools Community Lock Workstation Help
eClinicalWorks 8.0
S 0 D 0 R 43 T 2 L 0 M 32
Admin
Practice
Registry
Patient Recall
Lookup Encount...
Registry
Registry Reports
Quality Measures
Referrals
Messages
Documents
Billing
Quality Measures
Quality Measure Reports
Run Date 06/26/2008
Measure Dictionary TCNY Measures
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Reporting Interval Monthly
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Numerator:
Number of patients in denominator who have had smoking status identified or updated at least once in the last 12 months up to and including the last day of the reporting period
Denominator:
Number of unique patients, at least 18 years of age at the time of their last visit in the reporting period, who were seen in the reporting period
Cross Tabs Facility PCP PCG Insurance Race/Ethnicity Refine
PCP Numerator Denominator Percentage
Houser, Dougie 1 1 100.00%
Willis, Sam 61 74 82.43%
By selecting a particular row you can get a breakdown of patients in the numerator (green) vs. those not (black)
Patient List - Microsoft Internet Explorer
9362 aa, j FEMALE 11/11/1980
9363 aa, k FEMALE 11/11/1940
9366 aa, m FEMALE 11/11/1980
9291 AAA, AAAA MALE 01/01/1944
9341 AAA, HIV FEMALE 01/01/1945
9320 AAAA, test FEMALE 01/01/1960
9333 Angel, gfdsgfd MALE 01/01/1945
9323 Angel, John MALE 07/04/1945
9332 Angel, john2 MALE 01/01/1945
9263 asthma, test MALE 01/01/1945
9350 b, c FEMALE 11/11/1950
9351 b, d FEMALE 11/11/1980
9352 b, e FEMALE 11/11/1960
9136 Chol, Hi FEMALE 02/15/1988
9152 Doe, Janey FEMALE 05/05/1950
9181 Doe, John MALE 01/01/1950
9111 Franklin, Benjamin MALE 01/01/1933

2010 Goals

- Extend prevention-oriented EHRs to 2,100 providers of primary care, touching more than one million patients, including 570,000 Medicaid patients
- Provide participating practices with clinical quality scorecards
- Design and implement a quality improvement collaborative
- Pilot a recognition and "Pay-for-Prevention" incentive program for high-performing providers

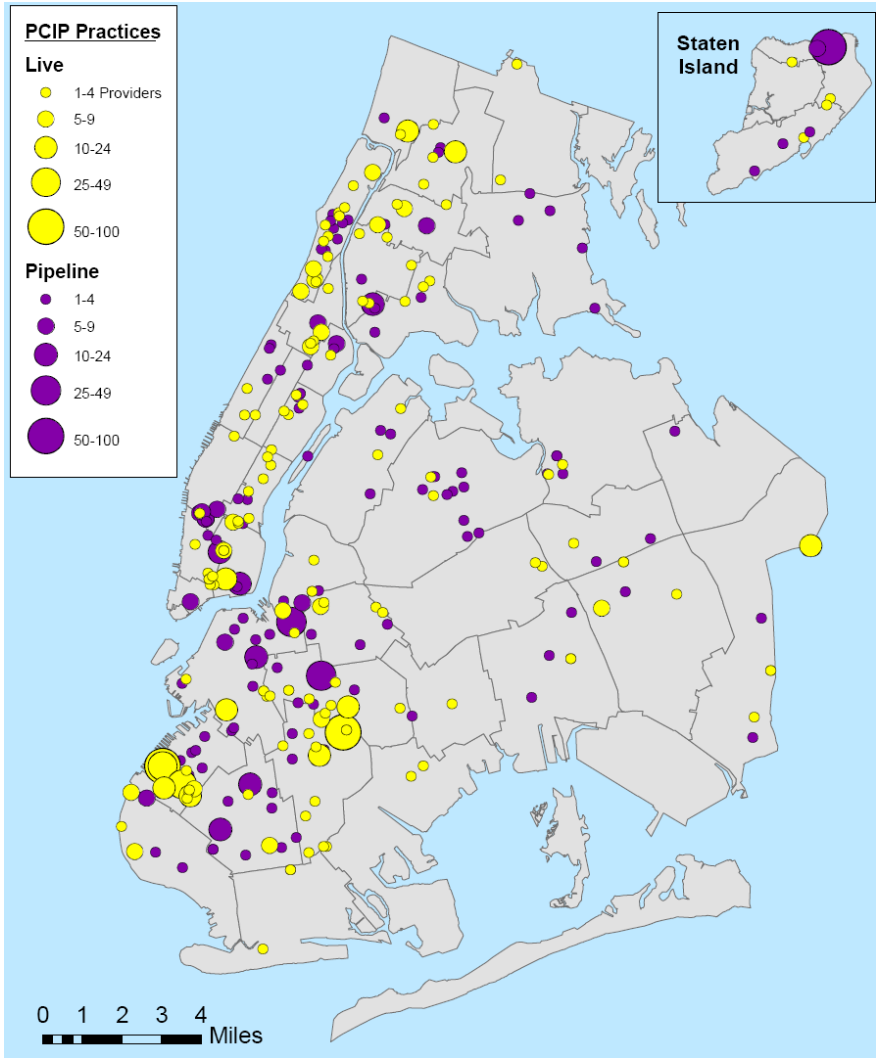
→ By 2010, more than half all high volume Medicaid providers in NYC will use a prevention-oriented EHR.

PCIP Progress to Date (Dec '08)

- **Signed Agreements**
  - 200 small practices: 400+ MDs
  - 22 CHCs: 400 MDs
  - 4 Hospitals: 500+ MDs
  - 1 Correctional Facility: 70+ MDs
- **Live on EHR**
  - 148 practices
  - 211 sites
  - 1002 providers

One new practice goes live on EHR ~every day

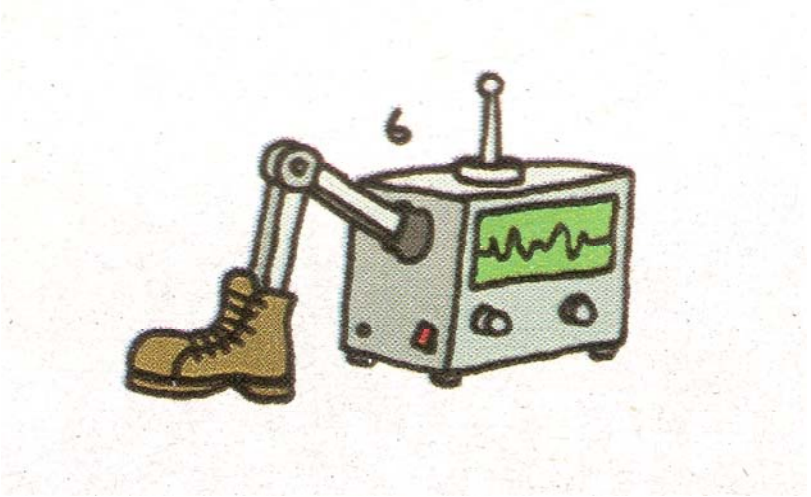
Total Cost to Govt ~20k/MD

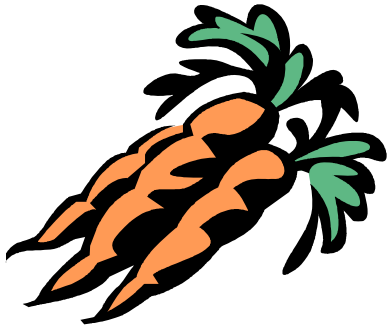


Operational Challenges

- Providers have competing practice priorities and limited resources
- Early adopters faced biggest hurdles
- Data required for quality measures reporting not uniformly recorded
- Lack of engagement of providers in QI activities and quality measures
- Health plans reluctant to commit funds to untested clinical quality incentive program

How do we engage providers?





Patents from 2008 and how they might look..
Number 6. Method and apparatus for providing incentives to physicians (7,389,245)

The New York Times Magazine - Endpaper
December 14, 2008

Health eHearts

Program Overview

- Grant from Robin Hood Fund
- $3-6M
- Automated reporting from EHR systems in NYC
- Participants will receive quality improvement assistance and quarterly reports on quality
- Rewards to be paid out at the end of 2009
- Providers to be recognized through press release and end of pilot gala

Rewards and recognizes providers for delivering excellent heart health

Program Goals

- Prevention as a top priority
- Focus on an area with maximum potential for saving lives (cardiovascular health)
- Reduce disparities
- Higher rewards for harder to treat patients
- Incentive amounts are large enough to matter

Quality Measures for Rewards

Aspirin Therapy	Ages 18 years or older with Ischemic Vascular Disease or ages 40 years or older with Diabetes on aspirin or another anti-thrombotic therapy
Blood Pressure Control	Patients 18-75 years of age with Hypertension, without Ischemic Vascular Disease or Diabetes who have a BP < 140/90
	Patients 18-75 years of age with a diagnosis of Diabetes AND Hypertension with the most recent BP below 130 systolic and 80 diastolic
	Patients 18-75 years of age with a diagnosis of Ischemic Vascular Disease AND Hypertension without Diabetes with a BP below 140 systolic and 90 diastolic
Cholesterol Control	Male patients >= 35 years of age and female patients >=45 years of age without Ischemic Vascular Disease or Diabetes who have a total cholesterol < 240 or LDL < 160 measured in the past 5 years
	Patients 18-75 years of age with a diagnosis of Ischemic Vascular Disease or Diabetes and Lipoid disorder who had a LDL < 100 in the past 12 months
Smoking Cessation	Patients ages 18 years or older identified as current smokers who received cessation interventions or counseling

Health Impact of TCNY Measures

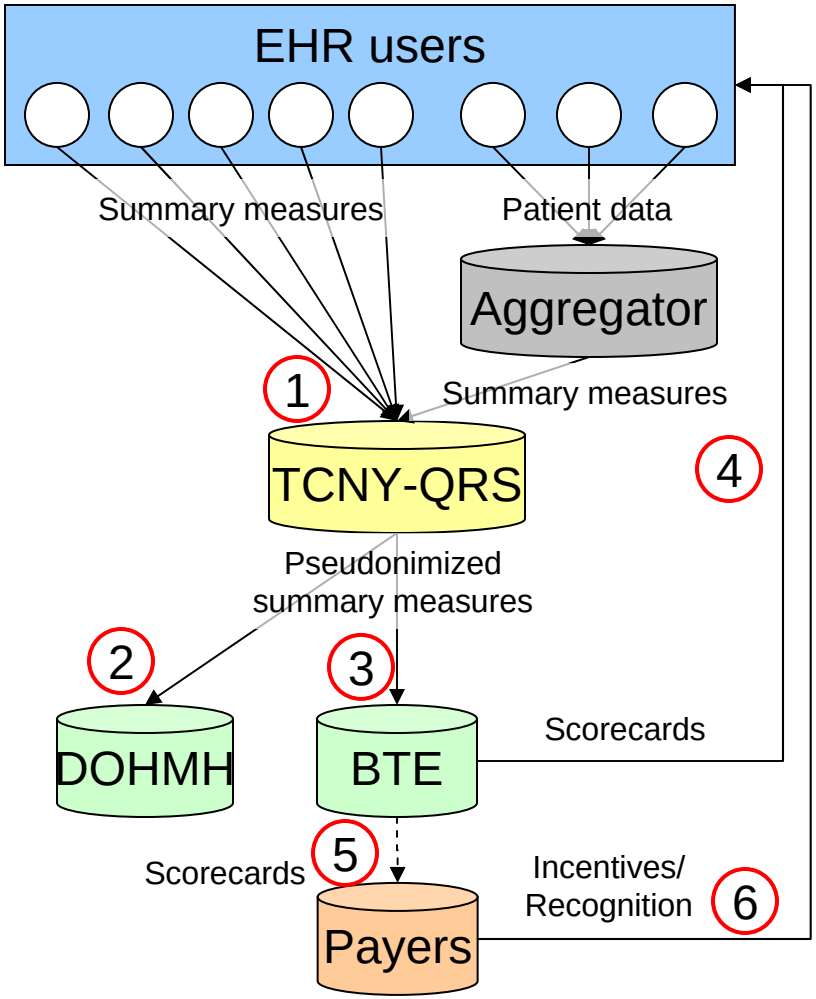
- 500 providers reaching the following targets (80%), over a decade, would cut premature deaths*:

Service	Estimated # Deaths Averted
Lipid screening, treatment, and control	1,900
Hypertension identification, treatment, and control	1,800
Tobacco use screening and brief counseling	900
Aspirin	400
Pneumococcal immunization	300
Colonoscopy and care of positives	260
Influenza immunization	210
Mammography screening and care of positives	100

→ Focusing on CVD-related TCNY measures can have a significant impact on the health of New Yorkers compared to other targets.

*Based on peer-reviewed research and, where available, NYC-specific data.

NYS-Funded Reporting System



(1) EHR users collect patient data and transmit summary measures in a standardized, psuedonimized format to the TCNY-QRS (Note: An aggregator will be required to standardize measures for some EHR users)

(2) NYC DOHMH uses pseudonimized measures for population surveillance

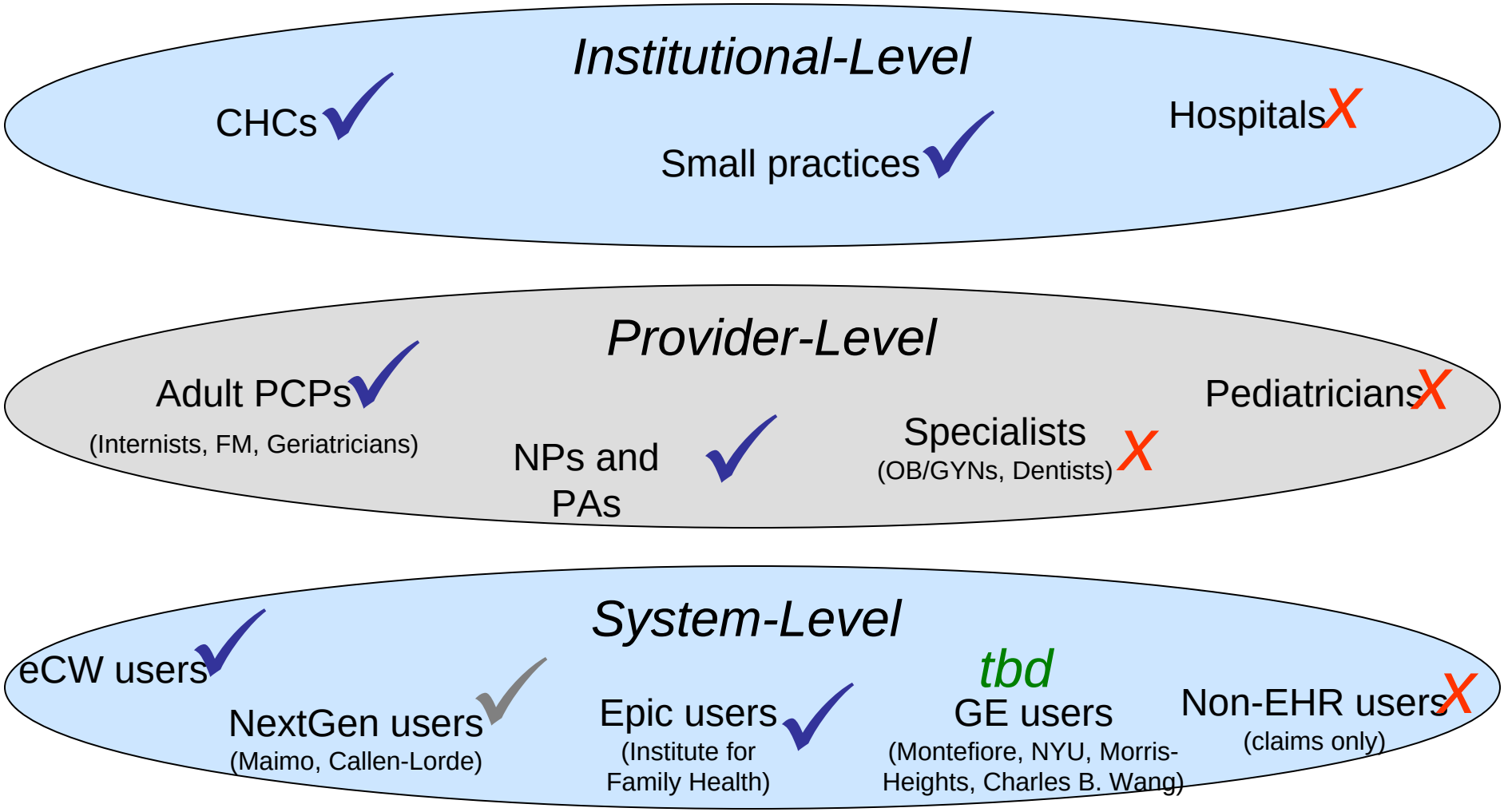
(3) BTE uses pseudonimized measures to assess performance of participating physicians

(4) EHR users receive scorecard from BTE and review results for practice QI. IPRO will provide QI and auditing services.

(5) VOLUNTARY: EHR users authorize BTE to pass performance assessment to contracted payers

(6) Payers recognize/send incentives to EHR users that qualify based on P4P benchmarks

Who is included in pilot?



PRIMARY ADULT CARE PRACTICE ELIGIBILITY CRITERIA & EXAMPLE AWARDS

- Electronically submit core quality measures to DOHMH
- Provide care at a practice with ≥200 patients across denominators of core measures
- Provide care at a CHC or small practice
- Verify completion of at least 1 QI meeting for practices with TCNY EHRs

Core Quality Measures	All Patients	High risk		
		Uninsured/ Medicaid	With Diabetes	Diabetes and Uninsured/Medicaid
Aspirin	$20	-	-	-
Blood Pressure Control	$20	2X	2X	4X
Cholesterol Control	$20	2X	2X	4X
Smoking Cessation	$20	-	-	-

Example of incentive payment: For a patient with diabetes and who is either Medicaid or uninsured, controlling a patient's blood pressure can result in an $80 incentive.

- Average Provider can earn between $10,000 to $20,000
- Maximum cap for any practice is $100,000

Pilot Program Process

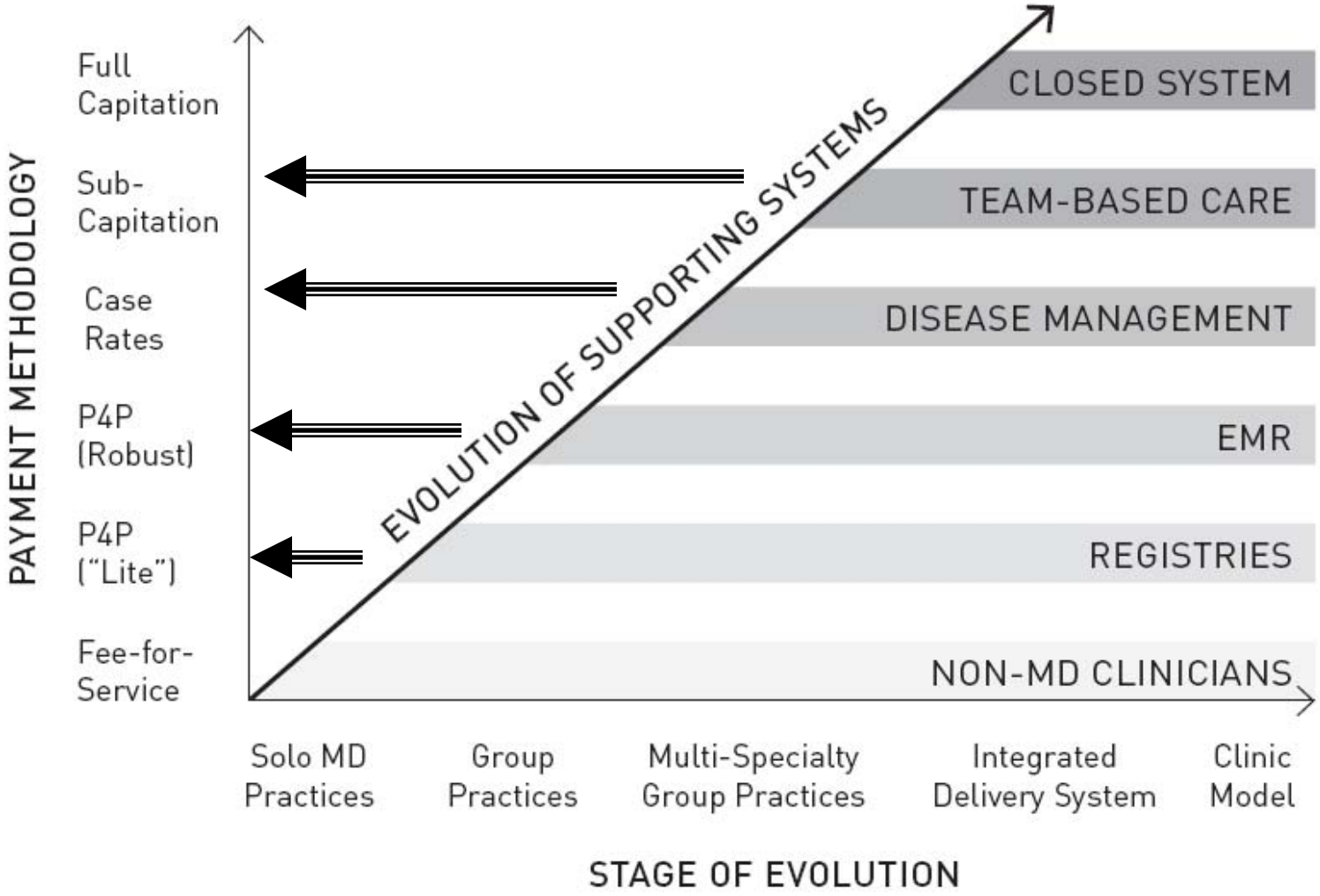
Enroll ~ 400 providers for pilot program

All providers will send automated reports to the QRS on four clinical quality areas in heart health
(the "ABCS": Aspirin, Blood Pressure Control, Cholesterol Control, Smoking Cessation)

Providers will have the opportunity to receive a quality incentive OR honorarium

All participants will be invited to a recognition dinner

The Vision: Extending Supporting Systems Across All Delivery Sites



Saving Lives After Heart Attacks

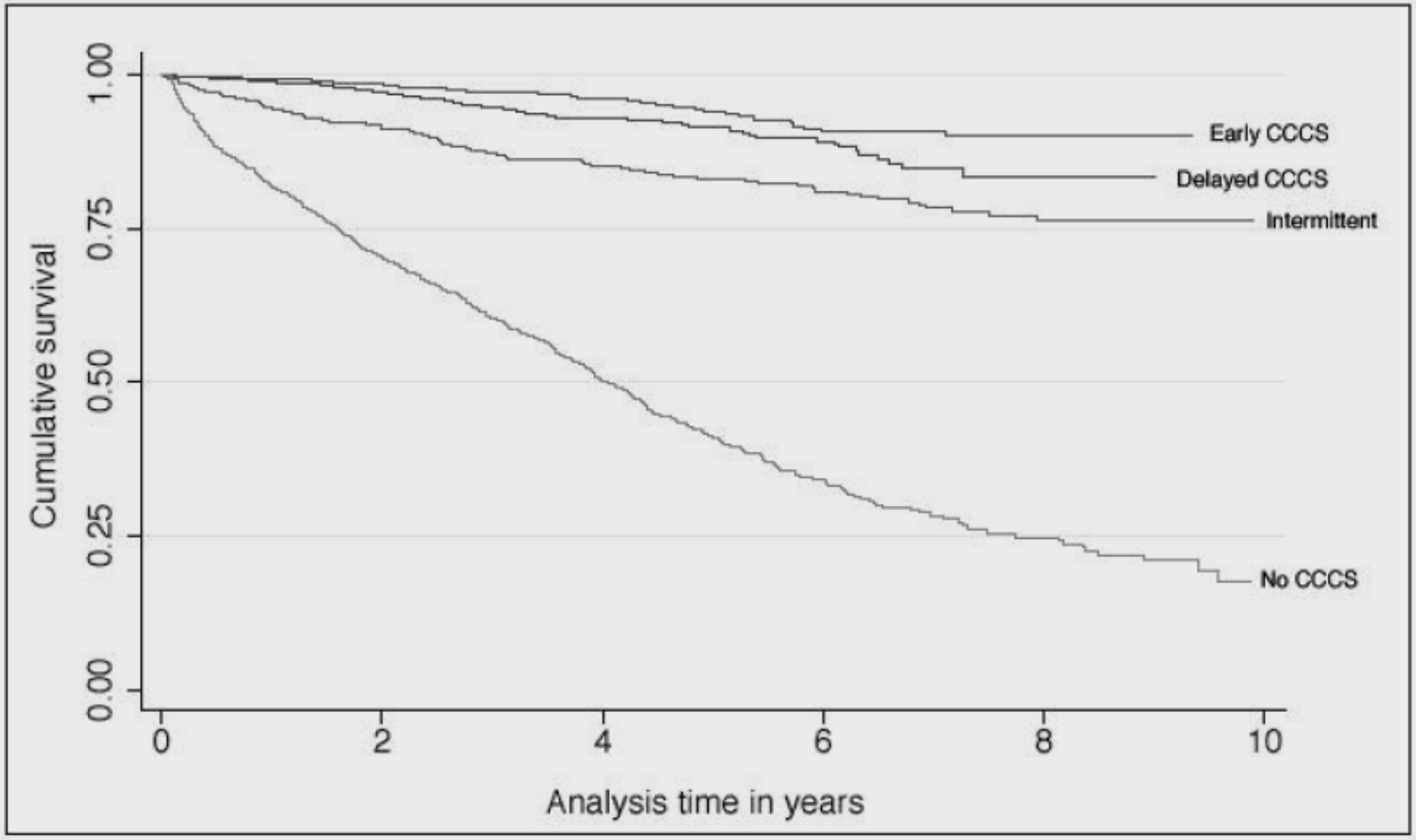


Figure 1. Kaplan-Meier curves for all-cause and cardiac-related mortality by year: All cause.

CCCS = Collaborative Cardiac Care Service

Aligning Forces for Quality Across Greater Cincinnati

Consistent, Actionable Primary Care Performance Measurement Across Greater Cincinnati

Aligning Forces for Quality | Improving Health & Health Care Across Greater Cincinnati

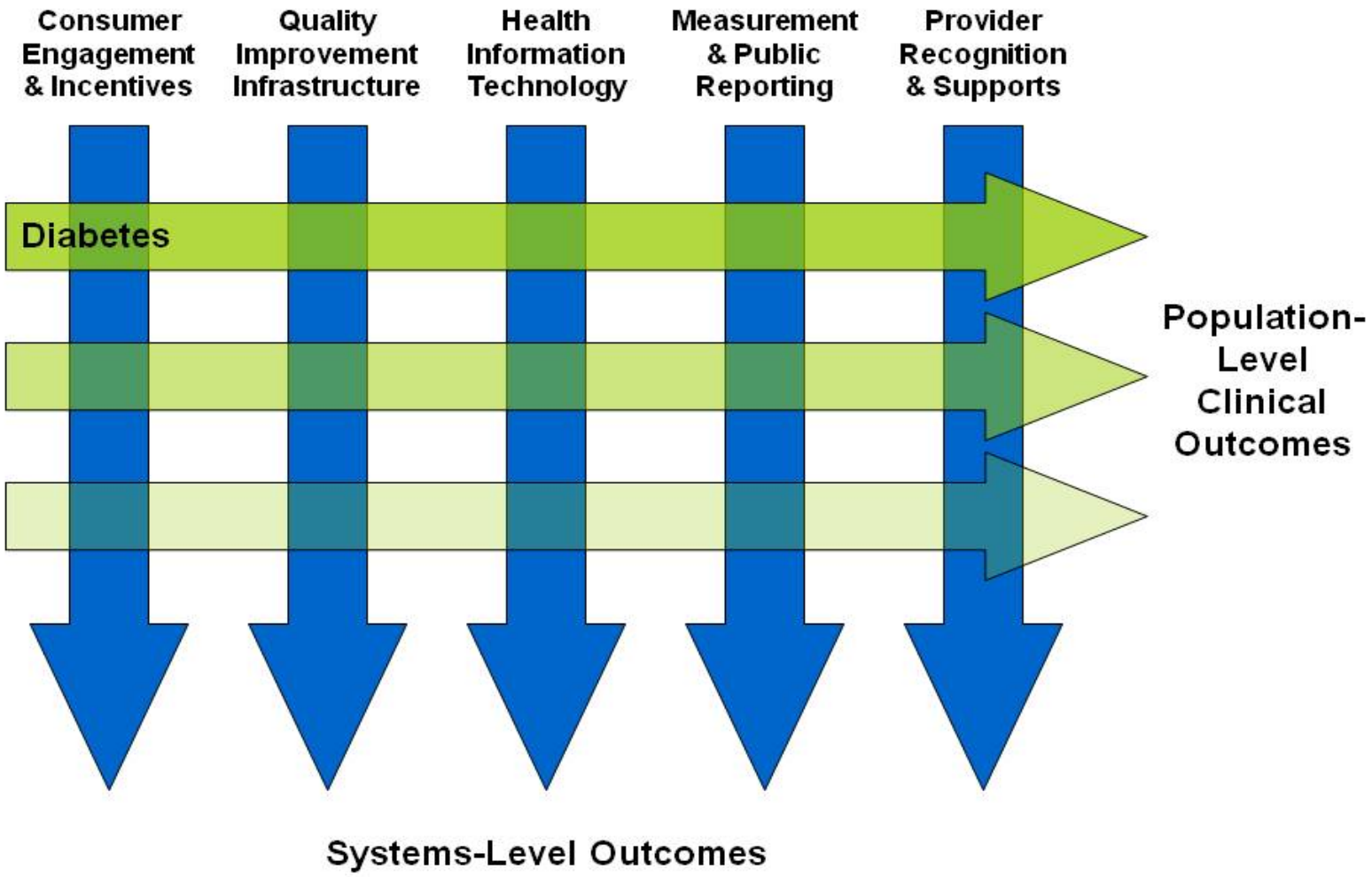
An initiative of the Health Improvement Collaborative of Greater Cincinnati and the Robert Wood Johnson Foundation

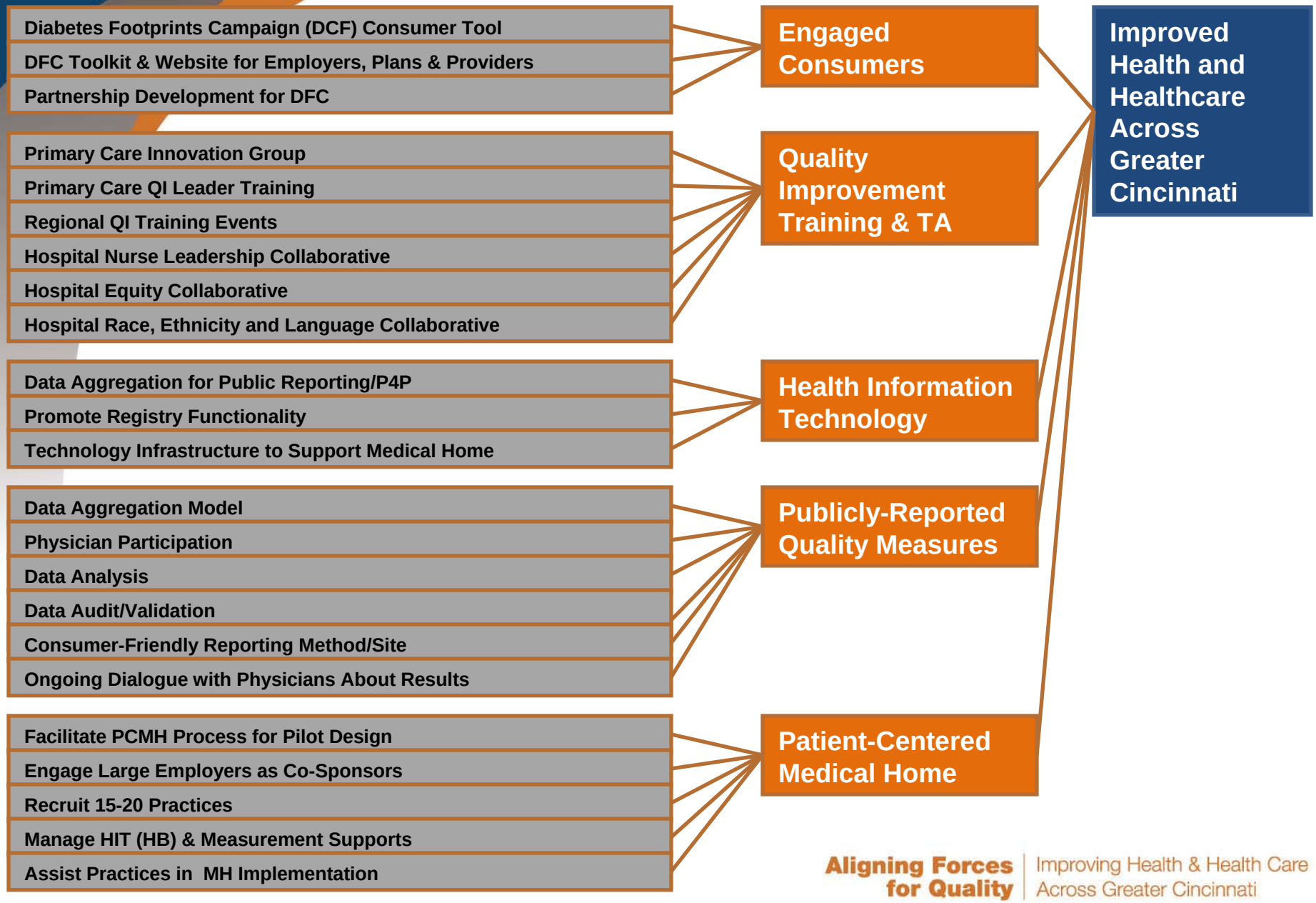
Robert Wood Johnson Foundation

Aligning Forces for Quality | Improving Health & Health Care Across Greater Cincinnati

An initiative of the Health Improvement Collaborative of Greater Cincinnati and the Robert Wood Johnson Foundation

Cincinnati AF4Q Framework





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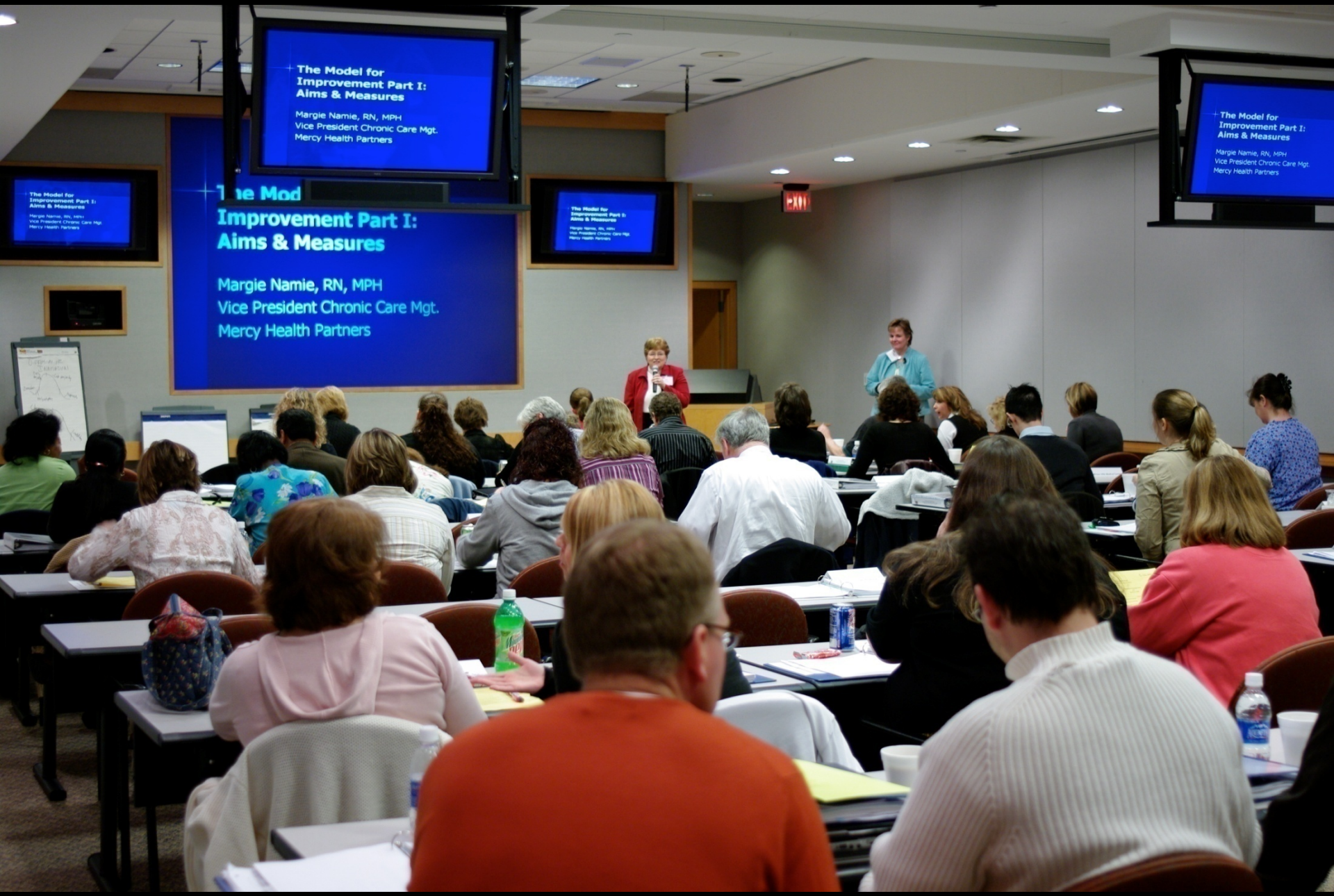
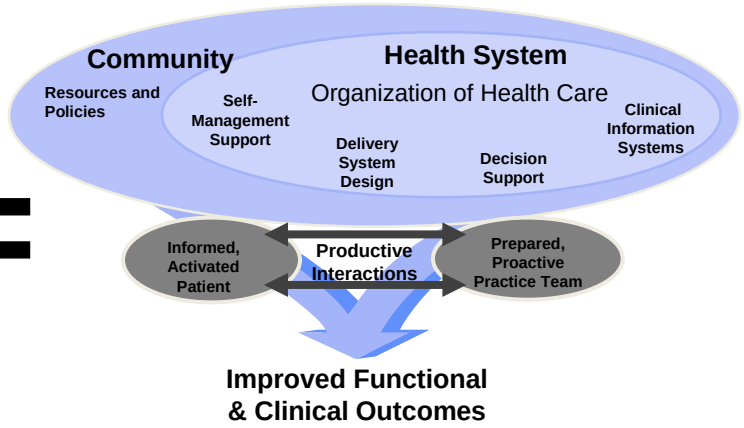

The Model for Improvement Part I: Aims & Measures
Margie Namie, RN, MPH
Vice President Chronic Care Mgt.
Mercy Health Partners
EXIT

The Patient-Centered Medical Home

=



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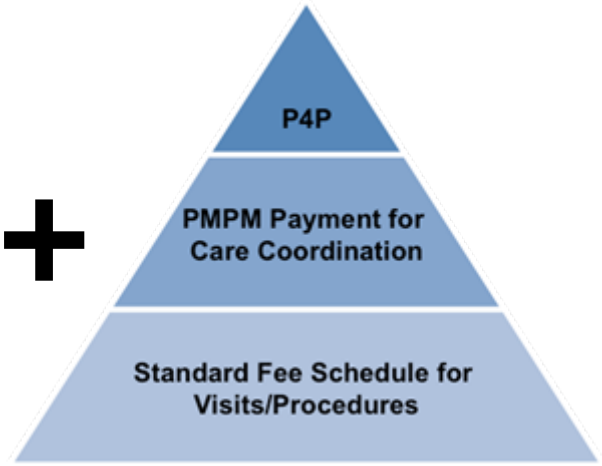


Patient-Centered Medical Home

Practice Transformation

Payment Reform

Aligning Forces for Quality | Improving Health & Health Care Across Greater Cincinnati

An initiative of the Health Improvement Collaborative of Greater Cincinnati and the Robert Wood Johnson Foundation

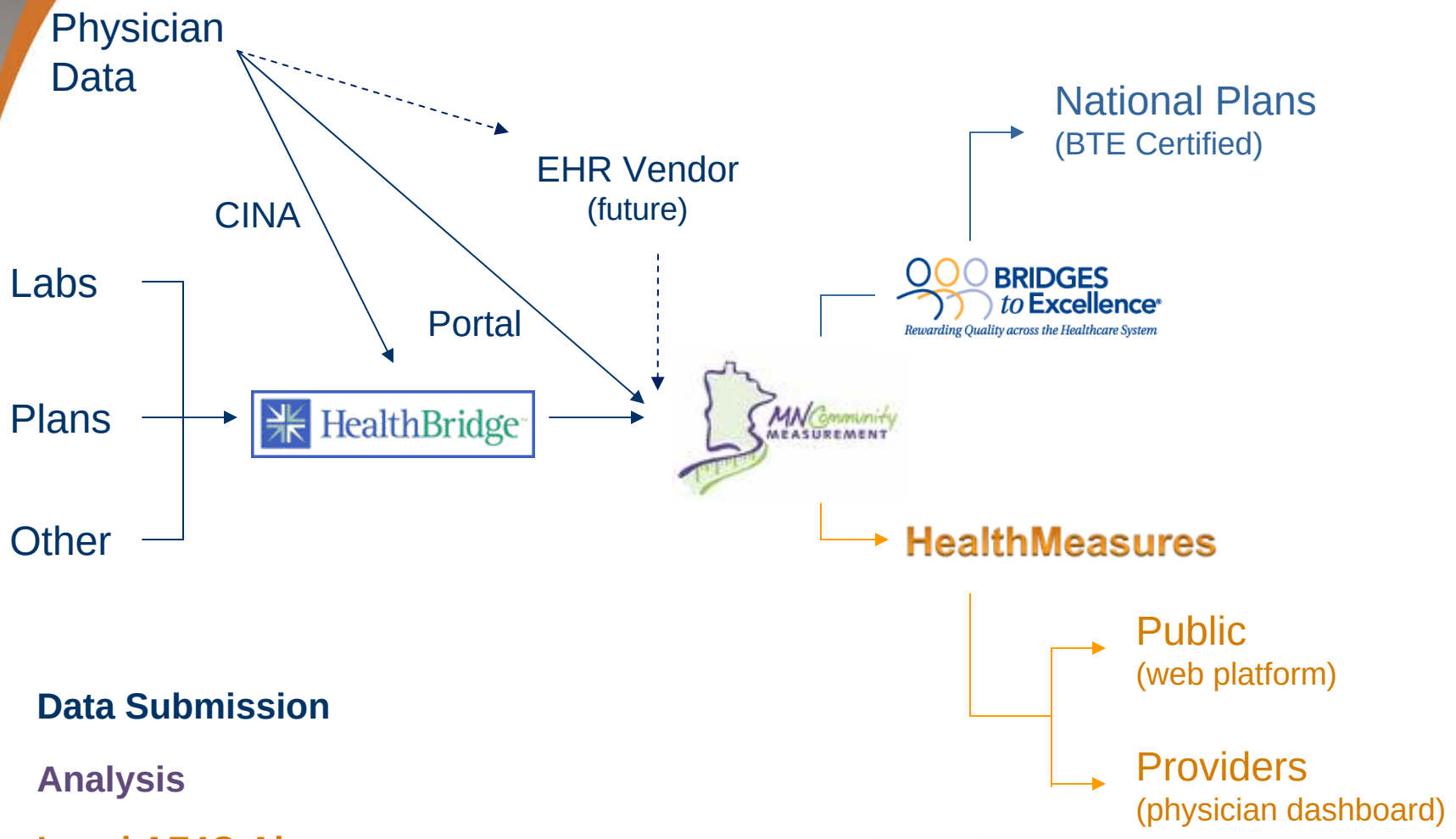
Contextual Factors Guiding Performance Measurement in Greater Cincinnati

1. Anti-Claims Bias
2. HealthBridge
3. Bridges to Excellence

Local physician leaders have told us that we must have…

- a level playing field
- measures that matter to physicians
- a methodology which is explicit and open to scrutiny
- an aligned incentive system

Cincinnati Performance Measurement Strategy



Data Submission

Analysis

Local AF4Q Aims

Provider Rewards

HealthBridge Electronic Health Record Automatic Data Extraction

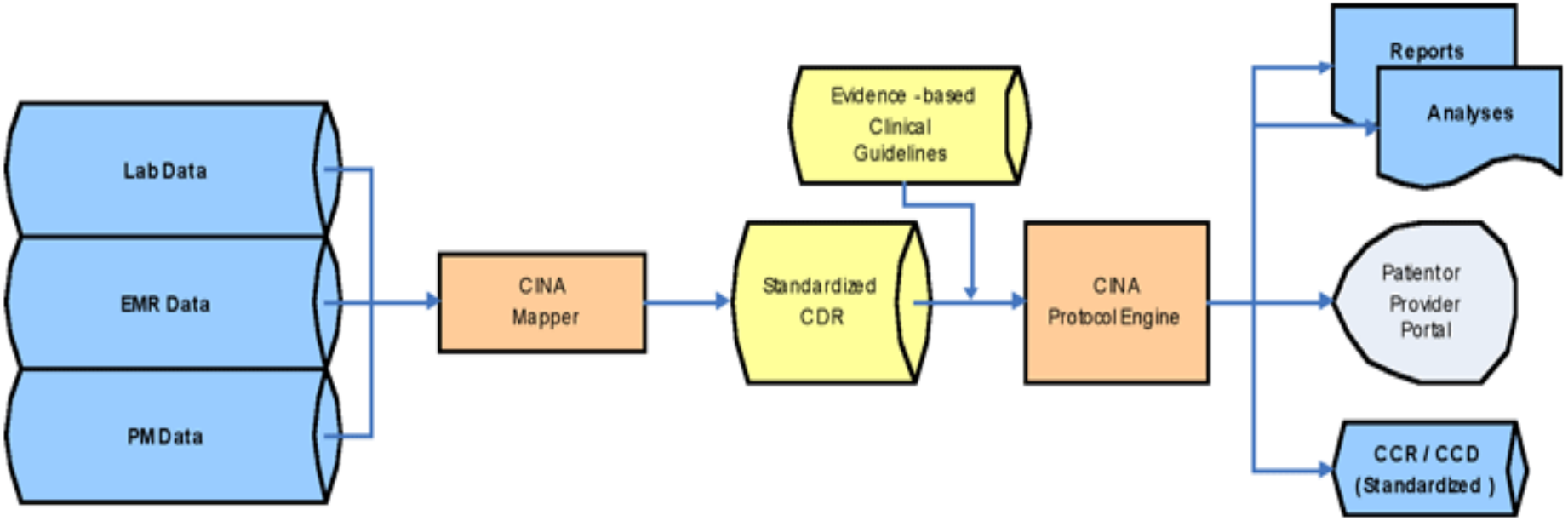
Physician Data

The CINA Protocol Engine

Overview

The CINA Protocol Engine (CPE) is a software system that will permit most any provider to implement best-practice clinical guidelines now. The CPE can read data from most data sources currently available within a clinical practice. These sources include Electronic Health Records (EHRs), Practice Management Systems (PMSs), Lab Information Systems (LISs), clinical data repositories (CDRs), patient registries, and other sources.

The CPE compares all available data against national guidelines (chosen by your providers) to produce a single-page report for each patient, identifying risks, goals and recommendations. The CPE doesn't tell the provider how to practice. It simply reminds the provider of those things that he or she has asked to be reminded of. The CPE also produces performance data that can be used to respond to pay-for performance reporting, trended over time, or aggregated with data from other practices for analysis.



CINA

CLINICAL INTEGRATION NETWORKS OF AMERICA

News

Press Releases

June 1, 2008
WomensBiz.us: Women to Watch

May 19, 2008
HealthBridge Selects CINA to Meet Deliverables for Community-Wide Project

May 15, 2008
CINA Thought Leaders Pinpoint Healthcare IT Developments Impacting Physicians, Payers and Patients at Annual TEPR Conference

March 27, 2008
CINA's Technology Helps Physicians Meet Requirements of Medical Home Model as Defined by NCQA

March 10, 2008
CINA Senior Vice President Cathy Bryan, RN Wins ACHE's Richard J. Stull Student Essay

Direct Data Submission Portal and Analytic Functions

Physician Data

Portal

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Welcome to the Data Portal!

Registration Need to register for an account? Click Here.

Contact Support with any questions.

Already have an account? Log In

Please Log In

E-mail Address

Password

I forgot my password.

LOG IN

Need Help? Have Questions? Contact Support

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Clinic Sites

All Sites

Clinic Site	MNCM ID	County	Status	Contact Information	Edit
Acme Clinic A	a1	Hennepin	Active	*Complete*	Edit
Acme Clinic B	a2	Hennepin	Active	*Complete*	Edit

Contact Support | Site Terms of Use | Data Use Agreement (PDF)

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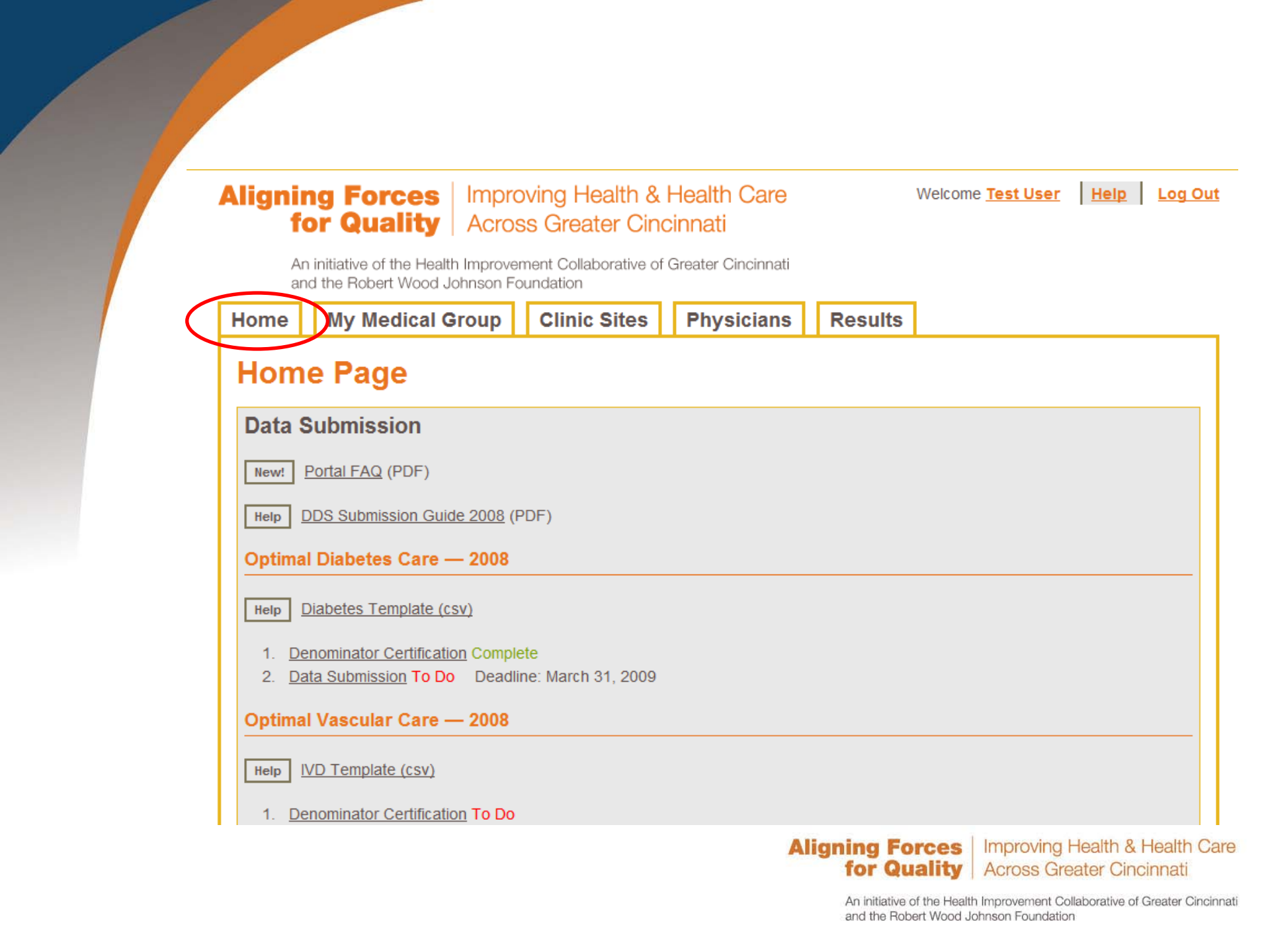
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DDS Submission Guide 2008 (PDF)
Optimal Diabetes Care — 2008
Help
Diabetes Template (csv)
1. Denominator Certification Complete
2. Data Submission To Do Deadline: March 31, 2009
Optimal Vascular Care — 2008
Help
IVD Template (csv)
1. Denominator Certification To Do
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Data Submission

New! Portal FAQ (PDF)

Help DDS Submission Guide 2008 (PDF)

Optimal Diabetes Care — 2008

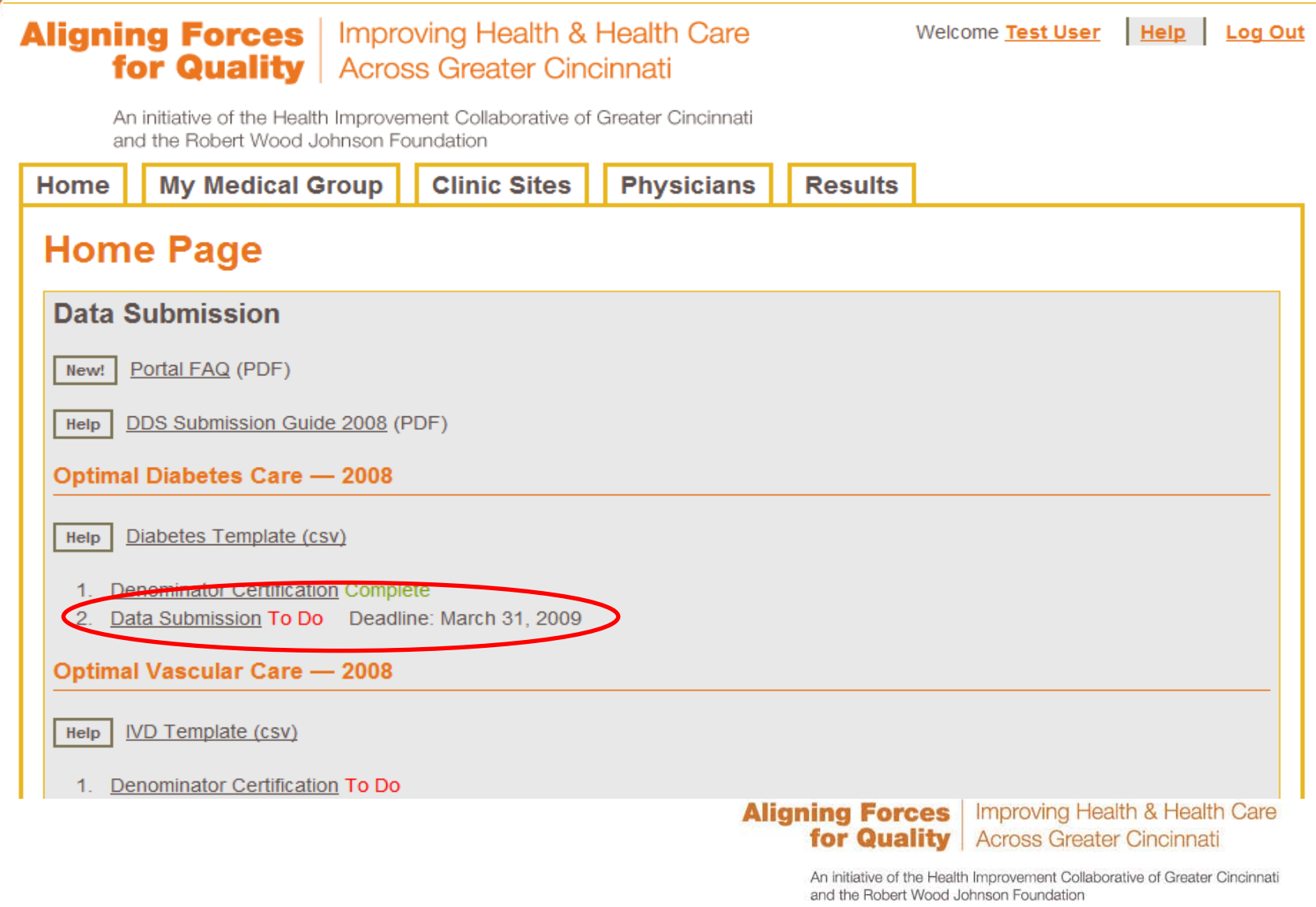
Help Diabetes Template (csv)

1. Denominator Certification Complete
2. Data Submission ~~To Do~~ Deadline: March 31, 2009

Optimal Vascular Care — 2008

Help IVD Template (csv)

1. Denominator Certification To Do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Home > Data Submission

Step 1: Enter Denominator Step 2: Review & Save Step 3: Upload Data
Step 4: Review & Submit Step 5: Done

Optimal Diabetes Care 2009 Report (2008 DOS) — TEST Medical Group

Clinic Site	Clinic ID	Methodology	Denominator Patients At Site	Denominator Patients Submitting	Not Reporting	Messages
Acme Clinic A	a1	Select...			☐	Please enter both the total patient count and number submitting.
Acme Clinic B	a2	Select...			☐	Please enter both the total patient count and number submitting.

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Home > Data Submission

Step 1: Enter Denominator **Step 2: Review & Save** Step 3: Upload Data
Step 4: Review & Submit Step 5: Done

Optimal Diabetes Care 2009 Report (2008 DOS) — TEST Medical Group

Clinic Site	Clinic ID	Methodology	Diabetes Patients At Site	Diabetes Patients Submitting	Messages
Acme Clinic A	a1	EMR	162	162	**Total Population** OK. Ready to Submit.
Acme Clinic B	a2	EMR	52	30	**Sample** OK. Ready to Submit.
			214	192	

Cancel Continue >>

Home > Data Submission

Step 1: Enter Denominator Step 2: Review & Save **Step 3: Upload Data**
Step 4: Review & Submit Step 5: Done

Help

Tips for successful data submission:

- Please be sure you are using the current template: Diabetes Template (csv). (Note that the Medical Group ID column is no longer part of the data submission format.)
- All clinics must be uploaded in a *single* spreadsheet.
- All fields must follow the format requirements described in the current Data Submission Guide (for example, Tobacco Status must be a 1, 2 or 3)
- If you are a Recognizing Excellence participant, be sure you have properly indicated the provider specialty using a number between 1 and 7.
- Please E-Mail Support if you require further assistance.

Optimal Diabetes Care 2009 Report (2008 DOS) — TEST Medical Group

- Please be sure you are using the current template: Diabetes Template (csv). (Note that the Medical Group ID column is no longer part of the data submission format.)
- All clinics must be uploaded in a *single* spreadsheet.
- All fields must follow the format requirements described in the current Data Submission Guide (for example, Tobacco Status must be a 1, 2 or 3)
- If you are a Recognizing Excellence participant, be sure you have properly indicated the provider specialty using a number between 1 and 7.
- Please E-Mail Support if you require further assistance.

Optimal Diabetes Care 2009 Report (2008 DOS) — TEST Medical Group

Denominator setup information submitted successfully.

Upload Data File (csv):

Browse...

Add to existing data for this medical group and period

Help Medical groups with very large data sets (e.g., more than 10,000 records) may want to consider uploading their data in multiple, smaller files. Be very careful with this option, however, as no validation steps are taken to ensure that you are not uploading duplicate data.

Cancel << Back to Step 2 Upload CSV and Continue >>

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Home > Data Submission

Step 1: Enter Denominator Step 2: Review & Save **Step 3: Upload Data**
Step 4: Review & Submit Step 5: Done

Upload Status

Upload File	Uploaded By	# Records	Started	Finished	Verify
Test_Group_Clinic_B_PC_Test.csv 1 Warnings View Errors & Warnings	Test User	192 / 192	12/18/2008 10:13:00 AM	12/18/2008 10:13:01 AM	Continue to Step 4 >>

Cancel | << Re-Upload Data (csv) File | Clear and Start Over

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Home > Data Submission

Step 1: Enter Denominator Step 2: Review & Save Step 3: Upload Data
Step 4: Review & Submit Step 5: Done

Optimal Diabetes Care 2008 Report (2007 DOS) — TEST Medical Group

Clinic Site	Clinic ID	Methodology	Diabetes Patients At Site	Diabetes Patients Submitting	Numerator Patients Actual	Rate	Messages
Acme Clinic A	a1	EMR	162	162	162	27%	**Total Population**
Acme Clinic B	a2	EMR	52	30	30	18%	**Total Population**
			214	192	192		Preliminary Rate

Cancel << Re-Upload Data (csv) File Clear and Start Over Save as Draft
Submit Data to Cincinnati AF4Q

Help Choosing **"Submit Data to Cincinnati AF4Q"** will lock data from further editing, and will send an e-mail to MNCM to begin the review and auditing process.

Results

Measure: Optimal Diabetes Care | Period: 2009 Report (2008 DOS) | Benchmark: Overall Cincinnati Rate

View Results

Optimal Diabetes Care 2009 Report (2008 DOS)

Clinics		[The D5] Optimal Care	(1) BP	(2) LDL-C	(3) A1c	(4) Tobacco	(5) Aspirin	
Bar Charts by Component:								
Cincinnati Overall		23%	56%	29%	69%	72%	67%	Historical
TEST Medical Group	[+]	19%	55%	21%	70%	78%	77%	Historical

Download Data

Results

Measure: Optimal Diabetes Care | Period: 2009 Report (2008 DOS) | Benchmark: Overall Cincinnati Rate

View Results

Optimal Diabetes Care 2009 Report (2008 DOS)

Clinics		[The D5] Optimal Care	(1) BP	(2) LDL-C	(3) A1c	(4) Tobacco	(5) Aspirin	
Bar Charts by Component:								
TEST Medical Group	Acme Clinic A	27%	61%	24%	74%	67%	59%	Historical
Cincinnati Overall		23%	56%	29%	69%	72%	67%	Historical
TEST Medical Group	[-]	19%	55%	21%	70%	78%	77%	Historical
TEST Medical Group	Acme Clinic B	18%	41%	32%	54%	92%	84%	Historical

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Results

Measure: Optimal Diabetes Care | Period: 2009 Report (2008 DOS) | Benchmark: Overall Cincinnati Rate

- Overall Cincinnati Rate
- Top 10 Clinics
- Choose Groups to Compare With

View Results

Optimal Diabetes Care 2009 Report (2008 DOS) - Acme Clinic A

	Denominator	[The D5] Optimal Care	(1) BP	(2) LDL-C	(3) A1c	(4) Tobacco	(5) Aspirin	
Bar Charts by Component:								
Christine Dietrich	6 patients	66%	66%	66%	83%	83%	100%	Historical
Michael Corleone	37 patients	47%	61%	54%	74%	67%	59%	Historical
Cincinnati Overall		**23%**	**56%**	**29%**	**69%**	**72%**	**67%**	Historical
Jon Allred	31 patients	11%	22%	66%	55%	55%	77%	Historical

Download Data

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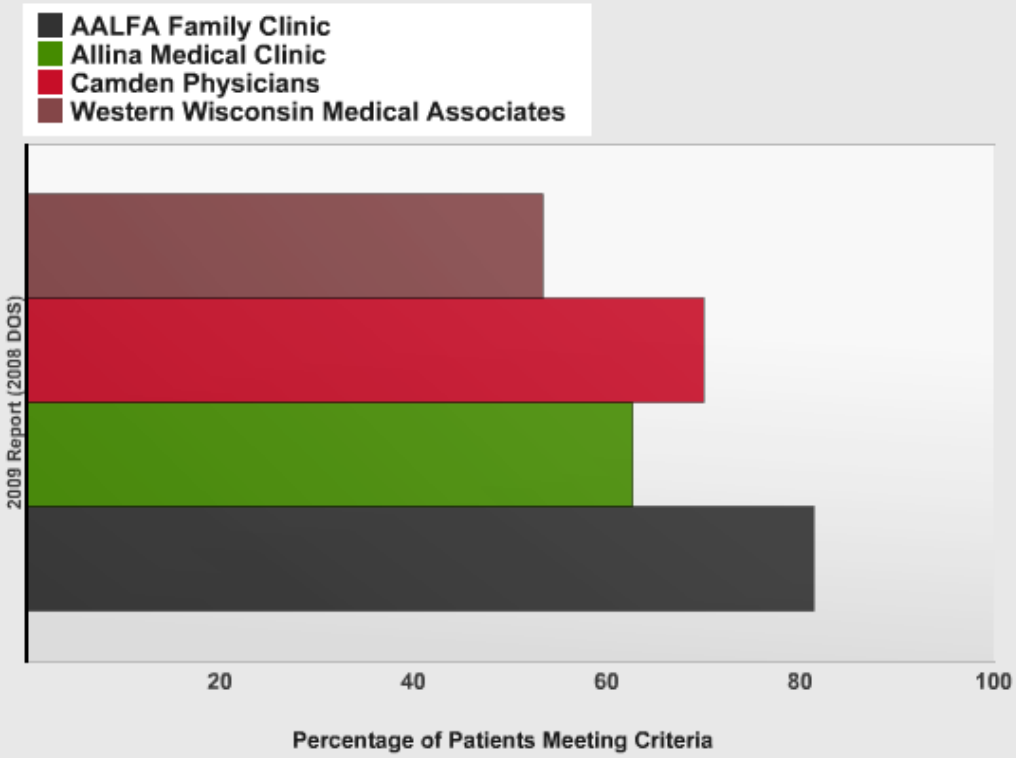
Component Measure Comparison
Optimal Diabetes Care 2009 Report (2008 DOS)

HbA1c

Percentage of patients with HbA1c scores < 7.0



Physicians

TEST Medical Group - Upload Physician File

Name	Physician ID	Clinic All
Jon Allred	1234567890	Acme Clinic A
Michael Corleone	5555555555	Acme Clinic A
Christine Dietrich	0909090909	Acme Clinic B
Oliver Frank	8888888888	Acme Clinic A
...		
...		
William Zabka	2323878765	Acme Clinic B

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Physicians

TEST Medical Group: Michael Corleone

Program	Current Recognition Level [What's This?]	Current Assessed Level [What's This?]	
Diabetes Care Link	Level 2	Level 1	Details
Cardiac Care Link	Level 1	Level 1	Details

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Physicians

TEST Medical Group: Michael Corleone

Program	Current Recognition Level [What's This?]	Current Assessed Level [What's This?]	
Diabetes Care Link	Level 2	Level 1	Details
Cardiac Care Link	Level 1	Level 1	Details

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Results - Diabetes Care Link

TEST Medical Group: Michael Corleone

January 1 2008 - December 31 2008

Current Assessed Level	Points	Current Recognized Level	Recognition Begin Date	Recognition End Date	Notes
Level 1	79.70				
Level 2	73.13	Level 2	March 01, 2009	February 29, 2011	
Level 3	62.29				

Details

Measure	Threshold	Min / Max	Your Results	L1	L2	L3
Poor Control Measures						
		Max:				

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Details

Measure	Threshold	Min / Max	Your Results	L1	L2	L3
Poor Control Measures						
HbA1c Control	> 9.0	Max: 27.5%	7.23% of patients	13.92	Pass	Pass
Blood Pressure Control	>= 140/90	Max: 40.0%	15.66% of patients	12.65	Pass	Pass
LDL Control	>= 130 mg/dl	Max: 40.0%	10.84% of patients	8.92	Pass	Pass
Poor Control Composite Measure						
HbA1c Control	> 9.0					
Blood Pressure Control	>= 140/90	N/A	27.71% of patients	N/A	28.92	28.92
LDL Control	>= 130 mg/dl					
Superior Control Measures						
HbA1c Superior Control	< 7.0	Min: 40.0%	56.63% of patients	5.66	5.66	Pass
Blood Pressure Superior Control	< 130/80	Min: 30.0%	59.04% of patients	5.90	5.90	Pass
LDL Superior Control	< 100 mg/dl	Min: 35.0%	75.90% of patients	7.59	7.59	Pass

Superior Control Measures						
HbA1c Superior Control	< 7.0	Min: 40.0%	56.63% of patients	5.66	5.66	Pass
Blood Pressure Superior Control	< 130/80	Min: 30.0%	59.04% of patients	5.90	5.90	Pass
LDL Superior Control	< 100 mg/dl	Min: 35.0%	75.90% of patients	7.59	7.59	Pass
Superior Control Composite Measure						
HbA1c Superior Control	< 7.0					
Blood Pressure Superior Control	< 130/80	N/A	27.71% of patients	N/A	N/A	8.31
LDL Superior Control	< 100 mg/dl					
Process Measures						
Opthalmologic Exam	N/A	N/A	60.24% of patients	6.02	6.02	6.02
Nephropathy Exam	N/A	N/A	83.13% of patients	4.16	4.16	4.16
Podiatry Exam	N/A	N/A	97.59% of patients	4.88	4.88	4.88
Smoking Status and Cessation Advice and Treatment	N/A	N/A	100.00% of patients	10.00	10.00	10.00
Totals				**79.70**	**73.13**	**62.29**

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Questions?