# Pay for Performance in the Context of the Military Patient-Centered Medical Home

**Michael Dinneen, MD, PhD**

**COL John P. Kugler, MD, MPH**

**Department of Defense**

**11 March 2009**

# Agenda

- Military Health System (MHS) Overview
- Our Burning Platform: A Crisis in Perception
- P4P and the Medical Home
- Lessons Learned
- Future Plans

# The Military Health System – Overview

- **Provider of premier care for warriors and families**
  - Uniquely prepared to offer warrior care (land, sea, air) and civilian care, in disaster relief (peace through medicine)
- **Supporter of war fighter; 95,000 military medical forces have deployed to combat theaters over the past 6 years**
- **Leader in health care, research, education, training**
  - Contribute more than 2,000 research publications/year
- **Employer of more than 129,000; we aspire to be the Nation's health care workplace of choice**
- **Health program for 9.2 million eligible beneficiaries**
- **Manager of $45B budget**

# World-wide Integrated Clinical Care

**Direct Care**

**Private Sector Care**

**63 military hospitals and 826 health and dental clinics; 129,000 total personnel**

**TRICARE network 210,000 private-sector physicians, virtually all civilian hospitals, and 55,000 pharmacies**

35% of Care

**9.2 M Eligible Beneficiaries**

65% of Care

# A Crisis in Perception: Our Burning Platform

- **Only about 50% of users of military hospitals and clinics believe they have a “personal” doctor (continuity)**
- **Our beneficiaries rate us below national averages in doctor’s communication and overall satisfaction with health care (communication/satisfaction)**
- **Our beneficiaries tell us they have difficulty finding appointments. (access)**
- **Measures of quality demonstrate that the MHS compares well with civilian institutions but, has opportunities for improvement. (quality)**

# Our Solution: The Patient-Centered Medical Home (7 Core Features)

- **Personal Primary Care Provider (PCMBN) (continuity).**
- **Primary Care Provider Directed Medical Practice (PCM is team leader) (communication).**
- **Whole Person Orientation (patient centered not disease or provider centered) (communication/patient satisfaction).**
- **Care is Coordinated and/or Integrated (across all levels of care) (continuity/communication).**
- **Quality and Safety (evidenced-based, safe medical care) (quality)**
- **Enhanced Access (meet access standards from the patient perspective) (access).**
- **Payment Reform (incentivize the development and maintenance of the medical home).**

# A Simple Model to Optimize Patient Satisfaction

# Domains and Measures for Phase One of Pay for Performance

- **Quality**
  - HEDIS Preventive Services
  - ORYX
- **Satisfaction**
  - Health Plan
  - Health Care
  - Doctor's Communication
- **Access**
  - Getting Needed Care
  - PCM appointment when available
  - 3rd next appointment

# Structure and Decisions

- **Tiger Teams Chartered**
  - Patient Centered Medical Home (primary care clinical subject matter representatives from the Army, Navy, Air Force and DoD)
  - Pay For Performance (clinical and resource management representatives from the Army, Navy, Air Force and DoD)
- **Types of Decision for Each Measure**
  - Threshhold
  - Value
  - Population Covered

# Quality

- **Adherence to HEDIS Guidelines**
  - HEDIS Cancer Screening, Asthma Controller Meds, Diabetic control and practice
  - 50th and 90th civilian percentiles
  - $5/$10
  - Relevant enrollees
- **Adherence to ORYX clinical practice guidelines**
  - CAC, SCIP measures, AMI measures, CHF measures
  - ORYX benchmark
  - $400 per patient that meets the benchmark per month
  - Relevant patients

  - Example:
  - For a hospital with 40,000 enrollees there may be 1000 diabetics. If that hospital meets the 90th percentile for HgB A1C screening then the hospital would get an additional 1000*$10 = $10,000 per month in operating funds.

# Satisfaction

- **Health Plan**
  - % Satisfied (8,9,10) with Health Plan
  - Internal DoD 50th, Civilian average
  - $10, $25
  - Enrollees
- **Health Care**
  - % Satisfied (8,9,10) with Health Care
  - Internal DoD 50th, 90th percentile, Civilian average
  - $1, $3, $5
  - Visits
- **Doctor's Communication**
  - % Response falling in best category (Always) with Doctor's Communication*
  - Internal DoD 50th, 90th percentile, Civilian average
  - $1, $3, $5
  - Visits

# Access

- **Access to Needed Care**
  - % Response falling in best category (Not a Problem) with Access to Needed Care*
  - Internal DoD 50th, 90th percentile, Civilian average
  - $10, $30, $50
  - Enrollees
- **3rd next appointment**
  - % of days when 3rd next appointment is within access standards for acute (1 day), routine (7 days), and well (28 days)
  - Internal DoD 50th, 90th percentile
  - $1, $3
  - Primary care Appointments
- **PCM appointment when available**
  - % of appointments when PCM is available that are with the enrollees PCM
  - Internal DoD 50th, 90th percentile
  - $1, $3
  - Primary Care Visits

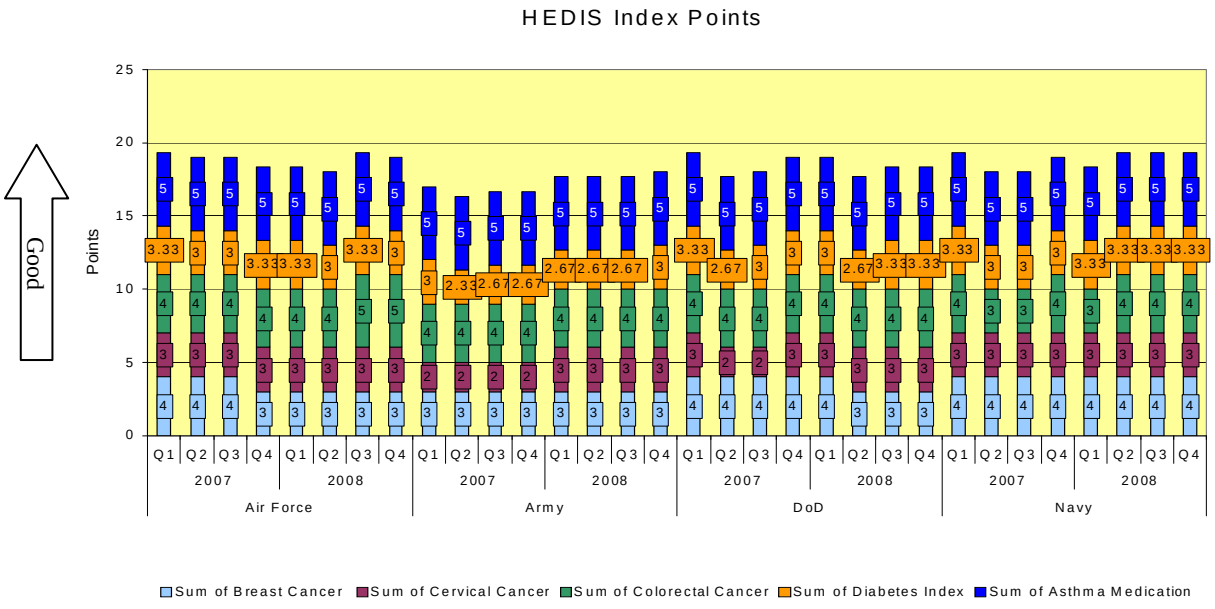
# Lessons Learned and Early Data

- **We see early improvement in HEDIS measures across the board**
- **Can not tell if the driver of improved performance is money or simply the Hawthorne effect**
- **Very popular with people who work in the hospitals - partly because of the clarity of communication of what leadership considers important**
- **Makes the concept of the patient centered medical home more tangible**
- **Need to combine with education, training and sharing of best practices to avoid frustration**

Y

# *HEDIS Quality Index*

**By utilizing pay for performance, can we get to green in 2009?**




**What are we measuring?:** This composite index scores each Service for their Prime enrollee population for compliance with Healthcare Effectiveness Data and Information Set (HEDIS) measures on seven treatment protocols (three diabetes measures are combined into one index). The selected HEDIS measures indicate the pervasiveness of routine screening or treatment in an enrolled population for five chronic or common diseases. Scores for each Service and DoD were assigned based on their percentile rank using the 2006/2007 NCQA Civilian Benchmarks. Index points are assigned for each protocol as depicted in the table to the right and summed in the chart above to create a total HEDIS quality index score.

**Why is it important?:** The selected measures support an evidence-based approach to population health and quality assessment. It also provides a direct comparison with civilian health plans and a means of tracking improvements in disease screening and treatment. Improved scores in this measure should translate directly to a healthier beneficiary population, reduced acute care needs, and reduced use of integrated health system resources.

**What does our performance tell us?:** The MHS ranks above the 50th percentile in all measures, but diabetes and cervical cancer are the lowest. The MHS has improved regularly in compliance with the guidelines, and is making incremental improvements in comparison to other health plans.

**Measure Advocate:**
COL John Kugler
TMA-OCMO; (703) 681-0064

**Monitoring:** Quarterly

**Data Source:** MTF and Services self reporting and the 2006/2007 NCQA Civilian Benchmarks.

**Other Reporting:** None

**Assessment Criteria:**

R < 18 points

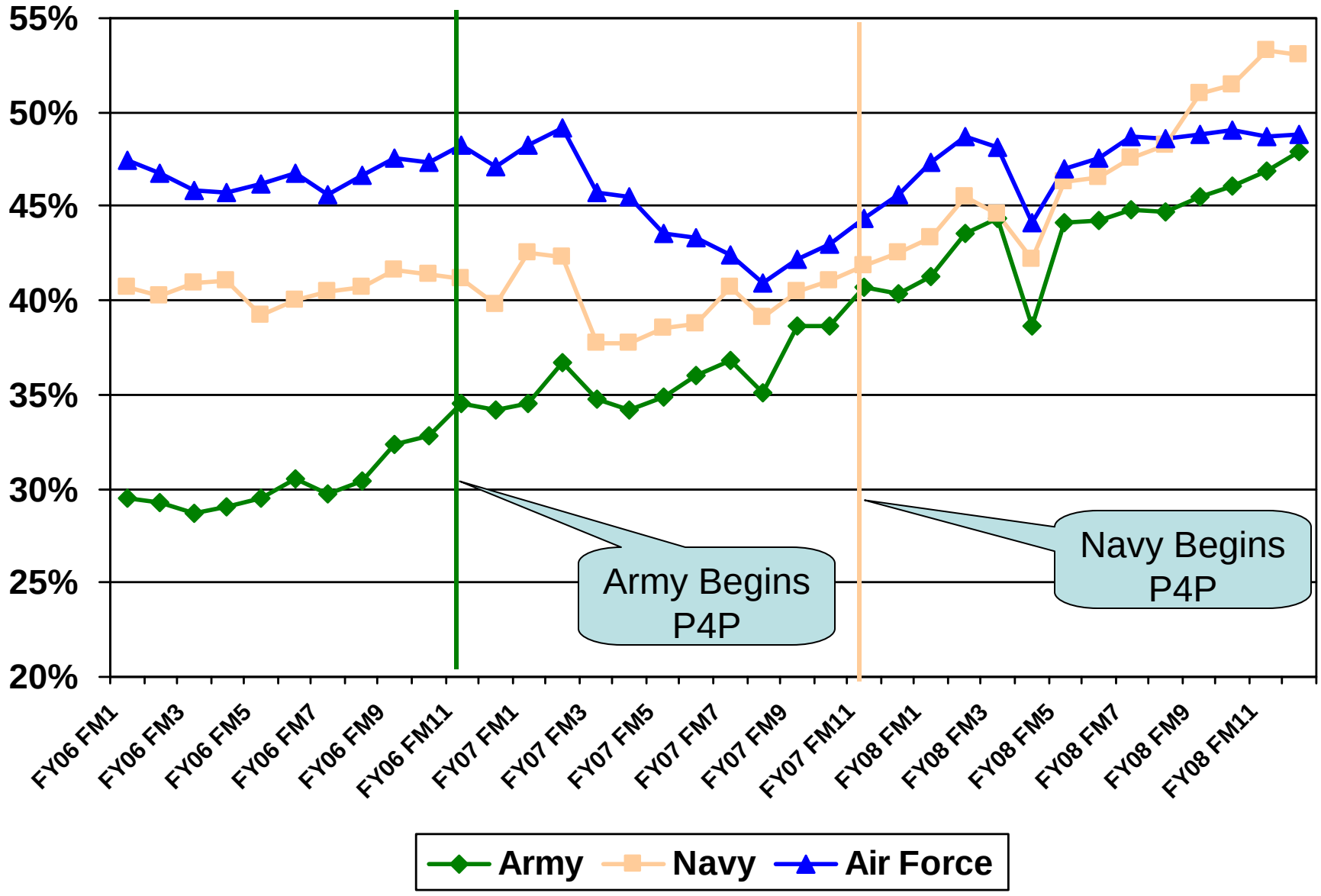
Y 18 – 20 ← Status

G > 20 points

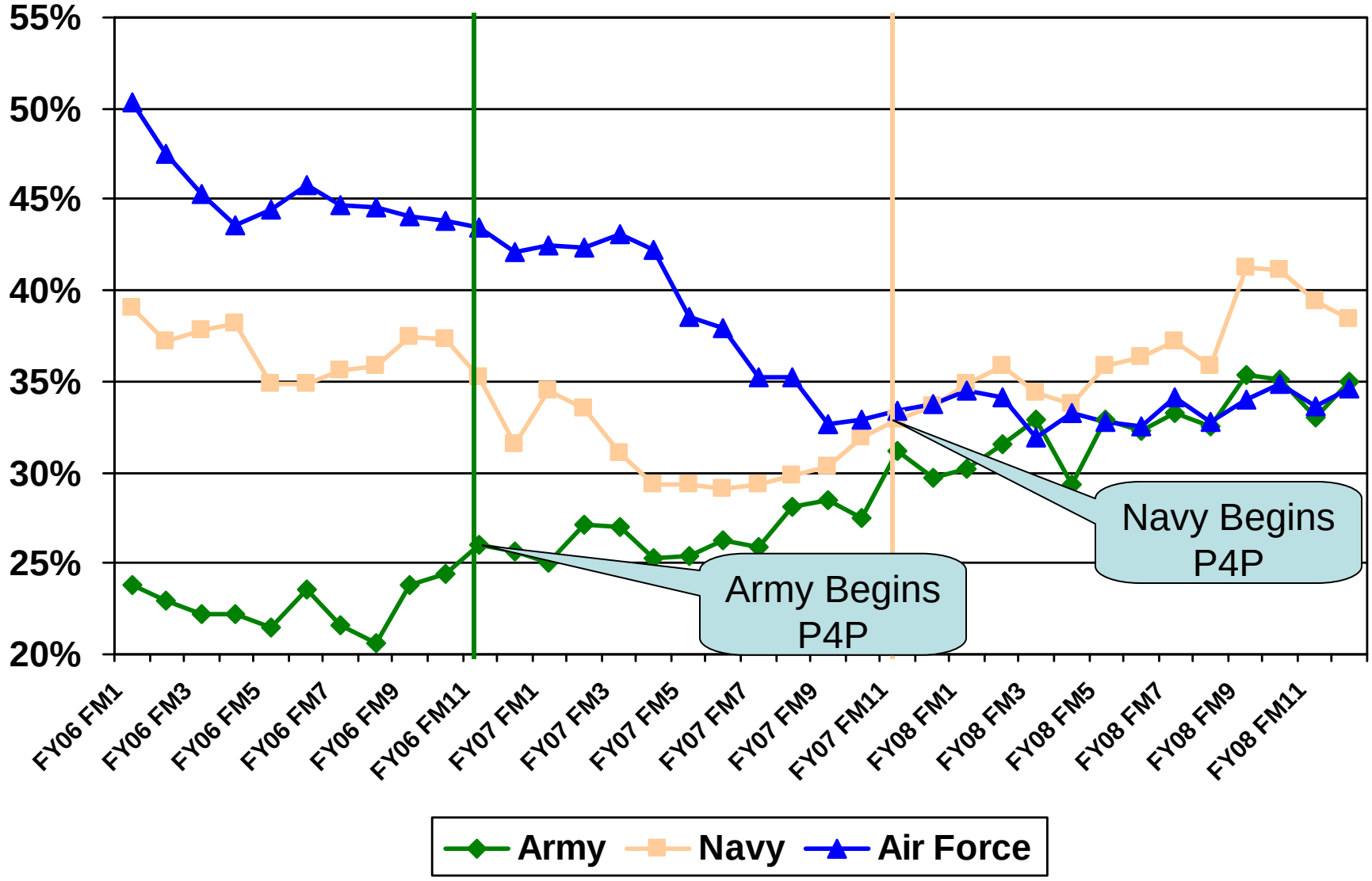
**Index Points**

| | |
|---|---|
| **>= 90%** | **5** |
| **<90th % and >=75th %** | **4** |
| **<75th % >=50th %** | **3** |
| **<50th % and >=25th %** | **2** |
| **<25th % and >=10th %** | **1** |
| **<10th %** | **0** |

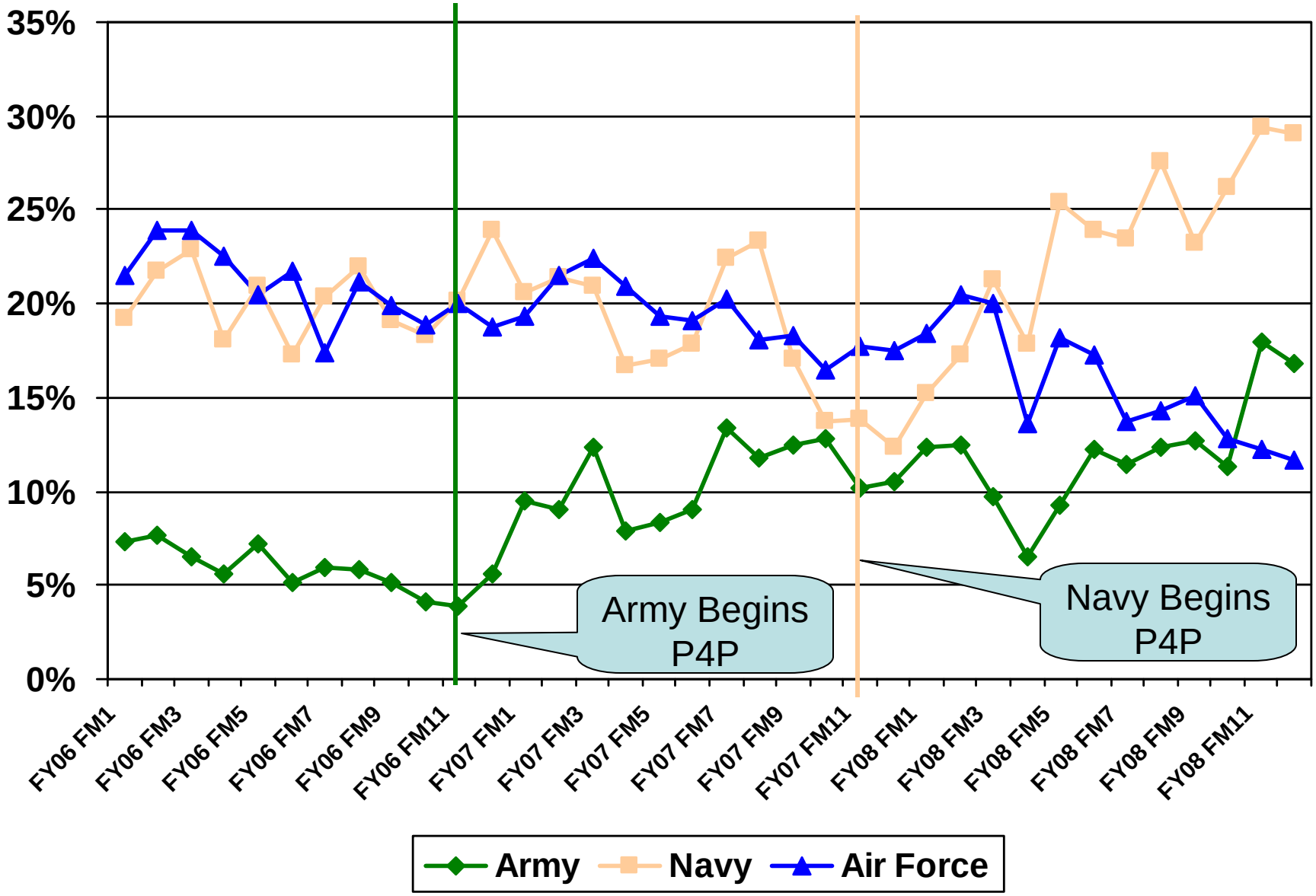
# Percentage of HEDIS Rewards Achieved (Overall)

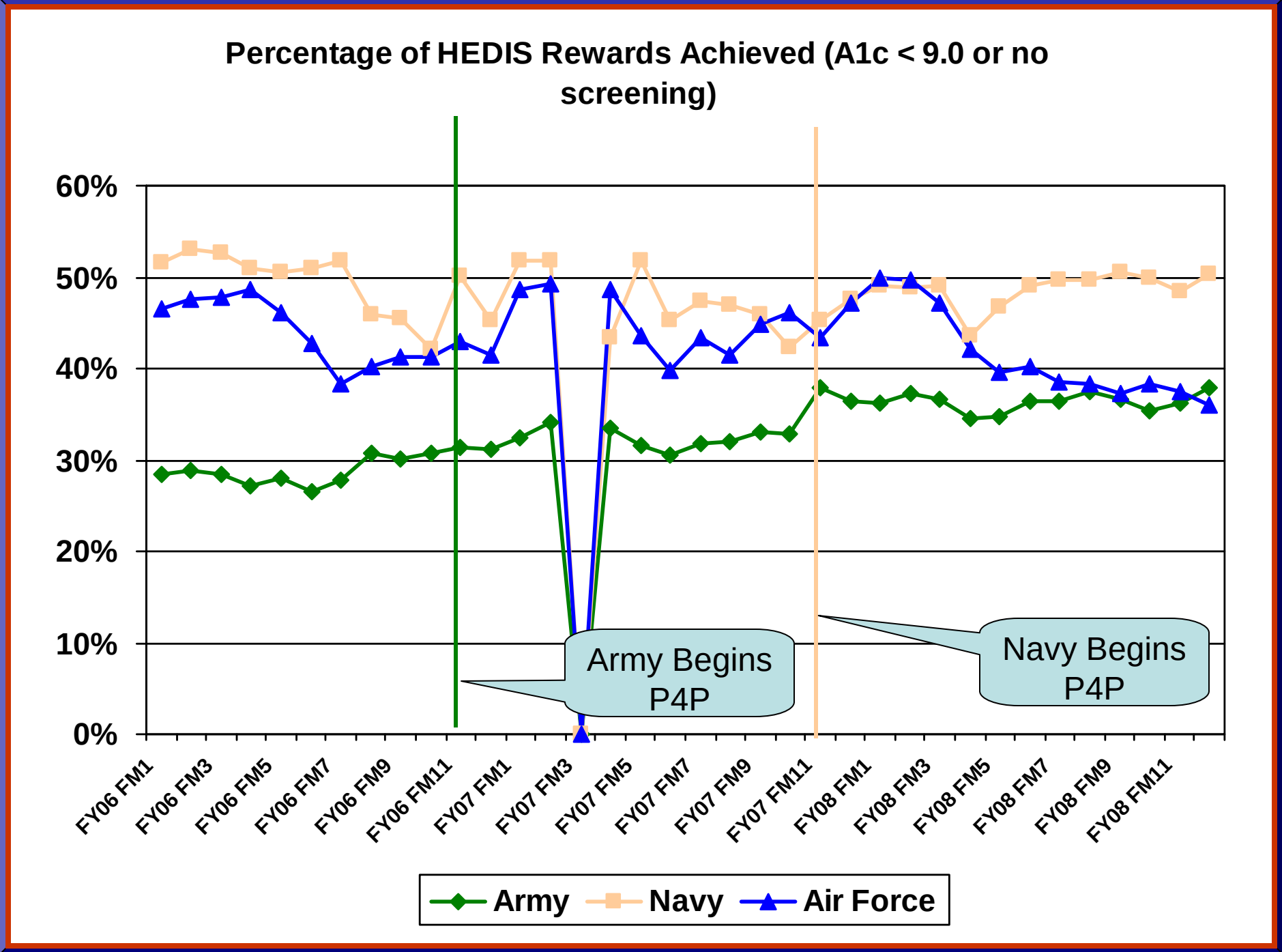


# Percentage of HEDIS Rewards Achieved (Cervical Cancer Screening)

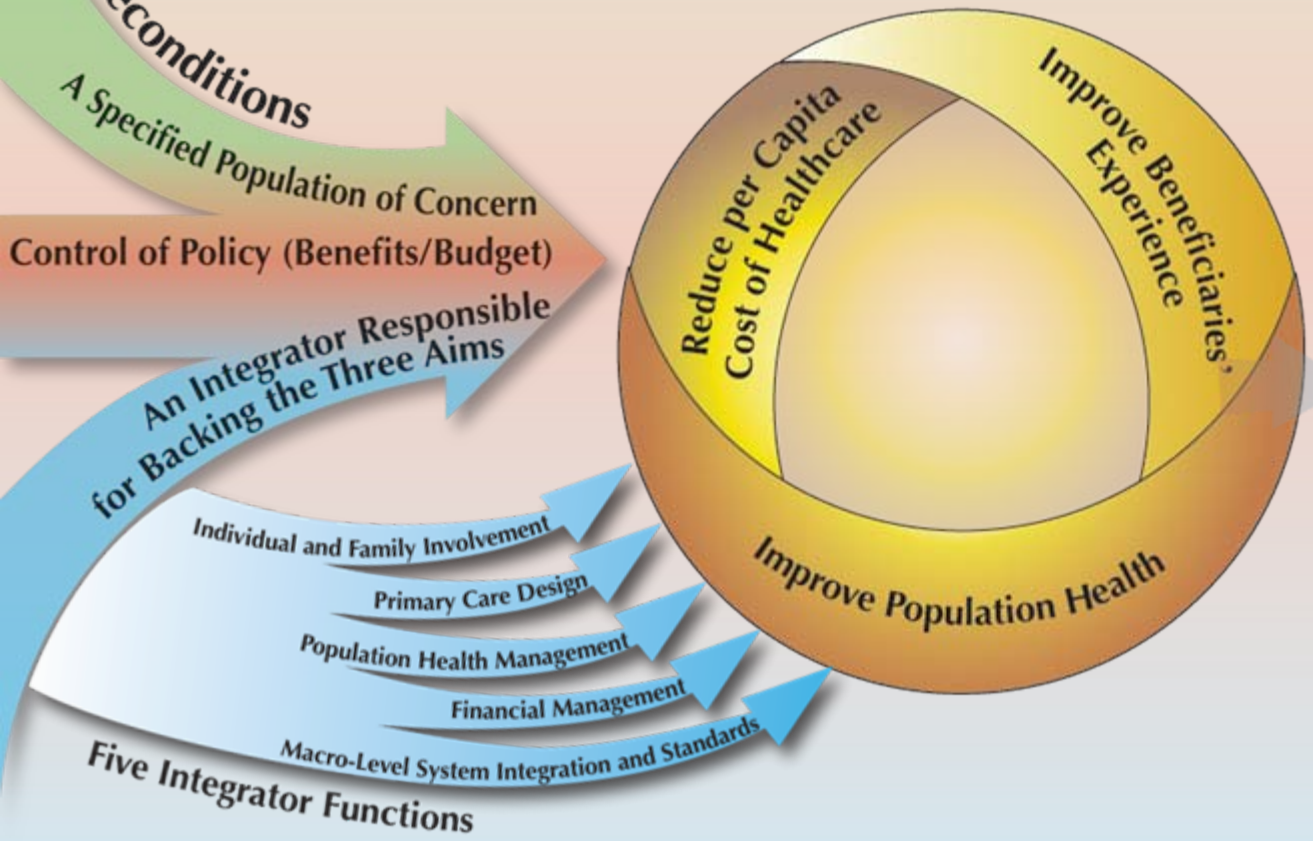


# Percentage of HEDIS Rewards Achieved (A1c Screening)




Percentage of HEDIS Rewards Achieved (A1c < 9.0 or no screening)
60%
50%
40%
30%
20%
10%
0%
FY06 FM1
FY06 FM3
FY06 FM5
FY06 FM7
FY06 FM9
FY06 FM11
FY07 FM1
FY07 FM3
FY07 FM5
FY07 FM7
FY07 FM9
FY07 FM11
FY08 FM1
FY08 FM3
FY08 FM5
FY08 FM7
FY08 FM9
FY08 FM11
Army Begins P4P
Navy Begins P4P
Army
Navy
Air Force

# Aspirational, Achievable Vision – A Fully Integrated Military Health System That Can Achieve the Triple Aim




**By focusing on the Triple Aim, the MHS will be able to**

- Improve and standardize transparent measures of quality and cost across time
- Measure and maintain accountability for population health needs and status
- Establish targets for cost
- Align payment and financing incentives to reward Triple Aim achievements
- Embrace disruptive innovations like minute clinics and the medical home



*Ref: The Triple Aim, Institute for Healthcare Improvement*

# Challenges

- **The “law of unintended consequences”**
  - Balance of access versus continuity versus quality versus cost.
  - Don’t incentivize “bad behavior”; “gaming” the system.
- **The “perfect being the enemy of the good”**
  - Start the program and the quality of data will improve
  - Start the program and the “poor” metrics will be identified
- **Where do you apply the reward?**
  - The hospital
  - The clinic
  - The individual
  - The patient
- **How do you sustain balanced performance in the long term?**
  - When to change to a new P4P focus
  - Readiness, Publications, etc