Pre-Conference I:
Pay for Performance for Newcomers

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Integrated Healthcare Association

P4P National Summit
March 9, 2009

Agenda

- Background
- Governance, Organizational Structure, Stakeholder Participation
- Setting Goals
- Selecting Measures and Level of Reporting
- Data Collection, Aggregation, and Validation
- Public Reporting
- Developing Incentives
- Funding Models
- Implementation Challenges

The Headlines from October, 1994

The Boston Globe

Spotlight

High hospital death rates

Study finds 10 facilities with above-average mortality

High Death Rates Noted At 10 Hospitals In State

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…Led to the Creation of MHQP in 1995

- **Provider Organizations**
  - MA Hospital Association
  - MA Medical Society
  - 2 MHQP Physician Council representatives
- **Government Agencies**
  - MA EOHHS
- **Employers**
  - Analog Devices
- **Two Ad Hoc Members**
- **Health Plans**
  - Blue Cross Blue Shield of Massachusetts
  - Fallon Community Health Plan
  - Harvard Pilgrim Health Care
  - Health New England
  - Neighborhood Health Plan
  - Tufts Health Plan
- **Consumers**
  - Exec. Director Health Care For All
  - Exec. Director New England Serve
- **Academics**
  - Stanley Hochberg, MD, Board Chair
  - Harris Berman, MD, Tufts Medical School

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MHQP's Performance Reporting Initiatives

- Five years of public release of physician performance of medical groups using clinical HEDIS measures
- Two statewide surveys of patient experience with PCPs and specialists, with a third survey and public release planned for 2010
- BQI pilot project creating AQA physician measures from merged database of Commercial and MA Medicare data
- Partnership with RAND to research impact of different methodology and decision rules in measuring efficiency, to evaluate reporting strategies, and to gain the perspectives of key stakeholder organizations around the utility of efficiency metrics
- Create metrics from clinical EMR data as part of MA eHealth Collaborative quality data warehouse (in partnership with CSC)

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MHQP's Brand Promise

Health care information you can trust

- MHQP provides reliable information to help physicians improve the quality of care they provide their patients and help consumers take an active role in making informed decisions about their health care.

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Achieving our Brand Promise: MHQP's Collaborative Process

- **Involving Physicians in Measurement Process**

  -Increased credibility and acceptance of end results

  -"Do it with me, not to me"

- **Aggregating Data Across Health Plans**

  -More data leading to greater validity

  -Allows reporting on more physicians

  -Avoids "dueling scorecards" or non-comparable data

- **Engagement Among Members of Broad Based Coalition**

  -Greater understanding of diverse views

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MHQP ORGANIZATIONAL STRUCTURE

MHQP Physician Council (16 Physicians Leaders)

MHQP Board of Directors

- Board Chair
- 6 Commercial Health Plan Seats
- MMS Seat
- MHA Seat
- 2 Physician Council Seats
- 2 Consumer Seats
- 1 State Seat (EOHHS)
- 1 Employer Seat
- 3 Ad hoc Seats
- MHQP Executive Director

MHQP Executive Committee

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Who is IHA?

- Statewide leadership group that promotes quality improvement, accountability, and affordability of health care in California
- IHA Membership
  - Major health plans
  - Physician groups
  - Hospital systems
  - Academic, consumer, purchaser, pharmaceutical and technology representatives
- IHA's principal projects
  - Pay-for-performance
  - Medical technology value assessment and purchasing
  - Measurement and reward of efficiency in health care
  - Health care affordability
  - Obesity prevention

California P4P Overview

- Five years of physician group measurement, reporting, and payment completed
- Common Measure Set
  - Used by all major health plans statewide
  - Performance on all measures has improved each year
- Public Report Card
  - Partner with State Office of the Patient Advocate http://opa.ca.gov/report_card/medicalgroupcounty.aspx
- Health Plan Payments
  - Over $265 M paid out to physician groups by health plans

CA P4P Participants

Health Plans:

- Aetna
- Anthem Blue Cross
- Blue Shield of CA
- Western Health Advantage
- CIGNA
- Health Net
- Kaiser*
- PacifiCare/United

Medical Group and IPAs:

- 235 groups
- 40,000 physicians

11 million commercial HMO members

** Kaiser participates in the public reporting only*

CA P4P Measurement Domains

- Clinical
  - Mostly HEDIS-based
- Patient Experience
  - Use CG-CAHPS
- IT-Enabled Systemness
  - Adapted from Physician Practice Connection
- Coordinated Diabetes Care
  - HEDIS-based and adapted Physician Practice Connection
- Appropriate Resource Use
  - Based on HEDIS Use of Services

Governance, Organizational Structure, and Stakeholder Participation

Key Questions on Governance

- Will you partner with other organizations?
- Who will have decision making authority?
- Who can provide input and how?
- When and how will you engage providers?
- Who will oversee the process?

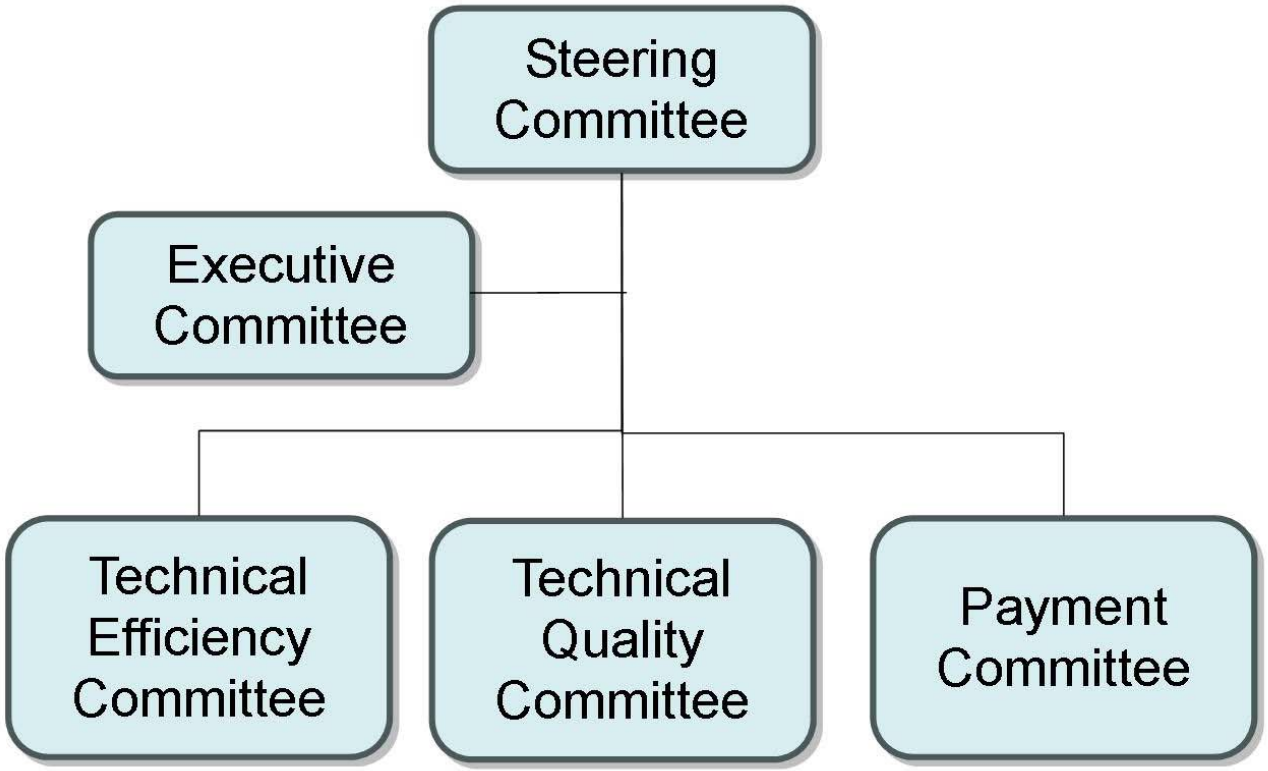
Building and Maintaining Trust

- Neutral convener
- Transparency in all aspects of program – no black box
- Governance and communication includes all stakeholders
  - Natural "tensions" between stakeholders creates accountability
  - Freedom to openly express ideas and concerns
- Data collection and aggregation done by independent third party

Gaining Buy-in

- Adoption of Guiding Principles
- Multi-step measure selection process
- Opportunity for all stakeholders to give input via public comment
- Consensus decision-making where possible
- Frequent communication via multiple channels
- Incorporate both business and clinical perspective/expertise

Pay for Performance Governance



CA P4P Governance

All Committees are multi-stakeholder

- Steering Committee – determine strategy, set policy
- Executive Committee – set agendas, priorities
- Technical Committees – develop measure set
- Payment Committee – develop payment methods
- IHA – facilitates governance/project management
- Sub-contractors
  - NCQA – data collection & aggregation; technical support
  - Thomson Reuters – efficiency measurement

CA P4P Physician Group Engagement

Program Strengths

- Physician groups are highly engaged
- 74% believe the measures are reasonable
- Widespread support for increased incentives
- Increased focus on quality improvement and IT capabilities

Program Weaknesses

- Lack of consumer interest in public reporting
- Concern about the potential for too many measures

Overall Rating - 65% rated the program as a "4" or "5" (on a 1 to 5 scale) for importance with a mean score of 3.86.

CA P4P Health Plan Engagement

Program Strengths

- Increased collaboration
- Push toward QI
- Investments in IT
- Greater accountability and transparency.

Program Weaknesses

- Improvements viewed as marginal
- Concerns about "teaching to the test"
- Lack of a positive ROI
- Failure of clinical data fed to raise plan HEDIS scores

Overall Rating - 2.5 mean score (1 to 5 pt. scale)

Setting Goals

Key Questions for Setting Goals

- What aspect(s) of health care delivery do you want to improve?
  - Clinical Quality?
  - Cost?
  - Access?
  - Infrastructure?
- What behaviors do you want to change?
- Are there particular areas or populations you want to focus on?
- Which physicians will be included?

Key Questions for Setting Goals

- What philosophy will your program have?

"DARWINIANS"

- "Survival of the Fittest"
- Set the bar high
- No breakthrough improvement without pushing
- Make thresholds more difficult over time
- Poor performers will (should) get consolidated

"SOCIAL DEMOCRATS"

- "A rising tide lifts all boats"
- Broad participation is important
- Set achievable goals to start
- Reward improvement as well as performance
- Technical assistance to help all groups succeed

Key Questions for Setting Goals

- What are your desire outcomes?
  - Results: need to be defined, quantifiable
  - Output: reports, tools, etc.

Goal of CA P4P: To create a compelling set of incentives that will drive breakthrough improvements in clinical quality and the patient experience

- What is "breakthrough"? Double-digit percentage point increase? Top quartile nationally? Timeframe?
- What about cost of care?

The Various "Business Cases"

- Physicians and Physician Groups
  - Valid and reliable performance feedback (and recognition)
  - Reduce reporting by multiple health plans of fragmented and contradictory performance information
  - Align high quality care with financial rewards
- Health Plans
  - Understand which incentives work and which don't
  - Satisfy purchaser demands for provider differentiation
  - Provides reciprocal ROI in competitive, non-exclusive systems
- Employers/Purchasers
  - Value for higher premiums
  - Complement to consumer choice and tiered benefit designs
- Employees/Consumers
  - Data to guide selection of high performing providers
  - Improved care and better outcomes

Balancing Stakeholder Needs

- Physician groups want:
  - Higher payments to fund investments
  - Slower expansion of measures
  - Transparency of payment methods
- Health plans want:
  - Demonstrated ROI in terms of:
    - Improved HEDIS and CAHPS scores
    - Addition of outcomes, misuse, overuse, efficiency measures
- Purchasers want:
  - Systemic improvement vs. “teaching to the test”
  - Demonstration of value

Selecting Measures and Level of Reporting

Use of Standardized Measures

Why?

- Based on scientific evidence
- Valid (accurately representing the concept to be measured)
- Precise (showing real differences in provider performance)
- Fully specified
- Reproducible
- Comparable across locations
- Can eliminate conflicting performance reports

Use of Standardized Measures

Sources:

- NCQA
- NQF
- AQA
- PCPI
- ICSI (Minnesota)

Issues with Standardized Measures

- No single standard
  - Multiple similar measures with slightly different specifications
- May not be ready for "prime time"
  - Not field tested
  - Not specified to sufficient level
  - Not applicable to different population

CA P4P Measure Selection Framework

1. **Importance:** Measuring something that matters for our population
   - significant financial and health impact
   - where significant variation exists
2. **Scientific Acceptability:** Based on medical evidence that's been weighed by a respected multi-stakeholder organization
3. **Feasibility:** Measurable by the health plans and POs, using a feasible data source
   - Can the measure be produced from electronic data sources?
4. **Usefulness:** Ability to work in the P4P environment
   - Applicable to large enough population in most POs to be statistically meaningful
   - Able to be improved by POs based on the California delivery system
   - Align with health plan measurement and improvement efforts
   - Specified sufficiently
   - Indicate room for improvement and variability across POs

The Tendency to "Tweak & Spiff"

"We only want to use well vetted, nationally accepted, standardized measures

BUT

let's just make this one little improvement ..."

Example: Potentially Avoidable Hospitalization

Overcoming the Tendency to "Tweak & Spiff"

Only make change:

- If there is something unique to CA or PO-level measurement
- After testing the measure to assess whether change is really needed

When Standardized Measures Don't Exist

Options:

- Wait for measures to be developed
- Work with measure experts to develop measures
- Use non-standard measure in use elsewhere

Example: Depression Management in Primary Care

Promoting Systems Approach in CA P4P

- Created Coordinated Diabetes Care Domain to focus attention on redesign needed to drive breakthrough improvement
- Considering use of multiple chronic care measure domains or comprehensive clinical measurement systems (e.g., Rand QA Tools) to encourage systemic improvements vs. “teaching to the test”

Data Collection, Aggregation, and Validation

Data Sources, Collection, Validation, & Aggregation

- Sources
  - Health plan encounter data
  - Provider reported data
  - Other electronic databases
  - Chart review
  - Member reported data
- Collection
  - Raw Data
  - Results
- Validation
  - Require external validation? How rigorous? Formal audit?
  - Use health plan internal validation of data?
- Aggregation
  - Opportunity to combine data across plans and/or product lines?
  - Who aggregates data?

The Data Problem

The data you want:	Claims Data	Paper Medical Record	Electronic Medical Record
• Easy to collect	Y	N	Y?
• Clinically rich	N	Y	Y
• Complete and consistent	N	Y?	Y
• Across product lines/payors	N	Y	Y
• Whole eligible population	Y	N	Y

Electronic only data collection limits clinical measurement

- Administrative data is not sufficient for meaningful clinical measurement
- Electronic clinical data has many sources other than an EHR (e.g., registries)
- The use of electronic data is a "forcing function" for better data collection and exchange
- The pace of P4P will be determined by the pace of health IT (and vice-versa)

Addressing the Data Problem

Enhancing claims data

- Identify and address data gaps
- Encourage use of CPT-II codes
- Develop supplemental clinical data
  - Lab results
  - Preventive care / chronic disease registries
  - Exclusion databases
- Push EMR adoption

Addressing the Data Problem

Data for retrospective measurement

vs.

Data for quality improvement

vs.

Data for decision support at the point of care

Validation / Audit of Data

- Ensures consistency of calculation and accuracy of results
- Intended use and available resources determine level of validation
  - Internal vs. external review
  - Sample vs. full validation
- Feed back submitted results to providers for validation prior to finalizing

Aggregating Data

Benefits:

- Increase sample size
  - More reportable data
  - More robust and reliable results
- Measure total patient population
- Produce standardized, consistent performance information

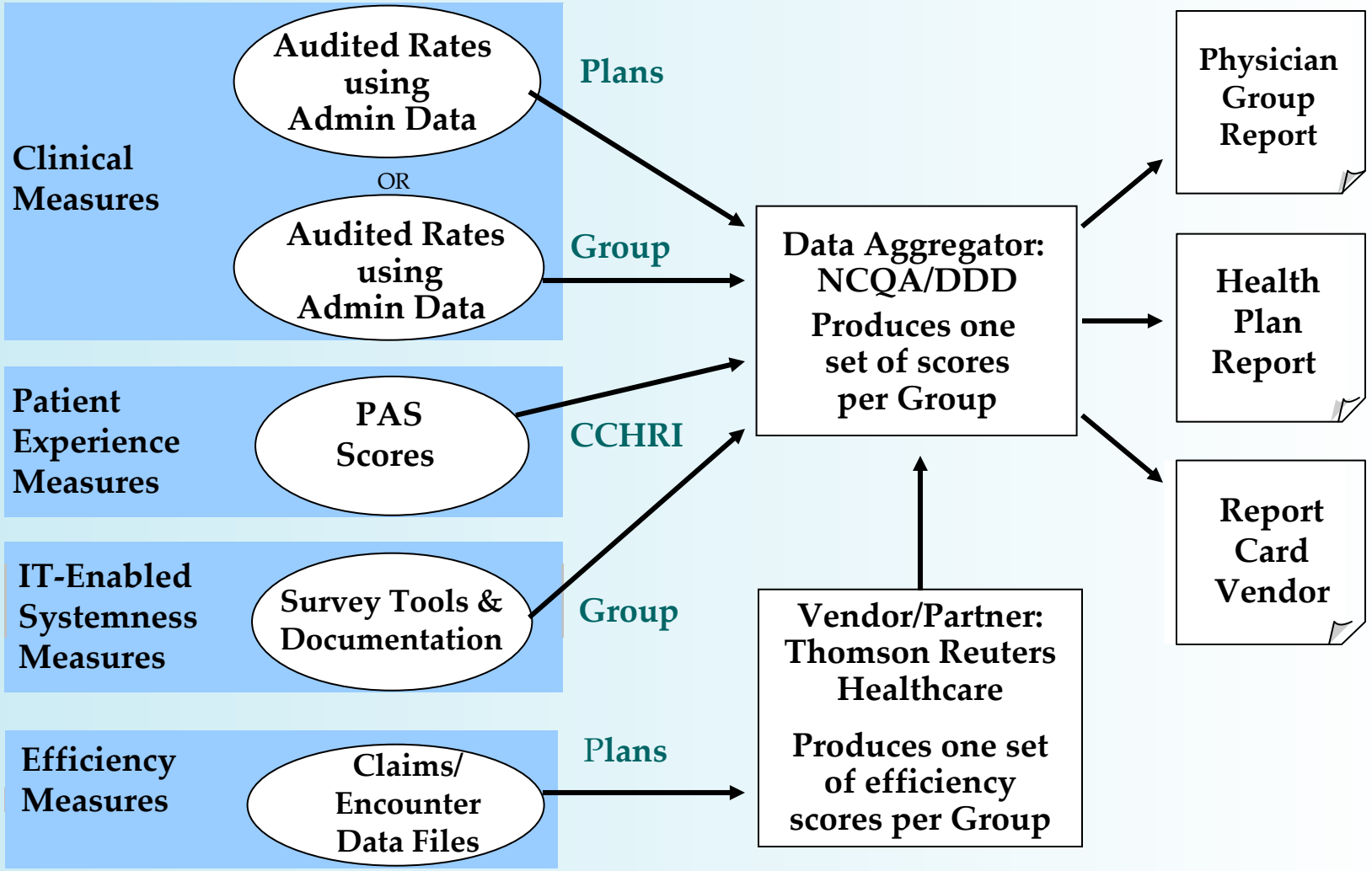
Requirements:

- Consistent unit of measurement
- Standard, specified measures

CA P4P Approach

- Data Sources
  - Only allow electronic data for full eligible population
  - Health plan data is supplemented by physician group self-reporting
- Data Collection
  - Plans and groups calculate measure results and submit numerator, denominator, rate
- Data Validation
  - All data / results must be audited by an NCQA-certified auditor
  - Plan reported results are shared with groups for validation prior to aggregating
- Data Aggregation
  - Combine results across plans to create a total patient population for each physician group

CA P4P Data Collection & Aggregation



Approaches to Data Aggregation

- Aggregate results (i.e. HEDIS measures by physician)
- Aggregate claims data
- Aggregate clinical EHR data
- Aggregate claims and clinical EHR data

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Challenges with Aggregating Claims

- Extremely Time Consuming
  - Data Use Agreements alone can take months to execute
- Expensive
- Methodological Complexity
  - E.g. Attribution of Patients to Physicians
    - Several ways and little strong empirical research to suggest any one way is the best

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Four Steps of Data Aggregation
(aggregating results)

1. Create master physician directory to aggregate data across plans
2. Link the HEDIS data across health plans
3. Aggregate HEDIS data for each physician and calculate performance rates
4. Aggregate physician scores to the group level

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1. Create a Master Physician Directory (MPD)

- Matched MD files from Plan A & Plan B
  - Unique identifiers (MA license number & UPIN)
  - Names, addresses, Folios, Bd. of Reg.
- Matched file from Plan C to the combined Plan A & B file; Plan D to combined A-C file; Plan E to combined A-D file
- Final reconciliation with Board of Registration file to verify mismatched license #s and add clinical specialty
- Started with 27,000 records from 5 plans & ended with 12,000 unique physicians;~5,800 of whom had HEDIS data

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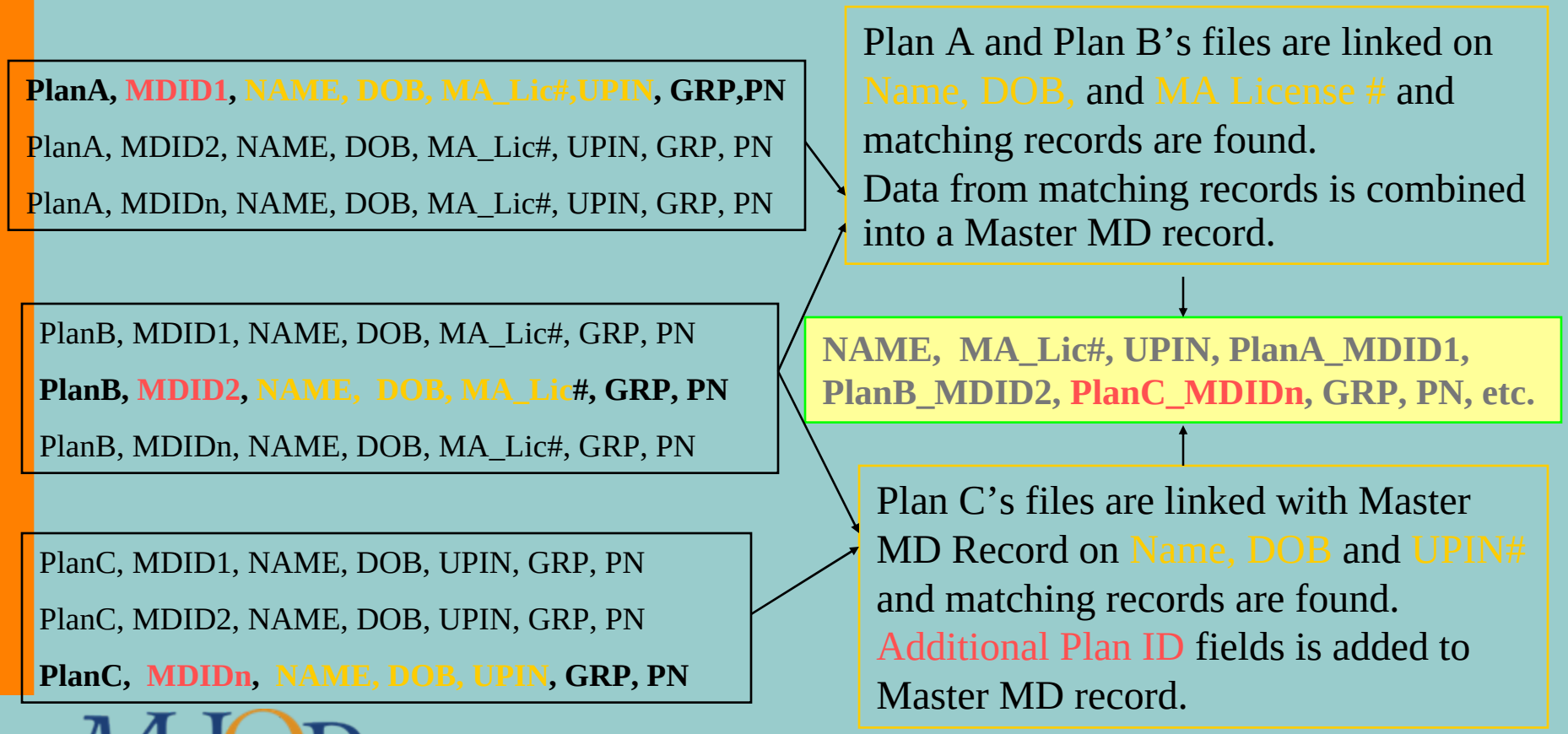
Create a Master Physician Directory (MPD)



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2. Link the HEDIS Data Across Health Plans

- Each MD record on MPD has a unique MHQP ID plus one or more health plan ID
- Using the plan ID on the HEDIS record, we matched each record to the MPD
- The MHQP ID was added to each HEDIS record and used to link all health plan records for the same MD

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Link the HEDIS Data Across Health Plans

Raw HEDIS Records

MPD Records

Plan A, MDID15, Meas1_num, Meas1_den, Meas2_num, Meas2_den …
Plan A, MDID46, Meas1_num, Meas1_den, Meas2_num, Meas2_den …
Plan A, MDIDn, Meas1_num, Meas1_den, Meas2_num, Meas2_den …

MHQP_ID76, MA license #, PlanA_MDID15, PlanB_MDID26, PlanC_MDIDn …
MHQP_ID77, MA license #, PlanA_MDID46, PlanB_MDID34, PlanC_MDIDn …

Linkable HEDIS Records

MHQP_ID76, Plan A, MDID15, Meas1_num, Meas1_den, Meas2_num, Meas2_den …
MHQP_ID77, Plan A, MDID46, Meas1_num, Meas1_den, Meas2_num, Meas2_den …

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Repeat for each health plan's HEDIS file and use MHQP ID to link data across plans

3. Aggregate HEDIS Data for Each MD & Calculated Performance Rates

- Some HEDIS scores were calculated solely with administrative data
- Other HEDIS measures were augmented by chart reviews
- For each MD, applied plan-specific Adjustment Factors to plan-specific numerators for measures where a plan had done chart reviews.
- Summed the adjusted numerators and denominators for each MD across plans using the MHQP ID and calculated *adjusted performance rates*

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4. Aggregate MDs Scores to Group Level

- 16,471 physicians are affiliated with MPD practices - 1/3 PCPs, 2/3 Specialists (1% hospitalists)
- 2,245 physicians are affiliated with multiple practices
- 3,386 practices in 211 medical groups
- 1,852 (55%) network-affiliated practices (12,208 physicians)
- 1,534 (45%) practices in independent medical groups (6,904 physicians)

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Enhancing the Group Assignments

- **Plan data & rosters from Physician Council**
- **Physician groups reviewed physician assignments in reports**
- **Web-based review**

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Selecting Level of Reporting

- If not reporting at physician level, need to map physician to appropriate practice site, medical group or network
- Administrative data do not support accurate mapping of physicians to groups
- There are no common definitions or structures of medical groups

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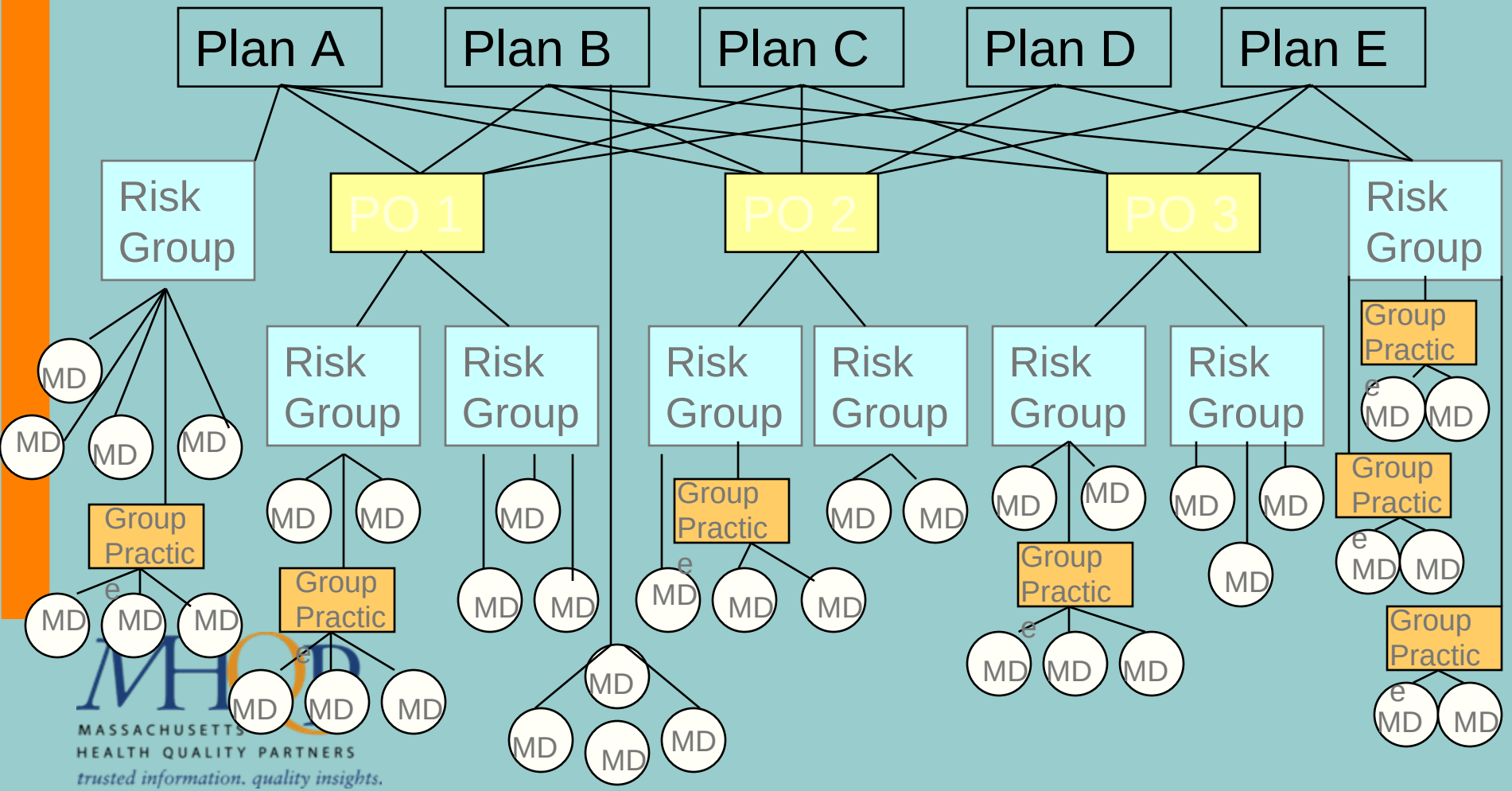
Reporting Levels Should Align with Physician Affiliation Structures



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MHQP's Master Physician Directory

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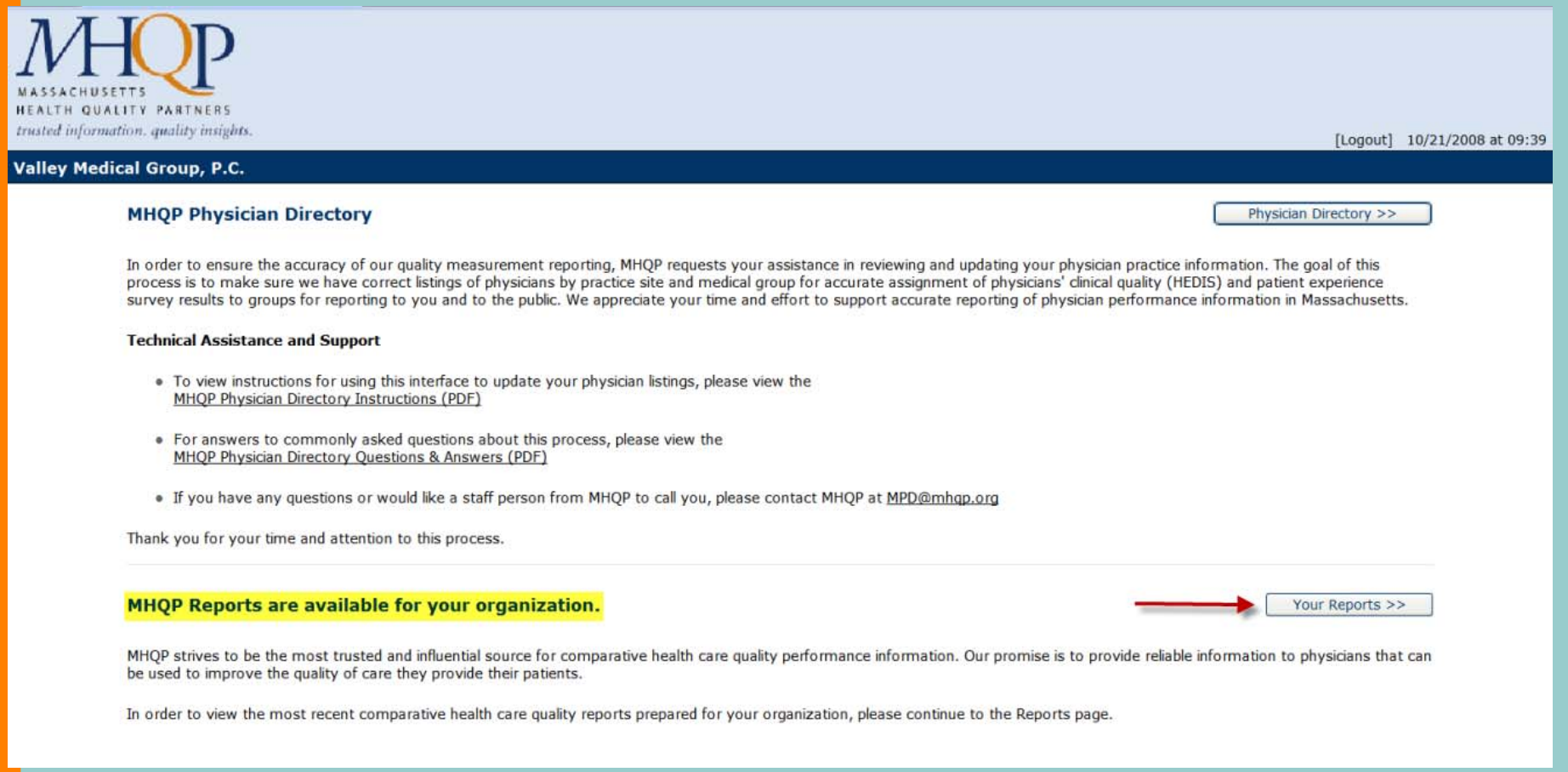

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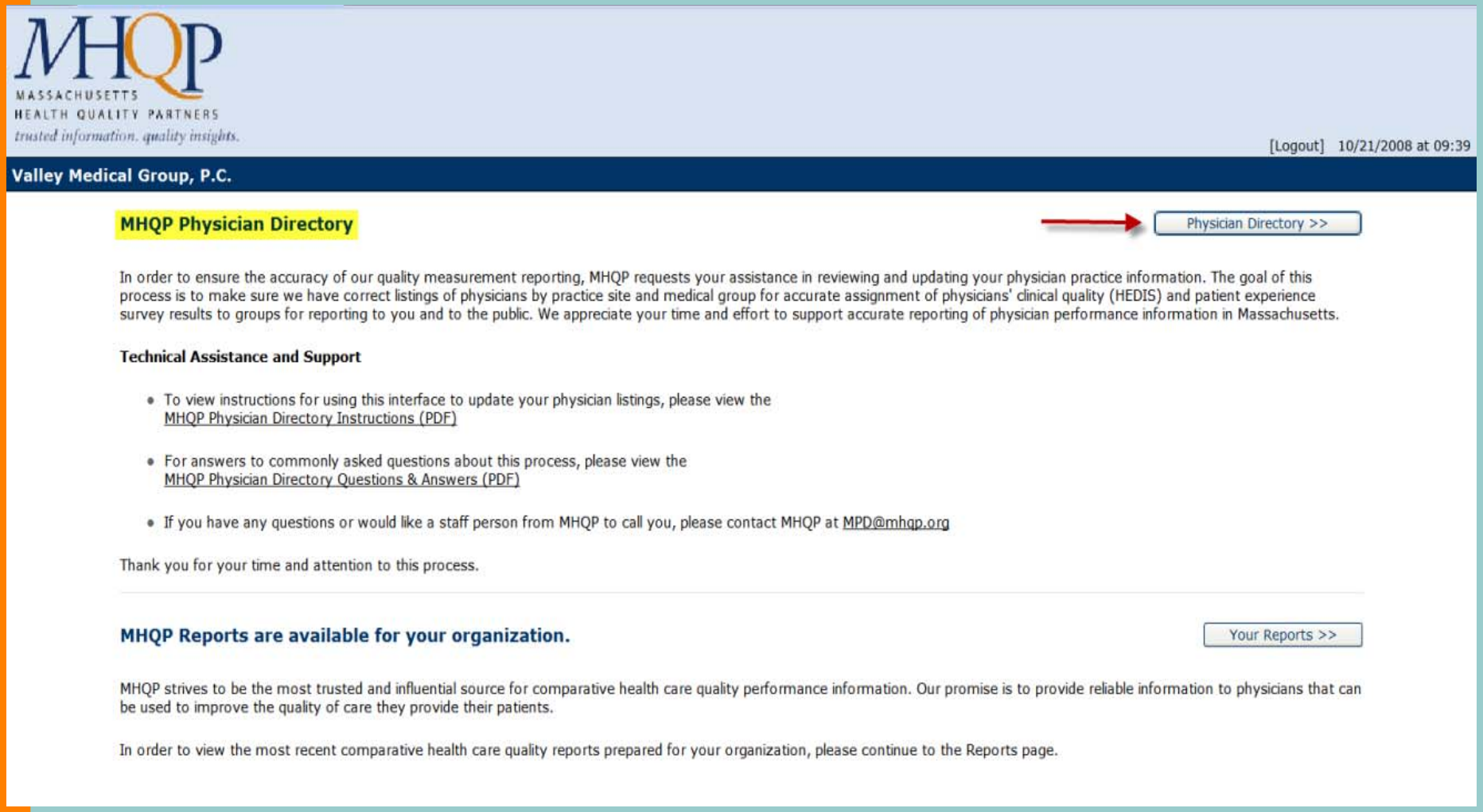

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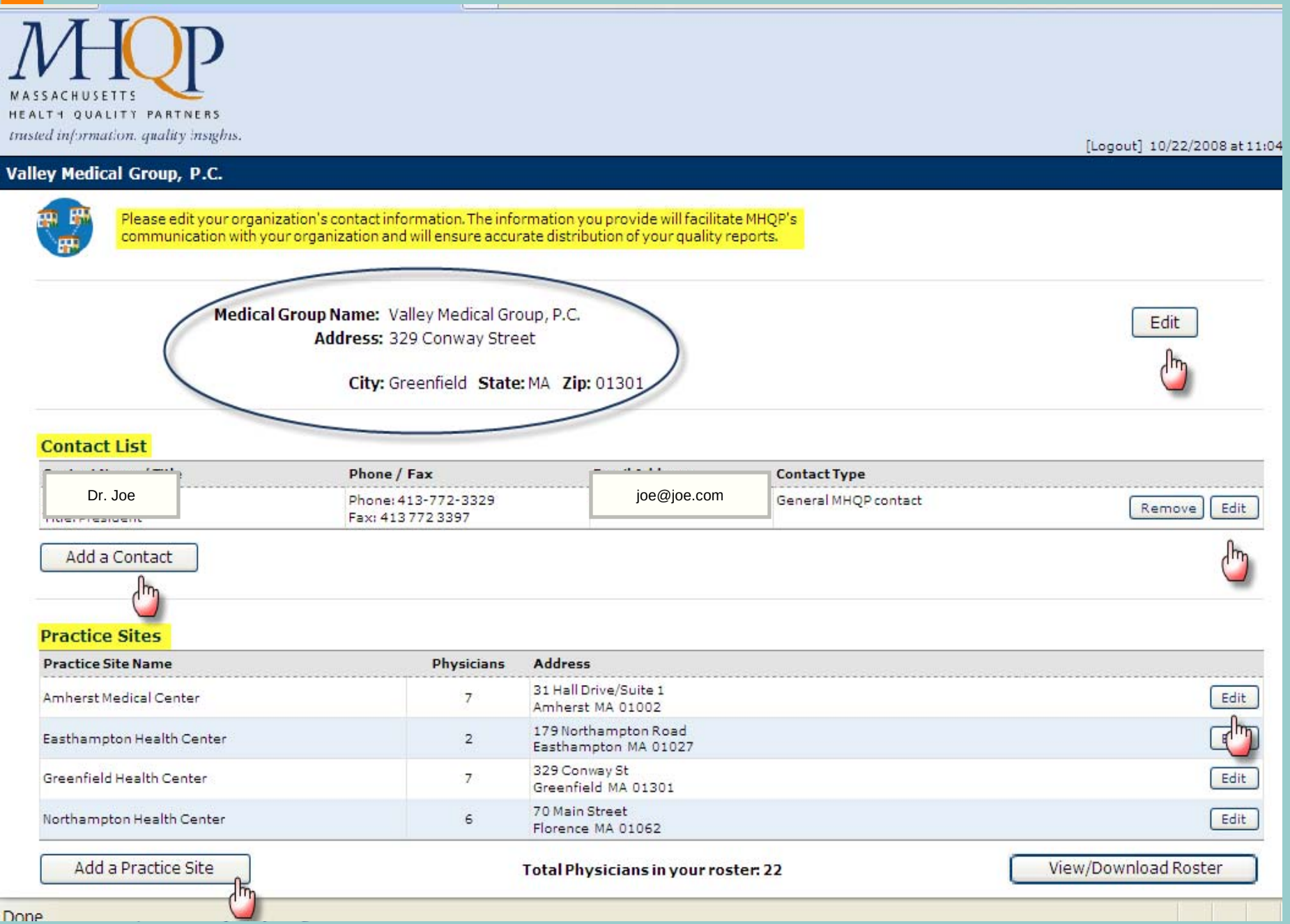
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[Logout] 10/22/2008 at 11:04
Valley Medical Group, P.C.
Please edit your organization's contact information. The information you provide will facilitate MHQP's communication with your organization and will ensure accurate distribution of your quality reports.
Medical Group Name: Valley Medical Group, P.C.
Address: 329 Conway Street
City: Greenfield State: MA Zip: 01301
Edit
Contact List
Phone / Fax
Contact Type
Dr. Joe
joe@joe.com
Phone: 413-772-3329
Fax: 413 772 3397
General MHQP contact
Remove
Edit
Add a Contact
Practice Sites
Practice Site Name
Physicians
Address
Amherst Medical Center
7
31 Hall Drive/Suite 1
Amherst MA 01002
Edit
Easthampton Health Center
2
179 Northampton Road
Easthampton MA 01027
Greenfield Health Center
7
329 Conway St
Greenfield MA 01301
Northampton Health Center
6
70 Main Street
Florence MA 01062
Add a Practice Site
Total Physicians in your roster: 22
View/Download Roster
Done

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[Logout] 10/22/2008 at 11:18

Practice Site: Amherst Medical Center

Please edit your practice site's contact information and physician roster. The information you provide will facilitate MHQP's communication efforts with your practice site, and ultimately improve the accuracy of your quality reports.

Practice Site Name: Amherst Medical Center
Address: 31 Hall Drive/Suite 1
City: Amherst **State:** MA **Zip:** 01002

Edit

Contact List

Contact Name / Title	Phone / Fax	Email Address	Contact Type
There are no contacts currently listed. Click 'Add a Contact' below to add contact information.			

Add a Contact

Return to Practice List

Practice Site Physicians

	Physician Name	DOB	MA License	All Specialties	Role at Practice	
1.	BAECHER, PAUL S	1/25/1954	80699	Family Practice, Geriatrics	Primary Care Physician	Remove Edit
2.	Chipkin, Stuart R	11/01/1956	52718	Endocrinology	Specialist	Remove Edit
	Dr. Fred	10/01/1947	11111	Family Practice	Primary Care Physician	Remove Edit
	Dr. George	11/24/1955	22222	Internal Medicine	Primary Care Physician	Remove Edit
	Dr. Bob	7/26/1969	33333	Internal Medicine	Primary Care Physician	Remove Edit
	Dr. Laura	7/04/1940	44444	Family Practice	Primary Care Physician	Remove Edit
	Dr. Susan	7/24/1956	55555	Internal Medicine	Primary Care Physician	Remove Edit
	Dr. Judy		66666			
	Dr. Allan		77777			

Return to Practice List

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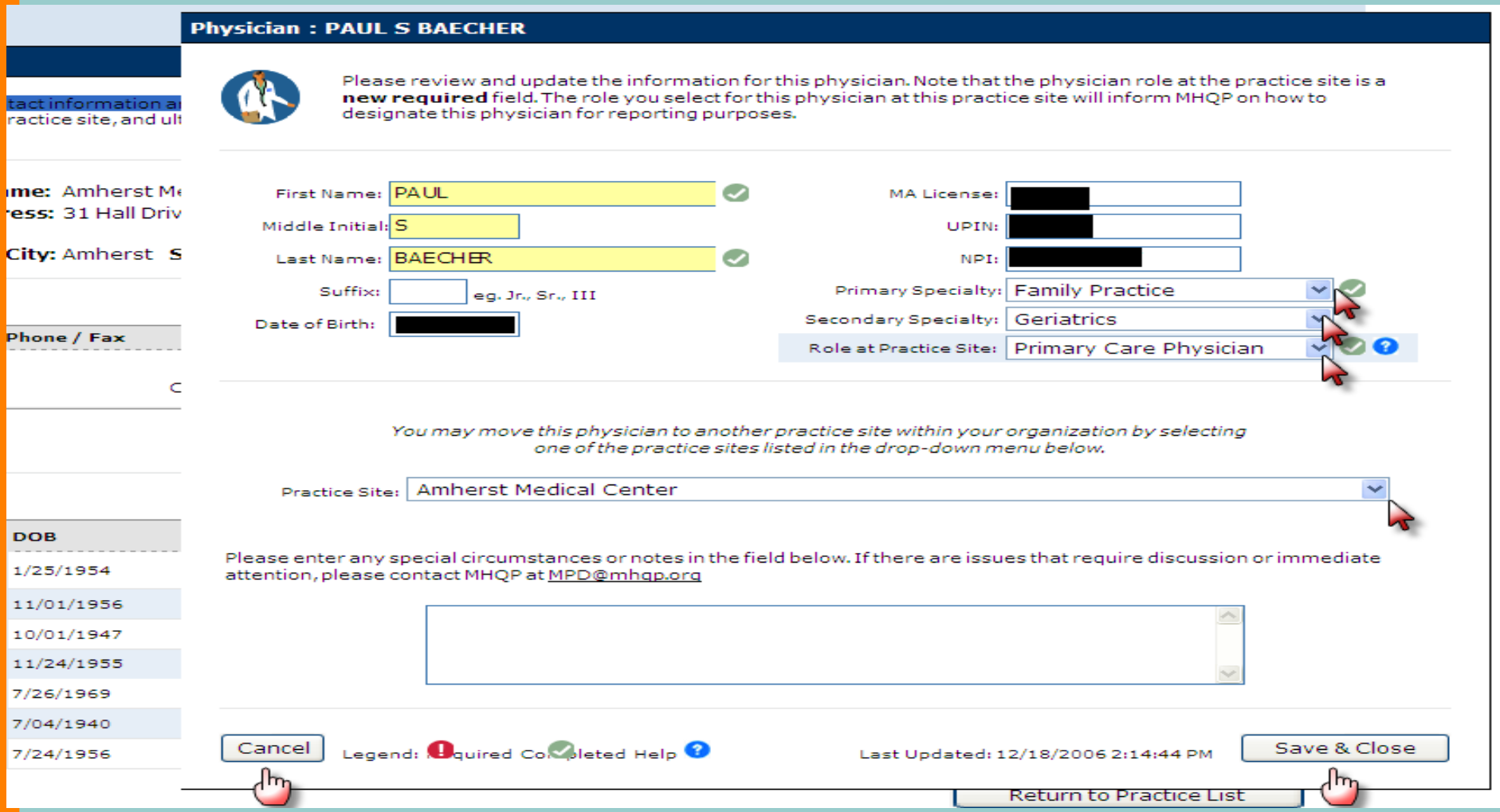

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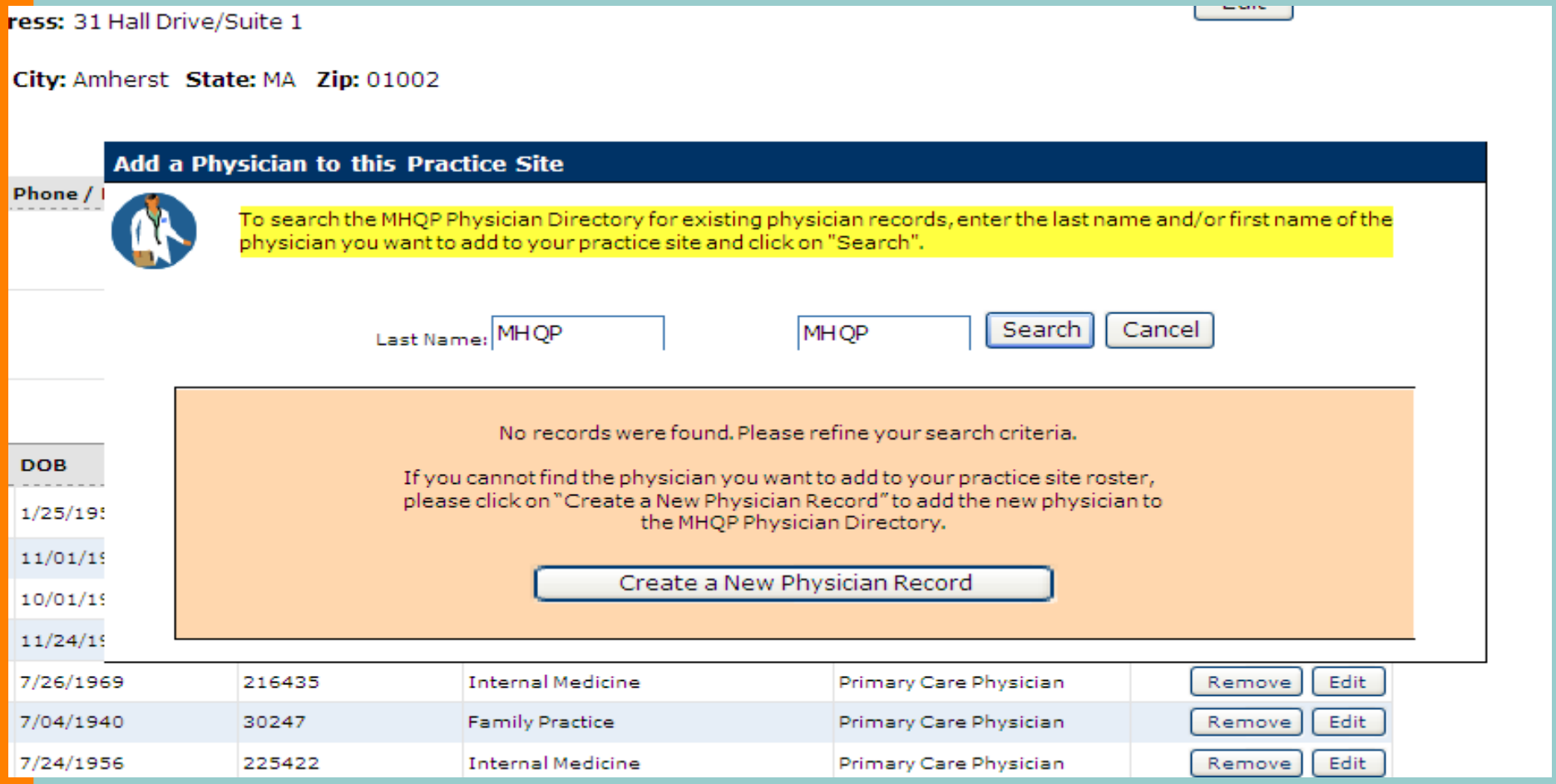

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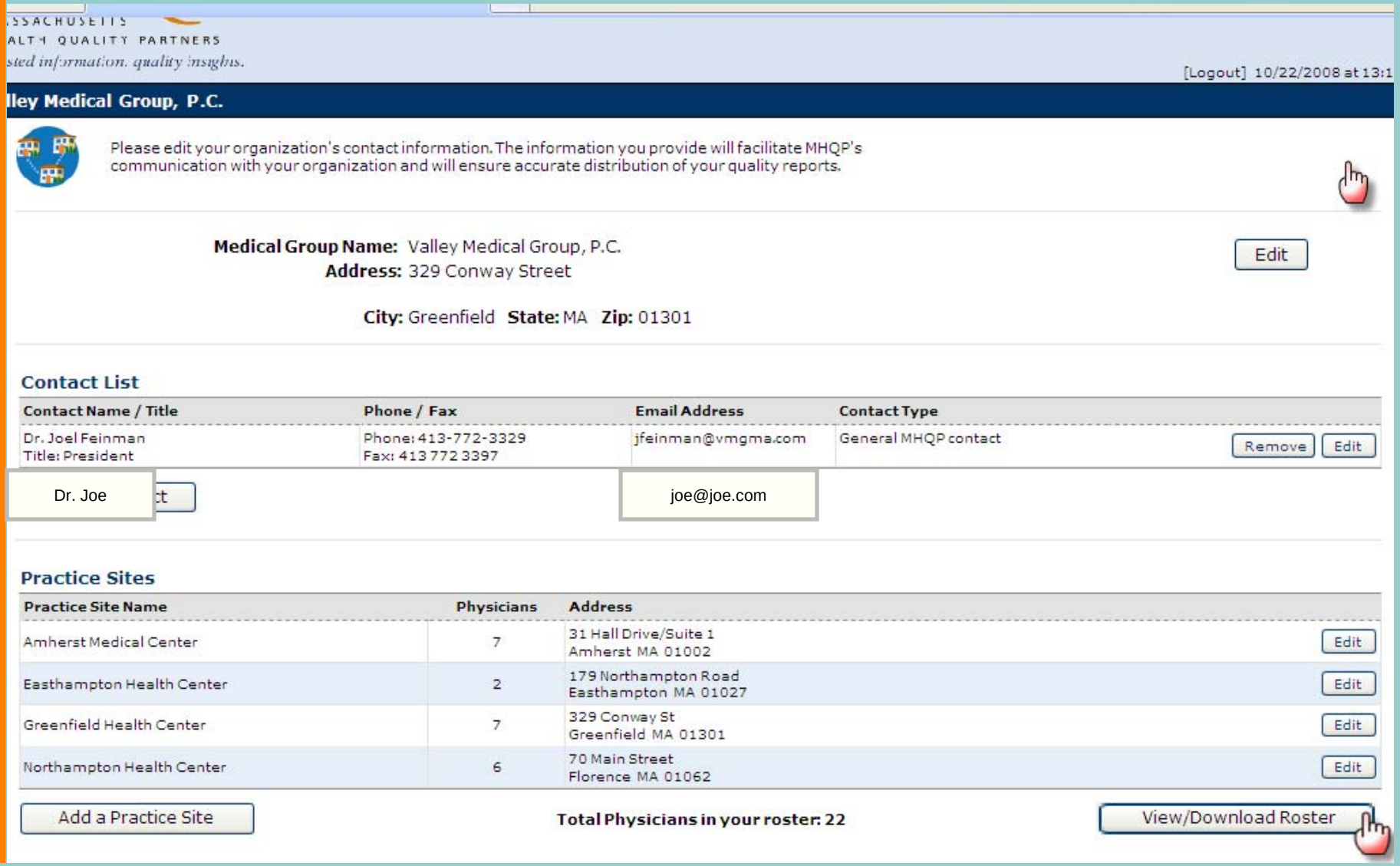

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Public Reporting Clinical and Patient Experience Results

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MHQP Physician Reports

MHQP provides private Commercial and Medicare Managed Care reports at the following levels:

- Comparison of results for 10 large physician networks - unblinded copy sent to each network
- Comparison of results for each network's affiliated medical groups – unblinded copy sent to network; each medical group gets a blinded copy with only its own results unblinded
- Comparison of results for all independent (i.e. no network affiliation) medical groups in a given geographic region – to each independent medical group within the region with the specific medical group's own results unblinded
- Comparison of results for practice sites within each medical group unblinded – to the medical group (and its network if affiliated with a network).

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Physician Network D

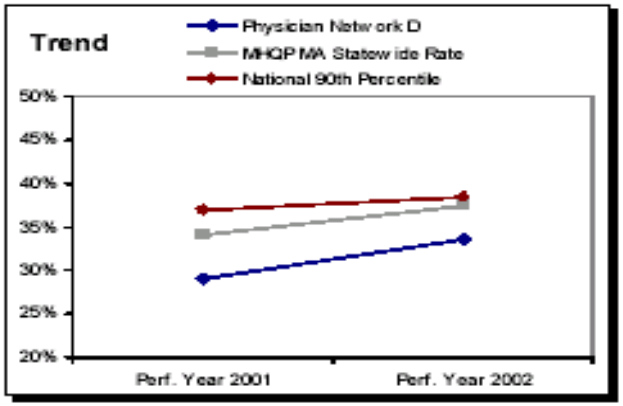
HEDIS 2003 Commercial Products

Chlamydia Screening in Women Ages 16 to 20

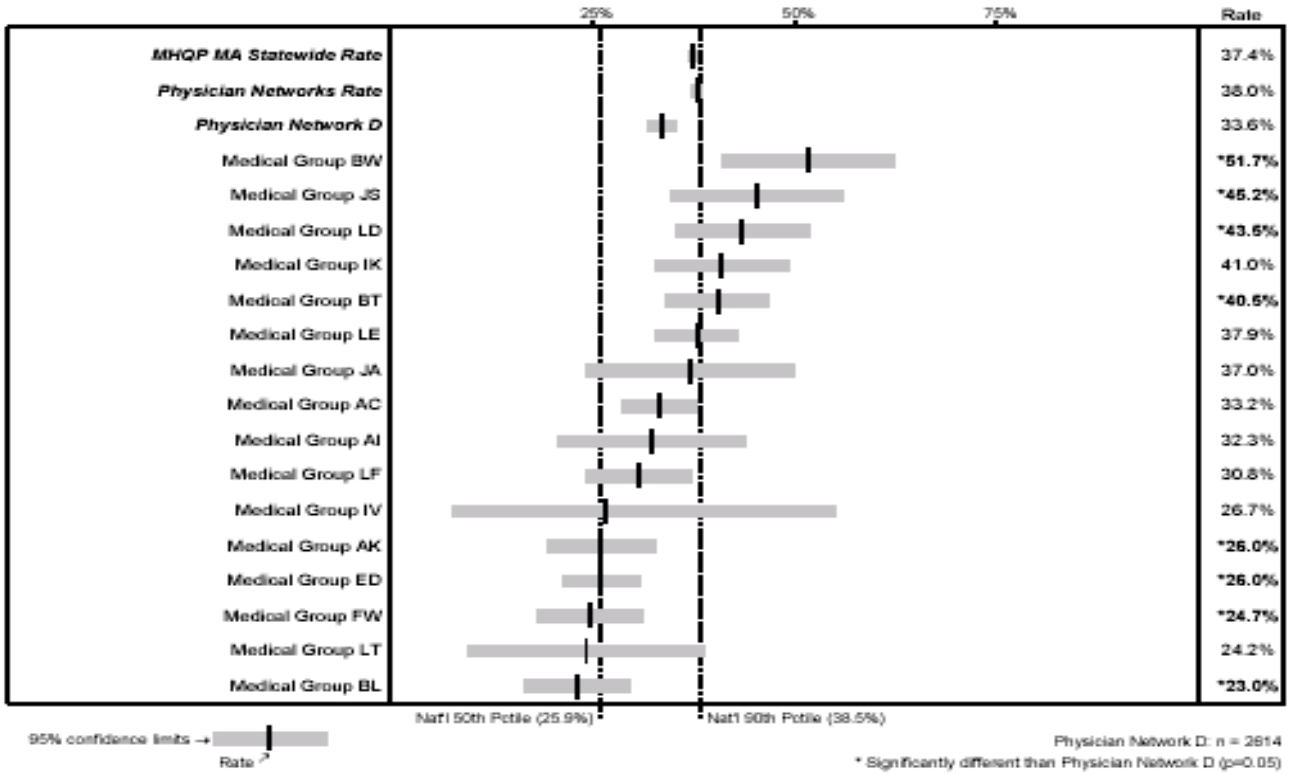
Description of Measure: The percentage of women, ages 16 to 20, who were members of one of the five participating health plans, had claims-based evidence of sexual activity and received a test for chlamydia during the measurement year.

Clinical Impact: About 40% of women with untreated chlamydia infections develop PID. Twenty percent of those who develop PID become infertile and 9% have a life-threatening pregnancy. There is an association between chlamydia infection and cervical cancer. Up to 75% of infected women are unaware of their chlamydia infection because there are no discernable symptoms. Unaware and untreated, they remain infected and contagious.

The costs of treating the consequences of untreated chlamydia are enormous. The CDC estimates that every dollar spent on chlamydia testing and treatment saves $12 in complications arising from untreated chlamydia. High cure rates can be achieved at a very low cost ($2-$8).



Percent of women ages 16-20 having claims-based evidence of sexual activity who received a test for chlamydia during the measurement year



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QUALITY INSIGHTS: PATIENT EXPERIENCES IN PRIMARY CARE

Begin By Selecting Massachusetts Doctors' Offices...

By distance from a particular zip code:

Find doctors' offices within
5 miles of zip code: Go

Office type: Adult Medicine Pediatrics Both

By name of a medical group:

Enter medical group name: Go

Office type: Adult Medicine Pediatrics Both

By name of a doctors' office:

Enter doctors' office name: Go

Office type: Adult Medicine Pediatrics Both

By name of a doctor:

Enter doctor's last name: Go

Office type: Adult Medicine Pediatrics Both

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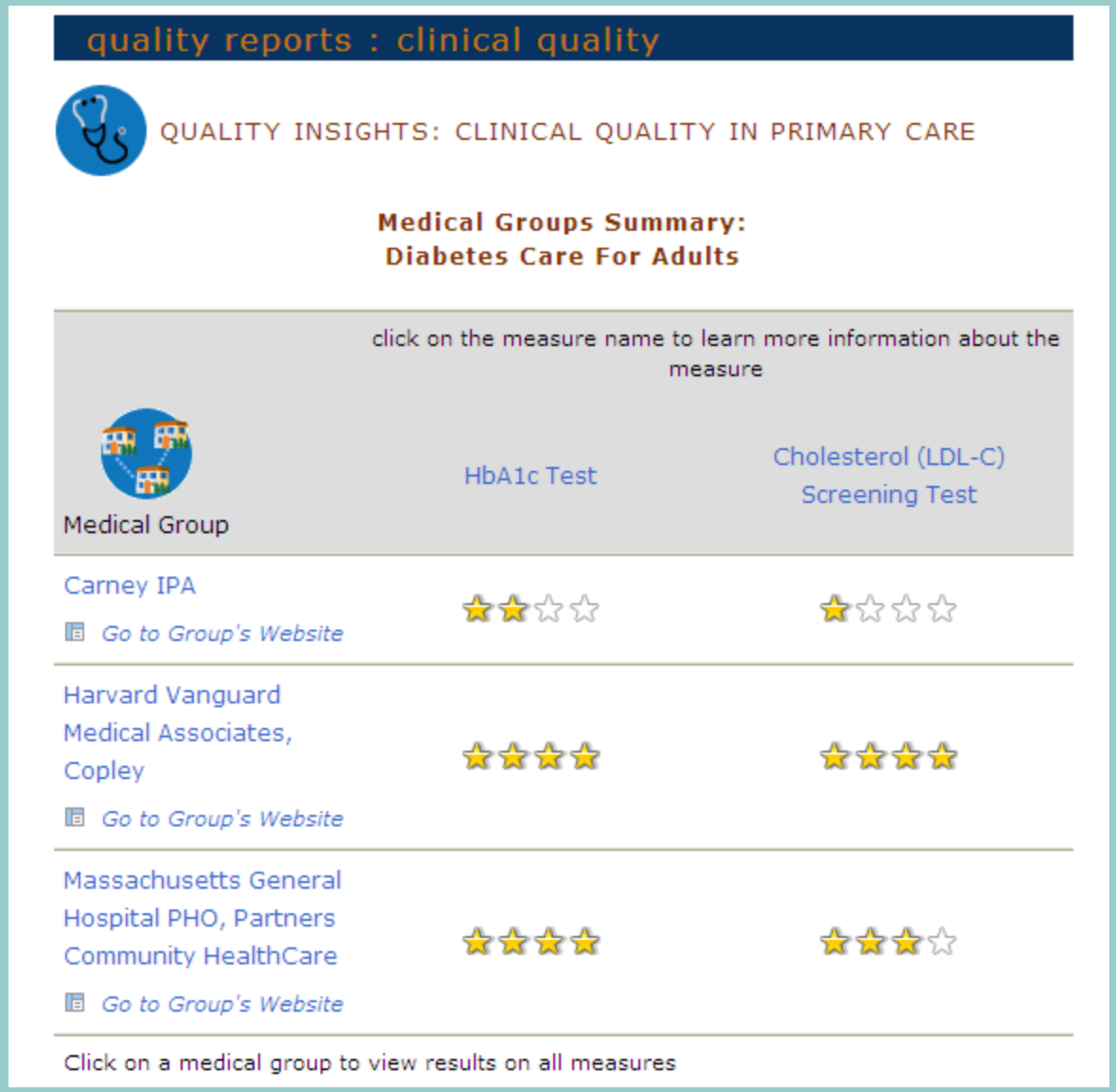

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The Headlines from February 3, 2005

Mass. doctor networks rated high in quality-of-care study

Harvard Vanguard, Partners, Lahey lead state in group's report

By Scott Allen
GLOBE STAFF

Doctors at Harvard Vanguard Medical Associates came out on top in the state's most ambitious physician report card, making highest among major physician networks in seven of 16 measures, from treating depression to screening women for sexually transmitted disease.

Two other physician networks, Partners Community Health Care and Lahey Clinic, were close behind in the ratings.

The report card, based on claims data provided by insurance companies, found that all nine networks that were rated consistently provide care well above the US average, and more often than not, in the top 10 percent. Nonetheless, the authors at Massachusetts Health Quality Partners hope that publishing detailed quality measures on the Internet will pressure physician groups to improve in areas where they lag behind their local peers.

"Our physicians are very competitive, so if they see they are not at the top, that's a big motivator," said Barbra Rabson, executive director of Health Quality Partners, a 10-year-old group composed of doctors, hospitals, insurance plans, and other medical interests.

The report card is unlikely to help individual patients select a primary care doctor, in part because it focuses on the performance of large organizations with hundreds of physicians scattered over multiple locations.

Many measures reflect less on doctors' skill than on how well organized the network is to provide long-term follow-up, such as ensuring that people with diabetes get annual eye exams.

DOCTORS, Page E4

DR. GROUP RATINGS ARRIVE

Practitioners wary as individual rankings up next from partnership

By JENNIFER KELLY POWELL

Just how good is your doctor? A Bay State group is making a crucial move today to help you find out.

The Massachusetts Healthcare Quality Partnership is releasing the first ever statewide rating of doctors' groups — a periodic tax similar report on doctors' practices.

The underlying goal is to improve overall health care quality, group leader Barbra Rabson said.

"This is an opportunity for us to say, 'What's going on here?'" she said.

It does so by showing doctors how they stack up against one another, alerting them to areas in which they may need to improve. It also allows consumers to choose their doctors based on quality, giving doctors an incentive to improve.

"We want to get those competitive juices flowing," Rabson said.

The report has been years in the making.

It doesn't give an overall score, but shows how doctors' groups stack up against one another and the national average in providing recommended services to patients. It's available online at mhqp.org/mhqpreport.

"It's an important start," said John McDonough, [illegible] for All-child. "The truth is that these kinds of analyses are very helpful in allowing provider performance."

The concept of rating doctors has proved controversial because of the difficulty of finding accurate measures. Each doctors' patients are different and have various complicating factors.

The partnership addressed some controversy by including doctors and value health care leaders in the planning of the report and using widely accepted measures.

"Physicians always have a little bit of anxiety about data being published on them, and this is the beginning of a process," said Dr. Tim Lee, head of Partners Community Healthcare Inc. "These measures aren't perfect, but they're pretty good, and they're meaningful."

He said his group is meeting with Harvard Vanguard to find out what they can learn from one another.

Harvard outperformed Partners in breast cancer screening, for instance, while Partners did better on well-child care. In both of those categories, however, they are both tops in the nation.

Other groups are expected to get together to talk about best practices.

"Almost all the systems are doing things we can learn from," Lee said.

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Summary Measures	Summary Performance
Quality of Doctor-Patient Interaction:	
Communication	★★½
Integration of Care	★★★★
Knowledge of Patient	★★★
Health Promotion	★
Organizational/Structural Features of Care:	
Organizational Access	★★½
Visit-Based Continuity	
Clinical Team	★★★½
Office Staff	★★
Global Rating:	
Willingness to Recommend	★★★

Summary Performance	
★★★★	Above the 85th percentile
★★★	Above the 50th percentile
★★	Above the 15th percentile
★	Below the 15th percentile

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QUALITY INSIGHTS: PATIENT EXPERIENCES IN PRIMARY CARE

Doctors' Office Summary: Care From Personal Doctors

click on the measure name to learn more information about the measure
click on the stars to learn about how patients answered each survey question

Doctors' Office	How Well Doctors Communicate with Patients	How Well Doctors Coordinate Care	How Well Doctors Know Their Patients	How Well Doctors Give Preventive Care and Advice
Acton Medical Associates (Pediatrics) *Go to Medical Group's Website*	★★★★	N/D	★★☆☆	★★★☆
Harvard Vanguard Medical Associates, Concord Hillside (Pediatrics) *Go to Medical Group's Website*	★★★★	★★★★	★★★★	★★★☆

Click on a doctors' office to view results on all measures

Select Category: Care from Personal Doctors

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Ways Your Doctor Can Help...

- **Learn about your medical history and current health problems**. The first time a doctor sees you as a new patient, he or she should ask about your medical history and that of close relatives. In future visits, the doctor should update the your medical history with information about current health problems and concerns.
- **Have a record-keeping system that makes it easy to find your health information**. A doctor's office can have systems that make it easy to find your past and present health information. This is needed whether doctors meet with you in the office, talk by phone, or consult with specialists about your treatment and care.
- **Learn about what matters to you**. This includes knowing your values and beliefs about treatments, care, and desired results. The doctor should take extra time to learn this information when meeting with you for the first time. When making decisions about treatment choices your doctor should talk with you about the benefits (how treatments can help) and risks (problems that can happen) of each treatment.

Ways You Can Help...

- **Give your doctor complete and accurate information**. This includes current health problems as well as medical history (medications, surgery, and illnesses). The doctor may also want to know about the medical history of your close family members. Make a list of important information you want to discuss before you see a doctor for the first time.
- **Talk about what is important to you—even if the doctor does not ask**. This includes religious beliefs or other values you have about treatments and care.
- **Discuss benefits and risks before you make a treatment choice**. Many times, there is more than one way to treat an illness or health problem. Talk with your doctor and learn as much as you want to know about the benefits (how treatments can help) and risks (problems that can happen) of each treatment choice.

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Care From Personal Doctors: How Well Doctors Know Their Patients

Acton Medical Associates (Pediatrics)

Go To Medical Group's Website

In the last 12 months, how often did your child's doctor seem to know all the important information about your child's medical history?

	responses	*percent*
Never	1	1%
Almost Never	2	1%
Sometimes	5	4%
Usually	9	6%
Almost Always	31	22%
Always	94	66%
Total	142	

How would you rate your child's doctor's knowledge about your child as a person (special abilities, concerns, fears)?

	responses	*percent*
Very Poor	2	1%
Poor	2	1%
Fair	6	4%
Good	21	15%
Very Good	40	28%
Excellent	73	51%
Total	144	

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Explanation Of The Star Ratings...

The star rating for each measure tells you how a doctor's office compares to all the other doctor's offices in the state that were part of the MHQP survey.

- Doctor's offices with 4 stars () did better than at least 85% of the doctor's offices in this survey
- Doctor's offices with 3 stars () did better than at least 50% of the doctor's offices in this survey
- Doctor's offices with 2 stars () did better than at least 15% of the doctor's offices in this survey
- Doctor's offices with 1 star () did less well than at least 85% of the doctor's offices in this survey
- The symbol N/D is displayed when MHQP does not have enough data to report this measure. This is usually because not enough patients answered the survey questions for this measure. Having too little data to report for a doctor's office does not mean that the quality of care delivered by that doctor's office is either good or bad.

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The Headlines from March 9, 2006

The Boston Globe

THURSDAY, MARCH 9, 2006

Patients weigh in on Mass. doctors

High ratings given on care

By Liz Kowalczyk
GLOBE STAFF

Massachusetts residents think their doctors are good communicators, who listen carefully and give clear instructions, according to the first statewide survey on patients' experiences with their care. But patients do not rate their interactions with physicians and their staffs as highly in other areas, including seeing them

SELECT SURVEY RESULTS

48,294 adults were questioned about their primary care physician.

Q. Would you recommend your doctor to your family and friends?

IN THE PAST 12 MONTHS...

Q. Did your doctor ever ask you if your health makes it hard to do the things you need to do each day?

Q. Did your doctor's office remind you to get preventive care (for example, flu shot, cancer screening, mammogram, eye exam)?

'Doctors have gotten the message that consumers have higher expectations. Publishing this data is a pretty gutsy move.'
JAMES CONWAY, *Institute for Healthcare Improvement*

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Lessons Learned from MHQP's Public Reporting

- Public release can be a positive experience!
- It is possible, and in our opinion preferred, to marry collection and reporting of performance data for quality improvement with collection and reporting of performance data public reporting
- The collaborative process takes longer, but leads to better end results
- You must pay attention to details
- You must pay attention to concerns, but not let them hijack your end goals

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Challenges of Public Reporting

- Increasing acceptance and usefulness of the reports for the physician community
- Making reports increasingly useful to consumers
- Keeping pace with market demands
- Developing market driven funding model to support performance reporting

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MAeHC QDC Functions

- Designed by MHQP and CSC; hosted by CSC
- Collects and reports on quality measure data to physicians, researchers and other users in the MAeHC communities
  - Extract pre-defined clinical data from health information exchange (HIE) systems in the three MAeHC communities
  - Store and manage this data on behalf of MAeHC
  - Create web-based quality reports at the physician, practice and community levels
    - To assess clinical performance in relation to peers
    - To target improvement opportunities and monitor progress

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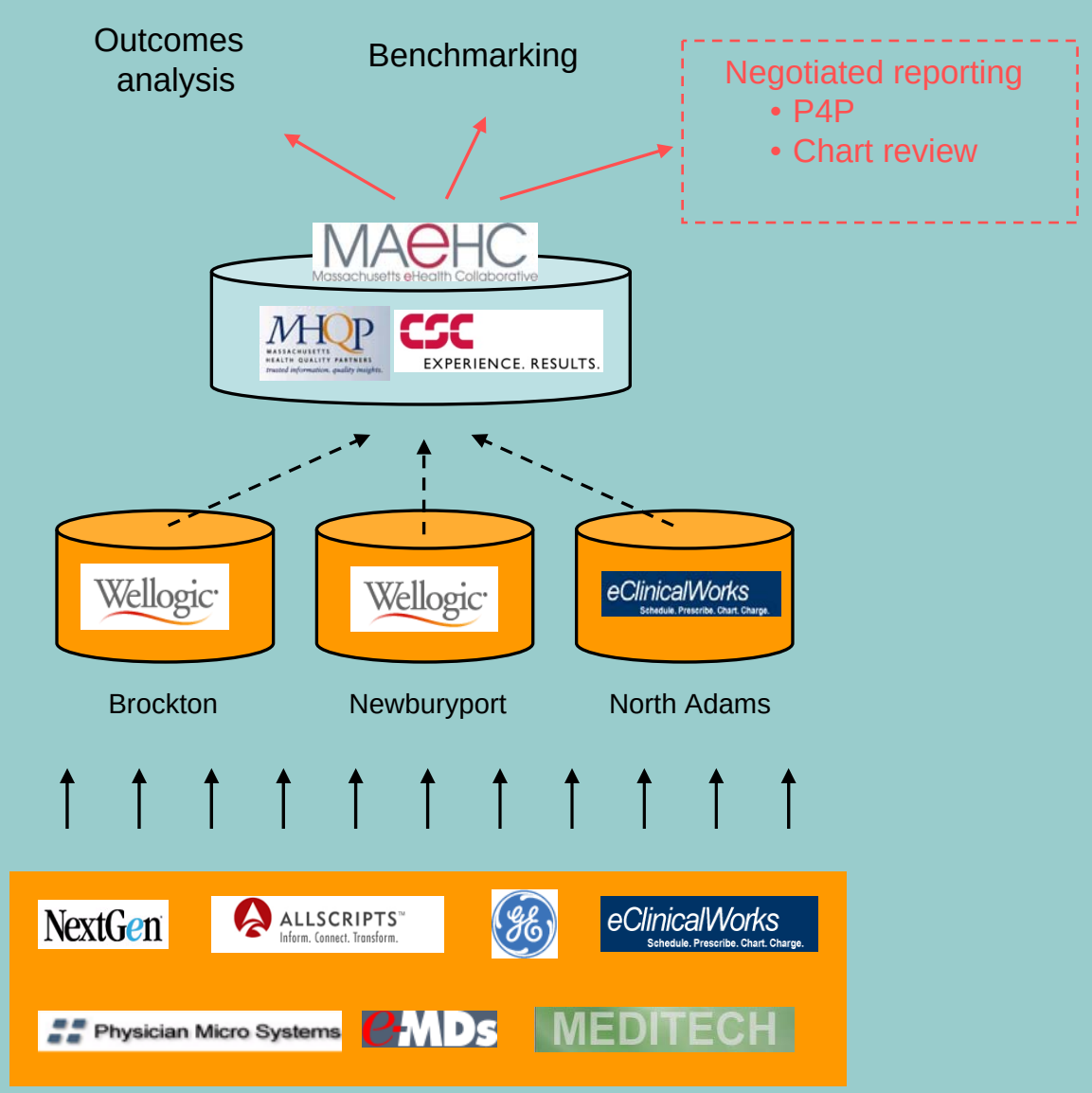
MAeHC ARCHITECTURE AND DATA FLOWS

MAeHC-level: Analysis

MAeHC-level: QDW

Community-level: HIE

Provider-level: EHR



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MHQP'S EFFICIENCY RESEARCH AGENDA

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MHQP/RAND Partnership

- Identify the key methodological issues that arise when constructing efficiency and effectiveness profiles at the physician level
- Evaluate methods for assessing efficiency and effectiveness together
- Identify the key policy issues that decision makers should consider when selecting and applying these metrics

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RAND

General Approach To RAND/MHQP Project

- Identify the methodological choices that one must make in creating performance scores
- Evaluate the options for addressing those methodological choices
- Examine whether the results change with the method chosen
- If the results are different, explore the implications of the choice
  - Policy
  - Response

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RAND

Methodological Issues in Efficiency and Effectiveness Scoring

- Attributing events to physicians
- Dealing with cost outliers
- Choosing minimum sample sizes
- Aggregating data
- Aggregating measures
- Putting the results together

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RAND

Efficiency Measurement in CA P4P

- Demand by purchasers and health plans that cost be included in the P4P equation

  Quality + Cost = Value

- Opportunity for common approach to health plan and physician group cost/risk sharing
- Demonstrate the value of the delegated, coordinated model of care

Efficiency Measures in CA P4P

1. Generic Prescribing
2. Population-Based
   - Overall Group Efficiency
   - Standardized and actual costs
   - DCG and geographic risk adjustment
3. Episode-Based
   - Overall Group Efficiency
   - Efficiency by Clinical Area
   - Standardized costs only
   - MEG, Disease Staging, and DCG risk adjustment

CA P4P Advantages for Efficiency Measurement

- Unit of measure – Physician group vs. individual physician measurement makes attribution more reliable
- Large sample size – Aggregation of plan data allows for adequate sample size
- Consistent benefit package – HMO/POS member population provides relatively consistent benefits
- Stakeholder trust – Relatively good

Developing Incentives

Key Questions for Incentives

- Should we use carrots or sticks – bonuses or penalties – or a combination?
- How should the bonus be structured?
- Should we use relative or absolute performance thresholds?
- How much money should we put into performance pay?
- Where do we find the money?
- How do we know if P4P is working?

Types of Incentives

Financial

- Pay for participation
- Pay for process
- Pay for performance bonus payments
  - for absolute or relative performance
  - for improvement
- Differential reimbursement / fee schedule
- Use of performance results to "tier" networks
- Compensation increase at risk
- Infrastructure / QI grants

Types of Incentives

Non-Financial

- Public reporting
- Peer to peer reporting
- Awards and public recognition
- Provider/staff education / technical assistance
- Steerage
- Reduced administrative requirements

Performance Incentives should be . . .

- Meaningful
- Targeted at those who are able to effect the desired change
- Sufficient relative to the level of effort required

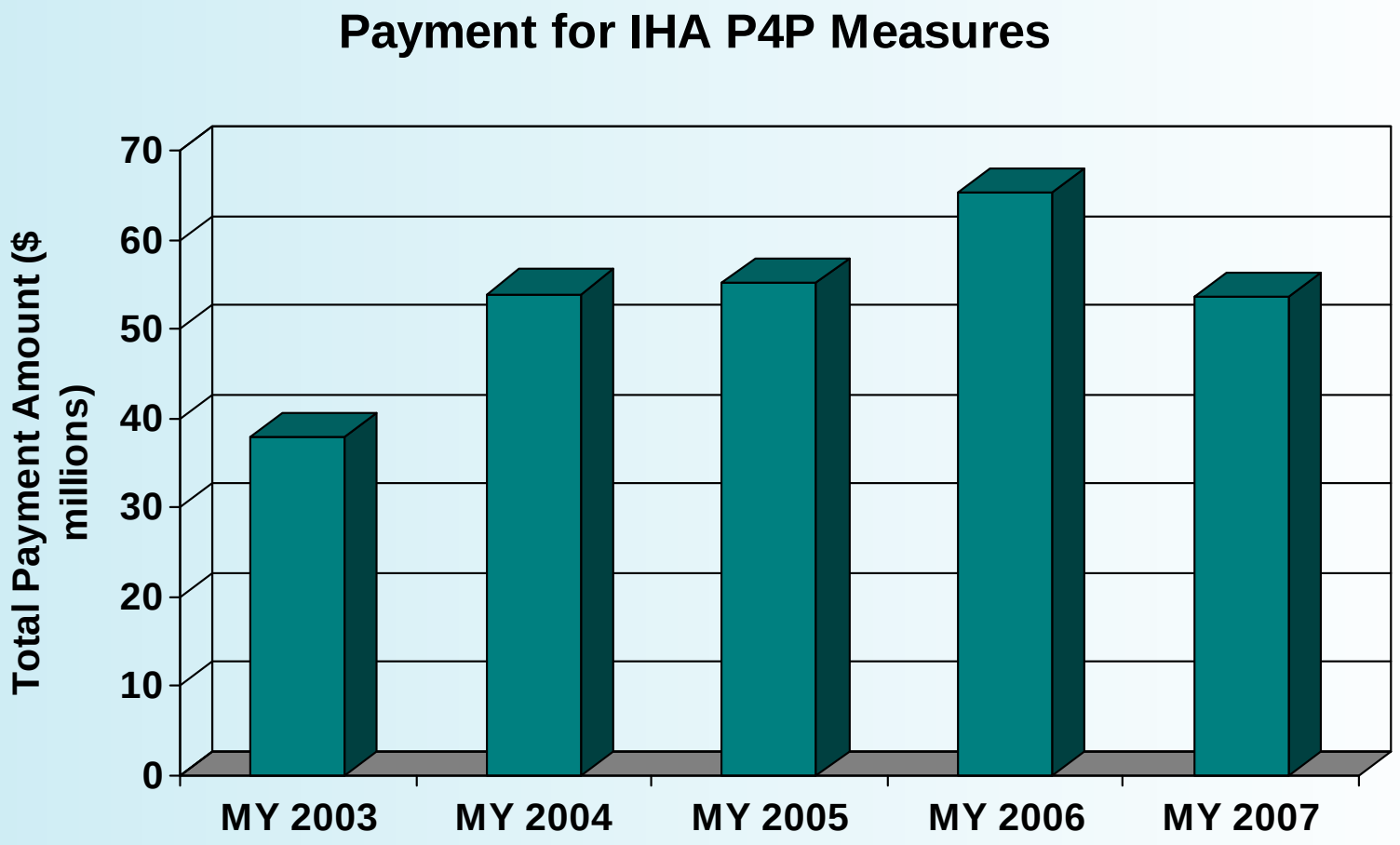
CA P4P Domain Weighting

Domain	2003-6	2007	2008	2009
Clinical	40-50%	50%	40%	40%
Patient Experience	30-40%	30%	25%	20%
IT Adoption	10-20%	X	X	X
IT-Enabled Systemness	X	20%	15%	20%
Coordinated Diabetes Care	X	X	20%	20%
Appropriate Resource Use	X	X	X	Gain-sharing

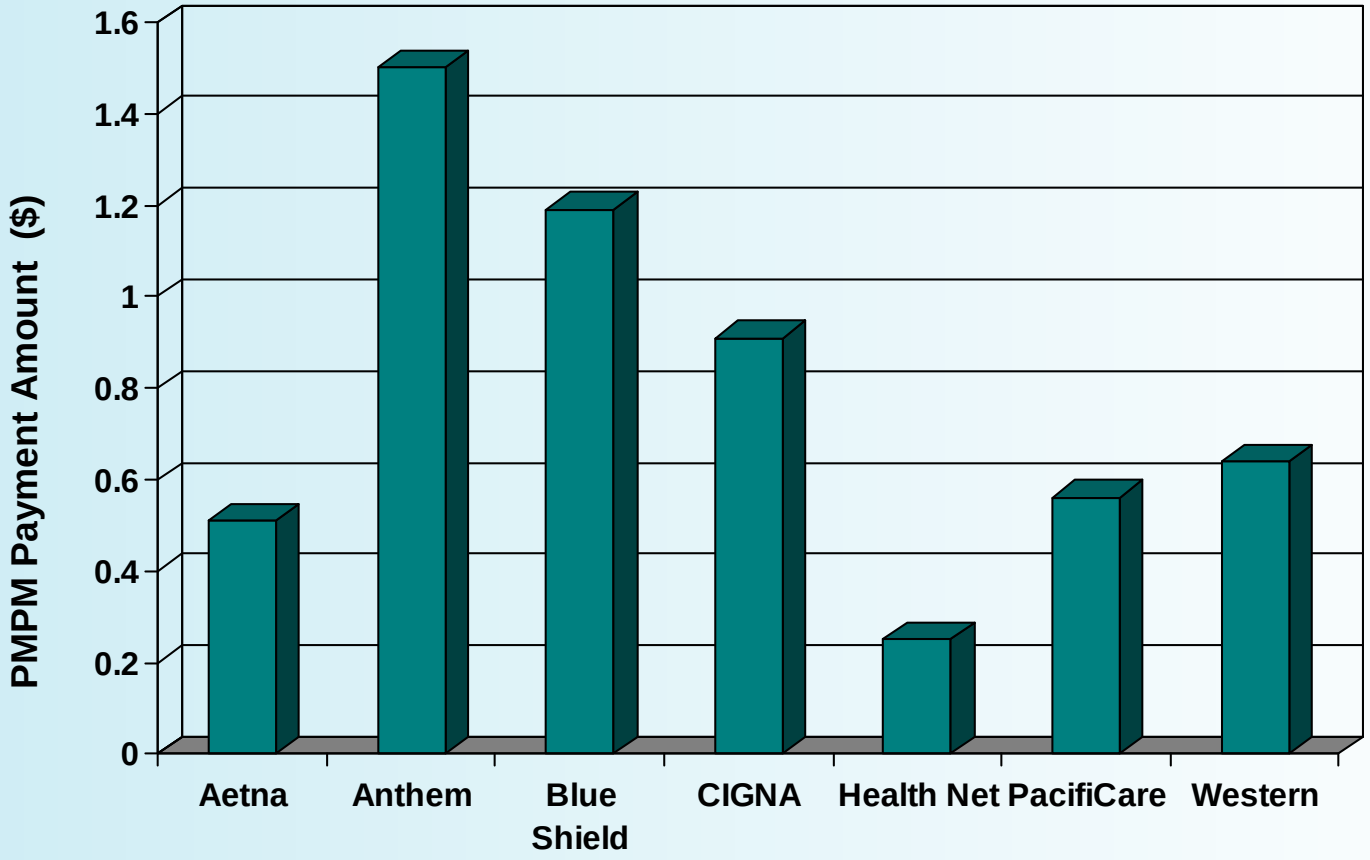
CA P4P Health Plan Payments

- Health plans pay annual incentive bonuses calculated as a certain dollar amount PMPM for:
  - meeting absolute or relative performance thresholds
  - improvement in performance
- Although the P4P Steering Committee recommends payment methodology, it is left to each participating health plan to design its own methodology
- A financial transparency report summarizing health plan's payment methodology is available on the IHA website
- No dollars at risk for the participating POs; upside potential only

CA P4P Health Plan Payments



CA P4P MY 2007 Payments by Plan



P4P Transparency Reports at http://www.iha.org/ftransp.htm

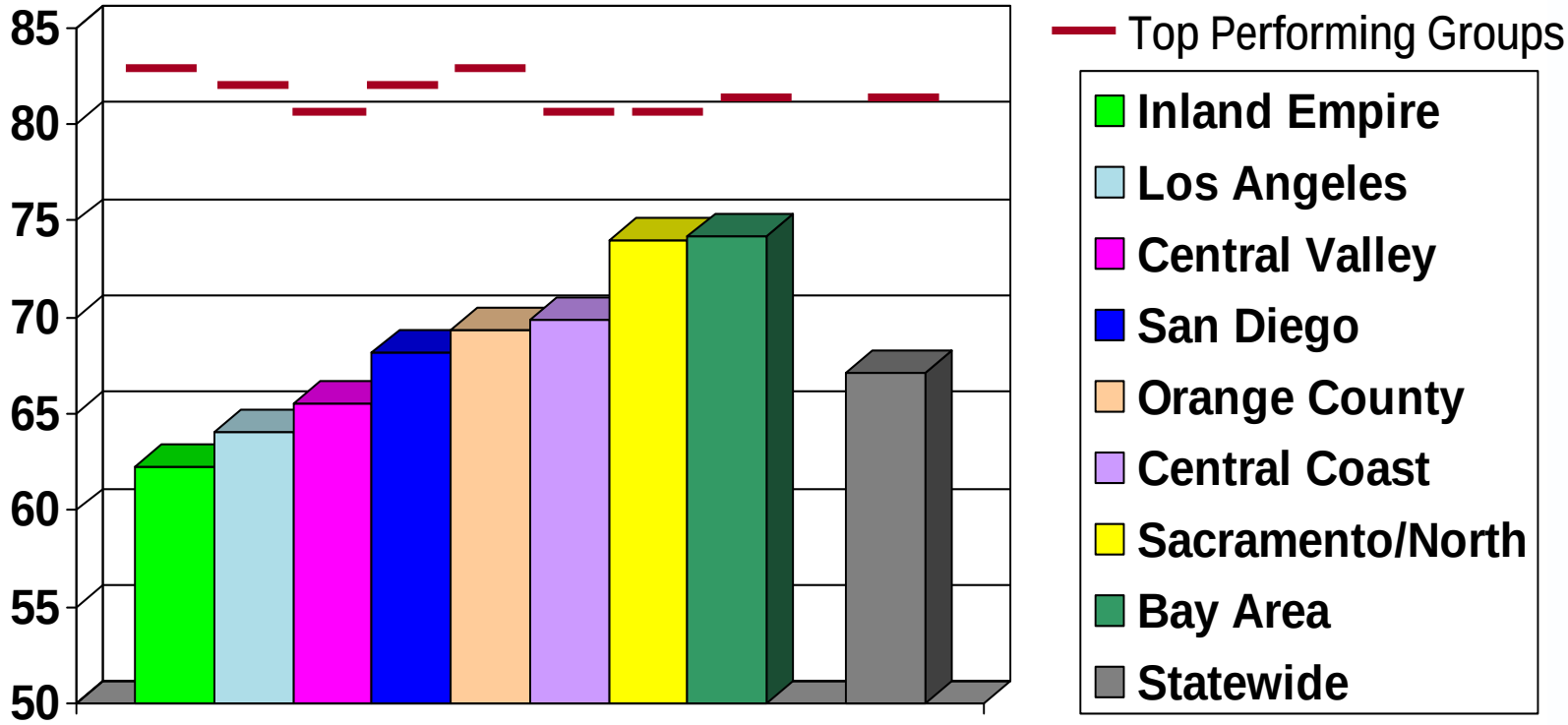
Increased Attention to "Pay" in CA P4P

- Resolved antitrust concerns; formed Payment Committee
- Reduce payment variability through methodology recommendations
- Eliminate "black box" by advanced notice of payment methodology
- Pay must keep pace with measures

Rich Get Richer, Poor Get Poorer?

- Wide variation across regions exists; contributes to overall "mediocre" statewide performance
- Lower performance in geographies with lower SES, lower reimbursement, and fewer PCPs / 100K population
- Leads to diminished physician and organizational capacity

CA P4P Regional Variation: Clinical Composite Score



MY 2007 Results by Region

CA P4P Payment Methodology Recommendations for MY 2009

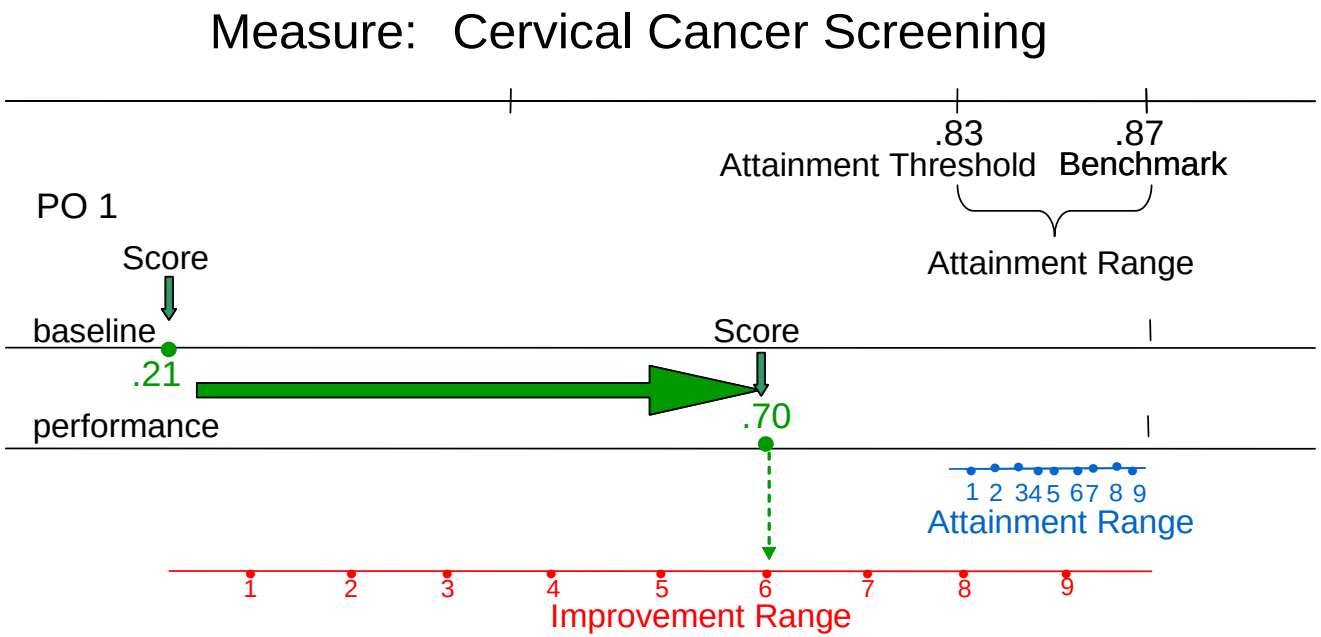
- Comprehensive Payment Methodology that incorporates both Attainment and Improvement
- Linking Payment Potential to Data Sharing
- Gain Sharing for Appropriate Resource Use measures

CA P4P Comprehensive Payment Methodology

- Score each measure 0-10 points for attainment and 0-10 points for improvement
  - Must be in top quartile to earn attainment points
  - 95th percentile and above earn full points
  - Improvement points based on gap closure
- Select higher of two scores for payment
- POs are only scored on measures for which they have a valid result, so they are not "punished" for not meeting the denominator criteria for certain measures due to PO size or population

Paying for Attainment & Improvement

Earning Quality Points Example



PO 1Earns: 0 points for attainment

6 points for improvement

PO 1 Score: maximum of attainment or improvement

= 6 points on this measure

Linking Payment Potential to Data Sharing in CA P4P

- Encourages bi-directional flow of data
- Two data sharing levels for groups
- Two-fold difference in payment for MY 2009, increasing to three-fold starting in MY 2010
- Health plans should redistribute any money they "save" due to lower payments to non-sharing groups
- Plans must be sharing pharmacy, facility, and other paid claims electronically available in order to apply the payment differential

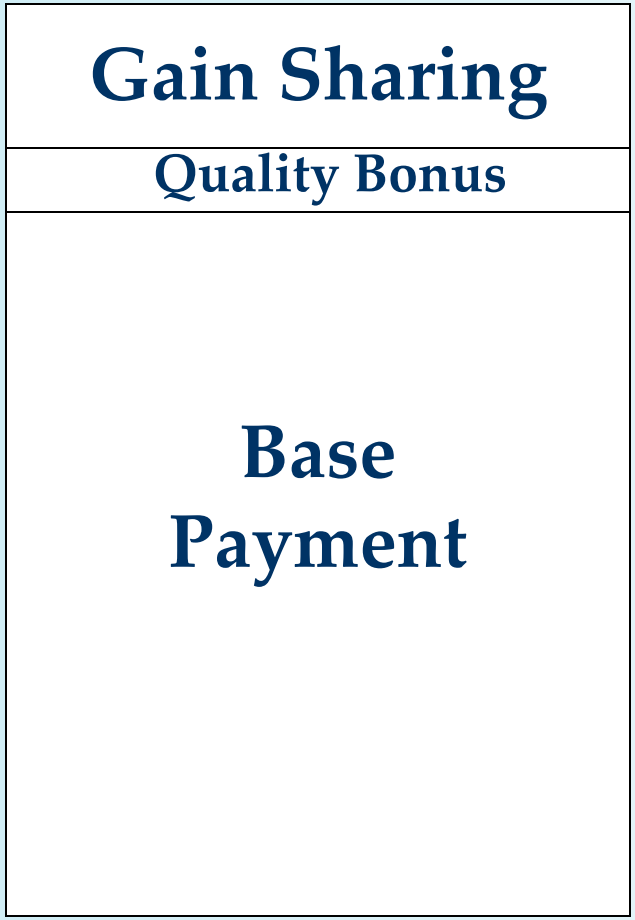
Gain Sharing for Appropriate Resource Use measures in CA P4P

- Each health plan determines total actual payments associated with services being measured for baseline year, and calculates unit cost for each service for each group
- Unit cost is multiplied by number of units saved in subsequent year to determine amount of savings for each group for each metric
- Savings is shared between the health plan, group, and premium trend reduction, based on the group's relative statewide/ regional performance
- To qualify for any savings payment, a group's performance cannot statistically significantly decrease for any metric

Gain Sharing for Appropriate Resource Use measures in CA P4P

PO's aggregated risk-adjusted score (statewide or regionally)	PO portion of savings	Health Plan portion of savings	Premium reduction portion of savings
Top quartile	50	25	25
50th to 74th percentile	40	30	30
25th to 49th percentile	30	35	35
Bottom quartile	20	40	40

Next Generation P4P: Incorporating Quality, Efficiency, and Gain Sharing



Performance-based Contracting:

- Quality Benchmarks
- Efficiency Targets
- 10+% Potential Payment

CA P4P Awards and Public Recognition

Awards

- Top Performing Groups
  - Overall
  - By Measurement Domain
- Most Improved Groups

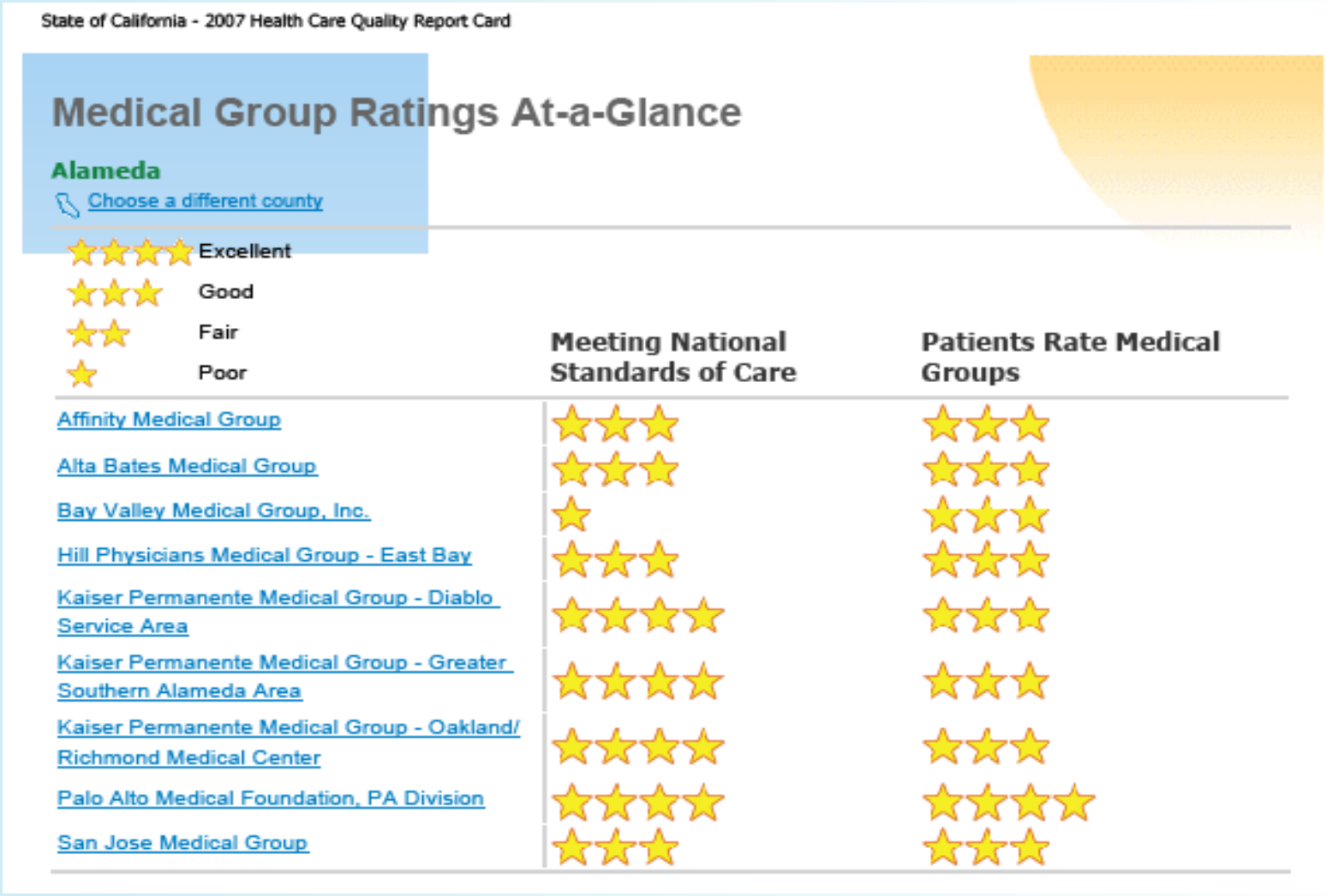
Recognition

- Awards Ceremony
- Certificate/Plaque
- Photo with Dignitary
- Press Release

CA P4P Public Recognition: Ron Bangasser Memorial Award for Quality Improvement

CA P4P Public Reporting

www.opa.ca.gov



State of California - 2007 Health Care Quality Report Card

Medical Group Ratings At-a-Glance

Alameda

Choose a different county

★★★★ Excellent
★★★ Good
★★ Fair
★ Poor

	Meeting National Standards of Care	Patients Rate Medical Groups
Affinity Medical Group	★★★	★★★
Alta Bates Medical Group	★★★	★★★
Bay Valley Medical Group, Inc.	★	★★★
Hill Physicians Medical Group - East Bay	★★★	★★★
Kaiser Permanente Medical Group - Diablo Service Area	★★★★	★★★
Kaiser Permanente Medical Group - Greater Southern Alameda Area	★★★★	★★★
Kaiser Permanente Medical Group - Oakland/ Richmond Medical Center	★★★★	★★★
Palo Alto Medical Foundation, PA Division	★★★★	★★★★
San Jose Medical Group	★★★	★★★

Funding Models

Administrative Costs

The following program components require funding:

1. Technical Support – measure development and testing
2. Data Aggregation – collecting, aggregating and reporting performance data
3. Governance Committees – meeting expenses and consulting support services
4. Stakeholder Communication – web casts, newsletters, and annual meeting
5. Program Administration – direct and indirect staff and related expenses
6. Evaluation Services – program evaluation
7. Legal Fees – consultation on antitrust, agreements, etc.

Funding Sources for Administrative Costs

- Grants
  - Initial development and technical expansion
  - Evaluation
  - Specific projects
- Sponsorship from Pharma companies
  - Stakeholder Meetings
  - Stakeholder Communications
- Health Plan Surcharge
  - Total budget allocated by plan membership as per member per year (PMPY) charge

Funding Sources for Financial Incentives

- New money
- Redirect from other programs
- Withhold
- Allocation from fee increase
- Gain sharing

Implementation Challenges

Legal and Political Issues

- Complying with HIPAA regulations
- Overcoming Non-Disclosure Agreements
- Addressing Data Ownership

Addressing Legal and Political Issues

Example #1: Lab results

- Code of Conduct for bi-directional data exchange
- Lab authorization form
- Disease Management Coordination initiative

Example #2: Efficiency measurement

- BAA
- Antitrust Counsel
- Consent to Disclosure Agreements
- No group-specific results shared first two years
- Publicly available sources of data

Some Guiding Principles

- Don't just "honor the problem."
- Partnership = self-interest as well as good will
- Everyone is right. No one is completely right.
- You can't manage what you can't measure.
- You can't improve what you never launch.
- Don't let the perfect be the enemy of the good.
- Do the right thing – it will please some and astonish the rest.

Some Suggestions for Getting Started

- Want some kind of track record for collaboration
- Find at least two visible champions
- Find the "credible convenor"
- Start with the clinicians…but don't wait too long to see the CEOs …
- Plan to spend lots of time on specs and data
- Use purchasers as leverage
- Bring in "validators" from other states
- Select and talk to the evaluators early

California Pay for Performance

For more information:

www.iha.org

(510) 208-1740

IHA
INTEGRATED HEALTHCARE ASSOCIATION

Pay for Performance has been supported by major grants from the California Health Care Foundation

For more information about MHQP…

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Website: www.mhqp.org

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