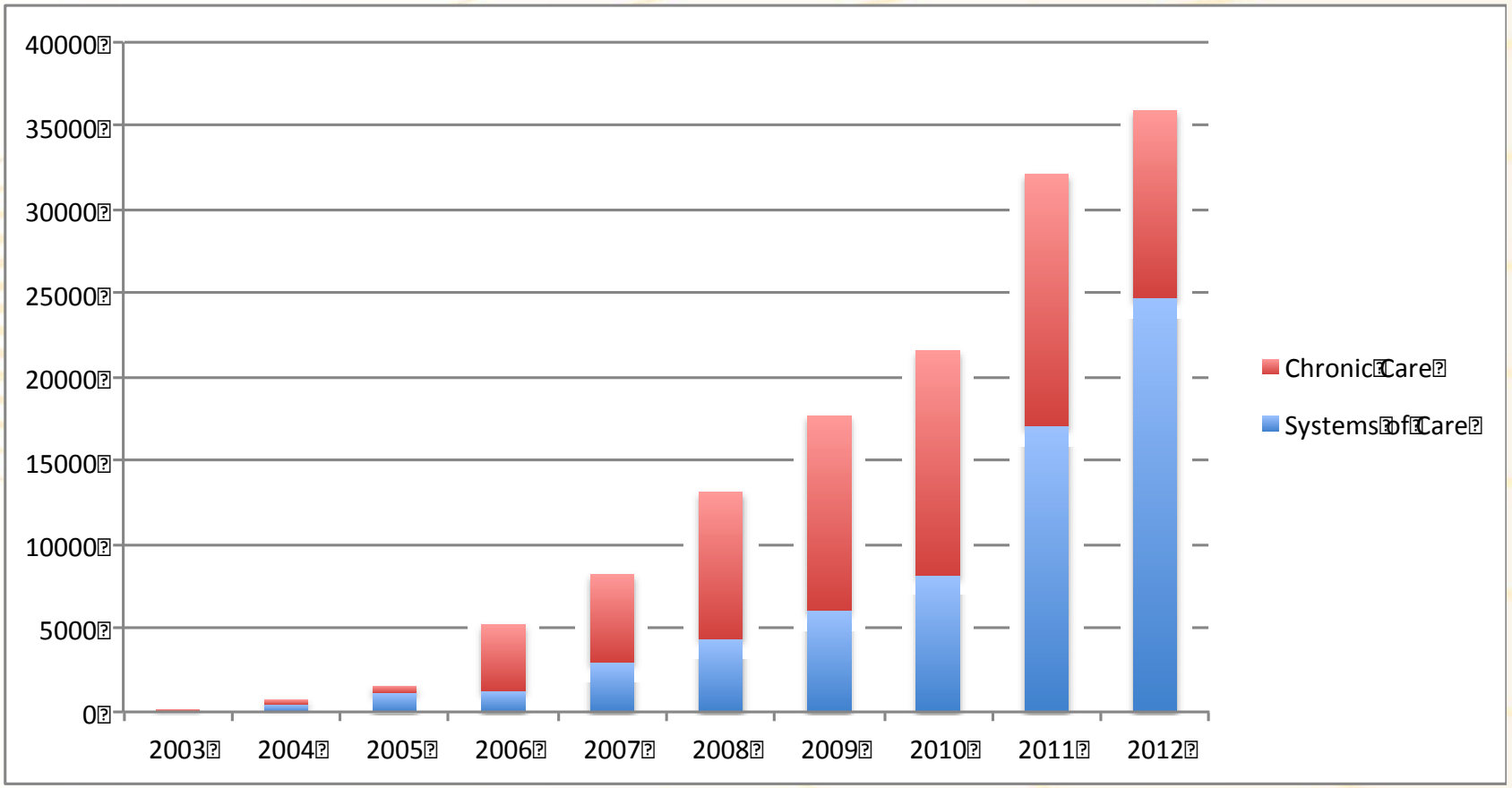
Does P4P Work?
Lessons from the field

IHA – February 19th 2013

Just about ten years ago…

- A few large companies set out to reward physicians for better managing patients with chronic conditions, and help employees find physicians that were better at managing chronic conditions
- Then, with a small grant from RWJF – an afterthought of Rewarding Results – Bridges To Excellence was born; we hired the NCQA to help us create the first survey of physician "systemness"; and we set out to also reward physicians who adopted systems and processes that could lead to better management of patients.

Growth in BTE Recognitions



Researched results

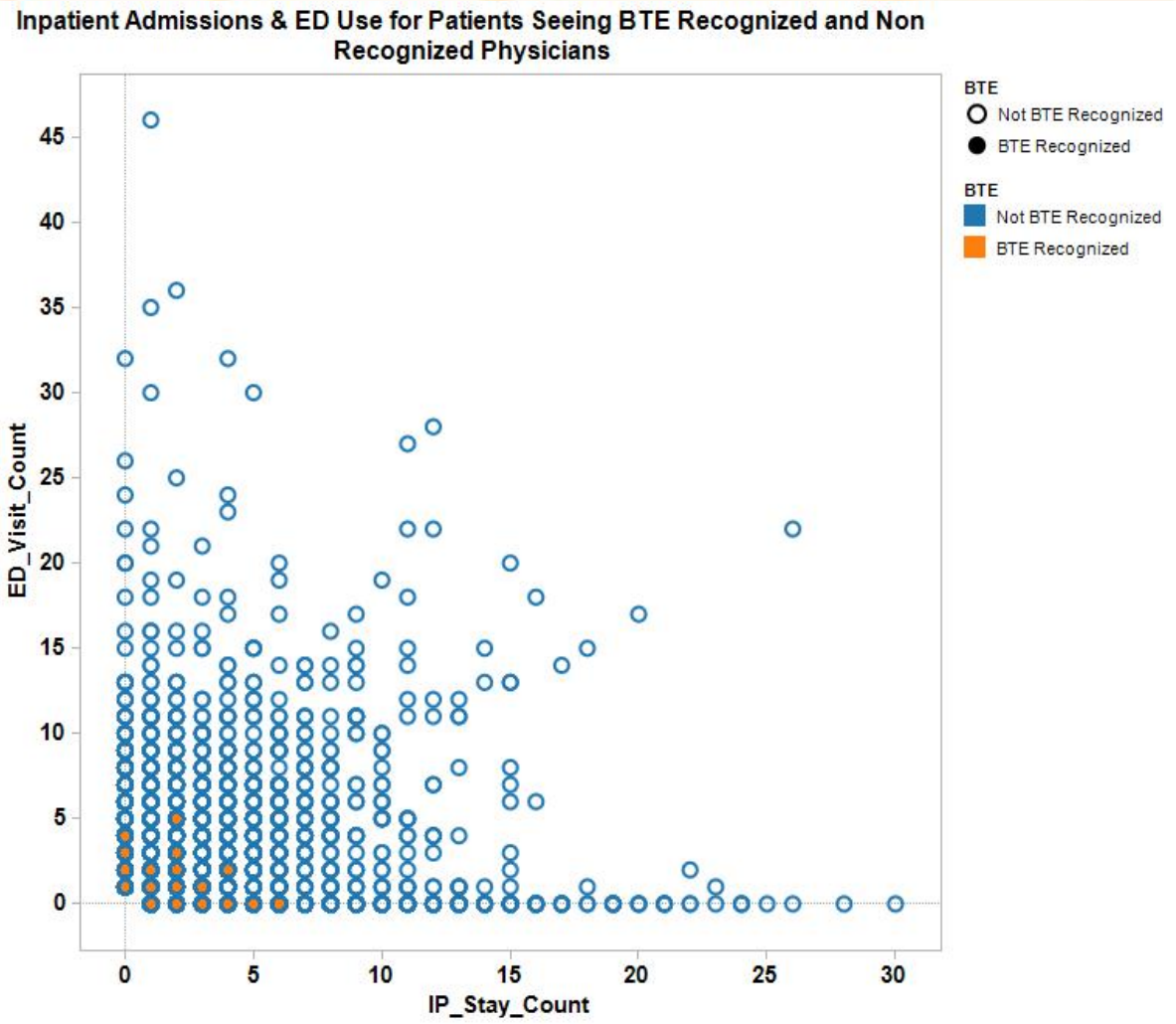
- What you measure matters – de Brantes F, Wickland P, Williams J - "The Value of Ambulatory Care Measures: A Payer's/Purchaser's Perspective" American Journal of Manage Care, June 2008
- The juice has to be worth the squeeze – de Brantes F, D'Andrea G, "Physicians respond to pay-for-performance incentives: larger incentives yield greater participation" American Journal of Managed Care, 09 May; 15(5):305-10
- You reap what you sow – Rosenthal MB, de Brantes F, Sinaiko A, Frankel M, "Bridges To Excellence: Recognizing High Quality Care" American Journal of Managed Care, October 2008

Why have we succeeded where others seem to have failed?

1. Focus on reducing costly defects
   - ED visits, IP stays, readmissions, patient safety failures…what we've called Potentially Avoidable Complications
2. Fuel intrinsic incentives
   - Dashboard with all patients, improvement over time, peer comparisons, benchmarks
3. Don't compromise on where you set the bar
   - The more costly patients have more defects that stem from more out-of-control biometrics

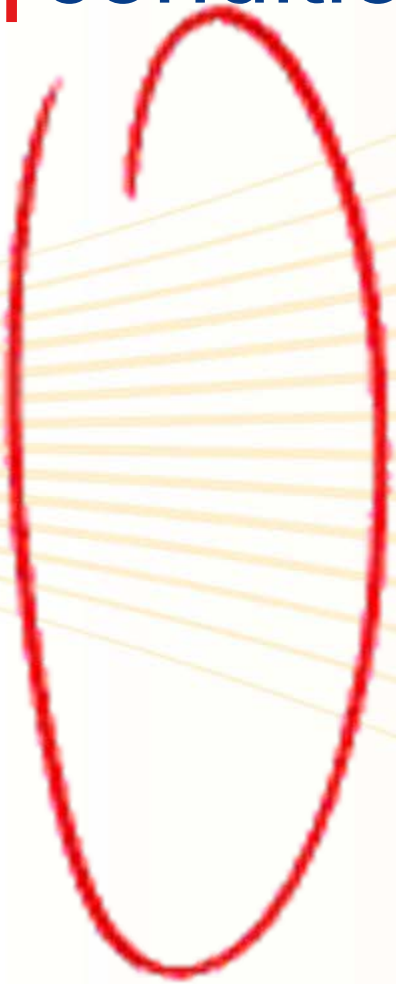
Costly defects in one community

- 15% of total commercial plan members had a least one Inpatient hospitalization or one ED visit (87,332 of 581,418 members)
- 833 patients had 6+ ED visits and accounted for 18% of total ED visits
- 6,170 patients had 3+ IP stays and accounted for 31% of total IP stays

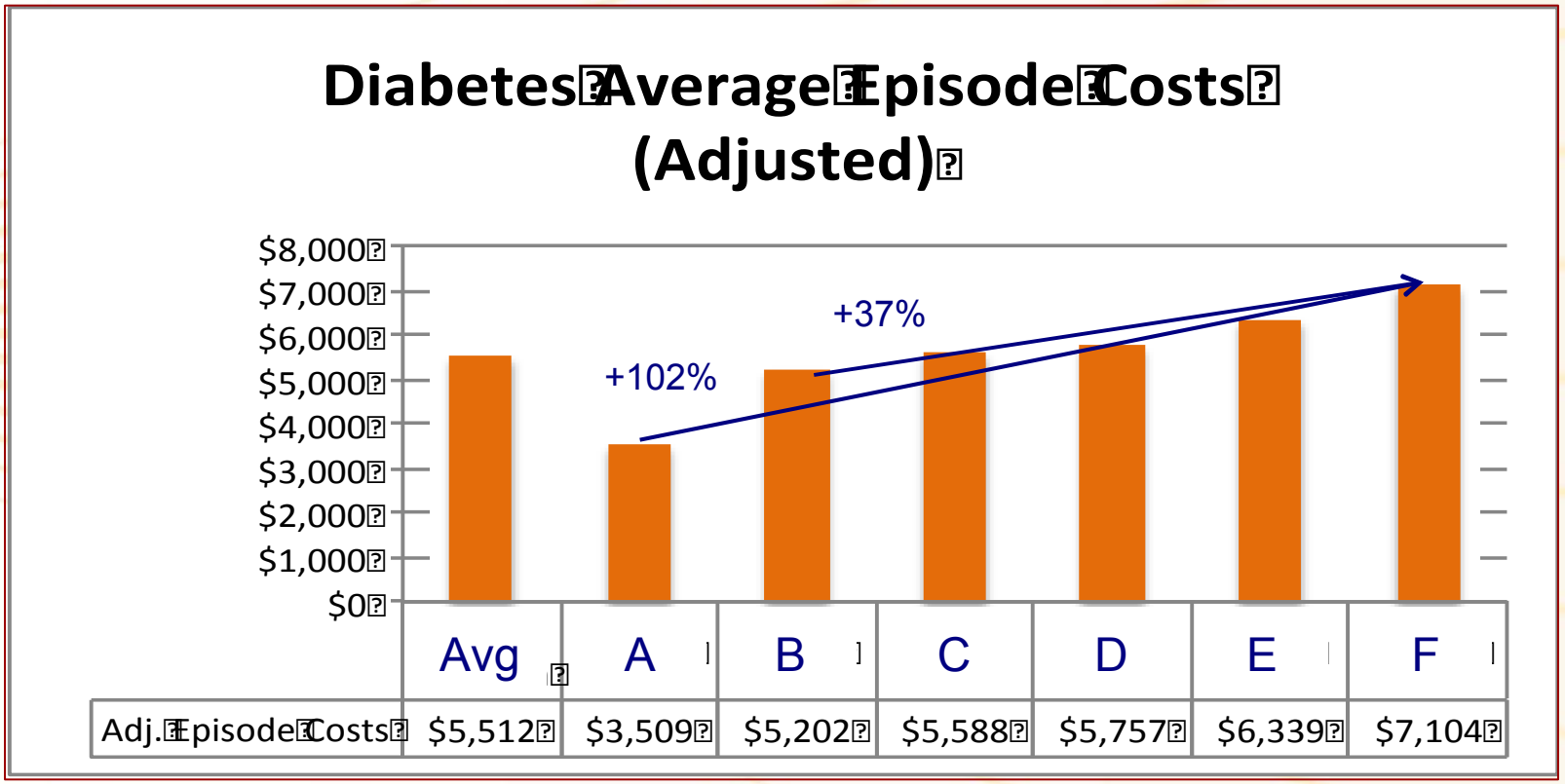


2012 Community Analysis, HCI[3]

Causes for admissions – chronic conditions

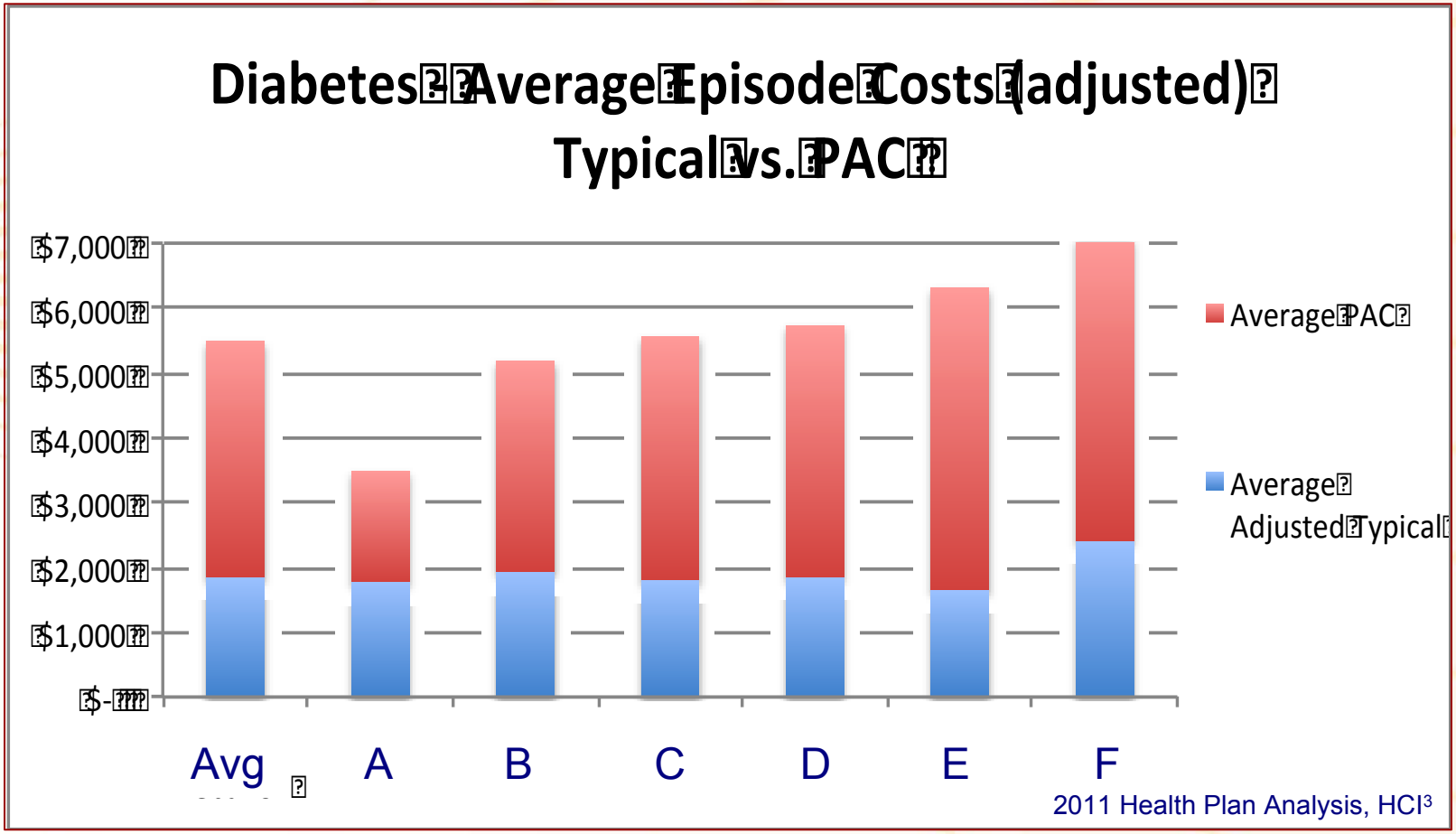


Consider these Practices…All part of the same "System"



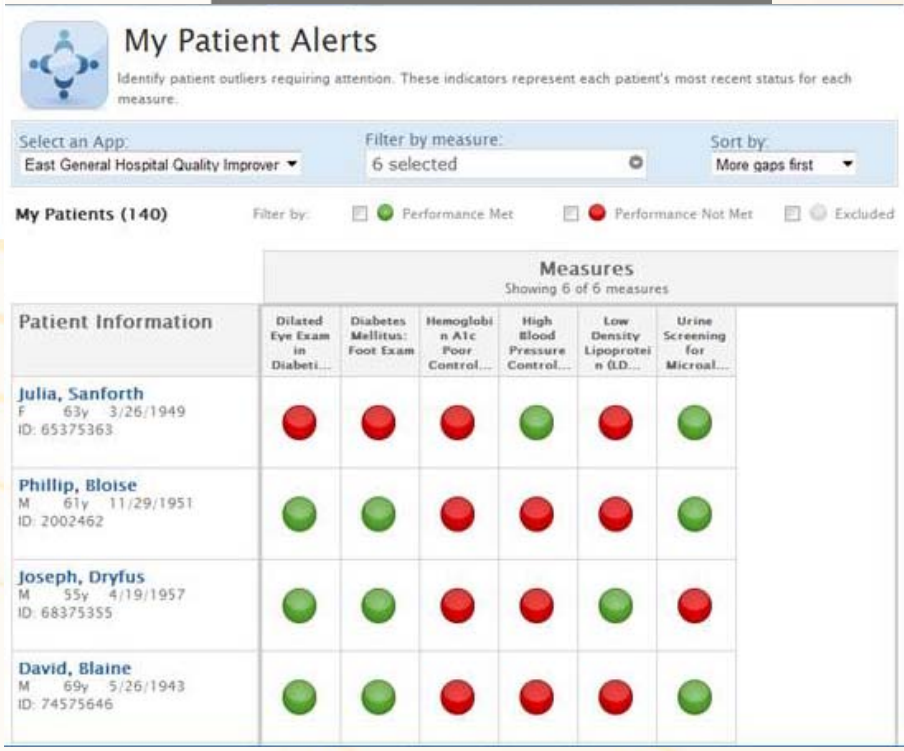
2011 Health Plan Analysis, HCI[3]

The difference in Diabetes episode costs is made up of complications



PAC: Potentially Avoidable Complications

Valid and actionable feedback loops motivate action



Measure roll-ups drill down to individual patient reports that identify misses

Getting to good, better, best

Clinical Measures	Measure Focus	Min	Possible Points Per Measure **Level 1**	**Level 2**	**Level 3**
Poor control measures					
HgBA1c Control	> 9.0	27.50%	15		
Blood Pressure Control	≥ 140/90	40.00%	15		
LDL Control	≥ 130 mg/dl	40.00%	10		
Poor control composite measure				40	40
HgBA1c Control	> 9.0				
Blood Pressure Control	≥ 140/90				
LDL Control	≥ 130 mg/dl				
Superior control measures					
HgBA1c Superior Control	< 7.0	40.00%	5	5	5
HgBA1c Superior Control	< 8.0	40.00%	5	5	
Blood Pressure Superior Control	< 130/80	30.00%	10	10	
LDL Superior Control	< 100 mg/dl	35.00%	10	10	
Superior control composite measure					25
HgBA1c Superior Control	< 8.0				
Blood Pressure Superior Control	< 130/80				
LDL Superior Control	< 100 mg/dl				
Process measures					
Body Mass Index			0	0	0
Ophthalmologic Exam			10	10	10
Nephropathy Assessment			5	5	5
Podiatry Exam			5	5	5
Tobacco Status and Cessation Advice and Treatment			10	10	10
Total possible points			100	100	100
Percentage of Points to pass			60	60	60

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