The Tenth National Quality Colloquium

Value-based Purchasing:
Trends in Ambulatory Care

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Objectives

• To recognize why a value-based purchasing (VBP) approach is needed
• To identify strategies that public and private purchasers are pursuing in order to improve the value of health care
• To assist providers in developing, implementing and evaluating VBP programs and activities
Problems with Quality in the US

- High cost
- Variability across regions, providers
- Lack of evidence-based practice, guidelines and standards
- Lack of access/prevention
- Lack of communication and coordination
International Comparison of Spending on Health, 1980–2008

Average spending on health per capita ($US PPP)

Total expenditures on health as percent of GDP

Source: OECD Health Data 2010 (Oct. 2010).
Price-adjusted Medicare Expenditures per Beneficiary by Hospital Referral Region (2008)

Source: The Dartmouth Institute
U.S. Adults Receive Half of Recommended Care, and Quality Varies Significantly by Medical Condition

Percent of recommended care received

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>Overall</td>
<td>55</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>76</td>
</tr>
<tr>
<td>Hypertension</td>
<td>65</td>
</tr>
<tr>
<td>Asthma</td>
<td>54</td>
</tr>
<tr>
<td>Diabetes</td>
<td>45</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>39</td>
</tr>
<tr>
<td>Hip fracture</td>
<td>23</td>
</tr>
</tbody>
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Source: The Dartmouth Institute
THE COST CONUNDRUM
What a Texas town can teach us about health care.
by Atul Gawande
JUNE 1, 2009

It is spring in McAllen, Texas. The morning sun is warm. The streets are lined with palm trees and pickup trucks. McAllen is in Hidalgo County, which has the lowest household income in the country, but it’s a border town, and a thriving foreign-trade zone has kept the unemployment rate below ten per cent. McAllen calls itself the Square Dance Capital of the World. “Lonesome Dove” was set around here.

McAllen has another distinction, too: it is one of the most expensive health-care markets in the country. Only Miami—which has much higher labor and living costs—spends more per person on health care. Photograph by Philip Toledano.

Source: The New Yorker, June 1, 2009
Description of the Value-based Purchasing (VBP) Model

“Value-based Purchasing” refers to a range of activities initiated by public and private purchasers of health care to use comparative performance information to publicly recognize, select, and financially reward health care vendors, particularly health plans and providers. The goal of value-based purchasing is to improve the quality, safety, and affordability of health care services.
VBP Strategies

- Collecting information and data on quality
- Selective contracting with high-quality plans and providers
- Offering incentives to providers (P4P)
- Offering education and incentives to consumers
- Designing health and disease management programs
Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program

VISION FOR AMERICA:
- Patient-centered, high quality care delivered efficiently.

GOALS FOR VALUE-BASED PURCHASING:
- Financial viability — where the financial viability of the traditional Medicare fee-for-service program is improved for beneficiaries and taxpayers.
- Payment incentives — where Medicare payments are linked to the quality and efficiency of care provided.
- Joint accountability — where physicians and providers have joint clinical and financial accountability for healthcare in their communities.
- Effectiveness — where care is evidence-based and outcomes-driven to better manage diseases and prevent complications from them.
- Ensuring access — where a restructured Medicare fee-for-service payment system provides equal access to high quality, affordable care.
- Safety and transparency — where value-based payment systems give beneficiaries information on the quality, cost, and safety of their healthcare.
- Smooth transitions — where payment systems support well-coordinated care across different providers and settings.
- Electronic health records — where value-driven healthcare supports the use of information technology to give providers the ability to deliver high quality, efficient, well-coordinated care.
U.S. Primary Care Doctors’ Reports of
Financial Incentives Targeted on Quality of Care

Percent of U.S. physicians reporting they receive or have potential to receive extra payment based on quality

- Achieving certain clinical care targets: 28%
- High ratings for patient satisfaction: 19%
- Managing patients with chronic disease/complex needs: 17%
- Enhanced preventive care activities: 10%
- Non-face-to-face patient interactions: 7%
- Adding nonphysician clinicians to team: 6%
- Any targeted care or meeting goals (US) *: 36%
- Any targeted care or meeting goals (Germany) *: 58%
- Any targeted care or meeting goals (UK) *: 89%

* Can receive financial incentives for any of six: high patient satisfaction ratings, achieve clinical care targets, managing patients with chronic disease/complex needs, enhanced preventive care (includes counseling or group visits), adding nonphysician clinicians to practice and non–face-to-face interactions with patients.

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.
**Smaller Practices Lag Behind Large Practices in Quality Monitoring and Clinical Benchmarking**

- Routinely receive and review data on patients’ clinical outcomes:
  - Solo practices: 34%
  - Small and medium practices (2–9 physicians): 43%
  - Large practices (10 or more physicians): 55%

- Routinely receive and review data on surveys of patient satisfaction:
  - Solo practices: 36%
  - Small and medium practices (2–9 physicians): 60%
  - Large practices (10 or more physicians): 75%

- Review areas of physicians’ own clinical performance against targets annually:
  - Solo practices: 46%
  - Small and medium practices (2–9 physicians): 66%
  - Large practices (10 or more physicians): 73%

- Routinely receive information on how clinical performance of practice compares to others:
  - Solo practices: 20%
  - Small and medium practices (2–9 physicians): 27%
  - Large practices (10 or more physicians): 42%

Jefferson University Physicians’ (JUP) Strategic Approach to VBP
Jefferson University Physicians (JUP) Faculty Practice Plan

- 20 Departments and divisions
- 650 Physicians
- 500,000 Ambulatory visits annually
Infrastructure to Maximize the Opportunity

- JUP Clinical Care Subcommittee (CCS)
- JUP Performance Improvement Team
- Value-based Purchasing Task Force
JUP Clinical Care Subcommittee (CCS)

- CCS consists of representatives from all clinical departments and oversees quality of ambulatory care
- David B. Nash, MD, MBA, Dean, Jefferson School of Population Health, chairs the JUP CCS
- Richard Jacoby, MD is the Director of JUP Ambulatory Care Performance Improvement
- JUP Administration is represented on CCS
The CCS monitors national and local trends in quality measurement and Pay for Performance, and provides education of faculty and practice staff.

The goal of the CCS is to create a JUP-wide quality culture, and to stimulate performance measurement and improvement in clinical departments and divisions.

Quality initiatives are selected, developed, and implemented in alignment with nationally endorsed measures.

Collaboration with practice operations and IT.
JUP Performance Improvement Team

- Funding from JUP supports a performance improvement team with clinical, statistical and administrative expertise
- Chaired by a physician dedicated to quality
- Meets weekly to discuss status of performance improvement/safety projects
- Liaison between CCS and the practices
Value-based Purchasing Task Force

• Convened by JUP Performance Improvement Team
• Monthly meetings with clinicians and administrators
• Liaison between practices and health plans
• Review of health plan reports and implementation of improvement initiatives
Specific Programs
JUP Participation in Pay for Performance Programs

- Commercial PPO
- Commercial HMO
- Medicaid HMO
- Medicare PQRS*

*Currently pay for reporting
Past Results

• Significant improvement in quality scores and reimbursement achieved through education, feedback on performance, and medical record reconciliation
• Individual provider reports for generic prescribing developed by PharmD
• Demonstration of the necessity of a quality team to spearhead project
• Family Medicine has established a departmental quality improvement team
Current Commercial PPO Contract

Divided into sections:

• Quality
  – Potentially Preventable Readmissions
  – Quality Measures

• Cost of Care
  – Medical Cost Management
  – Medical Episode Groups
  – Generic Prescribing
Current Commercial PPO Contract

• Action Plan
  – Engagement of already existing infrastructure
  – Establishment of ad hoc committees to oversee implementation and evaluation of quality interventions
  – Collaboration with providers and payers to get buy-in and feedback
Lessons Learned

• Need clarity and agreement on measurement parameters (and recognition of issues such as sample size, attribution)
• Need recognition of sicker, under-served, non-adherent populations
• Hospital and physician incentives need to be aligned
• Need frequent, timely feedback
Lessons Learned

• Providers do not believe that quality measures reflect quality of care
• Providers and practices need education on quality measures
• Improvement on quality program/indicators must be focus of senior management
• Incentives for physicians and administrators improve results
Emerging Models

• Efficiency measurement
• Accountable care organizations and case/bundled payments
• Primary care medical home and care coordination
• CMS VBP Program Proliferation
• CMS EHR Incentive Program/meaningful Use
Summarizing

• The focus of the health care debate is moving toward demanding efficient and effective care
• A critical mass of value purchasers is building; government has moved from following to taking leadership
• Value-based purchasing paradigms will transform practice plans by linking payments to the value of care
• Providers need to assess organizational structure and culture and proactively meet the challenge
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