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Pay for performance and public reporting on quality: changing the economic equation in healthcare

EXECUTIVE SUMMARY

The old mantra about achieving quality and efficiency in healthcare just won't go away. While researchers haven't been able to establish a direct link between the two—recent studies have found that achieving quality doesn't necessarily translate to less cost—the economics of healthcare won't let "well enough" alone, so to speak. The CMS/Premier Hospital Quality Incentive Demonstration and other initiatives, including those sponsored by health plans and employer groups, aim to integrate the twin beacons of healthcare through pay for performance programs, or P4P, and public reporting (or transparency) of provider quality scores.

Last year, CMS launched eleven ambulatory P4P demonstration projects and an equal number of inpatient ones across the country aimed at achieving quality and financial targets for about 20 core measures for diabetes, CHF, and MI, among other costly diseases; health plans are sponsoring other, similar projects. P4P is inextricably linked with transparency partly because, like the classic free market, it requires information to operate. Also, IT is an integral part of any P4P program because of its dependence on data.

In this issue of *Information Edge* we talk to several leading experts in P4P and public reporting, highlighting some of the latest and boldest examples in this fertile area. This is just the beginning of what could possibly become the greatest revolution in healthcare since the microscope, and it's all part of the increasingly smart use of IT in healthcare.

National experiment

"Pay for performance is a very important development," says Janet Corrigan, PhD, MBA, CEO of the National Committee for Quality Health Care, a Washington, DC-based not-for-profit educational institute and membership organization of senior executives from health systems and suppliers. NCQHC just released its CEO Survival Guide to Pay for Performance. "It's spreading at a rapid pace," she notes, with about 100 P4P programs in operation across the country in addition to the CMS demonstration projects.

"So, we have a tremendous amount of innovation and experimentation in pay for performance," says Corrigan, who estimates that current programs offer modest reward programs of less than 5% of compensation but go as high as 10% for physicians. As those percentages climb they will increasingly get the attention of providers, she says.

Also, as the measurement sets become more comprehensive, there are stronger incentives to standardize to ensure the programs are done well and safely as well as to provide more coordinated systems of care. For example, many areas of performance deal either with "handoffs" between providers or whether the chronically ill receive an organized set of services. Both of those factors demand coordination

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of care. That fact also places greater importance on implementation of electronic health records (EHRs) for the exchange of clinical information and heightened interest in community-wide or regional data-sharing networks.

Janet Corrigan, PhD, MBA, CEO, National Committee for Quality Health Care, Washington, DC

"Providers will find it extremely difficult to meet data requirements," says Corrigan, despite the fact that administrative and claims information may currently be used as the primary source for measurements, because as the sets become more comprehensive providers will need EHRs. Clinical decision support with its automatic prompts and reminders will also be imperative if providers want to perform well and share in the rewards of P4P.

"One of the reasons there's keen interest on the part of private and public purchasers in moving toward P4P is that under current fee for service providers are not financially rewarded for EHRs or other quality initiatives like multidisciplinary teams," says Corrigan. "Some of these payment systems are toxic to performance, so purchasers are trying to correct and align financial systems with advances in automation. If we're really going to embrace quality then we need to make a variety of changes, including payment, to encourage quality and remove barriers to it."

She says it's difficult to know how far P4P will go. "We're in an early stage. My hope is that we'll do careful evaluations and continue tweaking to get the maximum impact on our providers. Most P4P programs go hand-in-hand with public reporting and that will have an important impact by informing the lay public how much variability there is in quality. That will contribute to greater education and knowledge and help us move toward better marketplace performance," says Corrigan.

Reporting from California

"P4P is a catalyst that helps to focus attention on the need for general improvement in care quality and reform provider compensation," says Tom Williams, executive director of the Integrated Healthcare Association (IHA), an Oakland, Calif.-based not-for-profit that fosters collaboration among all stakeholders in the healthcare industry. "P4P is not just a U.S. issue, primary care doctors in England receive a third of their compensation based on performance," he says.

Tom Williams, executive director, Integrated Healthcare Association, Oakland, Calif.

IHA this month published a report detailing lessons learned from five years' experience with P4P in California, which it says is the nation's largest and most comprehensive quality-incentive program in the country to date. The initiative involves 225 physician groups representing about 35,000 doctors providing care for 6.2 million HMO patients in California.

IHA's P4P program completed three years of measurement, for the first two of which it could report results and payments. By meeting performance targets, physicians received a combined total of about $90 million in 2003/2004 P4P-related bonus

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payments from seven participating health plans. Payouts based on 2005 will be made later this year.

Transparency via public reporting is a key part of the California P4P program and, in that vein, organizers adopted the California State Office of the Patient Advocate's (OPA's) annual consumer-focused score card for HMO performance as the foundation for a clinical scorecard for California physician groups.

The score card is available online at www.opa.ca.gov, allowing consumers to select a particular county to view overall performance of all the groups that provide services in their area. They can then scroll down to see performance on each measure for each group.

While the IHA acknowledges that the program has not yet achieved "breakthrough improvement," physicians across the board have collectively improved across each measure in all three domains of clinical, patient experience and IT adoption results (see tables). In terms of clinical results, for example, 87% of groups reporting all clinical measures improved their overall clinical score by an average of 5.3 percentage points from Year 1 to Year 2. Performance on the individual clinical measures improved between 1.1 and 10.2 percentage points, according to the report, which acknowledges that actual rates are slightly lower than the national average, but that the gap is decreasing.

Sample of Improvements in Clinical Measures

Measure	Number of Groups Scored	Number of Groups Improving	Pct of Groups Improving	Average Pct Point Change in Performance
Clinical				
Clinical Average	46	40	87.0	5.3
Breast Cancer Screening	167	94	56.3	1.1
Cervical Cancer Screening	168	130	77.4	5.4
Asthma Overall	132	94	71.2	2.6
HbA1c Screening	166	100	60.2	3.5
Cholesterol Screening (Cardiac Patients)	46	41	89.1	10.2

Source: Integrated Healthcare Association

Improvement also occurred in the second year in overall patient experience results, with two-thirds of groups increasing by an average of 1.2 percentage points. From 2003 to 2004, improvement was seen in each of the survey questions covering patient experience measure of overall ratings of care and specialty care.

Patient Experience: Improvement across Many Physician Groups

Measure	Number of Groups Scored	Number of Groups Improving	Pct of Groups Improving	Average Pct Point Change in Performance
Patient Experience				
Survey Average	108	71	65.7	1.2
Rating of Doctor	115	62	53.9	0.5
Rating of All Health Care	115	73	63.5	1.4
Specialist Problems	109	64	58.7	2.2
Rating of Specialist	108	63	58.3	0.8

Source: Integrated Healthcare Association

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content. Additionally, grading of both the quality of evidence and the strength of major clinical recommendations adds additional support for implementing evidence-based medical practices.

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Welcome Jeff Reihl, executive vice president, Jerry Osheroff, M.D., chief clinical informatics officer, and the entire Micromedex team.

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March 8
HIPAA Security: A Discussion of Issues and Solutions
- Bob Gross, HIPAA program manager, University of Chicago Hospitals
- Suzi Birz, principal, HiQAnalytics, Chicago

March 15
Integrating the Enterprise: A University Hospitals Health System Case Study
- Joe Casper, senior VP, FCG, Long Beach, Calif.

March 16
The Connected Health Imperative
- Joseph C. Kvedar, MD, director, Partners Telemedicine, Partners Healthcare, Boston
- Khinlei Myint-U, corporate director, Partners Healthcare, Boston
- Douglas McClure, corporate director, Partners Healthcare, Boston

March 20
Improving ED Patient Flow at Provena
- Jeffrey Brickman, CEO, Provena, Mokena, Ill.
- Kathy Mikos, VP, Patient Services, Provena, Mokena, Ill.
- Lon McPherson, MD, VP, Medical Affairs, Provena, Mokena, Ill.
- Michael Ugwueke, VP, Operations, Provena, Mokena, Ill.

more events on next page

The most dramatic improvements were seen in IT adoption. From Year 1 to Year 2, there was a 54% increase in the number of groups qualifying for at least partial IT credit. In Year 2, more than half the groups reported some IT capability, versus only a third for Year 1. Of the groups that received no credit for IT in Year 1, more than a third demonstrated some IT capability in Year 2.

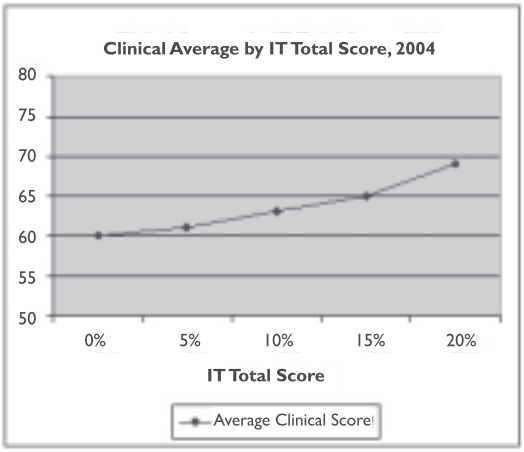
Improved 2004 IT Adoption Results

IT Measures	Pct of Groups	Pct of Groups	Pct increase in Groups Qualifying from 2003 to 2004
Integration of Electronic Clinical Datasets			
Actionable Reports	24.7%	39.1%	58.7%
Registry or Data Warehouse	16.7%	25.8%	54.0%
HEDIS Results	11.2%	37.3%	234.4%
Point of Care Decision Support Technology			
Electronic prescribing	4.7%	8.9%	91.1%
Electronic drug checks	4.2%	12.9%	207.9%
Electronic retrieval of lab results	16.7%	27.1%	61.9%
Accessing clinical notes of other practitioners	11.6%	21.3%	83.5%
Physician Preventive & Chronic Care Reminders	7.0%	12.0%	72.0%

Source: Integrated Healthcare Association

Of special interest to Scottsdale Institute members, the IHA report found a correlation between clinical and IT performance. Physician groups who received full credit on the IT measures had average clinical scores that were nine percentage points higher than physician groups who showed no evidence of IT adoption.

Correlation between Clinical and IT Performance



Source: Integrated Healthcare Association

Based on its experience, the California P4P program has revised its original mission and developed a set of recommendations to guide development and implementation over the next five years:

1. Increase incentive payments proportional to improvements in performance outcomes;
2. Aggressively develop and expand the performance measurement set;
3. Strengthen Pay for Performance administration to support an increasingly sophisticated program; and,
4. Further develop public reporting, research and public relations.

(The full report, "Advancing Quality through Collaboration: The California Pay for Performance Program," is available at www.iha.org.)

Pioneering public reporting in Kentucky

Like Daniel Boone blazing new trails in the Kentucky wilderness 200 years ago, Louisville-based Norton Healthcare is blazing trails in the same state—and the country—in its bold and courageous program for publicly reporting performance of its hospitals against objective quality indicators.

Launched just 11 months ago, the Norton Quality Report, available on its website at http://nortonhealthcare.com/, rates its hospitals against more than 200 nationally recognized quality indicators and practices. Where available, performance is also displayed for the average hospital in Kentucky and in the United States.

The quality report uses color-coded ratings—green (better than the national average), beige (near the national average) and red (worse than the national average)—and provides a descriptive phrase to identify an indicator. Clicking on the indicator triggers a pop-up box with a more detailed description. The indicators cover a multitude of areas ranging from patient satisfaction and infection control to pneumonia, heart attack and patient safety.

Dan Varga, MD, CMO, senior VP, Norton Healthcare, Louisville, Ky.

The objective was to make it easy to use, intuitive and understandable by the layperson—but also unimpeachable. "We wanted a quality report that was comprehensive, public and unassailable in its integrity," says Dan Varga, MD, CMO and senior VP at Norton in charge of the effort and current president of the Kentucky Medical Association. Making the report web-based allowed anyone to have access and enabled Norton to make the data as real-time as possible. While it's currently updated monthly, over time the goal is to make the data daily, which should be expedited by the fact that Norton just unified its IT platform on Meditech.

Making the report comprehensive meant going beyond just a few indicators of other programs like the JCAHO/CMS core measures. Finally, in terms of unassailability of objectivity, Norton used nationally accepted quality indicators from groups like JCAHO and CMS, but also the Agency for Healthcare Research and Quality (AHRQ), National Quality Forum (NQF) and the national Association of Children's Hospitals and Related Institutions (NACHRI).

Varga says two factors guided selection of quality portfolios: 1) Norton rejected "cherry picking" indicators just to look good, and 2) Regardless of what internal analysis could determine, the number measured was the number published. For example, even if Norton found that negative ratings from post-operative sepsis could be explained by factors outside the purview of the quality indicators the organization adopted, "We wanted to be absolutely faithful to the data rules," he says.

The response both internal and external has been positive. "Now, 11 months into this whole report, we can tell the world that public reporting did not put us out of business," declares Varga. "The reaction of the community has been largely 'Good for you!' The biggest impact without question is internal. People tend to focus on what needs improvement—to make that red box green. We've seen unequivocal improvement." The goal to make statistically significant improvements on at least half of the indicators within the first year, for example, have already been surpassed when Norton moved ahead on 90% of them within 10 months.

Montana's quality clinic

As one of 11 physician group practices participating as a P4P pilot in the CMS demonstration program, Billings Clinic, an integrated multi-specialty clinic and a hospital in Billings, Mont., has a two-fold goal to determine if it can 1) Reduce the rate of growth of Medicare costs, and 2) Do that while maintaining or improving quality.

Upcoming Events continued

March 21
Clinician and Physician Portals Update
- Scott Holbrook, KLAS, Orem, Utah

March 23
Bar Coding and Smart Pumps Impact Safety at Partners Healthcare
- Patrick Harding, project manager and lead analyst, eMAR, Brigham and Women's Hospital, Partners Healthcare System, Boston
- Anne Bane, RN, MSN, project manager, eMAR, clinical business owner, Brigham and Women's, Partners Healthcare System, Boston

March 29
Chronic Disease Registries: Supporting Proactive Care and Performance Improvement at New York City Health and Hospitals Corporation
- Louis J. Capponi, MD, CMIO, NYCHHC

April 24
Enterprise Deployment of SNOMED at Kaiser
- Robert H. Dolin, MD, Kaiser Permanente, HL7 Board Member and Co-chair of the HL7 Structured Documents Technical Committee, Oakland, Calif.

April 26
Options for Hosting Community IT Solutions
- Keith MacDonald, research director, FCG Emerging Practices, Boston

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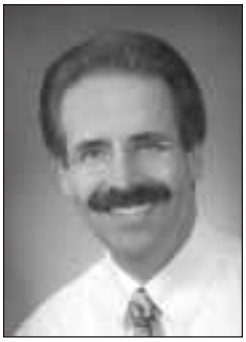
"Our mantra: Quality measures are all about ambulatory care and savings are all about inpatient care."

Billings Clinic has about 15,000 patients in its study group and an equal number in a comparison group, with the first patient group selected because they receive the predominance of their services from Billings Clinic. Both groups are comprised of Medicare patients living in the region.

Billings Clinic is just completing the second year of the four-year pilot; the first year was used to gather baseline data for financial and quality measurements. In the ensuing years that data will help determine if the clinic's rate of growth is less than the comparator group, in which case Billings Clinic would be able to share in that savings with the federal government.



Mark Rumans, MD, chief of staff, Billings Clinic, Billings, Mont.

In the first year after baseline data are gathered, 30% of payments are based on meeting quality targets, 70% on meeting financial targets. Those percentages change to 40/60 respectively in the second year, and 50/50 in the third. However, before those calculations kick in, there's a threshold of 2% between the study and comparator groups. "Each year we ramp up, which makes sense because there's more and more emphasis on integrating quality with financial factors," says Mark Rumans, MD, chief of staff at the Billings Clinic.

Under current rules, if the clinic saves Medicare $1 million, for example, it actually could get back as much as $700,000. The final amount, however, will be based 70% on financial targets and 30% on quality targets.

For Year One, CMS has identified core performance measures for diabetes and congestive heart failure, so Billings Clinic launched initiatives in those areas. It has implemented a robust disease-management program and, for diabetes, is leveraging IT to enable real-time data regarding such factors as a patient's hemoglobin A1c, eye and foot exams. For CHF, an outpatient monitoring program involves patients calling in daily to report weight and answer various questions.

"That program has been shown to reduce all admissions. Our mantra is quality measures are all about ambulatory care and savings are all about inpatient care," says Rumans. He says the clinic is focusing heavily on metabolic diseases like diabetes and hypertension to that end. Besides CHF, the focus in cardiology is on coronary artery disease. Also this year the pilot is targeting influenza and pneumococcal vaccination. In the third year colorectal and breast-cancer screening as well as end-of-life care will come under the P4P program. "We're trying to tackle all those at once. There's no quality measure for end-of-life care but that's an area in which we want to control costs better," he says.

Rumans says that as Billings Clinic rolls out its disease-management program it is applying it to all diabetics for which it cares, not just those under Medicare in the study. "Some of these initiatives are labor and IT intensive. If we're going to start reporting on some patients, we're going to report on all of them," he says. Rumans adds that the clinic's rollout of a Cerner clinical information system has not been altered by the P4P pilot but that it bumped up the chronic disease management component to an earlier phase of implementation.

"There's been lots of process change," around the P4P pilot, he says, the most extensive of which has involved increasing the CHF population to 1,500 from 300 in its telephone/web-based monitoring program.

The overall challenge in this CMS P4P pilot—at least financially—says Rumans, is meeting the 2% threshold before the clinic can begin to share in savings. There is some risk in loss of Medicare revenue by reducing admissions. "The worst financial scenario is we save Medicare 1.9% after expending resources and it results in being a loss to us."

Still, Rumans believes Billings Clinic is on the right path. "Our belief is that P4P in some variation is already upon us and will continue to evolve. We've already been able to influence providers and we're fully committed to public reporting. Contained within our vision statement is to provide the highest quality care to our patients."

Transparent America

With 55 million people to whom it provides services and about 26 million covered lives, Edina, Minn.-based UnitedHealthcare is one of the largest for-profit health insurer in the country—and a long-time advocate of providing information privately to physicians to encourage quality improvement. Now, like the national trend, that policy has become public.

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Lewis G. Sandy, MD, executive VP, UnitedHealthcare, Minneapolis

"We're strong proponents of information transparency to promote informed consumer choice and continuous improvement in care," says Lewis G. Sandy, MD, UHC's executive VP for clinical strategies and policy. "Our strategy is to institute information transparency for all our customers within a broad national network," rather than offering separate networks or products. The vehicle for this effort is UHC's Premium℠ Designation initiative, launched last year to make information available to consumers and providers on the UHC website rating how the 450,000 physicians in its network perform against national standards.

The program currently measures 19 medical specialties as well as cardiac hospitals in about 50 markets and will be rolled out to most of the country by the end of the year. UHC has worked closely with medical specialty societies like the American College of Cardiology to adopt those organizations' measures of care, which are typically based on structure and process rather than outcomes because the specialty groups consider the latter to be heavily influenced by clinical variables. UHC uses robust business-analytics software to drill down into claims information to measure how well a particular physician practice does against the standards of the specialty itself.

For example, UHC measures interventional cardiologists' compliance with giving patients beta blockers following heart attacks, restudy rates for diagnostic angiography and redo rates for interventional procedures.

A single star icon is given to those physicians who exceed the standards for quality. Efficiency measurements occur only after quality standards are met. "Quality has to come first. You don't want to measure efficiency just to identify a low-cost practice," says Sandy. If a physician meets the efficiency threshold, she receives a second star.

The program's goal is to integrate quality and efficiency. Says Sandy, "If you think about quality and efficiency on two separate axes, the sweet spot is in the upper-right quadrant. Our aim is to have everyone move to there. We'd like consumers to seek out providers in the upper-right quadrant." It's still too early to tell, he says, if that is in

"Quality has to come first. You don't want to measure efficiency just to identify a low-cost practice."

fact occurring but he says providers have shown a lot of interest in participating.

Have legs, will travel

One thing is clear: pay for performance isn't possible without IT-enabled business analytics.

Jeff Hanson, VP, Pay for Performance, Thomson Medstat, Ann Arbor, Mich.

"This P4P phenomenon has more legs than the Rockettes at Radio City Music Hall."

"P4P really is about data," says Jeff Hanson, VP, Pay for Performance at Thomson Medstat, an Ann Arbor, Mich.-based business-intelligence and database firm serving all sectors of healthcare. Medstat, a sister company of Scottsdale Institute sponsor Thomson Micromedex, has targeted P4P as an area of growth for its consulting and benchmarking services, he says.

"This P4P phenomenon has more legs than the Rockettes at Radio City Music Hall," says Hanson. "Health plans, physicians, hospitals, CMS—all these entities playing together in the sandbox. Now we have these data and need to determine what measures we're going to look at."

Hanson, who was president of the Bridges to Excellence program prior to joining Medstat, recalls CEOs complaining about how they'd spent billions on medical claims alone and their employees were still getting sick. "We couldn't tell them what they were getting for their money" because the business intelligence wasn't available, he says, adding, "I'm looking for a new doctor in Washington, DC. I know more about the auto I'm going to buy."

It's critical to partner with the physician community, which understands that every patient is different and that the healthcare system is riddled with nuances, says Hanson. At the same time, he acknowledges it's possible to arrive at "a pretty good idea of measures we need to collect. Pay for performance isn't about creating a penalizing system. One of its goals is to give information back to physicians so they can see where they are not meeting recognized quality standards and give them tools to get them there."

Conclusion: Not if, but…

David Classen, MD, VP at FCG and associate professor of medicine at the University of Utah, predicts that CMS will slow down the roll-out of required measures for P4P in response to pushback from the American Medical Association, but will eventually establish them as the basis for all Medicare payments.

David Classen, MD, VP, FCG, Long Beach, Calif., Associate Professor, University of Utah, Salt Lake City

"The trend is not going away. It's not a question of if but how fast, both in the inpatient and outpatient arenas. We will come to agreement on content and measures before we come to agreement on methods of reimbursement," which individual health plans will configure differently, he says.

NCQHC's Corrigan acknowledges that many physicians view P4P as just another new tool to manipulate them financially, but she says P4P is actually a boon for providers. "It's always easy to talk about these things from a policy perspective and entirely another thing to be on the front line. Providers are stressed now, under lots

of pressure. But current payment systems do not reward achieving quality and safety. P4P is not a perfect solution but it is a step in the right direction—and there has been a great deal of physician leadership and input," she says, including developing of measures by the Ambulatory Health Care Quality Alliance and the CMS demonstration projects.

"They will evolve over time. P4P is an enabler that opens the door. The good side is that it will be possible to still make money and do better for patients. Everybody wants that."

Medstat's Hanson's sees P4P evolving in a way that integrates incentive plans for both physicians and consumers. "They have to be partners. We need to nurture and support the patient/physician relationship. My vision is that in 10 years I'll be walking into my physician's office like I walk into my financial advisor's office, saying, 'Let's figure out what the best plan is,' almost like putting together a retirement plan."

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