

Pay for Performance Dr. Alice Loveys

*Taking HIT to the Next Level:
Physicians Working with Technology*

Maximizing Your EMR for P4P
(Really Your Office)

The Medical Society of the State of New York Task Force on Health Information Technology
Supported by the New York State Department of Health

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Objectives

- P4P evolution
- Organizations involved in P4P
- National, State and Local Initiatives
- Characterize Practices that Maximize returns in P4P programs

Provider Success in P4P

- Be involved in understanding P4P programs
- Need to be electronic
- Involve Staff
- Be prepared to change processes in office

Integrating new technology?

- Carefully consider the costs and benefits EMRs, Electronic Prescribing bring to the practice
- Calculate in P4P direct incentives, improved performance, public relations, improved patient safety
- Consider what plans with whom you contract are doing re: P4P and public reporting

Driving Forces

- “Healthcare is the one thing we purchase where we can neither guarantee the quality or the value” - Head of HR for a Fortune 500 Company

Driving Forces

- Purchasers of Healthcare
- Escalating Costs - Business
- Shifting of some costs to Consumers
- Largest Purchaser - The Federal Government
- Reimbursements for Physicians dropping

Theory and Evolution of P4P

- Best Practices to get the Best Value
- Value, what is spent to get desired outcome
 - not desired outcome at all costs
- Gather data - analyze the data
- Feedback to providers
- Reporting to Consumers

Theory and Evolution of P4P

- Where's the data?
- Initial p4p was off claims data
- Quality reporting tied to claims data (PQRI)
- Current models look at both process and outcomes
- To gather data is resource intensive
- Need data electronic

Carrot and the Stick

- HEADLINES
- HHS urges Congress to include IT adoption in physician payment fix bill
- CMS Drops Exemption To Drive Adoption of E-Prescriptions
- P4P - penalty for paper

Who Decides?

Advocacy

- Physician groups - AMA, ACP, AAP, AAFP, AOA
- Vendor Associations (HIMSS)
- Standards Organizations (HITSP)
- Credentialing/Reporting Organizations (NCQA, NQF, CCHIT, BTE, AHRQ)
- QIOs - Quality Improvement Organizations
- Foundations - Commonwealth Fund; Robert Wood Johnson

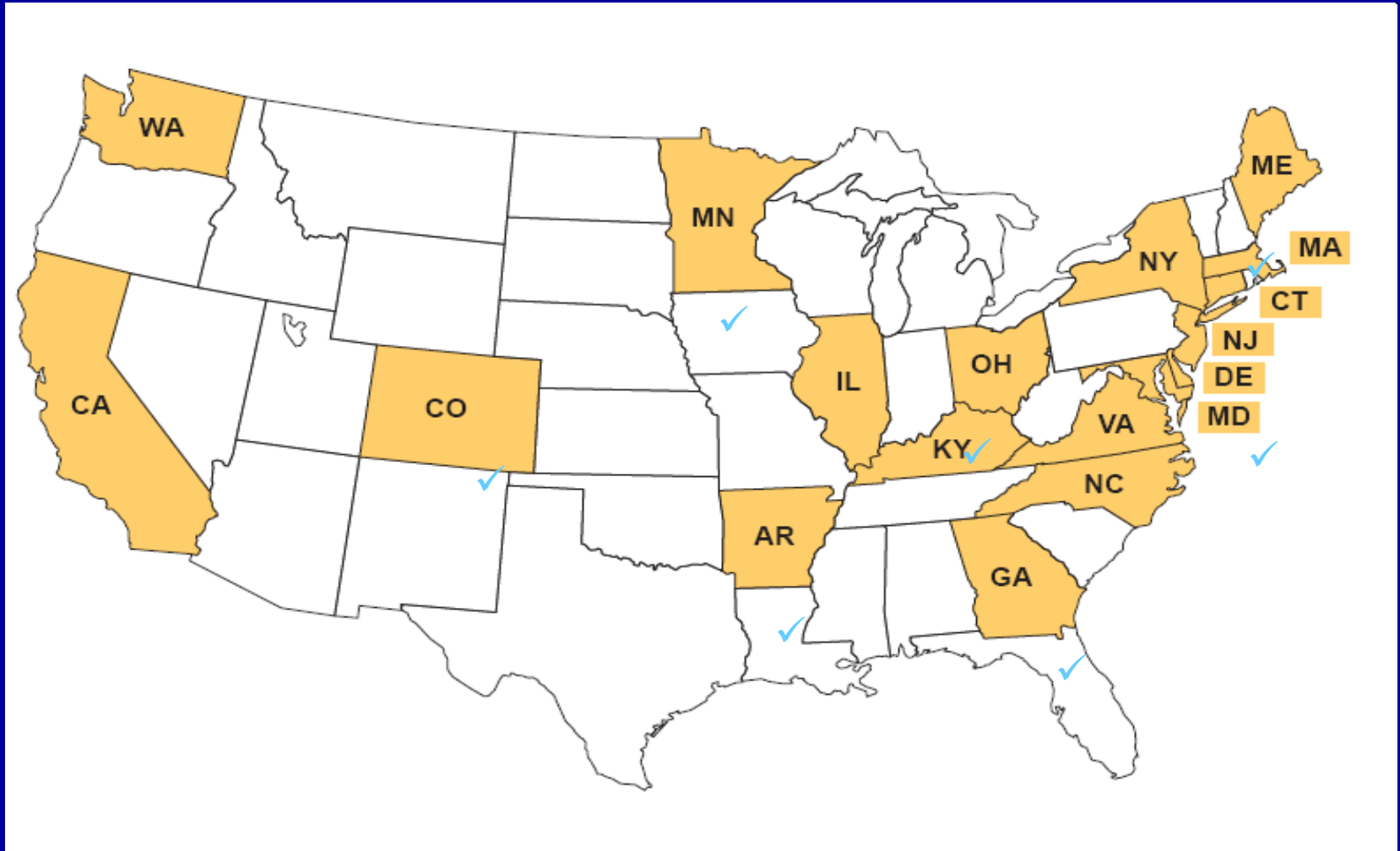
One Example
BTE
Lessons Learned

Bridges to Excellence Mission

- *Bridges to Excellence is a not-for-profit organization developed by employers, physicians, health care services researchers, and other industry experts with a mission to create significant leaps in the quality of care by recognizing and rewarding health care providers who demonstrate that they have implemented comprehensive solutions in the management of patients and deliver safe, timely, effective, efficient, equitable and patient-centered care.*

BTE today

Physician Office Link
Diabetes Care Link
Cardiac Care Link
Spine Care Link



8,500 BTE-Certified Physicians

BTE Programs That Tie Rewards to Results

- **Physician Office Link** – Based on NCQA's Physician Practice Connections (PPC v2), or the QIO Practice Assessment, practices that go through the recognition process successfully are rewarded up to \$50/pmpy
- **Diabetes Care Link** – Based on the NCQA's Diabetes Physician Recognition Program (DPRP), eligible physicians can qualify for \$80/diabetic/y
- **Cardiac Care Link** – Based on the NCQA's Heart-Stroke Recognition Program (HSRP), eligible physicians can qualify for up to \$160/cardiac/y
- **Spine Care Link** – Based on the NCQA's Back Pain Recognition Program (BPRP), eligible physicians can qualify for up to \$50/back pain/y

Progress in P4P

Lessons Learned from BTE*

- Early Programs suggest Incentives work
- Practices actively make process improvements in what they perceive to be a P4P environment
- P4P quality goals set the standard so keep them high: it promotes a culture of progress and continuous improvement
 - » *Bridges to Excellence

Progress in P4P

Lessons from BTE

- Rewards aren't currently high enough
- Recognition of structural investment for physicians
- Transformation process is financially difficult for practices
- Current lack of standards for electronic reporting
- Evolving programs for what gets reported

P4P and HIT

- Pay for Performance
- Initially Pay for Participation

Local CDPHP

2005 -2006 P4P

- \$4,000,000 of incentive paid out for being electronic and having some interoperability
- 5000k evidence of EMR
- 5000k for importing data
- 5000k if could export data

Hot off the Press

- CDPHP puts up \$1,000,000 to help small physician offices go electronic

NYS HEAL

- HEAL - Health Care Efficiency and Affordability Law
- HEAL V grants - specifically to encourage EMR adoption, quality reporting

National Headlines

From Ihealth Beat October 30, 2007

- Bush Administration To Reward Physicians for Using Health IT
- Participating physicians will receive additional Medicare payments

CMS/HHS

- Pilot Project
- 12 Communities Nationwide
- 1200 Physicians
- Communities not yet selected

P4P

- Pay for Participation is transitioning to *Pay for rePorting*
- Doctors in the program will be expected to do reporting

Pay for rePoring

- PQRI - Physicians Quality Reporting Initiative
- Quality reporting tied to claims
- Up to 1.5% bonus for Medicare payments

Organizations

NQF National Quality Forum

- Non-profit established 1998
- Leaders from consumer, purchaser, provider, health plan, and health service research organizations
- CMS has contracted with to recommend standards for reporting

NCQA

- National Committee for Quality Assurance formed in 1990
- Private not-for-profit
- Measure. Analyze. Improve. Repeat.
- Accreditation and Evaluation for Healthcare Systems and Providers

Newest Physician Recognition Program

- Patient Center Medical Home
- Strong support from Physician Organizations
- Patient Centered Primary Care Collaborative

- NCQA quality measurement
- Recognizing practices as patient-centered medical homes
- Evaluation tool: Physician Practice Connections[®]—Patient-Centered Medical Home (PPC-PCMH)

NCQA

Mission

To improve the quality of health care.

Vision

To transform health care through quality measurement, transparency, and accountability.

Physician Practice Connections[®] (PPC) Measurement

- Measures evaluate
 - Use of systems
 - Effectiveness in prevention
 - Management of chronic illness and patient safety
- Measures are “actionable” at physician practice level
- Measures are validated by relating them to performance

ACP, AAFP, AAP, AOA Joint Statement – April 2007

- **Personal physician** – each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- **Physician directed medical practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole person orientation** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- **Care is coordinated and/or integrated** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Patient Centered Primary Care Collaborative

- In North Carolina approach has resulted in substantial savings for Medicaid - \$231 million in 2005-2006
- A 2006 Commonwealth Fund - racial and ethnic disparities in access to care and quality are reduced or even eliminated and rates of preventive screenings improve substantially.

Patient Centered Primary Care Collaborative

- Business Savings - IBM's Experience
- Patient-centered primary care programs achieved high patient satisfaction and significant savings.
- IBM health care premiums are 6 percent lower for family coverage and 15 percent lower for single coverage, and IBM employees pay 26 percent to 60 percent less overall.*

» *when compared to industry norms

PPC-PCMH Content and Scoring

Standard 1: Access and Communication A. Has written standards for patient access and patient communication** B. Uses data to show it meets its standards for patient access and communication**	Pt 4 5 9	Standard 5: Electronic Prescribing A. Uses electronic system to write prescriptions B. Has electronic prescription writer with safety checks C. Has electronic prescription writer with cost checks	Pts 3 3 2 8
Standard 2: Patient Tracking and Registry Functions A. Uses data system for basic patient information (mostly non-clinical data) B. Has clinical data system with clinical data in searchable data fields C. Uses the clinical data system D. Uses paper or electronic-based charting tools to organize clinical information** E. Uses data to identify important diagnoses and conditions in practice** F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	Pt 2 3 3 6 4 3 21	Standard 6: Test Tracking A. Tracks tests and identifies abnormal results systematically** B. Uses electronic systems to order and retrieve tests and flag duplicate tests	Pts 7 6 13
Standard 3: Care Management A. Adopts and implements evidence-based guidelines for three conditions ** B. Generates reminders about preventive services for clinicians C. Uses non-physician staff to manage patient care D. Conducts care management, including care plans, assessing progress, addressing barriers E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	Pt 3 4 3 5 5 20	Standard 7: Referral Tracking A. Tracks referrals using paper-based or electronic system** Standard 8: Performance Reporting and Improvement A. Measures clinical and/or service performance by physician or across the practice** B. Survey of patients' care experience C. Reports performance across the practice or by physician ** D. Sets goals and takes action to improve performance E. Produces reports using standardized measures F. Transmits reports with standardized measures electronically to external entities	PT 4 4 Pts 3 3 3 2 1 15
Standard 4: Patient Self-Management Support A. Assesses language preference and other communication barriers B. Actively supports patient self-management**	Pt 2 4 6	Standard 9: Advanced Electronic Communications A. Availability of Interactive Website B. Electronic Patient Identification C. Electronic Care Management Support	Pts 1 2 1 4

**** Must Pass Elements**

PPC-PCMH Scoring

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	75 - 100	10 of 10
Level 2	50 – 74	10 of 10
Level 1	25 – 49	5 of 10
Not Recognized	0 – 24	< 5

Levels: If there is a difference in Level achieved between the number of points and “Must Pass”, the practice will be awarded the lesser level; for example, if a practice has 65 points but passes only 7 “Must Pass” Elements, the practice will achieve at Level 1.

Practices with a numeric score of 0 to 24 points or less than 5 “Must Pass” Elements are not Recognized.

PCMH “Must Pass” Elements

- **Written standards for patient access and patient communication**
- **Use of data to show meeting this standard**
- **Use of paper or electronic-based charting tools to organize clinical information**
- **Use of data to identify important diagnoses and conditions in practice**
- **Adoption and implementation of evidence-based guidelines for three conditions**
- **Active support of patient self-management**
- **Tracking system to test and identify abnormal results**
- **Tracking referrals with paper-based or electronic system**
- **Measurement of clinical and/or service performance**
- **Performance reporting by physician or across the practice**

Linkage of PCMH to Reimbursement: One Model

Pay for Performance
Quality, Resource Use and Patient Experience

Fee Schedule for Visits/Procedures

Payment per Patient for Qualified Medical Homes
(services not normally reimbursed)

Implementation of PCMH

- Regional sponsors (plan, coalition, employer group) to engage in demonstration projects
- Participating practices agree on core elements of PCMH
 - **Sign attestation of core principle of PMCH (as defined by AAP, AAFP, AAP, AOA)**
 - **Tool to Recognize practices as PCMH's using PPC-PCMH**
 - **Link to incentive payment for being a PCMH**
 - **Evaluate demonstration projects**

Prospective Evaluation of PCMH Demonstration Projects

- Likely to be multiple evaluators-decisions will be made by plans and foundations
- NCQA is working with Commonwealth Fund and medical organizations to create common evaluation elements
 - **Standard set of clinical performance measures (NQF endorsed, where possible, use of NCQA Recognition programs)**
 - **Resource use/cost measurement at group or “virtual group” level (PCMH vs. non-PCMH)**
 - **Patient experience of care measures (CG-CAHPS)**

CAHPS

- Consumer Assessment of Healthcare Providers and Systems
- Program through AHRQ - Agency for Healthcare Research and Quality
- Clinician & Group Consumer Assessment of Healthcare Providers Survey

Practice Success

- Lessons learned from RIPA - Rochester Individual Practice Association
- P4P program with Excellus BC/BS

Elements of Success

- **Determine the practice changes needed to improve measure outcomes**
 - **Calculate their costs and your ROI**
- The most successful practices involve staff in improvements
- Brainstorm other less costly ways to improve measure outcomes – involve practice staff

RIPA “Fishbowl” Experiment

- We gathered together Family Medicine committee members
- Put high performers in the middle
- What was the difference?
 - Those inside believed the measures would improve the care of their patients AND they were committed to improving their scores
 - Those outside were angry about P4P

RIPA Case Study – Incent your staff!

- A large primary care group pools their PFP funds
- 15% is set aside for bonuses to support staff
- Result: Receptionists help remind patients to get mammography and fill their CAD, DM and Asthma prescriptions

Implementation

- Remember - the most successful practices maintain registries and involve staff in improvements
- Meet with staff to organize the practice changes needed to improve measure outcomes
- Re-explore other ways to improve measure outcomes – involve practice staff

Communication

- Communicate measures to patients and encourage their participation
- Find out what others are doing and use their imagination and tools – ask who the best performers are
- Experiment with alternative strategies
- Chart and Share progress with the team
- Individualize results as much as possible

Summarizing to Succeed

- ORGANIZATION and feedback is critical
- Understand Change Management
- Use incentives as a way to better manage the practice
- Create prompting systems that don't involve the physicians!!!!
- Involve practice staff in the improvement process – consider sharing the “bonus”
- Promote more patient involvement

Role of Physician Leaders

- Involvement in shaping payment reform
- Consensus on performance measures
- Professional maintenance of certification aligned with performance goals
- Re-engineering practices to achieve greater efficiency and higher quality
- Partnering with other providers to improve care coordination, disease management, and transitional care
- Developing standards for advanced primary care practices, group practices, integrated delivery systems
- Sharing best practices and disseminating innovation

Web Sites

- Nqf <http://www.qualityforum.org/>
- BTE <http://www.bridgestoexcellence.org/>
- NCQA <http://web.ncqa.org/>
- PQRI <http://www.cms.hhs.gov/pqri/>
- PCPCC <http://www.pcpcc.net/>
- GA -cahps <http://www.cahps.ahrq.gov>

Acronyms

- AAFP - American Academy of Family Physicians
- AAP - American Academy of Pediatrics
- AHRQ - Agency for Healthcare Research and Quality
- AMA - American Medical Association
- AOA - American Osteopathic Association
- BtE - Bridges to Excellence
- CG-CAHPS - Clinician & Group Consumer Assessment of Healthcare Providers Survey

Acronyms

- HIMSS - Health Information Management and Systems Society
- HITSP - Health Information Technology Standards Panel
- NCQA - National Committee for Quality Assurance
- NQF - National Quality Forum
- RIPA - Rochester Individual Practice Association