Agenda

• Why Community Collaboration?
• Case Study: California P4P
  – Program Structure
  – Program Governance and Administration
  – Program Results
    • Performance
    • Public Report Card
    • Health Plan Payments
  – Program Evaluation
• Question and Answer
Integrated Healthcare Association (IHA)

- California leadership group
- Organized in 1996
- Equal stakeholder representation: Health plans, hospital systems, physicians
- Not a lobbying organization
- Attempts to influence policy through practice
Why Community Collaboration?

The Institute of Medicine (IOM) reports issue a call to action to improve the quality and safety of U.S. healthcare with specific recommendations:

- Quality measurement and reporting
- Public Transparency
- Incentives for quality improvement (Pay for Performance – P4P)
- Adoption of Information Technology
“..collaboration is the best strategy for dealing with problems of a world of growing interdependence. Collaboration is a process in which parties with a stake in a problem actively seek a mutually defined solution.”

Barbara Gray quoted in The Inter-Organizational Community, 1993, The Edwin Mellen Press by R.C. Anderson
**Defining Collaboration**

*Collaboration* is a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals.

The relationship includes:

- A commitment to mutual relationships and goals
- A jointly developed structure and shared responsibility
- Mutual authority and accountability for success
- Sharing of resources and rewards.

Case Study: IHA and California P4P

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

- ✔ Common set of measures
- ✔ A public scorecard
- ✔ Health plan payments
CA P4P History

- Statewide collaborative program
- 2000: Stakeholder discussions started
- 2002: Testing year
  - IHA received CHCF Rewarding Results Grant
- 2003: First measurement year
- 2004: First reporting and payment year
- 2007: Fifth measurement year; fourth reporting and payment year
The California P4P Players

- 8 health plans
  - Aetna, Blue Cross, Blue Shield, Cigna, Health Net, Kaiser, PacifiCare, Western Health Advantage

- 40,000 physicians in 228 physician groups

- HMO commercial members
  - Payout: 6 million
  - Public reporting: 12 million*

* Kaiser medical groups participated in public reporting only starting 2005
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* Starting in MY 2006, measures of absolute performance and improvement are included for payment.
IOM Recommendations for Medicare

Even

Clinical Quality: $1
Patient Centered: $1
Efficiency: $1

Uneven

Clinical Quality: $1.5
Patient Centered: $1
Efficiency: $0.5

CA P4P Program Governance

- Steering Committee – determine strategy, set policy
- Planning Committee – overall program direction
- Technical Committees – develop measure set
- IHA – facilitates governance/project management
- Sub-contractors
  - NCQA/DDD – data collection and aggregation
  - NCQA/PBGH – technical support
  - Medstat – efficiency measurement

Multi-stakeholders “own” the program
Gaining Buy-in

- Adoption of Guiding Principles
- Multi-step measure selection process
- Opportunity for all stakeholders to give input via public comment
- Open, honest dialog
- Frequent communication via multiple channels
CA P4P 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 and consultative services
CA P4P Funding Sources

• Grants from California HealthCare Foundation
  – Initial development and technical expansion
  – Evaluation

• Sponsorship from Pharma company
  – Committee meetings
  – Stakeholder Communications

• Health Plan Administrative Surcharge
  – Everything else
CA P4P Data Collection & Aggregation

Clinical Measures
- Audited rates using Admin data

Patient Experience Measures
- PAS Scores

IT-Enabled Systemness Measures
- Survey Tools and Documentation

Efficiency Measures
- Claims/ encounter data files

Data Aggregator: NCQA/DDD
Produces one set of scores per Group

Data Aggregator: Vendor/Partner: Medstat
Produces one set of efficiency scores per Group

Plans
- Physician Group Report

Group
- Health Plan Report

CCHRI
- Report Card Vendor
Overview of CA P4P Results

• Year over year improvement across all measure domains and measures
• Single public report card through state agency (OPA) in 2004/2005 and self-published in 2006
• Incentive payments total over $140 million for measurement years (MY) 2003-2005
• Physician groups highly engaged and generally supportive
CA P4P Performance Results

• **Clinical:** continued improvement across all measures
  - 1.9 to 4.8 percentage point increases from MY 2004 to MY 2005
  - 4.0 to 14.5 percentage point increases from MY 2003 to MY 2005

• **Patient experience:** modest improvement on all measures
  - 0.5 to 2.2 percentage point increases from MY 2003 to MY 2004
  - Methodology change in MY 2005, so no direct comparison

• **IT:** Expansion of capacity
  - 11 percentage point increase in the number of physician groups earning full credit from MY 2004 to MY 2005
Clinical Results MY 2003-2005

- Breast Cancer Screening
- Cervical Cancer Screening
- HbA1c Screening
- Chlamydia Screening
- Childhood Immunizations
Distribution of Overall Clinical Scores, by Measurement Year
Distribution of Overall Patient Experience Scores, by Measurement Year

Methodology Change 2004/2005
IT Measure 1: Integration of Clinical Electronic Data

Percentage of Groups

- Patient Registry
- Actionable Reports
- HEDIS Results

- MY 2003
- MY 2004
- MY 2005
IT Measure 2: Point-of-Care Technology

![Bar chart showing the percentage of groups using various electronic technologies across different measurement years. The chart includes categories such as Electronic Prescribing, Electronic Check of Prescription Interaction, Electronic Retrieval of Lab Results, Electronic Access of Clinical Notes, Electronic Retrieval of Patient Reminders, Accessing Clinical Findings, and Electronic Messaging. The chart compares the years 2003, 2004, and 2005.]
IHA Partnered in 2004 and 2005 with the California State Office of Patient Advocate (OPA) on a public report card:

- Widely disseminated
- Web-based and print versions
- “Consumer-friendly”
- Non-English availability
CA P4P Health Plan Payment

- Health plans pay financial bonuses to physician groups based on relative performance against quality benchmarks
  - $147 million paid out in first three years
  - 1-2% of compensation
  - Average PMPM payment varies significantly by plan, ranging from $0.25 to $1.55 PMPM

- Methodology and payment vary among plans

- Upside potential only
CA P4P Incentive Payment

- Relative performance vs. improvement?
- Float all boats – “Social Democrats”
- Survival of the Fittest – “Darwinians”
- Strong response from well managed, organized and capitalized groups
- Weaker response from underperforming groups/geographies
CA P4P Program Evaluation

- 5 year program evaluation by RAND and UC Berkeley (2003-2008)
- Physician groups highly engaged; view measures and public reporting favorably
- Payment and public reporting significant motivators
- Health plans and purchasers fear “teaching to the test” and want to measure overuse (efficiency)
- All stakeholders want to see ROI
In Conclusion:

P4P Policy Implications

- Unintended Consequences
- Socialization of Performance Measurement
- Payment Reform
- Care Delivery Process Redesign
- Health Information Technology
In Conclusion:
Collaboration Success Factors

Environment
• History of collaboration in community
• Group seen as legitimate leader in community
• Favorable political and social climate

Member Characteristics
• Mutual respect, understanding and trust
• Appropriate cross-section of members

Collaboration Success Factors

Process and Structure

- Members share stake in process/outcome
- Multiple layers of participation
- Development of clear roles and policy guidelines
- Appropriate pace of development

Collaboration Success Factors

Communication
• Open, frequent communication, often informal

Purpose
• Concrete, attainable goals/objectives

Resources
• Sufficient funds, staff and time
• Skilled leadership/facilitation

Questions?

For more information:

www.iha.org
(510) 208-1740
Appendices – Information Only

CA P4P Measurement Set
Efficiency Measurement
MY 2007 Clinical Measures

- Preventive Care
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Childhood Immunizations
  - Chlamydia Screening
  - Colorectal Cancer Screening

- Acute Care
  - Treatment for Children with Upper Respiratory Infection

- Chronic Disease Care
  - Appropriate Meds for Persons with Asthma
  - Diabetes: HbA1c Testing & Poor Control
  - Cholesterol Management: LDL Screening & Control (<130 and <100)
  - Nephropathy Monitoring for Diabetics
  - Obesity Counseling
Measure Selection Criteria

Include measures that are:
• Aligned with national measures (where feasible)
• Clinically relevant
• Affect a significant number of people
• Scientifically sound
• Feasible to collect using electronic data
• Impacted by physician groups and health plans
• Capable of showing improvement over time
• Important to California consumers
Advancement of Clinical Measure Set

- Original strategy was slow steady growth of the measure set
- Five Year Plan approved by Steering Committee in 2005 calls for aggressive development and expansion of the measure set
  - More clinical measures
  - Overuse and misuse measures
  - Outcomes measures
  - Specialty measures
2007 P4P Testing Measures

1. Appropriate Use of Rescue Inhalers
2. Potentially Avoidable Hospitalizations
3. Evidence-Based Cervical Cancer Screening of Average Risk, Asymptomatic Women
4. Childhood Immunization Status – Hepatitis A
5. Appropriate Testing for Children with Pharyngitis
6. Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis
7. Use of Imaging Studies for Low Back Pain
8. Annual Monitoring for Patients on Persistent Medications
9. Diabetes Care – HbA1c Good Control
Measure Adoption Process

1. Staff research
2. Technical Committee recommendations for testing
3. Steering Committee confirmation for testing
4. Public Comment for proposed testing measures
5. Technical Committee review and recommendations for modifications
6. Steering Committee review and approval
7. Adoption for testing
8. Testing
9. Return to step 2 for measure adoption process
No changes from MY 2006:

- Communication with Doctor
- Overall Ratings of Care
- Care Coordination
- Specialty Care
- Timely Access to Care
**MY 2007 Improvement**

Improvement over previous year P4P results:

*Health plans are encouraged to incorporate year-to-year improvement into their payment methodologies*
MY 2007 IT-Enabled “Systemness” Domain

• Replaces IT Domain
• Assesses to what extent Group uses systematic processes to consistently provide evidence-based, high quality care and service to all patients
• Online survey plus supporting documentation
• Re-certify for credit for unchanged measures for up to two years by submitting attestation and being subject to 5% audit
MY 2007 IT-Enabled “Systemness” Domain

• Incorporates two current IT Domain measures and Physician Incentive Bonus
  – Data Integration for Population Management
  – Electronic Clinical Decision Support at the Point of Care
  – Physician Measurement and Reporting

• Adds two new measurement areas:
  – Care Management
    • Coordination with practitioners, chronic care management, continuity of care after hospitalization
  – Access and Communication
    • Having standards and monitoring results
**Efficiency Domain**

- Consider cost / resource use alongside quality
- Compare across physician groups the total resources used to treat:
  1) an episode of care, and
  2) a specific patient population over a specific period of time
- Risk-adjusted for disease severity and patient complexity
Efficiency Domain

• Transparent methodology
• Measures that are valid, reliable, equitable
• Actionable information
1. Overall Group Efficiency
   • Episode and population based methodologies

2. Efficiency by Clinical Area: specific areas TBD
   • high variation
   • account for significant portion of overall costs
   • areas that can be reliably measured

3. Generic Prescribing
   • Using cost and number of scripts
Efficiency Domain

Overall Efficiency - Episode-Based

- An “episode of care” is defined as a time delimited series of separate but related services provided during the complete course of treatment for a patient’s specific disease, illness, or condition.
- The observed cost for each episode will be calculated and compared to the expected cost for the same type of episode, adjusting for disease severity and patient complexity, to calculate the efficiency of the treatment provided for that episode.
- The observed and expected costs for all episodes attributed to the PO are then summed and the ratio calculated:

\[
\text{Episode-Based Overall Efficiency} = \frac{\text{Sum of observed costs for all episodes}}{\text{Sum of expected costs for all episodes}}
\]

- Medstat’s Medical Episode Grouper (MEG), will be used to identify episodes of care from health plan enrollment and claims/encounter information.
- Disease severity is assessed through Thomson Medstat’s Disease Staging software.
- Patient complexity (age, sex and co-morbidities) is assessed through DxCG’s Diagnostic Cost Groups (DCG) software.
For population-based measures, the unit of analysis is the member.

- The overall, member-level observed costs are calculated and then compared to expected costs for members of the same complexity.
- The observed and expected costs for all members attributed to the PO are averaged and the ratio calculated:

\[
\text{Population-Based Overall Efficiency} = \frac{\text{Average observed costs PMPY}}{\text{Average expected costs PMPY}}
\]

- Patient complexity is assessed via DCGs
- For population-based measures, episodes of care (MEG) and disease severity adjustments (Disease Staging) are not employed
The episode-based methodology also allows examination of efficiency by clinical area. The observed and expected costs for each episode are calculated. Episodes within a specific clinical area can be identified through MEG. The efficiency of all episodes within the clinical area can be calculated as:

\[
\text{Efficiency by Clinical Area} = \frac{\text{Sum of observed costs for all episodes in clinical area}}{\text{Sum of expected costs for all episodes in clinical area}}
\]

The MEG software contains three built-in levels of episode aggregation as follows:

- **Episode-Level** (560 Episodes)
  - Example: Diabetes Mellitus Type 2 and Hyperglycemic States (Maintenance)

- **Episode Summary Group** (192 Episode Summary Groups)
  - Example: Diabetes (which includes ten episodes of Type 1 and Type 2 diabetes for both “maintenance” and “complications”)

- **Body System** (23 Body Systems/Etiology)
  - Example: Endocrine (which includes, but is not limited to, diabetes, thyroid conditions, neoplasm’s, adrenal insufficiency, goiter etc.)
The exact clinical areas to be reported will be determined based on the results of full scale testing, taking into consideration the following factors:

- Clinical areas where variation in resource use is high
- Clinical areas that account for a significant portion of overall costs
- Clinical areas that can reliably be measured for a majority of physician organizations
- Clinical areas with associated quality measures
- Clinical areas that include services for which POs can impact or influence efficiency