Provider Incentives to Improve Accountability

Friday, October 26, 2007
1:00 pm EDT

This audioconference is sponsored by a generous grant from the Robert Wood Johnson Foundation, through the Forum for State Health Policy Leadership.
Speakers

- Alan Glaseroff, President of the Humboldt - Del Norte Foundation for Medical Care and chief medical officer of the Humboldt-Del Norte Independent Practice Association

- Moderator:
  Tara Lubin
  Forum for State Health Policy Leadership
  National Conference of State Legislatures
  Phone: (202) 624-3558 | tara.lubin@ncsl.org
Provider Incentives to Improve Accountability

Critical Health Areas Project
Alan Glaseroff MD
Chief Medical Officer
Humboldt Del Norte IPA
10/26/07
Why Incentives?

“Doctors and hospitals are supposed to do a good job. Why should they receive extra money to do what they are supposed to be doing? Aren’t we paying enough already?”
Cost Pressures: Economically Unstable Trend

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits; 2004. Dental work by Arnie Milstein, MD, PBGH Medical Director
Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.
Percent of working adults insured, by household income quintile
1987-2003

And a Politically Unstable Trend:
Middle Income Workers are Being Eaten the Most Quickly


Adherence to Quality Indicators

- Breast Cancer: 75.7%
- Prenatal Care: 73.0%
- Low Back Pain: 68.5%
- Coronary Artery Disease: 68.0%
- Hypertension: 64.7%
- Congestive Heart Failure: 63.9%
- Depression: 57.7%
- Orthopedic Conditions: 57.2%
- Colorectal Cancer: 53.9%
- Asthma: 53.5%
- Benign Prostatic Hyperplasia: 53.0%
- Hyperlipidemia: 48.6%
- Diabetes Mellitus: 45.4%
- Headache: 45.2%
- Urinary Tract Infection: 40.7%
- Ulcers: 32.7%
- Hip Fracture: 22.8%
- Alcohol Dependence: 10.5%

Purchaser View: Quality and Cost-Efficiency

Actual Distribution of Physicians by Quality and Efficiency

High Quality
Low Efficiency

Higher →

High Quality
High Efficiency

Low Quality
Low Efficiency

Lower ←

Low Quality
High Efficiency

MD Longitudinal Efficiency Index
("Higher Efficiency" = lower relative cost for episode of care)

50th %ile

Adapted from Regence Blue Shield

© Pacific Business Group on Health, 2005
Looking at Total Cost of Care
Big-Tailed Spending Streams

Preferred MDs
Based on TCOC

Preferred MDs
Based on Unit Price

Physician Group A
Physician Group B
Physician Group C
Physician Group D
Physician Group E

Physician's Unit Price
Physician's TCOC Per Illness Episode

(<1.0 Means Better than Average)
Figure 6.1
National Health Expenditures in the United States, by Source of Payment, 2003

Total = $1.7 Trillion in National Health Expenditures, 2003

The Dartmouth Atlas Project works to accurately describe how medical resources are distributed and used in the United States. The project offers comprehensive information and analysis about national, regional, and local markets, as well as individual hospitals and their affiliated physicians, in order to provide a basis for improving health and health systems. Through this analysis, the project has demonstrated glaring variations in how health care is delivered across the United States. The project is run by Center for the Evaluative Clinical Sciences at Dartmouth Medical School.

Web Site: www.dartmouthatlas.org
Patterns of Medicare Spending

Humboldt Del-Norte

- Unadjusted Medicare Reimbursements
- Age, Sex, Race and Illness Adjusted Medicare Reimbursements
- Age, Sex, Race, Illness and Price Adjusted Medicare Reimbursements
Variation

- Underuse
  - Evidence-based services that should be utilized ~100% of the time if patient agrees (with room for clinical judgement)
- Misuse
  - Preference-based services that should reflect a patient’s choice given an unbiased presentation of clinically equal outcomes
- Overuse
  - Supply-sensitive services that vary greatly based on delivery system supply of specialists and hospital beds
It’s About Chronic Illness

• “Those With Multiple Conditions Cause Bulk Of Medicare Spending Growth”
  Sunday Health Policy UpDate (Health Affairs Web Exclusive) August 27, 2006

  “Virtually all of the growth in Medicare spending over the past 15 years can be traced to patients who were treated for five or more medical conditions during the year, according to a new study by economists Kenneth Thorpe and David Howard released today as a Web Exclusive on the Web site of the journal Health Affairs. These beneficiaries alone accounted for 76 percent of total Medicare spending in 2002, up from 52.2 percent in 1987.”
Humboldt Del-Norte

Framework for Creating a Regional Healthcare System

Stakeholder Collaboration
• Shared Vision
• Leadership

Shared Data & Performance Measurement

Engaging Consumers/Communities
• Public disclosure
• Consumer Education
• Consumer-directed care decisions

Improving Healthcare Delivery
• IT Connectivity & Support
• QI Models & Activities
• Consensus Guidelines
• Care Management
• Provider Networks

Aligning Finance/Insurance
• Benefits promote cost/effectiveness
• Administrative Standardization
• Performance Incentives

Informed, Activated Consumers

Motivated, Prepared Practices

Transformed Healthcare

Supportive Insurance & Payment

Improved Health Outcomes & Reduced Costs
Why “Align Incentives”? 

- Current system pays for quantity only
- Errors increase reimbursement
- Supply determines demand
- System punishes providers who see chronically ill patients (takes more time and effort, but underpaid)
- Savings from good work almost never accrue to those who created value (quality/cost)
Primary Care Score vs. Health Care Expenditures, 1996

Primary Care Score: 2 = Stronger
From Barbara Starfield, MD
Dwindling Numbers

<table>
<thead>
<tr>
<th>Year</th>
<th># US grads entering Family Medicine residency</th>
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</thead>
<tbody>
<tr>
<td>1992</td>
<td>1398</td>
</tr>
<tr>
<td>1997</td>
<td>2340</td>
</tr>
<tr>
<td>2005</td>
<td>1132</td>
</tr>
</tbody>
</table>

Pugno, Fam Med 2005;37:555
Letter to Administrator McClellan
Aug. 21, 2006:

- Develop payments for care coordination for chronically ill
- Payments in support of group visits, e-visits and telemedicine care
- Pay attention to the total cost of care, not just unit of service
**PBGH: Four Cornerstones of Value-Based Health Care**

- **Quality Standards**
  - “Systems need to be designed to collect quality-of-care information..”

- **Price Standards**
  - “episode of care costs for specific doctors and hospitals can measured and compared.”

- **Interoperable Health System**
  - “quickly and securely communicate and exchange data.”

- **Properly Placed Incentives**
  - “reward both those who offer and those who purchase high-quality, competitively-priced care”
The goal of P4P, as established by P4P stakeholders in 2001, is 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
Plans and Medical Groups – Who’s Playing?

Health Plans*
- Aetna
- Blue Cross
- Blue Shield
- Western Health Advantage (2004)

Medical Groups/IPAs
- 225 groups / 35,000 physicians

6.2 million HMO commercial enrollees

* Kaiser Permanente Medical Group is participating in reporting but not payment

- CIGNA
- Health Net
- PacifiCare
Program Governance

- Steering Committee – determine strategy, set policy
- Executive Committee – oversee operations monthly
- Technical Quality Committee – develop quality measure set
  - Focus is on “underuse”
- Technical Efficiency Committee – develop efficiency measures
  - Focus is on “overuse”
- Payment Committee – develop consistent approach
- IHA – facilitates governance/project management
- Sub-contractors
  - NCQA/DDD – data collection
  - NCQA/PBGH – technical support

Multi-stakeholders “own” the program
**Data Collection & Aggregation**

- **Clinical Measures**
  - Admin data
  - OR

- **Patient Satisfaction Measures**
  - PAS Scores

- **Systemness Measures**
  - Survey Tools and Documentation

**Data Aggregator - NCQA/Medstat**
Produce one set of scores per group

- **Physician Group Report**
- **Health Plan Report**
- **Score Card Vendor**

**Note:** Plans using aggregated dataset for payment calculations
2008 Clinical Measures

- **Preventive Care**
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Childhood Immunizations
  - Chlamydia screening

- **Acute Care**
  - Treatment for Children with Upper Respiratory Infection
  - Treatment for Adults with Acute Bronchitis
  - Imaging for Acute Low Back Pain
  - Potentially Avoidable Hospitalizations

- **Chronic Disease Care**
  - Appropriate Meds for Persons with Asthma
  - Diabetes: HbA1c Testing & Control
  - Cholesterol Management: LDL Screening & Control
  - Depression Management: “lost to follow-up”
  - Management of Patients on Persistent Medications

  **2009**
  - Blood Pressure Control
  - Diabetes Optimal Control
  - Avoidable Hospital Admissions
Patient Assessment Survey

- MD-Patient Interaction Composite
- Coordination of Care Composite Score
- Patient Access to Care Composite Score
- Office Staff Composite Score
**P4P Results**

- Historic collaboration across all stakeholders
- $55 million P4P payout in 2006
- 5.3% clinical improvement over first 5 years
- 1.2% satisfaction survey improvement over first 5 years
- Medical groups investing large amounts in IT, quality improvement

*Does P4P provide an answer to the quality/efficiency dilemma?*
### Table 6: Sample of Improvements in Clinical Measures

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

### Table 7: Patient Experience: Improvement across Many Physician Groups

<table>
<thead>
<tr>
<th>Measure</th>
<th>Number of Groups Scored</th>
<th>Number of Groups Improving</th>
<th>Pct of Groups Improving</th>
<th>Average Pct Point Change in Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Experience</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Survey Average</td>
<td>108</td>
<td>71</td>
<td>65.7</td>
<td>1.2</td>
</tr>
<tr>
<td>Rating of Doctor</td>
<td>115</td>
<td>62</td>
<td>53.9</td>
<td>0.5</td>
</tr>
<tr>
<td>Rating of All Health Care</td>
<td>115</td>
<td>73</td>
<td>63.5</td>
<td>1.4</td>
</tr>
<tr>
<td>Specialist Problems</td>
<td>109</td>
<td>64</td>
<td>58.7</td>
<td>2.2</td>
</tr>
<tr>
<td>Rating of Specialist</td>
<td>108</td>
<td>63</td>
<td>58.3</td>
<td>0.8</td>
</tr>
</tbody>
</table>
### Comparing Measures by Group Characteristics: Odds of Doing Better or Worse

<table>
<thead>
<tr>
<th>Compared to:</th>
<th>IPA</th>
<th>&gt; 50,000 Enrollees</th>
<th>51-200 Sites of Care</th>
<th>Tools at Point of Care (20 pts)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical Group</td>
<td>&lt; 15,000 Enrollees</td>
<td>Fewer than 10 sites</td>
<td>No Tools at Point of Care (0 pts)</td>
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<tr>
<td>Communication</td>
<td>No diff.</td>
<td>No diff</td>
<td>-13%</td>
<td>+24%</td>
</tr>
<tr>
<td>Timely care</td>
<td>+ 9%</td>
<td>No diff</td>
<td>No diff</td>
<td>No diff.</td>
</tr>
<tr>
<td>Diabetes Screening</td>
<td>-25%</td>
<td>+32%</td>
<td>+45%</td>
<td>+36%</td>
</tr>
<tr>
<td>Diabetes Good Control</td>
<td>+ 34%</td>
<td>+45%</td>
<td>+34%</td>
<td>+35%</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>-22%</td>
<td>+22%</td>
<td>No diff</td>
<td>+23%</td>
</tr>
</tbody>
</table>

Note: Odd ratios control for all group characteristics simultaneously (enrollment, # of physicians, # practice sites, income, IPA, North, IT measures); significant p<.01
One County’s Story

- Rural county, northwest CA
- 130,000 population (only 7% managed care)
- Humboldt Del Norte IPA (“delegated model”)
  - 29 primary care practices (including 7 safety-net clinics)
- Implementing Chronic Care Model: grant strategy
  - Humboldt Diabetes Project
  - Humboldt Breast Medicine Project
  - Creating Confidence in Chronic Care
  - Hypertension/Diabetes Project
  - Aligning Forces for Quality
- Community-wide registry (web-based): common database
- Health Education Alliance
Humboldt Diabetes Project

Build and Maintain a Chronic Care Infrastructure

Patients Involved In Self-Care
### Humboldt Del-Norte

#### Encounter Note

**Vitals**
- **Date:** 12/11/2003
- **Weight:** 192.8
- **Height:** 5' 0.0"  
- **Pulse:**  
- **Resp Rate:**  
- **Temp:**  
- **Systolic BP:** 134
- **Diastolic BP:** 66
- **BMI:** 37.8
- **Waist Circ:**  

**Diagnosed Conditions**
- **DM Type 2:** 1/1/2000
- **MikAlburs:** 1/3/01
- **Neuropathy:** 4/1/02
- **Hypertension:** 3/1/00
- **Depression NOS:** 10/3/01

**Potential Conditions**
- **Retinopathy**
- **Nephropathy**
- **CVD**
- **Heart MI**
- **PAD**
- **MDA-recurrent**
- **MDA-singlet**
- **Insomnia**
- **Chronic Pain**

**Diagnosis:** Date: 9/1/2003

**Medications**

<table>
<thead>
<tr>
<th>Class</th>
<th>Name</th>
<th>Dosage</th>
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</thead>
<tbody>
<tr>
<td>AG Inhibitor</td>
<td>Glucose 2</td>
<td>2/13/10</td>
</tr>
<tr>
<td>Insulin</td>
<td>Glucophage 2</td>
<td>4/2/02</td>
</tr>
<tr>
<td>Lithium</td>
<td>Metformin 2</td>
<td>1/2/02</td>
</tr>
<tr>
<td>Statins</td>
<td>Zocor 2</td>
<td>1/2/02</td>
</tr>
<tr>
<td>Beta Blocker</td>
<td>Metoprolol 2</td>
<td>1/2/02</td>
</tr>
<tr>
<td>Diuretics</td>
<td>Hydrodiuril 2</td>
<td>1/2/02</td>
</tr>
<tr>
<td>ACE Inhibitors</td>
<td>Lisinopril 2</td>
<td>1/2/02</td>
</tr>
<tr>
<td>SSRI's</td>
<td>Zoloft 2</td>
<td>1/2/02</td>
</tr>
</tbody>
</table>

**Laboratory Test Results**

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
<th>Date</th>
<th>PRefDec</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1A1C</td>
<td>12.2</td>
<td>12/1/2003</td>
<td></td>
</tr>
<tr>
<td>Chol</td>
<td>220</td>
<td>12/1/2003</td>
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</tr>
<tr>
<td>LDL</td>
<td>132</td>
<td>12/1/2003</td>
<td></td>
</tr>
<tr>
<td>HDL</td>
<td>50</td>
<td>12/1/2003</td>
<td></td>
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</table>

**My Clinic**

**Consults and Education**

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
<th>Date</th>
<th>PRefDec</th>
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<tbody>
<tr>
<td>Foot Exam</td>
<td>7/1/02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM Educ</td>
<td>6/302</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrit Educ</td>
<td>6/302</td>
<td></td>
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</tr>
<tr>
<td>Retire Educ</td>
<td>5/26/00</td>
<td></td>
<td></td>
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<tr>
<td>Dental Educ</td>
<td>4/1/00</td>
<td></td>
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<tr>
<td>CVD Educ</td>
<td>4/1/00</td>
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<td></td>
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<tr>
<td>MM Educ</td>
<td>2/24/00</td>
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<tr>
<td>Cardiac Risk</td>
<td>3/1/00</td>
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<td></td>
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<tr>
<td>SM Goal Set</td>
<td>12/1/03</td>
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<td></td>
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</tbody>
</table>

**Other Notes**

- **SM Goal Desc:**
- **Meter Type:**
- **Encounter Note:** private
- **CSD FU Desc:** private
- **Dep TX Plan:**

**Reminders**

- **Colon Cancer Screen:** 1
- **No Self Management:** 1
- **Abnormal Pap Result:** 3
- **Fasting Lipid Panel:** 3
- **Pap Smear Result:** 3
- **Diabetic Foot Plan:** 3

**Exercise wk**

<table>
<thead>
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<th>Test</th>
<th>Value</th>
<th>Date</th>
<th>PRefDec</th>
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<tr>
<td>LIPF</td>
<td>7</td>
<td>11/2/00</td>
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<tr>
<td>LIPF</td>
<td>50</td>
<td>5/2/00</td>
<td></td>
</tr>
<tr>
<td>LIPF</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>LIPF</td>
<td>New</td>
<td></td>
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</tbody>
</table>
**P4P in Humboldt**

- Brought in ~$350,000 via P4P (covering on 7% of total population)
- Half distributed to PCPs (incentivized to bonus staff)
- Half invested in quality improvement strategies
  - Network of “office champions”
  - Extra work (meetings, use of registry) rewarded
  - Partnering with Community Health Alliance
## OPA Public Reporting

**Getting the Right Medical Care**

- Based on patient records and recommended standards of care

<table>
<thead>
<tr>
<th>Name of Medical Group</th>
<th>Scored Lowest</th>
<th>Scored Average</th>
<th>Scored Highly</th>
<th>Scored Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brown &amp; Toland Medical Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Humboldt-Del Norte IPA</td>
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</tr>
<tr>
<td>Marin IPA</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Sonoma County Primary Care IPA</td>
<td></td>
<td></td>
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<tr>
<td>Sutter Medical Group of the Redwoods</td>
<td></td>
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<tr>
<td>The Permanente Medical Group - Bay Area</td>
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<tr>
<td>Valley of the Moon Medical Group</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Patient Rating of Care Experiences**

- Based on patient surveys of their care and service

<table>
<thead>
<tr>
<th>Name of Medical Group</th>
<th>Scored Lowest</th>
<th>Scored Average</th>
<th>Scored Highly</th>
<th>Scored Best</th>
</tr>
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<td>Sonoma County Primary Care IPA</td>
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<td>Sutter Medical Group of the Redwoods</td>
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<tr>
<td>Valley of the Moon Medical Group</td>
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<td></td>
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</tbody>
</table>

*The Permanente Medical Groups' quality program differs from the California Pay for Performance program that is reported here.*

[www.opa.ca.gov](http://www.opa.ca.gov)
Humboldt IPA - CaliforniaCare Patients
Who have not received Cervical, Breast and/or Colon Cancer Screening Services

**ALAN GLASEROFF, M.D.**

**Criteria:**
- **Cervical Cancer Screening:** One or more Pap test(s) during the current or previous 2 years.
- **Breast Cancer Screening:** One or more mammograms during the current or previous year.
- **Colon Cancer Screening:** One or more of the following screenings:
  - Fecal Occult Blood Test (FOBT) during the current year;
  - Colonoscopy during the current or previous 9 years;
  - Flexible Sigmoidoscopy during the current or previous 4 years;
  - Double Contrast Barium Enema (DCBE) during the current or previous 4 years.

Please indicate, in the "Comments" area, any reasons why the cancer screening was not appropriate for the patient or that the service was refused by the patient.

<table>
<thead>
<tr>
<th>Name and Address</th>
<th>DOB</th>
<th>Cervical</th>
<th>Breast</th>
<th>Colon</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Patient's Name</td>
<td>Pt. DOB</td>
<td>✓</td>
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<td>✓</td>
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<td>Patient's Name</td>
<td>Pt. DOB</td>
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Data is based on claims submitted as of 11/16/2005.

ALAN GLASEROFF, M.D.  
Monday, December 12, 2005
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<tbody>
<tr>
<td>HbA1c control: &gt;9% (poor control)</td>
<td>7.7%</td>
<td>6.9%</td>
<td>5.2%</td>
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<tr>
<td>HbA1c control: &lt;7% (good control)</td>
<td>52%</td>
<td>55%</td>
<td>59%</td>
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<tr>
<td>Patients with BP &lt;140/90</td>
<td>62%</td>
<td>59%</td>
<td>67%</td>
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<tr>
<td>Patients with BP &lt;130/80</td>
<td>32%</td>
<td>33%</td>
<td>37%</td>
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<tr>
<td>Patients with LDL&lt;130</td>
<td>60%</td>
<td>73%</td>
<td>78%</td>
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<tr>
<td>Patients with LDL &lt;100</td>
<td>32%</td>
<td>44%</td>
<td>49%</td>
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Humboldt Breast Medicine Project Results

<table>
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<tr>
<th></th>
<th>2005</th>
<th>2006</th>
<th>% improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Mammogram (&gt; 40yo women)</td>
<td>75%</td>
<td>85%</td>
<td>13.3%</td>
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</tbody>
</table>
P4P Concerns

- So far, only incremental improvement
- Law of unintended consequence
- Potential for perversity when significant money involved
  - Fire non-adherent patients
  - “I’ll never diagnose URI again!”
  - Clinicians’ vs. patients’ interests
- Teaching to the test
- Need reporting based on clinical data warehouses, not claims alone: Public Reporting from claims data alone understates quality by 20% (Greg Pawlson MD, NCQA)
Incremental vs. Breakthrough Improvement

- Implementation of Chronic Care Model requires more than P4P – evidence-based approach to breakthrough improvement
- P4P has provided resources to build IT and quality improvement capacity
- Will increased number of measures create breakthrough improvement?
- Will increased P4P payment (30% of total in UK) create breakthrough improvement?
- “Evolution vs. intelligent design” in healthcare
Role for Legislature

- Push for federal payment reform (Medicare and Medicaid) to implement elements of Chronic Care Model
- Encourage experiments in payment at state level
- Encourage P4P in state programs (at a minimum)
- Encourage regional health information exchanges to allow for more accurate public reporting of quality
- Use legislative platform to bring stakeholders together
Any Questions

- From the audience?
  - Please use the Q and A panel to submit your questions.

- After the call, email questions and suggestions for future web-conferences to:
  - health.chaps@ncsl.org
Sign up for the rest of this series Exploring Accountability in Health Care from Four Perspectives

Addiction November 2nd: *The Outcomes of Addiction Treatment and Approaches to Measuring Performance*
This web-assisted audioconference will help legislators address issues of performance measurement and Treatment efficacy in addiction treatment, including performance-based contracting and how states are increasing their return on investments. Dr. Brooks will discuss outcome and performance measures and their use in quality improvement and accountability, new ways to look at treatment effectiveness, and legislators’ options for promoting accountability through performance improvement initiatives. Ms. Johnson will discuss the Maine Office of Substance Abuse's performance-based contracting with its substance abuse treatment providers. **Register now at** [http://www.ncsl.org/public/registration/mtg_reg.htm?mtg=WC110207](http://www.ncsl.org/public/registration/mtg_reg.htm?mtg=WC110207).

- Adam Brooks, Ph.D., Scientist, Treatment Research Institute
- Kimberly Johnson, former Director, Maine Office of Substance Abuse

Access to Care November 9th: *Using Data and Performance Measures to Evaluate State Health Reforms*
This web-assisted audioconference will explore using data and performance measures to evaluate what works and what doesn’t in states’ expansion initiatives. This discussion will include what types of data and research that are most important to help states move forward on health reform. Mr. Leitz will give an overview on data and performance measures states can use to evaluate their expansion initiatives. Ms. Lipson, who is working on an evaluation of Maine’s Dirigo Health to be released in November, will discuss what types of indicators the study chose to assess Dirigo’s progress and the pros and cons of various data types and sources. **Register now at** [http://www.ncsl.org/public/registration/mtg_reg.htm?mtg=WC110907](http://www.ncsl.org/public/registration/mtg_reg.htm?mtg=WC110907).

- Scott Leitz, Assistant Commissioner, Minnesota Department of Health
- Debra Lipson, Senior Researcher, Mathematica Policy Research, Inc.
To follow up

- To register for other parts of this series exploring accountability in health care please go here http://www.ncsl.org/programs/health/webcast2.htm
- Feel free to contact us for more information at Health.chaps@ncsl.org
- For more program information and related links, and to see past programs: http://www.ncsl.org/programs/health/webcast2.htm
- This program was recorded and will be made available online.
Other Resources

- **Center for Health Care Strategies (CHCS)**
  - Physician Pay-for-Performance in Medicaid: A Guide for States

- **Commonwealth Fund Resources**
  - Evidence-Informed Case Rates: A New Health Care Payment Model
  - Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care