


Using Ambulatory Care Surveys in
The California P4P Program


CAHPS User Group Meeting
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The Problem c2000



The Organized Model Underperforming its Potential

- Enrollment falling
- Cost trends parallel PPO even if baseline is lower
- HEDIS scores lag national benchmarks
- CAHPS scores worse

Underlying Issues

- Fragmentation
- Lack of trust between plans and groups
- Perverse incentives in reimbursement model
- Lack of supporting infrastructure

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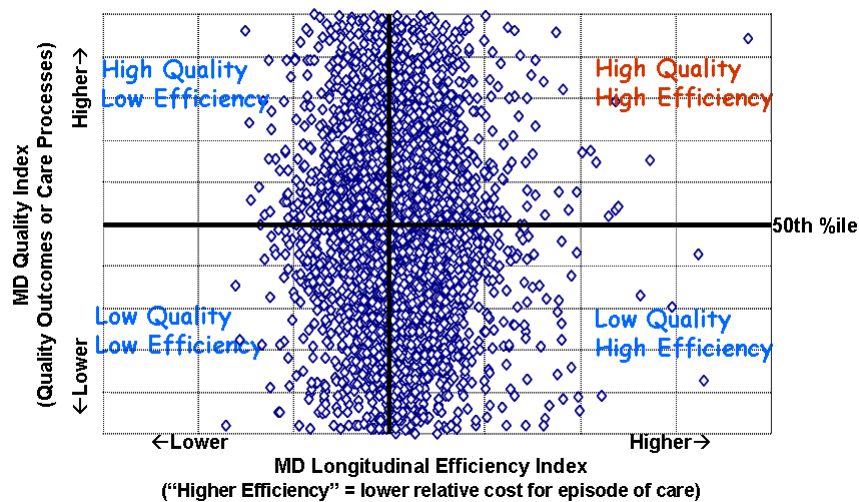
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An Employer's View of Provider Performance



Actual Distribution of Physicians by Quality and Efficiency



Adapted from Regence Blue Shield by PBGH

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Perverse Incentives of Current Payment Models



Neither Fee for Service nor Capitation alone
“adequately encourage or support the provision of
quality health care”...IOM

- FFS
 - Incentive to overuse services well documented
 - But the perverse result of good care, such as improved diabetic control, is lost income caring for sick patients
- Professional Capitation
 - Well documented concern about under-utilization
 - Investment in systems to improve care may help health plan bottom line through reduced hospitalization but providers may not see ROI

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P4P Program Overview



- **Large scale collaboration:** comprehensive quality incentive program for physicians: 7 health plans, 7 million commercial HMO members, 215 medical groups and 45,000 doctors
- **Common measure set:** for evaluation, public reporting and payment leverages market power and allows comparability
- **Incentive Payment:** each health plan uses its own methodology and formula to calculate bonus
 - \$37.4 million paid to physician groups for IHA P4P performance in first year; \$54 M in year two.
 - Additional \$69.75 million paid in individual plan incentives
- **Public Reporting:** consumers have information publicly available to compare groups on factors important to them via Health Net website (www.HealthNet.com) and the OPA report card on the state website (www.opa.ca.gov)

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Measurement Year Domain Weighting



	2003	2004	2005	2006
Clinical	50%	40%	50%	50%
Patient Experience	40%	40%	30%	30%
IT Investment	10%	20%	20%	20%
Individual Physician Feedback program			10% "extra credit"	10% "extra credit"
Improvement				X

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2006 Clinical Measures



- Preventive Care
 - Breast Cancer Screening
 - Cervical Cancer Screening
 - Childhood Immunizations
 - Chlamydia screening
- Acute Care
 - Treatment for Children with Upper Respiratory Infection
- Chronic Disease Care
 - Appropriate Meds for Persons with Asthma
 - Diabetes: HbA1c Testing & Control
 - Cholesterol Management: LDL Screening & Control
 - Nephropathy Monitoring for Diabetics
 - Obesity Counseling

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2006 Patient Experience



Consumer Assessment Survey ~ GCAHPS

- Communication with doctor
- Overall ratings of care
- Care Coordination
- Specialty care
- Timely Access to care

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2006 Information Technology



Measure 1 - clinical data integration at group level (i.e. population mgmt.)

Measure 2 - clinical decision support (point of care) to aid physicians during patient encounters

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P4P: Overall Picture re Outcomes



- Scores show improvement in all metrics for two years
- More improvement in clinical scores than satisfaction
- Closing gap between admin and hybrid scores
- Have not seen “halo” effect: only P4P metrics increased, no increase for related measures
- **Nearly all groups participate in Consumer Assessment Survey vs 35% before 2003**
- Over 50% of groups are making investments in IT to support improvement
- Metrics are evolving to include “efficiency”
- Groups are acting on the promise of a “business case for quality”

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Improved 2004 Clinical Results

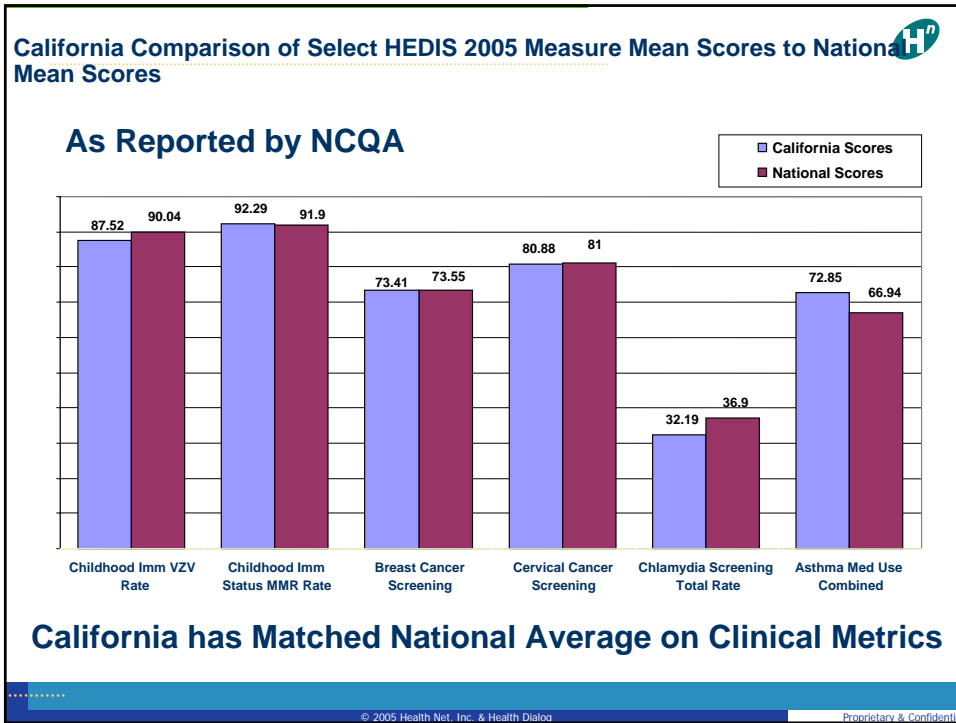


Measure	Number of Groups	Number of Groups Improving	Pct of Groups Improving	Average Change
Clinical				
Clinical Average	46	40	87.0	5.3
Breast Cancer Screening	167	94	56.3	1.1
Cervical Cancer Screening	168	130	77.4	5.4
Asthma Overall	132	94	71.2	2.6
HbA1c Screening	166	100	60.2	3.5
Cholesterol Screening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

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Less Improvement in 2004 Patient Experience Results.

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

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Patient Experience: Another View



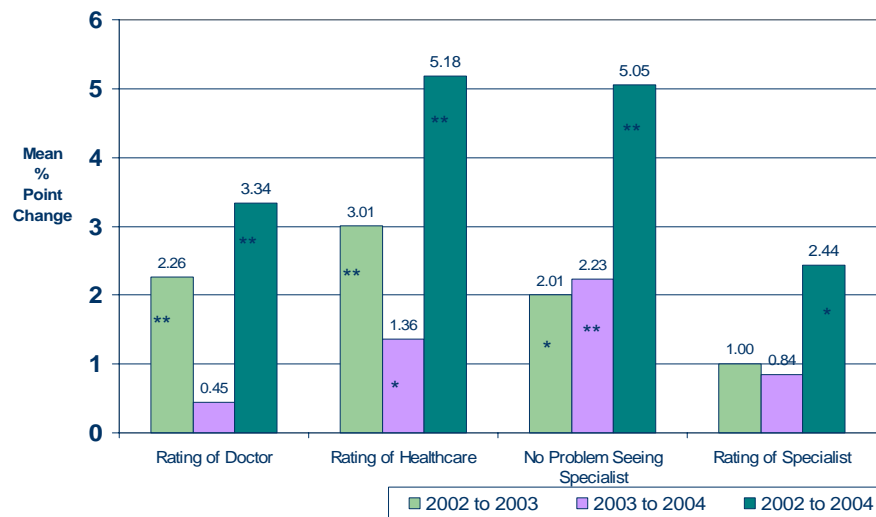
Patient Experience Measure (n=106 groups)	2005 vs. 2003 Performance Change (% points)
Rating of Doctor	2.7
Rating of All Care from Group	4.9
Rating of Specialist	3.0
Problem Seeing Specialist	5.0

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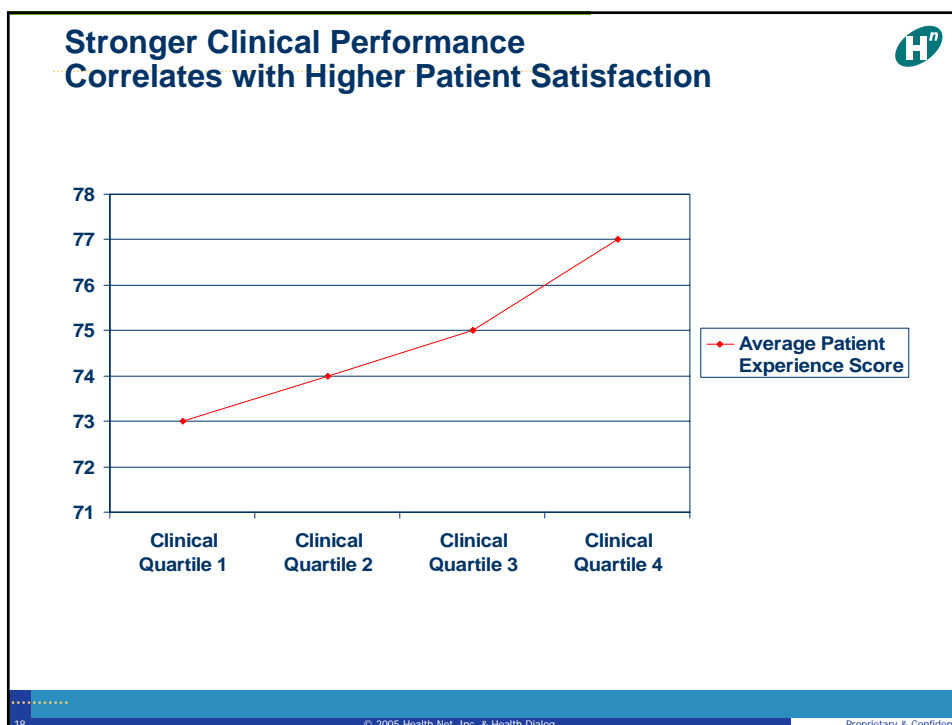
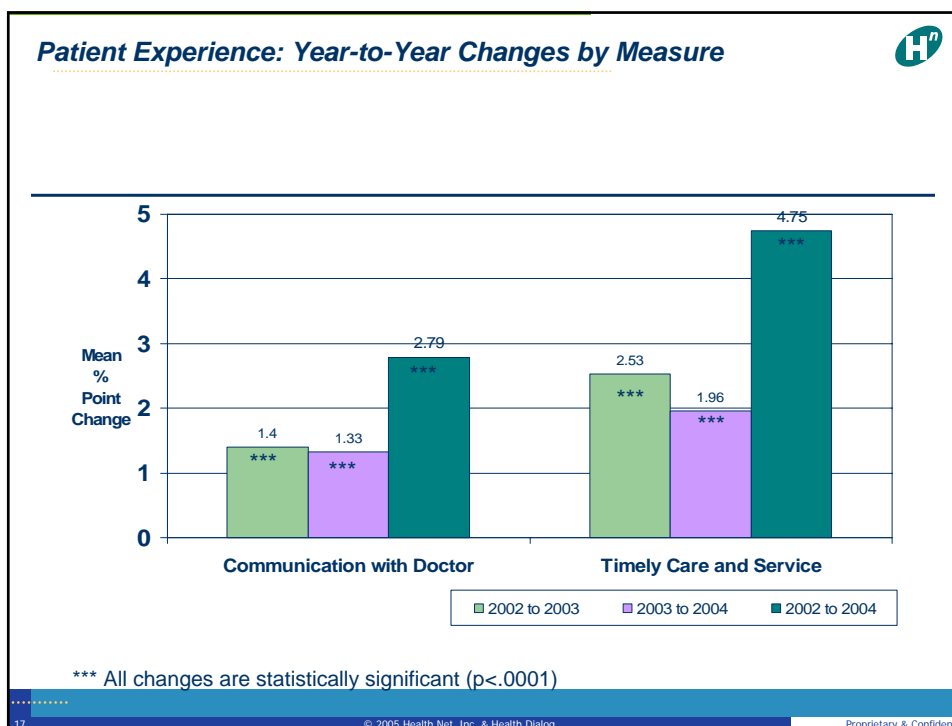
Patient Experience: Year-to-Year Changes by Measure

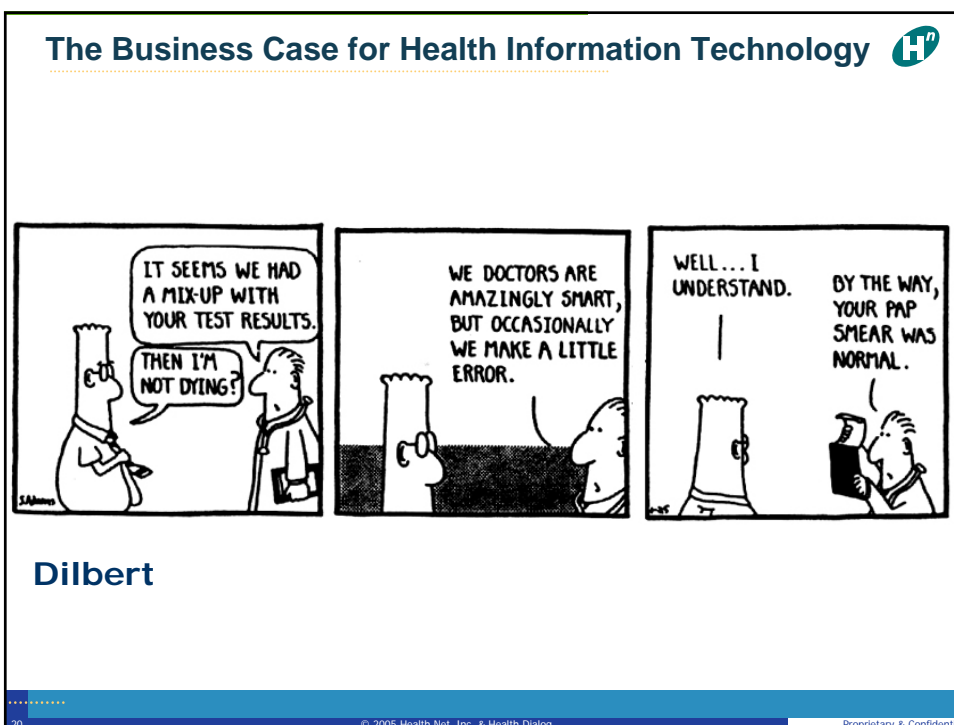
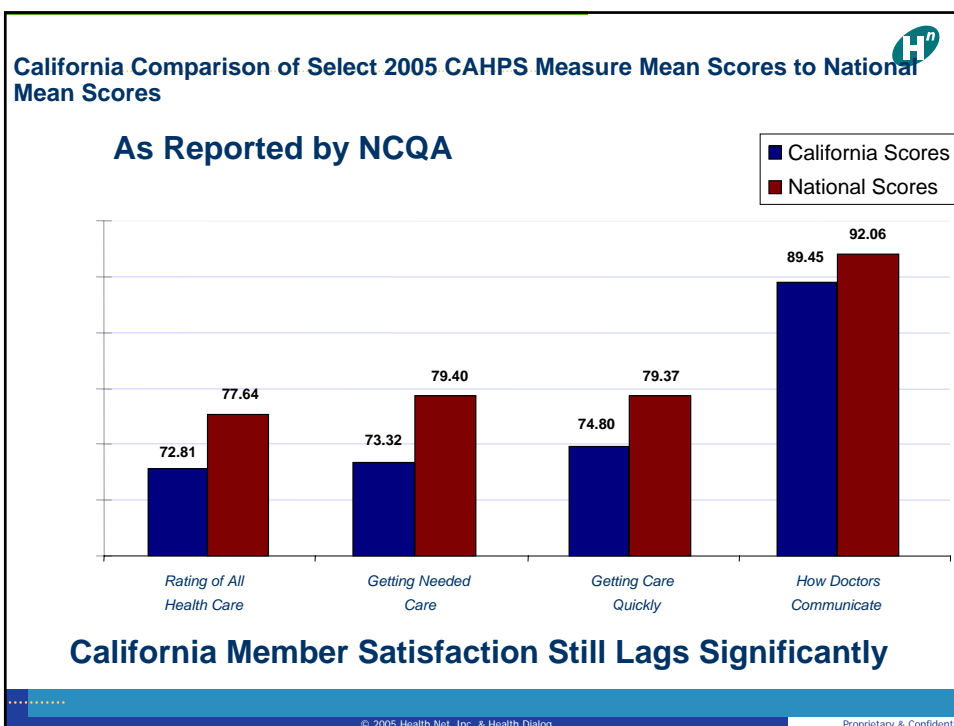


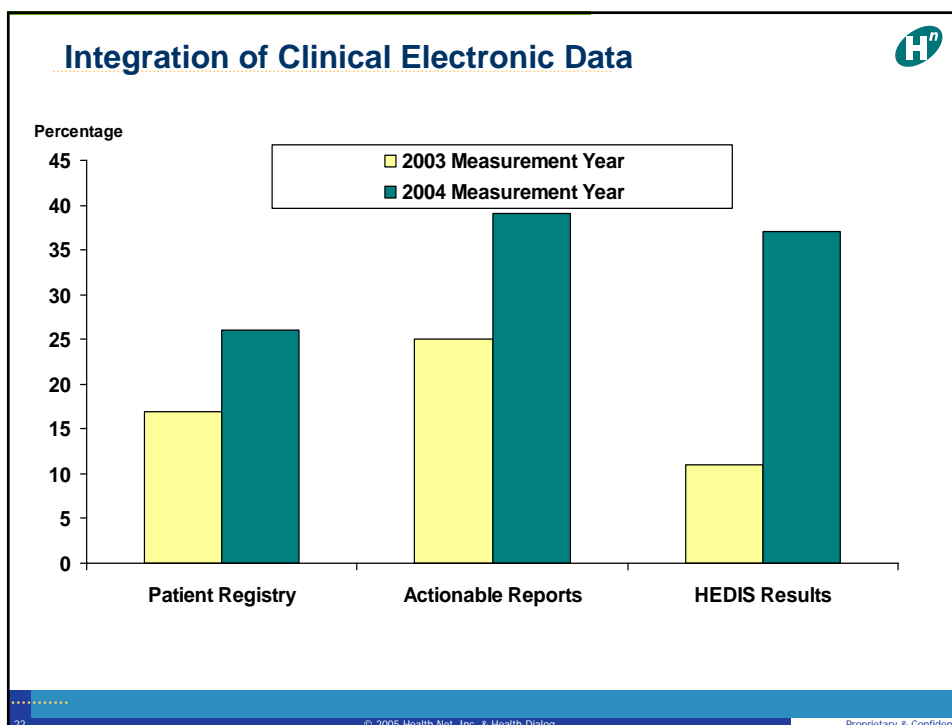
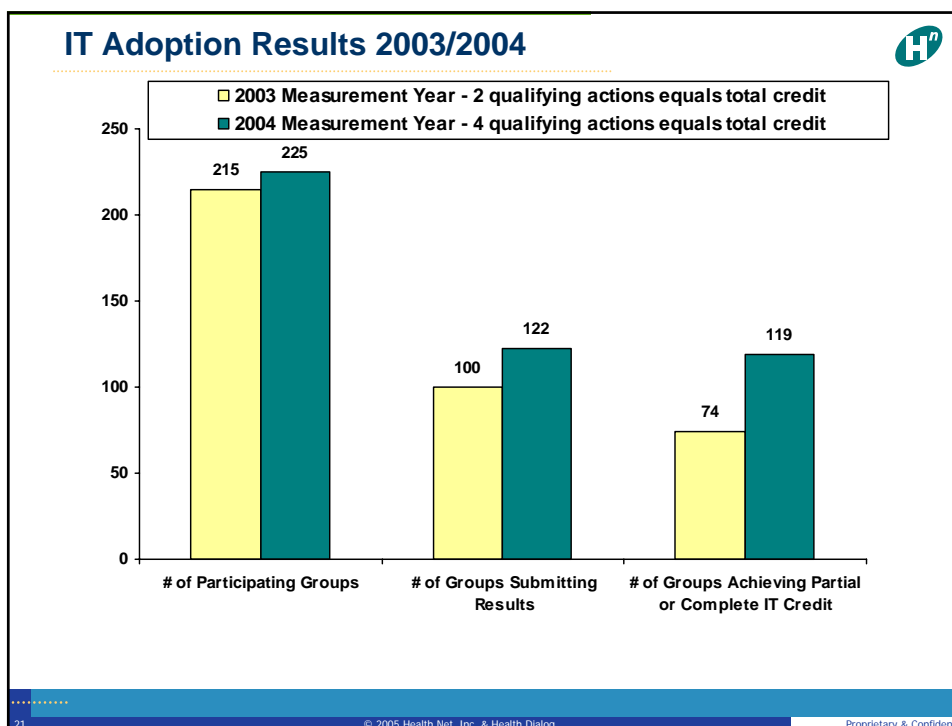
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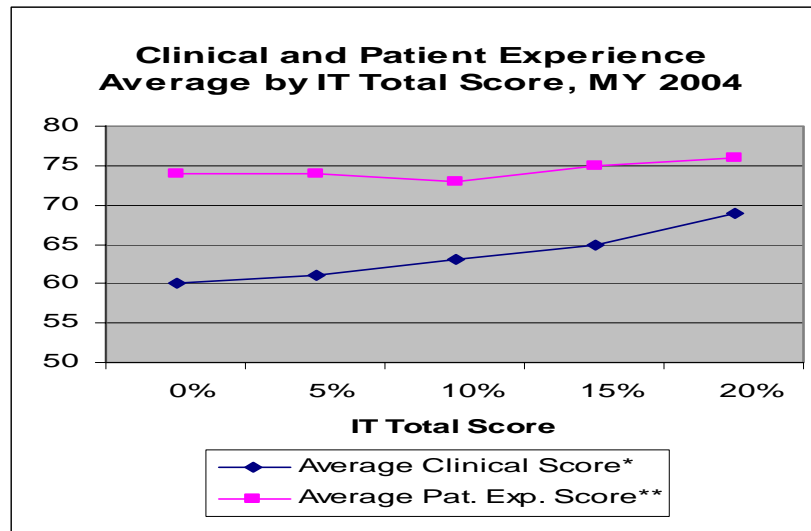
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Stronger IT Yields Better Clinical Quality: Year 2



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IHA evaluation: P4P is Important...



- Nearly all POs report that P4P is very important to their organization
- Helps push the quality agenda to the top within POs
- A place to start, a “work in progress”
- An important factor for changing physician behavior
- PO leadership state that incentives need to represent at least 5-10% of a doctor’s annual pay for them to pay attention

RAND

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What's Next for California P4P?



- National Trend with Significant Momentum
- More measures under evaluation
 - Rand (McGlynn) set of over 100 clinical metrics being tested by Humana & implemented by the British NHS*
 - Consider rewarding care redesign (ie advanced access): Predicts improved Member Satisfaction similar to IT Driving improved Clinical Scores
 - Developing “efficiency” metrics
- More \$\$: Performance-based pay a growing share of total compensation
- Raise the bar but also plan to reward improvement

*<http://www.bma.org.uk/ap.nsf/Content/NewGMSContract>

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Breakthrough in Chronic Care Program: Companion to P4P



- Built on the shoulders of the CCHRI Diabetes CQI program
- Curriculum
 - Strengthen Physician Group Systems
 - Leadership
 - Measurement and IT
 - Change management
 - Chronic Disease Model applied to Diabetes & CAD
 - Patient Experience
 - Advanced Access
 - Practice redesign
 - Patient communication
- Partnering with physician group trade association to implement
 - Goal to engage 70+ groups representing 80% of enrollment

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Two Views of Commercial P4P as of Fall 2005



- Not Much Happening Here
 - The only significant change is increased administrative data capture
 - Rewards going predominantly to groups with established record of higher performance (JAMA 10.12.05)
 - P4P may only be driving Darwinian consolidation among medical groups
- At a Tipping Point:
 - Efforts have been in progress for 5 years
 - Strongest evidence of change is in IT investment
 - We may be nearing the tipping point when demonstrable improvement spreads beyond early adopters

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