Why Pay-For-Performance?

“Every system is perfectly designed to achieve the results they get.”

- Don Berwick, MD
The U.S. Healthcare System

- Rising costs, stagnant quality
Rising costs, stagnant quality

Although the ranks of the uninsured has declined (9%), too many remain uninsured
The U.S. Healthcare System

- Rising costs, stagnant quality
- Although the ranks of the uninsured has declined (9%), too many remain uninsured
- Poor access to care even for those who are insured, and quality of care may not be good
Rising costs, stagnant quality

Although the ranks of the uninsured has declined (9%), too many remain uninsured

Poor access to care even for those who are insured, and quality of care may not be good

Low patient satisfaction with regards to Value, Accessibility, Communication
Why are things so bad?

For decades, what has driven healthcare profits is **Quantity** of care:

- How many patients can be seen
- How many procedures can be done
- How many inpatient beds could be filled
If Quantity is King…

- There is an incentive to do More care, not necessarily Good care
- Emphasis on actually fixing something is less valued
- Time-consuming activities – such as lifestyle intervention discussions, education, teaching – are less profitable than fast, highly lucrative procedures
Government, insurance plans, and increasingly the tax-paying patients themselves are realizing that for the amount of money spent in health care, there has been too little Return on Investment.
The Institute for Healthcare Improvement (IHI) is concerned about the rising cost of care, with the low returns in quality relative to the amount spent in the sector.

We spend 17% of GDP on healthcare, and this percentage is expected to grow to nearly 20% by 2020.
The Triple Aim

Emphasizes the following 3 dimensions concurrently:

1. Improving the patient experience of care
2. Improving the health of populations
3. Reducing the per capita cost of health care
Why the Triple Aim

- For the overall health and economy of our society, we need to address all three of the Triple Aim dimensions at the same time.
- As a Nation, we have only just recently started doing that...
No Turning Back Now

The country will no longer accept poor quality outcomes at high costs.

Patients want better access, better quality, and better communication.

Data transparency means patients are now educated consumers, and insurance companies are educated payers and buyers of healthcare services.
Clinicians want change, too!

Clinicians of all stripes want to be judged by the quality of care they give, not just by how many patients they can see.

Clinicians usually are more concerned about how well they are taking care of patients than how many patients they see, or how fast they are moving from patient to patient.
Value-Based Reimbursement

The country is moving towards a system that rewards access, quality, and cost reductions.

What matters more, increasingly, is doing Right by the patient, and keeping the patient as well as possible. If clinicians and healthcare systems can engage patients to do better, patients will develop fewer complications, require fewer inpatient stays, and cost less.
By the end of 2018, per the Dept of Health and Human Services, **90% of Medicare payments** will be in the form of value-based reimbursement, through:

- Accountable Care Organizations
- Hospital Quality incentives
- Bundled payments
The Importance of Analytics

- To thrive in the world of value-based reimbursement, practices and clinicians have to have systems that have the ability to track, analyze, and report quality indicators for individual patients as well as aggregate patient populations.

- Clinicians need systems that can collect, interpret, and report data in a meaningful way, allowing care teams to act on information.
The New World is here

We are moving towards a new healthcare paradigm, one defined by increasing:

- Accountability
- Transparency
- Value
The New World is here

We are moving towards a new healthcare paradigm, one defined by increasing:

- Accountability
- Transparency
- Value

ARE YOU READY?
Open Door Family Medical Centers

- Founded in the basement of a church in 1972

- We’ve grown a bit since then…
  - 5 Primary Care Sites
  - 7 School-based Health Centers
  - Family Medicine Residency program
  - Dental Residency program
By the end of 2016, we had:

- Over 100 Medical, Behavioral, and Dental clinicians providing care to...
- 51,000 patients in...
- 265,000 visits
After childhood, we see a considerable difference between the number of men and women that we see. We attribute this trend to the high number of women that we see during child-bearing age.
Insurance Coverage of Our Patients - 2014

- Uninsured: 50%
- Medicaid: 32%
- CHIP: 7%
- Medicare: 4%
- Private: 8%
Journey towards Pay for Performance

- 2001 - **Salary Armageddon**
- 2006 - NP/PA incentive introduced
- 2007 - eClinicalworks implementation
- 2008 - NP/PA incentive removed
- 2009 - Clinical report cards introduced
- 2011 - Pay for Performance implemented
- 2013 - Human Resources strengthened
- 2014 - Tableau database rolled out
- 2016 - Relevant database rolled out
  Azara pre-visit planning rolled out
Our Use of Clinical Report Cards

Why Measure Data?
Our Use of Clinical Report Cards

Why Measure Data?

How will clinicians feel about being tracked and measured?
Our Use of Clinical Report Cards

Why Measure Data?

How will clinicians feel about being tracked and measured?
Clinicians *Want* to Do Better

- The desire to excel is wired in most clinicians’ DNA
- Intuitively, we know that Quality concerns should outweigh Quantity concerns
A Clinical Report Card Must Be…

Non-Punitive!!
On Measuring, remember that…

“Not everything that counts can be counted, and not everything that can be counted counts.”

- Albert Einstein
Caveats to Measuring Quality

• It is impossible to judge any clinician solely by a quality report card

• It is impossible to capture all the work and effectiveness of a clinician by a simple set of metrics
Other factors **are** important...

- Bedside manner
- Follow-through and follow-up (loop closure)
- Camaraderie, effect on the morale of others
- Academic teaching
- Receptiveness to leadership and supervisor feedback and requests
A typical Clinician Report Card

A clinician’s report card, showing data:
1) By Goal
2) Open Door overall
3) Clinician’s site (Mount Kisco)
4) Clinician’s data from the most recent 2 quarters

<table>
<thead>
<tr>
<th>Third Quarter 2016 - Dr. XXX</th>
<th>Goal</th>
<th>Open Door</th>
<th>Mt. Kisco</th>
<th>2nd Quarter</th>
<th>3rd Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Diabetic Patients</td>
<td>58%</td>
<td>49%</td>
<td>50%</td>
<td>44%</td>
<td>43%</td>
</tr>
<tr>
<td>% with A1c &lt;7</td>
<td>&lt;15%</td>
<td>20%</td>
<td>18%</td>
<td>17%</td>
<td>19%</td>
</tr>
<tr>
<td>% with LDL in past 1 year</td>
<td>85%</td>
<td>81%</td>
<td>86%</td>
<td>81%</td>
<td>82%</td>
</tr>
<tr>
<td>% with Microalbumin in past 1 year</td>
<td>37%</td>
<td>74%</td>
<td>76%</td>
<td>81%</td>
<td>86%</td>
</tr>
<tr>
<td># of Hypertensive Patients</td>
<td>4673</td>
<td>464</td>
<td>459</td>
<td>158</td>
<td>163</td>
</tr>
<tr>
<td>% with BP controlled &lt;140/90</td>
<td>61%</td>
<td>71%</td>
<td>66%</td>
<td>75%</td>
<td>74%</td>
</tr>
<tr>
<td># of Women 24 to 65 y/o</td>
<td>93%</td>
<td>9156</td>
<td>1430</td>
<td>139</td>
<td>166</td>
</tr>
<tr>
<td>% with Pap in last 3 years</td>
<td>81%</td>
<td>68%</td>
<td>63%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td># of Women 42 to 75 y/o</td>
<td>93%</td>
<td>77%</td>
<td>75%</td>
<td>65%</td>
<td>69%</td>
</tr>
<tr>
<td>% with Mammogram in last 2 years</td>
<td>81%</td>
<td>68%</td>
<td>63%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td># of Adults &gt;50 y/o</td>
<td>81%</td>
<td>68%</td>
<td>63%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>% with Colon Cancer Screen</td>
<td>70%</td>
<td>46%</td>
<td>42%</td>
<td>43%</td>
<td>51%</td>
</tr>
<tr>
<td>% with Depression Screening</td>
<td>2%</td>
<td>57%</td>
<td>48%</td>
<td>59%</td>
<td>60%</td>
</tr>
<tr>
<td># of Asthma Patients</td>
<td>1137</td>
<td>151</td>
<td>42</td>
<td>41</td>
<td>41</td>
</tr>
<tr>
<td>% with Asthma Severity Assessed</td>
<td>50%</td>
<td>96%</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td># of Persistent asthma patients</td>
<td>768</td>
<td>115</td>
<td>30</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>% persistent asthma patients on a current control medication</td>
<td>90%</td>
<td>83%</td>
<td>88%</td>
<td>87%</td>
<td>89%</td>
</tr>
<tr>
<td>% patients &gt;13 assessed for smoking and follow-up complete</td>
<td>68%</td>
<td>88%</td>
<td>84%</td>
<td>88%</td>
<td>91%</td>
</tr>
<tr>
<td>% Adults &gt;65 with a Pneumovax</td>
<td>90%</td>
<td>82%</td>
<td>87%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>% Adults With a Tdap in 10 years</td>
<td>80%</td>
<td>70%</td>
<td>73%</td>
<td>71%</td>
<td>75%</td>
</tr>
<tr>
<td># of Adolescents 13-15</td>
<td>1994</td>
<td>171</td>
<td>21</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>% Adolescents UTD with 3 HPV 1 Tdap and 2 varicella 15 y/o</td>
<td>50%</td>
<td>76%</td>
<td>76%</td>
<td>71%</td>
<td>73%</td>
</tr>
<tr>
<td># of 2-4 year olds</td>
<td>1228</td>
<td>145</td>
<td>31</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>% 2 years olds UTD with Imms No Flu and 1 HepA</td>
<td>80%</td>
<td>92%</td>
<td>93%</td>
<td>100%</td>
<td>97%</td>
</tr>
<tr>
<td>% with Child weight assessment and counseling</td>
<td>15%</td>
<td>67%</td>
<td>58%</td>
<td>69%</td>
<td>71%</td>
</tr>
<tr>
<td>% with Adult weight assessment and counseling</td>
<td>31%</td>
<td>68%</td>
<td>65%</td>
<td>84%</td>
<td>79%</td>
</tr>
</tbody>
</table>
Pay For Performance

If clinicians and healthcare systems have done financially well in a pay for performance system modeled around volume of care, can we not do financially well in a system modeled around quality of care?
Pay For Performance

If clinicians and healthcare systems have done financially well in a pay for performance system modeled around volume of care, can we not do financially well in a system modeled around quality of care?

Of course, so let’s shift our focus, from pay by volume to something else!
Pay For Performance Poll

What are some of the areas that can fall under Pay For Performance review?

1. Productivity
2. Clinical Quality
3. Panel Size
4. Patient Satisfaction
5. All of the above
Open Door’s Pay For Performance

Salary Armageddon, 2001
  Productivity focused

NP/PA incentive, 2006
  Productivity focused

Clinical Pay for Performance, 2011
  Quality focused
2010 – plan devised to incorporate clinical quality metrics as a compensation component
2010 – plan devised to incorporate clinical quality metrics as a compensation component

2011 – plan rolled-out, using 8 metrics:
2010 – plan devised to incorporate clinical quality metrics as a compensation component

2011 – plan rolled-out, using 8 metrics:

1. Diabetics with an A1c < 7
2010 – plan devised to incorporate clinical quality metrics as a compensation component
2011 – plan rolled-out, using 8 metrics:
1. Diabetics with an A1c < 7
2. Hypertensives with BP < 140/90
P4P - Clinical Quality

2010 – plan devised to incorporate clinical quality metrics as a compensation component

2011 – plan rolled-out, using 8 metrics:

1. Diabetics with an A1c < 7
2. Hypertensives with BP < 140/90
3. Asthma persistent classes with controller med Rx’d
2010 – plan devised to incorporate clinical quality metrics as a compensation component
2011 – plan rolled-out, using 8 metrics:
1. Diabetics with an A1c < 7
2. Hypertensives with BP < 140/90
3. Asthma persistent classes with controller med Rx’d
4. Immunizations for little kids
P4P - Clinical Quality

2010 – plan devised to incorporate clinical quality metrics as a compensation component

2011 – plan rolled-out, using 8 metrics:

1. Diabetics with an A1c < 7
2. Hypertensives with BP < 140/90
3. Asthma persistent classes with controller med Rx’d
4. Immunizations for little kids
5. Immunizations for big kids
2010 – plan devised to incorporate clinical quality metrics as a compensation component

2011 – plan rolled-out, using 8 metrics:

1. Diabetics with an A1c < 7
2. Hypertensives with BP < 140/90
3. Asthma persistent classes with controller med Rx’d
4. Immunizations for little kids
5. Immunizations for big kids
6. Breast Cancer screening
2010 – plan devised to incorporate clinical quality metrics as a compensation component

2011 – plan rolled-out, using 8 metrics:

1. Diabetics with an A1c < 7
2. Hypertensives with BP < 140/90
3. Asthma persistent classes with controller med Rx’d
4. Immunizations for little kids
5. Immunizations for big kids
6. Breast Cancer screening
7. Cervical Cancer screening
P4P - Clinical Quality

2010 – plan devised to incorporate clinical quality metrics as a compensation component

2011 – plan rolled-out, using 8 metrics:
1. Diabetics with an A1c < 7
2. Hypertensives with BP < 140/90
3. Asthma persistent classes with controller med Rx’d
4. Immunizations for little kids
5. Immunizations for big kids
6. Breast Cancer screening
7. Cervical Cancer screening
8. E-Prescribing
P4P – Clinical Quality

2015 – metric goals revised. 5 metrics were added...

1. Depression screening and treatment
2. Colon Cancer screening
3. Tobacco cessation
4. Pneumonia vaccination
5. Tdap vaccination

…while E-Prescribing was dropped
P4P magnifies need to define the PCP or PCG

PCP = Primary Care Physician/Provider
PCG = Primary Care Giver

Data integrity is important

Clinician ownership of patient data is vital for P4P
Using Hypertension control as an example, we only assign the quality of a patient’s care to the PCP/PCG if:
Using Hypertension control as an example, we only assign the quality of a patient’s care to the PCP/PCG if:

1) Patient is assigned to that PCP/PCG
Using Hypertension control as an example, we only assign the quality of a patient’s care to the PCP/PCG if:

1) Patient is assigned to that PCP/PCG
2) Has been diagnosed with Hypertension > 12 months (eliminates concerns about newly diagnosed conditions)
Data is filtered for Accountability

Using Hypertension control as an example, we only assign the quality of a patient’s care to the PCP/PCG if:

1) Patient is assigned to that PCP/PCG
2) Has been diagnosed with Hypertension > 12 months (eliminates concerns about newly diagnosed conditions)
3) Has seen the PCP/PCG at least twice in the past 12 months (eliminates the concern about not having sufficient face-time with some patients on one’s panel)
<table>
<thead>
<tr>
<th>Primary Care P4P 2016</th>
<th>&quot;N&quot; needed</th>
<th>Baseline</th>
<th>2016 P4P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>50</td>
<td>70%</td>
<td>66%</td>
</tr>
<tr>
<td>BP &lt; 140/90, adults 18-59</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>30</td>
<td>80%</td>
<td>83%</td>
</tr>
<tr>
<td>A1c &lt; 9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>10</td>
<td>82%</td>
<td>88%</td>
</tr>
<tr>
<td>Persistent classes with ICS or montelukast</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations UTD thru 2 yrs</td>
<td>25</td>
<td>92%</td>
<td>90%</td>
</tr>
<tr>
<td>% UTD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>tracks kids 2-4 years of age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations UTD at 15 years</td>
<td>5</td>
<td>67%</td>
<td>66%</td>
</tr>
<tr>
<td>% UTD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 HPV, 1 TDaP, 2 Varicella</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paps, in last 3 years</td>
<td>100</td>
<td>74%</td>
<td>77%</td>
</tr>
<tr>
<td>Women age 24-65</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HP2020 goal is 66%
HP2020 goal is 80%
ODFMC goal is 90%
HP2020 goal is 50%
ODFMC goal is 66%
## Open Door P4P Primary Care metrics, 7-12 (of 12)

<table>
<thead>
<tr>
<th>Primary Care P4P 2016</th>
<th>&quot;N&quot; needed</th>
<th>Baseline</th>
<th>2016 P4P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammo, in last 2 years</td>
<td>7</td>
<td>100</td>
<td>66%</td>
</tr>
<tr>
<td>% done, &gt; 50 yo</td>
<td></td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>Women age 52-75</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRC</td>
<td>8</td>
<td>50</td>
<td>42%</td>
</tr>
<tr>
<td>% done &gt; 50 yo</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults age 51-75</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Pneumo</td>
<td>9</td>
<td>50</td>
<td>79%</td>
</tr>
<tr>
<td>% done</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults age 65 and older</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Tdap in last 10 years</td>
<td>10</td>
<td>50</td>
<td>64%</td>
</tr>
<tr>
<td>% done</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 18 and older</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression screening/treatment</td>
<td>11</td>
<td>100</td>
<td>53%</td>
</tr>
<tr>
<td>Age 12 and older</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco assessment/cessation</td>
<td>12</td>
<td>100</td>
<td>86%</td>
</tr>
<tr>
<td>Age 13 and older</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A clinician’s report card, showing data:
1) By Goal
2) Open Door overall
3) Clinician’s site (Mount Kisco)
4) Clinician’s data from the most recent 2 quarters

He is on track to:
Hit P4P metric
Miss P4P metric
Pay for Performance breakdown

2017 Formula

Bonus potential is 10% of salary for a clinician who is not in a leadership/managerial position

50% - clinician hits his/her productivity target
15% - clinician site hits productivity
25% - clinician’s clinical quality rating (1-4)
10% - individual goals set with clinician’s site medical director
### Determining Clinical Quality Rating

We rate clinical quality on a scale of 1-4.

Dr. XXX is on track to hit 10 of 12 P4P metrics.

<table>
<thead>
<tr>
<th>Metrics achieved:</th>
<th>Clinical rating:</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-12</td>
<td>4</td>
</tr>
<tr>
<td>7-9</td>
<td>3</td>
</tr>
<tr>
<td>4-6</td>
<td>2</td>
</tr>
<tr>
<td>0-3</td>
<td>1</td>
</tr>
</tbody>
</table>
Got That?

Any Questions?
Team vs Individual Incentives: Poll

What type of incentives work best?
1. Incentives based on individual clinician efforts
2. Incentives based on team efforts
3. Incentives based on both individual and team-based efforts
4. Incentives paid out to supervisory or managerial staff
Individual-based Incentives

- Help to motivate top performers
Individual-based Incentives

- Help to motivate top performers
- Help to inspire/attract underachievers
Individual-based Incentives

- Help to motivate top performers
- Help to inspire/attract underachievers

But…
Individual-based Incentives

- Help to motivate top performers
- Help to inspire/attract underachievers

But…

- May be viewed as unachievable or out-of-reach for lower performers
Individual-based Incentives

- Help to motivate top performers
- Help to inspire/attract underachievers

But…

- May be viewed as unachievable or out-of-reach for lower performers
- May lead to hyper-competition
Individual-based Incentives

- Help to motivate top performers
- Help to inspire/attract underachievers

But...

- May be viewed as unachievable or out-of-reach for lower performers
- May lead to hyper-competition
- May lead to gaming of the system, including cherry-picking patients and attempts to modify data
Team-based Incentives

- May help improve collaboration
Team-based Incentives

- May help improve collaboration
- May induce “positive” peer pressure
Team-based Incentives

- May help improve collaboration
- May induce “positive” peer pressure

But...
Team-based Incentives

- May help improve collaboration
- May induce “positive” peer pressure

But...

- Underperformers are partly “rewarded” for top performers’ influences
Team-based Incentives

- May help improve collaboration
- May induce “positive” peer pressure

But...

- Underperformers are partly “rewarded” for top performers’ influences
- Can lead to scapegoating of teammates viewed as underperformers
Team and Individual bonuses

Working Under a Clinic-Level Quality Incentive: Primary Care Clinicians’ Perceptions - Annals of Family Medicine, May/June 2015

Interviewed Primary Care clinicians in an ACO setting in Minnesota

Majority (73%) stated a preference for incentives based both on team and individual efforts. Of the minority wanting just one type, more wanted team-based bonuses than individual-based ones.
On the Horizon – Expanding P4P

- Will be incentivizing team-based care so that accountability for patients is increasing shared across a group of clinicians.
- Will be incentivizing support staff, because so many measures can be impacted by staff involvement: tobacco use and cessation efforts, cancer screening, depression screening, vaccination coverage.
On the Horizon – Expanding P4P

- Will add a Patient Perception domain
- Will add a Panel Size domain
- Possible addition of charting or Peer Review domain
Open Door PCP panel sizes

Primary care panel size:
Open Door PCP panel sizes

Primary care panel size:

1,400/1.0 FTE PCP over 12 months
Primary care panel size:

1,400/1.0 FTE PCP over 12 months

1,650/1.0 FTE PCP over 18 months
Open Door PCP panel sizes

Primary care panel size:

1,400/1.0 FTE PCP over 12 months

1,650/1.0 FTE PCP over 18 months

2,100/1.0 FTE PCP over 36 months
Clinicians want to excel in patient care
Clinicians want to do right for their patients
They need data to help guide their care
They need teams to help with their care

Incentives to align clinician, organization, and patient needs make sense!!!
Summary

Good clinicians are hard-to-find, highly-trained, independent-minded professionals that you want to nurture, support, and cultivate. Compensation strategies can **help or hurt** retention and recruitment, so choose wisely.

- Incentivize what you want to influence (productivity, quality, panel size, satisfaction, camaraderie/citizenship, etc)
- Make the system as fair and transparent as possible
- And if at first you don’t succeed, try and try again!
Questions???

dwu@odfmc.org

914.373.0419