

# Designing & Implementing Pay for Performance Within a Physician-Hospital IPA

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# Welcome and Introductions

- Michael Edbauer, DO

- Medical Director

- Nancy Hourigan, MBA

- Manager, Physician Compensation and P4P

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# Overview for Today's Discussion

- What is CIPA
  - History of our Physician-Hospital Programs
  - Our Change to Clinical Integration
  - What Pay for Performance Means to CIPA
  - Our Program and Results
  - Future of our Program
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# CIPA Western New York IPA, Inc

- ❑ Physician-Hospital IPA based in Buffalo, NY.
  - ❑ Includes 8 counties of WNY.
  - ❑ Jointly owned entity between the Catholic Health System (CHS) and physicians.
  - ❑ Shared governance with physicians having greater representation on the board.
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# Hospital Participants

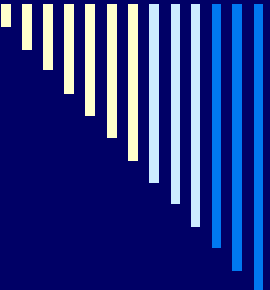
- Catholic Health System (CHS)
    - 4 Hospitals within CHS
    - 8 Skilled Nursing Facilities
    - 7 Diagnostic and Treatment Centers
    - 13 Primary Care Centers
  - Mt. St. Mary's Hospital
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# Physician Participants

- Approximately 815 Physicians
    - Approximately 260 Primary Care
    - Approximately 555 Specialist
    - Approximately 50 employed by CHS
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# History of CIPA Clinical Integration Program Including P4P

- History important to understand where we have come from and where we are looking to go.
  - Started as a risk based group with more of an emphasis on utilization management than quality improvement programs. This mirrors where most physicians have been.
  - In 2006 CIPA Board made decision to pursue Clinical Integration as the focus for the future.
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# Our Considerations in Developing the CI program

- Program needs to be real; something tangible to physicians.
  - Likely to result in quality improvement – wanted programs with proven success to get started.
  - Active physician input needed during development to make program successful.
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# Our Considerations in Developing the CI program

- Simplify administration of programs. Programs need to be easily understood, well communicated and actionable.
  - Acknowledged importance of IT in the overall improvement of care delivery and error reduction.
  - Programs need to be geared to increase physician participation in initiatives as well as rewarding of the outcomes – payment follows the work.
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# Our Considerations in Developing the CI program

- Acknowledged importance of patient education and patient involvement in care.
  - Enhance resources (staff, technology etc) to assist physicians in overall provision of care.
  - Need alignment with other components of delivery system (hospital)
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# Current Reality of Care Delivery

- Burden of care of patients with chronic disease continues to increase.
  - One study suggested that if every patient received all the care and counseling recommended by guidelines that each visit would exceed 60 minutes.
  - Many of the areas considered to be “Medical Care” can be provided by individuals other than physician but with physician oversight of the care.
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# Basic Assumptions Made in Developing Clinical Integration

- ❑ Physicians want to provide the best care possible to their patients.
  - ❑ There are economic factors which influence physician behaviors.
  - ❑ There are “system” limitations which influence physician behaviors.
  - ❑ Programs which simply focus on the economic factors without addressing system limitations will minimize the opportunities for improvement.
  - ❑ “Definition of Insanity”
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# What are The System Limitations?

- ❑ Inefficient access to information.
  - ❑ Insufficient physician staff to address all areas of patient needs.
  - ❑ Insufficient time and resources for patient education.
  - ❑ Inefficient process for communicating new care standards to physicians.
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# Effective Pay for Performance

- Program must address System Limitations as well as the Economic Factors
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# CIPA Definition of P4P

- All the resources utilized by CIPA to enhance the clinical outcomes for patients. This includes:
    - Direct payment to physicians for participation and performance in evidenced based programs.
    - Direct payment to physicians for their professional expertise.
    - Payments to offset cost of resources (technical and human).
    - Direct investment in resources and services to improve patient care in conjunction with physician.
    - Educational programs for providers, staff and patients.
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# Direct Payments to Physicians for Evidenced Based Programs

## □ Office Based

- Chronic Disease Management Program
    - Guidelines, Registry & Chart Review
  - Healthy Shots Immunization Registry
  - Coumadin Management Program
  - Disease Prevention Program
  - Consult Turnaround Time
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# Direct Payments to Physicians for Evidenced Based Programs

## □ Hospital Based

- Appropriate Length of Stay
  - Hospital Safety
  - Surgical Safety Program
  - Stroke Program
  - Radiology Transcription Sign Off
  - Pathology Proficiency
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# Direct Payment to Physicians for their Professional Expertise.

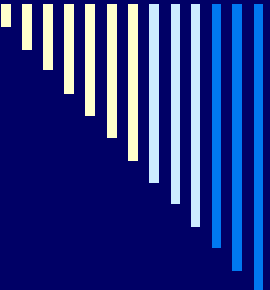
- Work Groups and Committees
  - Development of Order Sets and Pick Lists
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# Payments to Offset Cost of Resources

- Care Coordination Program
  - EHR
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# Direct Investment In Resources And Services To Improve Patient Care In Conjunction With Physician

- EMMI Program
  - Pediatric Nutritional Counseling and Intervention Program
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# Educational Programs For Providers, Staff And Patients.

- Care Coordination
  - Pediatric Nutritional Counseling and Intervention Program
  - EMMI Program
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# Selected Program Details

- Programs are administered separately but are integrated to reach our goals.
  - EHR and IT Support
  - Chronic Disease Management
  - Safety Programs
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# EHR and IT Support

- Stipend to support cost of CCHIT certified programs for 36 months
    - Over 27% of our physicians participating
  - Financial support for development of interfaces with hospital for lab, x-ray, etc
  - Hiring and training an EHR support specialist to maximize use of EHR's especially disease management
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# EHR and IT Support Cont.

- Incited the training and use of hospital based system for labs, reports imaging etc.
  - Payment to physicians to assist in development of electronic order sets and pick lists.
  - Investment in an electronic data base which can accept clinical reporting from practices electronically (diminish manual chart reviews & increase number of patients reviewed).
  - Received grant to begin connecting physicians with each other electronically.
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# Chronic Disease Management

- ❑ Developed and implemented guidelines for CAD, CHF, Depression, Diabetes, Coumadin Management, Asthma and Childhood Nutrition
  - ❑ Developed registries for these disease states for all our primary care physicians and applicable specialist.
  - ❑ Perform semiannual chart reviews for adherence to guidelines and measure quality of care.
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# Chronic Disease Management

- Hospital Core Measures also address the treatment of chronic disease (CAD and CHF) as well as pneumonia and surgical care.
  - Payment to physicians to assist in development of electronic order sets and pick lists to increase practice of evidenced based medicine.
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# Chronic Disease Management

- Care Coordination Program provides practices with financial support to employ a nurse to case manage and coordinate the care of high risk patients.
  - This program also covers the cost of patients in need of home care services not covered by insurance plans
  - Provides another link in care of patients in hospital, sub-acute, home care and the office
  - Provides additional resources for patient education including the nursing time, written materials and other programs (EMMI)
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# Chronic Disease Management

- Pediatric program pays for the cost of nutrition counseling and nutrition/fitness education for patients.
  - Begins to leverage personnel other than physicians to be part of team providing care to patients (supervised by physicians).
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# Safety Programs

- Helped fund the cost of a Hospital Safety initiative
  - Will provide financial incentive for physicians to complete education specific to hospital safety.
  - Assisting with the funding for a Infection Management Program
  - Financial incentive for surgeons to participate in a Operating Room Safety Program (based upon John Hopkins Model)
  - Medication Reconciliation program for hospital. This has direct impact on offices, sub-acute and nursing homes.
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# What Have We Achieved?

- ❑ The foundation of an improved infrastructure to dramatically change the way care is delivered.
  - ❑ Introduction of a new approach to delivery of care through an expanded care delivery team.
  - ❑ A set of programs which have strong support of the physicians and hospital.
  - ❑ Programs which are integrated to build upon each other.
  - ❑ A system which is able to adjust to the changes in best practice recommendations.
  - ❑ Improvement in Quality Measures and the care of our patients.
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# Specific Results

- Cycle 1-4 Participation and performance
    - Participation
    - Performance
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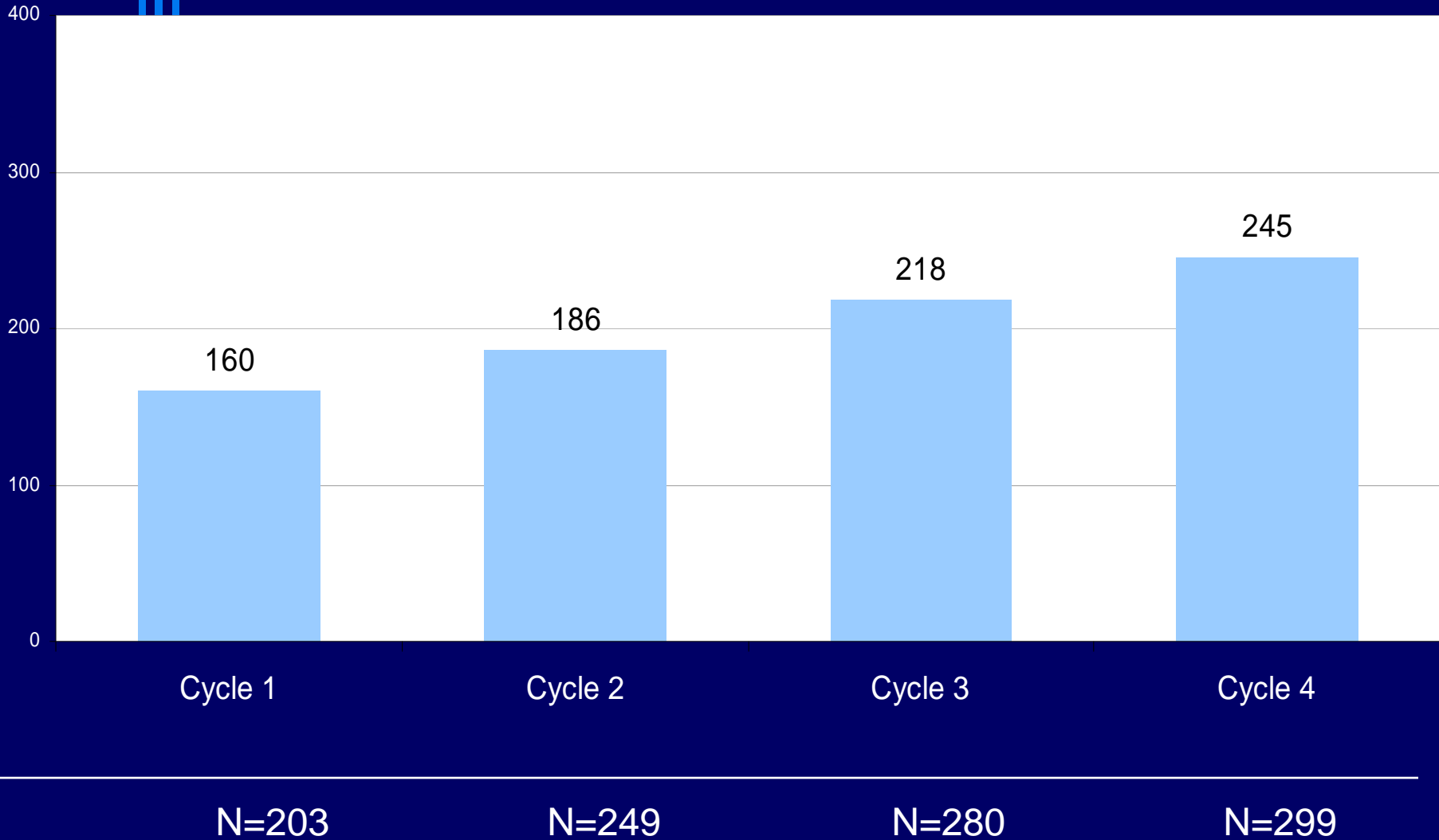
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# Chronic Disease Management

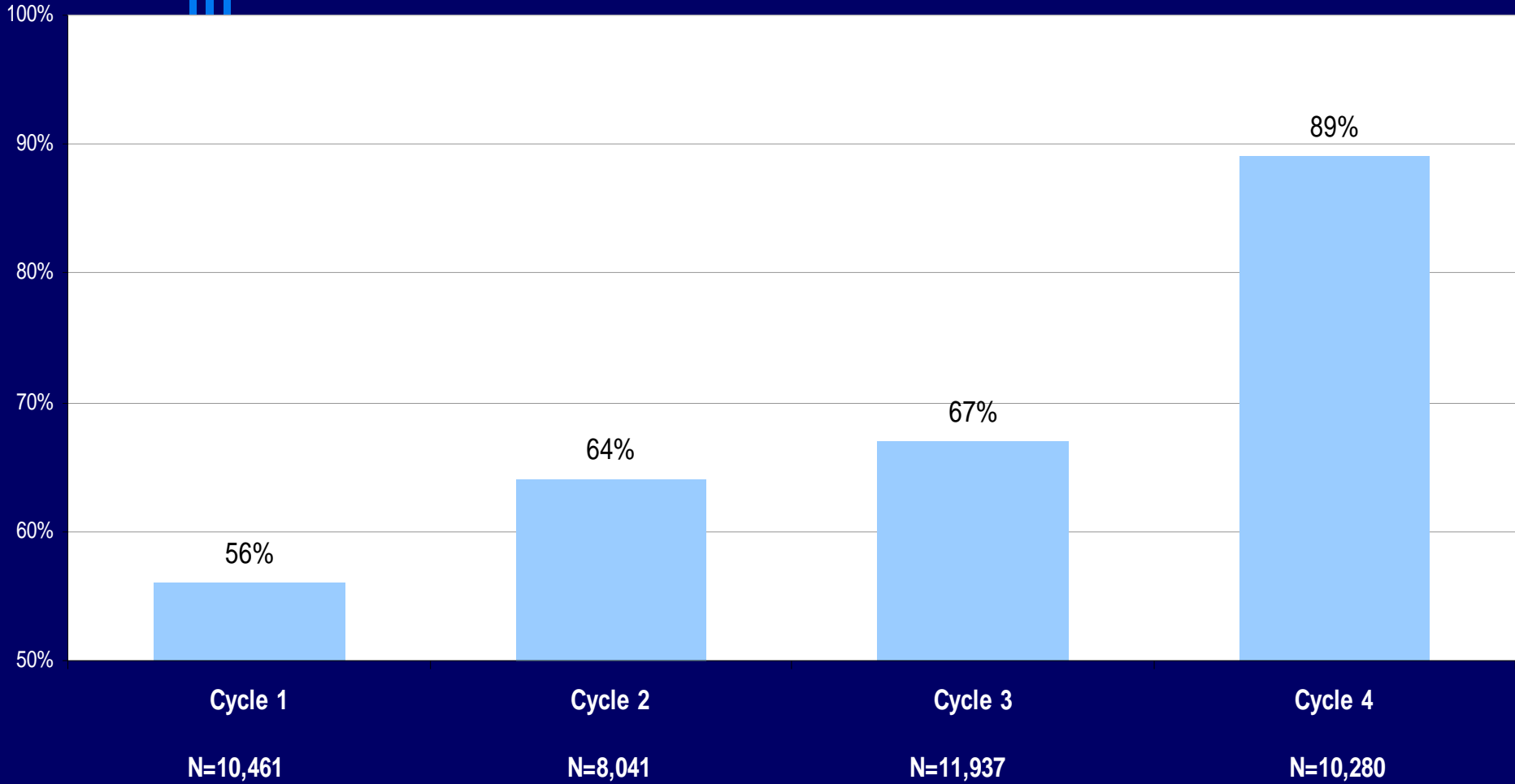
## □ Process

- Semiannual Program
  - Registry Provided
  - Online Data Entry
  - Claims Based Data
  - Scoring
  - Reports and checks are provided
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## Number of MDs participating in Chronic Care (Registry) Program

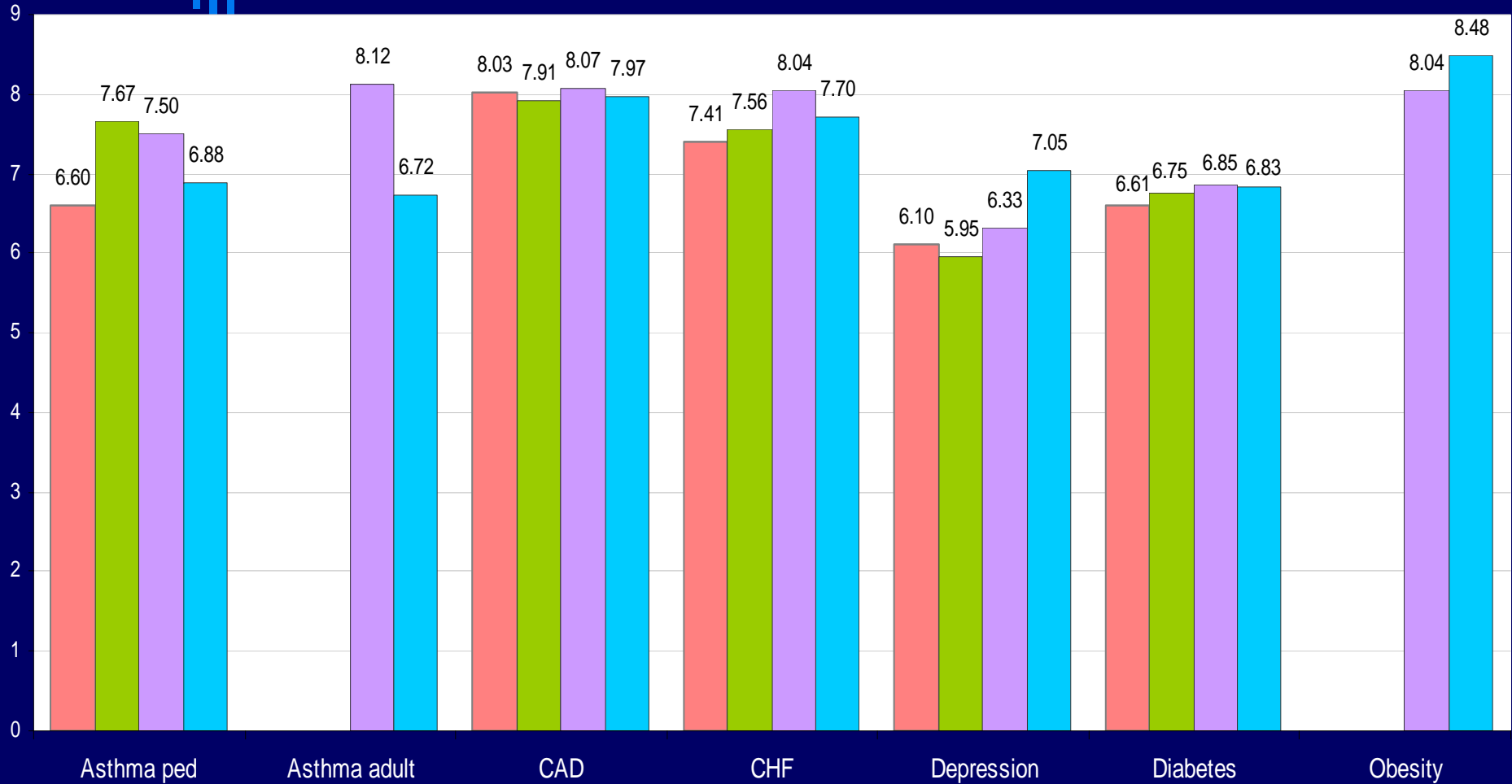


## Percentage of Records Reviewed in Chronic Care (Registry) Program

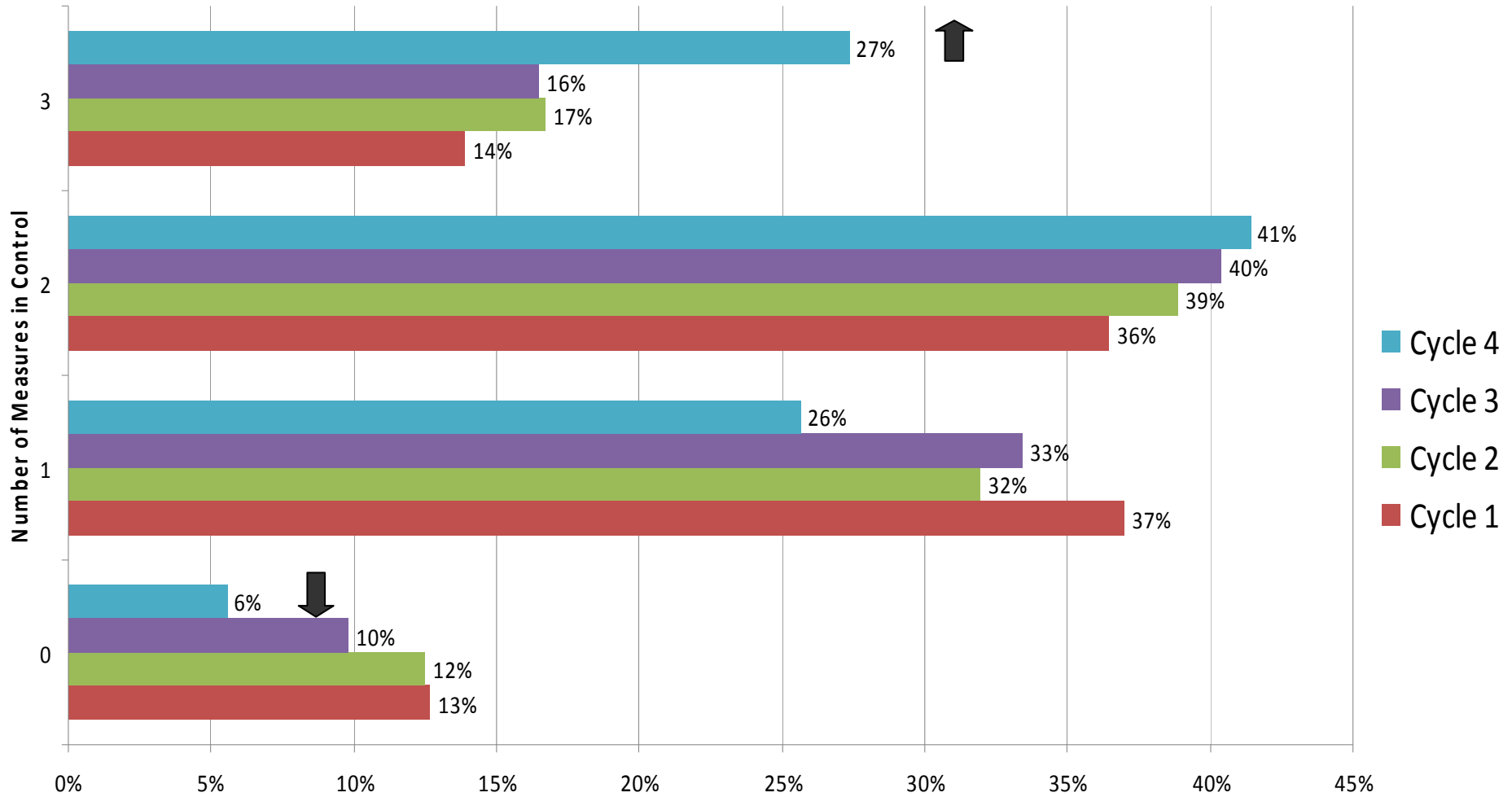


# Average Score by Disease State by Cycle

Cycle 1 Cycle 2 Cycle 3 Cycle 4



## Diabetes Measure of Perfect Care by Cycle





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# CIPA's Vision For The Future

- Continue to build upon the principles we have established. Specifically:
    - Continue the adoption of EHR to achieve universal use within our community within 5 years.
    - Achieve interconnectivity of private practice EHR's with one another and with the Catholic Health System.
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# CIPA's Vision For The Future

- Have all members of CIPA actively engaged in Clinical Integration programs which improve the quality and/or add value to the care of our patients.
  - Continue to expand the team model to provide the most appropriate and comprehensive care.
  - Continue to push further “upstream” to more effectively deal with primary prevention (greater emphasis on education, and health advocacy).
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# A Ripple In the Pond

The success of our collective efforts will be measured by future generations in the decreased incidence of preventable disease through healthy lifestyles; and the timely and efficient delivery of care when needed which is free of errors and based upon the best evidence available.

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