Local pay-for-performance program progresses

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Dean Health Plan (DHP) is in its seventh year of the Practitioner Incentive Model (PIM), its home-grown pay-for-performance program (P4P). Dean's P4P has progressed in scope, sophistication, and success over the years, with a primary focus on providing financial rewards for excellent care and service.

A number of important principles define the DHP program:

- DHP believes that providers offering higher quality care and service should be paid more than those who don't.
- PIM program success should mean wins for patients, providers, buyers, and the health plan. DHP has chosen metrics and thresholds and provided tools and staff to enable success for clinics that engage in the program.
- Incented metrics must be noncontroversial, and easily measured and understood.
- Data on which performance is measured should be beyond reproach.
- Providers should have the ability to impact chosen metrics.
- PIM should create savings at least equal to the owners' investment. The program is funded by equal contributions by Dean Health System and SSM Health Care.

Collaboration and partnership, starting with selection of metrics and thresholds, is central to the PIM program. A group of physicians and DHP staff modify the metrics and thresholds yearly. The committee includes a community "non-Dean" primary care physician, most recently from the Wildwood Clinic.

DHP evaluates its own, as well as competitors', performance on Health Plan Employer Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data to identify areas of opportunity that may serve as potential P4P metrics. Of late, DHP has placed emphasis on 3 areas: patient satisfaction, cost-effective prescribing, and the management of chronic disease. DHP evaluates patient satisfaction through administration of a quarterly satisfaction survey. The survey is sent to patients' homes and uses a subset of the ACAHPS (Ambulatory Consumer Assessment of Healthcare Providers and Systems) survey. The selected questions focus on areas of opportunity identified through DHP's CAHPS results. Cost-effective prescribing metrics are evaluated using pharmacy claims information, while management of chronic disease is evaluated using a combination of medical claims, laboratory, and self-reported clinical data.

Metrics of particular importance become "gates." Clinics must achieve or "pass through" gates to become eligible to receive any financial incentives for that program year. For 2007, gates include the following:

- patient satisfaction
- generic utilization
- tablet-splitting
- mail order utilization
- measurement of LDL and A1C for patients diagnosed with diabetes

The metric thresholds are determined based on the prior year's performance by PIM program participants. This insures that DHP is selecting thresholds that are deemed "doable" and are likely to result in success for participating clinics and practitioners. DHP is also committed to providing support to clinics to facilitate clinical process changes yielding more effective and efficient care, while also enabling clinics to succeed as part of the PIM program.

For example, DHP provides staff and tools to encourage clinical process change that will result in improvements in care. DHP staff has created a MicrosoftAccess database to facilitate clinics' ability to monitor the care received by their population of patients diagnosed with diabetes. The database is preloaded with demographic information for each DHP member with diabetes that is assigned to the

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clinic and then appropriate clinical data (e.g., HbA1c testing dates and results, LDL testing dates and results, blood pressure readings, etc.) are collected and entered into the patient's database record by clinic staff.

DHP also provides preformatted reports within the database tool that allow clinics to identify patients who may be missing needed services during a specified time period. DHP provides training and ongoing technical support to insure that clinic staff is consistently collecting the necessary clinical information and that physicians have access to information to identify patients that may need to be re-engaged in regular care. The advantage offered by this approach is that clinics receive a useful tool for monitoring and evaluating the care provided to a population of their patients (i.e., patients with diabetes) that then facilitates clinical process changes by encouraging clinic staff to view each interaction with a patient as an opportunity to provide necessary diabetes care. This is a change from typical clinical interactions that relied on the patient scheduling a "diabetes-focused visit" in which any diabetes related care would be discussed and addressed.

Clinics submit their diabetes care databases to DHP on a quarterly basis to augment available administrative claims information to insure that measured performance is a full and accurate representation of the care that has been provided. This has allowed DHP and its partner physicians to move beyond concerns about "bad data" (i.e., data sources that were solely based on medical claims information). Most clinics now see DHP as a partner in enabling success and utilize lessons learned to care for their "non-Dean" chronic disease patients. DHP staff and medical directors visit many of the participating clinics to share best practices and return to DHP with suggestions for improving the PIM program. High performing sites receive congratulatory plaques for waiting room display.

Is DHP accomplishing its PIM program goals?

Patient satisfaction remains of paramount importance and is monitored quarterly by clinic site. Generic utilization has risen from 44% in 2002 to 63.3% last year. Tablet splitting increased from 17% to 61% in 2005. Similarly impressive gains occurred for A1C and LDL measurement, diabetic blood pressure control, and nephropathy screening.

And has everyone "won?"

- Patients are receiving better diabetic care and clearly appreciate the emphasis on satisfaction. Their savings through co-pay reduction for tablet-splitting exceeded $900,000 in 2005 alone. While not quantified, co-pay savings through generic utilization are significant.
- Many providers earn meaningful bonuses that also cover the administrative costs of the program. Improved satisfaction means greater patient loyalty. Creating chronic disease registries enables better care with less needless variation.
- Buyers have healthier diabetic workers and medical cost trends can be flattened somewhat through cost-effective prescribing.
- DHP gains as the result of all of the above. Savings through increased generic utilization and tablet-splitting return our owners' investment.

While still controversial, pay-for-performance programs can play a very positive role for all participants. DHP expects to continue to improve, grow, and spread this effort in the near future.

Wisconsin Medical Journal

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