



IMPROVING HEALTH CARE: INNOVATIVE APPROACHES TO PAYING FOR QUALITY PERFORMANCE

2004



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Introduction and Opening Remarks

*Gail Warden
President Emeritus
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Emphasizing his passion for quality, Warden opened the third HAP conference on quality, “Improving Health Care: Innovative Approaches to Paying for Quality Performance.”

He looked back at the first year’s conference, recalling the opening speech on the challenges of quality by Michael Millenson, the author of *Demanding Medical Excellence*, calling it inspiring yet disturbing. Millenson presented an overview of the quality problem in this country; various national efforts to address quality improvement spurred by the Institute of Medicine (IOM) and the National Quality Forum; and the roles of purchasers, providers and health plans in improving quality.

IOM’s “Crossing the Quality Chasm” report offers recommendations for improving clinician/patient relations, a framework to better align incentives in payment and accountability and steps for promoting evidence-based practice—all to close the quality gap. Its groundbreaking report, “To Err Is Human: Building a Safer Health System,” uncovered the overwhelming statistic that as many as 98,000 people die in hospitals each year as a result of medical errors that could have been prevented. The report points to the fragmented health care delivery system and the lack of financial incentives for providers to improve safety and quality as two primary causes, and presents strategies for reducing preventable medical errors.

Last year’s HAP conference, engaging hospital and health system executives and trustees, explored the challenges these stakeholders face in improving quality in their own institutions. Discussion confirmed that many internal and external barriers to quality improvement exist, among them the fact that “payers do not reward good quality.”

Warden presented many questions for consideration during the day’s proceedings:

- ◆ What kinds of incentives will payers be willing to offer health plans and providers?
- ◆ Will they pay more for better quality or punish those for not providing it?
- ◆ “Will payers be willing to steer consumers to the organizations with the best quality performance?”
- ◆ How transparent are they willing to be about the performance?

Warden established three goals for this year’s conference:

- ◆ Understand emerging approaches to reward providers for improving health care quality.
- ◆ Learn how these approaches translate into measurable improvements in quality and reduce health care costs.
- ◆ Develop a shared understanding of the potential for cooperative, community-wide efforts to improve quality.

“HAP is committed to identifying ways to foster innovative solutions to improve quality. Our meeting addresses a key opportunity to understand the challenges of aligning payment practices to reward quality. I have no doubt that the ideas and programs discussed here today will lead to innovative approaches to improving the quality of health care in southeast Michigan.”

As a call to action, he asked the audience to think about what each of them can do to effect change and what new collaborative solutions it can support across organizational lines to achieve the major changes that are required for improving care.

“I have no doubt that the ideas and programs discussed here today will lead to innovative approaches to improving the quality of health care in southeast Michigan,” Warden said.

Warden expressed gratitude to this year’s conference sponsors—Novo Nordisk Managed Care, Amgen Inc., Abbott Laboratories and Merck & Co., Inc.



Interactive Exercise Demonstrates Strong Agreement: Quality Incentives Are Lacking

Views Vary on Ways to Improve and Measure Quality

*Don Hirt, Vice President
Organizational Performance &
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To set the pace for the conference, Don Hirt, HAP vice president, organizational performance and operational support, polled the audience—a mixture of hospital executive/administrative staff (25%), physicians (12%), purchasers (20%), health care organization board members (6%) and others (50%), – about its views regarding payment for quality.

- ◆ Hospitals and doctors are adequately rewarded for improving quality under present payment policies.

The statement drew an overwhelming response of “disagree” or “strongly disagree” from every segment.

- ◆ If quality of care improves significantly, purchasers of care (employers) should expect to pay less.

The majority of executives/administrators agreed with this statement. Most physicians agreed or remained neutral on the issue; 65 percent of purchasers strongly agreed or agreed; and board members were divided between “agree” and “disagree.”

- ◆ Who should play the lead role in defining what quality is and how it should be measured for use in payment policies? Public regulatory/oversight bodies, health care professional/provider organizations, employer coalitions, consumers or health plans?

Two thirds of the executive/administrators and 72 percent of physicians said health care professionals/provider organizations should play the lead role. Forty-seven percent of purchasers also chose health care professionals/providers, while most board members agreed with the other groups or pointed to public/regulatory oversight bodies as accepting the key role.

Besides selecting provider organizations, the majority of “other” audience participants ranked provider organizations first followed by consumers.

- ◆ Which of the following factors will be most influential in leading to levels of quality improvement that substantially impact overuse, under use and misuse of services?
 - 1) Vary health plan and insurer payments based on quality outcomes produced by providers;
 - 2) increased government regulation to assure quality;
 - 3) increased direct financial participation in the cost of care by consumers through higher deductibles and copayments;
 - 4) the development of products by health plans and insurers, which exclude/include providers based on quality; or
 - 5) increased transparency of provider quality performance through broad dissemination to the public of “quality report cards.”

The most popular responses among health care executives/administrators were varied health plan and insurer payments (38%) or increased transparency (32%). Physicians were split between the various choices, with the most popular response being varied health plan and insurer payments (36%). Forty-seven percent of purchasers and 80 percent of board members also believe varying health plan and insurer payments based on quality outcomes has the most influence.

The voting exercise demonstrated wide agreement that providers are not adequately rewarded for improving quality. There was a greater diversity of opinions regarding how costs savings are translated to the payers of care and the methods that will have the greatest impact on improving quality.

Interactive Voting Exercise Results: Opinions Vary on Rewarding Quality Performance							
Question A							
Hospitals and doctors are adequately rewarded for improving quality under present payment policies.							
	Strongly Agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly Disagree (%)	Total Responses	
Exec/Admins	4	4	0	44	48	25	
Physicians	0	0	0	33	67	12	
Purchasers	5	15	0	58	22	20	
Board Members	0	17	17	33	33	6	
Others	7	8	19	61	25	48	
All (Percent)	2%	8%	9%	43%	38%		
Total Responses	112						
Question B							
If quality of care improves significantly, purchasers of care (employers) should expect to pay less.							
	Strongly Agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly Disagree (%)	Total Responses	
Exec/Admins	12	52	19	13	6	25	
Physicians	5	42	33	17	5	12	
Purchasers	43	25	20	13	5	20	
Board Members	0	33	33	33	0	6	
Others	13	58	7	20	2	48	
All (Percent)	17%	42%	15%	17%	4%		
Total Responses	118						
Question C							
Who should play the lead role in defining what quality is and how it should be measured for use in payment policies?							
	Regulatory Oversight (%)	Providers (%)	Employer Coalitions (%)	Consumers (%)	Health Plans (%)	None of the Above (%)	Total Responses
Exec/Admins	0	64	0	12	4	4	25
Physicians	0	72	0	0	8	9	12
Purchasers	19	47	5	11	16	5	19
Board Members	33	56	0	17	0	0	6
Others	17	47	0	23	5	4	47
All (Percent)	14%	54%	2%	13%	9%	4%	
Total Responses	118						
Question D							
Which factors will substantially influence improvement in overuse, underuse, and misuse of services?							
	Vary Insurer Payments by Outcome (%)	Increased Government Regulation (%)	Higher Deductibles/Copayments (Consumers) (%)	Quality Based Provider Networks (%)	Provider Report Cards (%)	Total Responses	
Exec/Admins	38	0	23	12	32	28	
Physicians	37	0	19	27	16	11	
Purchasers	47	0	15	21	21	19	
Board Members	60	0	0	0	20	5	
Others	27	4	13	18	46	48	
All (Percent)	39%	2%	14%	19%	34%		
Total Responses	116						



Building a Better Business Case for Quality: Innovative Payment Methods

James L. Reinertsen, M.D.
President, The Reinertsen Group
Senior Fellow, Institute for Healthcare Improvement

“The payment model for quality care is in question,” began Dr. Reinertsen, pointing to a juxtaposition of articles he read last December—one by Dr. Brent James in the *New York Times*, stating that the incentive system is perverse since it exacts punishment for providing better care, and a letter written in *Health Affairs* by Donald Berwick, M.D., president and CEO of the Institute for Healthcare Improvement. Dr. Berwick congratulated the Centers for Medicare & Medicaid Services (CMS) for its Premier Hospital Quality Incentive Demonstration (HQI) project on pay for performance (see Guterman presentation for more on HQI).

But an even more vivid illustration of the questionable incentive system is a recent study by MIT scientists. They projected the effect on various stakeholders when perfect evidence-based medicine was applied to residents in Whatcom County, Washington, with diabetes and congestive heart failure based on current payment models.

The biggest winners were CMS, whose payment rates were lowered, and pharmaceutical manufacturers for an increase in otherwise under-used medications. The biggest losers: physicians and hospitals, who invested in services, systems and staff to deliver under-used services. “The model is not set up correctly to produce quality,” he said. “Those who can make it happen have to make the investment but instead, they stand to lose substantial amounts of money.”

Dr. Reinertsen said that if we believe the premise that every system is perfectly designed to produce the results it gets (a Dr. Berwick quote), our current system will not generate quality improvement in the care of patients with chronic disease. “There is an obvious need for change,” he emphasized.

Where We Stand Today

Although quality improvement has been around for a long time—Reinertsen dates it back to 1987 when Dr. Berwick invited colleagues to explore industrial quality methods in health care under a Hartford Foundation grant—here is what’s really happening today:

“We have a grand history of science projects that apply quality methods to a unit in a hospital, an office in a physician’s practice or to a particular disease and have shown some kind of improvement. Often these projects have been nicely written up and provided many photo-ops for CEOs.”

“We have a grand history of science projects that apply quality methods to a unit in a hospital, an office in a physician’s practice or to a particular disease and have shown some kind of improvement,” he said. “And often these projects have been nicely written up and provided many photo-ops for CEOs.”

What they failed to do, however, was to be scaled for and spread throughout an entire organization. They also have not provided system-level results, such as adverse drug episodes per 1,000 doses, hospital standardized mortality rates, per capita and per discharge costs, percent of those dying in the hospital, inpatient satisfaction and voluntary nurse turnover, which are aligned with the IOM Health Care Quality Initiative.

Dr. Reinertsen likened the failure to produce system-level results by comparing the goal of landing a boat of soldiers on the coast during World War II to the larger goal of invading Normandy.

He described three driving forces behind quality improvement: moral reasons, business imperatives and regulatory requirements, the latter being the strongest force—as judged by changes hospitals actually make.

The tide is changing somewhat as clinical quality becomes a hot topic spurred by moral imperatives and new business pressures, such as the CMS Premier Hospital Quality Incentive Demonstration, Bridges to Excellence and “voluntary” CMS reporting.

At a recent meeting, which Dr. Reinertsen moderated, hospital executives were asked how important clinical quality is to their strategies. The numbers of those acknowledging quality as critical have risen considerably when compared to just a year ago. Executives admitted that their views have changed as they accept more personal responsibility for quality, usually surrounding a bad event occurring in their hospitals. Meeting quality goals is becoming more of a criterion for keeping one’s job.

Dr. Reinertsen reviewed four business rules that apply to any industry in improving margins through better quality, but challenged their applicability to health care and relationship to current pay-for-performance models.

They are:

- ◆ More standardized, reliable methods of producing products and services will lead to lower unit costs.
- ◆ On the provider level, more efficient management of patient flow will lead to higher throughput.
- ◆ If you demonstrate better quality, you can command higher prices.
- ◆ If you have higher quality, you can attract more customers.

“If you do the first two things, you don’t need to be paid for performance,” Dr. Reinertsen said. “They illustrate the biggest, lowest-hanging fruit. There is a business case for quality for the taking if organizations apply quality improvement methods and just focus on the first two rules above.” On the other hand, the last two rules, he said, are the weakest business cases for quality, even though commanding higher prices through better quality is the basis of most pay-for-performance models.

Looking at Pay-for-Performance Options

Various managed care organizations, CMS and corporations pay bonuses for quality to hospitals and doctors—models that fall under three basic categories: tiered, threshold and cost. Tiered forms are exemplified by the CMS model, which rewards hospitals in the top decile with a two percent bonus for completing performance measures for certain conditions. It’s what Dr. Reinertsen calls “grading on a curve.”

The threshold model, though similar, rewards everyone who reaches a particular level of performance. The lower cost bonus structure, the least common method, pays more for doing less and rests on the idea that less is the right thing to do. All three models pay limited bonuses and apply to only a few conditions.

Dr. Reinertsen applauds their efforts for channeling attention to quality even if the three models have several shortcomings:

- 1) bonuses that focus on under use and fail to address overuse and misuse;
- 2) bonuses being created out of the general provider pool; and
- 3) small total bonuses, which have a small revenue effect and won’t necessarily translate into higher margins. His biggest concern is that these pay-for-performance models will deflect attention away from the real business issue—reducing costs through waste reduction.

Dr. Reinertsen introduced a completely new model called the Unified Field Theory-Applied, known as UFT-A, or as he jokingly said, Norwegian for “oy vey.” An alternative model moving beyond pay for performance, UFT-A was created around the notion that instead of paying more for quality, we should reward higher quality by reducing providers’ regulatory and administrative costs, which Dr. Reinertsen believes would align incentives for all stakeholders.

He firmly believes that UFT-A would address under use, overuse and misuse of services, engage physicians and follow the IOM’s Quality Initiative principles of patient-focused care, evidence-based medicine and integrated health care systems.

Attributing credit to health care attorney and consultant, Alice Gosfield, for the development of UFT-A, Dr. Reinertsen stressed that the model is founded upon a unified care system that integrates all operations and systems. Gosfield’s five principles are:

- ◆ **Standardize.** As Dr. Reinertsen learned through experience in his own practice, standardizing procedures, such as detailing treatment for rheumatoid arthritis during the first three months, reduced staff and provider time, costs and errors caused by variation. Lessons learned: you can practice health care within evidence-based medicine, not necessarily practicing it to the letter, and you can win back time in the process.
- ◆ **Simplify.** Current systems are cumbersome. It would make sense to develop a single, point-of-care template that combines billing documentation (which has little clinical relevance) with proof that the evidence-based care pathway was followed and accountability accepted for delivering the evidence-based care. A documentation template for delivering care for a clinical condition would save an enormous amount of time and expense in the care system.
- ◆ **Make payment clinically relevant.** Easily applied to physician payment, Dr. Reinertsen questioned why physicians are not paid for the cost of delivering a service based on what it actually costs according to cost accountants, rather than actuaries. For instance, add up total costs for delivering appropriate care to all diabetic patients in your practice and that is what you will be paid—even if it’s more than it now costs.
- ◆ **Engage patients.** Services rendered must imprint patient values onto the care plan.

“Much of what is measured in report cards today grades physicians for things they cannot control, but are really the responsibility of the care system in which they work.”

◆ **Fix accountability at the locus of control.**

Much of what is measured in report cards today grades physicians for things they cannot control, but are really the responsibility of the care system in which they work. If, however, we adopt the first four UFT-A principles, physicians will be more willing to be measured for what they ought to be held accountable for—their application of evidence-based medicine and their relationships with patients. Extra minutes gained from more efficient administrative processes give physicians more touch time to answer questions or take a hand, which makes physicians feel better about their profession and work.

Getting Started

Dr. Reinertsen spelled out the steps needed to get the UFT-A ball rolling:

- ◆ Select a clinical practice guideline, preferably a national one.
- ◆ Translate it into applicable ICD-9 and CPT codes.
- ◆ Develop necessary documentation templates for the guideline.
- ◆ Document the guideline for all practitioners.
- ◆ Account for variability.
- ◆ Engage the patient.
- ◆ Price services based on the cost of delivering care, not on billing charges.
- ◆ Measure compliance.
- ◆ Analyze and refine.

Putting the Theory to Work

Dr. Reinertsen used a 59-year-old woman with diabetes, a previous myocardial infarction and moderate congestive heart failure (CHF), for which she has been hospitalized, as an example. She meets with her physician, who outlines evidence-based approaches to treating her conditions—aggressive insulin therapy, exercise and weight control, lipid control including statins and enrollment in a nurse-run CHF management clinic operated by the hospital and the medical staff.

The physician gives the patient some videos and other materials about her medical conditions and asks her to review them, absorb them for a week, call if she has any questions and develop goals and treatment options.

During a subsequent visit with her care team, she sets the following goals for the next year—maintaining her HbA1c level under 7.5, weight under 140 pounds and blood pressure at 130/85 or better; lowering her cholesterol level to under 200 with LDL less than 130; and avoiding hospitalizations resulting from CHF.

The goals and care plan, signed off by the patient, are entered into a template and communicated to the health plan, care team and patient. The template not only drives the delivery and documentation of the care, but also measures and establishes accountability for outcomes.

So who is accountable for what? The patient must take responsibility for losing weight and staying engaged in the care plan; physicians must be accountable for process measures, such as timely tests for HbA1c levels and foot exams, and for the patient’s perception of the quality of her relationship with the physician. The health care delivery system must take charge of achieving overall outcomes—the goals set by the patient, including appropriate HbA1c levels and avoidance of hospital admissions for CHF.

The annual cost of delivering the care plan is estimated and confirmed by activity-based cost accounting applied to health care rather than by actuaries, who usually make the estimates. Based on annual costs, a monthly payment is made to the care team for as long as the patient remains under its supervision. And the biggest surprise is that an agreed upon payment to the physician and care team has been established at a margin above the costs of doing the right thing for the patient.

UFT-A: Advantages and Challenges

Dr. Reinertsen quickly summed up the UFT-A model's prime advantages:

- ◆ Is both patient-centered and evidence-based, not one or the other. When patients are brought into the care plan design, he believes that they may be more concerned about evidence-based medicine than their physicians.
- ◆ Speaks to physicians the way they think—getting paid for what they do right.
- ◆ Creates touch time.
- ◆ Deals with overuse and under use by providing a margin at or above the cost of delivering services rather than relying on historical cost patterns.
- ◆ Reduces administrative burdens.
- ◆ Provides incentives for innovation and cooperation.
- ◆ Creates common goals among all stakeholders and provides a win-win situation for all—patients receive higher quality care, providers earn a payment margin and health plans and payers dole out less as overuse is eliminated.
- ◆ Pays for the cost of practicing evidence-based medicine and lets the under use and overuse chips fall where they may.
- ◆ Can eliminate intrusive medical management and documentation requirements.
- ◆ Mitigates malpractice claims and lowers liability risk by more fully engaging the patient. Physicians who use guidelines have a six-fold lower risk of being sued.
- ◆ Has implications extending well beyond payment.

Yet with all of its advantages, the theory has its challenges. For example, it is not applicable to all organizations because many delivery systems aren't mature enough to deal with it. The single biggest challenge is the lack of good methods for doing activity-based cost accounting for health care.

Although Dr. Reinertsen presented a list of “yes, buts,” (protests from providers), he managed to poke holes into most of them. Leading the roster is the idea that clinical practice guidelines have been around for years and no one uses them; there are not enough to make them work; and there isn't enough available evidence resulting in agreement.

On the contrary, he described McLeod Regional Medical Center in the town of Florence, S.C., which followed all of the guidelines related to acute myocardial infarctions for 99 percent of its patients with the condition and cut its mortality rate in half.

As reflected by its superb outcomes based on evidence, the medical center takes a no-nonsense approach to following evidence-based medicine. When the head of quality wants to make sure physicians toe the line, she looks them in the eye and says, “Is your autonomy more important than patient outcomes?” That usually does the trick.

“Let's not start with the hardest evidence-based medicine problem, but with the most solid and build on it,” Dr. Reinertsen concluded. Reiterating his initial theme—every system is perfectly designed to produce the results it gets—Dr. Reinertsen admitted that our current payment system is inadequate. When only 55 percent of evidence-based services are being delivered to patients with chronic disease, there is a need for a different model with different results.

This chart compares revenue to the physician, direct time and other costs, patient and payer impact, and margins for the three more traditional models—tiered, threshold and cost—with UFT-A, which emphasizes clinical practice guidelines.

	Tiered Q Bonus	Threshold Q Bonus	Lower Cost Bonus	Pay cost of doing CPG
Revenue to MD	Higher for top tier only	Higher for those at threshold	Uncertain: Offset by lower RVU's?	<div style="display: flex; align-items: center;"> <div style="margin-right: 5px;">↑</div> Underuse <div style="margin-left: 10px; margin-top: 10px;">↓</div> Overuse </div>
Direct time costs	Higher	Higher	Uncertain, probably higher	Much lower: standardize, simplify, highest and best use of staff
Other direct costs	Higher (primary target is underuse)	Higher (primary target is underuse)	Lower (primary target is overuse)	<div style="display: flex; align-items: center;"> <div style="margin-right: 5px;">↓</div> Overuse <div style="margin-left: 10px; margin-top: 10px;">↑</div> Underuse </div>
Patient Impact	Better care, more services, less touch time	Better care, more services, less touch time	Better care, fewer services, ? Touch time	Better care, more or fewer services but driven by evidence and patient choice, more touch time
Payer Impact	Higher costs short term, unless bonus pool is self-funded by providers	Higher costs short term, unless bonus pool is self-funded by providers	Lower costs in short term	Lower costs because of predominance of overuse, effect of patient choice
Margin	?	?	?	Improved, mainly due to lower direct time costs

Source: Reinertsen and Gosfield, “Doing Well by Doing Good: The Business Case for Quality.” <http://www.uft-a.com>.

Bridges to Excellence

Quality initiatives currently on the board are making a dent in the move towards rewarding providers for high-quality performance. The IOM's "Chasm" report has certainly left its imprint on the way health care is delivered—challenging insurers, purchasers, providers and patients.

Bridges to Excellence, a coalition of those stakeholders, emerged to realign incentives around quality. Its objectives rest on three primary principles: 1) reengineering care processes to reduce errors and being rewarded for those changes; 2) significant decreases in misuse, overuse and under use, leading to reductions in waste and inefficiencies in the health care system; and 3) increased accountability and quality improvements, encouraged by sharing comparative provider performance data with consumers.

Three Bridges to Excellence programs have evolved out of these principles. Physician Office Link provides physician practices an opportunity to earn financial rewards by implementing processes to reduce errors and increase quality. Each office's performance on certain measures is disseminated through a report card.

Diabetes Care Link enables physicians to earn one-year or three-year recognition for high-quality diabetes care through bonuses. The program also offers a variety of tools and products to help diabetes patients become engaged in their care, achieve better outcomes and identify physicians who have satisfaction quality measures.

Cardiac Care Link, a similar program, rewards physicians for high-quality cardiac care and provides tools targeting cardiac patients.

Resources

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Pay for Performance: The IHA Experience

Making the Business Case for Quality for California Physician Groups

Thomas J. Davies, Chairman of the Board, Integrated Healthcare Association (IHA); Steering Committee Chair, IHA's Pay for Performance Project

As its name indicates, the Integrated Healthcare Association (IHA) is comprised of a voluntary, integrated group of stakeholders—physician groups, health plans, health care systems, purchasers, consumers and representatives from the pharmaceutical and technology industries—and is committed to developing an integrated managed health care system and to advancing the feasibility of capitation, despite its shortcomings, as a primary means of reimbursing network providers. “The combination of capitation and pay for performance aligns incentives, while fee-for-service only offers perverse incentives,” Davies said. IHA’s key strategies are policy development, public dialogue and innovative projects, such as pay for performance.

IHA accepts credit for the term “pay for performance” and its acronym, P4P, created in early 2000. “We did not want to call it ‘pay for quality,’” Davies said, “so we urged the use of ‘pay for performance’ because it resonates with businesses and sidesteps the issue of what quality is—a concept fraught with controversy. Additionally, there are other aspects of performance that are not related to clinical quality, such as the care experience and patient satisfaction.”

“The combination of capitation and pay for performance aligns incentives, while fee-for-service only offers perverse incentives.”

What’s Behind P4P

P4P is the nation’s largest performance-based provider rewards initiative, involving more than 300 physician groups (with approximately 30,000 physicians) serving seven million commercial HMO enrollees. The primary goal of P4P, Davies said, is to create a compelling set of incentives that will drive breakthrough improvements in clinical quality and the patient experience, as well as investments in information technology, resulting in better quality care, performance and patient experience.

P4P relies on a set of fundamentals, which include:

- ◆ Incentive payments to physician organizations, not individual physicians.
- ◆ Commercial HMO/POS enrollees.
- ◆ A balanced set of metrics.
- ◆ Audited administrative data for clinical scores, not data from chart reviews.
- ◆ Independent entity to aggregate data—a single platform for each medical group so that they do not have to generate their own scores for members.
- ◆ Public reporting through a single report card so all reported information will provide the highest degree of transparency.
- ◆ Rewards for improvement and performance. P4P will add incentives for improvement during the second and third years of the program.

“Rewarding improvement is important because rural and urban medical groups could be disadvantaged competitively due to patient compliance challenges and cultural barriers,” Davies explained.

P4P believes in the power of multiples—multiple health plans, common metrics and a single report card for each medical group—will drive performance rewards that add up to real dollars. The reality is that no one health plan in California has more than 20 percent enrollment of any one medical group so it is very difficult, if not impossible, for any one health plan to drive behavior change. Davies estimated that rewards of \$100 million, or more, might be paid by the six participating health plans later this year based on last year’s performance, depending on how each plan structures its own P4P program.

The health plans—Aetna, Blue Cross of California, Blue Shield of California, CIGNA Healthcare of California, Health Net, PacifiCare and Western Health Advantage—cover about seven million lives, or 70 percent of commercial HMO enrollees in the state.

IHA “owns” the project but does not govern it. The governance role is performed by a steering committee that is representative of all stakeholders—consumers, physician groups, purchasers, health plans and academics. IHA’s executive director provides steering

committee leadership. P4P project funding comes from the Robert Wood Johnson (RWJ) Foundation and the California Healthcare Foundation, as part of the RWJ Rewarding Results Program.

A technical committee headed by Steve Shortell, dean of the University of California School of Public Health at Berkeley, oversees the development of the program's measures and processes. The National Committee for Quality Assurance and the Pacific Business Group on Health assists with developing measures, makes recommendations for new measures, establishes threshold specifications, and designs data collection and reporting processes. Finally, a team from the RAND Corporation and U.C. Berkeley evaluates the measures.

Darwinians vs. Social Democrats

During the development stages of P4P, an interesting and apparent dynamic emerged at the steering committee level; two camps became evident that Davies referred to euphemistically as the "Darwinians" and the "Social Democrats." The Darwinians believe in survival of the fittest; the idea that if you build it, they will come; breakthrough improvements will be achieved through pushing higher thresholds, a consolidation of poorer performers, and winners and losers.

On the other hand, Social Democrats think that a "rising tide lifts all boats," broad participation is important, achievable goals are necessary at the start, improvement along with performance needs to be rewarded and for all groups to succeed, technical assistance must be available.

Physician Group Level P4P Measures

P4P measures and approaches reflect what physician groups, not individuals, do and are slowly being tweaked to better align measures between employers, health plans and medical groups, and to ensure the predictability of the measurement set. Although P4P incorporates fewer than 10 measures, Davies said it is difficult to resist the pressure to expand to 400. The idea is to raise the bar and carefully add measures over time. Depression care is one of the measures on the table.

During the first year, clinical measures were weighted at 50 percent, with patient satisfaction at 40 percent and information technology (IT) at 10 percent. For 2004-05, clinical measures will account for only 40 percent, while IT will be more heavily weighted at 20 percent.

Clinical measures at the onset covered both preventive care—screenings for breast and cervical cancer and childhood immunizations—and chronic disease care, including appropriate medications for people with asthma; HbA1c testing for those with diabetes; and cholesterol and LDL screenings for patients with coronary heart disease.

New measures will include control of diabetes, not just whether a patient received HbA1c testing; appropriate antibiotic use in children; advising smokers to quit; and chlamydia and colorectal screenings.

Patient satisfaction measures include communication with doctors, measured as a group, overall ratings of care, specialty care and timely access to care. Davies said that although the measures may be looking at relationships with individual physicians, they are geared towards the group level. P4P may introduce a measure to evaluate whether a medical group has a mechanism in place for measuring individual performance.

On the IT side, medical groups are required to either integrate data at the group level, such as patient registries to track how well patients are doing, or clinical support systems at the point-of-care. As an example, Davies pointed to an electronic scale, which transports a CHF patient's weight via telecommunications and enables case managers to follow-up on those with problems. During the second year, P4P will require medical groups to develop as least one clinical decision support tool and may up the ante to performing four IT activities during the year.

P4P Scorecard Plays Critical Role

The scorecard is an integral part of P4P, starting with a partnership with the California Office of Patient Advocacy (OPA), which is publishing its version of a unified scorecard at the medical group level. Davies said the single scorecard would avoid a dueling report card problem. The consumer-friendly OPA scorecard will be available at specific drugstore chains, on the web and in Spanish and Chinese.

Medical groups may submit clinical measures directly to the aggregator, (many of whom choose to do so), or they may rely on their data to be submitted from participating health plans. Davies said that direct submission offers medical groups an alternative and more credibility; although, he is not sure which yields better results—data from plans or providers. If medical groups do not meet specific encounter thresholds, they are not eligible to participate.

Patient satisfaction, measured through the Consumer Assessment Survey, and IT measures are submitted directly to the data aggregator, which scrubs data and provides reports back to medical groups on all their HMO patients and to each health plan. Plans receive one consolidated report card for each medical group with whom they contract, covering all patients of the medical group, not just those who are members of individual HMOs. It is expected that these reports will provide the basis for each HMO's incentive program awards to doctor groups.

To get participants' feet wet, P4P conducted a pilot program last year with 49 physician groups participating, 43 percent of whom had never previously programmed measures. The idea was to start to realign the perverse financial incentives that have plagued health care historically, Davies said.

The results indicated that 44 percent were top performers for at least one measure, with previous HEDIS® reporting experience as a predictor of performance. Mean scores for all measures except asthma were higher when reported by physician organizations. Davies said the pilot uncovered a gap in lab-based measures since there are only a handful of independent lab providers outside of the hospital setting. P4P anticipates integrating lab values into measures in the near future.

How does P4P operate? Each health plan determines its own incentive payment program for 2004 based on 2003 results. Based on individual plan announcements, bonuses are expected to vary significantly among the six participating health plans, ranging from \$1.60 to \$4.50 per member per month. Prior to P4P, Blue Shield of California, Health Net and Blue Cross of California already had performance reward programs in place, and they have indicated to the physician community they will weave P4P's measurements into their existing programs.

P4P: Picking up Steam

P4P is off to a good start despite initial skepticism from some physician organizations that did not believe the bonuses would represent "new" money. From the beginning, physician organizations have shared suggestions for improvements, such as taking some aspects of practice economics into consideration. Davies acknowledged that the metrics are not perfect, but asserted they are fair and represent a good starting point.

While P4P has taken giant steps, it still faces a few challenges—managing data discrepancies, meeting deadlines for reporting data, gaining health plan commitment and developing new technical assistance strategies. Davies is optimistic about growing support from health plans even though they initially, like some of the medical groups, were not sold on P4P. "What kept them at the table," he said, "was that no plan wanted to be the one to pull the plug."

Davies praised the health plan medical directors for attributing the program's success to the participating medical organizations.

A lingering concern is that publicized good performance may result in adverse selection for the best groups. Davies' hope is that health plans will implement some form of risk-adjusted capitation payment to take into

account physician group enrollment mix. "Thus," he said, "a medical group would be compensated appropriately for the actual risk they were taking on, and then rewarded additionally for doing a superior job with their panel of sicker patients."

As health care premiums continue to rise, Davies would like to see health plans translate the additional funds into increased allocations for P4P rewards. In addition, Davis questioned how much money is sufficient to change behavior and how much physician groups will invest in their IT infrastructures.

Future directions for P4P will contend with assessing the impact of patient demographics on physician group performance, finding ways to "harvest savings" that accrue to purchasers, and rewarding culturally competent networks in the ethnically diverse state of California. Some plans have already indicated they may pay additional bonuses to any physician group that can show plausible evidence they have passed on incentives to individual physicians.

How to Contact IHA

INTEGRATED HEALTHCARE ASSOCIATION

- Consult web site for updates – www.ihc.org
- Sign up for e-Updates: e-mail to abowers@ihc.org
- Contact IHA directly:
Integrated Healthcare Association
49 Quail Court, Suite 205
Walnut Creek, CA 94596
Tel: 925/746-5100 Fax: 925/746-5103

Pay for Performance - a Rewarding Results National Grant



The Leadership Imperative: Overcoming the Obstacles to Quality Improvement

Nancy M. Schlichting
President & CEO
Henry Ford Health System

During last year's HAP conference on "The Role of Health Care System Trustees in Improving Health Care Quality," participants had an opportunity to discuss major obstacles preventing the efforts of hospital or health system boards to improve quality. This year, CEO Schlichting revisited the challenges and suggested ways for leaders to overcome them.

Obstacle #1

We lack the capital for IT tools physicians and others need for quality.

Schlichting questions whether health care stakeholders are really ready for IT. "Is capital the problem or just an excuse?" she asked. She is concerned that health care leaders focus more on macro opportunities—large, expensive projects—instead of concentrating on micro projects with good outcomes and great impact, such as Henry Ford Health System's (HFHS) PACS project. (See sidebar, p. 15, on this cost-effective program.)

"You have to spend appropriate capital to get the outcomes you desire," she added. "Look for areas where you can have impact even with limited capital. You can improve quality without having to solve the entire problem."

“Physicians are highly competitive and want to succeed. If you tap the competitive spirit, physicians are quick to accept the challenge.”

Obstacle #2

Physicians were taught not to practice team-based and/or evidence-based medicine.

"That's an excuse, not an obstacle," Schlichting said. On the contrary, she said physicians are trained in science, are data-driven and continually work in teams, making them receptive to evidence-based models.

"Physicians are highly competitive and want to succeed," she continued. "If you tap the competitive spirit, physicians are quick to accept the challenge." HFHS has developed "perfection" goals, which the CEO said are ambitious but motivating. She noted that respect, involvement and leadership are necessary to drive the change process.

Obstacle #3

Physician and nurse culture does not encourage or reward reporting of errors.

"Create an organizational culture so that physician leaders understand how to react in the face of a problem," she said. "Leaders have to examine the root causes and issues driving quality problems by paying attention to the caregiver/patient quotient. Perhaps clinicians are working too many hours, leading to medical errors. Finally, provide more information to physicians, set high goals and reward for reporting errors to encourage a willingness to come forward when errors occur."

Obstacle #4

Key stakeholders (purchasers, payers, management, physicians) and others (lawyers, media, government) do not agree on what is good quality.

"Quality improvement is a journey, not an event," Schlichting said. "It takes determination and a consistent focus on quality and what it means. Don't let disagreement stand in the way; instead, develop appropriate dialogue and mutual understanding among stakeholders leading to consensus."

Obstacle #5

Boards focus disproportionately on financial results compared to quality results.

Schlichting agrees that board members understand financial information better than clinical data. "People tend to move into their comfort zones and typically for boards, that means not discussing clinical quality goals. It's important for health care systems to adequately explain quality objectives to board members. The role of board quality committees cannot be understated; they must be respected."

She recommends selecting board members who are passionate about quality improvement—those who are committed to quality objectives in their own businesses.

“Quality improvement is a journey, not an event. It takes determination and a consistent focus on quality and what it means. Don’t let disagreement stand in the way; instead, develop appropriate dialogue and mutual understanding among stakeholders leading to consensus.”

Obstacle #6

Payers do not reward good quality.

“Payment has always lagged, but this is starting to change,” Schlichting said optimistically. “We must learn to define payment in terms of quality. You have to create an environment that rewards quality, aligns incentives and communicates a consistent message. Without appropriate education, it is not easy to have a discussion about rewarding for quality.”

Obstacle #7

Physician leaders lack the data and the political will to sanction impaired or incompetent physicians.

“Share physician performance data routinely. The more often you do it, the easier it becomes for leaders to respond and address performance issues,” Schlichting said. “Attack conflict avoidance culture. It is often difficult to confront physicians who have the highest hospital admissions, but doing it sends a strong message about quality.”

Schlichting supports an atmosphere that encourages physicians to come forward with problems and helps them find solutions, and recommends that CEOs, physicians and board leadership confront quality issues. “Clearly defining the process contributes to handling situations more appropriately,” she added

Schlichting said it is imperative to protect nurse/physician collegiality. “If nurses become watchdogs of physicians with whom they work, that will not lead to a healthy environment,” the CEO said. “You need to allow confidential reporting while maintaining collegiality.”

Obstacle #8

Health care workers are untrained in how to maximize quality and patient safety.

Design education to address multiple needs, Schlichting said. She worries that education is often cut from the budget, but without enough training of both veteran and new employees, the health system will feel the economic impact.

There has to be transparency of information, Schlichting stressed. “When information is not available, there is nothing to motivate health care workers to pay attention to quality and patient satisfaction.”

Create a culture of quality—how leaders respond to a quality agenda will filter throughout the organization. “It has to start at the top,” she emphasized.

Finally, Schlichting is a strong advocate of teaching hospitals, which she believes have to assume greater responsibility and train future generations—show how quality and education can help produce better providers.

Obstacle #9

Boards feel detached in their ability to affect quality of care in their hospitals.

The board is ultimately responsible for quality of care and must be made to feel comfortable in that role, Schlichting commented.

Create an opportunity for focused, hands-on and understandable education. She recommends that board members spend a day in the hospital with their physicians to better understand the level of commitment to quality that is necessary for higher performance.

Schlichting also suggests that board members take advantage of their specialties, using experience from their full-time businesses to advance quality.

“There has to be transparency of information; when information is not available, there is nothing to motivate health care workers to pay attention to quality and patient satisfaction.”



Dr. Thomas Song house officer, Department of Radiology, and Dr. Denise Collins, vice chair, Department of Radiology, Henry Ford Hospital, use the PACS system to review a patient's radiology images online. The physicians can compare multiple views, zoom in and record measurements with the click of a mouse.

PACS Improves Quality; Saves Time and Money

Picture Archiving Communications System (PACS) replaces x-ray films with digital images, making it possible for Henry Ford physicians to access radiology images online through a virtual private network. The project, supported by a grant from HAP, has produced positive outcomes:

- ◆ Time saved waiting for x-rays to be developed. As many as 30 percent of physicians using PACS said that the system saved them eight or more hours a week.
- ◆ Eliminating the cost of film, chemicals and supplies to process images, resulting in an annual savings of \$1.4 million.
- ◆ Reduced monthly storage expenses.
- ◆ Eliminating the need to physically transport x-ray film to multiple locations. Prior to PACS, lost or temporarily misplaced film led to 10,045 of them not being interpreted; the number fell to 452 after installation of the system.
- ◆ Improved patient care through more timely results, earlier diagnoses and treatment and more direct physician/patient communication.
- ◆ Reduction in errors in reading x-rays.

Leaders Take Charge

After reviewing the nine obstacles that prevent board members from affecting quality, Schlichting established some critical priorities for leaders:

- ◆ Keep your eyes on the right ball—it is about people. You have to create an environment that supports your organization's culture and commits to quality.
- ◆ Set motivating and challenging goals. It is much more motivating to go after the gold, keeping in mind what patients expect.
- ◆ Offer resources to support quality; it will lead to return on investment.
- ◆ Engage physicians and nurses.
- ◆ Create an organizational structure that drives performance.
- ◆ Develop a board.

Despite the challenges that still exist, Schlichting is optimistic. "We recognize the problems and opportunities and understand more each year," she said. "Quality is becoming a competitive issue and is stirring more public policy debate." Schlichting also noted that we are getting better at measurement, paying for performance, setting perfection goals and achieving significant improvement. "The goal-setting is the most exciting because we are creating ones we really want," she concluded, "and they have to be high enough to stimulate improvement."



Incentives to Promote Quality Under Medicare

*Stuart Guterman
Director, Office of Research,
Development & Information, Centers
for Medicare & Medicaid Services (CMS)*

As CMS focuses on the new Medicare Modernization Act (MMA) and implements its many provisions, it uses its demonstration authority to test new initiatives that promote improvements in the quality of care. "As the single largest payer, CMS takes its role seriously in trying to put its weight behind initiatives to improve the health care system," Guterman said.

Among the programs in which CMS is involved is the Voluntary Hospital Reporting Initiative (VHRI), which was started by several of the largest hospital trade associations and was given greater force in Section 501(b) of the MMA. Although VHRI is a voluntary program, the MMA makes 0.4 percentage points of the annual update to hospital payment rates (about \$400 million annually) in fiscal years 2005 and 2006 contingent on participation, which involves reporting data on a "starter" set of 10 quality measures related to three clinical conditions.

Hospital Initiative Is 'Premier'

One of the more publicized quality initiatives is the Premier Hospital Quality Incentive Demonstration (HQI), in which providers share data on 34 quality measures related to five clinical conditions. "We have been talking about the need to reward quality and differentiate between payment for high- and low-quality providers," he said. "Premier invited CMS to put its money where its mouth is." Data collection started at the beginning of this year. The first results will be available next year. Although the bonuses are small—estimated Medicare payouts of \$7 million per year—Guterman believes that they provide impetus for improved performance, and there is even more incentive to improve because performance measures for the top 50 percent of hospitals in each clinical area will be posted on the CMS website. "No one wants to be at the bottom of the list," he noted.

The three-year demonstration project, open to any hospital in the Premier system, a nationwide organization of not-for-profit hospitals, currently has 275 participants as of March 31, 2003. The demonstration program will provide new money and will not just offset decreases in payment rates.

"We are hoping to establish the fact that if we can increase quality of care, Medicare will see savings," he said. "If we can show a savings offset, it will be easier to make the case for investment in more of these initiatives." CMS anticipates expanding the approach system wide.

Hospitals in HQI receive rewards for their performance on evidence-based quality measures for patients with acute myocardial infarction, heart failure, community-acquired pneumonia, coronary artery bypass graft (CABG), and hip and knee replacements.

As an example, Guterman described some of the process measures affiliated with CABG, including aspirin prescribed at discharge, prophylactic antibiotic received within one hour prior to surgical incision, inpatient mortality rate and post-operative hemorrhage, hematoma or physiologic and metabolic derangement.

Composite quality scores will be calculated annually for each demonstration hospital by combining individual measures into an overall quality score for each condition, which will be categorized into deciles to identify top performers. Hospitals in the top 10 percent receive a two percent bonus of their Medicare payments for diagnosis-related groups (DRGs) that relate to the measured condition, while those in the top 20 percent will earn a one percent bonus on their DRG payments. The project also includes the prospect of payment reductions for poor performance. Baseline performance thresholds established in year one will be applied to the third year. If hospitals do not exceed those scores, they may be subject to a penalty.

Even hospitals at the lower end of the distribution can avoid the penalty, however, if they improve their performance above the first-year thresholds. "We are hoping not to have to reduce anyone's payments," Guterman said. "It will be interesting to see whether more improvement will occur among hospitals at the low end rather than those at the higher performance levels."

Despite one conference attendee's concerns over penalizing physicians, Guterman emphasized that although there is the potential for a penalty, the system promotes the opportunity to improve.

Focusing on the Provider

Although CMS is excited by the hospital quality initiative, it recognizes that physicians are at the center of the provision of care. This has led to the development of several physician-focused initiatives, including the Physician Group Practice Demonstration (PGP) mandated by the Benefit Improvement and Protection Act of 2000. It targets large (200+ physicians) multi-specialty group practices that are affiliated with other providers and have well-developed clinical and management information systems. Many of these groups have office systems, such as sophisticated healthcare IT, in place that will make it easier for them to collect and report data and demonstrate their quality performance to purchasers.

The main objectives of the PGP project are:

- ◆ Encourage coordination of Part A and Part B services—including physician and all Medicare services.
- ◆ Promote efficiency through investment in administrative structure and process.
- ◆ Reward physicians for improving health outcomes and realizing savings.

Bonus payments in the PGP demonstration are based on annual performance targets established for each group and are earned if actual Medicare spending for assigned beneficiaries is less than the annual performance target minus a two percent savings threshold. After the two percent is taken off the top, physicians receive 80 percent of the savings, and Medicare gets the rest. However, 30 percent of the physician bonuses will be set aside to reward success in a set of quality measures.

Guterman said it is not sufficient to just reward for denying care, but that it is important to recognize the maintenance of quality and patient satisfaction. He is confident that the demonstration project will generate both costs savings and improved care.

Proposed quality measures include an annual influenza vaccine; annual HbA1c tests and biennial lipid profiles for diabetics; chest radiograph and an ECG after initial diagnosis of congestive heart failure (CHF); left ventricular ejection fraction (LVEF) test, which is a decrease in function of the left ventricle, following hospitalization for CHF; physician visits every six months for the chronically ill; and admission rates for Ambulatory Care Sensitive Conditions (ACSCs), for which hospitalization is thought to be avoidable if preventive care and early disease management are applied.

Evaluation will be based on organizational structure, leadership and management, financial stability, quality assurance, process and outcome measurement and the demonstration implementation plan. Guterman said that the demonstration project still requires approval of a waiver from current Medicare rules before the 11 chosen sites are approved and publicly announced.

Rewarding IT Development

CMS has one more program at the starting gate—the Medicare Care Management Performance Demonstration (MCMP), which is modeled after the Bridges to Excellence project being conducted in three sites around the country by General Electric, Verizon, FedEx, and several other large employers. Designed for small to medium-sized physician practices, it promotes the adoption and use of IT systems in physician offices and creates an infrastructure for Medicare's receipt of data from electronic office-based systems for use in technical assistance and public reporting.

The MCMP project, Guterman said, is to not only encourage and incentivize the adoption of IT, but also to apply the systems to quality improvement to better manage patients. "We will put money on the table for each patient a practice treats if the practice meets the criteria for IT and manages several specified beneficiaries who are chronically ill," he said.

One of the areas of most concern to CMS is the chronically ill Medicare population. Studies have shown that 20 percent have five or more chronic conditions, which translates into two-thirds of Medicare dollars going towards treating those patients. Additionally, they are treated by an average of 13.8 different physicians. "Unfortunately, there is nothing in fee-for-service that encourages these providers to coordinate efforts or communicate with each other," Guterman said. "We hope to address the chronically ill population by rewarding quality of care."

Go to www.cms.hhs.gov.

“One of the areas of most concern to CMS is the chronically ill Medicare population. Studies have shown that 20 percent have five or more chronic conditions, which translates into two-thirds of Medicare dollars going towards treating those patients. There is nothing in fee-for-service that encourages these providers to coordinate efforts or communicate with each other.”

Actionable Goals and Measures Drive Performance and Improve Outcomes

At the final presentation of the day, Mary Beth Bolton, M.D., senior vice president and chief medical officer for HAP, introduced a panel of three “early adopters” of provider profiling and quality financial incentives. These experts have many years of experience in analyzing data and creating quality performance measurement systems tied to incentives.

Systems for Clinical Performance Improvement: Tools and Rewards

*Kathleen Curtin
Vice President, Quality Management
Excellus Blue Cross Blue Shield*

Getting right to the core of paying for quality, Curtin believes that to be successful, you must have measurement systems and tools in place, as well as a strong partnership with physicians.

By accomplishing both, Excellus has been able to develop a performance improvement system, including a physician profile, patient-specific information and financial incentives.

Excellus Blue Cross Blue Shield, a \$4.1 billion, not-for-profit health care financing and delivery company that serves nearly two million people in Upstate New York, partnered with the Rochester Individual Practice Association (RIPA). The 900-physician organization serves 400,000 Blue Choice enrollees in an exclusive relationship and has 75 percent of the commercial managed care market in the area.

As Curtin explained, Excellus not only delivers the majority of services, but also establishes relationships with physicians in the service area and manages the care contracts, data and information that those relationships make possible.

Excellus, relying on both staff model (it acquired Univera) and mixed-model experiences, created physician profiles in Buffalo in 1996 and in Rochester in 2000, earning the insurer a Robert Wood Johnson “Rewarding Results” grant.

Excellus provides practitioners with measures for preventive and acute care and chronic illness, as well as patient-specific information for office follow-up. “By combining experiences from Buffalo and Rochester, we were able to develop the best performance improvement system in Rochester,” Curtin said.



Robert J. Jackson, M.D., MMM, Medical Director, Wyandotte IPA and Oakwood Primary Care Physicians, PC, Medical Advantage Group; Kathleen Curtin, Vice President, Quality Management, Excellus Health Plan; and Paul Harkaway, M.D., President, Huron Valley Physicians Association

The performance profile measurement report has been critical to measuring and ensuring quality care. Another report, the quality measures report, compares physicians’ performance to others in their group and in the community.

A patient management reminder, generated automatically in partnership with a medical services vendor, lists needed services, drugs and lab tests prescribed for the patient and the patient’s hospital experience. Physicians in Buffalo annually receive the status of preventive, acute and chronic services for their patients, who also receive the same information. A pilot is underway in Rochester to deliver a reminder at the time of appointment.

Curtin said that they are interested in providing actionable information to physicians, engaging patients in self-management and providing incentives not just for clinical measures, but also for efficiency and service quality. In short, preparing physician offices to deliver quality service.

Other reports track utilization for diabetes, otitis, sinusitis, asthma, heart disease and preventive health services. The Rochester report rolls several measures into one for each condition and integrates an efficiency measure with episode groupers and patient satisfaction information.

Based on efficiency information, the performance improvement system helped save Rochester \$4.5 million around acute care and use. Excellus plans to highlight pharmacy opportunities and provide more information on radiology and lab.

Keys to Success

Curtin attributes the success of the Excellus' incentive program to:

- ◆ Shared vision by top management in both the health plan and participating physicians.
- ◆ Work teams comprised of physician champions, data analysts, administrators and programmers.
- ◆ Emphasis on overuse issues and appropriate drug use.
- ◆ Integrated database drives actionable clinical behavior change.
- ◆ Shared goals and logic between physicians and the plan.
- ◆ Ongoing education with physicians.
- ◆ Responding to criticism and feedback. It is necessary to listen to every single thing a physician says. If the health plan finds that its data is incorrect, then it must be willing to change the information system or the payment stream.
- ◆ Establishing a simple appeals process and a budget to support it.

"We really believe that if the measurement system is tied to incentives, performance can improve over time," she concluded.

Recipe for Improving Physician Performance in a Private Practice Community: Revealing the Secret Ingredients

Paul Harkaway, M.D., President, Huron Valley Physicians Association (HVPA)

While everyone else was solving the problems of Y2K, HVPA was stumbling onto the secret recipe for introducing performance change to physician groups. "We really stumbled onto the recipe; it wasn't through a grand design or after lots of thoughtful deliberation," Dr. Harkaway said. He applied Winston Churchill's comments to physicians, saying, "They can always be counted on to do the right thing, but only after they have exhausted all the other possibilities."

Secret Formula Revealed

Dr. Harkaway unveiled his secret formula more willingly than Coke or Pepsi would ever share their beverages' undisclosed recipes:

- ◆ **Prove performance change is worthwhile** by showing how it can improve the hospital and health plan's bottom line.

- ◆ **Have the "will" to change.** Many physicians are resistant to change, which can be overcome and facilitated with physician leadership and champions.
- ◆ **Provide specific data.** Give the physician information about the right patient and the right disease—and correctable and actionable information, such as recognizing that a woman needs a mammogram. Dr. Harkaway believes that little has been done in this area, but that it is critical to managing what is measured.
- ◆ **Leverage peer pressure.** Dr. Harkaway believes that competition between providers is the ultimate secret weapon—nuclear stuff and the Guns of Navarone combined.

"Physicians may be a little upset by being called marginal in most aspects of their lives, but telling them they are bad doctors or not as good as another doctor—that is a potent factor. When a colleague tells you that your asthma scores are embarrassing, that's a heavy dose of motivation," he said.

- ◆ **Provide monetary incentives.** The way to show value is with dollars. Without financial incentives, you are saying it is important enough to do something, but not important enough to pay you for it.
- ◆ **Provide tools.** Tools should not be used to demonstrate the difference between good and bad doctors through profiling, but to help bad doctors become good ones. If performance expectations are set, physicians need tools to succeed.

But the most important new source of data is the physician. Information originates in the physician's office, but often nothing is tapped into the front end or available at point-of-service. He used blood pressure recording as an example of data that are not easily recovered because they must be extracted from the chart and can be difficult to access.

Concurring with Curtin, Dr. Harkaway emphasized the important use of tools to improve physician performance. HVPA utilizes monthly, personalized physician mailings to keep providers abreast of their patients' tests and screening results for conditions such as asthma and diabetes, and exception reporting if physicians receive incorrect information concerning patients.

Doctors' offices generate patient mailings on the physician's own letterhead, which ensures that the right patients receive relevant information. The letters remind patients that necessary health screenings are due. Requisition forms accompany the patient letters so they can follow through on doctors' orders.

Earnest and Worthwhile Causes

In describing performance measures, Dr. Harkaway said that most have focused on HEDIS outcomes, which he believes are only rudimentary in measuring care but important.

Some of the newer measures HHPA is considering are:

- ◆ Admission avoidance, not days per 1,000 patients, but based on which patients can be better taken care of in the outpatient setting than in the hospital.
- ◆ Length of stay reduction.
- ◆ Blood pressure control.
- ◆ Depression control.
- ◆ Diagnostic imaging.
- ◆ Service excellence at the point of service as compared to rating the system as a whole.
- ◆ E-health.
- ◆ Access. It doesn't matter how good a doctor is if you can't get in to see him or her when you need help.
- ◆ Polypharmacy.
- ◆ Coordination and communication.

The HHPA Measurement Formula

HHPA has developed a "complicated" formula to measure physician performance: the number who received a desired intervention or experienced a desired outcome divided by the number who should have received the intervention or outcome. The resulting ratio is multiplied by the number of patients in a panel times the incentive—\$2 per member per month as an example—to create the quality incentive awarded to physicians.

Dr. Harkaway shared a chart representing the number of eligible members receiving three or more bronchodilators and a steroid inhaler. Performance improved considerably between January 1999 (prior to incentives), and April 2000. "There is proof that the formula actually works in an independent practice environment," he concluded.

Diamonds From Coal: Improving Physician Performance

*Robert J. Jackson, M.D.
Medical Director for Wyandotte IPA (WIPA),
Oakwood Primary Care Physicians P.C. (OPCP), and
Medical Advantage Group*

To put the physician performance programs for Wyandotte IPA (WIPA) and Oakwood Primary Care Physicians (OPCP) into perspective, Dr. Jackson explained that both groups are primarily comprised of private practice physicians. WIPA is a multi-specialty group. OPCP is a group of hand-picked PCPs, who were chosen based on perceived quality and cost-effectiveness.

The Positive Influence of Managed Care

Both IPAs maintain strong contracts with the top performing southeast Michigan health plans. With both IPAs so strongly enmeshed in managed care, Dr. Jackson stressed why success in that environment is so important and discussed managed care's positive influence on quality. Health care needs to be affordable or the consequences will be significant. The cost of living continues to rise, along with unemployment and the number of uninsured.

He also noted that managed care assigns the PCP the role of key care coordinator, which provides better care. "Physicians in managed care understand that they need to meet certain expectations—both quality and financial—for which they will be monitored. Another advantage, which comes as no surprise, is managed care's ability to generate data that the plan can deliver to physicians to help improve care for their panel of patients.

"Fee-for-service (FFS) doesn't have the same access to data, although some metrics are available, because patients are not assigned to any one doctor," Dr. Jackson said. "In addition, FFS has not traditionally monitored quality of health care, whereas managed care plans pay physicians for what they should be doing (improving quality) anyway and measuring clinical quality outcomes."

Ensuring Quality Physician Performance

Dr. Jackson said managing physicians, who are independent thinkers, is like herding cats. They come when enticed—much like cats that answer to food and catnip. Better understanding physicians leads to better performance, he said.

Doctor Jackson identified the best ways to ensure high physician performance:

- ◆ Choose cost-effective, quality physicians willing to work in managed care.
- ◆ Align them with different co-pays to reflect their performance.
- ◆ Provide frequent and clear expectations, measures and goals.
- ◆ Share data related to their performance and that of affiliated specialists.

He listed other reasons behind quality performance: compensation aligned with expectations; routine and periodic feedback through report cards; and less important, managing marginal performance and adverse action.

“Although there often are not too many bad performers, they need to know, as do those performing well, or they will lose the incentive to keep running hard. A medical director can’t let a poor performing, unmotivated cadre of doctors spoil the entire group’s performance,” he said.

Key to Organizing Physician Groups

Dr. Jackson also offered some useful hints about developing physician groups and the important role of leaders. He suggested selecting PCPs who have perceived higher quality and shorter lengths of stay for inpatient care. He also recommended keeping groups small for more cohesion, allowing PCPs to choose an elite group of specialists and developing a new group instead of revamping an older one.

Strong leaders as those who are dedicated and respected so that others will follow; who need to work harder than each PCP—not just show up for meetings—and be compensated for it; and who must develop thoughtful followers. In addition, he said board members must understand the importance of leadership and the difficult decisions leaders may face.

Change Is Never Easy

If a physician group is going to change, it cannot be in incremental stages—incremental change delivers incremental results—Dr Jackson warned, or you may find physicians frozen in place. To successfully introduce change, he emphasized clearly defining the new expectations; recognizing the turmoil associated with change and physicians’ dislike for it; and continually preaching that “we will succeed.” He had to go out on a limb when he promised WIPA they would make a profit this year.

Improvement tools are critical. The IPAs created a pocket drug formulary to educate physicians about drugs and their costs. Dr. Jackson said he has seen a jump from 44 percent to 60 percent in generic use, which he mentioned may be more of a performance measure than one of quality.

He also recommended a report card with HEDIS performance data or health plan quality goals to ensure physicians know what is important in improving their practices. But key to all of these suggestions is creating a tool physicians can actually use to change what they are doing.

An example of physician actionable quality data is a print-out of an individual patient with diabetes, indicating what he or she needs, rather than an entire list of patients with diabetes. The latter necessitates pulling 50 different charts and generating too much paper. Since physicians treat one patient at a time, they need connection with one person at a time.

Finally, Dr. Jackson noted the importance of data analysis capabilities to reconfigure claims; someone to translate data into useful reports; and collaboration with all stakeholders to improve performance.

Challenges for Stakeholders

Dr. Jackson identified barriers to improving PCP performance. On the health plan side, he suggested that they pay less for procedures they would like performed less frequently and pay more for desired procedures to incentivize physicians. He guaranteed that if every patient receiving a flu shot generated a \$50 profit, the number of immunizations would jump, or if there were less profit on MRIs, there would be fewer procedures. It is worthwhile looking at the profit margin, he said, when paying for things and it may be worth it to pay for quality, such as reimbursing physicians for every mammogram they order.

Dr. Jackson acknowledged that hospitals are successfully maximizing income by not discouraging patients from using the emergency room and are participating in soft contracting—payer referrals to outpatient radiology, for example—which diverts resources from PCP and specialists’ offices where most quality care occurs.

Purchasers do not get off scot-free either: He is concerned that purchasers have moved too slowly to increase copayments for consumers and are unwilling to pay more for quality improvement infrastructure, such as developing electronic medical records, and encouraging health plans to pay doctors more for improving their information technology capabilities.

Dr. Jackson also does not spare the patients and lawyers, blaming our litigious society for doctors pushing mistakes underground, thus preventing continuous quality improvement; an unwillingness to make lifestyle changes to improve health or prevent disease; and the aging population that will strain our health care system.

Panel Q&A

Following are responses from the panel to audience questions:

Q... What is the motivation behind developing a physician group infrastructure?

A... To manage risk and reimbursement from payers.

Dr. Harkaway emphasized that although he favors independence, “no physician is an island. Independent physicians have to be connected to other groups to provide coordinated care, and we were preparing ourselves for that integration,” (referring to HVPA). “If you are too small, it is impossible to influence your environment,” he said.

Although Curtin noted that while health plans provide a technical infrastructure, physicians are the source of setting standards. Excellus created an infrastructure in the plan, allowing RIPA and its technical team direct access to the plan’s mainframe to drill down and manipulate information. “Where you resource the technical infrastructure is the crucial question,” she said.

Q... How do you align patient and physician incentives?

A... “The idea of having information directly accessible to the patient is the next generation of improvement,” Curtin said. “Our one-year patient report is a start but is inadequate, and we don’t yet have any of the information on the Web. We are moving in the direction that the patient should have as much information about their care as their physician has.”

Dr. Harkaway mentioned what he considers a poignant moment when a patient comes to see the doctor, laden with a bag of pills and wondering if all of the drugs are necessary now that her benefits have changed and some of the drugs have become unaffordable. “There is a need for patients to have more skin in the game,” he said.

Dr. Jackson attributed the misalignment of patient/physician incentives to health literacy or the lack of it. “When you have as many as 25 percent of patients who can’t understand and process information, the root cause of non-compliance, it is difficult to align incentives,” he said. He recommends changing the message to meet a patient’s needs, such as making a complicated letter reminding a patient to get a mammogram much simpler. “We need to start thinking about what kind of communication individual patients need.”



Closing Remarks

*Mary Beth Bolton, M.D.
Panel Moderator, Senior Vice President
& Chief Medical Officer, HAP*

“Each of our speakers addressed similar themes with different perspectives on how to improve quality, but they all agree that they are challenged by gaps in care,” Bolton said. “The evidence is louder and clearer that these gaps continue to persist.”

She emphasized the importance of heeding Dr. Reinertsen’s advice to find out where waste in the health care system exists because there are a lot of wasted resources and money, along with gaps in care. Dr. Bolton recommended shifting overused and misused resources to areas where there are little or none.

She referred to IHA’s collaborative efforts and noted that Michigan is involved in a Quality Improvement Consortium and in a new initiative, a statewide credentialing program. “We are the kind of state and environment ripe for collaborative efforts with health plans and physician groups partnering to share data,” she said.

“There is clearly a business case for quality. Although not all the data are available, there are a growing number of studies that indicate that doing the right things first lead to improvement in functional status, quality and cost.”

“There is clearly a business case for quality. Although not all the data are available, there are a growing number of studies that indicate that doing the right things first lead to improvement in functional status, quality and cost,” she continued. “Quality improvement has been around for a long time in the industry, but there is a lot more work to be done—creating electronic medical records, patient registries, computerized physician order entry and disease management programs. Our customers make quality improvements in their businesses and expect us to do the same thing.”

Your efforts put the stake in the ground, she said, and noted that even the government is serious about paying for quality and is looking for innovative ways to partner with providers. “These efforts have fueled enthusiasm for what has been cropping up around the country anyway, and I applaud them and look forward to more,” she said.

“We are totally committed at HAP to developing more innovative ways of improving quality, recognizing it and paying for it.”

“If CMS is recognizing quality, HAP can follow suit by reinforcing the same quality metrics instead of inventing our own. There is a lot of evidence-based medicine that has not yet been implemented so we don’t need to come up with new guidelines,” Dr. Bolton said.

“We are totally committed at HAP to developing more innovative ways of improving quality, recognizing it and paying for it. One way to do this is to ensure that members are educated and have access to tools not only on the Internet, but in ways that address different ethnic and cultural backgrounds.

“Community collaborations are very powerful; our work in Michigan has been very inspiring,” she concluded. “We have learned a lesson that you don’t have to make your own tools and do it your own way, but that we can work together.”

Improving Health Care: Innovative Approaches to Paying for Quality Performance

Release Date: Nov. 2004

Expiration Date: Nov. 2005

Target Audience:

These proceedings will have appeal to a broad leadership audience, including: employer purchasers of health care, hospital trustees and executive management; hospital leaders responsible for finance and contracting; physician leadership including chief medical officers and network medical directors; health plan and insurer executive management; government leadership, especially public payers, e.g., Medicaid; and others.

Educational Objectives

Upon completion of this program, participants should be able to:

- ◆ Identify barriers that confront stakeholders in making the business case for improving health care quality and how to eliminate those barriers.
- ◆ Explain emerging approaches to reward providers for improving health care quality in ways that create common incentives across the community.
- ◆ Discuss how these approaches translate into measurable improvement in quality and reductions in health care cost for the purchasing community.
- ◆ Develop a shared understanding of cooperative community-wide activities that can be extended across all health plans and providers.

Program Completion Time

Based upon trials, the estimated time to complete this exam is 2.5 hours.

Sponsorship

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Physician Accreditation

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PLEASE NOTE: Participants who received CME credit for attending the live HAP conference on May 19, 2004 in Dearborn, Michigan will not be eligible to receive credit for completing this program.

CME Questions

- Which of the following is **not** a business rule for improving margins through better quality:
 - More standardized, reliable methods for producing products and services lead to lower unit costs.
 - Demonstrating better quality commands higher prices.
 - Higher quality does not necessarily attract more customers.
 - More efficient management of patient flow leads to higher throughput.
- The Unified Field Theory-Applied (UFT-A) incorporates:
 - Rewarding higher quality by reducing providers' regulatory and administrative costs.
 - Patient-focused care.
 - Evidence-based medicine.
 - Integrated health care systems.
 - All of the above.
- Which of the following is **not** a result of UFT-A:
 - Enabling the physician to spend less time with a patient.
 - Reducing administrative costs.
 - Providing incentives for innovation and cooperation.
 - Creating common goals among all stakeholders.
 - Lowering liability risk.
- What percent of evidence-based services are being delivered to patients with chronic disease?
 - 30 percent.
 - 45 percent.
 - 55 percent.
 - 15 percent.
- Which of the following was not a motivation behind the Integrated Healthcare Association's (IHA) decision to choose "pay for performance" over "pay for quality?"
 - "Quality" was too broad a term.
 - There are other aspects to performance that do not relate to quality.
 - "Quality" does not resonate with businesses.
 - "Quality" has too many different connotations.
- Pay for Performance (P4P) relies on a set of fundamentals including which of the following:
 - Incentive payments to individual physicians.
 - Fee-for-service enrollees.
 - Data from chart reviews.
 - A balanced set of metrics.
- Which of the following plans is not participating in P4P?
 - Blue Cross of California.
 - Kaiser Permanente.
 - Aetna.
 - Health Net.
 - CIGNA Healthcare of California.
- "Social Democrats" responding to P4P believe in which principles;
 - Broad participation.
 - Achievable goals initially.
 - Rewards for improvement and performance.
 - Available technical assistance.
 - All of the above.
- During 2004-05, P4P clinical measures will account for which percent of total measures:
 - 50 percent.
 - 45 percent.
 - 60 percent.
 - 40 percent.
- New measures for P4P include:
 - Control of diabetes.
 - Appropriate antibiotic use in children.
 - Advising smokers to quit.
 - Colorectal screenings.
 - Chlamydia screenings.
 - All of the above.
- The Premier Hospital Quality Incentive Demonstration (HQI) allows providers to share data on developing quality, effectiveness and efficiency measures.
 - True
 - False
- Which of the following is not a condition measured in HQI?
 - Heart failure.
 - Community-acquired pneumonia.
 - Asthma.
 - Acute myocardial infarction.
 - Hip and knee replacements.
- In HQI, the top 10 percent of participating hospitals for each clinical condition will receive what percent bonus to their payments for Medicare patients treated for that condition?
 - One percent.
 - Two percent.
 - Three percent.
 - Five percent.
 - Ten percent.

14. What percent of the Medicare population has five or more chronic illnesses?
 - a. 25 percent.
 - b. 10 percent.
 - c. 20 percent.
 - d. 35 percent.
 - e. 50 percent.
15. The upcoming Centers for Medicare & Medicaid Services' Medicare Care Management Performance Demonstration will focus on what?
 - a. Improving efficiency.
 - b. Adopting information technology systems.
 - c. Managing patients with chronic disease.
 - d. Both (b) and (c) are correct.
16. Rochester's performance improvement system helped save \$4.5 million around the following?
 - a. Preventive care.
 - b. Chronic care.
 - c. Use of services.
 - d. Acute care.
17. The success of Excellus' incentive program is due to:
 - a. Shared vision by the plan and participating physicians.
 - b. Integrated technical work teams.
 - c. Focus on overuse and appropriate drug use.
 - d. Physician education.
 - e. All of the above.
18. The secret formula for introducing performance change, espoused by Paul Harkaway, M.D., president of Huron Valley Physicians Association (HVPA), includes all but the following:
 - a. Leveraging peer pressure.
 - b. Using data.
 - c. Incentivizing with money.
 - d. Providing profiling tools that indicate differences between good and bad doctors.
19. HVPA is not considering which new measure:
 - a. Admission avoidance.
 - b. Number of hospital admissions.
 - c. Reduction in length of stay.
 - d. Blood pressure control.
 - e. Depression control.
20. Advice on paying for quality performance from Robert Jackson, M.D., medical director of two physician groups, recommends which of the following:
 - a. Developing large physician group participants.
 - b. Using adverse action when necessary.
 - c. Outlining expectations and goals.
 - d. None of the above.

CME EXAM AND EVALUATION FORM

Improving Health Care: Innovative Approaches to Paying for Quality Performance.

To receive CME accreditation, circle the correct response, complete the requested information, and mail this form to Medical Education Resources or fax the form to 303-798-5731. Certificates will be mailed to the address listed below and please allow three weeks for processing.

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Program Evaluation

Circle the letter which best reflects your opinion of the following statements, using the following rating scale:

Program Rating:

1 = Strongly Disagree 2 = Disagree 3 = Neutral
4 = Agree 5 = Strongly Agree

1. The program objectives were met.

1 2 3 4 5

2. The program content was useful and relevant.

1 2 3 4 5

3. The program was presented in an organized manner.

1 2 3 4 5

4. The program will change the way you practice.

1 2 3 4 5

5. The author/faculty demonstrated expertise in the topic.

1 2 3 4 5

6. The material was presented at an acceptable level of expertise.

1 2 3 4 5

The program was unbiased and non-promotional

Yes No If no, please explain _____

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1. a b c d e

2. a b c d e

3. a b c d e

4. a b c d e

5. a b c d e

6. a b c d e

7. a b c d e

8. a b c d e

9. a b c d e

10. a b c d e

11. a b c d e

12. a b c d e

13. a b c d e

14. a b c d e

15. a b c d e

16. a b c d e

17. a b c d e

18. a b c d e

19. a b c d e

20. a b c d e

Additional Comments: _____

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