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# Clinical Performance Measurements and Incentives Enable Value Based Purchasing

Jerry Reeves MD

The year 2005 was a banner year in health care. The average cost for family health insurance premiums exceeded the full-time annual income of a minimum wage worker. Health premiums leaped 74% in 5 years. That's 5.5 times as fast as general inflation and 2.3 times as fast as business income growth. General Motors spent \$5.2 billion on health care for its US employees, retirees and dependents. That represents \$1,525 for every car and truck produced. Starbucks CEO Howard Schultz recently told lawmakers he spends more on healthcare for employees than on coffee, a situation he termed "completely non-sustainable".

Meanwhile, overall improvements in quality and safety of health care have lagged far behind. The National Committee on Quality Assurance (NCQA) reported HMO and point of service health plan performance improved on 40 out of 43 measures of quality. However, enrollment in these types of plans declined while enrollment increased in PPO plans that usually don't publicly report their quality performance scores. About three times as many people are enrolled in PPO health plans as in HMO health plans. Healthcare purchasers who measure PPOs' adherence to evidence based guidelines have found performance to often be 20% to 30% lower than for HMOs. As overall quality and safety performance measures remain essentially flat and costs rapidly increase, the value of health care purchases steadily deteriorate. The deteriorating value of health services and greater availability of medical data tools to measure and report performance are compelling health benefits purchasers to take more active roles in driving health care reform. The era of accountability and transparency is upon us.

The Hotel Employees and Restaurant Employees International Union (H.E.R.E.I.U.) Welfare Funds provide PPO-type health insurance coverage for approximately 175,000 lives in 22 states. About 115,000 reside in Las Vegas, Nevada. This challenging population has high health care needs and limited disposable time and income. Their tendency is to delay healthcare services even though out of pocket costs are relatively low. Costs and quality of health services they receive are influenced not only by cost per unit but also by number of units of service and by the effectiveness (impacts on outcome) of those units of service. Negotiated discounts alone are insufficient to maintain affordability of health care. Therefore we have applied robust data analysis of medical, pharmacy, and laboratory claims and test results to guide our corrective actions to manage costs and improve outcomes.

## Value Based Purchasing Strategies

The key steps necessary to enable purchasing of health services with higher value (higher quality and safety at affordable costs) include:

1. Comprehensive information on sources of costs and root causes of outliers
2. Risk adjusted comparisons of clinical performance and outcomes
3. A will to act on the findings
4. Multiple contacts of patients and providers to engage them
5. Incentives aligned with desired behaviors
6. Sustained interventions
7. Leverage

In this article we review how H.E.R.E.I.U. has engaged in each of these steps.

### *Comprehensive information on sources of costs and root causes of outliers*

We created a data warehouse over 10 years by engaging internal health information technology data analysts recruited from major consulting firms as well as outside consultants who assisted with the design and the mapping of fields to unique patient and provider identifiers. Medical claims, pharmacy claims, and laboratory test results populate the data warehouse. Monthly reports from this resource show our direct medical costs are primarily driven by payments to participating physicians (35%) and hospitals (29%) and for prescription drugs (23%). Further analysis has indicated that the primary root causes of physician costs are excessive use of specialists and procedures disproportionate to the outcome improvements attributable to these services. Unnecessary visits to hospital emergency departments and outpatient surgery facilities are root causes of avoidable hospital costs. More than half of emergency room visits are for urgent conditions that could be safely handled in extended-hours urgent care clinics and more than 1/3 would be more appropriately handled in a doctor's office or by phone. Unit costs for outpatient surgeries are usually much lower in free-standing (as opposed to hospital) ambulatory surgery facilities. Excessive prescription drug costs can often be avoided through more frequent use of safe and effective generic drug alternatives. About 1,000 Las Vegas patients fill more than 8 prescriptions per month. In our plans, the average cost per prescription is \$55 less for generics than for equivalent brand drugs. Review of outlier high cost cases often reflects that failure of outpatient management is a root cause. Poor adherence to evidence based preventive care guidelines and late interventions for patients with diabetes, high cholesterol, and hypertension contribute to avoidable high hospital costs for strokes, heart attacks, and kidney failure.

### *Risk adjusted comparisons of clinical performance and outcomes*

We analyze claims and lab result data from our data warehouse to display risk adjusted performance comparisons of contracted hospitals and doctors. For instance we show that the top performing hospital in our network in Las Vegas performs at the 82<sup>nd</sup> percentile, the lowest performer at the 3<sup>rd</sup> percentile, and the median at the 48<sup>th</sup> percentile nationally on CMS core measures (acute myocardial infarction, heart failure, and pneumonia). We compare risk adjusted average prices, complication rates and mortality rates of hospitals using 3M™ All Patient Refined Diagnosis Related Groups (APR-DRG) to compare performance variations within our network with hospitals in other States. We show that the most expensive primary care and specialist physicians in our network cost about eight times as much on average to manage common episodes in their respective specialties (ear infection, bronchitis, urinary tract infection, angina, knee surgery, etc.) compared to their least expensive peers. Primary care physicians vary widely in their prescribing of generic drugs, from as low as 30% to as high as 65%. We found that 1% of our physicians prescribed 50% of the oxycontin dispensed to our participants. Geographic variations can also be substantial. For instance, radiology costs are 3 times higher per participant in West Virginia than in Las Vegas and pharmacy costs are 36% higher per participant in Atlantic City than in Chicago.

### *A will to act on the findings*

Actions we have taken to achieve behavior change include changes in benefit design and coverage, communication campaigns, pay for performance programs, patient incentive programs, and network changes. We have increased participants' out of pocket expenses for ER visits, hospital outpatient surgeries at high cost facilities, and brand drugs. We expanded our network of after hours urgent care clinics. We offer a free pharmacy with 250 generic drugs available at no out of pocket cost. We discuss present and past performance, competitors' performance, and benchmark measures with network hospitals and doctors to develop commitment to performance improvements. We implemented a pay for performance program for high performing primary care physicians weighted 3 times as heavily on quality (guideline adherence) measures as on efficiency (Episode Treatment Group) measures. After ongoing counseling of poor performers, if there was lack of corrective action, we have discontinued contracts with physicians due to lack of business need to continue the relationship.

### *Multiple contacts of patients and providers to engage them*

We communicate frequently with beneficiaries informing them of top performers through newsletters, shop steward meetings, provider directories and phone discussions with people choosing their doctor. Our web site offers a one stop shop to help them find a good doctor with extended hours who speaks their language, answer questions about their benefits and claims, answer questions about their health conditions and treatment alternatives, and assist with navigating our health care system. Periodic health fairs and free flu shots reach out to engage members in early preventive care. Blue Ribbon Panels and Quality Improvement meetings with physicians, hospitals and medical opinion leaders engage professionals in collaboratively developing and implementing solutions.

### *Incentives aligned with desired behaviors*

Incentives to change behaviors include recognition, rewards, rules and penalties. After recognizing top performing doctors in our directories and communications, there was a 30% market share shift from lower performing to higher performing family practitioners. Doctors who received performance bonuses offered more extended hours and joined physician panels championing improved diabetes care. Guideline adherence rates slightly improved. Requiring care plans approved by pain management specialists in order for the insurance to pay for oxycontin resulted in dramatic decrease in inappropriate oxycontin use. The sentinel effects related to discontinuing contracts with low performing physicians appeared to significantly improve hospital, physician and pharmacy cost trends.

### *Sustained interventions*

Patient incentives over a four year period improved our maternity care from a baseline of late pregnancy care and high rates of premature babies. Paying \$100 to pregnant patients and an additional \$100 to their doctors when prenatal care included seven prenatal visits beginning in the first trimester was associated with rates of prematurity (<32 weeks gestation) and low birth weight (< 5 lbs) dropping to 50% lower than the national average.

### *Leverage*

We collaborated with 23 large employers and union health trusts in Las Vegas to form the Health Services Coalition representing 320,000 lives. Initially the focus was on group purchasing of hospital contracts on behalf of all member groups to achieve better rates. We have subsequently expanded the initiatives to include hospital quality initiatives (LeapFrog, National Quality Forum, American Heart Association Get with the Guidelines Program, and NRC Picker Patient Experience Surveys as contractual performance requirements), city-wide hospitalist contracts for participating members, and a city-wide generics marketing campaign. Partnering with these additional organizations has proven effective in gaining contracting leverage. We also experienced improved generic medication fill rates, performance measures of patient experience and patient safety, and in-hospital care coordination. We are looking forward to implementing a Coalition Health Data Warehouse containing data from all members to leverage the benefits of data analysis and care improvement interventions on behalf of all members.

### *Summary*

These sustained efforts have been effective in improving processes and outcomes of care and containing costs. The Table shows the comparisons of health cost trends within the Funds compared to national healthcare cost trends. We intend to continue advancing our goals of value based purchasing to sustain affordable higher quality healthcare for our beneficiaries.

Table

## Comparative Cost Trends US Insurers vs. HEREIU Health Trusts

YEAR	USA	HEREIU Health Trust
2003	14.7%	5.8% (Las Vegas)
2004	12.6%	3.7% (Las Vegas)
2000 – 2004	11.4%/yr	8.7%/yr (Non-Vegas)
1995 – 2004	NA	5.4%/yr (Las Vegas)

Las Vegas programs are larger and more mature. Small group programs are younger.

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