



THE MEDICARE PHYSICIAN GROUP PRACTICE DEMONSTRATION: LESSONS LEARNED ON IMPROVING QUALITY AND EFFICIENCY IN HEALTH CARE

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ABSTRACT: In April 2005, the Centers for Medicare and Medicaid Services (CMS) initiated the Physician Group Practice demonstration, which offers 10 large practices the opportunity to earn performance payments for improving the quality and cost-efficiency of health care delivered to Medicare fee-for-service beneficiaries. This report is based on the proceedings of a 2006 site conference held in Baltimore and cosponsored by The Commonwealth Fund, CMS, and the Agency for Healthcare Research and Quality. The meeting provided a forum for PGPs to: 1) explore specific care management models, including methods for implementation and assessment of effectiveness; 2) accelerate learning across PGPs through information sharing; and 3) harvest knowledge and develop a plan for case studies and descriptive reports on successful care management models. A number of promising practice changes were discussed, such as increasing patient engagement, expanding care management, improving care transitions, and expanding non-physician roles.

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CONTENTS

About the Authors.....	iv
Executive Summary	v
Section 1. Introduction.....	1
1.1 Rationale.....	3
1.2 Cost Performance Incentive Methodology	3
1.3 Quality Performance Incentive Methodology	3
1.4 For More Information.....	4
Section 2. Background on the Participating Physician Group Practices	5
2.1 Participating PGPs.....	5
2.2 Beneficiary Characteristics.....	7
2.3 PGP Intervention Strategies	8
2.4 Performance Year 1 Results	9
Section 3. Strategies to Improve Care.....	11
3.1 Motivating Physician and Organizational Change	11
3.2 Leveraging Tools to Improve Quality and Efficiency.....	14
3.3 Patient Attribution	18
Section 4. Health Care Redesign Processes	20
4.1 Improving Workflow	20
4.2 Integrating Care Management into Clinical Practice	24
4.3 Managing Care Transitions	29
4.4 Redesigning Primary Care Practice.....	32
4.5 Demonstrating Value, Building Payer and Organizational Support	35
Section 5. Implications for Medicare and the U.S. Health Care System	37
5.1 Change Opportunities	37
5.2 Unsolved Challenges	39
5.3 Methods for Identifying and Disseminating Lessons Learned.....	40
Appendix A. Contact Information for PGP Demonstration Participants.....	42
Appendix B. Summary of Key Change Concepts	44

LIST OF FIGURES AND TABLES

Figure 2.1 Locations and Service Areas of PGP Demonstration Participants	6
Table 2.1 PGP Demonstration Participants: Organizational Characteristics.....	7
Table 2.2 Selected Characteristics of Beneficiaries Assigned to Participating PGPs in Performance Year 1, April 2005–March 2006	8

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EXECUTIVE SUMMARY

In April 2005, the Centers for Medicare and Medicaid Services (CMS) initiated the Physician Group Practice (PGP) demonstration, which offers 10 large practices the opportunity to earn performance payments for improving the quality and cost-efficiency of health care delivered to Medicare fee-for-service (FFS) beneficiaries.

A legislative mandate for the PGP demonstration was included in the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000. Three goals have been outlined for the demonstration:

1. Encourage the coordination of health care furnished under Medicare.
2. Promote investment in care management processes for efficient service delivery.
3. Reward physicians for improving health care processes and outcomes.

The practices participating in the demonstration span all four census regions. They each have at least 200 physicians, and together number more than 5,000. The PGPs include freestanding group practices, components of integrated delivery systems, faculty group practices, and a physician network organization comprising small and individual physician practices. Together, they provide the largest portion of primary care services for more than 220,000 Medicare FFS beneficiaries.

The demonstration includes a base year and three performance years covering the following time periods:

- Base Year: January 1, 2004–December 31, 2004
- Performance Year 1: April 1, 2005–March 31, 2006
- Performance Year 2: April 1, 2006–March 31, 2007
- Performance Year 3: April 1, 2007–March 31, 2008

An evaluation of the demonstration is also planned to assess the interventions applied by the participating PGPs and the quality and cost results.

The demonstration incentives toward improving traditional FFS reimbursement are similar to capitation incentives and reward efficient and effective provision of care. Participating PGPs should therefore be motivated to reduce unnecessary utilization of

services and improve quality of care for Medicare FFS patients. Performance indicators on both quality and cost-efficiency are used in the calculation of performance payments.

CMS is encouraging physician groups to better coordinate care for chronically ill beneficiaries and also aims to promote active use of clinical and utilization data to improve efficiency and outcomes. Increased investments in information technology and quality improvement systems are expected as a result of the demonstration.

This report is based on the proceedings of a site conference held in Baltimore on November 30 through December 1, 2006 and cosponsored by The Commonwealth Fund, CMS, and the Agency for Healthcare Research and Quality. Staff from the 10 PGPs gathered to participate in workshops and to report lessons learned. They also discussed how these lessons could be exported to other providers. In addition, the conference gave PGPs opportunities to compare experiences across practices; exchange ideas about how to improve and expand their interventions in the future; and discuss the broader implications for the Medicare program.

Specifically, the meeting provided a forum for PGPs to: (1) explore in-depth specific care management models, including methods for both implementation and assessment of effectiveness; (2) accelerate learning across PGPs through information sharing and establish methods for continued sharing; and (3) harvest knowledge and develop a plan for case studies and descriptive reports on successful care management models. Reports are planned to be disseminated to physician groups of all sizes and type of organization to improve health care quality and efficiency.

About the Physician Group Practice Demonstration

Each PGP earns quality performance payments based on the size of its quality performance pool and the proportion of quality targets it has met. The demonstration includes 32 quality measures drawn from CMS's Doctor's Office Quality (DOQ) project, focusing on measures from five condition modules: coronary artery disease, diabetes, heart failure, hypertension, and preventive care. One of the diabetes measures, for example, is the percentage of diabetics who received an HbA1c (blood sugar) test at least once per year.

For each quality measure, PGPs must satisfy at least one of three targets: 1) the higher of either 75 percent compliance or, where comparable data are available, the mean value of the measure from the Medicare Health Plan Employer Data and Information Set (HEDIS); 2) the 70th percentile Medicare HEDIS level (again, where comparable data are available); or 3) a 10 percent or greater reduction in the gap between the level achieved

by the PGP in the demonstration's base year and 100 percent compliance in Year 1. The first two targets are threshold targets, while the third is an improvement-over-time target.

The quality measures are phased in over the course of the demonstration, with the diabetes measures active in Year 1, the heart failure and coronary artery disease measures added in Year 2, and all five modules now becoming active in Year 3. Two types of measurement processes have been used to calculate quality performance: one method uses Medicare claims (billing) data for seven of the quality measures, while the other uses data abstracted from beneficiaries' medical records for the other 25 quality measures.

A comparison population is also defined for each PGP to provide a benchmark for assessing cost-control performance. For this demonstration, comparison beneficiaries were drawn from each PGP's local market area, including the counties where at least 1 percent of a PGP's assigned beneficiaries reside. Comparison beneficiaries are limited to those with characteristics similar to assigned beneficiaries. For example, they are all FFS beneficiaries, without any periods of Medicare Advantage enrollment during the given year.

The PGP demonstration tests a unique reimbursement mechanism that rewards providers for coordinating and managing the overall health care needs of the FFS Medicare patient population. The demonstration also offers CMS the opportunity to assess whether a new financial incentive structure could improve service delivery and quality for Medicare beneficiaries and ultimately prove cost-effective.

Under the demonstration, researchers calculated Medicare savings for each PGP by comparing actual spending to a target. They set the target as the PGP's own base year per capita expenditures (i.e., the Medicare expenditures per beneficiary treated by the PGP during the calendar year prior to the demonstration) trended forward by the comparison group's expenditure growth rate (i.e., the growth rate of expenditures per beneficiary in the area from which the PGP draws its patients). Case-mix adjustments are made to account for changes over time in the types of patients treated by the PGP and in the types of patients included in the comparison group. Medicare savings in excess of 2 percent are distributed to each PGP based partly on the magnitude of savings achieved by the PGP and partly on its performance on the set of demonstration quality measures.

Results from Year 1 of the Demonstration

During Year 1, the quality of care performance targets focused on the 10 diabetes quality measures. All the participating PGPs improved the clinical management of their diabetes patients. Specifically, all 10 groups achieved benchmark or target performance levels

on at least seven of the 10 diabetes quality measures. Moreover, two PGPs—Forsyth Medical Group in North Carolina and St. John’s Health System in Missouri—met all 10 benchmarks. In addition, all groups increased their scores on at least four diabetes measures, eight groups increased their scores on at least six measures, and six groups increased their scores on nine or more measures.

Two of the groups in the demonstration—Marshfield Clinic in Wisconsin and University of Michigan Faculty Group Practice—earned performance payments of \$7.3 million for meeting DOQ quality and cost-efficiency measures as their share of a total of \$9.5 million in savings to the Medicare program. In addition, other groups had lower risk-adjusted expenditure growth rates for their assigned diabetes populations compared with their local market comparison groups, but not sufficiently lower to earn performance payments.

Both groups that shared in savings had inpatient and outpatient risk-adjusted expenditure growth rates for their assigned populations that were lower than those of their comparison group populations. These lower growth rates are consistent with the demonstration's goals to coordinate health care services provided under Medicare and improve efficiency.

Implications for Medicare and the U.S. Health Care System

Demonstration staff and PGPs have identified a number of promising change opportunities, ongoing challenges, and strategies for disseminating lessons learned.

Promising Change Opportunities

Increasing Patient Engagement

The PGPs believe that involving patients more deeply in pre-visit processes and self-management support has the potential to improve quality while containing costs. The goals are to make physician visits more effective and accurate in the treatment that can be provided and to enable complementary services to be provided in a more timely fashion if reimbursement can be made available.

Increasing patient self-management is a goal for both general care management programs and chronic disease care. Much of day-to-day chronic disease care can be provided by patients themselves or by family members. This care includes adherence to prescribed medications; consistent attendance at regular physician visits; active communication with physicians and nurses regarding symptoms and problems; prompt

attendance for ordered testing services; and maintaining diet and exercise programs as consistently as possible.

Demonstration PGPs are working on a number of patient education and coaching programs to promote improved patient self-management. The demonstration incentives could be one way to fund these programs if PGPs can demonstrate that savings can be achieved.

Expanding Care Management

Demonstration PGPs are now focusing on heart failure care management since it has the potential for significant cost savings through reduced hospital admissions. Many PGPs are intensifying their efforts through daily telemonitoring programs, nurse telephone management, patient education, and other interventions.

The PGP demonstration incentives provide one way of funding these programs through performance payments for demonstrated cost savings. PGPs are also interested in exploring direct incentives, such as per-member per-month capitated reimbursement for heart failure case management, which could fund a range of non-visit services, such as telephonic nurse case management.

Improving Care Transitions

Health care providers historically have given too little emphasis on care transitions, partially because clinical responsibilities and associated reimbursements are often divided between providers. The demonstration incentives reward PGPs for reducing overall Medicare spending, however, so they have a financial incentive to better manage the many care transitions that may be required for treatment of chronic diseases.

A number of PGPs are testing new transition management programs that may apply to patients with particular diagnoses or those undergoing particular types of transitions, such as the transition from hospital to home. Preventing hospital readmissions through timely outpatient follow-up care by physicians has been a particular focus of these programs since it has the potential to reduce costs and also patient morbidity.

In addition, demonstration staff are also exploring management of other types of transitions, such as those from hospitals to nursing homes. Since those organizations are often separate corporations, they typically have not shared data on patients effectively in the past, and communication regarding care transitions has often been incomplete. Coordinating care among the multiple specialist physicians who may treat high-risk

patients is also a potential area for improvement, since they may not communicate well about treatments and prescriptions a patient has received.

Expanding the Roles of Non-Physician Providers

Demonstration staff are also focusing on expanding non-physician provider roles in an effort to improve clinical workflows. They have studied redesigning primary care practice to increase the use of non-physicians, such as through greater use of planned visits; integrating care management into clinical practice, such as delegating some types of patient testing or exams (e.g., diabetic foot exams) to non-physicians; expanding patient education; and providing greater data support to physicians to enhance the quality and cost-effectiveness of their clinical work.

Physician buy-in to these efforts has sometimes been a challenge, but many of the PGPs have had success in implementing the new non-physician roles, and all are optimistic about incorporating these roles more broadly in the future. If the new roles are well-structured, and the staff well-trained, then physicians may view them as complementing the care they provide and enabling them to concentrate on the elements of care that clearly need their expertise.

The PGP demonstration incentives provide the potential for reimbursement of non-physician care that has not been traditionally funded and where it can show an impact on cost savings and quality of care. These factors provide PGPs with broader flexibility to implement new roles and to test new care models.

Ongoing Challenges

Some PGPs have had issues with the speed of implementation for new interventions. Since the demonstration is currently active for three performance years, PGPs need to organize cost saving and quality improvement interventions quickly so they will be able to show positive outcomes early in the demonstration and earn performance payments. Moreover, the Medicare savings are calculated on a cumulative basis, so early savings provide an ongoing advantage in terms of potential bonus payments in succeeding years. Several PGPs, however, have indicated that motivating physician and organizational change has taken longer than expected, and their interventions have not become fully operational until Year 2.

Some PGPs have also noted data and reporting lags. Ideally, rapid feedback of data on assigned beneficiaries would enable PGPs to more quickly evaluate the impact of

specific interventions and revise them as needed during the demonstration. Claims data take some time to accumulate, however, so rapid feedback has been difficult to achieve.

Limited reimbursement for non-physician care and medical home programs has also been a broad concern. While the PGP demonstration incentives may indirectly fund these efforts, PGPs recommend that some type of direct reimbursement for these services also be considered by CMS to provide stronger incentives and funding for non-demonstration providers.

While care management programs have been actively developed for a number of conditions, most notably diabetes and heart failure, several additional types of care management programs should be more fully developed and tested. Examples cited by PGPs include care management and multiple chronic disease care management. Both are viewed as having potential for reducing costs at the same time as improving quality of care, but the optimal clinical approaches for these programs have not yet been identified.

Similarly, a number of innovations in primary care are being tested. A planned visit concept has been discussed, as has improving workflow through better data systems and team-based care. Optimal approaches for these interventions are still being worked out, and Year 3 of the demonstration may bring additional lessons learned in these areas.

Disseminating Lessons Learned

Exporting lessons learned from the demonstration can be achieved through a number of approaches. One of the most important is to focus on high-leverage change ideas. Given the broad range of health care delivery interventions being proposed around the country, a benefit of the demonstration could be to identify those with the highest potential for producing positive cost and quality outcomes. They can then become the focus of more intensive efforts for motivating physician and organizational change, since those efforts often need a sharp focus on a limited number of interventions to be successful. While this report includes a number of promising change ideas highlighted by the participating PGPs, other providers will need to carefully select those that fit best with their organization and environment.

Another important dissemination method could be to engage physicians in efforts to export change ideas beyond their organizations. This method could be challenging, however, given the workloads and time limitations faced by physicians. The PGPs are taking a range of approaches for engaging physicians in change efforts, including recruiting physician champions for leading design and implementation of new health care delivery

interventions; educating physicians about the importance of new care delivery models; offering financial incentives; and fostering competition on quality-of-care indicators.

Cross-organizational affinity groups or benchmarking collaboratives could also be a way to engage physicians and other PGP staff in structured interactions with other providers to spread their experiences and lessons learned. Such groups have the benefit of extensive ongoing interactions that may stretch over many months and even years. Ideas can be cross-fertilized; tested and measured in practice; and results shared among all.

PGP demonstration conferences involving outside providers and other interested parties are another dissemination approach. Virtual conference breakout sessions could also be held periodically by conference call and WebEx to facilitate information sharing.

Finally, round-robin site visits among demonstration PGPs could be another way to maintain involvement and give staff the chance to hear about interventions being applied by other providers. These visits could be targeted to PGPs reporting particular success with selected interventions, and in-depth written case studies could result. These case studies could be disseminated broadly on the Web and summarized for conference presentations and journal articles.

For More Information

Additional information regarding the methods used for measuring quality and financial performance under the demonstration can be found on the CMS Web site. Reports on the PGP “Demonstration Bonus Methodology Specifications” and the PGP “Demonstration Quality Measurement and Reporting Specifications” can be found at the following URL: <http://www.cms.hhs.gov/DemoProjectsEvalRpts/>. To access these reports on that Web page:

1. Click on “Medicare Demonstrations” in the box on the upper-left-hand side of the screen.
2. Scroll down to “Medicare Physician Group Practice Demonstration” in Year 2000. Bypass the “select from the following options” section.
3. Scroll down to the downloads section. Select the following two reports from the PDF files: “Performance Payment Methodology Specifications” and “Quality Specs Report.”

**THE MEDICARE PHYSICIAN GROUP PRACTICE
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QUALITY AND EFFICIENCY IN HEALTH CARE**

**SECTION 1
INTRODUCTION**

In April 2005, the Centers for Medicare and Medicaid Services (CMS) initiated the Physician Group Practice (PGP) demonstration, which offers 10 large practices the opportunity to earn performance payments for improving the quality and cost-efficiency of health care delivered to Medicare fee-for-service (FFS) beneficiaries.

A legislative mandate for the PGP demonstration was included in the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000. Three goals have been outlined for the demonstration:

1. Encourage the coordination of health care furnished under Medicare.
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The practices participating in the demonstration span all four census regions. They each have at least 200 physicians, and together number more than 5,000. The PGPs include freestanding group practices, components of integrated delivery systems, faculty group practices, and a physician network organization comprising small and individual physician practices. Together, they provide the largest portion of primary care services for more than 220,000 Medicare FFS beneficiaries.

The demonstration includes a base year and three performance years covering the following time periods:

- Base Year: January 1, 2004–December 31, 2004
- Performance Year 1: April 1, 2005–March 31, 2006
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An evaluation of the demonstration is also planned to assess the interventions applied by the participating PGPs and the quality and cost results.

The demonstration incentives toward improving traditional FFS reimbursement are similar to capitation incentives and reward efficient and effective provision of care. Participating PGPs should therefore be motivated to reduce unnecessary utilization of services and improve quality of care for Medicare FFS patients. Performance indicators on both quality and cost-efficiency are used in the calculation of performance payments.

CMS is encouraging physician groups to better coordinate care for chronically ill beneficiaries and also aims to promote active use of clinical and utilization data to improve efficiency and outcomes. Increased investments in information technology and quality improvement systems are expected as a result of the demonstration.

This report is based on the proceedings of a site conference held in Baltimore on November 30 through December 1, 2006 and cosponsored by The Commonwealth Fund, CMS, and the Agency for Healthcare Research and Quality. Staff from the 10 PGPs gathered to participate in workshops and to report lessons learned. They also discussed how these lessons could be exported to other providers. In addition, the conference gave PGPs opportunities to compare experiences across practices; exchange ideas about how to improve and expand their interventions in the future; and discuss the broader implications for the Medicare program.

Specifically, the meeting provided a forum for PGPs to: (1) explore in-depth specific care management models, including both methods for implementation and assessment of effectiveness; (2) accelerate learning across PGPs through information sharing and establish methods for continued sharing; and (3) harvest knowledge and develop a plan for case studies and descriptive reports on successful care management models. Reports are planned to be disseminated to physician groups of all sizes and type of organization to improve health care quality and efficiency.

The meeting offered insight and real-time feedback to CMS and health care policymakers on what works (and what does not work) as Medicare considers various national approaches for rewarding providers for improving health care quality and efficiency. In addition, the meeting illuminated how physician behavior and health care systems change in response to the pay-for-performance incentives in the PGP demonstration, the interventions that have proven effective, and how those interventions can be exported to other providers in the U.S. health care system.

1.1 Rationale

The PGP demonstration tests a unique reimbursement mechanism that rewards providers for coordinating and managing the overall health care needs of the FFS Medicare patient population. The demonstration also offers CMS the opportunity to assess whether a new financial incentive structure could improve service delivery and quality for Medicare beneficiaries and ultimately prove cost-effective.

1.2 Cost Performance Incentive Methodology

The PGP demonstration is being conducted in an FFS context, with beneficiaries assigned to a participating PGP based on provision of services during a given year. A beneficiary who receives at least one evaluation and management (E&M) service from a participating PGP during a given year is eligible for assignment to the demonstration. In addition, beneficiaries may be assigned to the demonstration if they received more E&M services from the participating PGP than from any other physician practice over the course of a year.

A comparison population is also defined for each PGP to provide a benchmark for assessing cost-control performance. For this demonstration, comparison beneficiaries are drawn from each PGP's local market area, including the counties where at least 1 percent of a PGP's assigned beneficiaries reside. Comparison beneficiaries are limited to those with characteristics similar to assigned beneficiaries. For example, they are all FFS beneficiaries, without any periods of Medicare Advantage enrollment during the given year.

For each PGP, Medicare savings from the demonstration are calculated by comparing actual spending to a target: the PGP's own base year per capita expenditures trended forward by the comparison group's expenditure growth rate. Case-mix adjustments are made to account for changes over time in the types of patients treated by the PGP and the comparison group. The PGP receives cost and quality performance payments if it achieves Medicare savings of more than 2 percent.

The portion of savings greater than the 2 percent threshold is used to calculate performance payments. Medicare retains 20 percent of the savings beyond the 2 percent threshold, and the remaining 80 percent goes into a PGP's quality performance "bonus pool." For Year 1, each PGP received 70 percent of the amount in its bonus pool directly as a cost performance payment—this share fell to 60 percent in Year 2 and 50 percent in Year 3. The remaining savings in the PGP's bonus pool become available for quality bonus payments.

1.3 Quality Performance Incentive Methodology

Each PGP earns quality performance payments based on the size of its quality performance pool and the proportion of quality targets it has met. The demonstration includes 32

quality measures drawn from CMS's Doctor's Office Quality (DOQ) project, including measures from five condition modules: coronary artery disease, diabetes, heart failure, hypertension, and preventive care. One of the diabetes measures, for example, is the percentage of diabetics who received an HbA1c (blood sugar) test at least once per year. The quality measures are phased in over the course of the demonstration, with the diabetes measures active in Year 1, the heart failure and coronary artery disease measures added in Year 2, and all five modules now becoming active in Year 3. Two types of measurement processes have been used to calculate quality performance: one method uses Medicare claims (billing) data for seven of the quality measures, while the other method uses data abstracted from beneficiaries' medical records for the other 25 quality measures.

PGPs become eligible for quality performance payments by meeting threshold and improvement-over-time targets. For each quality measure, PGPs must satisfy at least one of three targets: 1) the higher of either 75 percent compliance or, where comparable data are available, the mean value of the measure from the Medicare Health Plan Employer Data and Information Set (HEDIS); 2) the 70th percentile Medicare HEDIS level (again, where comparable data are available); or 3) a 10 percent or greater reduction in the gap between the level achieved by the PGP in the demonstration's base year and 100 percent compliance in Year 1. The first two targets are threshold targets, while the third is an improvement-over-time target.

1.4 For More Information

Additional information regarding the methods used for measuring quality and financial performance under the demonstration can be found on the CMS Web site. Reports on the PGP "Demonstration Bonus Methodology Specifications" and the PGP "Demonstration Quality Measurement and Reporting Specifications" can be found at the following URL: <http://www.cms.hhs.gov/DemoProjectsEvalRpts/>. To access these reports on that Web page:

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3. Scroll down to the downloads section. Select the following two reports from the PDF files: "Performance" and "Quality Specs Report."

SECTION 2

BACKGROUND ON THE PARTICIPATING PHYSICIAN GROUP PRACTICES

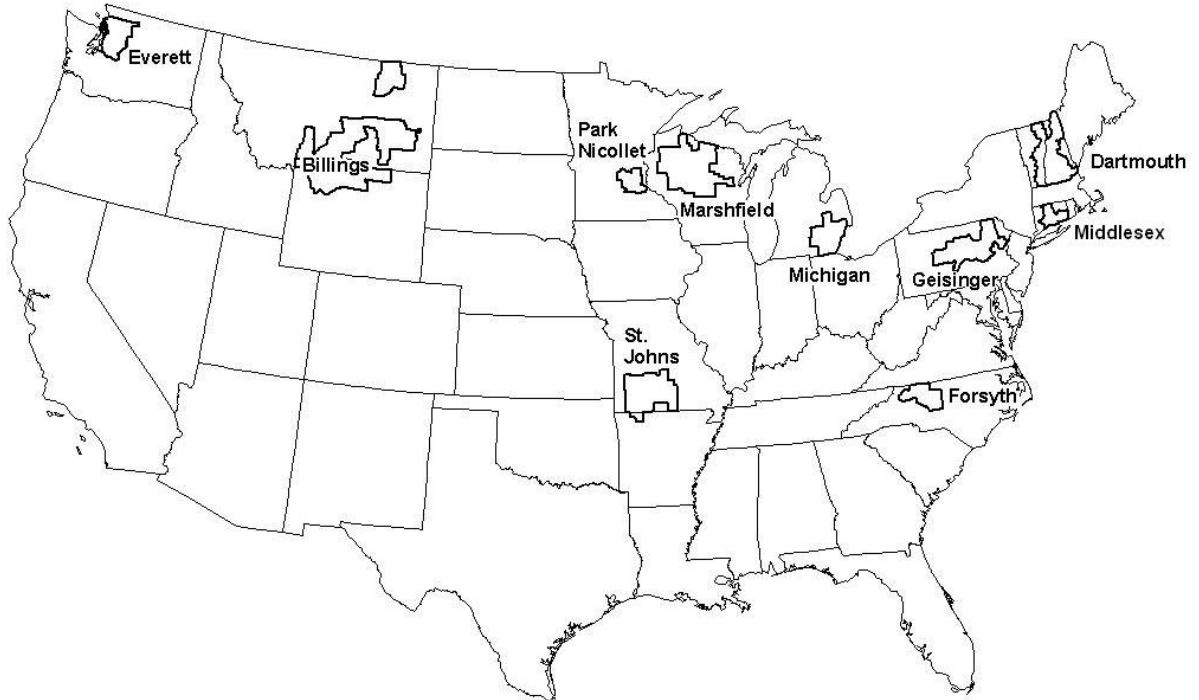
This section includes a description of the participating PGPs and presents baseline information on Medicare beneficiaries assigned to the demonstration PGPs.

2.1 Participating PGPs

Ten large PGPs are participating in the demonstration, spanning all four census regions in the country. Their locations and service areas are shown in Figure 2.1. Four PGPs are located in the Midwest, three in the Northeast, two in the West, and one in the South. They include the following:

- Billings Clinic in Montana
- Dartmouth-Hitchcock Clinic in New Hampshire
- Everett Clinic in Washington State
- Forsyth Medical Group in North Carolina
- Geisinger Health System in Pennsylvania
- Marshfield Clinic in Wisconsin
- Middlesex Health System in Connecticut
- Park Nicollet Health Services in Minnesota
- St. John's Health System in Missouri
- University of Michigan Faculty Group Practice

Figure 2.1
Locations and Service Areas of PGP Demonstration Participants



Source: RTI International.

The participating PGPs each have at least 200 physicians and together represent more than 5,000 physicians. They include freestanding group practices, integrated delivery systems, faculty group practices, and physician network organizations. Eight of the participating PGPs are part of an integrated delivery system and are thus affiliated with a hospital. The remaining two groups are collaborating with hospitals in their service areas. Characteristics of participating PGPs are summarized in Table 2.1.

Table 2.1
PGP Demonstration Participants: Organizational Characteristics

Participant	Organizational Structure	Part of Integrated Delivery System	Includes Academic Medical Center	Owns an HMO¹	Not-for-Profit	Number of Providers
Dartmouth-Hitchcock Clinic	Faculty/Community Group Practice	Yes	Yes	No	Yes	907
Billings Clinic	Group Practice	Yes	No	No	Yes	232
Geisinger Clinic	Group Practice	Yes	No	Yes	Yes	833
Middlesex Health System–IRMA	Network Model	Yes	No	No	No ²	293
Marshfield Clinic	Group Practice	No	No	Yes	Yes	1,039
Forsyth Medical Group	Group Practice	Yes	No	No	Yes	250
Park Nicollet Clinic	Group Practice	Yes	No	No	Yes	648
St. John's Clinic	Group Practice	Yes	No	Yes	Yes	522
The Everett Clinic	Group Practice	No	No	No	No	250
University of Michigan Faculty Group Practice	Faculty Practice	Yes	Yes	Yes	Yes	1,291

¹ HMO may be owned by an associated health system.

² For-profit subsidiary of a not-for-profit health system.

Source: RTI International.

2.2 Beneficiary Characteristics

Table 2.2 presents selected characteristics of the beneficiaries assigned to the participating PGPs in demonstration Year One from April 2005 through March 2006. As noted, the assigned beneficiaries represent a subset of all the Medicare beneficiaries who had at least one E&M visit at the PGP. Assigned beneficiaries are those that received a plurality of their E&M services from the participating PGP. Data indicate that the number of assigned beneficiaries per PGP ranged from 13,575 to 57,756 in Year 1. Overall, the number of assigned beneficiaries totaled 223,893 at the 10 PGPs.

Table 2.2 indicates that assigned beneficiaries received a mean number of E&M visits ranging from 5.0 to 6.8 across the participating PGPs in Year 1. Moreover, the PGPs provided on average of three-quarters or more of the total E&M services received by assigned beneficiaries. These data indicate that the PGPs have substantial primary care contact with their assigned beneficiaries and multiple opportunities to influence the quality and efficiency of the care they receive.

Eligibility data in Table 2.2 indicate that the proportion of beneficiaries assigned to the PGPs that are eligible due to disabilities ranges from 12 to 22 percent. Similarly, the proportion eligible for Medicaid in addition to Medicare ranges from 9 to 19 percent.

Table 2.2
Selected Characteristics of Beneficiaries Assigned to
Participating PGPs in Performance Year 1, April 2005–March 2006

	Range Across the 10 PGP Demonstration Participants	
	Minimum	Maximum
Medicare Patients		
Total ¹	13,575	57,756
Assigned Beneficiaries ²	9,313	42,017
Evaluation and Management (E&M) Visit Utilization of Beneficiaries		
Mean Number of E&M Visits per Beneficiary	5.01	6.83
Mean Proportion of E&M Services Provided at the PGP	0.74	0.90
Percentage of Beneficiaries by Medicare Eligibility		
Aged	74.2%	87.9%
End-Stage Renal Disease	0.3%	3.4%
Disabled	11.8%	22.4%
Percentage of Beneficiaries by Medicaid Eligibility		
Medicaid-Eligible at Least One Month in Year 1	8.7%	19.3%
Percentage of Beneficiaries by Age		
< 65	12.0%	25.5%
65–74	37.5%	44.4%
75–84	27.3%	36.2%
85 +	8.1%	14.3%

¹ Beneficiaries who received at least one office or other outpatient E&M visit at a participating PGP.

² Beneficiaries who received a plurality of their office or other outpatient E&M services (measured by allowed charges) at a participating PGP.

Source: RTI International.

2.3 PGP Intervention Strategies

The PGPs are implementing a variety of management programs to improve efficiency and quality of health care for Medicare FFS patients. These programs include chronic care management, high risk/high cost care management, transitional care management, end-of-life/palliative care programs, and initiatives designed to standardize and improve quality of care. Demonstration staff expect that these care management programs will generate cost savings by reducing avoidable hospital admissions, readmissions, and

emergency department visits. Initially, PGP participants focused on reducing avoidable admissions and readmissions among congestive heart failure patients and increasing influenza and pneumovax vaccine rates because of the potential for short-term payback. Some PGPs are focusing on smaller numbers of very expensive patients, usually those who are hospitalized multiple times.

PGP participants have also responded to the demonstration's incentives by enhancing their information technology infrastructure and applying it to the Medicare FFS population. They are relying mostly on in-house personnel expertise and enhancements to existing information technology infrastructure. Some, however, are partnering with or have purchased systems from outside vendors.

Demonstration participants believe that attainment of quality and efficiency goals is a function of the system of care and the efforts of the entire care team. Thus, performance payments should be used to improve systems, not to incentivize individual physicians. Consequently, if they earn performance payments, PGP participants have indicated they will first seek to recoup their investment in systems and infrastructure necessary to generate savings under the demonstration rather than share it with individual physicians.

To improve performance on the quality indicators, the PGP participants' main strategies are: 1) use of provider education and feedback, including data profile reports comparing individual providers to their peers or other benchmarks; 2) better adherence to quality of care protocols on the part of both patients and physicians through care management interventions; and 3) implementation of standardized, evidence-based care models and protocols.

The PGPs are making major efforts to promote knowledge of standardized, evidence-based "best practice" models among their physicians through redesigning workflow processes, adding health-maintenance modules to existing electronic medical records, and developing patient registries with the ability to prompt physicians to act on information at a specific point of care. Widespread adoption of these standard care models should improve quality and reduce costs.

2.4 Performance Year 1 Results

The quality-of-care performance targets focused on the 10 diabetes quality measures during Year One, and all of the participating PGPs improved the clinical management of their diabetes patients. Specifically, all 10 groups achieved benchmark or target performance levels on at least seven of the 10 diabetes quality measures. Moreover, two

PGPs—Forsyth Medical Group and St. John’s Health System—met all 10 benchmarks. In addition, all groups increased their scores on at least four diabetes measures, eight groups increased their scores on at least six measures, and six groups increased their scores on nine or more measures.

In addition, two of the groups—Marshfield Clinic and University of Michigan Faculty Group Practice—earned performance payments of \$7.3 million for quality and cost efficiency as their share of the \$9.5 million in savings to the Medicare program. Other PGPs also had lower Medicare spending growth rates than their local markets during Year 1 but not sufficiently lower to earn performance payments.

The two groups that shared in savings had lower inpatient and outpatient risk-adjusted expenditure growth rates for their assigned populations than those of their comparison group populations. This finding is consistent with the demonstration's goals to coordinate health care furnished under Medicare and improve efficiency. In addition, eight of the 10 groups had lower risk-adjusted expenditure growth rates for their assigned diabetes populations compared with their local market comparison groups.

SECTION 3

STRATEGIES TO IMPROVE CARE

This section summarizes conference sessions on lessons learned from the demonstration thus far regarding three strategies to improve care. They include: 1) motivating physician and organizational change; 2) leveraging tools to improve quality and efficiency; and 3) patient attribution. PGP staff intend to export these lessons to other providers.

3.1 Motivating Physician and Organizational Change

Following are topics for motivating physician and organizational change, including preparing individual physicians for pay-for-performance initiatives; methods for communicating and implementing change across an organization; techniques for promoting physician buy-in; and strategies for capturing providers' attention.

3.1.1 Strategies for Instituting Change

Instituting change in any organization can be difficult and slow. The PGP demonstration includes implementation of new interventions as well as expansion of existing programs to new populations. Both efforts require some form of shift in current workflow and practices. Seven steps for successfully implementing change have been identified:

1. Generate a sense of urgency by defining and communicating the problem and importance of action.
2. Build a coalition to implement change throughout a system. Change cannot be completed by a single individual.
3. Create and share a vision of how processes could be implemented and how suggested changes could improve outcomes for both providers and patients.
4. Empower staff to identify and clear away obstacles.
5. Communicate and recognize short-term wins such as cost savings, improved quality, and better patient management.
6. Instigate PGP investment in the process by recognizing implementation lessons learned and adding processes that may improve overall change.
7. Sustain change by emphasizing new patient management techniques and treatments.

Several broader strategies for motivating change have also been identified: 1) development of data or information systems; 2) use of teamwork; and 3) building strong leadership.

Development of Data or Information Systems

Development of systems to collect and report data on efficiency and quality measures is useful for improving physician buy-in. To increase this buy-in, data included in these systems should be carefully reviewed, adequately tested, and timely. Data lags may increase difficulties in motivating physicians, and inaccurate or incomplete data may distort the picture of what the patient needs or how the physician has responded.

Also challenging is the development of systems for transfer of accurate and timely data. For example, external data for assigned beneficiaries who receive a significant amount of care outside the PGP would be valuable for care planning but are unavailable. This lack of information presents an obstacle to proper care management. Comprehensive, real-time, accurate, clinically relevant, and actionable data is the ideal.

Another method for promoting buy-in is to encourage physicians to participate in data collection and information system development processes. For example, physicians can aid in the development of clinically significant quality or performance measures, such as key aspects of diabetes or heart failure treatment.

Data systems allow for tracking quality measures and giving feedback to providers. If a measure is not being met, a data system can alert the provider of missed tests or other elements of care. These alerts are often implemented in electronic health records. For example, some PGPs are flagging patients that lack annual flu vaccinations.

Use of Teamwork

Staff often prefer providing health care as a team in which members work together to determine optimal care for a patient. PGPs have found that working in teams results in an increase in their own and patient satisfaction as well as improvement in quality measures. Each team member makes a different professional contribution.

In a team-based system, physicians can shift some responsibilities to physician assistants or other non-physician providers, which can substantially decrease their workloads. A common concern, however, is that physicians may hesitate to shift some of their work because they are uncertain of the abilities of other staff. The implementation of a team-based system may therefore involve changing the general physician mindset. Another challenge is the often limited opportunity for teams to sit together and discuss care.

The best way to begin implementing this form of process change is to develop standardized educational toolkits for the physicians, physician assistants, and other staff who may be taking on new tasks. It is also important that teams be provided with adequate time to meet and discuss patient care.

Strong Leadership

The implementation of new interventions requires strong leadership from both the physician and administrative sides. Administrative leaders are important for generating interest in management systems and securing resources. Physician champions for these types of interventions are also very important since they are involved in all patient care interventions. The best advocates are often the peers of individuals who will be affected by the program. Thus, physician champions are usually the best candidates for communicating the benefits of new clinical interventions.

3.1.2 Challenges with Motivating Organizational and Physician Change

PGP staff have identified several challenges to motivating organizational change. One is the difficulty in harmonizing primary care provider and specialist perspectives. Some beneficiaries may be assigned to a PGP for the demonstration based on visits to specialists. As a result, PGP providers may have difficulty managing and taking responsibility for patients whose primary care provider may be outside the PGP. In addition, specialists may have a hard time showing quality improvement because specialist measures are not included in the demonstration.

A second challenge is physician buy-in. Several demonstration staff have struggled with motivating physicians to engage in the process. In some cases, physician buy-in is hindered by attitudes within the organization (e.g., “that’s not mine,” “that’s not true,” “the sample is not big enough,” etc.).

Increasing physician buy-in can be promoted in at least four ways. First, physicians respond to proof of causality between the new intervention and improved quality of care. They are generally interested in doing the right thing and improving the quality of care. When a clear set of actionable steps or ideas that work to increase the quality of care are provided, skeptical staff will gain confidence. Second, physicians may be more willing to engage in activities if competition is introduced by comparing performance measures among physicians. Third, financial incentives tied to performance measures may increase motivation for meeting targets. Finally, as noted, the availability of timely and reliable data is paramount for improving physician buy-in.

3.1.3 Summary of Key Change Concepts

1. Provide incentives for physicians to be change leaders.
2. Get physicians to believe in the data; involve them in developing measures and testing data systems.
3. Develop a systematic approach for implementing change.
4. Institute a team-oriented model for clinical care.
5. Allow teams the time needed to meet and discuss their tasks fully.

3.2 Leveraging Tools to Improve Quality and Efficiency

The PGP demonstration has included a review of applied clinical tools and administrative strategies. A number of challenges for applying these tools were identified in addition to key data needs.

3.2.1 Tools for Improving Quality and Efficiency

Several tools have assisted demonstration staff in meeting their present and future goals. They include: 1) information systems for improving coordination of care; 2) risk adjustment systems; 3) alternative visit structures; and 4) case management.

Information Systems

Registries enable providers to gain access to a broader set of point-of-care information for review prior to a health visit. This type of information is useful for providing accurate care and facilitating discussions between patients and providers during health care visits. St. John's Health System uses its disease registry to generate "visit planner" documents prior to each health care visit that help physicians plan and structure the visit. The visit planner serves as a checklist for physicians to ensure that needed tests and services are provided.

Another strategy is to develop registries that capture patient comorbidities and integrate registries initially developed for individual diseases. This integrated information allows for more complex care management vs. individual disease management. The University of Michigan and St. John's Health System have both developed registries for chronic diseases instead of focusing on a single condition, and they have found them to be valuable tools for improving coordinated care and delivery.

Electronic health records may automate orders for patient care prior to appointments. Registries or EHRs not only identify patients for different care interventions, they can

also allow for the management of these interventions, including tracking utilization measures and facilitating reporting on performance and quality measures.

These types of records also help ensure compliance with standardized care processes. Geisinger Clinic, for example, uses its electronic health record to track a broad set of quality measures known as the diabetes bundle, which assesses how well each physician provides care in relation to a set of 13 evidence-based indicators for each of their diabetic patients.

Risk Adjustment Systems

Some PGPs have utilized internal scheduling and billing systems to risk-adjust their populations. The University of Michigan maps diagnoses to risk adjustment categories to estimate assigned beneficiary risk scores and track that information over time. Commercial health insurance plans utilize claims data to predict the current and prospective likelihood of re-hospitalization. Claims data can provide the same type of information for Medicare beneficiaries.

Reviewing diagnosis data has also allowed some groups to track diagnoses and understand which are not being captured consistently in claims data. This process allows groups to identify coding issues and implement correction processes to help ensure more complete and accurate coding of diagnoses and procedures.

Alternative Visit Structures

The current structure of the patient visit may not be optimal for ensuring the best possible care. As a result, demonstration staff have modified or enhanced the structure of the health care visit. Some have moved toward planned visits, which allow for more useful discussions between the provider and the patient.

Other PGPs have introduced or considered group visits, which involve several patients being seen by a single physician or team of providers at one time. During these visits, patients with similar conditions gather and speak with a physician together. Some patients appreciate the group visit because it allows for more interaction. They can benefit from the discussion between a physician and another patient, particularly if they have similar conditions.

The group visit concept is fairly new and may require pilot testing before an optimal structure is identified. Dartmouth-Hitchcock Clinic is one demonstration member opening a new clinic designed to provide shared appointments or group visits.

Participating PGPs are also trying to make greater use of the electronic visit, or e-visit, where patients can communicate with their physicians over the Web or by e-mail. The e-visit is already a billable event for several commercial health care plans, although not for Medicare patients. Extending Medicare reimbursement to e-visits or other alternate types of visits would be useful for improving efficiencies within the health care system.

A broader justification for alternative visit structures is cost-cutting. If the health care system continues with the traditional visit-based model, it will invariably continue to become more expensive. Incorporating new components into the visit-based model may make the entire health care system more sustainable.

Case Management

Case management can reduce gaps in care through early interventions and improved compliance. For example, one element of case management may be referral for palliative care. Case management programs often work from data registries, which identify patients that would benefit from an intervention. Both physician buy-in and non-physician support is important for effective case management. Case management programs have been documented to improve efficiencies.

Several sites have opted to focus their patient care interventions, particularly case management, on specific patient populations defined by disease, utilization, or medications. For example, sites have indicated that there is potential financial gain from high risk patient stratification. This helps to provide care to those who need it most, enabling clinical programs to be better focused on the needs of severely ill patients. Several groups have decided to focus care management on patients with congestive heart failure and chronic obstructive pulmonary disease. Those diseases have been identified at areas where cost savings could be achieved in the short term, in addition to quality gains. Dartmouth-Hitchcock Clinic indicated they are increasing their programs for depression and chronic pain.

3.2.2 Challenges

Some challenges associated with these efforts include the need for additional investment in new staff and the need for buy-in from current staff, particularly physicians. This buy-in, however, does not always come easily.

New interventions may also require new infrastructure. Group visits, for example, may require new space. The visits may also introduce scheduling and other logistical challenges that should be addressed by a staff person dedicated to those concerns.

As with any new intervention, estimating the number of full-time equivalents that would be required to carry out the intervention can be difficult. Determining skill sets required of new hires may also be taxing. New interventions generally involve a considerable amount of training of both old and new staff. The training and change process can be slow moving and usually requires a significant amount of staff time.

Several implementation difficulties have been identified with the interventions discussed above. First, lack of timely data on assigned beneficiaries makes targeting dynamic care for them difficult. More current data would provide groups with a greater opportunity for mid-course corrections to their interventions, improved ability to identify patients requiring additional care, and better focus of resources on specific populations in need.

Second, communication within some PGPs has sometimes been inadequate. Internal communication about the demonstration and related interventions is necessary for alignment of incentives and for knowledge in general within the organization. Improving communication between physicians, nurses, and other staff is important to sustain interventions; otherwise, they may stall.

Third, leadership is needed for good case management and other patient care interventions, especially physician leadership and buy-in. Immediate buy-in is often difficult because physicians insist on proof that an intervention works before committing.

Similarly, supplemental financial incentives are not intact for case management or for planned visits, which require additional work. In addition, non-physician staff roles must be considered in reimbursement schedules. To understand what type of reimbursement should be provided for these different interventions, demonstration leaders must better understand the components of each intervention required for sustainability and then attach a financial value to them.

Finally, changing the mindset of physicians reticent to meet changes such as the introduction of new visit structures is often difficult. As noted, comparing quality and performance measures among physician peers and to other groups generates a competitive atmosphere and encourages providers to improve. Moreover, unless

incentives are provided, project fatigue can set in overtime and reduce motivation after the initial enthusiasm has faded.

3.2.3 Summary of Key Change Concepts

1. Create a blended patient registry for all chronic conditions that identifies patients with multiple chronic conditions.
2. Identify ways to improve infrastructure and provider and patient acceptance for group visits and e-visits.
3. Focus case management by diagnosis and high impact patients
4. Integrate case management with planned visits and point-of-care information from disease registries.

3.3 Patient Attribution

The PGP demonstration assigns or attributes patients to PGPs based on a plurality of allowed office or other outpatient E&M charges. The assignment of patients to a PGP implies that it is responsible for managing the care provided to those patients. Discussed below are several issues that have arisen with this patient attribution methodology. Also noted are demonstration design changes that could improve the generalizability of the demonstration and optimize reimbursement provided to group practices.

3.3.1 Attribution Model

PGPs have faced several challenges concerning the demonstration attribution model for physician services. Some patients being assigned to a particular PGP may not have had primary care provided to them there. Instead, they may have been assigned based on specialty care they had received at the PGP if the care was billed using office or other outpatient E&M codes.

Another attribution issue is rewarding the right physician for positive patient outcomes when multiple physicians have treated a patient. Individual provider attribution is a problem in that situation, since the patient may not have had a predominant number of visits to any of the provider groups.

The “medical home” model idea could result in the simplest attribution: each patient chooses a medical home, which is a physician or practice that is responsible for that patient’s care management. The medical home receives a per-beneficiary, per-month add-on payment for providing certain defined services.

The specific bundle of services that would fall into the medical home's responsibilities would need to be carefully defined prior to implementation of this type of model. Quality and efficiency measures should also be included, as should mechanisms for avoiding or mitigating conflicts between the multiple physicians who may be treating that patient.

3.3.2 Demonstration Refinements and Challenges

The PGPs have offered several alternative approaches to the attribution model. They have recommended that attribution be based on chronic condition charges, for instance, instead of total E&M charges.

Two major challenges for optimizing reimbursement under the demonstration have been identified. First, the need for investment to build the right intervention infrastructure is a concern. A practice has only a finite amount of resources available upfront; this could potentially affect the interventions and result in sub-optimal outcomes. Also, groups may not show savings due to lack of sufficient upfront investment.

A second challenge is limited data availability. PGPs could improve both patient management and efficiency if they knew assigned beneficiaries' treatment histories before initiation into the demonstration. In addition, receipt of timely data would be particularly beneficial given the short duration of the demonstration.

3.3.3 Summary of Key Change Concepts

1. Focus attribution on visits to primary care providers.
2. Focus attribution on patients with specific conditions.
3. Test prospective attribution through beneficiary selection of providers in a medical home model.
4. Encourage more up-front investments by PGPs in systems and interventions. This practice would improve care by increasing the likelihood of earning additional reimbursement to provide for a reasonable return on those investments.

SECTION 4

HEALTH CARE REDESIGN PROCESSES

This section summarizes conference sessions on lessons learned regarding five approaches for health care redesign efforts. They include: 1) improving workflow; 2) integrating care management and case management into clinical practice; 3) managing care transitions; and 4) redesigning primary care practice; and 5) demonstrating value and building payer and organizational support

4.1 Improving Workflow

An important step to improving workflow is identification of inefficiencies in the current system at both the macro and micro levels. PGP participants have targeted several problems in their clinical workflows. They include: 1) lack of access; 2) insufficient follow-up; 3) staff resource allocation; and 4) fragmented patient care interventions.

Lack of Access

Quality measurement reports routinely indicate that some patients are not receiving an appropriate level of care for their conditions. This lack of access may result from several factors, including an inefficient workflow process in which the right care is not routinely provided at the right time. Workflow improvements, described below, could lead to appropriate care being more frequently provided during regularly scheduled patient visits.

Insufficient Follow-Up

A commonly used technique to enhance communication between clinicians and patients is the “teach-back” method. In this approach, patients are asked to repeat instructions regarding care management back to the clinician. Teach-back studies at some PGP demonstration sites reveal that 80 to 90 percent of patients misunderstand what physicians tell them during health care visits. This lack of communication indicates a need for additional follow-up with patients regarding instructions provided during visits. Workflow improvements that address this issue could lead to better treatment adherence and improved health outcomes.

Staff Resource Allocation

Another issue is to ensure that the right staff person with the right skill set is completing a task at an appropriate time. An example provided by demonstration participants involves the diabetic foot exam quality measure. Several sites indicated that medical

assistants could be conducting foot exams instead of physicians. In addition to freeing up physician time, this would empower medical staff and make them feel more strongly that they are part of the care team.

Fragmented Patient Care Interventions

Care management programs and patient registries successfully assist with the management of individuals with a single ailment. Beneficiaries often have multiple chronic conditions, however, that need to be treated or managed simultaneously. To address this issue, demonstration PGPs have stressed the need for broader, more integrated care management techniques and patient registry systems. Moving away from the “silo” approach to disease management, which focuses on just one disease at a time, and into more complex care coordination and management could improve workflow efficiency.

4.1.1 Interventions to Improve Workflow

The improvement of clinical workflow efficiency requires thoughtful implementation of interventions to initiate practice redesign and in some cases a significant culture change within an organization. PGPs have implemented: 1) planned visits; 2) information systems; 3) systems for complex care management; 4) medication reconciliation; and 5) standardization of protocols.

Planned Visits

Planned visits usually involve generating lists of beneficiaries that will be visiting the clinic soon, to allow for review of all of their recent medical tests. If any relevant results are missing, providers are then able to conduct same-day testing to ensure a complete record is available to the physician at the time of the patient’s visit.

Through appropriate planning for the visit, the patient, physician and relevant medical information can all be present in the room at the same time, allowing for more accurate discussions regarding care planning. In addition to providing the right care at the right time, this helps to reduce physician inertia (i.e., “let’s take care of it next time”).

Information Systems

All of the sites participating in the PGP Demonstration have introduced some form of information technology that makes clinical data more readily available at the point of care, including EHRs and patient registries. This supports the introduction of planned visits.

These systems have improved workflow efficiencies in several ways without requiring new hires or taxing current staff. EHRs can include abnormality prompts that indicate to a provider that certain tests are missing for a particular patient. These types of prompts can improve the workflow as well as quality of care. One site includes each of the three components of the diabetic foot exam in its EHR, so that alerts appear within the record if any of the components are not completed.

Complex Care Management

Medicare populations often have several comorbidities that need to be treated simultaneously. Therefore, traditional disease management programs that target only one of the conditions a patient has may not be the most efficient approach to care management. Some of the sites participating in the PGP demonstration have recognized the need for complex care management that addresses a beneficiary's multiple comorbidities.

One improvement to workflow efficiencies would be to enhance interventions so they incorporate the full spectrum of diseases suffered by a patient. Another approach is to include beneficiaries with different types and combinations of conditions in patient registries.

Complex care management could be enhanced by combining disease-specific patient registries. As noted, several sites participating in the PGP demonstration have developed or are developing broader patient registries that are not specifically focused on any one disease.

Complex care also involves training staff to provide care for a range of chronic conditions. It also involves training different levels of staff (e.g., nurses and social workers) to provide coordinated care across a system. This type of care management provides support for medical needs and helps beneficiaries overcome personal barriers such as by providing referrals for transportation needed for medical care. It can be provided either in person or by telephone.

Medication Reconciliation

Medicare beneficiaries often require treatment with multiple medications, but the more medications a patient requires, the lower their likelihood of compliance and the higher the likelihood of dangerous drug interactions. Improved medication reconciliation is therefore important since it addresses both of those concerns, and can potentially reduce the occurrence of unnecessary hospitalizations or re-hospitalizations. Several sites participating in the PGP demonstration report success in their efforts to introduce

medication reconciliation processes. They have found that it requires significant upfront investment, but then minimal ongoing work.

However, sites also found that, although beneficial, medication reconciliation can be difficult to implement for several reasons. First, it can add considerable time to the discharge process. Some sites have tried to limit the time involved by integrating medical reconciliation processes into their EHRs. A second issue is that it is difficult to decide who should be initiating medication reconciliation. Due to the burden associated with the process, a physician is not the ideal choice. After auditing medication lists generated by medical assistants, one of the sites decided that RNs or LPNs are probably the best professionals for this task. However, once medication lists are generated they require physician review. Another issue is to determine the best setting for this process. A primary care physician, for example, may be reluctant to alter medications prescribed by a specialist.

One useful technique is generating medication lists for the patient prior to a health care visit. Patients would be responsible for comparing the list to the medications they have at home and for informing a clinician of any discrepancies. Some sites prompt patients to bring in their medications for health care visits. One site has patients check medication list printouts in the waiting room prior to a visit. This also engages the patient more in their own health care, which can enhance self-management and improve efficiency.

Standardization of Protocols

Standardizing protocols by defining individual roles within a care team or documenting best practices for future use is important for improving workflow. Standardized protocols help to ensure that the right person is completing the right task at the appropriate time. They also facilitate the dissemination of important information. This can result in long term cost savings. Part of the strategy for standardizing protocols is ensuring that they are focused within the scope of the practice.

Increasing teamwork can involve the movement of less clinically advanced work to medical assistants. At one site, medical assistants prepare patient paperwork as the patients sign in for their visits. The medical assistant reviews problem lists and follows up on lab work. Medical assistants are provided with earpieces so that they can be contacted by physicians at any time during the course of the health visit. Although expensive, this has proven to improve efficiency. Medical assistants at other sites assist with patient education, such as repetition and reinforcement of physician orders. This

type of education is useful, since patients often do not absorb all of the information provided to them by physicians during a visit.

Teamwork has also involved on-site patient educators (e.g., diabetes educators). They can be used as ad hoc consultants to providers and patients, thus simultaneously improving quality of care and supporting physicians. However, some sites have experienced difficulties with the financial investment required for educators. The cost-effectiveness of this intervention needs further study.

4.1.2 Challenges with Improving Workflow

It is important to stress that cultural change requires physician buy-in for success. For example, physician buy-in and input into the development of standardized protocols helps to ensure that they are carried forward at the front lines. However, physician buy-in does not always come easily. One problem found by some sites is pushback from physicians about engaging in a team approach to care.

Piloting is important before implementing significant organizational change. It provides an opportunity for gathering data to prove that an intervention either works or does not work. Also, more generally, learning about and breaking through barriers is easier at a smaller scale. If a program does not work during the pilot phase, it need not be carried forward.

4.1.3 Summary of Key Change Concepts

1. Test methods for implementing planned visits
2. Develop methods for more effective medication reconciliation, such as providing medication lists to patients in the waiting rooms
3. Develop standardized protocols to delegate more clinical care tasks from physicians to RNs and/or medical assistants, such as anticoagulation management (RNs) or diabetic foot exams (MAs)

4.2 Integrating Care Management into Clinical Practice

Care management techniques are being implemented or expanded by most participating sites to achieve the goals of the demonstration. Several models for care management have been used, including the visit model, the telephonic model, and the clinical pharmacist model. This section discusses challenges with developing or maintaining the different models of care management and offers strategies for improving their implementation and effectiveness.

4.2.1 Strategies for Successful Integration of Care Management

Information Systems

A contributor to the success of care management programs at several sites has been the development of a reliable data or information system. Sites have found that the development of a disease registry should follow several key steps. Park Nicollet Health Services, for example, spends a significant amount of time working with their patient registries, cleaning the data and targeting patients with specific diseases. Once the data have been cleaned and checked, they are used to create reports for physicians and other staff.

Sites have found that it is helpful to start with claims data for building patient registries, although recognizing that coding in claims may contain some inaccuracies. The second step would be to compare information from the claims data to clinical data to verify and revise the coding as needed. In this process, Park Nicollet found that heart failure and chronic obstructive pulmonary disease diagnoses are sometimes over-reported in claims data. The University of Michigan cross-validates their registry data automatically, using lab data, pharmacy data, and medical device data. They have found that even after this automated validation process some chart review verification is still necessary.

Accurate data are important for making care management and patient-centered interventions work well. A physician's tolerance for data inaccuracies when dealing with patient data is fairly low, particularly if it identifies a patient as having a disease that is not present. Patients also may also become concerned if they learn of these inaccuracies.

St. John's Health System has begun flagging diagnoses in their registry that do not appear in the claims. In addition to helping with workflow and the quality of care, this type of intervention highlights coding problems within their billing system.

Park Nicollet has had success with a home monitoring system that collects basic data (e.g., weight, shortness of breath) from congestive heart failure patients on a daily basis. Changes in patient status can then be more quickly noticed by nursing staff, who review the data inputs and work closely with physicians as part of the care team. This home monitoring system involves four case managers serving over 500 patients. Billings Clinic utilizes a similar model using the same vendor.

Care Redesign and Standardization

Care process redesign involves improving and standardizing clinic-based workflows and community and virtual care models independent of their setting. As noted

in the previous section, expanding team-based care has been emphasized by all of the sites.

The Dartmouth-Hitchcock Clinic uses their registry to prioritize care management and engage physicians in its use. This type of care management may involve the use of planned care teams to minimize the time burden on physicians. Non-physicians assist physicians with the management of schedules and HbA1c tests, for example. Some sites have medical assistants providing foot exams to diabetic patients. However, in order to achieve buy-in for shifting clinical work in this way, it is important to show that it results in some improvement to quality of care.

Reimbursement/Incentive Models

Involving physicians in care management is difficult for several reasons, including reimbursement and burden. One method for engaging physicians is to provide them with feedback reports from patient registries or other data systems. These reports can foster competition among physicians and may be tied to financial bonuses. These strategies can improve physician engagement.

Everett Clinic indicated that it found that quality bonus payments as low as 5 percent to be useful in engaging some physicians in care management. Other groups, however, have found that financial incentives are not sufficient to motivate physicians. Several groups indicated that physicians are more interested in system improvements and infrastructure that can facilitate their daily clinical work. Geisinger Clinic, for example, found that workflow improvements result in larger impacts on quality performance than financial incentives provided to physicians.

Assigning performance payments to sites or offices, rather than to individual physicians, has been successful. This approach promotes a more team-oriented focus and increases the sample sizes so that results for quality performance measures are more statistically stable. The office- or group-level incentive model can also address the issue that some patients with multiple conditions may be treated by multiple physicians.

Provider-Based Care Management

Provider-based care management is more accurately described as “relationship-based care management,” with a goal of strengthening the patient-provider relationship. Most frequently, this includes the introduction of care management nurses who facilitate the patient-physician relationship. The nurses communicate with both the physicians and patients and ensure that clinical protocols are followed.

Disease management companies argue that this form of care management is ineffective. They have recognized the need for significant resources to implement care management programs and have emerged as a solution for health care providers to design and implement programs aimed at improving care and generating savings.

Although the disease management vendors have significant experience and offer programs that work population-wide, integrating their programs into the clinical care process is difficult. Vendors may have phone banks and collect information from patients, for example, but the data they glean is often outside the context of patient care and therefore not immediately relevant to physicians. Some vendors send faxes regarding patients to physicians' offices, but they are usually out of context and are often thrown in the wastebasket. Vendors do not have access to patients' medical records, nor do they have the authority to initiate changes to therapy as nurses who work under protocols authorized by providers.

Provider-based care management allows for one group of clinical staff to develop and execute the care processes. It provides a single standardized set of care processes, enables shared care planning, and creates a more simple structure for reporting and accountability. This management technique also improves communication between different sites of care, and it generates data that better integrate with clinical systems, billing data, registries, and profiles.

Patient Stratification for Care Management

Providing care management to all patients with a given diagnosis might not result in the most cost-effective use of resources. As a result, several sites have started using their internal information systems to target patients that would benefit most from care management interventions. The University of Michigan, for example, uses its diabetes registry to stratify patients by blood pressure and HbA1c levels. The stratification data provide information to nurses so that they know which patients to focus on. The patients viewed as needing the most attention are those with a blood pressure greater than 150/90 or HbA1c greater than 7. LDL levels are also tracked. Similarly, Forsyth Medical Group uses yearly data that is refreshed on a weekly basis to quantify patients' disease burdens, so that the staff's focus can be shifted to the patients most in need of services.

4.2.2 Challenges with Integrating Care Management

Patient Feedback and Engagement

It is often difficult to get patients to understand key messages and responsibilities with respect to self-care and care management. Clinical assistants can support physicians

in accomplishing this task. It may also be beneficial to integrate care management programs into the physician offices. For example, patients may not respond to advertisements or suggestions to attend a diabetes day. One of the sites that conducted this type of program noted that the intervention attracted only an already-motivated subgroup of patients. That subgroup accounted for only approximately one-third of the targeted patients. Instead, physicians should consider providing diabetes care when patients come in for flu treatment, since that will cover a broader set of diabetics. The flu is what will bring many of the less-motivated diabetes patients into physician offices.

Complex Care Management

Complex care management requires training nurses so that they can understand and treat clinical issues for several different conditions. It is difficult to know how many diseases one nurse may be able to manage for a patient. This issue needs further study.

Complex care management could be enhanced by combining disease-specific patient registries. Several of the sites participating in the PGP Demonstration have developed or are developing broader patient registries that are not specifically focused on any one disease.

Lack of Financial Incentives and Physician Buy-in

Primary care physicians are compensated mainly on the number of office visits they provide. As a result, visits are viewed as the unit to measure productivity. This form of reimbursement makes it difficult for physicians to provide the broader range of care management services that they believe would be useful for many patients and still earn a fair income. In many cases, physicians may forego providing non-visit services to some patients in order to conduct additional visits with other patients.

The current reimbursement structure often does not provide financial incentives to clinicians to provide education or counseling, non-office based care, home-based oversight, or non-physician visits. Providing separate reimbursement for these interventions would help build the support necessary for successful care management.

Moreover, effective care management programs require contributions from a range of clinicians and staff involved in the patient care process. Unfortunately, there is not reimbursement available for all of these resources. Providers offering care management programs can not bill for many of these services and are required to cover the costs for these interventions themselves. Financial incentives need to be added to make these services more sustainable.

4.2.3 Summary of Key Change Concepts

1. Develop broad-based patient registries that can cover multiple diseases and can also stratify patients by severity.
2. Expand use of community-based and virtual care techniques
3. Develop reimbursement for non-visit and non-physician care that is correlated with proven outcomes.
4. Focus on provider-based care management instead of payer-based or vendor-based management.

4.3 Managing Care Transitions

A care transition occurs when a patient is transferred from one provider to another. This may involve transfers within a facility, transfers between facilities within a larger integrated delivery system, or transfers in or out of a particular facility. For elderly patients with chronic conditions, poor transition management can result in hospital readmissions or increased visits to emergency facilities.

4.3.1 Key Elements of Care Transitions

Sites indicated that care transitions should include several key elements: 1) a medication reconciliation process; 2) transition coaching; 3) telephonic management; and 4) quality measurement specific to the transition process.

Medication Reconciliation

A well-constructed medication reconciliation process can both decrease morbidity and increase cost savings by reducing the likelihood of readmission. However, the correct list of elements for a medication reconciliation process is still somewhat unclear and needs to be researched further. It is also not yet clear which staff are right for providing medication reconciliation in different patient care situations and at what point in the care process it should be conducted.

This process is often very resource-intensive and requires trained staff, especially if chart review is involved. The University of Michigan has pharmacists providing medication reconciliation at the time of discharge, with follow-up provided by nursing staff. Although the program is currently in a pilot phase, the results to date indicate favorable outcomes.

An important element of medication reconciliation is checking and documentation of adverse drug effects for patients across all available data systems, including both

prescription and over-the-counter medications. Medication lists, with instructions for taking each medication, are also important so that they can be reviewed with patients at each visit.

Transition Coaching

Transition coaching should be provided at the time of discharge to both the patient and any family members or caregivers. Involving family or other caregivers if the patient is being discharged to home is important. Transition coaching can also include issues related to transfers to skilled nursing facilities; other post-acute care settings, such as hospice or palliative care programs; and outpatient management.

Some patients have especially high needs for transition coaching. They include patients with multiple hospitalizations, patients with potential gaps in care, and patients with chronic illness. One difficulty is the accurate identification of these patients so that transition coaching is more precisely targeted to the most vulnerable groups.

Telephonic Management

Telephonic systems have redefined the provision of home health care and enabled expanded access to several types of medical services for patients in need. Telephonic management also facilitates care transitions by allowing for daily follow-up post-discharge.

Telephonic management requires patients to check in with providers via the telephone. The specific program offered to a patient should relate directly to their primary discharge diagnosis. Congestive heart failure patients, for example, may be required to weigh themselves daily and respond to automated questions. Any changes in a patient's condition can trigger nurse or physician follow-up.

Some sites, however, found several recurring problems with implementing telephonic management. First, a patient can sometimes be too sick to participate. Second, a shortage of primary care visit slots can cause problems when staff need to respond quickly to changes in a patient's condition. Third, an absence of real-time data on the medical transition plan may be disconcerting, although a patient's family caregivers may be able to assist with providing this information.

Quality Measurement for Care Transitions

To better understand what works best for managing care transitions, recording and tracking quality of care data specifically designed for transition issues is important. Some examples of measures that may be appropriate for assessing care transitions are: hospital

readmission rates, the Care Transitions Measure (CTM) patient survey scale, medication reconciliation assessments, and medication error rates post discharge.

4.3.2 Challenges

As with any new intervention, challenges occur with implementing care transition processes. First, ownership of care transitions is an issue. Identifying who should be responsible for and held accountable for transition management is difficult, as is assigning ownership when reimbursement is not tied to transitions, and when the knowledge base is limited. Ownership and accountability should be determined at the system level and require an alignment of incentives. This determination may be difficult if multiple provider organizations are involved. Suggested staff for care transition management are nurses, social workers, and physician assistants.

Second, the current reimbursement system does not pay for care transition management. For care transition efforts to be sustainable, some form of reimbursement is necessary. Tying payments to the prevention of readmissions could be beneficial: CMS could pay based on the documented value of the intervention (e.g., a decreased readmission rate).

Third, methods for generalizing the care transition process across different health care systems or settings have not been developed. Some transitions will be to different provider organizations and some will be between departments within one large integrated delivery system. Also unclear is which transition process should apply to which patients. For example, how should care transition management be provided for patients with dementia vs. patients with no cognitive impairment?

Finally, lack of access to patient data in other providers' medical records, or restrictions on transfer of patient data to other organizations, could hinder transition management. In most cases, however, the data are readily available in the care setting. The most important data needs include an updated electronic medical record as well as discharge information.

4.3.3 Summary of Key Change Concepts

1. Integrate medication reconciliation and transition coaching into the care transition process.
2. Identify ownership and accountability for care transitions.
3. Develop methods for defining and measuring effective care transitions.

4. Determine reimbursement for effective care transition management.
5. Test ways to tailor transition management to the different needs of different types of patients.

4.4 Redesigning Primary Care Practice

PGPs are trying to develop best practice models for primary care under new types of provider incentives. Several groups are redesigning their primary care practices from acute, reactive care systems to more proactive systems that focus on prevention and planned care for chronic conditions.

4.4.1 Challenges Presented by the Current Structure

The acute care physician visit model is not optimal for all aspects of primary care. Anti-coagulation clinics work well as an intervention, for example, but they require little physician time and can be highly protocol-based. This type of between-visit intervention can improve quality and reduce hospital admissions, emergency room visits, and utilization of higher levels of services. It can also shift care to lower staffing levels. Moreover, this type of intervention could be applied to a range of chronic diseases.

The care provided through newer interventions being developed as alternatives to the traditional acute care visit are generally more patient-focused. They include:

- non-physician care
- telephonic management
- on-line visits
- patient education
- care coordination
- nursing visits
- actionable data reporting
- e-prescribing
- home monitoring
- medication reconciliation
- multidisciplinary care teams

The reimbursement system, however, is lagging behind innovation in these new treatment models. Reimbursement should be better aligned with these new treatments so they can become more financially sustainable for providers.

4.4.2 Redesigning Primary Care

Medical Home

In this model, each patient chooses a “medical home,” which is a physician or practice that is responsible for that patient’s care management. Implementation of this model requires a thoughtful review of what the medical home’s responsibilities would entail. It is important to avoid or mitigate conflicts between the multiple physicians who may be treating that patient. The medical home can act as a gatekeeper for referral services, and may be the best location for the medication reconciliation process. In general, the medical home would be a patient’s first point of contact with the health care system. At the University of Michigan, Blue Cross beneficiaries commit to a medical home provider and that provider receives a lump sum payment based on the condition that is being treated (e.g., diabetes).

Planned Visits

Planned visits are possible with large data systems (e.g., registries, electronic health records) that analyze data and provide physicians and other clinicians with pertinent information about the patient prior to a visit. A visit planner report may, for example, provide a list of overdue tests for a patient that could be performed prior to or immediately preceding a visit. Visit planning also usually includes other elements to make the visit more patient-centered.

Population Management

Management of patient populations is also important. This includes interventions focused at the population level and reports generated for populations. Group visits provide an opportunity for population management. During these visits, patients with similar conditions can gather and speak with a physician together. Some patients appreciate the group visit because it allows for more interaction. A patient can benefit from the discussion between a physician and another patient, particularly if the two patients have similar conditions.

Access Improvements

Utilizing alternative forms of the patient visit may allow for improvements in access. With group visits, for example, providers can substantially increase their patient panel size. Access could also be improved by providing care telephonically or through an

e-visit. In addition, access can be increased by encouraging non-physician staff to be a more active part of the care team. Physicians would be able to increase their patient panel size if they limit their interactions with patients to evaluations or tests that cannot be shifted to other staff.

Increasing access to care is important for quality and efficiency improvements. Delaying a patient visit for months could result in severe medical problems. Open access or advance access—allowed by some of the newer care models—permit patients to schedule visits on shorter notice. These models may also help to prevent emergency room visits.

4.4.3 Challenges

Similar to the challenges found for other interventions, the various elements of primary care visit redesign are not reimbursed in the current payment system. Sites recommended that reimbursement be tied not only to visits, but that a per-member per-month fee should be applied to provide funding for additional patient care. Alternatively, global fees could be provided for chronic disease care, supplemented by piece payment rates for patient education, telephonic care, and on-line care. In general, the movement should be from visit payment to more global condition payment.

A second challenge, again common to many of the interventions discussed, is improving physician buy-in. New care models can only be successful if physicians are on board with the changes and take a leadership role. However, it is sometimes difficult for physicians to accept major clinical process changes. Moreover, new types of care may require additional full-time staff and there may also be space or other infrastructure barriers. For example, not many physician offices are designed for group visits.

Finally, limited data availability is a challenge for implementing these new types of care. The PGPs indicated that it would be helpful to have more frequent feedback about populations of patients, their costs and quality of care. Sites also mentioned that increased data sharing across transitions and between providers would be beneficial, although privacy concerns remain an issue.

4.4.4 Summary of Key Change Concepts

1. Shift away from the visit-centric model of primary care.
2. Test and implement a range of alternatives, such as telephonic care, on-line care, coordination of care across providers, home monitoring, team visits, medication reconciliation, and others.

3. Test medical home models for patients with chronic diseases
4. Increase access to primary care provider team members, so that patients have “someone who knows you.”
5. Develop reimbursement methods to support non-visit care.

4.5 Demonstrating Value, Building Payer and Organizational Support

Value can be measured as the outcomes and experience from an intervention correcting for the costs and time required for its development and implementation. The value of an intervention can help decide whether it would be useful for the broader community and also provides a case for investment. Value is frequently measured through gains in efficiency and improvements in quality.

Case management is one intervention that has shown considerable value. During this session sites emphasized the value of case management, the strategies used to create a sustainable case management system, and challenges for its implementation.

4.5.1 Case Management

Case management models can take several forms. It can be provided for a single condition or as complex case management for patients with multiple chronic comorbidities. The sites participating in the PGP demonstration are utilizing case management models to improve efficiency and quality. Patients are often targeted for case management interventions based on the presence of particular conditions or high utilization rates for health services. Most sites in the PGP demonstration are initially targeting congestive heart failure patients for case management.

Some sites have employer groups that purchase their case management programs for commercial health insurance plans. St. John’s Health System, for example, has employer groups purchasing their case management services for \$5 per-member per-month. This type of reimbursement mechanism is valuable for sustainability. However, before requesting reimbursement for case management, it is important to prove the value or cost-effectiveness of the program for.

4.5.2 Challenges

Reimbursement for case management is difficult. Medicare fee-for-service reimbursement impedes case management by not providing financial support for those kinds of activities. Payments need to be redesigned to fit the case management and team-based care management models. It is also important to leverage well-defined interventions into a sustainable, permanent national payment system. However, once

patients recognize the value of these programs, they may be willing to pay out-of-pocket for some services. The sites are concerned that the PGP Demonstration model may not be sustainable. For example, the model would collapse if there are no more savings possible with respect to the comparison group.

Leadership is also needed for good case management and other patient care interventions, especially physician leadership and buy-in. Immediate buy-in is often difficult because physicians need proof that an intervention works before committing their support. The implementation of planned visits and teamed workflows are other provider improvements that should be considered for additional reimbursement.

4.5.3 Summary of Key Change Concepts

1. Case management has proven value.
2. Focus case management on high cost patients or diagnoses with proven interventions such as congestive heart failure.
3. Reimburse case management outside of fee-for-service, such as a capitated rate per-beneficiary per-month.

SECTION 5

IMPLICATIONS FOR MEDICARE AND THE U.S. HEALTH CARE SYSTEM

This section reviews promising change opportunities, unsolved challenges, and methods for identifying and disseminating lessons learned from the PGP demonstration.

5.1 Change Opportunities

Four change opportunities that cut across conference sessions have emerged as especially promising. They include: 1) increasing patient engagement; 2) expanding care management for chronic disease; 3) improving care transitions; and 4) expanding roles of non-physician providers.

Increasing Patient Engagement

Opportunities for involving patients more deeply in pre-visit processes and self-management support are promising interventions for both improving quality and containing costs. Pre-visit processes include planned visits and alternatives to traditional acute care physician visits. The goals are to make physician visits more effective and accurate and to enable complementary services to be provided in a timely fashion if reimbursement can be made available.

Increasing patient self-management is a goal for both care management programs and chronic disease care in general. Much of day-to-day chronic disease care is actually provided in patients' homes, either by themselves or by family members. This includes adherence to prescribed medications, consistent attendance at regular physician visits, active communication with physicians and nurses regarding symptoms and problems, prompt attendance for ordered testing services, and maintaining diet and exercise programs as consistently as possible.

Demonstration sites are working on a number of patient education and coaching programs to promote improved patient self-management. The PGP demonstration incentives are one way to fund these programs if sites can demonstrate they have achieved savings.

Expanding Care Management

PGP demonstration sites are focusing on heart failure care management since it is a condition with potential for significant cost savings through reduced hospital admissions. As a result, many sites are intensifying their management programs through daily telemonitoring programs, nurse telephonic management, patient education, and other interventions.

Diabetes has also been a focus of care management. Interventions such as diabetes educators, patient registries, intensified quality of care tracking, and feedback reports have been broadly applied. Sites are also interested in exploring direct incentives, such as per-member per-month reimbursement for heart failure or diabetes case management that could fund a range of non-visit services.

Improving Care Transitions

Providers have historically given too little emphasis on care transitions, since both clinical responsibilities and the associated reimbursement are often divided between providers. PGP demonstration incentives, however, reward sites for reducing overall Medicare spending, so they have financial incentives to better manage the many care transitions that may be required for treatment of chronic diseases.

A number of sites are testing new transition management programs, that may apply to patients with particular diagnoses or those undergoing particular types of transitions, such as the transition from hospital to home. Preventing hospital readmissions through improved outpatient follow-up care has been a particular focus of these programs, since it has the potential to reduce costs and also reduce morbidity for patients.

Expanding the Roles of Non-Physician Providers

Expanding non-physician provider roles has been an important part of the demonstration. A number of new or expanded non-physician roles are being tested, including conducting some types of patient testing or exams (such as diabetic foot exams), expanding patient education, and providing greater data support to physicians to enhance the quality and cost-effectiveness of their clinical work.

Physician buy-in to these efforts has sometimes been a challenge, but many PGP demonstration sites have had success in implementing new non-physician clinical roles, and all sites are optimistic about their potential for the future. If the new roles are well structured, and the clinicians well-trained, physicians can view them as complementing the care they provide and enabling them to concentrate on the elements of care that need their expertise.

The PGP demonstration incentives provide the potential for reimbursement of non-physician care that has not been traditionally funded and where it can demonstrate an impact on cost savings and quality of care. Reimbursement provides sites with broader flexibility to implement these new roles and to test new care models.

5.2 Unsolved Challenges

Sites have a number of remaining challenges in their efforts to respond to the PGP demonstration incentives. Speed of implementation for new interventions, for example, has been an issue for some sites. Since the demonstration is currently active for three years, sites need to organize cost saving and quality improvement interventions quickly so they will be able to show positive outcomes early in the demonstration and earn performance payments. Several sites, however, have indicated that motivating physician and organizational change has taken longer than expected, and their interventions did not become fully operational until Year 2.

Data and reporting lags are also an area of concern. Ideally, rapid feedback of data on assigned beneficiaries would enable sites to more quickly evaluate the impact of specific interventions and revise them as needed during the demonstration. Claims data take some time to accumulate, however, so rapid feedback using those data has been difficult to achieve. Many sites are supplementing claims data with patient registries focused on specific diseases or high-risk patients.

Limited reimbursement for non-physician care and medical home programs has also been of broad concern. While the PGP demonstration incentives may indirectly fund these efforts, sites recommend that some type of direct reimbursement for these services also be considered by Medicare. This funding would both provide some guaranteed financial return to sites investing in these programs and also encourage non-demonstration providers to more actively invest in testing these promising interventions.

While care management programs have been actively developed for a number of conditions, most notably diabetes and heart failure, sites have indicated several additional types of care management programs that should be more fully developed and tested. Examples include chronic obstructive pulmonary disease care management and complex case management. Both are viewed as having potential for reducing costs at the same time as improving quality of care; the optimal clinical approaches for these programs, however, have not yet been identified. Several sites are testing these programs, so additional lessons learned regarding these new types of care management programs may emerge by Year 3.

Similarly, a number of innovations in primary care are being tested. The planned visit concept and improving workflow through better data systems and team-based care are promising techniques. Optimal approaches are still being worked out, and Year 3 may bring additional lessons learned in these areas.

Finally, upfront investments required for care innovations are often substantial and may be difficult to justify given the uncertainty surrounding the likelihood of performance payments under the demonstration. This issue, however, may be better clarified after one or two demonstration payment cycles have been completed and the likelihood of receiving performance payments is better understood.

5.3 Methods for Identifying and Disseminating Lessons Learned

Exporting lessons learned from the demonstration to benefit the U.S. health care system as a whole can be achieved through a number of approaches. One of the most important is to focus on high-leverage change ideas. Given the broad range of health care delivery interventions being proposed around the country, a benefit of the demonstration can be to identify those that have the highest potential for producing positive cost and quality outcomes. The interventions can then be the focus of more intensive efforts for motivating physician and organizational change.

Another important method will be to engage physicians in efforts to export change ideas beyond their organizations. Physician buy-in and peer testimonials can be challenging, however, given the workloads and time limitations faced by physicians at each site. The PGPs are taking a range of approaches for engaging physicians in change efforts, including recruiting physician champions for leading design and implementation of new health care delivery interventions; educating physicians about the importance of new care delivery models; offering financial incentives; and fostering competition regarding performance on quality-of-care indicators.

Cross-organizational affinity groups or benchmarking collaboratives could be another way of engaging physicians and other PGP staff in structured interactions with other providers. Such gatherings have the benefit of allowing for ongoing interactions across organizations that may stretch over many months and even years, where ideas can be cross-fertilized, tested, and measured in practice, and where results can be shared among all of the organizations involved.

Additional PGP demonstration conferences are another approach that can provide sites and other providers with the opportunity to share their experiences and exchange ideas on their most promising interventions and methods for implementing them effectively. The conferences cannot be held as frequently as needed because of their costs, however, so virtual conference breakout sessions could be held periodically by conference call and WebEx. The virtual sessions would enable sites to stay engaged in the process of exchanging and exporting lessons learned during the time between conferences.

Round-robin site visits are another way to maintain involvement and also provide site staff and other providers with a chance to directly observe the interventions being applied by providers. They could be targeted to sites reporting particular success with selected interventions, such as care management, complex case management, or transition management. Site visits also provide opportunities for participants to talk with a broader range of staff, patients, and family members who are involved in implementing new interventions or are affected by them. These visits can result in a richer set of perspectives on the processes needed for effective implementation and the potential outcomes achieved.

In-depth written case studies could complement the site visits to successful PGPs by recording the observations collected by participants during the visits and through follow-up questions and discussion that could be conducted by phone and e-mail. Case studies could also include selected data provided by sites to better illuminate the processes they have applied and outcomes achieved. Case studies could be disseminated broadly by posting them on the Web and summarizing them for conference presentations and journal articles.

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Appendix B
Summary of Key Change Concepts

Topic	Key Change Concepts
Motivating Physician and Organizational Change	<ul style="list-style-type: none"> • Develop a systematic approach for implementing change. • Get physicians to believe in the data—involve them in developing criteria and testing data systems. • Develop a team-oriented model for clinical care. • Allow teams the time needed to meet and discuss their tasks fully. • Provide incentives for physicians to be change leaders.
Leveraging Tools to Improve Quality and Efficiency	<ul style="list-style-type: none"> • Create a blended patient registry for all chronic conditions that identifies patients with multiple chronic conditions. • Focus case management by diagnosis and high-impact patients. • Identify ways to improve infrastructure and provider and patient acceptance for group visits and e-visits. • Integrate case management with planned visits and point-of-care information from disease registries.
Patient Attribution	<ul style="list-style-type: none"> • Focus attribution on visits to primary care providers. • Focus attribution on patients with specific conditions. • Test prospective attribution through beneficiary selection of providers in a medical home model. • Encourage more up-front investments by PGPs in systems and interventions to improve care by increasing the likelihood of earning additional reimbursement to provide for a reasonable return on those investments.
Improving Workflow	<ul style="list-style-type: none"> • Test methods for implementing planned visits. • Develop methods for more effective medication reconciliation, such as providing medication lists to patients in the waiting rooms. • Develop standardized protocols to delegate more clinical care tasks from physicians to RNs and/or medical assistants, such as anticoagulation management (RNs) or diabetic foot exams (MAs).

Topic	Key Change Concepts
Integrating Care Management into Clinical Practice	<ul style="list-style-type: none"> • Develop broad-based patient registries that can cover multiple diseases and can also stratify patients by severity. • Expand use of community-based and virtual care techniques. • Develop reimbursement for non-visit and non-physician care that is correlated with proven outcomes. • Focus on provider-based care management instead of payer-based or vendor-based management.
Managing Care Transitions	<ul style="list-style-type: none"> • Integrate medication reconciliation and transition coaching into the care transition process. • Identify ownership and accountability for care transitions. • Develop methods for defining and measuring effective care transitions. • Develop reimbursement for effective care transition management. • Test ways to tailor transition management to the different needs of different types of patients.
Redesigning Primary Care Practice	<ul style="list-style-type: none"> • Shift away from the visit-centric model of primary care. • Test and implement a range of alternatives, such as telephonic care, on-line care, coordination of care across providers, home monitoring, team visits, medication reconciliation, and others. • Test medical home models for patients with chronic diseases. • Increase access to primary care provider team members, so that patients have “someone who knows you.” • Develop reimbursement methods to support non-visit care.
Demonstrating Value, Building Payer and Organizational Support	<ul style="list-style-type: none"> • Case management has proven value. • Focus case management on high-cost patients or diagnoses with proven interventions such as congestive heart failure. • Reimburse case management outside of fee-for-service, such as a capitated rate per beneficiary per month.

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.commonwealthfund.org.

[*Rewarding Excellence and Efficiency in Medicare Payments*](#) (September 2007). Karen Davis and Stuart Guterman. *Milbank Quarterly*, vol. 85, no. 3.

[*Medicare's Quality Improvement Organization Program Value in Nursing Homes*](#) (Spring 2007). Anthony Shih, Diane M. Dewar, and Thomas Hartman. *Health Care Financing Review*, vol. 28, no. 3.

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