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Pay for Performance: Here to Stay

Pay for performance (P4P) programs were developed primarily by health plans to address the poor quality of health care provided in the United States in the aftermath of the 1999 Institute of Medicine report *To Err is Human: Building a Safer Health System*. Although limited connection has been established between P4P programs and higher quality, almost all private payors offer P4P programs. In 2007, government (federal and state), employers and commercial payors sponsored 148 P4P programs, and there are expected to be as many as 160 programs in 2009. Existing P4P programs combine measures related to process of care, outcomes, patient satisfaction, information technology, and cost efficiency, although the first three measures are the ones most commonly used.



Click here to read [Craig Holm's article, Physician-Hospital Relationships: Shifting Out of Passive Mode, published in HealthLeaders Media The Corner Office](#)

Click here to read the HS&S e-newsletter, *Reducing Subsidization of Employed Physicians*

The majority of P4P programs focus on primary care physicians. The programs evaluate and incentivize the physicians mainly using the [Healthcare Effectiveness Data and Information Set \(HEDIS\)](#) measures developed by the National Committee for Quality Assurance (NCQA). Although some P4P programs have expanded to include specialists, the measures are more limited. The validity of the P4P measures is the main concern that physicians have expressed regarding P4P programs.

Larger physician practices find it easier to participate in P4P plans. Practices with electronic medical records (EMR) receive a higher percentage of their revenue from P4P programs, but practices without an EMR can also earn P4P incentives by streamlining their operations. Practices of all sizes can use external organizations like [Bridges to Excellence](#) to help implement these programs.

P4P for Hospitals

Click here to read the HS&S e-newsletter, *Primary Care Physician Shortage: Reality or Hype?*

Commercial payors currently sponsor more than 40 P4P programs related to hospital inpatient care. The Centers for Medicare and Medicaid (CMS) will incorporate P4P programs into Medicare reimbursements to hospitals in 2009 making the programs an integral part of health care delivery. The Medicare P4P programs are part of a broader CMS value-based purchasing plan. Since hospital P4P programs are relatively new, the metrics are primarily evidence-based process of care measures.

P4P programs can help hospitals establish standard care delivery processes. Hospitals can also use the clinical process data that they are required to record and report as part of P4P programs to assess their own performance and promote quality improvements. Regular reporting of in-house quality measures can highlight specific behavior patterns or program areas that need to be addressed. Organizationwide communication about performance on P4P and in-house quality measures will also promote transparency and build a culture of quality.

Click here to read Sam Steinberg's article, *Determining the Value of a Physician Practice*, published in *Managing the Margin*

Successful implementation of P4P programs depends upon physicians being actively engaged in the process, from the planning phase to the delivery of evidence-based care. Physicians should lead the redesign of clinical processes, share knowledge about best practices, and educate peers about the validity of the P4P measures. Providing physicians with regular feedback about their performance will also help keep them engaged.

Changes in the care delivery processes and P4P reporting requirements might require hospitals to reallocate resources to these programs and the information infrastructure that supports them. Since P4P programs are still evolving, hospitals must be prepared to adapt their staffing and other processes around these program changes.

P4P and Hospital Size

Depending on their vantage point, hospitals can have varying experiences with P4P program implementation and corresponding financial incentives.

- Large academic medical centers and larger hospitals, many of whom have robust quality improvement infrastructure in place, are more likely to be motivated by the improvements in the quality of care rather than the financial incentives of P4P programs. Because the quality infrastructure already exists, it may also be easier to implement and ensure compliance with P4P measures.
- Conversely, smaller community hospitals and rural hospitals can use P4P financial incentives to fund future quality improvement efforts, although initial investments will be required to set up these programs.
- It might also be easier for smaller hospitals to adapt to frequent P4P program changes since the medical staff is smaller and it's often less difficult to obtain physician buy-in.
- For P4P programs based on relative performance versus peer hospitals, the results and associated financial incentives for small hospitals are likely to be more variable due to the limited numbers of certain types of cases.

Premier/CMS Hospital Quality Incentive Demonstration (HQID)

HQID is a pilot program for the value-based purchasing initiatives that CMS plans to implement nationally in 2009. The three-year pilot was launched in 2003 by Premier health care alliance™ and CMS to test the premise that financial incentives can promote delivery of high-quality inpatient care and better patient outcomes, thereby reducing overall cost of care. After the conclusion of the first three years, HQID was extended through September 2009.

Voluntary participants in the pilot included 262 hospitals across 38 states. The participants represent a mix of teaching, community, urban, and rural hospitals. Hospitals submit quality data for heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements. In all, more than 30 evidence-based, nationally accepted quality measures including process of care indicators, outcomes indicators, and patient safety indicators are being reported. CMS calculates a composite quality score (CQS) for each hospital utilizing all the measures related to each clinical condition and pays the hospitals bonuses based on their performance.

At the end of the first three years, Premier reported that the average

CQS at HQID hospitals had increased by 15.8 percent, including improvements of 4.4 percent between the project's second and third year. The results validated CMS' hypothesis that financial incentives have a positive impact on quality of care. CMS awarded more than \$24.5 million in bonuses to the top performing hospitals over the first three years of the project. For each clinical condition, hospitals in the top two deciles received bonus payments of 2 percent and 1 percent of their Medicare reimbursement respectively. Hospitals that did not exceed the bottom two deciles for each condition were penalized 1 percent and 2 percent respectively.

Top performing HQID hospitals cited commitment from leadership and administrative staff, comprehensive physician engagement, and the involvement of interdisciplinary teams in designing and implementing care delivery standards as critical success factors.

With the success of CMS/Premier HQID program, P4P is likely to remain a permanent fixture in our health care delivery system. For both physicians and hospitals, P4P programs represent an opportunity to strengthen quality infrastructure, elevate the caliber of quality programs, and advance efforts to deliver high-quality care.

For more information on pay for performance, contact [Maria Finarelli](#) at 703.255.2889 or [Nivi Pillai](#) at 215.399.1863.



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