OBJECTIVES

- Outline a program designed to assist with the evaluation of disease management and performance using laboratory data

  A. By physician
  B. By physician groups
  C. Sorted by insurance carrier
OBJECTIVES continued

- Outline the use of lab data to monitor physician compliance for following standard practice and payor guidelines

- Review the concept of, Pay for Performance (P4P) and how the clinical laboratory can play an active and critical role

OBJECTIVES continued

- We will review our experience in using applications developed to “grade” physicians and evaluate how physicians react to payor defined guidelines

- Outline how the tools may be used to enhance our practice and provide a competitive edge to a laboratory system

- Reveal how these tools can assist PHO’s, hospitals, physicians and payors to evaluate physicians
PAY FOR PERFORMANCE
(Value based Purchasing)

I. Fundamental concept:
   A. Links compensation to how providers adhere to practice standards
   B. Practice standards are evidence based and tied to outcomes
   C. Primary areas of focus:
      1. Disease management
      2. Adoption of payor guidelines
      3. Preventive care

WHY?
The system is flawed and out of control

- Failure of traditional payment models:
  Fixed price model: this is what is paid
  Capitation (fixed cost model)
  FFS

- How does the US measure up?
  Healthcare delivery less than optimal NCQA - 40-80,000 patient die unnecessarily because they receive less than optimal care

- Failure to provide needed care not uncommon

- Adherence to clinical quality outlines varies by physician and condition
### CLINICAL QUALITY GUIDELINES

Adherence to quality indicators by condition

- Care of HTN: 65%
- Care of CAD: 68%
- β-blocker after MI: 45%
- ASA w/AMI: 61%
- Pneumo. Vac.: 64%
- Colorectal screen: 38%
- Osteoarthritis: 57%
- AF: 25%
- HIP fracture: 23%
- ETOH dependence: 11%

### P4P DRIVERS

- Cost of medical errors
- Lack of proper management
- Variability of care delivery
TYPES OF PAYMENT MODELS

PROGRAMS

- **Cost Differential**: reduced copay if employees use providers that meet standards
- **Direct Payment**: direct reimbursement to providers for alternative forms of healthcare
- **Share Withholds**: withhold part of payment until provider meets goals
- **Discount arrangements**: providers get discounts such as liability insurance with adoption of IT

MODELS

**UK 2004 P4P Initiative**

- National Health Service launches Quality and Outcomes Framework (QOF)
- 146 quality indicators covering 10 chronic illnesses, organization of care and patient experience
- 20% funding incentive leads to:
  - Increased staff
  - Increased technology investment
MODELS

**California**
- Incentive based upon quality measures NOT utilization management
- Voluntary
- Public score cards

**Medicare**
- Several demonstration projects
  - Rewarding High quality
  - Efficient healthcare
- Mixed reviews

DOWNSIDE – Focus Limited

**De-selection**
- Providers graded in regards to AIC will refuse to care for patients whose outcomes falls below standard non-compliant, therefore, worsens the provider’s assessment
PAY FOR PERFORMANCE

- Measurement of physicians is broadening, *Like it or Not*
- Linkage to reimbursement
- Despite concerns on a variety of fronts which include:
  1. Philosophical
  2. Economic
  3. Ethical
  4. Practical

PAY FOR PERFORMANCE

- Goal is to provide:
  1. Meaningful
  2. Standardized
  3. Evidence based measures
  4. Recognize and NOT penalize physicians that treat patients with significant comorbidity
P4P PROBLEM:

- Measurement methods NOT standardized
- The entire process regardless of one's personal view pushes providers and payors towards a greater use and reliance on data management and information technology
- How is the information doled out? *The Promulgation Gap*

HOW CAN LABS HELP?

Management Tools

- Work with providers and payors to outline programs using data that assist in the achievement of the P4P
- Establish programs to help reinforce standards of practice
- Labs can bring a purely objective prospective to physician performance and accountability
TWO INTERESTED GROUPS:

- **Payor:** labs can affiliate to create repositories for lab information which can then be used to:
  1. Evaluate physicians and physician organizations
  2. Assist in payor deferred disease management programs

- **Provider:** labs can use information to help with:
  1. Disease management
  2. Outcome performance
  3. Patient compliance
  4. Treatment efficacy

THE END POINT:
More Dollars but Better Care?

- $55 M – 2006
  California Board Integrated Healthcare
- CMS – 2007 – PQRI Program
  1.5% of allowable CMS fee schedule
A laboratory collaborative system the Joint Venture Hospital Laboratories (JVHL) using HEDIS data developed a uniform monitoring and reporting program, for CKD to

1. Detect CKD
2. Reinforce payor defined disease management
**PAYOR/LAB ORGANIZATION**

**DESIGNED DISEASE MANAGEMENT PROGRAM**

- **CKD Program**
  - eGFR calculated
- Sorted using <60 ml/min/1.73 m sq using MDRD equation
- Using a letter notification system over 9,000 letters sent/yr with 2 programs

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**SAMPLE LETTER**

Dear Physician:

Chronic kidney disease (CKD) is a growing public health problem. In Michigan, as in the rest of the United States, the incidence and prevalence of CKD is rising. Increasing evidence indicates that some of the adverse outcomes associated with CKD can be delayed or prevented by early detection and treatment. As part of OmniCare Health Plan’s (OmniCare’s) ongoing effort to provide high-quality, cost-effective health care to our members, we are partnering with our designated laboratory vendor, Joint Venture Hospital Laboratories (JVHL), and its affiliate Professional Laboratory Management, Inc. (PLM) to assist you in evaluating your OmniCare patients for possible renal disease.

The following patient in your practice had laboratory studies performed on the date indicated below. We have provided the estimated GFR* using the MDRD equation) for this patient below.

- **Patient Name:** Test Patient
- **Patient Date of Birth:** 01/01/1950
- **Patient Sex:** M
- **Facility where lab was drawn:** Hospital Consolidated Lab
- **Date of Service:** 12/17/2007
- **Estimated GFR (Non African American):** 46
- **Estimated GFR (African American):** 56
- **Creatine mg/dl:** 1.2

We have placed a copy of Michigan Quality Improvement Consortium (MQIC) clinical practice guideline for chronic renal disease on the back of this letter for your reference. We have also enrolled this member in our renal disease management program. If you feel that this program is not appropriate for this member or if we can be of further assistance, please contact us at 866-782-8507 ext. 1527. OmniCare appreciates your continued dedication and assistance in providing the best care possible for our members.

Sincerely,

Gary S. Assarian, D.O., FACP
Medical Director
Joint Venture Hospital Laboratories

Joseph L. Blount, M.D., MPH, FACP
Associate Medical Director
Quality Management

---

**Calculation assumptions:** The GFR estimate is based upon the MDRD equation for adults only. African American patients have an additional factor of 1.210 which should be multiplied by the value given to obtain the true value for African American patients. GFR is expressed in mL/min per 1.73 m².

**Additional reference material is available at the following sites:**

- www.nkfm.org
- www.nkidp.nih.gov
- www.nkdep.nih.gov/GFR-calc-adult.htm
CKD PROGRAM

- Notification included National Kidney Foundation Guidelines (NKF) and recommendations to manage patients with stages 2-5 CKD quality guidelines

QUALITY GUIDELINES

Michigan Quality Improvement Consortium Guideline
Diagnosis and Management of Adults with Chronic Kidney Disease

November 2006

The following guideline recommends diagnostic and therapeutic management of chronic kidney disease by clinical stages.

<table>
<thead>
<tr>
<th>Stages of CKD</th>
<th>Diagnosis &amp; Management</th>
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<tbody>
<tr>
<td>Stages 2-4</td>
<td>Screening &amp; Diagnosis</td>
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<tr>
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<td>Evaluation of comorbid conditions (e.g., diabetes, hypertension, coronary artery disease, cardiovascular disease)</td>
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<td>Treatment modification for chronic medication, drug interactions, microalbuminuria, and albuminuria</td>
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<td></td>
<td>Glucose 2-galactoseuria and other abnormalities</td>
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<tr>
<td></td>
<td>Evaluation and management of asymptomatic conditions (e.g., diabetes, hypertension, coronary artery disease)</td>
</tr>
<tr>
<td></td>
<td>Treatment modification for chronic medication, drug interactions, microalbuminuria, and albuminuria</td>
</tr>
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<td></td>
<td>Glucose 2-galactoseuria and other abnormalities</td>
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</table>

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<th>Stages 5</th>
<th>Screening &amp; Diagnosis</th>
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<td>Evaluation of comorbid conditions (e.g., diabetes, hypertension, coronary artery disease, cardiovascular disease)</td>
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<tr>
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<td>Treatment modification for chronic medication, drug interactions, microalbuminuria, and albuminuria</td>
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<tr>
<td></td>
<td>Glucose 2-galactoseuria and other abnormalities</td>
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</table>

Quality Principles of Treatment

- Stage 1 (GFR 60-29):初期 intervention of GFR decline - maintenance of proteinuria, microalbuminuria, and microalbuminuria in urine
- Stage 2 (GFR 29-19): Comprehensive management of GFR decline - maintenance of proteinuria, microalbuminuria, and microalbuminuria in urine
- Stage 3 (GFR 19-14): Comprehensive management of GFR decline - maintenance of proteinuria, microalbuminuria, and microalbuminuria in urine
- Stage 4 (GFR 14-10): Comprehensive management of GFR decline - maintenance of proteinuria, microalbuminuria, and microalbuminuria in urine
- Stage 5 (GFR <10): Comprehensive management of GFR decline - maintenance of proteinuria, microalbuminuria, and microalbuminuria in urine

As indicated
**Evaluation of program:**
- **Survey**

**CONCLUSIONS CKD PROGRAM:**

- Notification program is extremely valuable to physicians
- Positive response regarding letter serving as an aid to their practice
- 93% felt there is a value to JVHL notification program

**NEXT STEP**

1. Follow disease progress by
   a) Patient
   b) Plan
2. Demographic studies to evaluate geographic variance
3. Conduct population studies
JVHL designing a program to use lab data for diabetic patients to create tools to monitor

1. Disease management
2. Guideline compliance

PREVALENCE OF DIABETES & PRE-DIABETES

- **Total**: 23.6 million children and adults -- 8.0% of the population -- have diabetes.
- **Diagnosed**: 17.9 million people
- **Undiagnosed**: 5.7 million people
- **Pre-diabetes**: 57 million people
- 1.6 million new cases of diabetes were diagnosed in people aged 20 years or older in 2007
14.2% of the American Indians and Alaska Natives aged 20 years or older who received care from IHS had diagnosed diabetes. After adjusting for population age differences, 16.5% of the total adult population served by IHS had diagnosed diabetes, with rates varying by region from 6.0% among Alaska Native adults to 29.3% among American Indian adults in southern Arizona.

In Adults prevalence by race/ethnicity:
- 6.6% of non-Hispanic whites
- 7.5% of Asian Americans
- 10.4% of Hispanics
- 11.8% of non-Hispanic blacks

Among Hispanics rates were:
- 8.2% for Cubans
- 11.9% for Mexican Americans
- 12.6% for Puerto Ricans.

DIABETES PRACTICE GUIDELINES
Adopted from ADA. – Clinical Practice Recommendation 2009

- Standards of Care require that a number of parameters be evaluated on a continuous basis annually and that certain thresholds and criteria are achieved to reduce disease morbidity.
- These guidelines serve as a basis of this grading and monitoring tool developed by the JVHL.
A1C

- Perform the A1C test at least two times a year in patients who are meeting treatment goals (and who have stable glycemic control).
- Perform the A1C test quarterly in patients whose therapy has changed or who are not meeting glycemic goals.
- Use of point-of-care testing for A1C allows for timely decisions on therapy changes, when needed.

ADA Guidelines

GLYCEMIC GOALS IN ADULTS

Lowering A1C to below or around 7% has been shown to reduce microvascular and neuropathic complications of type 1 and type 2 diabetes. Therefore, for microvascular disease prevention, the A1C goal for nonpregnant adults in general is <7%.

ADA Guidelines
**DYSLIPIDEMIA/LIPID MANAGEMENT**

**Screening**
- In most adult patients, measure fasting lipid profile at least annually. In adults with low-risk lipid values (LDL cholesterol <100 mg/dl, HDL cholesterol >50 mg/dl, and triglycerides <150 mg/dl), lipid assessments may be repeated every 2 years.

**ADA Guidelines**

**NEPHROPATHY SCREENING AND TREATMENT**

**General recommendations**
- To reduce the risk or slow the progression of nephropathy, optimize glucose control optimize blood pressure control. (A)

**Screening**
- Perform an annual test to assess urine albumin excretion (UAE) in type 1 diabetic patients with diabetes duration of 5 years and in all type 2 diabetic patients, starting at diagnosis. (E)
- Measure serum creatinine at least annually in all adults with diabetes regardless of the degree of UAE. The serum creatinine should be used to estimate GFR and stage the level of chronic kidney disease (CKD), if present. (E)
### COMPLIANCE SCORE AVERAGE BY NUMBERS OF PHYSICIANS WHO ORDERED STUDIES ACCORDING TO ADA GUIDENCE STANDARDS FOR DM PATIENTS

<table>
<thead>
<tr>
<th>Payer</th>
<th>Active Members</th>
<th>Members with Diabetes diagnosis in past 13 months</th>
<th>Percentage of members with Diabetes Diagnosis</th>
<th>Unique Doctor count for Diabetes Patients</th>
<th>A1C Results Requested</th>
<th>A1C Results Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Care Network</td>
<td>634,822</td>
<td>42,715</td>
<td>6.7%</td>
<td>5,918</td>
<td>53,563</td>
<td>45,233</td>
</tr>
<tr>
<td>Community Care Assoc, Inc (HealthChoice)</td>
<td>1,185</td>
<td>305</td>
<td>25.7%</td>
<td>105</td>
<td>98</td>
<td>77</td>
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<tr>
<td>DMC Care</td>
<td>26,911</td>
<td>7,816</td>
<td>6.6%</td>
<td>492</td>
<td>1,440</td>
<td>1,340</td>
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<tr>
<td>Genesee County Health Plan</td>
<td>22,965</td>
<td>2,327</td>
<td>10.3%</td>
<td>252</td>
<td>2,725</td>
<td>2,343</td>
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<tr>
<td>Great Lakes Health Plan</td>
<td>181,692</td>
<td>5,764</td>
<td>3.2%</td>
<td>1,219</td>
<td>5,638</td>
<td>5,128</td>
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<tr>
<td>Health Alliance Plan</td>
<td>579,747</td>
<td>18,915</td>
<td>3.3%</td>
<td>3,171</td>
<td>17,840</td>
<td>16,207</td>
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<tr>
<td>Health Plan of Michigan</td>
<td>186,517</td>
<td>2,783</td>
<td>1.5%</td>
<td>1,102</td>
<td>3,111</td>
<td>2,299</td>
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<tr>
<td>Midwest Health Plan</td>
<td>77,457</td>
<td>5,271</td>
<td>6.8%</td>
<td>799</td>
<td>4,992</td>
<td>4,668</td>
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<tr>
<td>Molina</td>
<td>207,232</td>
<td>18,023</td>
<td>8.7%</td>
<td>1,690</td>
<td>6,955</td>
<td>5,763</td>
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<td>Omnicare</td>
<td>56,111</td>
<td>3,441</td>
<td>6.1%</td>
<td>359</td>
<td>2,225</td>
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<tr>
<td>Priority Health</td>
<td>44,354</td>
<td>4,228</td>
<td>9.5%</td>
<td>923</td>
<td>4,329</td>
<td>3,660</td>
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<tr>
<td>Total Health Care</td>
<td>72,352</td>
<td>2,355</td>
<td>3.3%</td>
<td>505</td>
<td>1,803</td>
<td>1,880</td>
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**SOME THING TO NOTE ON HOW THE DIABETES COMPLIANCE SCORES WERE COMPILED**

1. All claims JVHL received from selected payer received in the past 13 months were processed.
2. If a claim had any diagnosis (primary, secondary etc.) which started with 250 the patient was added to the diabetes list.
3. Each of the patients on the diabetes list was given a score as follows:
   a) One point for each A1C (83036) which had results.
   b) One point for each of the following tests that were resulted: Micro Albumin (82043), Cholesterol (82465), LDL Calculated (13457-7), eGFR
4. The patient was assigned to the requesting physician from the most current claim.
5. All patient scores for the Physician were added together and divided by the number of patients to get the average score for that physician.
## PATIENT COMPLIANCE SUMMARY SCORE CARD
**SORTED BY PATIENT AND PHYSICIAN DIABETIC PARAMETERS OVER A ONE YEAR PERIOD INCLUDING RESULTS**

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### PHYSICIAN SCORING PROCESS

- **Scoring:**
  - based upon the number of required monitor events, according to ADA guidelines that a diabetic patient need to receive during a given 12 month period. These include:
    - >Hgb A1C 4 / year if greater than 7%
    - >lipid studies annual (includes LDL, C-total)
    - >renal studies annual (includes microalb, eGFR)

**THIS IS NOT DESIGNED TO REVIEW ALL OF THE PARAMETERS THAT CAN BE MONITORED OR THOSE THAT MAYBE RECOMMENDED BY OTHER AGENCIES**
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<th>Alb</th>
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### Summary:

- **13 payor groups were reviewed:**
  - range of non compliance (4 points or less)
  - 54 – 74 % , average score 67%

Only 1/3 of the diabetic patients being followed up properly according to ADA guidelines.

There are significant differences in compliance when patient groups are compared by plan.
Summary continued

- There are significant differences in follow up and monitoring compliance between physicians.
- Using patient and claims data will result in targeted improvement of monitoring compliance and offers an objective means to compare physicians and physician groups.
- Compliance information could be offered to clients to help in efforts to monitor patients.
- Benefits of having this information available to the providers and payors is limitless and an important link between a client and the lab.