



Getting to Safe, Affordable, Effective, Patient-Centered Care: Good Data Are Only the Beginning

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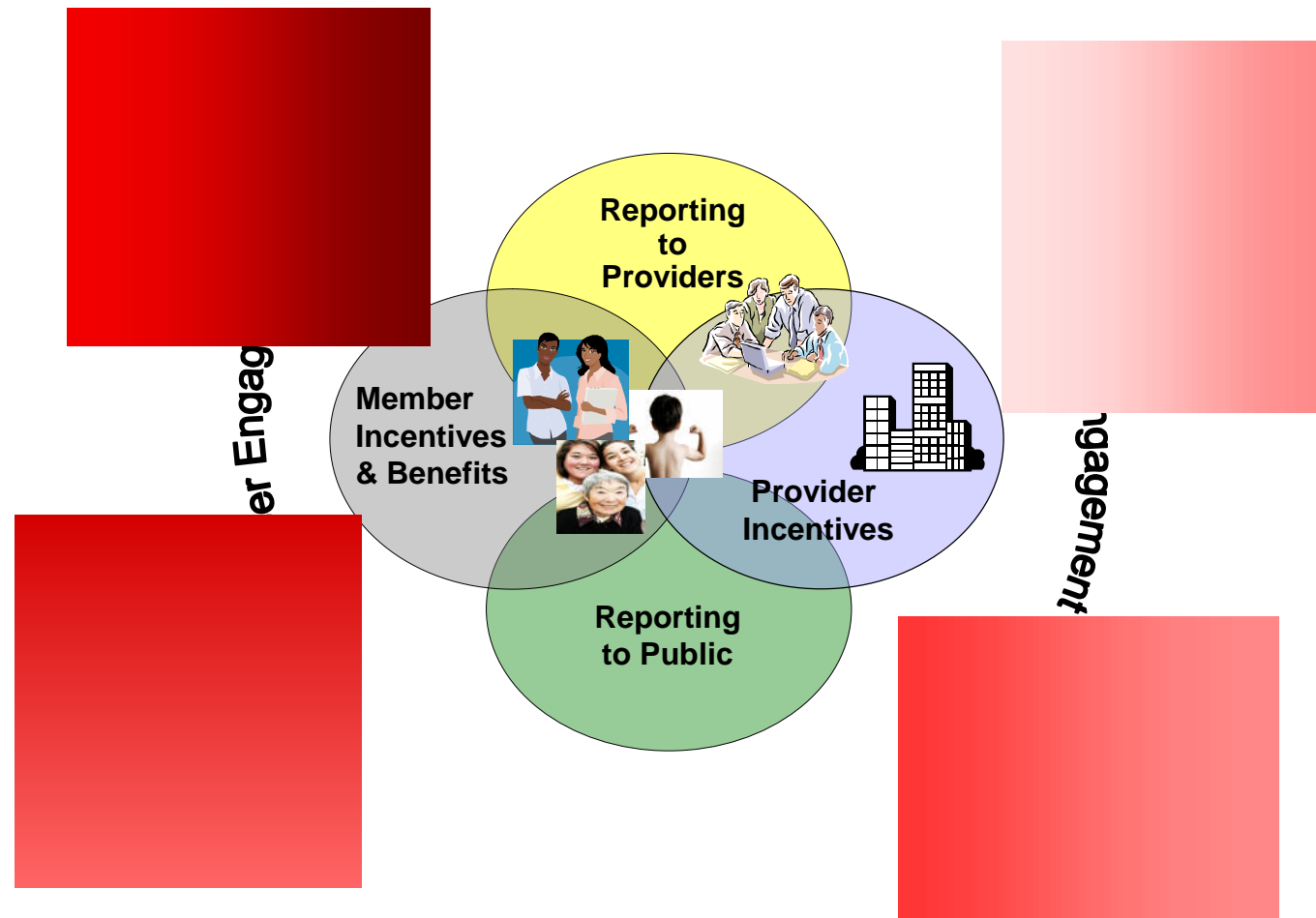


A health care system that provides safe, timely, effective, affordable, patient-centered care for everyone in Massachusetts.

Advancing Quality, Outcomes and Affordability: Role of Performance Measurement and Reporting Programs

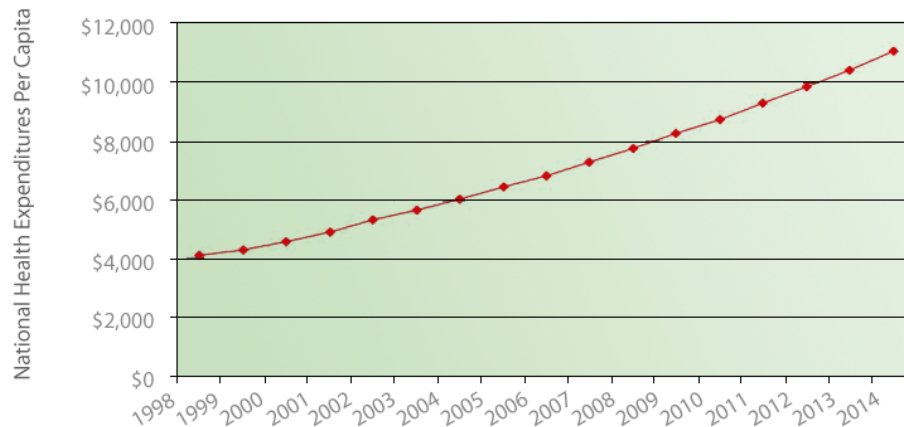


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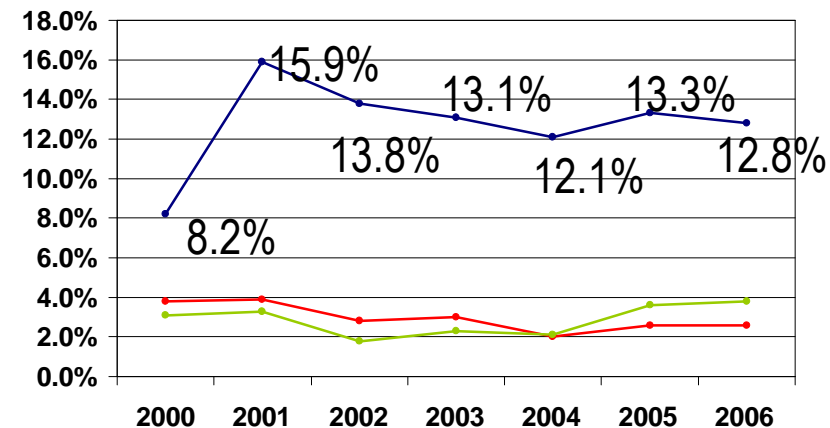
The Economic Imperative

Health care spending per capita is projected to nearly double over the next 10 years.



Source: CMS, Office of the Actuary, National Health Statistics Group

BCBSMA's medical cost trend is growing five times faster than workers' earnings, and nearly four times the rate of inflation.



— BCBSMA — Workers' Earnings — Overall Inflation
Medical Trend

Sources: BCBSMA, Bureau of Labor Statistics

Key components of the Alternative Contract Model



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Unique contract model:

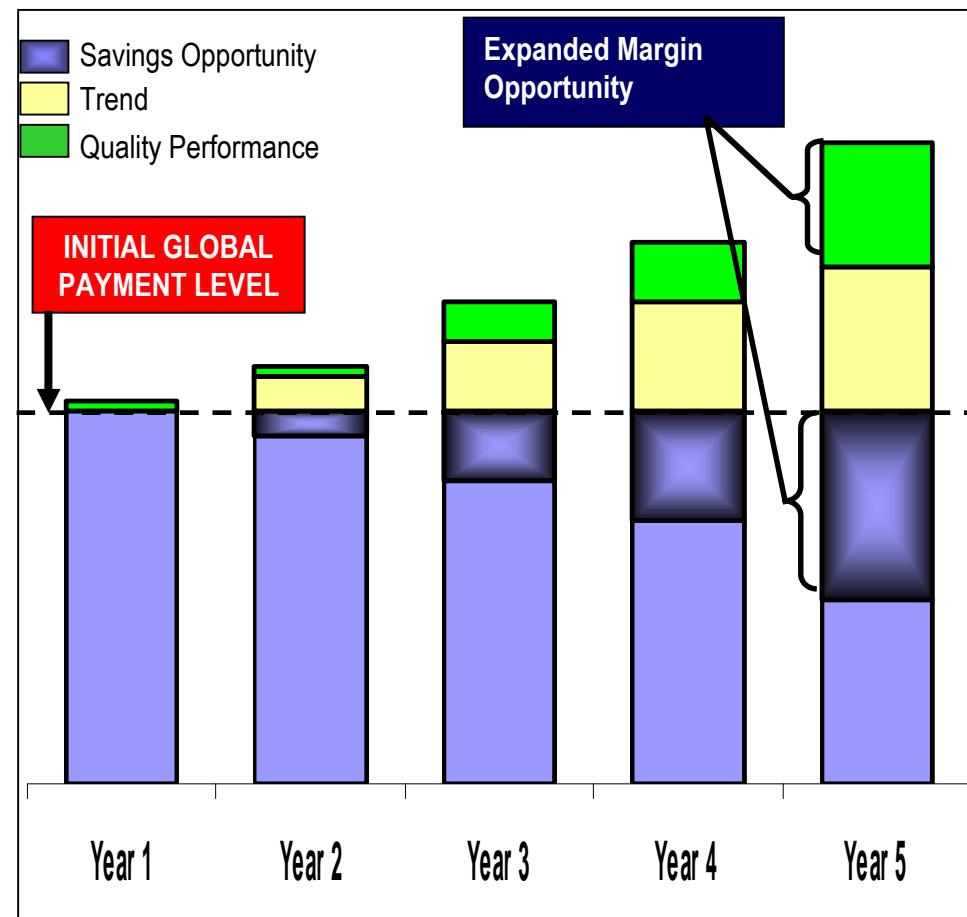
- Physicians & hospital contracted together as a “system” – accountable for cost & quality across full care continuum
- Long-term (5-years)

Controls cost growth:

- Global payment for care across the continuum
- Annual inflation tied to CPI
- Incentive to eliminate clinically wasteful care (“overuse”)

Improved quality, safety and outcomes:

- Robust performance measure set creates accountability for quality, safety and outcomes across continuum
- Substantial financial incentives for high performance (up to 10% upside)



AQC Measures - Illustration Only - Not Actual Provider Scores

Ambulatory Measures			
Measure	Score	Weight	
Process	Depression		
	1 Acute Phase Rx	2.5	1.0
	2 Continuation Phase Rx	1.5	1.0
	Diabetes		
	3 HbA1c Testing (2X)	3.0	1.0
	4 Eye Exams	1.0	1.0
	5 Nephropathy Screening	1.2	1.0
	Cholesterol Management		
	6 Diabetes LDL-C Screening	2.8	1.0
	7 Cardiovascular LDL-C Screening	2.1	1.0
	8 Breast Cancer Screening	1.2	1.0
	9 Cervical Cancer Screening	1.3	1.0
	10 Colorectal Cancer Screening	2.4	1.0
	Preventive Screening/Treatment		
	Chlamydia Screening		
	11 Ages 16-20	3.1	0.5
	12 Ages 21-25	1.8	0.5
Pedi: Testing/Treatment			
13 Upper Respiratory Infection (URI)	1.6	1.0	
14 Pharyngitis	1.4	1.0	
Pedi: Well-visits			
15 < 15 months	2.6	1.0	
16 3-6 Years	2.0	1.0	
17 Adolescent Well Care Visits	1.5	1.0	
Outcomes	Diabetes		
	18 HbA1c in Poor Control	3.2	3.0
	19 LDL-C Control (<100mg)	2.4	3.0
	Hypertension		
	20 Controlling High Blood Pressure	1.3	3.0
Cardiovascular Disease			
21 LDL-C Control (<100mg)	2.4	3.0	
Patient Exper.	Patient Experiences (C/G CAHPS/ACES) - Adult 3		
	22 Communication Quality	1.9	1.0
	23 Knowledge of Patients	1.9	1.0
	24 Integration of Care	2.1	1.0
	25 Access to Care	2.4	1.0
Patient Experiences (C/G CAHPS/ACES) - Pediatric 3			
26 Communication Quality	1.0	1.0	
27 Knowledge of Patients	1.5	1.0	
28 Integration of Care	2.5	1.0	
29 Access to Care	2.8	1.0	
Experimental	30 Experimental Measure A	5.0	1.0
	31 Experimental Measure B	5.0	1.0
Weighted Ambulatory Score		2.2	

Hospital Measures			
Measure	Score	Weight	
Process	AMI		
	1 ACE/ARB for LVSD	2.0	1.0
	2 Aspirin at arrival	2.5	1.0
	3 Aspirin at discharge	1.5	1.0
	4 Beta Blocker at arrival	1.5	1.0
	5 Beta Blocker at discharge	1.3	1.0
	6 Smoking Cessation	1.0	1.0
	Heart Failure		
	7 ACE LVSD	1.3	1.0
	8 LVS function Evaluation	1.0	1.0
	9 Discharge instructions	1.8	1.0
	10 Smoking Cessation	3.0	1.0
	Pneumonia		
	11 Flu Vaccine	2.5	1.0
	12 Pneumococcal Vaccination	2.9	1.0
	13 Antibiotics w/in 4 hrs	1.4	1.0
	14 Oxygen assessment	1.0	1.0
15 Smoking Cessation	3.1	1.0	
16 Antibiotic selection	3.0	1.0	
17 Blood culture	3.5	1.0	
Surgical Infection			
18 Antibiotic received	1.3	1.0	
19 Received Appropriate Preventive Antibiotic	1.4	1.0	
20 Antibiotic discontinued	3.0	1.0	
Outcomes	21 In-Hospital Mortality - Overall	3.0	1.0
	22 Wound Infection	2.1	1.0
	23 Select Infections due to Medical Care	2.8	1.0
	24 AMI after Major Surgery	2.4	1.0
	25 Pneumonia after Major Surgery	3.4	1.0
	26 Post-Operative PE/DVT	2.0	1.0
	27 Birth Trauma - injury to neonate	1.0	1.0
	28 Obstetrics Trauma-vaginal w/o instrument	1.5	1.0
Hospital Patient Experience (H-CAHPS) Measures			
29 Communication with Nurses	4.0	1.0	
30 Communication with Doctors	3.0	1.0	
31 Responsiveness of staff	2.5	1.0	
32 Discharge Information	2.8	1.0	
Experimental	33 Experimental Measure C	5.0	1.0
	Weighted Hospital Score		2.3

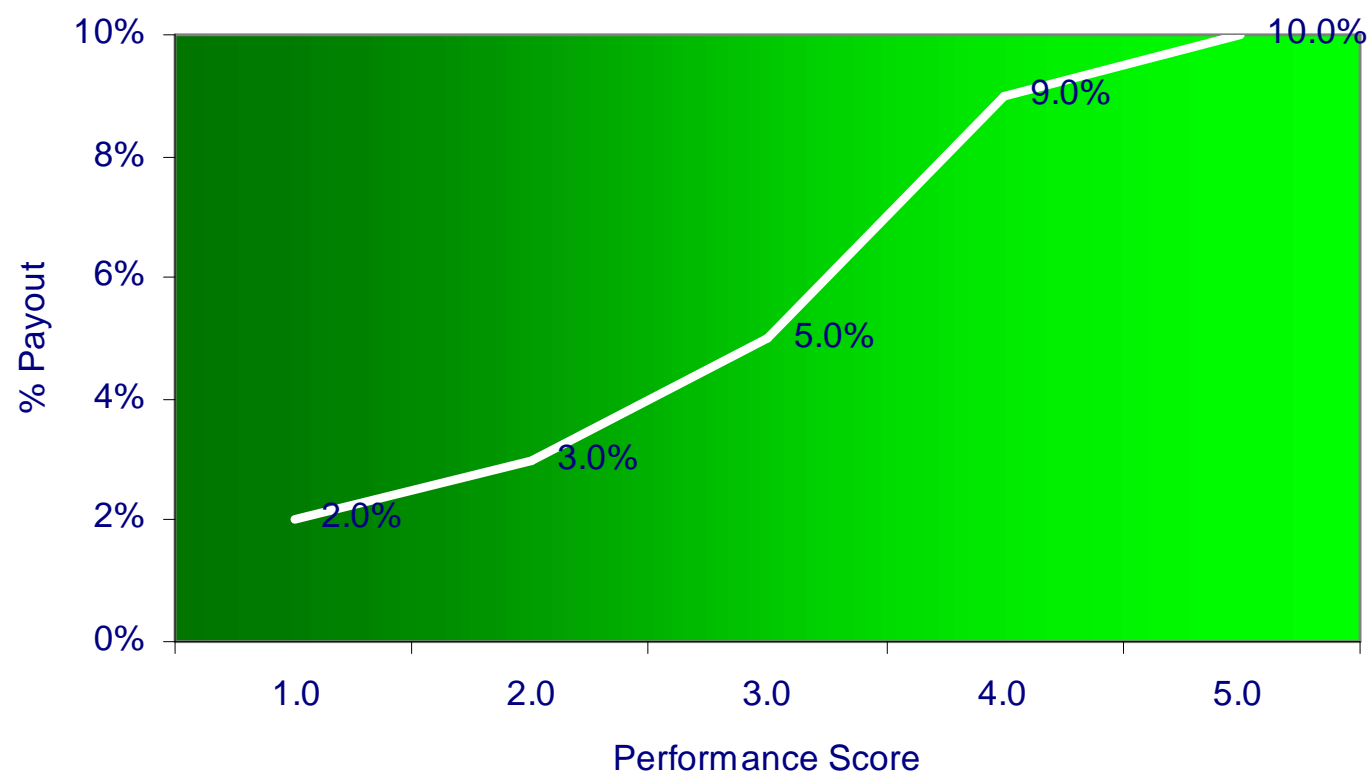
Aggregate Score 2.3

Performance Achievement Model



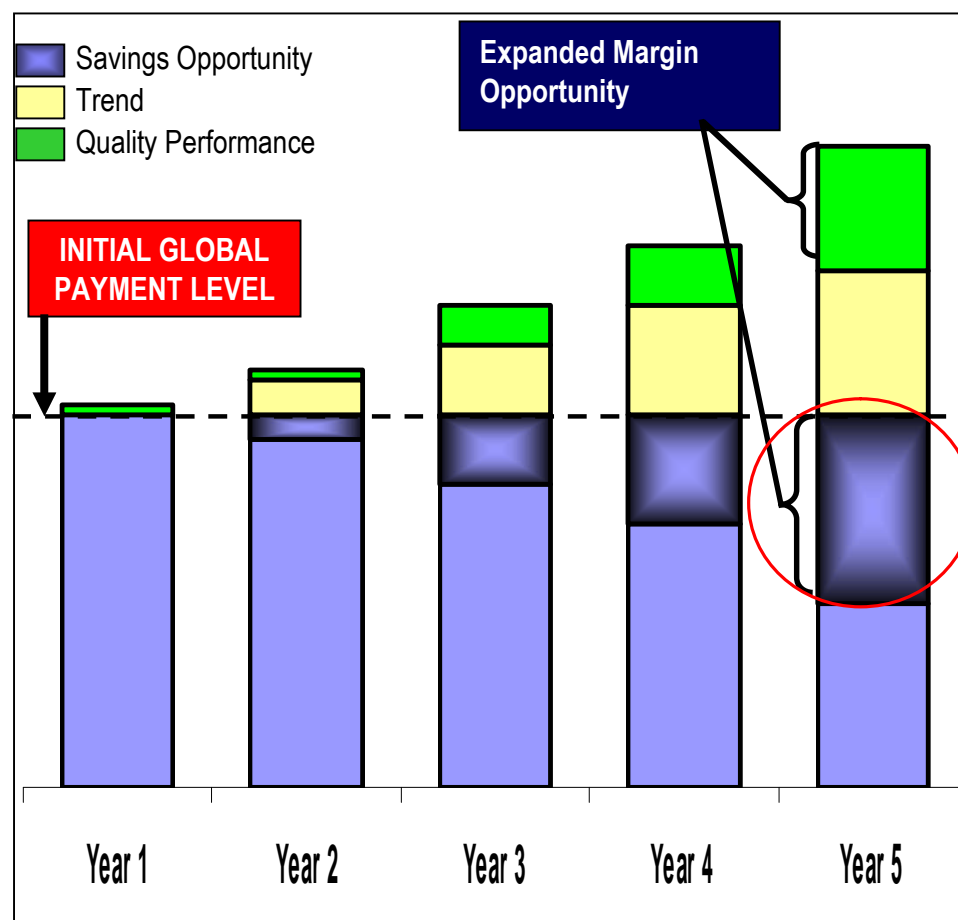
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Performance Payment Model



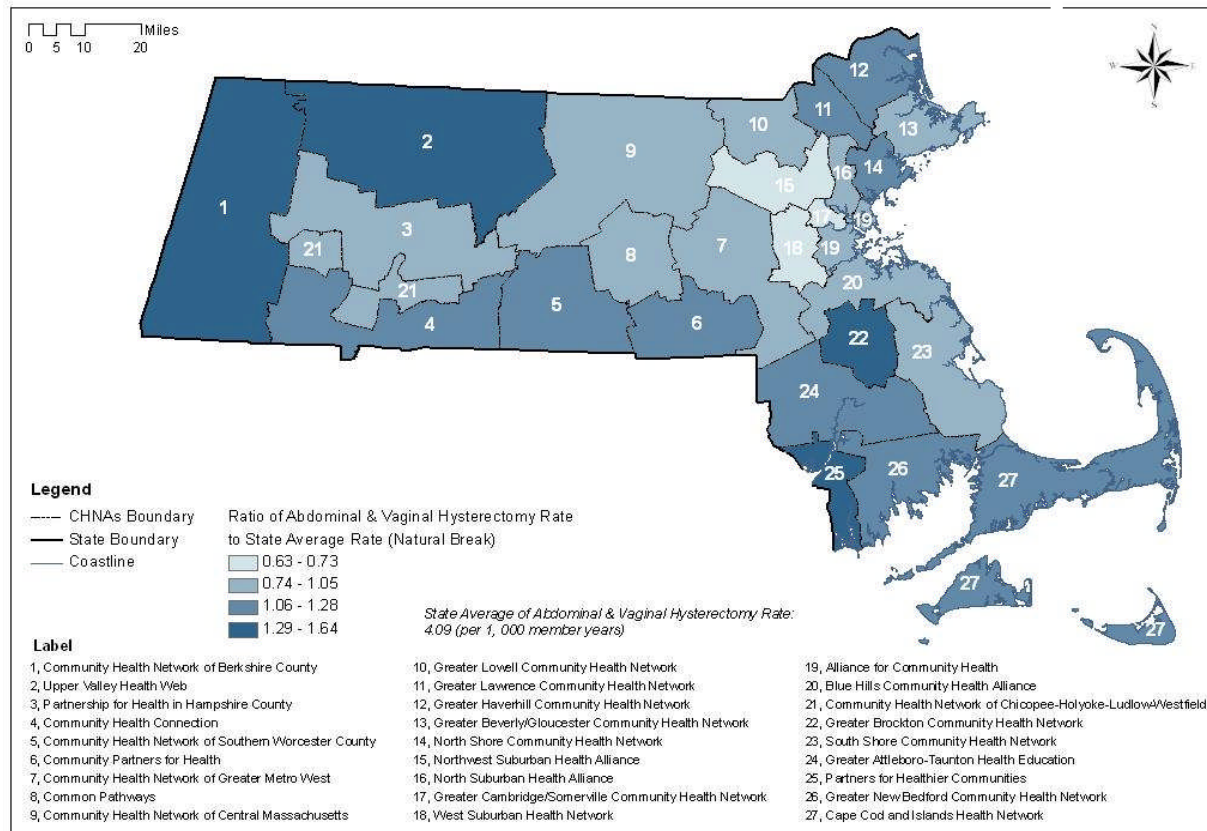
Key Components of the Alternative Contract Model

Performance Improvement: Cost and Efficiency



Geography is Destiny: Practice Pattern Variation

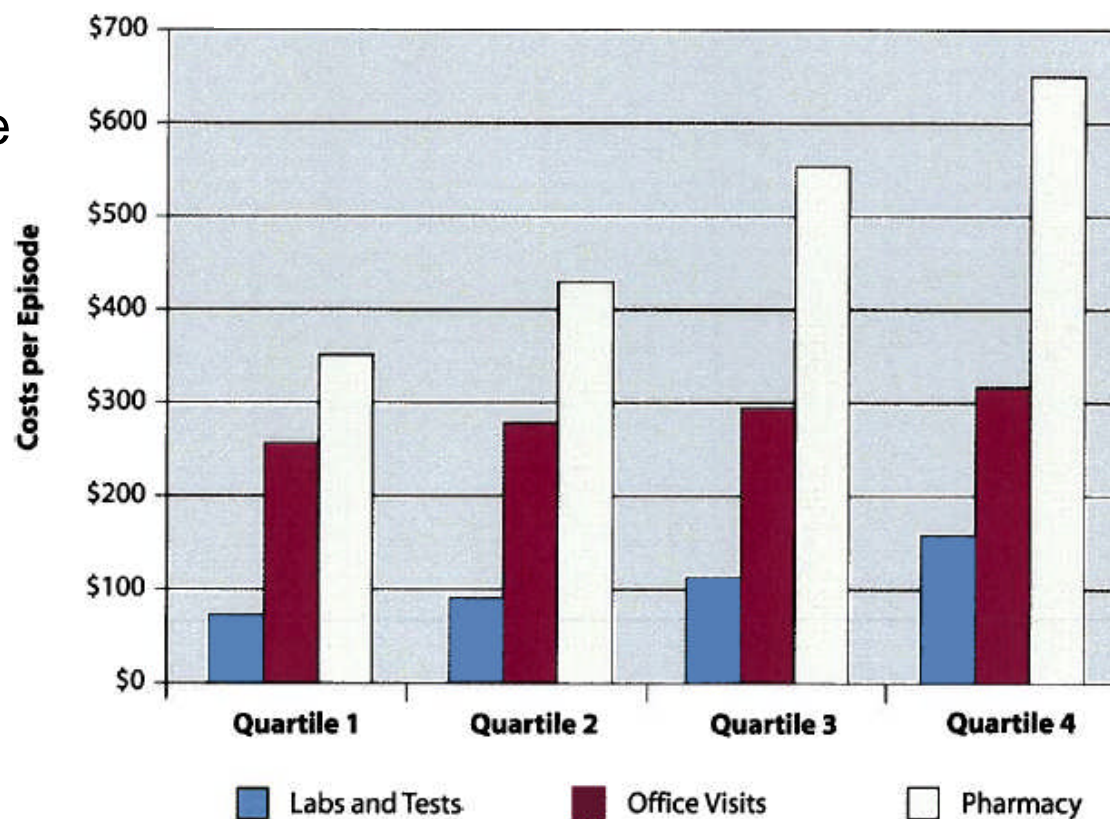
**FSP: Abdominal & Vaginal Hysterectomy
(BCBSMA, 2005-2007)**



Practice Pattern Variation Analysis (PPVA)

Unpacking differences in the treatment components of specific episodes across clinicians in a single, defined medical specialty

The results are highly actionable because they get to the root of variations in treatment costs for a defined and highly-specific clinical circumstance among physicians of the same specialty



Source: Greene RA, et al. *Health Affairs* 2008; w250-259

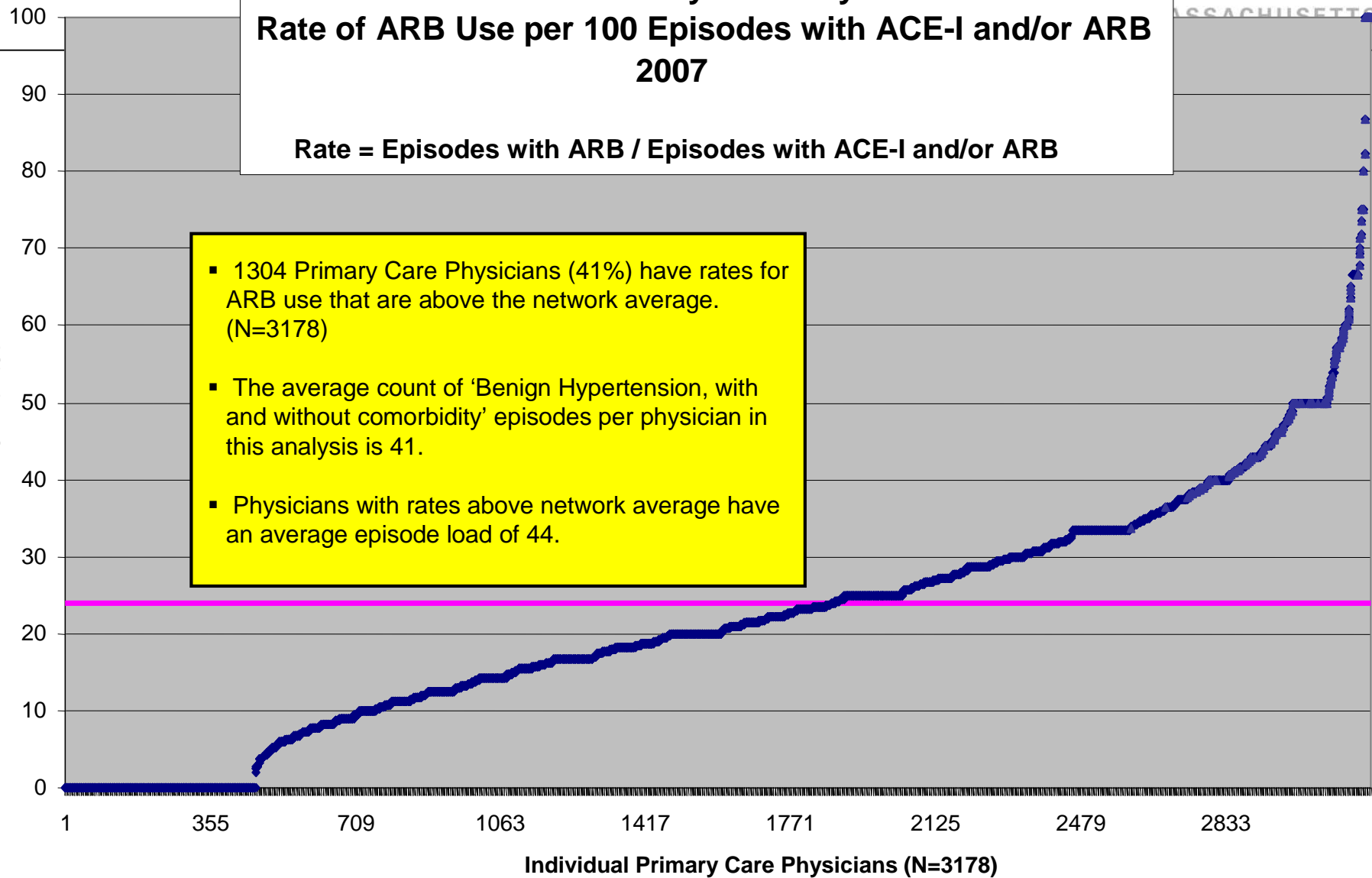
Benign Hypertension, With and Without Comorbidity Individual Primary Care Physicians Rate of ARB Use per 100 Episodes with ACE-I and/or ARB 2007



Rate = Episodes with ARB / Episodes with ACE-I and/or ARB

Rate of Arb Use per 100 Episodes
with ACE-I and/or ARB

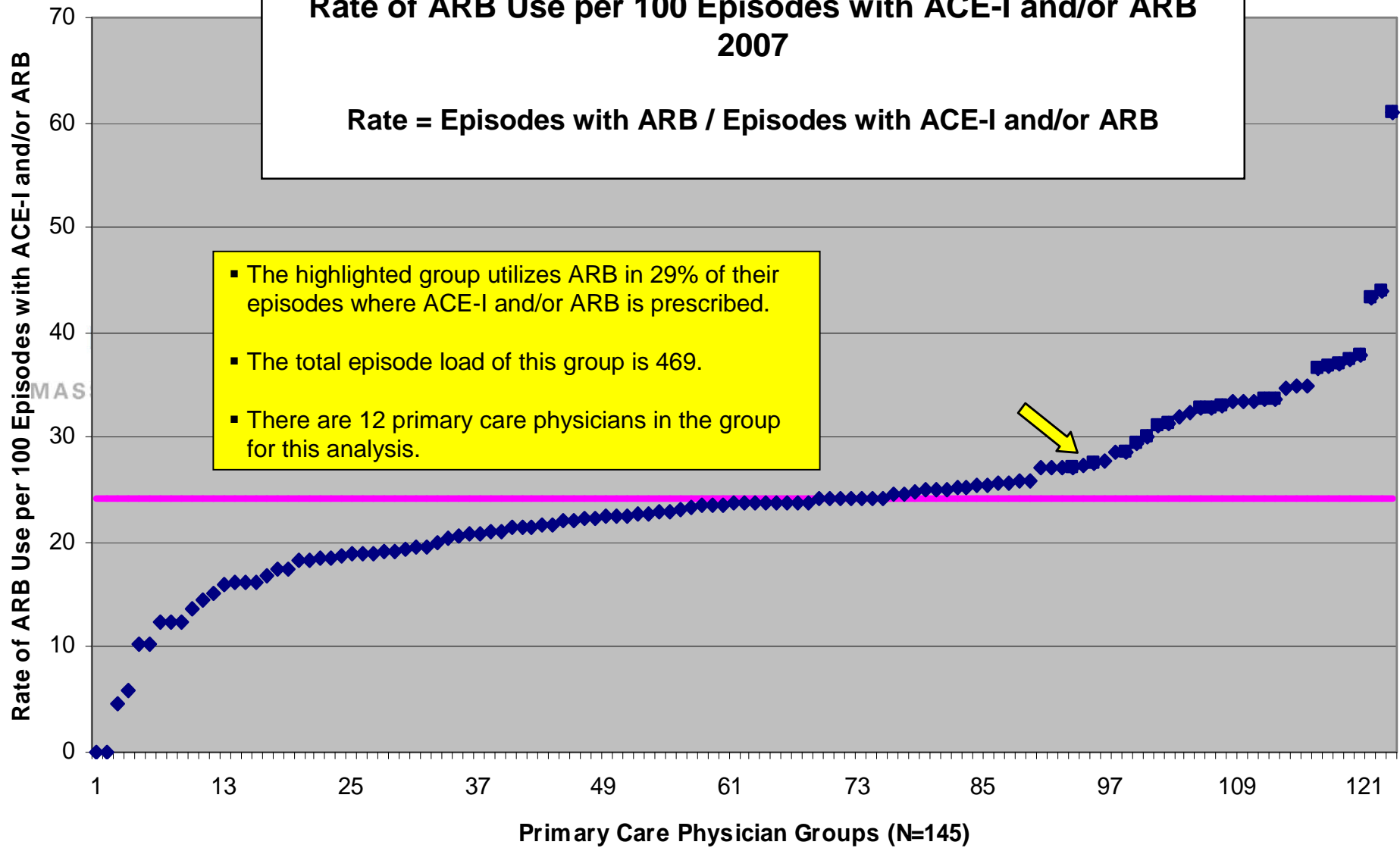
- 1304 Primary Care Physicians (41%) have rates for ARB use that are above the network average. (N=3178)
- The average count of 'Benign Hypertension, with and without comorbidity' episodes per physician in this analysis is 41.
- Physicians with rates above network average have an average episode load of 44.



Benign Hypertension, With and Without Comorbidity Primary Care Physicians by Group Rate of ARB Use per 100 Episodes with ACE-I and/or ARB 2007

$$\text{Rate} = \text{Episodes with ARB} / \text{Episodes with ACE-I and/or ARB}$$

- The highlighted group utilizes ARB in 29% of their episodes where ACE-I and/or ARB is prescribed.
- The total episode load of this group is 469.
- There are 12 primary care physicians in the group for this analysis.

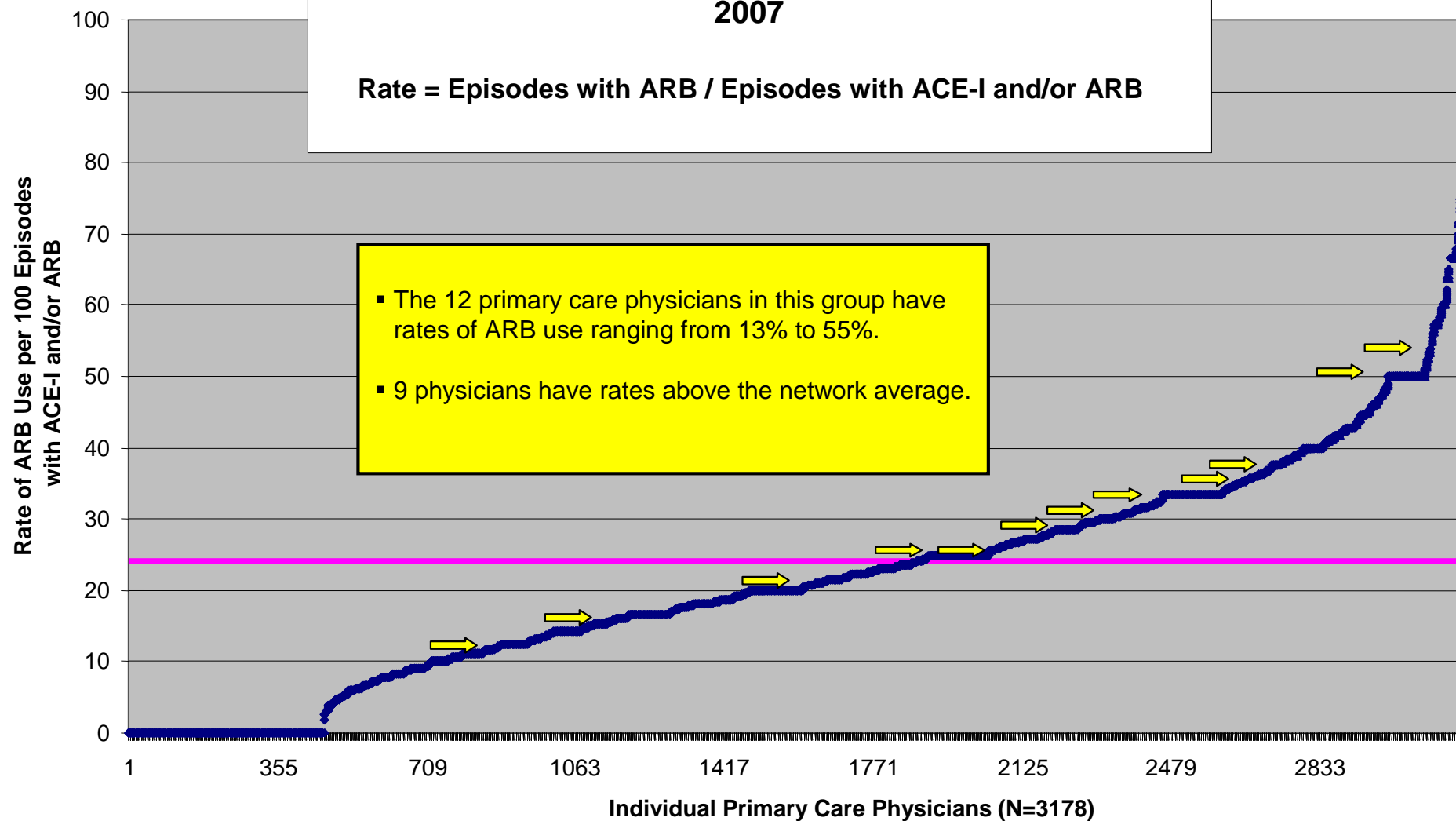




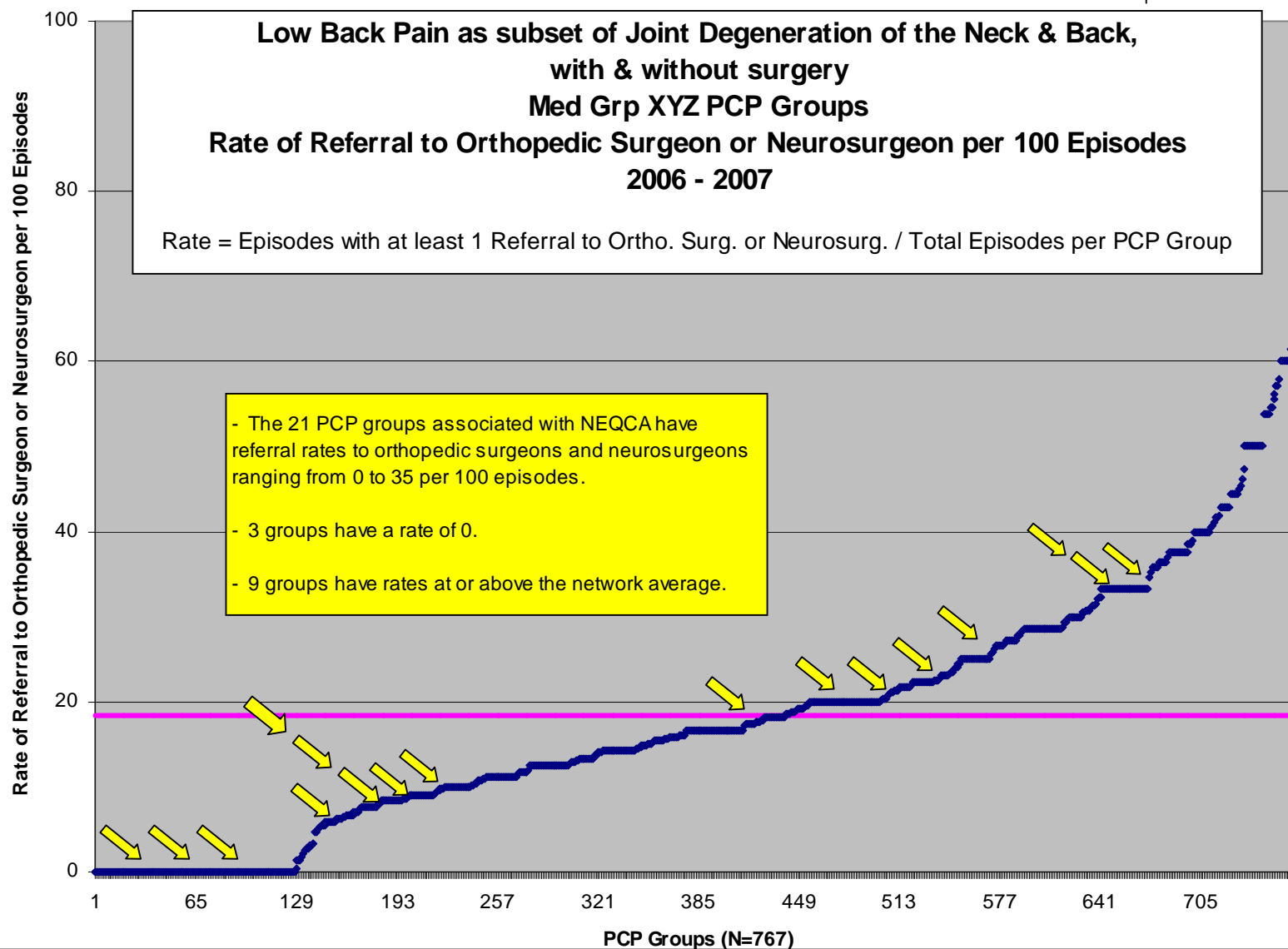
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**Benign Hypertension, With and Without Comorbidity
Individual Primary Care Physicians
Rate of ARB Use per 100 Episodes with ACE-I and/or ARB
2007**

Rate = Episodes with ARB / Episodes with ACE-I and/or ARB



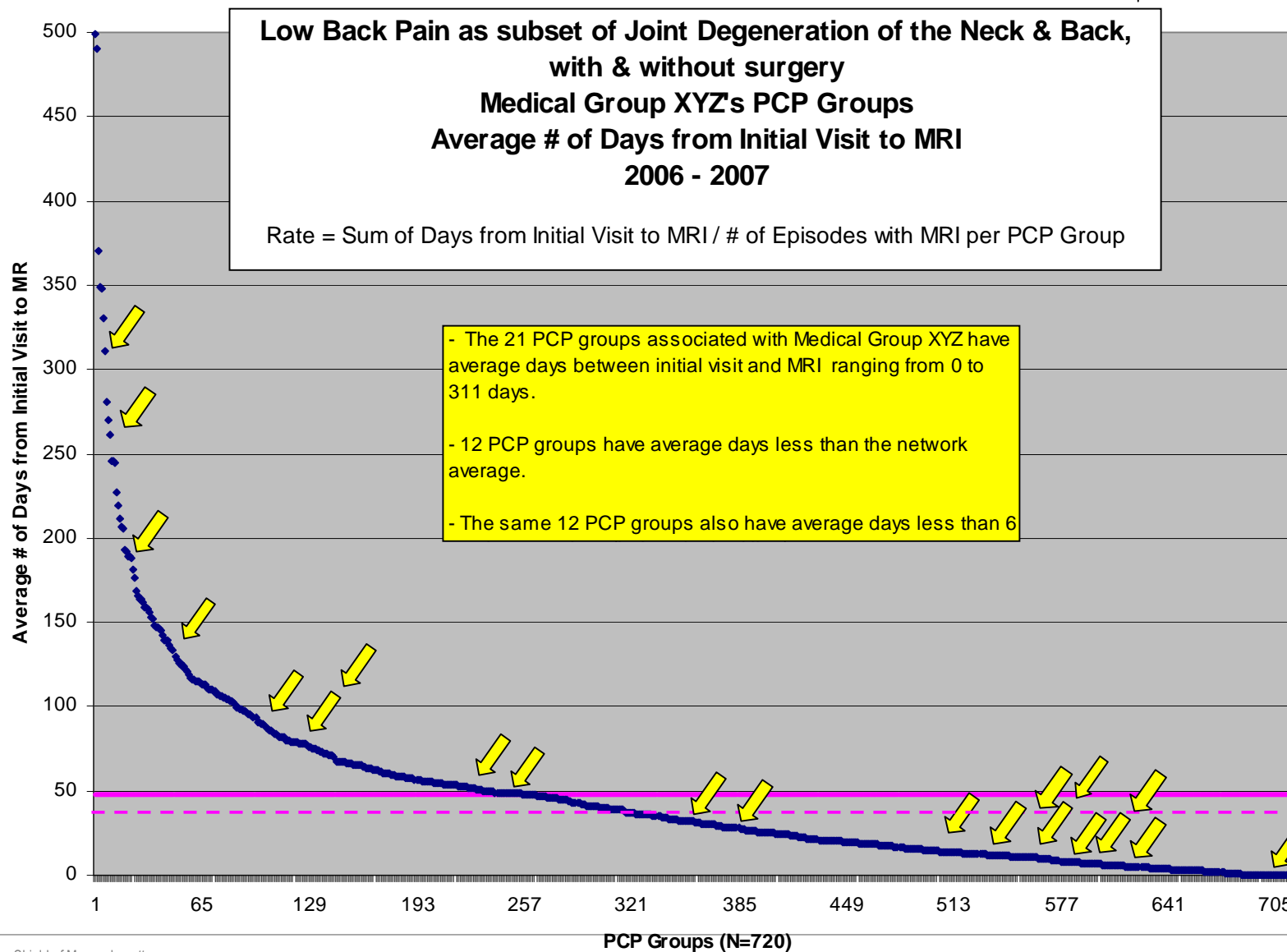
Variations in PCP Referral for Low Back Pain



Variations in Days-to-MRI for Low Back Pain



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Select PPVA Topics Provided to AQC Groups



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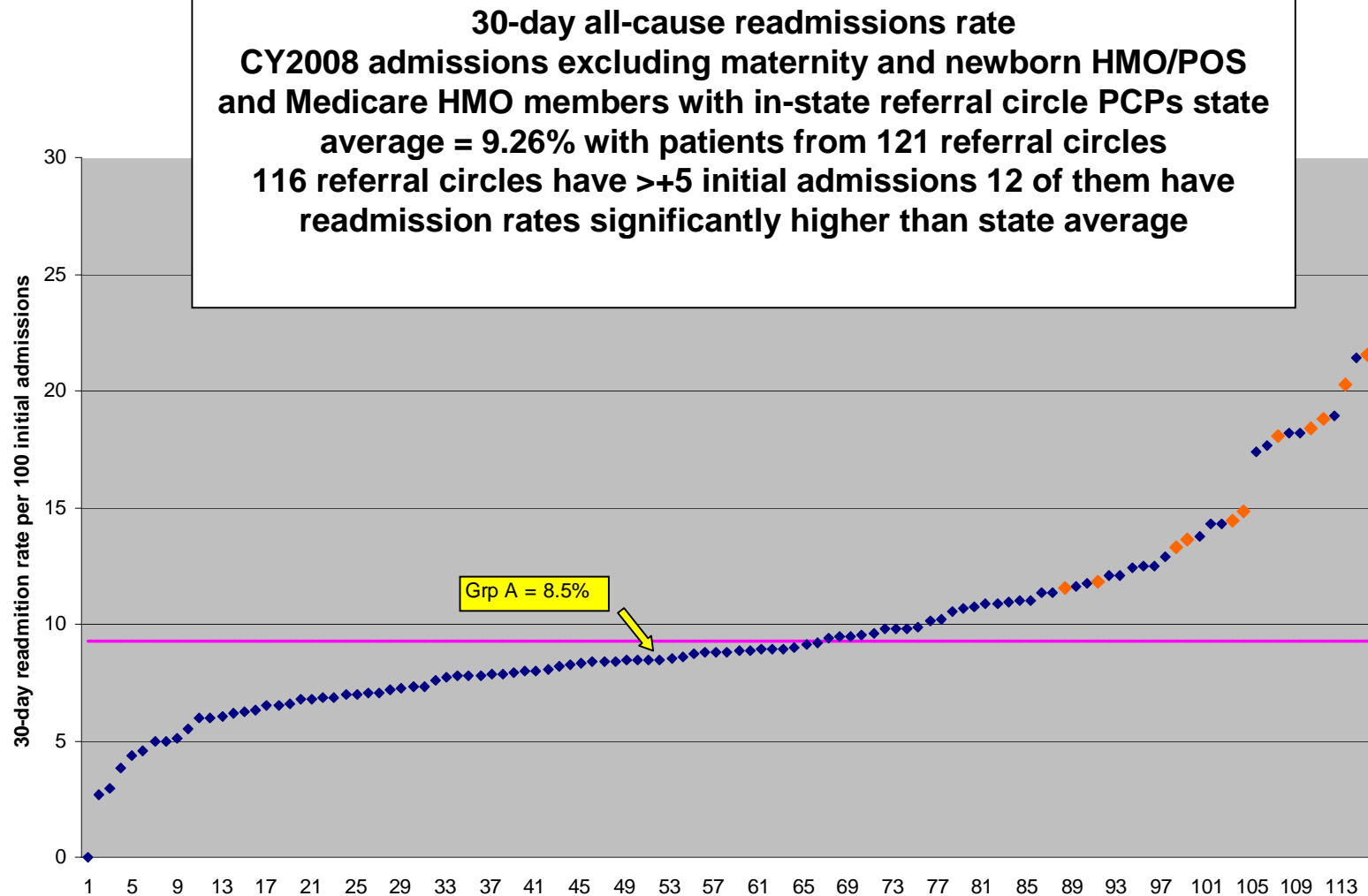
Condition	Primary Drivers of Variation			
	Rx	Imaging	Specialty Referral	Procedure
Hyperlipidemia	X		X	
Benign Hypertension	X	X	X	
Inflammation of Esophagus			X	X
Joint Degeneration of Knee			X	X
Depression	X			
Migraine	X	X	X	
Inflammation of Skin	X		X	X
CAD, Ischemic Heart Disease (except CHF, w/o AMI)	X	X	X	X
Sinusitis (Acute & Chronic), Allergic Rhinitis	X		X	X
Arthritis	X		X	
Low Back Pain	X	X	X	X

Avoidable Use of Hospital Resources
Ambulatory Care Sensitive Admissions
Non-Urgent Emergency Department Utilization
30 Day All-cause Readmissions

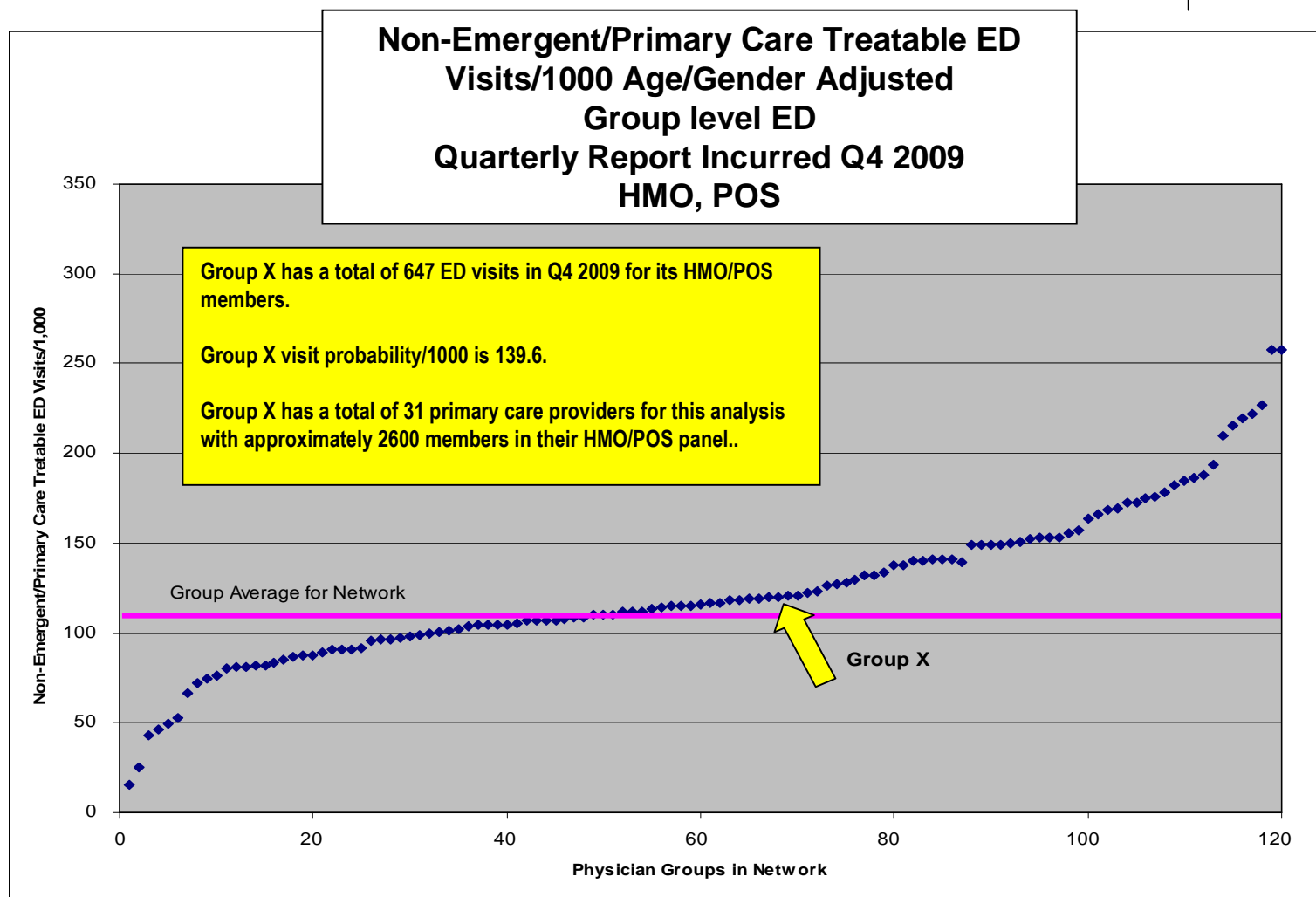
Variation in 30-Day Readmission Rates by PCP Group



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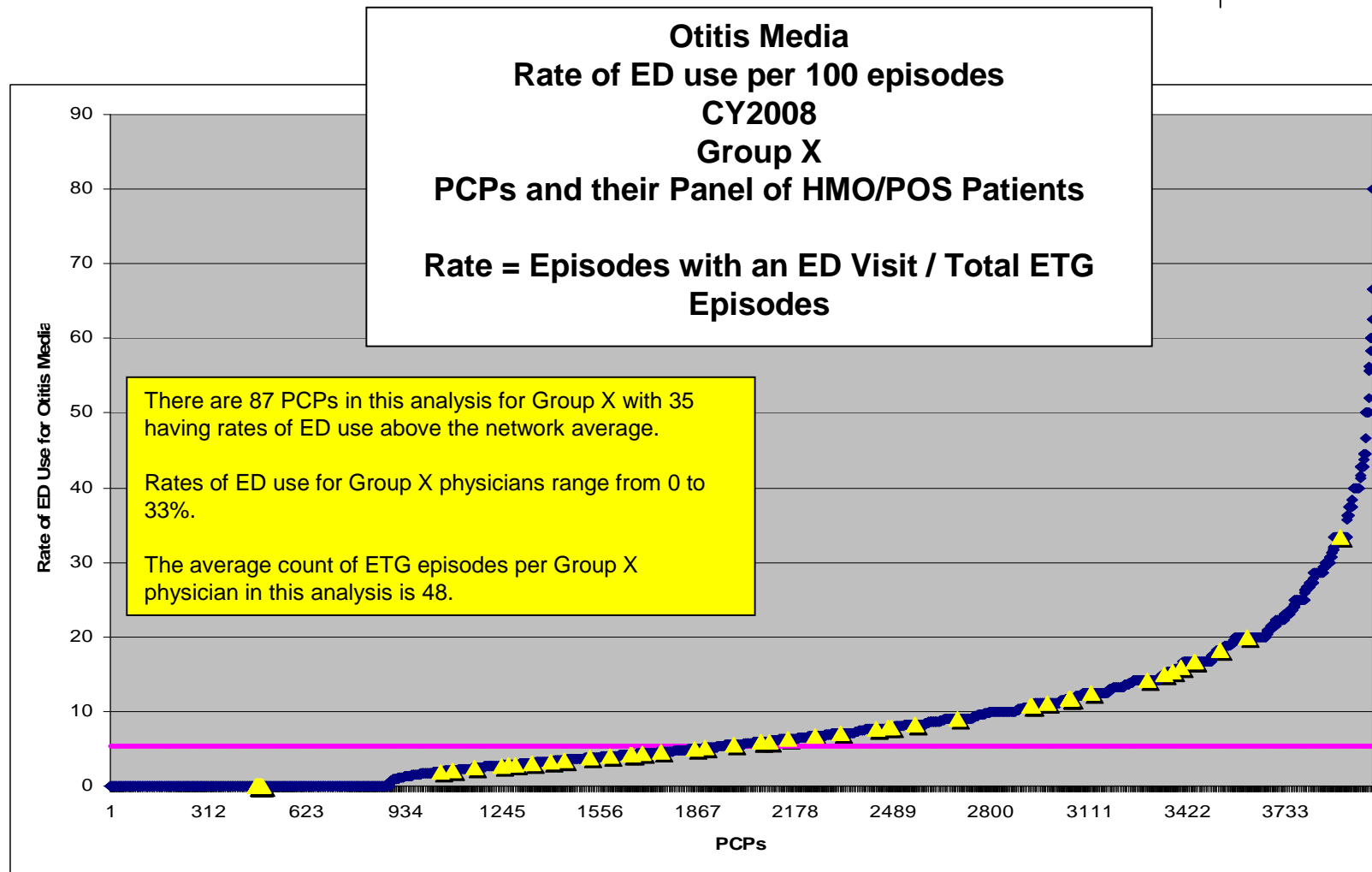
Variation in Non-Emergent ED Visit Rate by PCP Group





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Within-Group Variation in ED Visits for Otitis Media



- Without measurement, we don't know where we are on the journey
- But imprecise measurement used in “high stakes” ways undermines our collective efforts
- Rapid and substantial performance improvement appears to follow when the stage is set with:
 - Substantial financial incentives for improvement on measures that are well accepted, widely validated and clinically important
 - Ongoing and timely data to inform improvement efforts
 - Organizational structure and leadership commitment to the goals
- Under a payment model that creates accountability for resource use (e.g., global budget), cost and efficiency measures do not need to meet criteria for “high stakes” use.
 - Incentives for improvement on this domain is built into the payment model
 - Measurement is needed to support accountability and success – but not for high stakes
- Clinically-specific, specialty-specific approach to displaying practice pattern variations appears powerful to engaging physician leaders and front line in (passionately) addressing clinical waste.

For More Information



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Doctor and the Doll by Norman Rockwell

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