Integrated Healthcare Association

Innovation through Collaboration

Data Brief

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Using Value Based P4P Results to Target Performance Improvement

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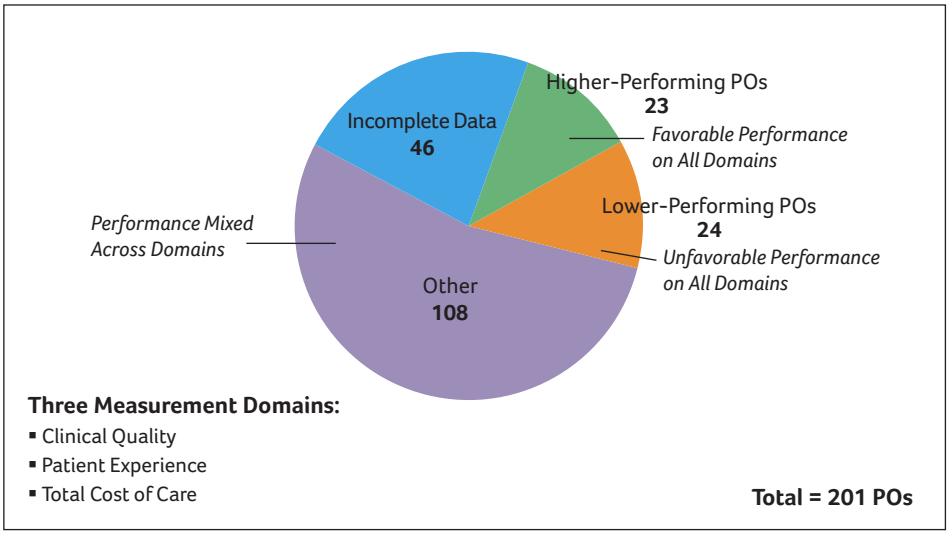
As public and private payers increasingly move toward value-based payment methods that better align provider incentives to deliver high-quality, affordable, patient-centered care, it is necessary but insufficient to hold providers accountable for the quality and cost of care. An equally important component of scaling the triple aim of better care, better health, and smarter spending is assisting lower-performing providers to improve.

Through the California Value Based Pay for Performance (VBP4P) program, the Integrated Healthcare Association (IHA) recognizes physician organizations (POs) that perform in the top 50 percent in all three major VBP4P measurement domains: higher clinical quality, better patient experience, and lower total cost of care. In a new analysis, IHA compares and contrasts these Excellence in Healthcare Award winners with their counterparts at the other end of the performance spectrum—POs performing in the lower half of the distribution on all three measure domains (see Data Source).

Exhibit 1: Value Based P4P Physician Organization (PO) Performance by the Numbers



Source: Integrated Healthcare Association

Setting the Performance Bar

The IHA VBP4P program aligns performance measures, incentives, and public reporting across 10 health plans and 200-plus POs caring for more than 9 million Californians enrolled in commercial health maintenance organization (HMO) and point of service (POS) products. People cared for by VBP4P-participating POs and health plans represent more than 95 percent of the commercial enrollment in California HMO/POS products, which typically outperform commercial preferred provider organization (PPO) products on both clinical quality and cost measures, according to the *California Regional Health Care Cost & Quality Atlas*.

Put simply, even lower-performing physician organizations caring for HMO/POS patients and participating in VBP4P are likely outperforming their PPO counterparts. And their very participation in VBP4P puts them on a path to better performance supported by feedback and tools to focus on where improvement is needed.

Of the 201 POs participating in measurement year (MY) 2014 VBP4P, 155 had data across all three major measurement domains: clinical quality, patient experience, and total cost of care. Using the median performance of all POs to set the bar, the 24 POs with performance unfavorable to the median on all three measure domains were classified as lower performing, while the 23 POs with performance equal to or favorable to the median on all three measure domains were classified as higher performing (see Exhibit 1). The remaining POs (108) were classified as "Other," meaning their performance varied across the measurement domains—for example, a PO might perform above the median on clinical quality, below the median on patient experience, and above the median on total cost of care where lower is better.

About a quarter of POs (46) were classified as "Incomplete Data" because they lack data for one or more measure domains—15 POs were missing data for both patient experience and clinical quality, 30 for patient experience only, and one for clinical quality

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only; all POs had data for total cost of care. The main reason for missing patient experience and clinical quality data was PO size—too few patient surveys completed or too few patients qualifying for a clinical measure to generate valid results.

Variation in Physician Organization Performance

Exhibit 2 shows the variation in average performance between lower- and higher-performing physician organizations in each measurement area. Patient experience performance varies less than clinical quality and total cost of care (TCC) performance: There is a difference of more than 16 percentage points between the average clinical achievement scores of the higher and lower performers, while the difference in average patient experience scores for the two cohorts is much smaller—less than 7 percentage points. Average TCC varies by $857 between the two cohorts; the average TCC for the lower-performing POs is about 20 percent higher than for the higher-performing POs.

Combining Clinical Quality, Patient Experience, and Cost Performance

Exhibit 3 shows the distribution of all 155 physician organizations with complete data, using the intersection of the median of patient experience scores and the median of clinical achievement scores to create quadrants. An additional cost dimension is added for the lower-performing and higher-performing POs as indicated, respectively, by orange and green triangles.

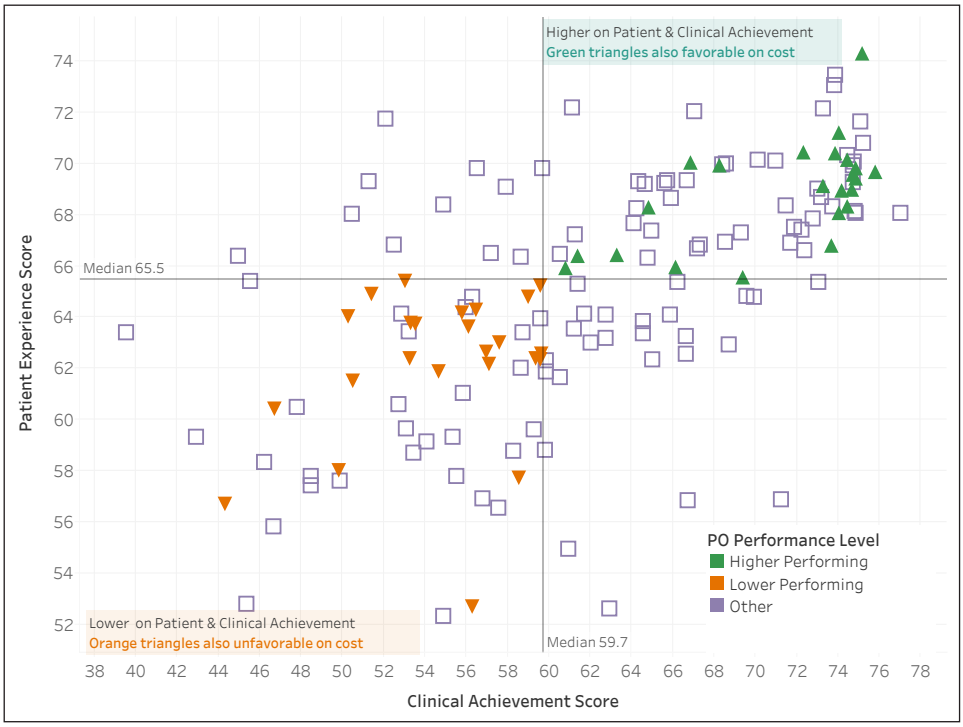
Of note, cost is not associated with either clinical quality or patient experience. Not all POs with lower performance on clinical quality and patient experience are high cost. And, conversely, many POs that perform well on clinical quality and patient experience are not lower cost. Some lower-performing POs are close

Exhibit 2: Physician Organizations (POs), by Performance Level

Measure Name	All POs	POs with Complete Data (Valid Data in All Three Domains)	Lower-Performing POs*	Higher-Performing POs**	Other POs
Clinical Achievement Score (median = 59.7)					
Average Score	59.6	62.5	54.7	71.1	62.4
Number of POs	185	155	24	23	108
Patient Experience Score (median = 65.5)					
Average Score	65.1	65.0	62.1	68.9	64.9
Number of POs	156	155	24	23	108
Total Cost of Care (median = $3,915) (risk and geography adjusted)					
Average	$3,918	$3,960	$4,277	$3,420	$4,004
Number of POs	201	155	24	23	108

*Below the median for clinical achievement score and patient experience score; above the median for total cost of care.
**Above or equal to the median for clinical achievement score and patient experience score; below the median for total cost of care.
Source: Integrated Healthcare Association.

Exhibit 3: Overlaying Lower- and Higher-Performing Physician Organizations (POs) Relative to 108 Other POs with Complete Data, by Clinical Quality and Patient Experience Performance



Note: Reflects all 155 POs with data available on all three measure domains: clinical quality, patient experience, and total cost of care (adjusted for risk and geography).
Source: Integrated Healthcare Association.

to being on the favorable side of the medians, but others would need to improve their performance substantially.

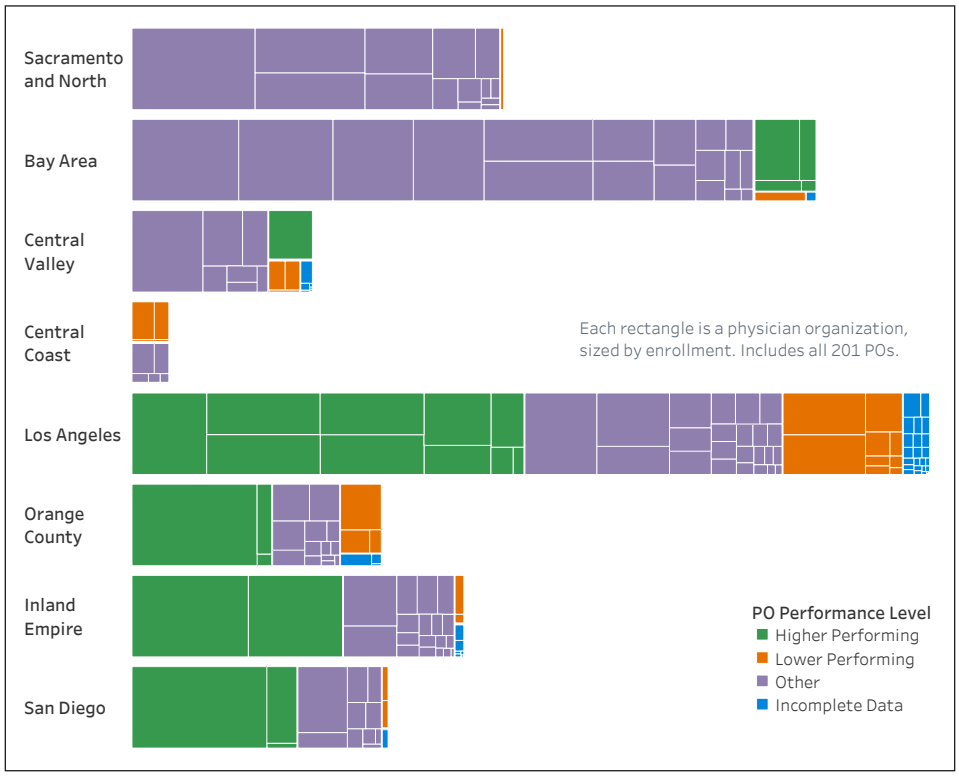
Geographic Variation

Statewide, 7.2 percent of commercial HMO/POS enrollment, or about 600,000 people, are served by lower-performing physician organizations. Across California, as shown in Exhibit 4, the Central Coast region stands out with the highest share of lower-performing POs and the highest share of enrollment served by lower-performing POs. One-third of POs (3 of 9) in the Central Coast region were lower performing vs. 12 percent statewide. Similarly, half of the Central Coast region's HMO/POS enrollment (almost 56,000 people) is served by lower-performing POs vs. 7 percent statewide.

Almost 350,000 people in Los Angeles are served by lower-performing POs. Los Angeles also has the largest number of lower-performing POs (9), representing 13 percent of the region's POs, a similar proportion to the state. The region has a large number of POs relative to enrollment; statewide most POs with incomplete data are small and based in Los Angeles. Although the Los Angeles region has lower median costs than most regions, cost varies widely there; as a result, this relatively low-cost area has both many lower-performing and many higher-performing POs.

Both the Bay Area and Sacramento/North regions had only one lower-performing PO, with about 1 percent of the enrolled regional HMO/POS population in

Exhibit 4: Physician Organization (PO) Performance Level and Size, by Region



Note: One blue PO rectangle in Central Coast is not visible due to its small size.
Source: Integrated Healthcare Association.

Data Source

This data brief is based on the Integrated Healthcare Association Value Based Pay for Performance (VBP4P) program data for California physician organizations (POs) in measurement year 2014. The analysis included 201 POs and identified a lower- and higher-performing cohort of POs across the three major VBP4P measurement domains: clinical quality, patient experience, and total cost of care.

Domain Measurements: A broadly representative measure was selected to represent each domain:

- **Clinical Quality**—This domain is represented by a composite of all clinical measures recommended for VBP4P payment, the Clinical Achievement Score. See Exhibit 5 for a list of the 21 clinical measures reflected in this composite score.
- **Patient Experience**—This domain is represented by a composite of all patient experience measures recommended for payment, the Patient Experience Score. This composite includes the following measures from the annual Patient Assessment Survey, administered by the California Healthcare Performance Information System: Doctor-Patient Interaction, Timely Care and Service, Coordination of Care, Office Staff, Health Promotion, and Overall Rating of Care.
- **Total Cost of Care (TCC)**—This domain is represented by average cost per enrollee per year, adjusted for both risk and geography. TCC reflects actual payments for each enrollee's care, including professional, pharmacy, hospital, ancillary, and enrollee cost-sharing. Costs above $100,000 per enrollee are truncated.

Median Thresholds: For each domain measurement, POs were categorized as either favorable to the median (equal to or better) or unfavorable. Medians reflect all 201 POs. Note that TCC is reverse scored such that favorable to the median translates to equal to or below.

Designation of Lower- and Higher-Performing Cohorts: POs were classified as lower performing if they were unfavorable to the median on all three domain measures, with 24 POs grouped in this cohort. POs were classified as higher performing if they were equal to or favorable to the median on all three domain measures, with 23 POs grouped in this cohort.

each region being served by lower-performing POs. The Bay Area had four higher-performing POs, while Sacramento had none.

Variation in Clinical Quality Measures by Performance Level

Exhibit 5 includes 21 clinical measures used in IHA's VBP4P program. These 21 clinical measures are the inputs to the composite clinical achievement score, one of the three measurement domains used to categorize physician organizations as higher and lower performing.

The measures encompass a range of clinical priorities, from preventive measures, such as cancer screening and vaccination, to chronic illness management, such as blood sugar control in diabetics, to the appropriate use of services, such as use of imaging studies for low back pain. For some measures, such as Diabetes Care: HbA1c Control < 7.0% and Proportion of Days Covered by Medications, there is very little difference in performance between lower- and higher-performing

Exhibit 5: VBP4P Clinical Measures: Average Physician Organization (PO) Rates by Performance Level

Clinical Category	Clinical Measures	All POs with results		PO by Performance Level	
		No. of POs	Score	Score for Lower-Performing POs	Score for Higher-Performing POs
Cardiovascular	Proportion of Days Covered by Medications: RAS Antagonists	190	67.4	62.2	73.8
	Proportion of Days Covered by Medications: Statins	188	60.5	62.4	67.2
Diabetes	Proportion of Days Covered by Medications: Oral Diabetes Medications	184	62.6	63.9	68.0
	Diabetes Care: Blood Pressure Control <140/90 mm Hg	187	43.6	21.4	76.1
	Diabetes Care: HbA1c Control < 7.0%	185	35.3	36.1	40.0
	Diabetes Care: HbA1c Control < 8.0%	187	54.8	54.1	64.1
	Diabetes Care: HbA1c Poor Control >9.0%	187	34.5	36.1	23.6
	Diabetes Care: HbA1c Testing	187	87.4	84.1	92.7
	Diabetes Care: Medical Attention for Nephropathy	187	84.9	83.3	90.4
Musculoskeletal	Use of Imaging Studies for Low Back Pain	161	81.5	76.6	86.9
Prevention & Screening	Breast Cancer Screening	186	75.5	71.7	85.9
	Chlamydia Screening	173	53.6	47.7	65.2
	Childhood Immunization Status: Combination 3	117	66.0	36.7	84.7
	Colorectal Cancer Screening	192	59.4	57.1	74.3
	Evidence-Based Cervical Cancer Screening—Appropriately Screened	189	52.9	42.8	73.1
	Human Papillomavirus Vaccine for Female Adolescents	128	22.5	17.6	28.0
	Human Papillomavirus Vaccine for Male Adolescents	130	16.2	12.0	21.5
	Immunizations for Adolescents: TD/Tdap	149	79.1	70.4	88.2
Respiratory	Asthma Medication Ratio	119	79.9	75.7	83.8
	Appropriate Testing for Children with Pharyngitis	109	74.8	50.5	91.5
	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	150	51.4	44.2	63.0

Source: Integrated Healthcare Association.

POs. However, other measures show large performance gaps between the lower- and higher-performing POs—for example, a 55-percentage-point difference for Diabetes Care: Blood Pressure Control <140/90 mm Hg. Some of this difference may be due to data collection and reporting challenges rather than performance.

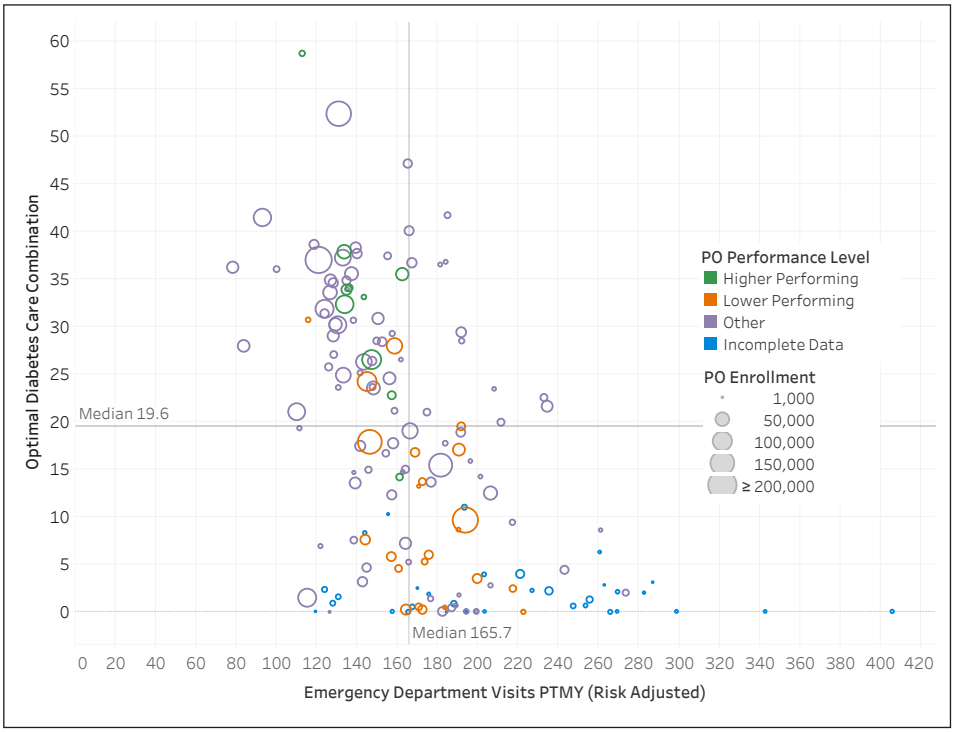
A Connection to Explore: Diabetes Care and Emergency Department Visits

The optimal diabetes care combined measure includes four diabetes care measures (blood pressure control <140/90 mm Hg; HbA1c control < 8.0%; medical attention for nephropathy; and two HbA1c tests) and reflects the percent of people with diabetes who met all of these four clinical care guidelines. For lower-performing POs, only 9.8 percent of their patients met all four guidelines, compared to 36.8 percent for higher-performing POs. This represents a substantial opportunity for improvement.

Further, an analysis of the VBP4P MY 2014 data shows an association between diabetes care and emergency department (ED) visit rates (see Exhibit 6). Performance on the optimal diabetes care measure is negatively correlated with ED rates (r = -.53), meaning that higher scores on diabetes care and lower ED visit rates tend to be present in the same POs. The reverse is true as well—lower scores on diabetes care occur with higher ED visit rates.

Because diabetes is a major chronic health condition in the U.S., this finding is compelling. From a clinical perspective, the association between diabetes care and ED visits is plausible and worthy of additional monitoring and exploration over time and across different populations to see if it is sustained. In the exhibit, PO size is reflected by the size of the bubble. As can be seen, POs with lower performance on diabetes care and higher ED use tend to be smaller in size.

Exhibit 6: Relationship Between Optimal Diabetes Care and Emergency Department Visits, by Physician Organization (PO)



Note: PTMY = per thousand member years.
Source: Integrated Healthcare Association.

Implications

There are significant opportunities to target performance improvement efforts by using VBP4P results to identify POs that do not perform well on certain combinations of measures. This analysis identified POs with performance unfavorable to the median on all three VBP4P measurement domains of clinical quality, patient experience, and total cost of care. A particularly large opportunity to improve performance related to the triple aim goal of better care, better health, and smarter spending exists in the Central Coast and Los Angeles regions, where about two-thirds of the 600,000 Californians served by lower-performing POs live.

Analyzing physician organization performance on other combinations of measures can reveal other clinical areas and geographic regions with performance improvement opportunities. Identifying where performance lags through these types of analyses can help POs, health plans, purchasers, policymakers, and performance improvement organizations know where to focus intervention efforts.

Acknowledgments

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