

## Assessing a pay-for-performance model

Clinicians can't bill the government for a phone call to a Medicare or Medicaid patient and so have little incentive to use the phone for follow-up. But what if a call encourages a diabetic to stick to his diet, or a patient with heart disease to continue her beta-blocker therapy? Such a phone call might prevent a costly hospitalization, thereby saving the government thousands of dollars—not to mention providing better care to the patient. The Centers for Medicare and Medicaid Services (CMS) are trying to address this flaw in their payment system with a new demonstration project, called the “pay-for-performance” initiative.

The Dartmouth-Hitchcock network was one of 10 physician groups nationwide selected to participate in the three-year trial—the second CMS demonstration project Dartmouth is involved in this year. But unlike the \$5-million project on informed decision-making (see page 5), this CMS trial doesn't come with money up front.

Currently, CMS reimburses physicians, clinics, and hospitals based on the number and complexity of services they provide to Medicare and Medicaid patients. Under the system being tested in this trial, CMS will compare the total cost of care for the 20,000 Medicare patients who primarily use the Dartmouth-Hitchcock physician network to the cost of care for other similar patients in the region. CMS will also assess the quality of care delivered by each participating group, using 32 measures of common chronic illnesses and preventive services.

**Bonus:** If Dartmouth-Hitchcock provides high-quality care that's less expensive than that of its competitors, CMS will pay the network a bonus based on both the cost savings and the quality of care. In year one, bonuses will be based 70% on cost savings and 30% on quality; in year two, 60% on savings, 40% on quality; and in year three, savings and quality will be equally weighted.

For nonprofit physician groups like Dart-

mouth-Hitchcock, “the thought is that with the extra money that you make, you can invest in your care system to provide those services that you don't get direct reimbursement for,” says Barbara Walters, D.O., senior medical director for DHMC. Such services include information technology, disease registries, and enhanced nursing care.

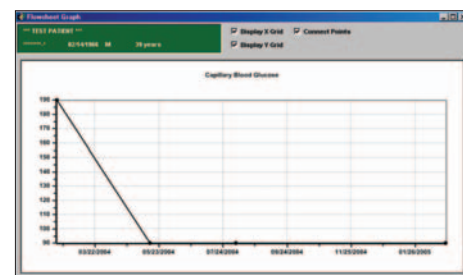
Many physicians are skeptical of the new payment model because of its emphasis on cutting costs. “If the program is focused on quality, one would expect to see a greater percentage of the [payment pool] across all three years based on quality,” said John Armstrong, M.D., a trustee of the American Medical Association (AMA) in an AMA newsletter. “The upfront expense of providing more preventative care has the potential to save money over the long run by avoiding costly treatments years down the road,” the AMA article went on, “but the project's three-year span might not be long enough to register this.”

Yet whether or not the initiative saves money, improving the coordination of care “is the right thing to do clinically,” says Walters. “It's what we should all be attempting to do—all physicians.” The trial, she adds, is “certainly better than the incentives that we have without this kind of a system.”

**Leader:** Measuring and improving the quality of care has been a focus for DHMC since the late 1970s, when the organization emerged as a leader in medical outcomes research. Now, for the first time, Dartmouth-Hitchcock and the other groups participating in the initiative—such as the Geisinger Health System in Pennsylvania and the University of Michigan Faculty Group Practice—will be compensated by CMS for providing better care, not just more care.

As part of the CMS initiative, Dartmouth-Hitchcock is about to roll out a new software program for managing diabetic patients. It was created by John Butterly, M.D., vice chair of the Department of Medicine; several other clinicians; and Debra Dulac,

| Date Charted        | 02/24/2004<br>11:01 AM | 03/02/2004<br>12:26 PM | 03/14/2004<br>2:14 PM | 03/14/2004<br>12:51 PM |
|---------------------|------------------------|------------------------|-----------------------|------------------------|
| Type                | Type 1 controlled      | Type 1 controlled      | Type 1 controlled     | Type 1 controlled      |
| Date of Diagnosis   | 03/03/2004             | 03/03/2004             | 03/03/2004            | 03/03/2004             |
| Hemoglobin A1c      | 8.7                    | 8.7                    | 8.7                   | 8.7                    |
| Systolic BP         | 128                    | 132                    | 128                   | 132                    |
| Diastolic BP        | 80                     | 80                     | 80                    | 80                     |
| Weight (kg)         | 72                     | 72                     | 72                    | 72                     |
| Weight (lb)         | 158                    | 158                    | 158                   | 158                    |
| HbA1c (paper)       | 25.27                  | 28.84                  | 28.84                 | 32.05                  |
| Cholesterol (mg/dl) | 88                     | 96                     | 96                    | 100                    |
| Comment             | pre-procedure          |                        |                       |                        |



Dartmouth-Hitchcock is part of a federal project to see if software like this can improve care and save money.

R.N., director of the Clinical Information System (CIS). It puts all the clinical information about a diabetic patient in one location—instead of scattered among a multitude of forms and electronic repositories. The concept sounds simple, but it's actually rare among health-care systems.

**Data:** “It's extremely unique,” says Dulac, because of the breadth of disease-specific information it contains. The program includes everything from lab-test results to dietary instructions to health goals for the patient. Any data can be graphed and printed so patients can take it home. And, because it runs on CIS, more than 6,000 clinicians at all Dartmouth-Hitchcock locations, not just DHMC in Lebanon, can make use of the tool.

The diabetes initiative jibes nicely with CMS's own description of the pay-for-performance initiative: “Physician groups will use a variety of care-management strategies to improve care under the demonstration. These include increased use of disease-management and case-management services . . . electronic medical records, disease registries, and evidence-based guidelines.”

Determining best practices and spreading those practices in a coordinated way is “what we're really trying to do,” explains Walters. “Best practices decrease variation. Decreased variation decreases waste. Decreased waste saves money.”

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