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Integrated Resources for the Middlesex Area, LLC Physician Group Practice Demonstration

Site Visit Final Report

Prepared for

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EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) initiated The Physician Group Practice (PGP) Demonstration in April 2005. This 3-year demonstration offers participating PGPs the opportunity to earn bonuses for improving the efficiency and quality of care delivered to Medicare fee-for-service (FFS) beneficiaries. Ten large PGPs are participating in the demonstration.

CMS contracted with RTI International, an independent, nonprofit research organization, to evaluate the PGP Demonstration. As part of its evaluation, RTI is conducting site visits at each of the 10 PGPs participating in the demonstration in the winter of 2005-2006. The purpose of these site visits is to understand the decisions of the PGPs to participate in the demonstration and their early implementation and operational experience with the demonstration. This report contains findings for Integrated Resources of the Middlesex Area, LLC (IRMA).

IRMA is a subsidiary of the Middlesex Health System (MHS). The largest component of MHS is the Middlesex Hospital, a general acute care 275 bed hospital. The hospital generates from 65 to 70 percent of its revenues from outpatient services. Other major components of MHS (in addition to Middlesex Hospital and IRMA) are: Middlesex Health Services, which operates an assisted living facility; a primary care physician group; and a real estate management company. MHS, through its subsidiaries, comprises 15 service lines in 24 community locations. These include: three emergency departments; outpatient surgery; an assisted living facility; home care; a family practice residency program; outpatient behavioral health care, including partial hospitalization and day programs; a family advocacy program; and community medicine.

There is an independent practice association (IPA) called Middlesex Professional Services (MPS) [1] that represents the physicians affiliated with Middlesex Hospital for contracting purposes. IRMA coordinates initiatives between MPS physicians and the hospital. Some physician offices are located in MHS facilities, although most practice in their own private offices.

Demonstration Participation and Strategy. IRMA is attempting to stay at the forefront of the pay-for-performance (P4P) movement among physician group networks (as opposed to what more tightly integrated delivery systems can manage)—IRMA believes that payers will demand increased collection of quality data from physicians and will use those data to vary payments in payer-specific P4P programs. IRMA had participated in P4P programs with some private payers. Participating in the Medicare PGP Demonstration is also seen as a strategic move to accustom physicians to P4P programs, and also to influence the design of quality measure standard.

IRMA's overarching strategy for the PGP Demonstration is disease management and improved coordination of care for patients with chronic conditions or otherwise having multiple comorbid conditions. This part of the strategy relies on expanding existing disease management programs to include Medicare patients and creating new programs. The most significant existing

[1] Throughout this report we use the terms "MPS physicians" and "IRMA physicians" interchangeably.

program that is being expanded is the diabetes care management program. New programs include disease management for congestive heart failure (CHF) and for specific cancers.

Patient Care Interventions. IRMA's goal is to reduce hospitalizations and readmissions and to improve post-admission care. The interventions that IRMA is using to realize this goal include disease management programs for diabetes, asthma, and CHF; implementing evidence-based practice standards for cancer patients; and improved care coordination and remote monitoring for frail elderly patients with multiple comorbid medical conditions. With the exception of the CHF and cancer disease management programs, these programs existed prior to the PGP Demonstration. IRMA is expanding many of these programs under the PGP Demonstration.

One new program created specifically for the PGP Demonstration is the CHF disease management program, the goal of which is to reduce hospital readmission rates through improved self-management and compliance with follow-up care. Patients are identified for inclusion in this program when they are admitted to Middlesex Hospital for CHF-related conditions (identification is admission-based, rather than population-based, because of limited resources available for the roll-out of this program). Prior to discharge, the case managers in this program work with the patient, the hospital, and any post-acute care provider (e.g., home care, SNF, etc.) to ensure that patients understand and follow their post-discharge care. Once patients enrolled in this program are discharged, the case managers provide education and follow-up communication with the patient and physician.

Provider Participation and Relations. As expressed in IRMA's original proposal, MPS as an organization supports participating in this demonstration. However, IRMA chose to seek individual opt-in agreements from each physician on the hospital's medical staff to make sure they understood the demonstration terms and conditions. To ensure physicians had sufficient information to agree to participate, the physicians have been provided information about the PGP Demonstration both during the decision to participate as well as through various venues since the demonstration has started. Since IRMA involves a network of practices rather than a single practice, they may have faced more of a challenge than other PGP sites in physicians making the decision to participate in the demonstration. The IRMA CEO and the Chief Medical Officer gave presentations and other materials about the goals of the demonstration, summaries of the assignment and Medicare savings calculation methodologies, and the quality measures so that the physicians could decide whether to participate. Since the demonstration started, IRMA staff have continued to educate providers on quality measure collection, Medicare savings goals, and disease management and care coordination resources available to themselves and their patients.

In order to provide physicians with feedback on how well the network as a whole and how their practices are meeting quality measure targets, IRMA is developing a system to provide practices with "report cards" for quality measures. Practices will only be informed of their own and the total network performance. The first years' report cards only contain information on the diabetes measures. As IRMA begins to collect the additional quality measures, these will be included in the report cards.

Demonstration Quality Indicators. IRMA found the PGP Demonstration quality measures to generally be appropriate; the measures were described as "in the right direction."

IRMA staff suggested using NCQA and other certification programs as indicators for participants having high-quality patient care programs and initiatives. However, they expressed some concern with the fact that they perceived the quality measures as only "underutilization" measures identifying cases where patients were given too little care—IRMA would have liked to have seen "overutilization" measures included as well.

In addition to generally using care and disease management programs to help patients improve their own care and quality measure performance, IRMA is introducing materials intended specifically for physicians. The quality measure "report cards" (described above) will encourage physicians to improve their quality measure performance by comparing their performance to their peers' and appealing to their pride in their professionalism. Also, flowsheets are being provided to help physicians track care provided to diabetes patients. These will assist providers in the monitoring of their patients and contribute to the quality improvement goals of the group.

Information Technology. IRMA is using health information technology (HIT) systems that had been developed by Middlesex Hospital over a number of years. This system provides electronic retrieval of diagnostic tests provided by MHS and is accessible by the participating physicians. It is not a comprehensive electronic medical record, as outpatient physician office visits are not included. As improvements are made to the HIT system, particularly for ambulatory services, these improvements will be adapted for use for the demonstration. Examples include the development of diabetes, asthma, and CHF disease registries. IRMA, through MHS, uses MIDAS software for case management, disease management, and quality improvement initiatives. The program also has "smart tracks" that provide reminders to case managers regarding patients that are due for visits, tests or telephone follow-up.

SECTION 1
INTRODUCTION

1.1 Background

The Centers for Medicare & Medicaid Services (CMS) initiated The Physician Group Practice (PGP) Demonstration in April 2005. This three-year demonstration offers participating PGPs the opportunity to earn bonuses for improving the efficiency and quality of care delivered to Medicare fee-for-service (FFS) beneficiaries. Ten large PGPs are participating in the demonstration.

CMS contracted with RTI International, an independent, nonprofit research organization, to evaluate the demonstration. As part of its evaluation, RTI is conducting site visits at each of the 10 participating PGPs in the winter of 2005-2006. The purpose of these site visits is to understand the decisions of the PGPs to participate in the demonstration and their early implementation and operational experience with the demonstration. RTI is producing a site visit report for each of the 10 demonstration PGPs. Material from the site visit reports will be included in CMS' Report to Congress on the PGP Demonstration, due at the end of 2006. This report is for Integrated Resources for the Middlesex Area, LLC (hereafter “IRMA”).

1.2 Sources and Methods

The primary source for the site visit reports is the one-day, on-site interviews conducted by RTI staff. The IRMA site visit took place on February 17, 2006 at IRMA offices in Middletown, Connecticut. The interviews were divided into multiple sessions by the following topic areas:

1. Demonstration Participation and Strategy—The purpose of this session was to understand IRMA’s motivation for participating in the demonstration and to understand how the demonstration relates to the PGP’s overall strategy and operational goals.

2. Patient Care Interventions—The purpose of this session was to gather information on programs that have been implemented by IRMA due to the demonstration to improve disease management and coordination of care and to understand how these interventions have improved efficiency.

3. Provider Participation and Relations—The purpose of this session was to determine the extent of provider participation in demonstration activities and to understand the financial and non-financial incentives that may exist for providers due to the demonstration.

4. Quality Improvement and Measurement—The purpose of this session was to determine whether programs that specifically target quality of care have been implemented as part of the demonstration and also to gather information on how those interventions were implemented.

5. Information Technology—The purpose of this session was to gather information on how the demonstration may have changed health care reporting and data collection systems for any interventions such as patient care activities or quality interventions.

Some participants varied by session based on their area of expertise. The agenda for the site visit is attached as Appendix A. IRMA participants included its Chief Executive Officer, Chief Medical Officer, Board Chairs, Chief Information Officer, Quality Coordinator and other information technology, clinical and quality assurance personnel. Edward Drozd and John Kautter of RTI conducted the interviews according to a pre-defined, semi-structured interview protocol. Fred Thomas (in person) and John Pilotte (via telephone) of CMS also participated in the interviews.

In addition to the interviews, this report draws on written materials provided by IRMA during or after the site visit, or as part of the demonstration project. These materials include IRMA's demonstration implementation protocol and its demonstration baseline and quarterly reports. Also, MHS' web site was consulted for background information. Finally, we drew some information on IRMA's Medicare assigned beneficiary population from RTI's analysis of Medicare claims and enrollment data for the demonstration.

Statistics cited in this report occasionally varied slightly among alternative sources. For example, the reported number of physicians associated with IRMA might differ slightly among the MHS web site, demonstration reports, and RTI's site visit interview notes. Generally these differences are not consequential, and could arise from different time frames, inclusion criteria, definitions, etc. In this report, we cited numbers from written demonstration reports or materials submitted by IRMA or published sources (e.g., MHS' web site) rather than our site visit notes, where possible. We also preferred statistics that were reported consistently across multiple sources. If a statistic seemed anomalous, or we were unsure of it or could not verify a precise magnitude, we indicated a general order of magnitude in this report, but did not cite a precise number. However, even if some statistics are subject to slight variation or uncertainty, we felt it was important to cite some specific numbers to adequately characterize IRMA and its demonstration participation. We submitted this report to IRMA staff for their review of its factual accuracy.

1.3 Overview of the Report

The next section describes IRMA as an organization and the environment in which it operates. The third report section discusses why IRMA chose to participate in the PGP Demonstration and how doing so fits into its overall strategy. The fourth section describes patient care coordination initiatives, and the fifth section includes initiatives in provider education, feedback and incentives. The sixth section discusses demonstration quality measures and reporting, and the seventh the role of information technology in the demonstration.

SECTION 2
ORGANIZATIONAL STRUCTURE, ENVIRONMENT AND STRATEGY

2.1 Organizational structure

IRMA is a subsidiary of the Middlesex Health System (MHS). The largest component of MHS is the Middlesex Hospital, a general acute care 275 bed hospital. The hospital generates from 65 to 70 percent of its revenues from outpatient services. Other major components of MHS (in addition to Middlesex Hospital and IRMA) are: Middlesex Health Services, which operates an assisted living facility; a primary care physician group; and Middlesex Health Resources, a real estate management company. MHS, through its subsidiaries, comprises 15 facilities in 24 community locations. These include: three emergency departments; outpatient surgery; an assisted living facility; home care; a family practice residency program; outpatient behavioral health care, including partial hospitalization and day programs; a family advocacy program; and community medicine.

The healthcare system is comprehensively integrated by IRMA, which provides a unique infrastructure and support system providing direction for the system and assisting in achieving unified goals for quality improvement and cost reduction. IRMA is owned entirely by MHS and, in addition to its subcontract with the hospital for quality improvement, case management, public reporting, and other services, has three primary functions: (1) contracting, (2) information management, and (3) medical management of patients' care with goals of maintaining high quality and efficiency.

There is an independent practice association (IPA) called Middlesex Professional Services (MPS)[2] that represents the physicians affiliated with Middlesex Hospital for contracting purposes. IRMA coordinates initiatives between MPS physicians and the hospital. Some physician offices are located in MHS facilities, although most practice in their own private offices.

2.2 Environment

2.2.1 Service Area

Figure 1 shows the IRMA Medicare service area for 2004 based on patient residence data. Counties where at least one percent of Medicare FFS beneficiaries assigned[3] to IRMA reside are included in this service area map. The beneficiary assignment map generally accords with interview participants' descriptions of the IRMA service area—many residents of Middlesex County visit IRMA physicians, few residents of areas closer to Hartford visit IRMA physicians, and some residents from communities to the southwest and southeast of Middletown also see IRMA physicians.

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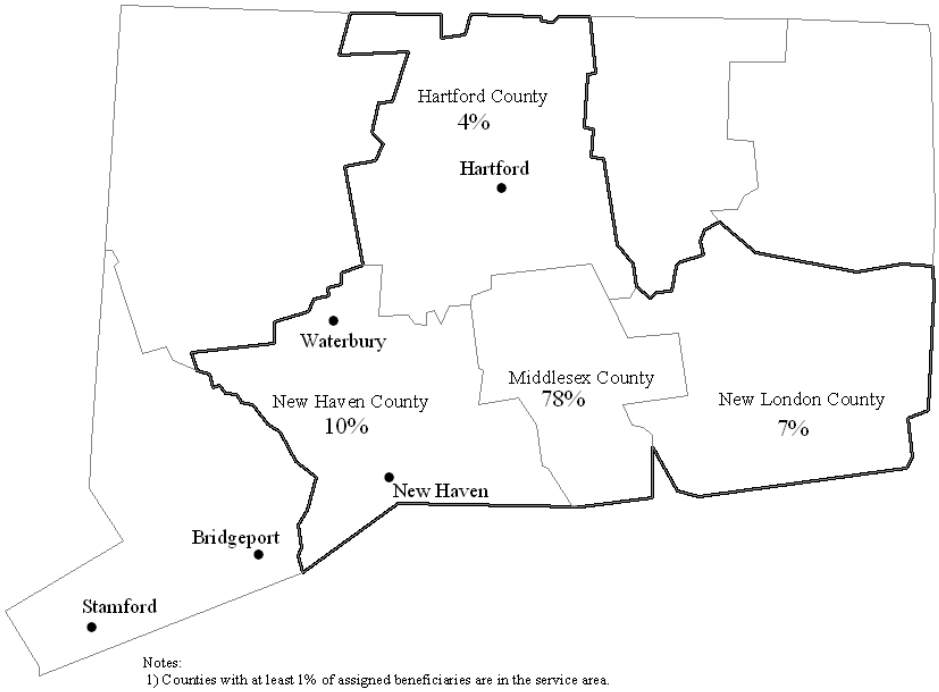
2 Throughout this report we use the terms "MPS physicians" and "IRMA physicians" interchangeably.

3 A beneficiary was assigned to IRMA if the plurality of its office and other outpatient evaluation and management allowed charges were incurred at IRMA.

Figure 1
IRMA Medicare Service Area for 2004

Integrated Resources of the Middlesex Area (IRMA) Service Area
PGP Demonstration Base Year, Calendar Year 2004
Connecticut



Notes:
1) Counties with at least 1% of assigned beneficiaries are in the service area.
2) Numbers in service area counties are percentages of service area assigned beneficiaries residing in the county. These percentages are used to weight comparison group county expenditure growth rates.
3) Due to rounding the percentage of assigned beneficiaries residing in the service area counties may not sum to 100%.

Source: RTI International

2.2.2 Patients

Table 1 shows selected characteristics of IRMA's assigned Medicare patients available from Medicare administrative files. IRMA provided an office or other outpatient evaluation and management visit to 22,550 Medicare patients. Of these, 17,551, or 78 percent, received the plurality of their evaluation and management services from IRMA and so were assigned to IRMA for the PGP Demonstration. Assigned beneficiaries received about seven evaluation and management (E&M) visits on average from all providers, with 86 percent of the associated Medicare allowed charges provided by IRMA on average.

Eighty-nine percent of IRMA's assigned Medicare patients are eligible for Medicare due to age, 11 percent due to disability (under age 65), and less than one percent due to end stage renal disease (ESRD). Eleven percent had at least one month of Medicaid eligibility in 2004. Ninety-seven percent were white.

2.2.3 Payers

IRMA's inpatient enrollment mix is 47 percent Commercial payers (27 percent PPO & HMO, 14 percent traditional indemnity, and six percent other), 44 percent Medicare (the vast majority of which is Medicare FFS), 4 percent Medicaid, 3 percent self/pay uninsured, and 2 percent other.

2.2.4 Competitors

IRMA has a 62 percent market share in the MHS service area. IRMA's main competitors are tertiary centers located in New Haven and Hartford.

2.3 Major Strategic Initiatives

One of IRMA's strategic initiatives has been, and continues to be, improving communication and coordination of care between the hospital and physicians and among physicians. The hospital has set up a "hospital data repository," a health information technology (HIT) system that stores information on inpatient and outpatient laboratory tests, radiological results and notes, history and physical information, and other diagnostic and procedure information *performed in Middlesex Hospital*. Physicians participating in this demonstration can access these data in their own offices to be able to easily and quickly track their patients while in the hospital as well as their patients' disease over time from prior hospitalizations to other diagnostic tests. Currently, however, medical record information from physician office visits, and visits to providers outside of the MHS system, are not incorporated in this database. IRMA is exploring expansions of this repository to include more information from ambulatory settings to further improve coordination of care. However, these expansions are subject to budgetary and legal constraints.

IRMA is also trying to stay at the forefront of the pay-for-performance (P4P) movement among physician group networks (as opposed to what more tightly integrated delivery systems can manage)—IRMA believes that payers will demand increased collection of quality data from physicians and will use those data to vary payments in payer-specific P4P programs. IRMA has supported physicians and the hospital in P4P programs with various private payers.

Table 1
Selected Characteristics of Medicare patients, IRMA, 2004

	No. of Beneficiaries	Percentage or Amount
Medicare Patients		
Total[1]	22,550	100%
Assigned Beneficiaries[2]	17,551	77.8%
Characteristics of Assigned Beneficiaries		
Average Number of Evaluation and Management Visits[3]	17,551	6.59
Average Percentage of Evaluation and Management Care provided by IRMA[4]	17,551	86%
Distribution of Assigned Beneficiaries		
Total	**17,551**	**100%**
Medicare Eligibility		
Aged	15,591	88.8
ESRD	47	0.3
Disabled	1,913	10.9
Medicaid Eligibility		
Not Medicaid Eligible for any months in 2004	15,669	89.3
Medicaid Eligible at least 1 month in 2004	1,882	10.7
Age		
Age < 65	1,940	11.1
Age 65 – 74	6,768	38.6
Age 75 – 84	6,440	36.7
Age 85 +	2,403	13.7
Race		
White	16,932	96.5
Black	408	2.3
Unknown	19	0.1
Asian	61	0.3
Hispanic	46	0.3
North American Natives	7	0.0
Other	78	0.4

NOTES:
[1] Beneficiaries provided at least one office or other outpatient evaluation and management visit by IRMA.
[2] Beneficiaries who received the plurality of their office or other outpatient evaluation and management allowed charges at IRMA.
[3] Percentage of all office and other outpatient evaluation and management Medicare allowed charges provided to the beneficiary that were provided by IRMA.
[4] Office or other outpatient evaluation and management visits.

SOURCE: RTI Analysis of Calendar Year 2004, 100% Medicare Claims Files and Enrollment Datasets

SECTION 3
DEMONSTRATION PARTICIPATION AND STRATEGY

3.1 Reasons for Participating

Participation in the PGP Demonstration affords IRMA the opportunity to further push their quality objectives. Under the demonstration, IRMA has the ability to earn bonus payments that will be reinvested into their infrastructure to improve some disease management programs initiated for their commercial population that have been successful in improving care quality and cost savings (particularly diabetes care programs to improve patients' use of necessary preventive care and testing). They are interested in extending these care services to the Medicare FFS population. For IRMA, the demonstration essentially makes the provision of good quality care more feasible.

IRMA is also interested in showing that their network model can be successful in quality performance improvement initiatives. Interview respondents remarked that the IRMA network, composed of numerous private practices of varying sizes, is more representative of how physicians are organized in the U.S. than are most of the other PGP Demonstration participants. In particular, decision-making power is much more decentralized among the physicians in the network (IRMA physician practices had the option of not participating, but they all agreed to opt in), and strategies, technologies, and other investments cannot be decided by only the organization's leaders. However, IRMA leadership and participating physicians felt that it was important for their organization to be in the forefront of P4P initiatives to ensure that these programs, which they believe are inevitable, are designed with the needs of group networks (particularly IRMA) in mind. The possibility of learning from other participants about their programs' successes and challenges was also an important motivator for IRMA's participation.

Potential loss of inpatient revenues was a potential concern for IRMA and Middlesex Hospital in its decision-making process to participate in the demonstration. Because IRMA planned to implement disease management and care coordination programs for selected high-cost patients (see below for details), Medicare inpatient volume might fall as these patients experience fewer hospitalizations. However, the potential loss of inpatient revenue for all patients (not just Medicare beneficiaries) was believed to be small, and they considered the demonstration as another opportunity to be on the quality of care frontier. Hospital volumes in inpatient units and the emergency department have been high during the first year of the demonstration, so any volume reductions that could have happened do not seem to have materialized.

3.2 Demonstration Strategy

IRMA's overarching strategy for success in the demonstration is through disease management (DM) and improved coordination of care. IRMA plans to "pick the low-hanging fruit" (high-cost patients with chronic conditions) by improving the care they receive. Part of implementing this strategy involves the expansion of existing disease management programs to include Medicare FFS patients and the creation of new programs, such as DM for congestive heart failure (CHF) and for specific cancers.

A second component of their strategy is leveraging IRMA's close ties with other components of MHS to improve care coordination and management. Because of physicians' electronic access to various hospital medical record information systems in their offices, programs that include improved coordination of care between hospitalists and community physicians should have a good chance of success. Also, MHS' home care unit is cooperating with the CHF, asthma, and diabetes DM programs to improve patients' compliance with post-discharge care, communicate patient status to physicians, and provide patient education. The fact that Middlesex Hospital is the sole hospital in its county, and that IRMA physicians are the dominant network, makes this cooperation with hospital units easier.

The third component of IRMA's demonstration strategy is to provide constituent practices with quality measure data to encourage physicians to improve measured quality. The purpose of these "report cards," which would only be seen by the practices themselves, is to use physicians' professional pride to encourage them to continually improve, both absolutely and relative to other IRMA practices.

3.3 Relationship to Group Practice Strategy

As noted in Section 2.3, IRMA believes the push for P4P programs by payers will be inevitable. By participating in the demonstration, they would like to be able to influence these programs more generally (i.e., not just for Medicare, but for private payers as well). They believe that much of the focus has been on large physician groups under a single management structure, and these groups would have additional financial and other resources at their disposal, especially for making health information technology infrastructure improvements. However, IRMA believes that a network model, with good coordination with a hospital, can perform well in a P4P program, but only if the organizational limitations of a network are accounted for in the program design. Participating in the demonstration also furthers IRMA's goals of improving coordination of community (non-hospital) based care as well as to expand the use of evidence-based practice.

3.4 Leadership and Implementation Team

The demonstration implementation team is led by IRMA's Chief Medical Officer (CMO) and Chief Executive Officer (CEO). In particular, the CMO was described as the "driving force" behind IRMA's participation. However, the decision to participate was made by IRMA's Board of Directors, composed of representatives of Middlesex Hospital and several community physicians.

3.5 Implementation and Operational Challenges

For IRMA, the quality measure data collection will be the biggest operational challenge. The increased amount of paperwork and chart review resulting from the addition of the 24 chart-based measures was unanticipated, and IRMA did not have much of an infrastructure already in place to collect them. They would have preferred staying with the original eight quality measures to reduce the burden of collecting data for and reporting the additional measures. In fact, IRMA had some initial problems with the first round of quality data reporting. However, they have developed systems (using paper forms included in patients' charts) for staff at practices to more easily and quickly report the measures.

Another potential challenge IRMA identified was the timeliness of the claims data taps provided by RTI and CMS. Being successful under the demonstration requires good care management. Data lags prevent IRMA from knowing who their patients are and thus providing adequate care management to these patients. IRMA is developing and maintaining its own disease-specific registries, but knowing which patients are assigned would be helpful.

An additional concern IRMA expressed was that for hospice patients, the period spent enrolled in hospice is not incorporated into the demonstration design, i.e., it is not used in the beneficiary assignment algorithm, nor is it used in the bonus payment formula. IRMA believes that this will penalize the group for encouraging appropriate use of hospice for its patients. Patients in hospice programs should have lower Medicare expenditures than similar patients not in hospice. By excluding expenditures for patients enrolled in hospice, IRMA remarked that they will not be credited, relative to physicians who do not encourage hospice use, for the lower Medicare expenditures of the patients they successfully referred to hospice. Since IRMA believes they are more successful at encouraging hospice than other area physicians, they feel disadvantaged by this aspect of the demonstration design.

Finally, IRMA had a strong negative reaction to what they thought was a late change in the demonstration financial design involving the 2 percent threshold.

SECTION 4
PATIENT CARE INTERVENTIONS

IRMA began its disease management programs when they were accepting capitated contracts on behalf of the hospital and MPS. As these contracts expired, they were able to maintain these programs through grants and in cooperation (including funding) with other payers. For the PGP Demonstration, IRMA has modified many of its existing disease management, case management, and education programs and begun the process of creating new programs better tailored to its Medicare patients. Some of the new programs are already in operation, others are still in the planning stage. The disease management programs are available to all patients seen at IRMA practices regardless of payer type; however, the majority of patients enrolled in these programs have consistently been 65 years of age or older.

Because of IRMA's connection with MHS, it has been able to leverage other components of MHS to augment its patient care interventions. One of the components most involved in IRMA's PGP Demonstration-related interventions is Middlesex Hospital Homecare. Homecare staff and systems are involved in patient education, encouraging patient compliance with post-discharge and chronic condition self care, and telemonitoring of clinical indicators of chronic disease progression, as described below.

4.1 Diabetes Disease Management

IRMA offers an NCQA-accredited disease management program in diabetes. This program is being expanded for the PGP Demonstration. IRMA's program focuses on in-person patient education (e.g., helping patients learn how to self-manage their disease to prevent, or at least significantly slow, the progression of their disease) as well as coordinating care across physicians and other providers. In particular, services provided through the disease management programs include telephonic follow-up, assistance with obtaining free medications, home visits and reminding patients of and accompanying patients to physician appointments. These programs also involve educating providers and other clinical staff on current treatment guidelines and standards. Patients are most frequently enrolled in these programs through physician referral. During the first quarter of the PGP Demonstration (April 1 through June 30, 2005), there were 62 new Medicare FFS beneficiaries enrolled in the Diabetes Education Program and three new Medicare FFS beneficiaries enrolled in the more intensive Diabetes Care Program.

4.2 Asthma Disease Management

IRMA also has an NCQA-accredited disease management program in asthma. Although this program initially was set up so that patients were recruited upon admission to Middlesex Hospital for asthma-related condition, patients are now enrolled directly by a physician referral. However, patients must meet guidelines set by the National Heart, Lung, and Blood Institute (NLHBI) for classifying a patient as having severe persistent asthma. The goal of this program is to improve patients' disease self-management skills. In addition to providing telephonic follow-up, assistance with obtaining free medications, and reminders of (and occasionally accompanying to) physician appointments, this program also works with IRMA physician practices to be sure that patients' asthma condition is communicated to physicians. During the first quarter of the demonstration, two new Medicare patients were enrolled in this program.

4.3 Congestive Heart Failure (CHF) Disease Management

The CHF disease management program was created specifically for the PGP Demonstration. The program's goal is to reduce hospital readmission rates through improved self-management and compliance with follow-up care. Patients are identified for inclusion in this program when they are admitted to Middlesex Hospital for CHF-related conditions (identification is admission-based, rather than population-based, because of limited resources available for the roll-out of this program). Prior to discharge, the case managers in this program work with the patient, the hospital, and any post-acute care provider (e.g., home care, SNF, etc.) to ensure that patients understand and follow their post-discharge care. Once patients enrolled in this program are discharged, the case managers provide education and follow-up communication with the patient and physician. During the first quarter of the PGP Demonstration, there were eight new enrollees in the Chronic Heart Failure Program.

4.4 Cancer Care Management Programs

IRMA has recently created and expanded a few care management programs for patients with lung, breast, and colon cancer. The lung cancer care management program is the oldest, and was expanded in 2005 to include breast cancer and colorectal cancer. This program works with patients and physicians to ensure that treatments follow evidence-based practice guidelines, including for psychological, nutritional, and palliative care.

4.5 Home Care-Based Programs

Two case management programs based from Middlesex Hospital Homecare were implemented in the past two years. First, the Heart Smart Program was launched in 2004 and is designed to provide case management services to cardiac patients enrolled in homecare services. IRMA has found this program to be successful and estimates that it has helped decrease hospital readmission rates by about two-thirds.

Second, the HomeMed program, a telemonitoring program designed to provide minimal case management services to frail elderly Medicare beneficiaries with multiple comorbid conditions (including, but going beyond, those covered by the other disease and case management programs) was implemented as a pilot program in 2005. Patients enrolled in HomeMed receive a device installed in their home that monitors vital signs. The program has shown some evidence of decreased readmission rates. During the first quarter of the PGP Demonstration, there were 83 new enrollees in the Heart Smart program and 39 new enrollees in the HomeMed program.

SECTION 5
PROVIDER PARTICIPATION AND RELATIONS

5.1 Provider Education

As expressed in IRMA's original proposal, MPS as an organization supports participating in this demonstration. However, IRMA chose to seek individual opt-in agreements from each physician on the hospital's medical staff to make sure they understood the demonstration terms and conditions. To ensure physicians had sufficient information to agree to participate, the physicians have been provided with information about the PGP Demonstration both during the decision to participate as well as through various venues since the start of the demonstration. Since IRMA involves a network of practices rather than a single practice, they may have faced more of a challenge than other PGP sites in physicians making the decision to participate in the demonstration. The IRMA CEO and the Chief Medical Officer gave presentations and other materials about the goals of the demonstration, summaries of the assignment and Medicare savings calculation methodologies, and the quality measures so that the physicians could decide whether to participate.

Since the demonstration started, IRMA staff has continued to educate providers on quality measure collection, Medicare savings goals, and disease management and care coordination resources available to themselves and their patients. This has been provided during grand rounds, during other presentations, and with written materials. IRMA-affiliated physicians are continuously involved in reviewing the status of the demonstration with hospital and departmental leadership. In particular, several IRMA-affiliated physicians are members of IRMA's (and the hospital's) Board of Directors and are given regular reports on its progress. Also, IRMA demonstration implementation staff do give feedback to physicians on the quality performance of their practice and that of the organization as a whole.

5.2 Provider Performance Support and Feedback

IRMA is developing a system to provide practices with "report cards" showing how the network and individual practices are performing with respect to the demonstration quality measures. Practices will only be informed of their own and the entire network's overall performance on the quality measures. Information on other practices' performance will not be revealed to each practice. Because the diabetes quality measures are the first on which demonstration participants will be evaluated, and the fact that IRMA is focusing first on only collecting the diabetes quality measures in the first performance year, the first years' report cards only contain information on the diabetes measures. As IRMA begins to collect the additional quality measures, these will be included in the report cards.

Because the chart-based quality measures are somewhat burdensome for small practices to collect efficiently, IRMA staff has developed a hard copy sheet to add to patients' charts for the collection of data as tests (e.g., foot exam) are conducted. After some initial challenges, IRMA has reported success (with respect to provider burden and reporting frequency) with this data collection method.

5.3 Provider Compensation and Incentives

IRMA has a committee of physicians who are charged with the oversight of this project. This committee outlined some principles for bonus distribution: repayment for demonstration-related expense, an administrative fee for IRMA to defray costs of continuing programs, and distributing the balance to participating physicians. This committee did not determine a specific methodology, but a general principle is that distributions should go to physicians whose actions "made a difference." However, because of the change in the demonstration terms and conditions, including to the bonus calculation whereby only savings *beyond* two percent are shared, IRMA is uncertain whether any of these distributions will be more than token amounts.

Since the IRMA practices are separate entities from MHS (and from each other), physicians in individual practices will continue receiving compensation according to practice rules. Much of this compensation is based on RVU productivity.

SECTION 6
DEMONSTRATION QUALITY INDICATORS

6.1 Appropriateness

IRMA found the PGP Demonstration quality measures to generally be appropriate; the measures were described as "in the right direction." IRMA staff suggested using NCQA and other certification programs as indicators for participants having high-quality patient care programs and initiatives. However, they expressed some concern with the fact that they perceived the quality measures as only "underutilization" measures identifying cases where patients were given too little care—IRMA would have liked to have seen "overutilization" measures included as well (no specific "overutilization" were given). IRMA also advocated the use of the National Quality Forum's (NQF's) NQF-endorsed™ ambulatory care consensus standards to go beyond the four diseases (diabetes, CHF, CAD, and hypertension) and preventive care screening used for the PGP Demonstration. Using the NQF-endorsed™ ambulatory care consensus standards would standardize the measures to avoid different payers using different measure sets for P4P quality measurement.

6.2 Improvement Strategy

IRMA's plan for improving quality measure performance is focused on successful implementation of their case management programs; disease management programs for diabetes, asthma and CHF; and the distribution of clinical pathway information and practice guidelines. The quality management services provided by IRMA are provided to the entire patient population, which includes Medicare patients.

In addition to generally using care and disease management programs to help patients improve their own care and quality measure performance, IRMA is introducing materials intended specifically for physicians. The quality measure "report cards" (described in Section 5) will encourage physicians to improve their quality measure performance by comparing their performance to their peers' and appealing to their pride in their professionalism. Also, flowsheets are being provided to help physicians track care provided to diabetes patients. These will assist providers in the monitoring of their patients and contribute to the quality improvement goals of the group.

6.3 Collection and Reporting

IRMA cited several issues with data collection for the demonstration quality measures. First, there are a substantial number of measures that are being used in the demonstration data collection and reporting. Some of these measures differ slightly from those used by other payers, which will require some time for adjustment. Because of the need to develop patient care interventions tailored to the populations targeted by the quality measures, and the limited initial resources available to develop them, IRMA appreciates the phasing in of the full set of quality measures.

The second major issue with the quality measures is the reliance on a significant number of chart-based measures. With only paper charts available throughout the system, it is difficult to capture visit-based measures such as blood pressure measurement during last patient visit and

diabetic foot exams. Also, not all of the patient's data is available in a single chart. Data collection for the quality measures will require a review of multiple patient charts. As a result, the collection of these measures is somewhat burdensome for small practices to collect efficiently. This has resulted in initial challenges in collecting the necessary volume of measures from all affiliated practices. To surmount these data collection challenges, IRMA staff have developed a hard copy sheet added to practices' patients' charts to collect the chart-based measures as tests are conducted. After some initial challenges, IRMA has reported success (with respect to provider burden and reporting frequency) with this data collection method.

SECTION 7
INFORMATION TECHNOLOGY

7.1 Strategy

IRMA is using health information technology (HIT) systems that were available through Middlesex Hospital to meet the objectives of the demonstration. There are very few resources available for HIT improvements specific to the demonstration. Rather, as MHS makes improvements to its HIT system, particularly for ambulatory services, these improvements will be adapted for use for the demonstration. MHS would like to improve the ability of physicians to input clinical data from office visit encounters into the MHS HIT system. In fact, MHS is currently implementing such a system for its Primary Care Residency program. However, legal restrictions (including the Stark anti-kickback laws) prevent MHS from giving IRMA practices hardware and software to input data into the HIT system, and practices have limited resources to devote to purchasing such a dedicated system.

7.2 Systems and Initiatives

7.2.1 Patient Registries

IRMA has developed multiple disease registries that capture disease information for patients that can be used by physicians, the developers of care programs, and for training purposes. The registries, for diabetes, asthma, and CHF, have been, and are being, developed by both technical and clinical staff. They capture patient lab data, claims data and logistic information for all diabetes patients regardless of payer. Registry data has been very useful for measuring IRMA's ability to provide care and to track progress with quality measures.

7.2.2 Information Management

One of IRMA's core functions is to advise MHS on providing information useful to physicians. This includes creating information systems that provide shared clinical and cost information to both providers and payers. These systems are integrated into a central system that registers and bills for all patient encounters. The ancillary departments incorporated into this system include the laboratory, pharmacy, radiology, dictation, pathology, and cardiology. This Clinical Data Repository (CDR) provides information to assist physicians, nurses and other clinicians in providing care. The CDR interacts with the data systems of these departments and hospital central billing to make these data available to IRMA physicians in their offices.

IRMA, through MHS, uses MIDAS software for case management, disease management, and quality improvement initiatives. The program also has "smart tracks" that provide reminders to case managers regarding patients that are due for visits, tests or telephone follow-up.

7.2.3 Other Systems and Initiatives

IRMA has participated in helping the hospital pilot an electronic health record (EHR) in its Family Practice Residency program this year.

APPENDIX A
AGENDA FOR IRMA SITE VISIT

Site Visit Agenda for Integrated Resources for the Middlesex Area, LLC
PGP Demonstration Evaluation by RTI

February 17, 2006

9:00–9:30 a.m.	Evaluation and Site Visit Background
9:30–10:30 a.m.	PGP Demonstration Participation and Strategy
10:45–11:45 a.m.	Patient Care Interventions .
11:45 a.m.–1:00 p.m.	Lunch
1:00–2:00 p.m.	Provider Participation and Relations
2:00–3:00 p.m.	Quality Improvement and Measurement
3:15–4:15 p.m.	Information Technology
4:15–4:45 p.m.	End of Day Wrap-up