July 2006

Forsyth Medical Group
Physician Group Practice Demonstration

Site Visit Final Report

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RTI Project Number 0208506.002

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CMS Contract No. 500-00-0024 Task Order # 13

July 2006

This project was funded by the Centers for Medicare & Medicaid Services under contract no. 500-00-0024 Task Order # 13. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. RTI assumes responsibility for the accuracy and completeness of the information contained in this report.

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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 conducted site visits at each of the ten PGPs participating in the demonstration in the winter of 2005–2006. The purpose of these site visits was 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 Forsyth Medical Group (FMG).

FMG is a division of Novant Health, a not-for-profit, integrated healthcare system based in North Carolina. FMG is structured as a set of Primary Practices organized around a hospital system. It consists of over 30 practices at locations in eight counties in North Carolina. Hospital affiliations of FMG include Forsyth Medical Center, Medical Park Hospital and Thomasville Medical Center. FMG includes 175 employed physicians and 75 mid-level providers in 15 specialties.

Strategy and Reasons for Participation. FMG has focused on quality since the late 1990s, when it initiated a program to improve coordination of diabetes care. This program has been a stepping stone to many other quality improvement initiatives within the group. FMG's goal is to be in the top 10 percent for all of the PGP Demonstration quality measures in the next 5 years, and to maintain or improve both patient and physician satisfaction. FMG's primary reason for participating in the PGP Demonstration is to enhance their vision of improved patient care. They also see the potential for getting providers off the "fee-for-service treadmill" and increasing the level of integration within their system.

FMG has three initial strategies for success under the demonstration: (1) risk stratify patients based on illness severity so that they are referred to appropriate case or disease management programs; (2) focus on improving reversible risk factors; and (3) educate providers and staff on the current hospital discharge process and improve this process. Key activities for their strategy include chronic disease management, case management, care coordination programs, and the development of educational tools for providers.

Cost Savings Strategy and Patient Care Interventions. FMG plans to achieve cost reductions under the demonstration by focusing their strategy and interventions on DRG loss leaders: congestive heart failure, chronic obstructive pulmonary disease, diabetes patients with infected foot ulcers, and hospitalizations for nursing home placements.

Several formal patient care programs and interventions existed for FMG prior to the start of the demonstration.; they included a Diabetes and Nutrition Center, a Heart Failure Clinic, the New Beginnings Pulmonary Rehabilitation Program, a Preventive Cardiology Program, a Stroke and Neurovascular Center, Case Management in Acute Inpatient Facilities, and various patient

education programs. The focus under the demonstration has been to improve the identification of FMG Medicare FFS beneficiaries who would benefit from these pre-existing programs.

Under the PGP Demonstration, FMG has developed a Comprehensive Organized Medicine Provided Across a Seamless System (COMPASS) disease management program, that expands and integrates several existing disease management programs, and serves as a vehicle for raising recognition and awareness of these interventions. They have also introduced an outpatient case management program that identifies and provides support to high cost and high risk patients.

Provider Education, Feedback, and Incentives. Providers have been educated about the demonstration through meetings and presentations conducted by the Steering Committee. Meetings provide the opportunity for providers to learn and to share information, ideas, best practices and general progress under the demonstration. Providers receive performance feedback through the Corporate Clinical Improvement group. The Director of Clinical Services meets with individual providers and practices to review quarterly audit results.

Providers at FMG receive a base salary along with incentive payments based on the practices' productivity and financial performance. FMG is making some effort to move towards a compensation structure that includes provider salaries based in part on quality of care, but several challenges remain for implementation. Bonuses paid out under the demonstration are not received by individual providers. They are first used to cover upfront investments, and then distributed to the overhead budgets of individual practices. The practices would be able to use the funds to improve infrastructure, health care quality and efficiency.

Demonstration Quality Indicators. FMG indicated that the demonstration quality measures are reasonable, with the exception of the diabetes blood pressure measure. They believed that the blood pressure control measure should be based on multiple blood pressure measurements instead of a single one. FMG expressed concern over the plurality of care beneficiary assignment methodology because they believe they are being penalized for not being able to affect quality measures when a patient's primary care physician is outside of FMG.

FMG uses a "green light/red light" system to track targets reached versus negative trends. These reports are produced at the practice and practitioner level and highlight where there may be a need for improvement. FMG plans to improve quality measures by using a Disease Management Worksheet, increasing patient awareness of COMPASS, instituting an eye exam letter for ophthalmologists and optometrists to send back to FMG, and distributing materials to providers such as pocket information cards, tool kits for disease management and monofilaments for foot exams. FMG believes that improvement of quality measures under the demonstration is tied closely to patient care interventions.

Information Technology and Infrastructure. FMG uses both internal Novant Health information technology (IT) resources and external resources provided through Salem Health Solutions, a Novant Health subsidiary. Salem Health Solutions is working to generate Member Profiles for high risk patients identified through diagnoses, providers, prescription information, and cost data.

FMG also uses externally developed software packages such as Medical Manager software, which assists with practice management tasks such as appointment scheduling, medical histories, patient tracking and reminder systems. They also use Quality Care Guidelines software to identify patients in need of a visit or preventive care. FMG does not yet have an electronic health record (EHR). However, they have plans to implement an EHR in the near future.

SECTION 1
INTRODUCTION

1.1 Background

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 support and evaluate the demonstration. As part of its evaluation, RTI is conducting site visits at each of the ten 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 ten 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 presents findings for Forsyth Medical Group (FMG).

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 FMG site visit took place on January 12, 2005 at FMG offices in Winston-Salem, North Carolina. The interviews were divided into multiple sessions, including the following topic areas:

1. Demonstration Participation and Strategy—The purpose of this session was to understand FMG'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 FMG 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. FMG participants included its Executive Vice President, Director of Finance, Director of Quality Improvement and Disease Management, Director of Clinical Services, Manager of Clinical Services, Director of Operations, providers and practice representatives as well as information technology, clinical, care management, and quality improvement personnel. Dr. Michael Trisolini and Dr. Lori Kaler of RTI conducted the interviews according to a pre-defined, semi-structured interview protocol. Heather Grimsley of CMS also participated in the interviews.

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

Statistics cited in this report sometimes varied slightly among alternate sources. For example, the reported number of FMG's care sites might differ slightly among the FMG web site, FMG 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 FMG or published sources (e.g., FMG's 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 FMG and its demonstration participation. We submitted this report to FMG staff for their review of its factual accuracy.

1.3 Overview of the Report

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

SECTION 2
ORGANIZATIONAL STRUCTURE, ENVIRONMENT, AND STRATEGY

2.1 Organizational Structure

FMG is a division of Novant Health, a not-for-profit, integrated healthcare system based in North Carolina. Novant Health was formed in July 1997 by the merger of Carolina Medicorp of Winston-Salem, North Carolina and Presbyterian Health Services of Charlotte, North Carolina. Thomasville Medical Center joined the system a few months later, in November 1997. The system currently consists of seven hospitals, three nursing home and senior residential facilities, physician practices, outpatient surgery centers and rehabilitation and community outreach programs.

FMG is structured as a set of Primary Practices organized around a hospital system. It consists of over 30 practices at locations in eight counties of North Carolina, each owned by Novant Health corporate. The number of practices has been increasing steadily as Novant Health has been actively purchasing physician practices to increase its number of locations in North Carolina.

Hospital affiliations of FMG include Forsyth Medical Center, Medical Park Hospital and Thomasville Medical Center. Forsyth Medical Center is an 847-bed non-profit, tertiary care hospital offering a full continuum of emergency medicine, surgical, rehabilitative and behavioral health services. Thomasville Medical Center is a 148-bed private, non-profit hospital providing a full spectrum of acute outpatient community wellness and home health services. The smallest hospital is the Medical Park Hospital, a 136-bed non-profit facility specializing in outpatient procedures including elective and surgical procedures.

FMG consists of approximately 175 employed physicians and 75 mid-level providers (e.g., nurse practitioners, physician assistants) in 15 specialties. Approximately 45 percent of these providers work in primary care. FMG provides more than 1.2 million patient visits annually.

FMG is responsible to the Board of Trustees of Novant Health, Triad Region. FMG has a physician-directed governance system in which routine operational and clinical responsibilities have been delegated to a Physician Leadership Board.

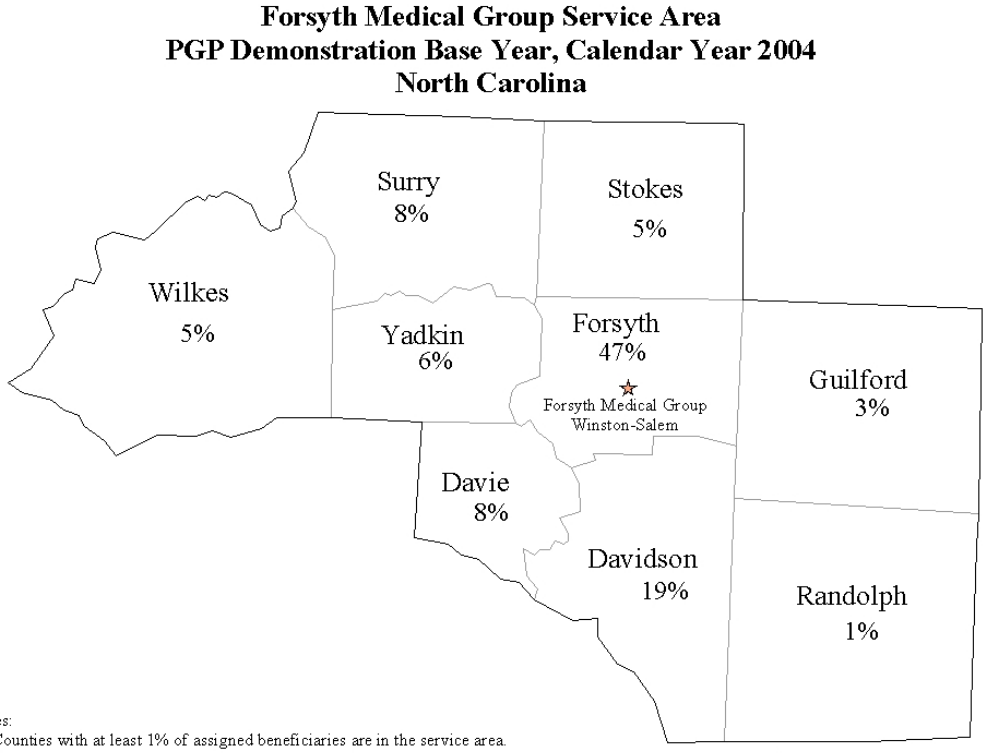
2.2 Environment

2.2.1 Service Area

Novant is located in western North Carolina and serves more than 3.4 million people in 32 counties reaching from southern Virginia to northern South Carolina. FMG draws 47 percent of its Medicare patients from Forsyth county, which includes Winston-Salem, North Carolina.

Figure 1 shows FMG's Medicare service area for 2004 based on patient residence data. Counties where at least 1 percent of Medicare FFS beneficiaries assigned[1] to FMG reside are included in this service area map.

Figure 1
Forsyth Medical Group Service Area for 2004



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

There are approximately 113,719 Medicare beneficiaries living in nine county Novant Health service area. ***Table 1*** shows selected characteristics of FMG's assigned Medicare patients available from Medicare administrative files. In 2004, FMG provided an office or other outpatient evaluation and management visit to 25,943 Medicare patients. Of these, 14,688 or 57 percent received the

[1] A beneficiary was assigned to FMG if the plurality of its office and other outpatient evaluation and management allowed charges were incurred at FMG.

Table 1
Selected characteristics of Medicare patients, Forsyth Medical Group, 2004

	No. of Beneficiaries	Percentage or Amount
Medicare Patients		
Total[1]	25,943	100%
Assigned Beneficiaries[2]	14,688	56.6%
Characteristics of Assigned Beneficiaries		
Average Number of Evaluation and Management Visits[3]	14,688	4.88
Average Percentage of Evaluation and Management Care provided by FMG[4]	14,688	74%
Distribution of Assigned Beneficiaries		
Total	**14,688**	**100%**
Medicare Eligibility		
Aged	12,227	83.2%
ESRD	36	0.2%
Disabled	2,425	16.5%
Medicaid Eligibility		
Not Medicaid Eligible for any months in 2004	12,098	82.4%
Medicaid Eligible at least 1 month in 2004	2,590	17.6%
Age		
Age < 65	2,454	16.7%
Age 65 - 74	6,031	41.1%
Age 75 - 84	4,668	31.8%
Age 85 +	1,535	10.5%
Race		
White	13,155	89.6%
Black	1,408	9.6%
Unknown	17	0.1%
Asian	32	0.2%
Hispanic	20	0.1%
North American Natives	8	0.1%
Other	48	0.3%

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

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

plurality of their evaluation and management services from FMG and so were assigned to FMG for the PGP demonstration. Assigned beneficiaries received 4.88 evaluation and management visits on average from all providers, with 74 percent of the associated Medicare allowed charges provided by FMG on average.

Eighty-three percent of FMG's assigned Medicare patients are eligible for Medicare by age, 17 percent by disability (under age 65), and less than 1 percent by end stage renal disease. Eighteen percent had at least 1 month of Medicaid eligibility in 2004. Ninety percent were white.

2.2.3 Payers

FMG serves approximately 40,000 Medicare beneficiaries including both Medicare Advantage members and Medicare FFS enrollees. It is estimated that the Medicare plus Choice penetration rate is around 8 percent in FMG's service area.

2.2.4 Competitors

No information available.

2.3 Major Strategic Initiatives

FMG has had a focus on quality since the late 1990s, when they initiated a program to improve coordination of diabetes care. Diabetes quality measures were instituted at FMG in 1997. At that time, they were achieving 90 percent of NCQA targets. From this experience, FMG learned that they could significantly improve a patient's health by emphasizing a common patient-focused goal and building a group culture of improved performance.

The overall plan for FMG is to provide quality care and to enhance reimbursement methods so that they can demonstrate improvements in quality health care and cost containment. FMG's goal is to be in the top 10 percent for all of the PGP Demonstration quality measures in the next 5 years, and to maintain or improve both patient and physician satisfaction.

SECTION 3
DEMONSTRATION PARTICIPATION AND STRATEGY

3.1 Reason(s) for participation

FMG's primary reason for participating in the PGP demonstration is to enhance their vision of improved patient care. Providing reimbursement based on health care efficiency and quality and not strictly on volume was thought to be a good way to get providers off the "fee-for-service treadmill" and to motivate them about providing quality care.

FMG also indicated that participation in the PGP demonstration would increase the level of integration within their system, putting FMG in a better position for negotiation with other payers. The group mentioned that the goal of integrated healthcare systems has changed over the last 5 years, progressing towards a pay-for-performance approach.

Additionally, the PGP demonstration provides a significant financial incentive for FMG to move forward with their vision. The fact that the demonstration has only positive incentives, and no penalties was important in their decision to participate. This made the demonstration more financially attractive.

The demonstration also garners positive attention for Novant Health. It allows those involved understand and see the possibilities for new reimbursement systems in the future.

3.2 Demonstration Strategy

FMG has three initial strategies for success under the demonstration: (1) risk stratify patients based on illness severity, so that they are referred to appropriate case or disease management programs; (2) focus on improving reversible risk factors; and (3) educate providers and staff on the current hospital discharge process and improve this process. The key activities for implementation of this three-part strategy include chronic disease management, case management, care coordination programs, and the development of tools to educate staff and patients. Since several disease and case management programs existed at FMG prior to the demonstration, the main focus for the demonstration is to improve the identification of Medicare FFS patients who could benefit from these types of services.

FMG plans to achieve cost reduction goals through reduced hospital admissions and decreased hospital days, which will be achieved by providing improved preventive care and case management. They are currently focusing on DRG loss leaders to decrease expenses and increase cost efficiency. They believe that the hospital loses money on patients with congestive heart failure, chronic obstructive pulmonary disease, diabetes patients with infected foot ulcers, and hospitalizations for nursing home placements. This approach has helped to keep the hospital on board with the demonstration.

3.3 Relationship to Group Practice Strategy

The PGP demonstration fits into the overall strategic plan for FMG very well. The PGP demonstration's goal of improving the quality of care received by Medicare beneficiaries is consistent with FMG's mission. The demonstration was thought to be a natural evolution of their

internal quality program. Providers believe that participation in the demonstration has helped to refresh the strategies for quality improvement at FMG, which had been leveling off in recent years.

Interest in demonstration participation has also spread to the more rural FMG practices located outside of Winston-Salem. The demonstration has increased opportunities for practices to learn from each other and has sharpened the focus on rural practices.

3.4 Leadership and Implementation Team

The Novant Corporate Quality Board was assigned oversight of the PGP demonstration and established a Steering Committee to direct the activities associated with the demonstration. The Steering Committee consists of nine practitioners, one physician from each of the main Medicare FFS sites. It is responsible for evaluating best practices and facilitating communication regarding the project. They are also responsible for identifying representatives of all departments and resources that interact with the Medicare FFS population to facilitate communication across the organization. The Medical Director at each site holds monthly meetings with clinical service managers and practice managers to facilitate the dissemination of ideas and strategies discussed during Steering Committee meetings to all FMG staff. In addition to the Steering Committee, the Practice Standards Committee is playing an active role in monitoring and evaluating the standards being measured by the group.

The role of different staff involved with the PGP Demonstration is individualized to the practices. Physicians have been empowered to run their practices and make decisions locally. They are also encouraged to use the patient care interventions described in Section 4. Providers are encouraged not to distinguish patients by payer, and believe that providing better care is the right thing to do. In general, FMG has seen an increase in physician satisfaction over the past 5 years.

3.5 Implementation and Operational Challenges

FMG challenges have centered on implementing a change model that addresses comprehensive chronic care management in an environment that is volume driven. Nurses, office managers, and mid-level providers have been needed to support the infrastructure changes produced by the initiatives.

FMG also believes that participation in the demonstration allows for exposure of weaknesses, which is thought to be a risk. Additionally, FMG has struggled with the burden of increased responsibility with no immediate payoff or upfront infrastructure investments from CMS. Participation in the demonstration has increased the level of staff work on a daily basis, and has increased costs for individual practices, who are taking on the majority of the burden. They recognize that a return on investment will come in the upcoming years; however, a payoff tied more closely to the interventions would be preferred.

Demonstration-related interventions have involved an approximately $250,000 annual investment in staff, that is expected to remain constant throughout the demonstration. The initial expenditures for interventions have been approximately $300,000. FMG has consciously tried to

keep costs at a minimum by identifying pre-existing programs that could easily be integrated into the demonstration.

FMG is concerned that the duration of the demonstration may not be sufficient to show efficiency improvements. This is due to two factors. First, they have encountered challenges in their attempts to change current care management programs. Second, they have estimated a lag of about 18 months to 5 years between the implementation of patient care initiatives and improvements in efficiency. Because the demonstration ends after 3 years, and at least part of the cost savings are expected to be realized in the years after the end of the demonstration, they believe that they may not receive a sufficient return on their investments aimed at improving efficiency and generating cost savings. Therefore, FMG believes that some bonus payments should be based strictly on quality improvements, which could more easily be improved in the short-term.

FMG indicated that the decision made early in the demonstration regarding the 2 percent threshold almost derailed FMG's participation in the demonstration. They indicated that they scaled back on initial upfront investment in the demonstration due to this change in design.

FMG suggested that they could have better targeted and improved their initiatives with more timely data from CMS. In particular, data that would assist with the identification of beneficiaries that would fall into their comparison group would have been useful. They believe that increased knowledge of their "opponent" in the demonstration, and the strengths and weaknesses of this opponent, would increase their chances of success under the demonstration.

SECTION 4
PATIENT CARE INTERVENTIONS

At demonstration baseline, FMG had five major disease management interventions in place as well as a more general care management initiative in acute inpatient facilities. We describe each of these programs in turn. Then, we describe more generally FMG's chronic disease management, care coordination, and case management systems.

4.1 Diabetes and Nutrition Center

The Forsyth Medical Center Diabetes and Nutrition Center was developed to educate patients with diabetes on their disease and proper nutrition. The program is monitored by an advisory board that includes FMG endocrinologists. The Center is not a division of FMG; it is an affiliate of FMG that serves the entire service area. Individuals receiving services from the Center can not be identified as FMG patients. However, there is a strong assumption that FMG providers consistently refer diabetes patients to the Diabetes Center, and therefore FMG could garner efficiencies from the management of diabetes through the Diabetes Center.

The services offered through the Center include diabetes education programs, survival skills programs, a gestational diabetes and pregnancy program, outpatient insulin administration/insulin pump training, medical nutrition therapy, pediatric diabetes education and diabetes prevention education. These services are open to any patient self-referred or physician-referred, and are staffed by certified diabetes educators, certified insulin pump trainers, registered nurses and registered dietitians. Center staff are all employees of Novant Health, the parent organization for FMG.

4.2 Heart Failure Clinic

The Forsyth Heart Failure Clinic (HFC) is designed to help heart failure patients understand and manage their condition to improve patient quality of life and prevent avoidable hospitalizations. The HFC is monitored by an advisory board that includes FMG cardiologists. The HFC is not a division of FMG; it is an affiliate that serves the community and surrounding counties of FMG's service area.

The services offered through the program include an accurate diagnosis of the etiology of heart failure, personalized medical therapy, evaluation and referral for an implantable defibrillator, evaluation for surgical therapy, home therapies, intensive education programs, case management, nutritional counseling, cardiac rehabilitation, stress testing and support groups. These services are open to any patient self-referred or physician- referred.

A substantial number of referrals to the HFC come from acute inpatient admissions and case management. Primary sites of referral for FMG patients include the Forsyth Medical Center and the Thomasville Medical Center. Since heart failure is most common in individuals over 65, and the Medicare managed care market share in FMG practices is only about 8 percent, it is assumed that the HFC is managing care for Medicare FFS patients.

The type of staff involved in HFC services include cardiologists, a chaplain, nurse case managers, nurse practitioners, nutritionists, exercise physiologists and pharmacists. All of the staff are employees of Novant Health, the parent organization of FMG.

4.3 New Beginnings Pulmonary Rehabilitation Program

FMG utilizes the respiratory services associated with Forsyth Medical Center and Thomasville Medical Center. The New Beginnings Pulmonary Rehabilitation Program is a six—ten week medically supervised program offered through the medical centers that includes monitored exercise, nutritional education, smoking cessation, and self-management education. The program is an affiliate of FMG serving the community and surrounding counties of FMG's service area.

Patients can be either self-referred or physician-referred to the program, which is promoted through internet sites, presentations to providers, operational committees and the community. Patients are generally referred to the program after acute inpatient admissions and by case managers. The primary sites for referral of FMG patients include the Forsyth Medical Center and the Thomasville Medical Center.

Program staff includes a pulmonologist, respiratory therapists, nurses, nutritionists, exercise physiologists, counselors, a chaplain, and pharmacists. All program staff are employees of Novant Health.

4.4 Preventive Cardiology Program

Forsyth Medical Center performs a significant number of invasive cardiology procedures annually. As a result, it has developed a network to provide services that reduce heart health risks, specifically in patients with coronary artery disease. The program is an affiliate of FMG, serving the community and surrounding counties of FMG's service area.

The services provided through the program include risk evaluation, lipid management, smoking/tobacco cessation, a heart health living program, a peripheral artery disease program, and the New Beginnings Cardiac Rehabilitation Program. These services are open to all patients who are either self-referred or physician-referred. FMG patients are primarily referred to the Preventive Cardiology Program by Forsyth Medical Center and Thomasville Medical Center. All Preventive Cardiology Program staff are employees of Novant Health, the parent organization of FMG.

4.5 Stroke and Neurovascular Center

The Stroke and Neurovascular Center's mission is to reduce disability and death from stroke, promote patient recovery from neurologic events and to provide Primary Prevention in high risk populations and the community at large. A 2003 Forsyth Medical Center Study estimated that 60 percent of adults between the ages of 40–70 in Forsyth County were at risk for stroke. Thus, the Stroke and Neurovascular Center and its emphasis on preventive screening, medical management, and rehabilitation services can significantly affect the utilization of health resources.

Services provided by the Center are open to all patients. The program is monitored by an advisory board that includes neurologists from FMG. The Center's staff is made up of a team of vascular neurologists, vascular neurosurgeons, emergency medicine professionals, interventional neuroradiologists, and rehabilitation specialists. Activities are staffed by employees of Novant Health, the parent organization of FMG. The Center is a referral associate of FMG and it serves the community and surrounding counties of the related service area. However, there is no method to determine how many FMG patients have received services from the Center.

4.6 Case Management in Acute Inpatient Facilities

Case management for FMG patients who are admitted to Forsyth Medical Center or Thomasville Medical Center is coordinated by the Inpatient Physicians of Forsyth (IPOF), an FMG group. Case management is usually performed by registered nurses who coordinate patient care to ensure quality and cost-effectiveness. It is expected to decrease hospital lengths of stay and prevent recurrent hospitalizations. Services provided by case managers include coordination of patient care during hospital stay, assurance of continuity of care and availability of resources and services, and discharge planning. Inpatient case management is a basic inpatient service for transition of patient care.

As part of the PGP demonstration, FMG introduced a more formal discharge process for Medicare beneficiaries. All of their discharges are now directed to the central nurse call center, where follow-up appointments can be scheduled. Discharge appointments made through this system have been ranging from 250–350 a month, which is thought to be a success.

4.7 Patient Education

FMG is affiliated with several patient education programs that are primarily used to improve the management of chronic illness. The programs include the Lipid Management Program, the Healthy Living Program, the LEARN Weight Management Program, the Smoking Cessation Program and the Stress Management Program. Each of these programs targets at least one risk factor for chronic disease. For Example, the LEARN (Lifestyle, Exercise, Attitudes, Relationships, and Nutrition) Weight Management Program helps patients gain control of their weight, learn to manage stress, and improve fitness.

The programs are open to all patients through either self referral or physician referral, with the exception of the Lipid Management Program, which requires physician referral. The programs us a combination of physicians, registered nurses, registered dieticians, certified social workers, exercise physiologists, and support staff. All of the programs are staffed by Novant Health employees.

4.8 Chronic Disease Management

Disease management programs at FMG are developed internally. FMG believes that using internal resources versus external disease management vendors is important because internal staff have experience with providers, have access to medical records, and are more familiar with other internal programs and services.

Under the PGP demonstration, FMG developed a comprehensive disease management program, Comprehensive Organized Medicine Provided Across a Seamless System (COMPASS), offered to all FMG patients, including Medicare beneficiaries. Services provided under COMPASS include educational materials, medication management, appointment assistance, education on health resources and related classes, physician referral and case management. It expanded and integrated several existing disease management programs, and served as a vehicle for them to be publicized more intensively throughout the system. FMG has experienced a positive response to COMPASS, which is now gaining name recognition across its system.

The Disease Management Worksheet, a new initiative at FMG, is a color coded worksheet highlighting values for various quality measures related to diabetes, congestive heart failure, coronary artery disease and preventive care. The worksheet was developed to increase the available documentation of services provided to all Medicare beneficiaries at FMG. This worksheet was designed by the Steering Committee and physicians.

FMG is also working on developing and implementing a "recall system" that will remind high risk patients of upcoming visits and any necessary follow-up visits. This system will involve the development of organized tracking sheets that will be circulated to practice managers and physicians.

4.9 Outpatient Case Management

Case management existed at FMG prior to participation in the PGP demonstration. However, at that time case management was restricted primarily to the inpatient setting. Under the demonstration, FMG has expanded case management to an outpatient setting. Currently the outpatient case management program involves one case manager, a new hire for the demonstration, who manages approximately 55 patients. The case manager initially contacted patients based only on physician referral to case management. However, the case manager is now working with a list of patients with targeted diagnoses and high costs. High cost patients include those with three or more hospital admissions, health care expenses from $50,000 to $100,000, or diabetic patients with decubitus ulcers or skin ulcers. Once high risk and high cost patients have been identified, the case manager works proactively to eliminate unnecessary hospital and emergency room admissions.

FMG has also set up a nurse call-in program that facilitates primary care appointments for recently discharged patients. The outpatient case management program at FMG has received a positive response from both the physicians and patients involved.

One specific challenge with outpatient case management, and referral to educational programs in general, is that accessibility to certain programs varies by geographic location of the physician practice. FMG believes that patients seen at the outlying, more rural practices may not be able to travel to different clinics and program locations. It is therefore important for those sites to provide similar services at the practice level. Thus strategies for case management and patient education may vary somewhat across different FMG physician practices.

SECTION 5
PROVIDER PARTICIPATION AND RELATIONS

5.1 Provider Education

Providers are informed about the demonstration through meetings similar to a Town Hall Meeting. The meetings provide an opportunity for providers to share information, ideas, best practices, and progress under the demonstration. Steering Committee members and Medical Directors also meet with clinic staff and individual physicians to provide education and updates throughout the demonstration. Presentation topics during these meetings have included a general introduction to the PGP Demonstration, the new discharge process instructions, and disease management worksheet training. FMG's Steering Committee will continue to provide this type of information to its providers and other staff.

5.2 Provider Performance Support and Feedback

The Corporate Clinical Improvement group, an internal division of Novant Health, sets quality measures and produces individual provider feedback reports on these measures. A set number of chart audits are conducted for each provider. These charts are randomly selected from the provider's patient population.

Making individual providers and practices aware of their performance supports discussion of the quality indicators and allows them the opportunity to address any concerns. The Director of Clinical Services meets with individual providers and practices to review the results of the quarterly audits. Although efficiencies or cost savings have not been estimated, provider feedback reports are presumed to have a positive impact on individual delivery of quality care.

The FMG chart auditing procedures also assist with an evaluation of coding practices at FMG. After performing these chart audits, the compliance director estimates an 80 percent compliance with coding within the group.

5.3 Provider Compensation and Incentives

Physicians receive a base salary and have the opportunity to earn an incentive payment at FMG based on their practice's bottom line (i.e., total revenue less total expenses). Any bonuses are generally linked to practice productivity and financial performance. The bonuses eventually are distributed to providers within the practice. FMG leadership has a proposal to develop a provider salary based in part on quality of care. However, it is thought that this type of compensation structure would be difficult to implement due to inaccuracies in quality measurement, problems with patient compliance to treatment regimens, and other administrative problems (e.g., incorporating a quality bonus into a salary pool system).

The PGP demonstration financial incentives are not intended to be distributed to individual providers. The practices have an overhead budget to take care of patients; any additional bonus, after covering upfront investments, would go towards this overhead budget and through it efforts to improve infrastructure, health care quality and efficiency. Providers have reacted favorably to this structure, and indicated they felt they were being treated fairly and that they believe that demonstration participation is beneficial to their practices.

Non-financial incentives include payment of fees associated for the NCQA Diabetes and Heart/Stroke Recognition Program. It is believed that this would encourage physicians to participate and would ultimately result in improved diabetes and heart and stroke preventive care. After the first quarter of the demonstration, 56 FMG providers had been recognized for Diabetes Care and 28 physicians and three practices had been recognized for Heart/Stroke Care. The Novant Clinical Improvement area staff also provides support for applications to this program.

SECTION 6
DEMONSTRATION QUALITY INDICATORS

6.1 Appropriateness

FMG was generally pleased with the selection of quality measures for the demonstration. They felt the measures were nationally endorsed and in line with NCQA measures. FMG also found that the targets set under the demonstration were fair and consistent. Ideally, the quality measures would be risk adjusted; however, FMG recognized the difficulties associated with this type of adjustment. Additional quality measures suggested for the demonstration included measures relating to mental health/depression and medication reconciliation.

One measure criticized by FMG was the diabetes blood pressure (BP) measurement, which includes patient BP from the last patient visit. FMG felt that inclusion of a single BP measurement was unfair and unreliable. FMG suggested that the average of multiple measurements over time would provide a more accurate assessment of BP control. FMG found that a significant proportion of their patients have elevated BP measurements in the office compared to the measurements recorded on their home monitors.

FMG was concerned about the beneficiary assignment algorithm used in the demonstration. With the plurality of care assignment methodology it was possible that a beneficiary could be assigned to the group having seen only specialists at FMG. Without a primary care physician (PCP) at the group, it is difficult to measure and improve on some of the quality indicators. FMG feels that due to this design they will be penalized for their inability to affect the quality measures for those patients.

6.2 Improvement Strategy

Clinical improvement initiatives in diabetes and quality indicators have been tracked at FMG since 2003. The group has instituted a “green light/red light” system to track targets reached versus any negative trends. The “green light/ red light” reports are produced periodically for individual practices and practitioners as feedback reports.

FMG’s goal is to reach 90 percent of the HEDIS® or NCQA values. There has been an increase in the number of indicators since its inception and performance has shifted in a positive trend in most categories. FMG believes that this program has adequately prepared them for the measurement and improvement of quality indicators under the demonstration.

Moving forward under the demonstration, FMG plans to improve quality indicators by using the Disease Management Worksheet, increasing patient awareness of COMPASS, instituting an eye exam letter that ophthalmologists and optometrists can return back to the PCP, and distributing pocket information cards, tool kits for disease management and monofilaments for foot exams to providers. It will also educate staff on creating an environment for behaviour change and motivational coaching in chronic disease, and implement or expand case management systems and the central nurse call center.

6.3 Collection and Reporting

Commercial and Medicare Advantage insurers often provide feedback reports indicating service utilization and quality performance against NCQA HEDIS® measures. Although these insurers tend to target HEDIS® measures they also often include additional preventive health measures that are not official HEDIS® measures. The feedback is report driven and these groups do not offer any financial incentives for improvement. Reports are generated quarterly and the results are shared with medical directors and clinical practice counsel as well as individual providers.

Since a general reporting system was established prior to the start of the PGP demonstration, there has not been any overall additional expenditure dedicated to quality indicator measurement and reporting under the demonstration. Individual practices, however, are responsible for the expenses incurred to improve the quality within their practices. Practices that have been more aggressive about meeting quality measures have incurred greater costs, which is unfavorable. However, FMG is hopeful that stricter guidelines at the practice level will allow for decreased health care expenditures in the long run, and enable them to earn bonus payments under the demonstration.

SECTION 7
INFORMATION TECHNOLOGY

7.1 Strategy

FMG uses both internal Novant Health information technology (IT) resources and external resources provided through Salem Health Solutions, a Novant Health subsidiary. Salem Health Solutions is a health information analytics organization that evolved due to extensive disease management activities.

7.2 Systems and Initiatives

The FMG corporate intranet has been helpful in coordinating medical care. All hospital inpatient and outpatient reports are made available to providers over the intranet. These reports include patient history, results from physicals, emergency room visits, medicine reconciliation, labs and radiology services. The availability of this information is useful for avoiding duplication in testing and has ensured that providers have access to the most current hospital data for their patients.

Salem Health Solutions is working with the CMS-generated data to match it to the FMG data warehouse. They have developed Member Profiles for FMG. The profiles are developed for high risk patients, which are identified through diagnoses, providers, prescription information and cost data. These profiles are helpful for identifying patients who could benefit from case management.

FMG practices use Medical Manager software for practice management tasks such as appointment scheduling, medical histories, patient tracking and various reminder systems. The actual module(s) used from Medical Manager vary by practice. Although the software has been useful, FMG indicated some barriers to its use. They felt that the system was not user friendly and that training individuals to use the system was challenging due to the various levels of IT experience among staff.

FMG also utilizes Quality Care Guidelines software, which is designed to identify beneficiaries who had not had an office visit during a given time period as well as those who had not yet received preventive care (e.g., pneumonia vaccination). The information generated by this software is to be used by practices to follow-up on care and to generate letters and reminder cards for appointments and preventive care to be sent to patients.

Although FMG has not developed an EHR to date they are planning to move in that direction. They are currently looking to purchase a new EHR system due to the non user-friendly nature of Medical Manager. FMG believes that the implementation of an EHR would not have a significant impact in cost savings and quality improvement for 2–3 years and therefore has not accelerated its development for the demonstration.

APPENDIX A
AGENDA FOR FORSYTH MEDICAL GROUP SITE VISIT

Site Visit Agenda for Forsyth Medical Group
PGP Demonstration Evaluation by RTI

January 12, 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