July 2006

St. John's Health System 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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CONTENTS

List of Figures

List of Tables

EXECUTIVE SUMMARY

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 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 St. John's Health System (SJHS).

SJHS is a fully integrated healthcare delivery system consisting of six hospitals, ninety clinics, two health plans, eight pharmacies, fourteen regional ambulance services, six home health/hospice agencies and a skilled-care nursing home facility. SJHS is owned by the Sisters of Mercy Health System located in St. Louis, Missouri. Net revenues for the system are estimated at $1.2 billion annually. St. Johns Hospital, Springfield and St. John's Clinic are the groups participating in the PGP demonstration.

Demonstration Participation and Strategy. SJHS is interested in improving health care provided to the Medicare fee-for-service (FFS) population. Their goal is to create focus from the currently fragmented nature of the health care delivery system. SJHS is using a four part strategy under the demonstration: (1) physician buy-in, (2) investment in information technology, (3) investment in "core resources" (e.g., case management) and (4) alignment of incentives across the system. SJHS is currently expanding initiatives that were previously embraced for the managed care populations to the Medicare FFS populations. Additionally, the PGP demonstration has accelerated the development of other initiatives within the system (e.g., the Patient Registry). SJHS was initially reluctant to participate in the demonstration as participation would likely lead to reduced fee-for-service inpatient revenue for SJHS. However, it was recognized that if the project was successful, the community would benefit by reducing overall health care cost and that Medicare beneficiaries would benefit with improved health status, which would offset the reduced revenue SJHS would likely see.

Patient Care Interventions. SJHS's focus is on reducing hospital admissions through improved management of chronic illness. SJHS is working to reduce admissions/readmissions in congestive heart failure, chronic obstructive pulmonary disease, and diabetic patients. These populations are thought to be contributing significantly to avoidable hospitalizations within the system. The main focus of patient interventions at SJHS has been improved case management systems. Case management provides a mechanism to better coordinate and manage complex chronic illnesses as well as a means for educating patients regarding disease self-management skills.

Provider Participation and Relations. The PGP demonstration steering committee has been educating providers regarding the demonstration and the progress of initiatives under the

demonstration. Clinical Regional Directors and regional office managers have been disseminating information to all regional physicians and the steering committee has been making announcements regarding the demonstration through SJHS intranet and email systems. A poster competition has been organized by the steering committee to further educate providers on best-practices relating to performance and quality improvement under the demonstration.

SJHS provides physicians with real-time data to keep them engaged in performance and quality improvement. Performance data are collected in the Patient Registry and are available to providers through a web-interface. Clinic leaders refer to this data to assess the performance of individual physicians within the clinic as well as the clinic overall. They provide feedback and support to individual providers who appear as outliers. Financial incentives exist for providers to improve health care quality and resource use at SJHS, which have been expanded to include the Medicare FFS population. The payment of rewards under the Clinic Ministry Achievement Program (CMAP) is based on the achievement of financial goals, customer service, materials management, pharmacy and a balanced set of utilization and quality measures.

Demonstration Quality Indicators. SJHS indicated that the demonstration quality measures are reasonable, with the exception of the diabetes blood-pressure measure. They argued that this measure should be based on multiple blood-pressure measurements instead of a single measurement. SJHS raised concern about the alignment of measures across payers and stressed that inconsistent measures across initiatives drives up costs substantially.

The Medical Management Advisory Council (MMAC) at SJHS serves as the quality improvement and utilization management committee for the health system. The MMAC utilizes data to identify opportunities for improvement and develops corrective action plans using Rapid Cycle Improvement and Plan-Do-Study-Act (PDSA) methodologies. The main strategies for improvement are linked to initiatives undertaken by the Information Technology Department as well as the financial and other incentives existing for providers.

Information Technology. SJHS stressed that success under the demonstration requires investment in an information technology (IT) solution. SJHS's IT solution for the demonstration has been the development of the Patient Registry. The registry is a health outcomes database that draws data from a range of sources throughout the system including clinic registries, billing systems, scheduling systems, lab data and claims data. Summary reports and trend reports can be accessed by individual providers through a web-based application. This has allowed for real-time data to be made available to individual providers and clinic leadership. Although the system would have been completed regardless of demonstration participation, the PGP demonstration accelerated its development and deployment across the system. SJHS is also in the midst of evaluating and implementing an electronic health record (EHR) that can be used at the patient level in everyday practice, but this is viewed as a longer-term project that will only be implemented in several years, too late for the PGP demonstration. The Patient Registry is the main IT application for the PGP demonstration.

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 St. Johns Health System (hereafter "SJHS").

1.2 Sources and Methods

The primary source for this site visit report is the one-day, on-site interviews conducted by RTI staff. The SJHS site visit took place on December 14, 2005 at SJHS offices in Springfield, Missouri. The interviews were divided into multiple sessions on the following topic areas:

1. Demonstration Participation and Strategy—The purpose of this session was to understand SJHS' 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 SJHS 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, including SJHS participants for the site visit, is attached as Appendix A. SJHS participants included the Chief Executive Officer, VP Medical Management Services, Department Chair for Primary Care, VP Primary Care, Medical Director of Managed Care, Medical Director of Quality Resources, VP Clinic Finance, President of St. John's Clinic, Executive Director of Medical Management, VP Information Systems and other information technology, clinical and quality assurance personnel.

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

Statistics cited in this report sometimes vary slightly among alternative sources. For example, the reported number of physicians employed by SJHS might differ slightly among the SJHS 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 SJHS or published sources (e.g., SJHS'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 SJHS and its demonstration participation. We submitted this report to SJHS staff for their review of its factual accuracy.

1.3 Overview of this Report

The next section describes SJHS as an organization and the environment in which it operates. The third report section discusses why SJHS 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

St. John's Health System (SJHS) is a fully integrated healthcare delivery system consisting of six hospitals, ninety clinics, two health plans, eight pharmacies, fourteen regional ambulance services, six home health/hospice agencies and a skilled-care nursing home facility. SJHS is owned by the Sisters of Mercy Health System located in St. Louis, Missouri. Net revenues for the system are estimated at $1.2 billion annually. St. Johns Hospital, Springfield and St. John's Clinic are the groups participating in the PGP demonstration.

The St. John's Hospital consists of one central hospital and five regional hospitals. The Springfield location occupancy averages at about 450-525 patients. The St. John's Clinic is a physician-driven multi-specialty medical practice employing over 450 physicians. Over 40 percent of the physicians are primary care physicians. The clinic is divided into three divisions: the Regional Division, the Springfield Division and the Rolla Division. In the past year there have been approximately 1.4 million visits to the clinic.

SJHS's Board of Directors is responsible for the quality and efficiency of care provided by the system. The Board approves the *Quality Improvement and Utilization Management Plan* and provides oversight of the System's Quality Improvement, Utilization, Management, Credentialing and Health Promotion programs. To ensure the success of the demonstration project, SJHS has designated an Implementation Task Force to oversee the project.

2.2 Environment

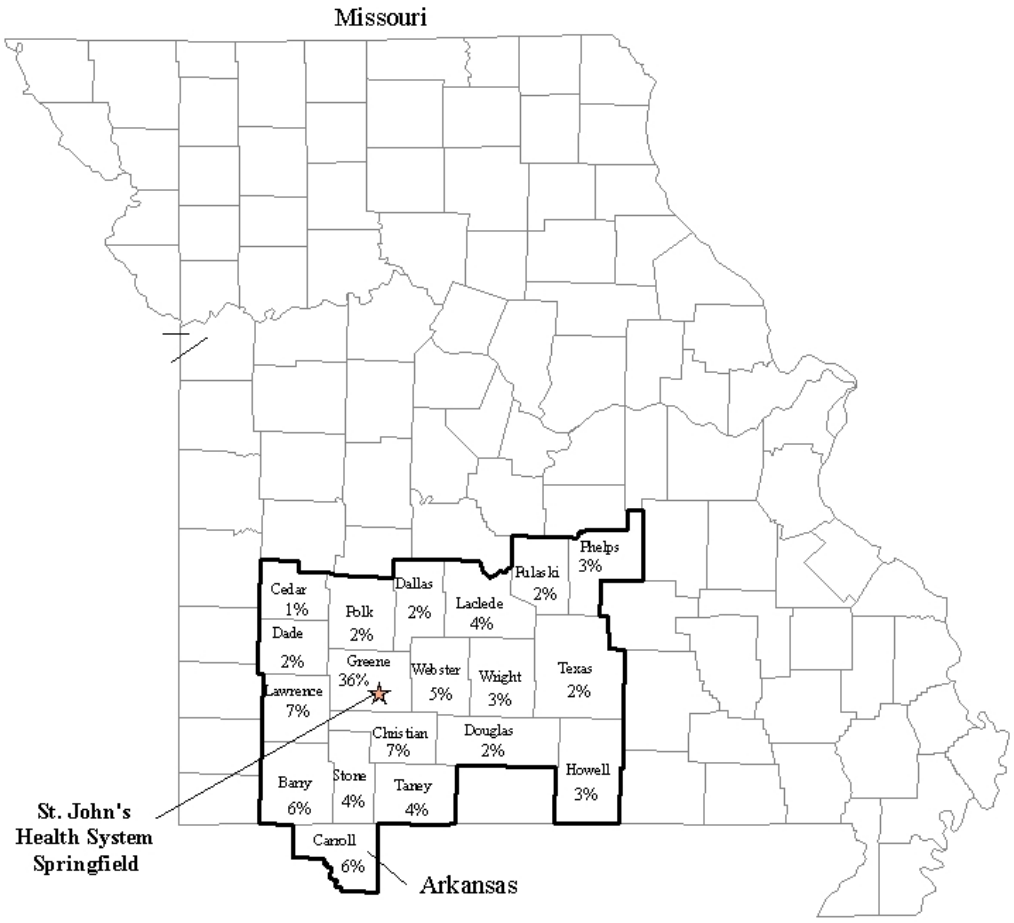
2.2.1 Service Area

SJHS serves a large geographic area in Southwest Missouri and Northwest Arkansas. Its primary service area consists of thirteen counties; however the system's seventy clinic locations serve residents in over thirty counties across Southwest Missouri and Northwest Arkansas.

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

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

Figure 1
St. John's Health System Medicare 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

Table 1 shows selected characteristics of SJHS's 2004 assigned Medicare patients available from Medicare administrative files. SJHS provided an office or other outpatient evaluation and management visit to 45,270 Medicare patients. Of these, 31,233 or 69 percent received the plurality of their evaluation and management services from SJHS and so were assigned to SJHS for the PGP demonstration. Assigned beneficiaries received 4.80 evaluation and management visits on average from all providers, with 87 percent of the associated Medicare allowed charges provided by SJHS on average. SJHS feels that the PGP demonstration beneficiary assignment algorithm worked well for SJHS since Medicare patients tend to stay within the system within Springfield. The mean annualized Medicare per capita expenditure for SJHS's assigned beneficiaries was $6,348 in 2004.

Eighty-one percent of SJHS's assigned Medicare patients are eligible for Medicare by age, 19 percent by disability (under age 65) and less than one percent by end stage renal disease. Fourteen percent had at least one month of Medicaid eligibility in 2004. Ninety-nine percent were white.

2.2.3 Payers

About 35.5 percent of SJHS's patients are insured by traditional Medicare. The distribution of patient insurance type at SJHS is almost 9% Medicare HMO, 30% managed care (health maintenance organizations [HMO] and preferred provider organizations [PPO]), 4.5% traditional indemnity, 14% traditional Medicaid, and 6% self-pay or uninsured.

The St. John's Health Plan, offered through SJHS, contracts directly with many of the largest employers in the system's service area. This managed care plan includes over 65,000 participants.

2.2.4 Competitors

SJHS has one major competitor in the Springfield area, CoxHealth (Cox). Cox is a health system with three hospitals and over fifty regional physician clinics throughout the Ozarks. Cox provides care to patients in twenty-two counties throughout Southwest Missouri and Northern Arkansas. The system's net patient care revenue for fiscal year October 1, 2003 to Sept 30, 2004 was estimated at $650 million.

2.3 Major Strategic Initiatives

SJHS is committed to "creating a culture of safety" for its patients through quality improvement initiatives. SJHS tracks quality measures for the PGP demonstration in addition to Health Plan Employer Data Information Set (HEDIS®) standard measures. SJHS has also joined the Institute for Healthcare Improvement's "100,000 Lives Campaign". This goal of this campaign is to save 100,000 patient lives by implementing six quality improvement initiatives: (1) deploy rapid response teams, (2) deliver reliable, evidence-base care for acute myocardial infarction, (3) prevent adverse drug events, (4) prevent central line infections, (5) prevent surgical site infections and (6) prevent ventilator-associated pneumonia.

Table 1
Selected characteristics of Medicare patients, Saint John's Health System, 2004

	No. of Beneficiaries	Percentage or Amount
Medicare Patients		
Total[1]	45,270	100%
Assigned Beneficiaries[2]	31,233	69.0%
Characteristics of Assigned Beneficiaries		
Average Number of Evaluation and Management Visits[3]	31,233	4.80
Average Percentage of Evaluation and Management Care provided by SJHS[4]	31,233	87%
Per Capita Annualized Medicare Expenditures[5,6]	31,233	$6,348
Distribution of Assigned Beneficiaries		
Total	**31,233**	**100%**
Medicare Eligibility		
Aged	25,338	81.1%
ESRD	111	0.4%
Disabled	5,784	18.5%
Medicaid Eligibility		
Not Medicaid Eligible for any months in 2004	26,728	85.6%
Medicaid Eligible at least 1 month in 2004	4,505	14.4%
Age		
Age < 65	5,879	18.8%
Age 65 - 74	12,956	41.5%
Age 75 - 84	9,429	30.2%
Age 85 +	2,969	9.5%
Race		
White	30,793	98.6%
Black	169	0.5%
Unknown	53	0.2%
Asian	53	0.2%
Hispanic	40	0.1%
North American Natives	55	0.2%
Other	70	0.2%

NOTES:

[1] Beneficiaries provided at least one office or other outpatient evaluation and management visit by SJHS.

[2] Beneficiaries who received the plurality of their office or other outpatient evaluation and management allowed charges at SJHS.

[3] Percentage of all office and other outpatient evaluation and management Medicare allowed charges provided to the beneficiary that were provided by SJHS.

[4] Office or other outpatient evaluation and management visits.

[5] Annualized Medicare expenditures per beneficiary are calculated by dividing actual expenditures by the fraction of the year the beneficiary is alive and eligible for Medicare (eligibility fraction), and are capped at $100,000.

[6] Weighted by the eligibility fraction.

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

SJHS's primary reason for participation in the PGP demonstration is to make a difference for the Medicare FFS population. SJHS's goal is to create focus from the fragmentation currently existing in the American health care delivery and reimbursement system. SJHS intends to demonstrate that "silos" are not good for healthcare and they are interested in providing empirical evidence that care coordination works to improve health care quality and to generate cost-savings.

The St. John's Health Plan contracts with several large employers in their service area. Employers experiencing any increase in health care costs have always looked at hospitals as the cause for increased medical insurance premiums. Southwest Missouri is no different. Participation in the PGP demonstration affords SJHS the opportunity to show their commitment to the continuation of affordable health care in southwest Missouri, while at the same time demonstrating their continued commitment to improve the health status of people in the communities they serve.

Being a fully integrated health system, it was the SJHS physicians who championed the participation in the PGP demonstration project. SJHS physicians, being well-versed in managed care through their participation in the SJHS managed care plans, were looking for an opportunity to move from "ill-care" to "well-care" for their Medicare FFS patients, similar to how managed care was able to do this for the Medicare Advantage patients. SJHS physicians recognized that what would be provided under the demonstration is "quality medicine" and that it is "the right thing to do". Physician buy-in to the PGP demonstration has been a driving factor in its success at SJHS.

3.2 Demonstration Strategy

SJHS identified four pillars to success under the PGP demonstration. First, physician buy-in is crucial; without the support of individual physicians the implementation of the demonstration would be unsuccessful. Second, an information technology (IT) solution or significant commitment from the IT department is needed. SJHS has made a major investment in developing a patient registry to track health outcomes across clinics and providers (a detailed description of this registry and other IT initiatives is provided in section 7). Third, SJHS emphasized the need for investment in "core resources," including the coordination of care by case managers and social workers. SJHS has currently invested $500,000 in developing these "core resources" and they expect to invest an additional $1.5 million. The fourth and final pillar for success under the PGP demonstration for SJHS is an alignment of incentives. For the most part this involves the alignment of quality related performance measures, however, to a lesser extend this also includes the alignment of cost and efficiency performance measures.

SJHS stresses that improvements to quality and efficiency represent two distinct strategies that are not mutually exclusive. Improvements in efficiency do not necessarily improve quality. SJHS has found that utilization measures generally need to be paired with a "balancing"

quality measure. Efficiency improvements, in general, require getting ahead of the issues and minimizing complications as well as reducing the utilization of high cost procedures such as MRI, CT and PET scans. An improvement strategy would require change in communications, resolution of payment barriers, financial incentives and improved training in medical schools and provider education systems about key process indicators and rapid improvement cycles. In addition to these strategies, SJHS stressed the importance of diminishing the existence of health care silos.

Generating cost savings under the demonstration will be difficult due to demonstration time constraints. Although SJHS has developed a strategy to improve efficiency, they stressed that showing savings may require more time than provided for the demonstration due to the need for turning around access patterns (e.g., fragmentation of care, behavior/entitlement and non-compliance). The main efficiency goal for SJHS is to reduce admissions.

Given limited time to show improvement under the demonstration, SJHS has prioritized the diseases that they will target initially. SJHS recognizes that not much can be done to reduce costs in diabetic patients in the short run as most interventions for this population would only show cost savings 5-10 years down the road. SJHS opted to focus their cost savings initiatives on the congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) populations. Specific interventions for these populations are described in section 4.

3.3 Relationship to Group Practice Strategy

The PGP demonstration fits with initiatives previously embraced by SJHS for their managed care population. SJHS has previously built an infrastructure around disease management and coordination of care. Their health plans already provide cost-effective and quality care. Participation in the PGP demonstration is expected to help extend programs and develop new initiatives for an additional payer population, Medicare FFS patients. This will work towards diminishing the “silos” that currently exist in health care delivery.

3.4 Leadership and Implementation Team

SJHS senior management is aware and supportive of the demonstration. SJHS’s demonstration implementation team is overseen by the Medical Management Advisory Council (MMAC), the Health Plans Board and the Clinic Executive Committee. The core steering committee includes the Department Chair of Primary Care, the VP of Primary Care, the VP of Medical Management Services and the Executive Director of Medical Management. The core team oversees two distinct groups working on demonstration initiatives: (1) the Clinical Planning Team and (2) the Technical Team.

The Clinical Planning team provides feedback regarding demonstration initiatives. Physicians are thought of as the “life blood” of this team. The Clinical Planning team also oversees the Long Term Care Communication Task Force and any Case Management initiatives. The Technical Team is also physician lead and is responsible for managing the SJHS Patient Registry and risk adjustment initiatives. Team members also oversee chart abstraction procedures for data reporting and documentation.

In general, Medical Directors act as the physician's eyes throughout the demonstration; they are responsible for ensuring that the demonstration initiatives are fitting into the general workflow of the physicians. SJHS staff believe the demonstration has integrated itself into core business quickly and is now transparent throughout the organization.

3.5 Implementation and Operational Challenges

SJHS's integrated structure provides incentives to move all initiatives across the system and is quoted as one of the primary reasons for why SJHS has been able to implement the demonstration relatively quickly. One disadvantage of being an integrated system in the project is the likelihood of reduced FFS revenue from hospitalizations due to improved efficiency in the health care provided for Medicare beneficiaries. It was because of this characteristic that the system leadership initially expressed reluctance to support participation in the project. However, SJHS believes that the expected market growth in the region would naturally offset decreases in utilization resulting specifically from the PGP demonstration.

SJHS staff believe that the PGP demonstration time frame is too short. In their view, the actual first performance year was only a few months since a substantial portion of the time was spent assimilating markers and implementing initiatives. SJHS mentioned that the length of the demonstration program substantially influenced their strategy under the demonstration.

SJHS was keen on participating in the PGP demonstration under the initial contract. OMB's changes involving the 2% target savings and the 5% cap on payments were less palatable. SJHS was concerned about this and other contract and agreement modifications during the beginning stages of the demonstration. They almost dropped out of the demonstration. However, they acknowledged the importance of the demonstration in improving care provided to Medicare FFS patients and therefore remained on board.

Increases in physician workload have been challenging to adapt to under the demonstration. The demonstration has involved a significant amount of upfront investment with no immediate guarantee of return. This has been particularly difficult to communicate to those involved in the demonstration, who are taking it on faith that they will eventually be paid for the work they are currently undertaking.

Extension of the PGP demonstration to smaller, non-integrated systems was thought to be difficult as the funds available for upfront investment could be limited. SJHS indicated that their success under the demonstration is largely due to an overall system investment of over a half a million dollars. Such a large investment may be difficult for smaller systems. However, if other groups were able to commit to the "four pillars" (i.e., physician buy-in, IT solution, "core resources" and alignment of measures) then the demonstration could be generalized and successful at other groups.

SECTION 4
PATIENT CARE INTERVENTIONS

At demonstration baseline, SJHS had three major disease management interventions in place: (1) The Outpatient Diabetes Education Self Management Training Program, (2) The Asthma Resource Center and (3) The Cardiac/Pulmonary Rehabilitation Center. In this section, we describe each of these programs in turn and also describe SJHS's broader case management systems and other patient care interventions.

4.1 Outpatient Diabetes Education Self Management Training Program

The primary goal of the Outpatient Diabetes Education Self Management Training Program is to help patients diagnosed with diabetes develop self-management skills. Participation in the program is open to all diabetes patients. Patients enter the program by physician referral and then begin a three part educational series.

The first session involves a one hour visit with a diabetes educator during which the patient's medical history is reviewed and needs are assessed. Patients receive a blood glucose meter to monitor their blood sugar level. The second session is a group education session taught by a registered nurse and registered dietician specializing in diabetes. The group session educates patients on topics such as the nature of diabetes, proper diet and exercise, the importance of communication with health care providers etc. The third and final session is a follow-up session that tracks the patient's progress in achieving blood sugar control and integrating self-management techniques into daily activities. Additional services available through the program include Medical Nutrition Therapy, Intensive Insulin Therapy, Gestational Diabetes Education, Insulin Pump training and Management.

During calendar year 2004, 210 Medicare FFS patients received training from this program. Patients entering the program saw, on average, a 1% reduction in HbA1c levels post-education. Feedback from participants regarding the program has been overwhelmingly positive.

4.2 Asthma Resource Center

The goal of the Asthma Resource Center is to improve asthma control and reduce the number of acute exacerbations. Participation in the program is open to all patients with asthma. Patients are seen at the center as soon as possible following an encounter in the emergency room (ER), urgent care center or primary care physician office.

Patients using the Asthma Resource Center (ARC) are seen for two visits. During the initial visit, a physician assistant reviews the patient's medical history and health services utilization. The physician assistant also assesses medication compliance, determines asthma triggers, assesses physical needs and educates the patient regarding the disease and treatments. Patients leave the session understanding the importance of an Asthma Action Plan and the importance of peak flow meter monitoring. The second visit is a follow-up visit involving a physical assessment and a review of medication use and compliance. The physician assistant then develops a written Asthma Action Plan with recommended changes in medications and reminds patients to follow-up with primary care physician in 4-6 weeks. Primary care physicians receive copies of the patient reports generated at the ARC.

During calendar year 2004, 15 Medicare FFS patients were enrolled in this program. Quality improvements were not tracked for the Medicare FFS population; however, a reduction in emergency room utilization was seen in the Commercial and Medicare HMO populations. Additionally, an increase in the use of preventive medications has been seen in the Commercial population.

4.3 Cardiac/Pulmonary Rehabilitation

The goal of Cardiac/Pulmonary Rehabilitation program is to improve the quality of life of patients with cardiac and pulmonary problems and to reduce their utilization of healthcare resources. Participation in the program is open to all patients referred by a physician. The focus of this program is on patient education on topics such as disease process, signs and symptoms of compromise that should be reported, use of medications and other prescribed treatments and discharge guidelines (for inpatients). Outpatient education assists patients in formulating goals and developing plans for lifestyle modification.

Inpatient cardiac and pulmonary rehabilitation provides 1:1 education between patient and educator. Outpatient rehabilitation can be provided on either a 1:1 basis or a group basis. Some patients may require tele-management, which is offered to CHF patients and provides 1:1 education and assessment between patient and educator via the telephone. Tele-management provides CHF patients with contact to a healthcare provider, which often results in improved treatment compliance and early assessment of decompensation of heart failure.

During calendar year 2004, 3,446 Medicare FFS patients received inpatient cardiac and pulmonary rehabilitation services. There were also 125 new Medicare FFS patients that received outpatient cardiac and pulmonary rehabilitation services. Patients have provided positive feedback on the program; satisfaction surveys have been in the 90+ percentile.

4.4 Disease Management

SJHS offers disease management programs for many diseases including diabetes, CHF, COPD, asthma and depression. These programs are physician driven and have a goal of providing necessary education and skills for the self-management of chronic disease.

4.5 Case Management Systems

Case management and utilization management are the main interventions for SJHS under the PGP demonstration. Case management is important to decrease the fragmentation of health care delivery. Four nurse case managers have been hired for the demonstration. This is thought to be sufficient for the goals of the demonstration. It is believed that additional case management staff will not be needed since patients move both in and out of case management. The goal of case management is not to provide long-term assistance, but instead to provide patients with the tools necessary to “graduate” from requiring case management. For the St. John’s Hospital admissions, inpatient case managers work with 50 patients each on average; and for the managed care population, the outpatient case managers work with approximately 3,000 patients. It is expected that similar ratios will be seen for the Medicare FFS population.

One important aspect of case management at SJHS is patient education regarding disease self-management skills. SJHS's case management system is structured for this type of education and is focused on changing patient behaviour and improving self management of disease.

SJHS identifies patients for case management through emergency room (ER) visits and through diagnosis data. Patients receiving ER treatment for chronic illness have been of particular interest because often this type of visit may indicate health care access issues. Once patients have been identified they are stratified, based on patient need, to case management, resource centers or telephonic case management. This type of stratification procedure makes case management affordable. Patients with limited risk are usually assigned to telephonic case management, which provides a platform for regular (quarterly) follow-up of patients. Counseling can be provided by nurse case managers to help with behaviour changes for both patients and families. The counseling is not always related to a specific disease process.

Patients most frequently end up in case management at SJHS due to treatment non-compliance. The primary reason for non-compliance has been a lack of clarity and understanding between providers and patients. Generally, Medicare patients need reinforcement of the decisions they are making to manage their disease. Case managers offer this type of support and assist patients in developing a sense of self-worth. From a case manager's perspective, patients entering the case management system are primarily looking for an attentive provider. Therefore, successful case management requires the development of a solid relationship between patient and case manager.

Currently, SJHS has initiated a CHF and COPD case management system. For CHF approximately 75 patients are receiving formal case management, 166 patients have been referred to the HF Resource Center, and 7 are receiving Telephonic Case Management. For COPD, 46 patients are receiving case management, 1 patient has been referred to Pulmonary Rehabilitation and 35 patients are receiving Telephonic Case Management.

The case management systems in place for Medicare FFS patients are new and the population involved in the systems is expected to grow throughout the demonstration years. New strategies to improve case management include a movement towards personalized online journals for patients and voice activated technologies. However, these have not yet been implemented at SJHS.

Challenges that exist with case management in the Medicare FFS population have included difficulties in moving patients from one level of care to another (e.g., acute home health to other home health) and working with Medicaid home health agency issues. Additionally, it is difficult to provide case management to a patient with a primary care provider outside the system. This situation presents obstacles to accessing patient health care records and requires coordination with providers outside SJHS. It is therefore important for case managers to develop a rapport with external primary care providers. Working with external primary care providers to provide case management could be a drawback for SJHS under the demonstration, since it is possible that by doing this they are assisting in the management of their comparison group Medicare patients.

4.6 Other Patient Care Interventions

Currently the use of social workers at SJHS is limited; however, SJHS intends to expand the role of social workers under the demonstration as this would provide greater continuity of care. SJHS staff believe that much of the fragmentation in health care can be rooted in social issues and therefore, social workers would be helpful in improving the system. At SJHS social workers would travel to the various clinics to provide support, particularly in advanced care planning.

SJHS was recently awarded an Arthritis grant to educate patients on how to live with this chronic illness. The education program teaches patients self-care concepts similar to the case management systems. The program requires a substantial amount of marketing to identify and target individuals who would benefit from the program. Although this intervention is outside the PGP demonstration, SJHS expects that there will be spillovers from this program affecting the Medicare FFS population participating in the demonstration.

SJHS has also developed a Medication Access Program to assist low income and high risk beneficiaries with access to low-cost medications through pharmaceutical manufacturers. The Medication Access Program has received over 150 referrals from Medicare patients, who were subsequently found to be eligible for assistance.

SJHS is in the beginning stages of developing a long-term care communication plan task force that will be charged with evaluating the communication process between long-term care facilities and emergency departments. There is also new emphasis at SJHS on immunization assessment and palliative care programs. Palliative care programs would also provide support for advanced care planning.

4.7 Patient Notification of the Demonstration

SJHS has identified patients from the nineteen selected sites and has notified patients about the demonstration through signage and brochures. SJHS has set up a telephone line that responds to patient demonstration concerns; however the phone line has been used infrequently to date.

SECTION 5
PROVIDER PARTICIPATION AND RELATIONS

5.1 Provider Education

Physicians at SJHS are increasingly becoming aware of the PGP demonstration interventions. Although physicians have been interested in the new interventions there has been some resistance. Some physicians, for example, may be cautious in utilizing the case management systems, particularly since those services are not currently reimbursable under Medicare, unlike managed care.

Engaging primary care physicians in new interventions and the demonstration in general involves explaining the full context of the PGP demonstration, including what is happening nationally with other similar initiatives, so that the reality of the project is accurately conveyed. It is also important for physicians to be reminded about why it is that SJHS is participating in the demonstration; the main reason being that "it is the right thing to do."

The demonstration steering committee at SJHS has been making announcements regarding the demonstration through their intranet and email systems. Providers have been educated about using new tools (e.g., the Patient Registry) for meeting the goals of the demonstration. Newsletters published by the system have included articles regarding PGP demonstration participation, specifically addressing topics such as the quality measures and the strategy for the deployment of the project. Additionally, the Clinic Regional Directors and regional office managers have been disseminating information to regional physicians including Patient Registry education and reports, monthly progress updates and future action plans

SJHS has set up a poster competition for clinician offices to be held in February, 2006. The posters are required to be relevant to the PGP demonstration goals and must provide evidence on how physicians have been using the FOCUS-PDSA methodology to improve performance. The poster competition will provide education to all physicians regarding the demonstration and will recognize clinics for deploying operational strategies related to the demonstration. Participation is encouraged and monetary prizes will be awarded for the top posters as judged by a selection committee. SJHS expects to have 6-7 poster contributions in this first year.

In addition to being educated about the demonstration and resulting initiatives, SJHS has been focusing on providing communication training to providers. As mentioned previously, one of the main reasons that patients are referred to case management is due to non-compliance resulting from a lack of understanding by the patient. Communication training for providers and education on why patients do not adhere to treatment is important in solving this non-compliance issue and could ultimately result in avoided hospitalization and decreased ER visits.

5.2 Provider Performance Support and Feedback

Physicians need to see real-time, front line data to remain engaged. This allows them to see how they perform and allows them to respond to deficiencies in performance. Providing physicians with older, out-dated performance data (e.g., assigned beneficiary claims data

provided by CMS/RTI) is not engaging. The Patient Registry, described in chapter 7 is the primary tool used to provide real-time time feedback to providers regarding performance measures. Clinic leaders refer to the data in the Patient Registry to track individual provider performance as well as the performance of the clinic. Leaders provide feedback and support to providers who appear as outliers in terms of performance improvement.

5.3 Provider Compensation and Incentives

Physicians at SJHS are compensated using a bottom-line plan (i.e., revenues minus expenses). There is very little cross-subsidy of expenses within the system, so currently any costs occurring in physician offices due to data reporting and increased documentation under the PGP demonstration are borne by the physician offices themselves. Physicians have been taking it on faith that they will eventually receive a financial return for their increased work. One downside of this is that when incentives (e.g., bonus payments under the demonstration) are not tied closely and quickly to interventions it is difficult to get physician buy-in and support for initiatives. SJHS is working on strategies to reduce burden on PCP offices and to provide incentives to providers to work with the demonstration initiatives.

Financial incentives exist for performance improvements by providers at SJHS. The financial incentives existing under managed care at SJHS have been expanded to include the Medicare FFS population. The Clinic Ministry Achievement Program (CMAP) is a financial incentive program designed to improve health care quality and resource use at SJHS. All physicians employed by the Clinic are eligible to participate in the program. The program is based on the achievement of financial goals, customer service, materials management, pharmacy measures, and a balanced set of utilization and quality measures. The PGP demonstration quality measures have been included as part of CMAP.

One potential challenge with this type of system is that providers may decide to stop caring for sicker chronically ill patients to keep their performance measures high. To limit these disincentives, the CMAP is structured such that it pays a reward based on the number of patients a physician “gets to the right place”. This payment system provides incentives to providers to treat more patients. Experience with the system shows that physicians with the heaviest patient loads are doing well. Over time, CMAP has become a part of physician culture at SJHS.

SECTION 6
DEMONSTRATION QUALITY INDICATORS

6.1 Appropriateness

SJHS expressed concern about the PGP demonstration diabetes blood-pressure measure, which considers blood pressure during the last patient visit. This measurement is thought to not adequately capture blood pressure control since blood pressure can fluctuate substantially from one visit to the next for a number of reasons, such as use of cold or flu medications and the "white coat syndrome". SJHS suggests that the measure for blood pressure control include an average of multiple measures over time.

6.2 Improvement Strategy

The Medical Management Advisory Council (MMAC) serves as the quality improvement and utilization management committee for the health system. The council utilizes data to identify opportunities for improvement and then plans and evaluates actions taken to improve care and services. Corrective plans are implemented using Rapid Cycle Improvement and Plan-Do-Study-Act (PDSA) methodologies. The main strategies for improvement are linked to the new initiatives undertaken by the IT department as well as financial and other incentives existing for providers.

Improvements on quality measures were much slower than anticipated by SJHS. SJHS believes that the main reason for this has been the short time period. They are confident that they will meet the targets set for all measures under the PGP demonstration. Evidence for the diabetes quality measures currently shows improvement from 2004 to 2005.

6.3 Collection and Reporting

The PGP demonstration measures, although similar to some HEDIS® measures, are just different enough to require additional work and documentation. Alignment of the PGP demonstration measures with other initiatives (e.g., HEDIS®) would have been ideal to cut down on the amount of work required. SJHS anticipates that the second year of the PGP demonstration will require much more work, due to the measures requiring more manual data entry.

Data collection and reporting under the PGP demonstration is costly. The difficulty and costs associated with improving a specific measure depends on the nature of the measure. Blood pressure, for example, requires a more intensive time investment since manual data entry is required. The Patient Registry and Site Visit Planner described in section 7 have been extremely useful tools in the collection and organization of data for the demonstration. The Patient Registry almost eliminates the need for chart based reviews, which can require high upfront costs.

Several PGPs have encountered difficulties with the inclusion of the foot exam as one of the diabetes quality measures. This has not been a problem for SJHS as they have created an internal dummy code to indicate the completion of a foot exam. SJHS has found that this dummy code has been a time saving tool, eliminating the need for individual patient chart review.

SECTION 7
INFORMATION TECHNOLOGY

7.1 Strategy

Investment in IT is seen as crucial to being successful under the PGP demonstration. IT has been developing tools to collect and report performance data for individual physicians at SJHS. The major initiative undertaken by SJHS's IT department has been the development of the Patient Registry, described below.

7.2 Systems and Initiatives

7.2.1 Patient Registry

The Patient Registry is a health outcomes database developed and managed by SJHS. It was implemented in July, 2005 and contains data on over 100,000 Medicare patients. The registry draws from a series of data sources throughout the system including the clinic registries, billing systems, scheduling systems, lab data and claims data. Individual providers can access the database and create reports using a web-based application.

One very useful feature of the Patient Registry is its ability to generate a Visit Planner. The Visit Planner allows providers to create lists of patients that will be seen during the course of the day. They provider receives a one page summary for each patient showing test dates and results. It also highlights tests for which the patient is due. In general, providers have found the Visit Planner very useful for organizing and collecting patient data. It has helped to boost usage of the Patient Registry by physicians.

SJHS's Patient Registry is one of the system's largest efforts for the demonstration. The original impetus for the Patient Registry was for managed care populations and to provide a tool that would assess gaps in care and physician performance. Therefore, although the registry would have been created regardless of the demonstration, SJHS's participation in the demonstration has acted as a catalyst for its completion.

The push for the development of the registry came at a good time for IT, since they were revising their web structure at the same time and the development of the registry required similar systems. The PGP implementation team provided IT with a preliminary design for the registry and in six months the system was running. Once developed, the PGP implementation team rolled out the registry to individual providers and senior leadership. IT currently provides technical support for the registry and continues to make revisions to the system based on feedback from users.

The Patient Registry has been a collaborative effort between developers, managers and directors. The design, implementation and testing of the registry required approximately 2 FTEs. The team continues to work on improvements to the registry.

7.2.2 Other IT Systems and Initiatives

SJHS does not currently have an electronic health record (EHR); however, one is under development. The EHR under development will use an electronic chart interface that creates an integrated record to serve as a clinical repository. An EHR has been deployed to pilot sites within SJHS and the evaluation of this pilot program continuing. SJHS estimates that the implementation period for the EHR will last 2-3 years. In comparison with the Patient Registry, the EHR would be used at the patient level in everyday practice. The Patient Registry provides population level data that is useful for tracking physician performance. The Patient Registry was developed before the EHR since it was thought to be more crucial to the PGP demonstration. Once both systems are finalized data from an individual patient's EHR will be fed directly into the Patient Registry.

Additional software used in the demonstration includes the decision support software created for case managers and the 24/7 nurses. This software provides consistency between managers and triage protocols, which is expected to decrease ER visits and emphasize office visits, self care and urgent care.

Data warehouses that have been developed by SJHS include the physician management application, physician billing system and the case-mix repository (CMR) that are both used to improve patient targeting. Each of the data collection systems existing within SJHS are used to generate clinical, financial and operational reports. Clinical reports track health services utilization, quality measures and patient disease status. They also promote compliance with disease-specific guidelines. Financial reports track the impact of interventions on costs/savings and monitor expenses at all levels within the system. Operational reports assist Medical Management Services to appropriately assign patients to case managers or telephonic programs. Many of these measures are tracked on the monthly "Dashboards" that are circulated within the system.

APPENDIX A
AGENDA FOR ST. JOHN'S HEALTH SYSTEM SITE VISIT

Site Visit Agenda for University of Michigan Faculty Group Practice
PGP Demonstration Evaluation by RTI

December 14, 2006

9:00–9:30 a.m.	Evaluation and Site Visit Background
9:30–10:30 a.m.	PGP History and Organization Structure, Demonstration Participation, and Strategy
10:45-11:45am	Patient Care Activities/Interventions to Improve Efficiency
11:45am-1:00pm	Lunch
1:00-2:00pm	Provider Participation and Relations
2:00-3:00pm	Quality Improvement
3:15-4:15pm	Information Technology