Curriculum Guide on Managing Care:
A Systems-Based Approach

Version 1.2

Sample Pages from the Instructional Materials Provided in the Guide

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Forms
- Checklist for Course Director: Implementing the Rotation and the Sessions
- Teaching Site Profiles:
  - A Profile of the Managed Care Organization Participating in the Rotation
  - A Profile of the Community Practice Participating in the Rotation

- Evaluation Forms:
  - Resident Feedback Form: Session Evaluation Form

- Resident Feedback Form: Overall Rotation Evaluation Form
- Faculty Feedback Forms
- Course Director Summary Form

- Confidentiality Agreement for Residents Regarding MCO Sessions

Part II. Session Instructional Materials

List of Sessions

Faculty Overview and Orientation

Community Practice sessions
Managed Care Organization sessions

Instructional Materials: Sessions in binder and on CD-ROM

- **Managed Care Organization Perspective Session:** Quality Assurance and Improvement
- **Community Practice Perspective Session:** Utilization Management in the Community Practice

Instructional Materials: Sessions on CD-ROM only:

Community Practice Perspective Sessions:

Population-Based Care and Patient Management
Referral Management
Patient Education / Health Education
Practice Management Systems and Operations
Reimbursement and Compensation

Managed Care Organization Perspective Sessions:

Utilization Management in the MCO
Provider Performance Reports
MCO-Physician Contracting
Case Management
Disease Management
Pharmacy Management
Evaluating New Medical Technology

Provider Performance Reports

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Objectives

Residents will be able to:

- Describe specific measures that can serve as useful feedback to PCPs, specialists, or a provider group
- Identify what types of data are most often used, and discuss how to select what data to use
- Define risk adjustment
- Identify factors that contribute to changes in practice patterns based on the reported information
- Describe how a physician or group can use provider reports to improve practice

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Overview of Discussion

- Definitions
- Context for provider reports
- Key issues
  - Selection of measures
  - Sources of data
  - Controls and benchmarks
  - Risk adjustment
  - Provider relations
  - Practice improvement

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Definitions

- Provider Reporting: Giving information on a provider's clinical practice, aggregated across a number of patients.
- Provider Profiling: Giving provider-specific information, aggregated across a number of patients, for the purpose of comparing individual physicians to their peers or other benchmarks.

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Context for Provider Reports

Doctors need to know:

- Am I taking good care of my patients?
- Are my patients happy with the care I provide?
- Am I practicing as cost-effectively as I can?
- Can I improve my delivery and coordination of care? How?

6

Key Issues in Provider Reporting and Profiling

- Selection of measures
- Sources of data
- Controls and benchmarks
- Risk adjustment
- Provider relations
- Practice improvement

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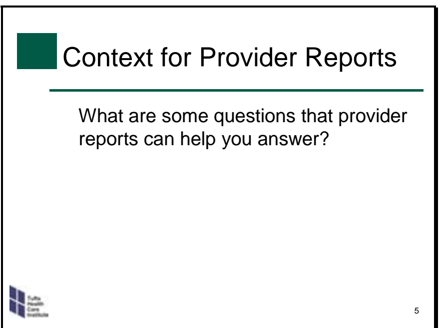
Provider Performance Reports

Faculty Notes for Slides - Samples

These slides should be clear enough for your discussion with the residents. Here are some additional background notes for certain slides.



Residents can reveal their understanding of the uses of provider reports. The next slide suggests some answers to the question.

Sample: Orientation / Slides / Notes

Context for Provider Reports

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- Am I taking good care of my patients?
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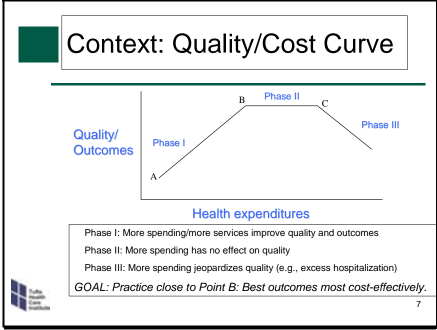
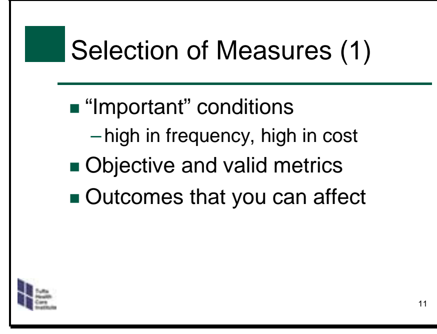
Residents can reveal their understanding of the uses of provider reports. The next slide suggests some answers to the question.



Quality and cost are usually positively associated to a certain point. Past that point, quality gained per extra unit of cost often becomes minimal. Then there often comes a point where quality declines with extra expense, e.g., procedures with minimal positive benefit but increased risks of morbidity; unnecessary diagnostic tests which may result in false positives and generate costly and possibly harmful diagnostic and therapeutic procedures.



a. Choose to measure outcomes of "important" conditions. That is, they are common and/or expensive (in terms of cost or quality), e.g., hospitalization, common invasive procedures like arthroscopy or endoscopy.
b. Use (or develop) an objective and valid metric. For example: mortality rate, cost per patient, cost per prescription, re-admission rate, patient satisfaction (from a validated survey instrument).
c. Don't waste time on outcomes you cannot affect. For example, rather than worrying about the length of stay for your patients who are occasionally admitted to a hospital where you don't have privileges, focus on practice patterns at your local hospital.

Provider Performance Reports
Cases for Discussion

Instructions: Please read the following case vignettes and answer the discussion questions for each case.

Case: The HMO sends you a report saying that your diabetic patients are getting annual eye examinations only half as often as the patients of other PCPs in the plan. You are certain that they must have made a mistake somewhere.

Q. What are possible explanations?

Case: Your group's medical director calls a meeting to discuss how to reduce the very high rate of home health care use by the group's patients.

Q. Is this utilization pattern necessarily a problem? What are possible explanations?

Provider Performance Reports
Answers to Cases for Discussion – Faculty Guide
(Do not distribute to trainees)

Instructions: Please read the following case vignettes and answer the discussion questions for each case.

Case: The HMO sends you a report saying that your diabetic patients are getting annual eye examinations only half as often as the patients of other PCPs in the plan. You are certain that they must have made a mistake somewhere.

Q. What are possible explanations?

A. Claims data may be incomplete (e.g., optometrists/ophthalmologists may not have properly billed for these services--unlikely if they are paid fee-for-service but possible if they are fully capitated).

You may have referred your patients for these services but they are not complying (remember, though, that if you are trying to provide high quality care, then compliance is your problem, too).

Note that this example and the ones that follow are not risk-adjusted. Perhaps the patient panels are different with respect to age and gender. Perhaps certain kinds of patients gravitate to one physician due to formal or informal specialization in one area. If the panels are truly comparable, then focus on those areas of variation that are most important (again, in terms of cost or quality).

Case: Your group's medical director calls a meeting to discuss how to reduce the very high rate of home health care use by the group's patients.

Q. Is this utilization pattern necessarily a problem? What are possible explanations?

A. Home health care (HC) is just one part of a larger medical budget. To the extent that HC is used as an appropriate substitute for acute or subacute inpatient care, it is not a problem. If HC is high, along with associated categories (inpatient care, DME, OT and PT) then it may signal an opportunity to reduce inappropriate overuse of services.

Alternatively, the group's patients may truly be sicker. Do they have older patients (is it a group of geriatricians?) or do they attract sicker patients (are many of the doctors practicing both as PCPs and a subspecialty that might attract more complex patients to them?)

Provider Performance Reports
Further Instructional Opportunities

Note to Faculty: Please select one or more of the following activities or discussion topics to continue instructing the trainees in how this content applies to actual settings and practical situations.

1. Routine Reporting Set. Have the residents review your health plan's standard set of reports to provider units and individual physicians. Discuss the range of variables captured, the mix of cost and utilization data, the frequency of data dissemination, the method for risk adjustment, and other important aspects of the routine reports. Also indicate the plan's ability to produce more detailed reports upon request.

2. Report Definition and Data Processing. Describe for the residents the steps and participants in the processes of deciding what information to report, collecting the data, and producing the actual reports. Discuss the difficulties and shortcomings, such as statistical validity and completeness of claims data.

3. Report Distribution. Discuss the procedures and issues in providing these reports to their audiences: who presents them, who receives them, the plan's responses to questions or complaints from providers, etc. Have the residents meet one of the staff who deal directly with providers around these reports; the residents might also attend a meeting between plan and providers.

4. Marketplace Perspective. Discuss your health plan's reports in the broader context of the local marketplace. How do provider groups deal with multiple reports from different health plans for distinct panels of patients? Are local delivery systems producing their own profiles? What do you project as trends in performance reporting for the next few years?

Provider Performance Reports

Post-Test Questions

1. A technique to standardize the information in performance reports for comparison purposes is:
   A. Show units of service and costs for one quarter (3 months)
   B. Calculate utilization and costs as rates per patient or per 1000 patients
   C. Annualize all utilization and cost figures
   D. Calculate utilization and costs as rates per member or per 1000 members

2. The most common source of data for performance reports is:
   A. HEDIS results
   B. Claims data
   C. Member surveys
   D. Utilization management data from cases requiring review and authorization

Provider Performance Reports

<u>Post-Test Questions</u>
(Faculty Guide with Answers)

1. A technique to standardize the information in performance reports for comparison purposes is:
    A. Show units of service and costs for one quarter (3 months)
    B. Calculate utilization and costs as rates per patient or per 1000 patients
    C. Annualize all utilization and cost figures
    D. Calculate utilization and costs as rates per member or per 1000 members

    Answer: D.

    Per member per month or per member per year, or per 1000 members per month/per year are used to compare performance of a panel of members. If patients only were the denominator, it would omit other members of the same physician or practice panel who may or may not need care but who are included in the enrollment database. The time frame of data in the reports varies, with annualized figures frequently provided.

2. The most common source of data for performance reports is:
    A. HEDIS results
    B. Claims data
    C. Member surveys
    D. Utilization management data from cases requiring review and authorization

    Answer: B.

    Claims data are widely available and relatively easy and inexpensive to access and use. Compared to other data sources, claims data are generally the most complete.