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PROJECT BRIEF 2012

Incentivizing the Outcome

Paying for Population Health at Hawaii FQHCs

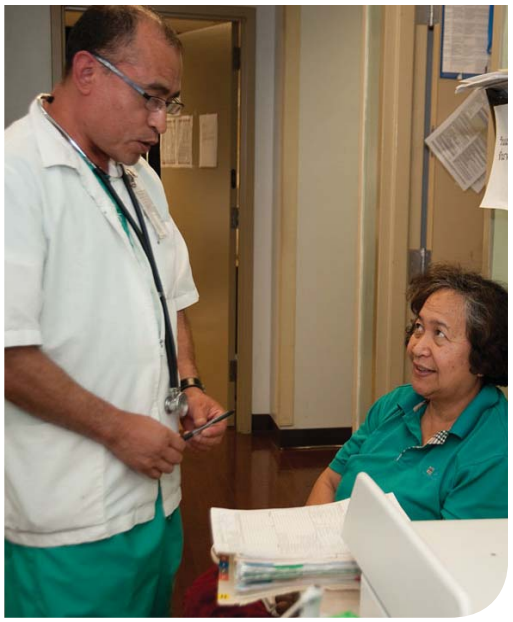
WHAT IS PAY-FOR-PERFORMANCE (P4P)?

According to the Agency for Healthcare Research and Quality, pay-for-performance (P4P) programs incentivize providers who improve standards of care. These programs are developed together with health plans and health organizations, such as hospitals and smaller clinics, to offer financial rewards to clinic staff or their patients who meet predefined measures.[1] P4P enables payors to better align payment with quality of care delivered. Incentive programs can be beneficial for addressing accomplishments in clinical care, efficiency, patient satisfaction, and use of information technology (IT) improvements.[2]

AAPCHO, in collaboration with four of its Hawaii member Federally Qualified Health Centers (FQHCs) and one member health plan, designed and developed a P4P program specifically targeting FQHC provider performance and improvements in patient health outcomes. FQHCs, also known as community health centers (CHCs), are community-based and patient-directed organizations that provide comprehensive primary health care services and non-clinical enabling services (education, translation and transportation, etc.) to vulnerable populations including high-risk, low-income, uninsured patients. Most often in a FQHC setting, patient care is managed by a provider team that includes a support staff who in addition to primary care providers, also play an integral role in providing care to patients. FQHCs also offer additional services that are not typically seen in primary care settings, such as oral, dental, behavioral health, and pharmacy services.[3] Studying incentive programs at the FQHC level is beneficial for both developing culturally and linguistically appropriate models of care tailored to these medically underserved populations and for understanding and documenting the processes unique to these settings.

AAPCHO'S PAY-FOR-PERFORMANCE PROJECT

AAPCHO's P4P program examined financial rewards given to groups of FQHC staff for improvements in reducing hospitalizations and emergency room visits for patients with psychosocial conditions. These groups consisted of physicians, nurses, medical assistants, case managers, care coordinators, and other support staff. AAPCHO's program is unique from other emerging FQHC research because of its focus on rewarding health center teams, not just individual primary care providers, who serve high-risk low-income Asian American, Native Hawaiian, and



PROJECT SITES

Federally Qualified Health Centers

- *Bay Clinic, Inc.* (Hilo, Hawaii)
- *Kalihi-Palama Health Center* (Honolulu, Hawaii)
- *Waimanalo Health Center* (Waimanalo, Hawaii)
- *Waianae Coast Comprehensive Health Center* (Waianae, Hawaii)

Health Insurance Plan

- *AlohaCare* (Honolulu, Hawaii)

PACIFIC INNOVATION COLLABORATIVE

The Pacific Innovation Collaborative (PIC) was a project that created a shared data repository of clinical information from select health centers and health insurance plans. Health center and patient information could be accessed by clinical staff in order to align quality improvement efforts with the development of performance-based measurements as outlined by the federal Centers for Medicare & Medicaid Services.

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PERFORMANCE MEASURES

Emergency Room Visits: Number of low-income patients (FPL < 200%) visiting the emergency room for mild/acute problems, who have diabetes or cardiovascular disease and a psychosocial condition.

Hospitalizations: Number of low-income patients (FPL < 200%) who were hospitalized for diabetes or cardiovascular disease and a psychosocial condition.

PROJECT EXPECTED OUTCOMES

- Improve the health status of target high-risk AA&NHOPI patients
- Improve the quality of care provided at project FQHCs
- Contribute to the limited research and data about P4P incentives and the implications for low-income AA&NHOPI populations
- Promote a team-focused culturally/linguistically appropriate models of care and interventions
- Track and analyze health plan-provided data through an electronic data repository and reporting system
- Utilize the project to share best practices and lessons learned for future interventions and P4P initiatives

other Pacific Islander (AA&NHOPI) patients in Hawaii.

Another distinctive aspect of AAPCHO's P4P program was its project sites' use of health information technology (HIT) developed through AAPCHO's Pacific Innovation Collaborative (PIC) project in combination with their Electronic Medical Records (EMR). Performance and improvement measures at P4P program health centers utilizing PIC HIT (P4P+HIT) were compared to non-P4P+HIT program health centers located throughout Hawaii who did not all have EMR in place. The overall intent was to examine whether a team-level P4P incentive program would be successful in this type of setting.

A three-year study was conducted to investigate the effectiveness of health center interventions that included financial rewards for reducing emergency room visits and hospitalizations in high-risk low-income patients with multiple conditions most of whom were AA&NHOPI. Each health center distributed specific monetary amounts to teams of providers and patients who worked together to improve and address patient care for the two measures. Interventions were tracked using patient data on ER visits and hospitalizations through the PIC HIT online reporting system. The reporting system allowed project sites to pull patient information to check for indicators that baseline improvements were made/not made based on a given period in which FQHC-specific interventions were implemented. For this study, those periods occurred in intervals of six months, with evaluations conducted at the end of each period.

KEY FINDINGS

Findings show that emergency room visits did visibly decrease, but the rates of patient hospitalizations remained unchanged. Further analyses show that the P4P incentives did not have a direct effect in decreasing emergency room visits. This may be due to many concurrent initiatives at the FQHCs that targeted the same high-risk populations that were being assessed in AAPCHO's P4P+HIT program. These initiatives were difficult to isolate in the health centers' numerous ongoing efforts and economic changes as a result of health reform. Therefore, a combination of various strategies at the FQHCs could account for the decrease in ER visits, illustrating that monetary incentives may not be the main motivators for clinic staff and patient improvements.

Based on qualitative findings improvements in the processes of care were made through the hiring of care coordinators and other personnel that would help with patient services, and expansion of their existing IT infrastructure. Project members felt that hiring of care coordinators and case managers led to a more personable experience that contributed to patients becoming more proactive in their own health care. These new staff members built rapport and trust with FQHC patients,

contributing to the health centers' overall holistic vision of patient wellness. Members also determined that developing and refining the project's IT component, the online reporting manager, led to visible improvements in patients who visited the emergency room. Personnel hired for patient care coordination were able to navigate the online reporting system and utilize the tool to track and follow up with patients who went to the emergency room or were hospitalized. Lastly, sites were also able to determine and collect lessons learned that could be applied to future incentive and other research-related projects.

Based on overall analysis of AAPCHO's P4P+HIT program, the decrease in ER visits proves a benefit for cost and resource savings at project FQHCs. The sites saw this as a positive aspect of the program given the many challenges that they faced during project implementation.

CHALLENGES, LESSONS LEARNED, AND RECOMMENDATIONS FOR A P4P INCENTIVE PROGRAM

Project members met regularly to discuss their progress in implementing interventions at their sites. They determined several challenges when applying the incentive program at their clinics: staffing, communication, technology, and competing priorities. These were not standalone challenges, but were contingent in facilitating each other. **Table 1** illustrates the challenges the health centers faced and key strategies they developed with recommendations for future studies in P4P.

CHALLENGE	ISSUES	STRATEGIES	RECOMMENDATIONS
Staffing	• Limited providers & support staff • Turnover of key project personnel • Minimal staff buy-in due to competing priorities	• Hired care coordinators, case managers	• Create protocols for newly added staff
Communication	• Communication between project directors and providers/support staff • Need for more detailed communication of expectations • CHC to hospital integration	• Provided resources to support key staff to better understand incentive program expectations on a regular basis	• Develop toolkits, guidelines, protocols for new/future staff • Develop Train-the-trainer workshops • Designate/hire care coordinators to follow up with patients
Technology	• Individual FQHC IT limitations • Different levels of IT readiness	• Conducted multi-level readiness assessments • Hired IT staff for development and quality assurance	• Hire or assign IT staff for data extraction and troubleshooting
FQHC Competing Priorities	• P4P program is not the only project sites were involved with • Staffing limited for multiple projects		• Gain staff buy-in from the start • Communicate project benefits to health centers staff on a regular basis • Contingency planning: provide back up plan for unforseen challenges

Table 1.

AAPCHO's P4P+HIT program sites saw this project as a way to gather information about their own clinics and document improvements and lessons learned that could be applied to future incentive program studies. Further lessons learned and recommendations for future incentive programs and models are outlined on the following page.

"I think it's okay for us to see the ups and downs [of incentive programs]. I think it's more to inform us, so that we can be more closer to the data and really [understand] how our patients are presenting, and what are the opportunities we have for improvement, how large... or how small those opportunities [are] to help them to determine how... we shift or change the interventions that we're currently providing."

P4P Project Member, April 2012

- Based on the processes and types of interventions implemented at each site, a shift to pay-for-service may yield more substantial results than the current pay-for-performance model.

- Rewarding provider teams and patients monetary amounts based on the needs and culture of their communities and staff may be more effective than providing standard incentive amounts/financial awards. However, it is possible that the incentive amount and program support may not have been specific and strong enough to impact provider and patient behavior change.

- The exchange of data is not only important for health center researchers and providers alike, but also useful for informing clinic day-to-day operations and decisions. As new payment models demonstrate the value of data, it is increasingly evident that efficient processes to access and retrieve data at an end-user level be available from health plans and other entities involved in comprehensive patient care.

- The measurement period of evaluation in 2009 – 2010 in six-month increments did not appear to be a sufficient amount of time to fully implement interventions and track progress. Longer periods of measurement (e.g. one year increments) may yield better results.

- The target patient populations for the current P4P+HIT program are complex patients with multiple health conditions. This is a challenge for health centers to make improvements for patients with complex problems. Future studies should further consider the types of patients and the measurement period for which change is expected.

- Quality improvement efforts require systemic commitment from providers, frontline staff, IT support, executive leadership, and health plans to realize meaningful change. Diabetic patient data was limited and difficult to extract from the health plan due to their current IT infrastructure and competing priorities stemming from health reform changes, preventing AAPCHO from conducting full analysis on improvements made for this measure. Future studies should consider the reality of data limitations and how to resolve them, especially for sites that are still implementing EMR or who may have difficulty extracting certain information.

- Sustaining patient engagement for a complex population requires invested efforts of support staff that may not be readily available at some FQHCs. The demand for services may outweigh a FQHC's capacity to provide that service. Future studies should consider whether resources for FQHCs are sufficient to contribute to systemic change and investment by FQHCs required to affect provider and patient behavior change.

- Future studies should create memorandums of agreement that identify staff expectations, and roles and responsibilities should be regularly revisited in case of staff turnaround or changes to clinical operations.

CONCLUSION

It is evident that much work still needs to be done to evaluate the effectiveness of incentive programs at FQHCs. However, we conclude that project health centers were successful in creating and developing culturally sensitive and appropriate

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interventions to improve AA&NHOPI patient care. Limited resources in staff and IT, competing priorities, and communication barriers were a few major challenges each site faced. Yet, this project helped to serve as a foundation and stepping-stone for further incentive program research at FQHCs serving high-risk low-income AA&NHOPI patients. Lastly, future studies should consider motivating factors for staff at FQHCs. Monetary incentives might not be the best motivators for providers who are invested in the care of the patients within their local community. Other considerations include incentivizing CHCs based on the service of care provided.

For more information about AAPCHO's Pay-for-Performance Project or other Health Information Technology initiatives, contact:

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NOTES

1. Agency for Healthcare Research and Quality. March 2012. *Pay for Performance (P4P): AHRQ Resources*. Rockville, MD. Retrieved May 1, 2012, from http://www.ahrq.gov/qual/pay4per.htm.
2. Robert Wood Johnson Foundation. December 2007. *The Synthesis Project: Policy Brief*. No. 13.
3. Hawkins, D. and Groves, D. 2011. "The Future Role of Community Health Centers in a Changing Health Care Landscape." *Journal of Ambulatory Care Management.* 34(1): 90-99.

USEFUL RESOURCES

1. AAPCHO's research web page: http://research.aapcho.org
2. Agency for Healthcare Research and Quality (AHRQ) P4P resource page: www.ahrq.gov/qual/pay4per.htm.
3. Berlowitz, D., Burgess Jr., JF, Young, GJ, eds. February 2006. "Improving Quality of Care: Emerging Evidence on Pay-for-Performance. *Medical Care Research and Review*. 63(1 Suppl). AHRQ Pub. No. OM06-0036.
4. *Incentivizing the Outcome: Paying for Population Health at Hawaii Federally Qualified Health Centers*. Fact Sheet. Association of Asian Pacific Community Health Organizations. 2011.

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