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Lehigh Valley Hospital-Muhlenberg  
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# Competing in a Pay-for-Performance Environment

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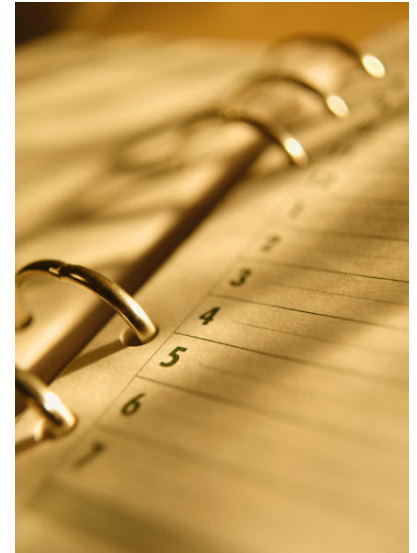
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# Session Agenda

- Background and Evolution of P4P
- What Does the Future Hold?
- Tools for Success



# The What and Why of P4P

## What is P4P...

*A program for aligning incentives to support the delivery of high-quality care*

- Government-sponsored projects—Annual Payment Update (APU), Premier demo, MedPac recommendation, Value-Based Purchasing (VBP), Physician Group Practice (PGP) demo
- Private payer demonstration projects (LeapFrog Group, Bridges to Excellence)

## Why P4P...

*Imperative to improve quality*

- Institute of Medicine (IOM) reported that 98,000 lives lost due to medical errors
- Public reporting of health care organization performance
- Institute for Health Improvement (IHI) 100,000 Lives Campaign (and now 5 Million Lives Campaign)

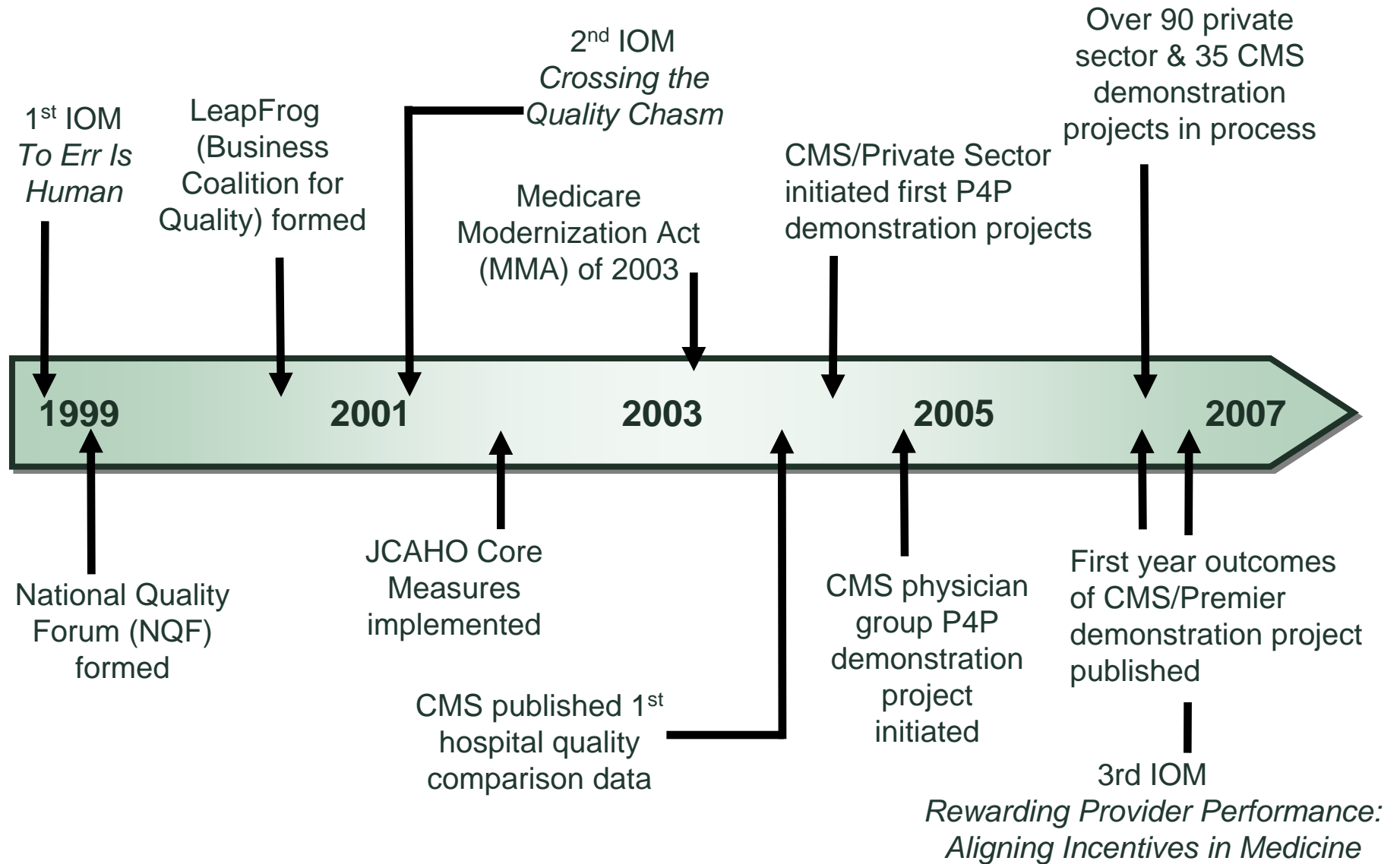
*Imperative to control costs*

- Consumer-driven focus on reducing their out-of-pocket costs for health care
- Employer focus on reducing health care insurance costs

**CMS:**

***“The right care for every person every time”***

# Evolution of P4P Plans



# P4P Initiatives Vary by Provider Type

## Acute Care Hospitals

- CMS is taking the lead
- Large 3-year demo project currently underway with CMS/Premier ...recently extended for 3 more years
- CMS Rural Community Hospital program currently being developed
- CMS accepting additional proposals for demo projects
- The LeapFrogGroup assisting business coalitions in developing shared savings programs



## Physicians

- Private sector is taking the lead (e.g., Bridges to Excellence, IHA, BCBS, United)
- CMS is currently funding its first physician P4P project—a 3-year shared savings project involving 10 large multi-specialty practices (covering 5,000 physicians)
- Several other demo projects set to begin in 2007, including small or mid-sized practices
- Beginning July 1, 2007, CMS will offer **all** physicians a 1.5% bonus to participate in voluntary quality reporting program (no public reporting...yet)



## Other Provider Initiatives

- Nursing Homes
- Home Health
- End Stage Renal Disease (ESRD)
- Disease Management



Agreement that clinical, patient experience, and IT measures to be used

# CMS P4P Initiatives for Acute Care Hospitals

## 1st Generation CMS APU

## 2nd Generation CMS/Premier

## 3rd Generation CMS MedPac

	1st Generation CMS APU	2nd Generation CMS/Premier	3rd Generation CMS MedPac
<b>Scope</b>	<ul style="list-style-type: none"> <li>Voluntary in 2003, mandatory as of 2004</li> </ul>	<ul style="list-style-type: none"> <li>Demonstration project with 260+ voluntary participants</li> </ul>	<ul style="list-style-type: none"> <li>Demonstration project pending approval</li> </ul>
<b>Funding</b>	<ul style="list-style-type: none"> <li>No “net new dollars” to Medicare program</li> </ul> <div data-bbox="577 568 871 673" style="border: 1px solid black; border-radius: 15px; padding: 5px; display: inline-block; margin-left: 100px;">                     Plan to be budget neutral with penalties + savings                 </div>	<ul style="list-style-type: none"> <li>Aggregate impact depends on performance of hospitals                             <ul style="list-style-type: none"> <li>– \$9M “net new dollars” were distributed in each of first two years</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>No “net new dollars” to Medicare program, rather redistribution among hospitals                             <ul style="list-style-type: none"> <li>– Funded by withhold from providers</li> </ul> </li> </ul>
<b>Measures</b>	<ul style="list-style-type: none"> <li>Starter set of 10 measures in three categories: AMI, Heart Failure (HF), and Pneumonia</li> <li>21 measures in FY07 (incl. surgical infection prevention)</li> <li>27 measures in FY08 (incl. patient satisfaction &amp; mortality)</li> </ul>	<ul style="list-style-type: none"> <li>34 measures in five categories: AMI, Heart Failure (HF), Pneumonia, CABG, and Hip/Knee Replacement</li> </ul>	<ul style="list-style-type: none"> <li>Measures not yet determined</li> </ul>
<b>Penalty/Reward</b>	<ul style="list-style-type: none"> <li>Focus on <b>reporting</b></li> <li>Must submit measures to receive full market basket update</li> <li>Withhold of 0.4% points of market basket update for non-compliance (through FY06)</li> <li>Withhold increased to 2% points in FY07 and beyond</li> </ul>	<ul style="list-style-type: none"> <li>Focus on <b>performance</b></li> <li><b>Top 2 deciles rewarded</b> with 1-2 percent payment increase</li> <li>In Year 3 must show improvement over Year 1 baselines or penalty</li> <li>Penalty/Reward based on composite score for each condition + patient volume</li> </ul>	<ul style="list-style-type: none"> <li>Focus on <b>performance</b></li> <li><b>Top 2 deciles rewarded</b> <ul style="list-style-type: none"> <li>– Can receive more than original withhold</li> </ul> </li> <li><b>Other hospitals effectively penalized</b> since no return of withhold</li> <li>Reward based on composite score for each condition + patient volume</li> </ul>

# Financial Impact Varies by P4P Approach

The financial impact on individual hospitals or certain types of hospitals differ significantly between 2<sup>nd</sup> Generation (CMS/Premier) and 3<sup>rd</sup> Generation (CMS MedPac) programs.

(millions of dollars)	<u>Premier/CMS</u>	<u>CMS MedPac</u>	<u>Difference</u>
Bonus	\$39.5	\$139.8	\$100.3
Penalties/Withholds	30.5	139.8	109.3
Net Impact	9.0	0.0	(9.0)
<b>Urban</b>			
Bonus	\$34.0	\$117.1	\$83.1
Penalties/Withholds	25.2	119.8	94.6
Net Impact	8.8	(2.7)	(11.5)
<b>Rural</b>			
Bonus	5.3	21.5	16.2
Penalties/Withholds	5.1	18.8	13.7
Net Impact	0.2	2.7	2.5

More potential upside *and* downside for individual hospital under CMS MedPac

CMS MedPac approach is less favorable to urban hospitals than rural hospitals

Source: "Snapshot of Hospital Quality Reporting and Pay-for-Performance Under Medicare", *Health Affairs*, January/February 2006

# CMS P4P Initiatives for Acute Care Hospitals

## The Final Generation?

### CMS Value-Based Purchasing (VBP) - *Proposed*

<b>Scope</b>	<ul style="list-style-type: none"> <li>Replaces CMS' APU program</li> <li>Commences Oct 1, 2008 (FY2009)</li> </ul>
<b>Funding</b>	<ul style="list-style-type: none"> <li>Budget neutral</li> <li>No "net new dollars" to Medicare program beyond APU</li> </ul>
<b>Measures</b>	<ul style="list-style-type: none"> <li>Builds on existing measures of APU program</li> <li>Some current APU measures will be excluded from the financial incentive</li> <li>Incorporates hospital outpatient measures (in FY09)</li> <li>Potentially incorporates efficiency, outcomes, emergency care, patient safety, and structural measures in FY10-FY11</li> <li>Compressed data submission period (60 days after close of reporting period, down from 135 days, and monthly instead of quarterly)</li> </ul>
<b>Penalty/Reward</b>	<ul style="list-style-type: none"> <li>Focus on <b>reporting</b> and <b>performance</b></li> <li>Measures will be publicly reported for a period before being included in financial incentive</li> <li>Financial incentive no longer tied to APU</li> <li>Percentage of DRG payment "conditional on performance" (a.k.a. at-risk)</li> <li>Rewarded for <b>attainment</b> and <b>improvement</b></li> </ul>

### Details yet to be worked out:

- The percentage of DRG payment "at-risk"
- Which components of the DRG payment should be included as the basis of the incentive (base payment rate only or including capital costs, DSH, IME, or outliers)
- How "residual funds" will be handled...potential options:
  - Kept by Medicare
  - Distributed to all providers based on performance
  - Distributed to top performers only
- Plus the myriad other details on how this actually will work

Source: Medicare Hospital Value-Based Purchasing, Options Paper, 2<sup>nd</sup> Public Listening Session, April 12, 2007, CMS.

# CMS Value-Based Purchasing Proposal

## Scoring Performance:

**Attainment:** A hospital earns 0-10 points for each VBP measure based on where its score fell relative to the attainment threshold and the benchmark

**Improvement:** A hospital could earn 0-9 points based on improvement from its prior year's score

Higher of attainment or improvement score is used

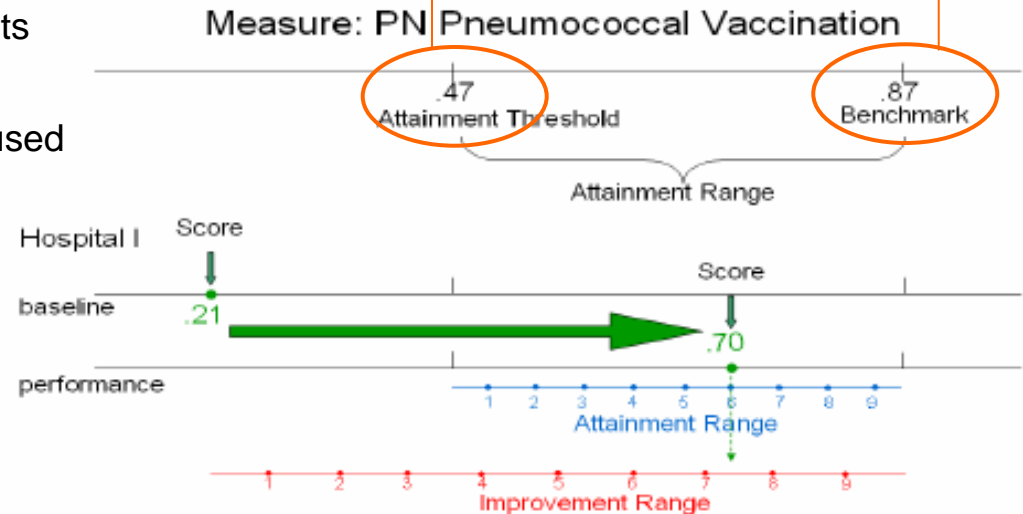
### Total VBP score =

Total earned points (=sum of earned points across all measures) / Total possible points (=total measures reported by hospital × 10 points) × 100%

*For illustrative purposes only*

Attainment threshold set at performance of median hospital (50<sup>th</sup> percentile) in previous period

Benchmark set at mean of the top performing 10% of all hospitals in previous reporting period



Hospital I Earns: 6 points for attainment

7 points for improvement

Hospital I Score: maximum of attainment or improvement

= 7 points on this measure

Source: Medicare Hospital Value-Based Purchasing, Options Paper, 2<sup>nd</sup> Public Listening Session, April 12, 2007, CMS.

# CMS Value-Based Purchasing Proposal

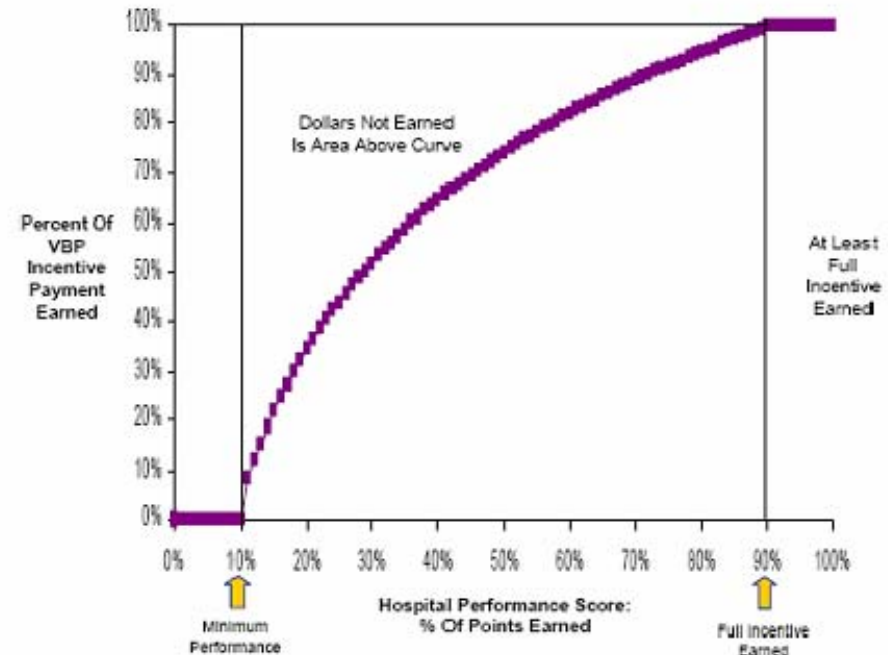
## Translating Performance Score into Incentive Payment:

- Minimum Performance Level**      Level below which a hospital would receive no incentive payment
- Benchmark Level of Performance**      Required for a hospital to obtain full incentive amount
- Exchange Rate**      Translates the performance score to the percent of incentive payment earned. Could be 1:1, greater than 1:1, or less than 1:1

### Steepness/Shape of Exchange Curve:

- Could be flat (linear) or non-linear
- A steep curve for lower performance scores could acknowledge the likely higher initial fixed costs associating with launching a quality program

*For illustrative purposes only*



**Illustration of Non-Linear Exchange Function**

Hospital	Overall Performance Score (% of total points achieved)	Incentive Payment (% of payment earned)
Hospital B	100%	100%
Hospital A	58%	80%
Hospital I	75%	92%
Hospital L	6%	0%

Source: Medicare Hospital Value-Based Purchasing, Options Paper, 2<sup>nd</sup> Public Listening Session, April 12, 2007, CMS.

# Other Major Initiatives – Bridges to Excellence

The Bridges to Excellence (BTE) is a national coalition that coordinates a pay for performance **program that rewards physicians for compliance** around three health care “Links.” By participating in the BTE program, physicians also get access to tools to assist in compliance and patient care.

	<u>Physician Office Link</u>	<u>Diabetes Care Link</u>	<u>Cardiac Care Link</u>
Target Physicians	<ul style="list-style-type: none"> <li>All Physicians</li> </ul>	<ul style="list-style-type: none"> <li>PCPs</li> <li>Endocrinologists</li> </ul>	<ul style="list-style-type: none"> <li>PCPs</li> <li>Cardiologists</li> </ul>
Sample Measures	<ul style="list-style-type: none"> <li>Scope of patient education</li> <li>IT adoption/functionality</li> </ul>	<ul style="list-style-type: none"> <li>Blood pressure</li> <li>Lipid testing</li> </ul>	<ul style="list-style-type: none"> <li>Use of aspirin</li> <li>Cholesterol control</li> </ul>
Physician Incentives	Up to \$50/pt./year	Up to \$80/pt./year	Up to \$160/pt./year
Est. Employer Costs	Approx. \$50/pt./year	Approx. \$150/pt./year	Approx. \$190/pt./year
Est. Employer Savings	Approx. \$110/pt./year	Approx. \$350/pt./year	Approx. \$390/pt./year



**Bridges to Excellence Fast Facts (as of March 07)**

- Recognized physicians: 3,025
- Bonuses earned to-date: \$7.6 million
- 18 states & DC with Operational BTE Programs: AR, CA, CO, CT, DC, DE, GA, IL, KY, MA, ME, MD, MN, NC, NJ, NY, OH, VA, WA
- Targeted for FY2008: FL, **PA**, SC



# Other Major Initiatives – The LeapFrogGroup



The Leapfrog Hospital Rewards Program (LHRP) is a private-sector initiative for employers and health plans to provide incentives and rewards for hospital performance in 5 clinical areas:

- Acute myocardial infarction (heart attack)
- CABG (bypass surgery)
- Percutaneous coronary intervention (angioplasty)
- Community acquired pneumonia (CAP)
- Deliveries/newborn care

**Hospitals ranked in two categories**

*Quality Measures  
(e.g., mortality)*

*Resource Efficiency Measures  
(e.g., readmission rate)*

## What do Participating Hospitals Potentially Get?

- Bonus payments from purchasers and health plans for superior performance sustained improvement
- Public recognition of superior quality, safety and efficiency
- Increased market share by encouraging patients with financial incentives to seek care in high performance hospitals (e.g., differential co-pays)
- Use of tiered networks to favor hospitals with superior/improved performance with better payments
- Benchmark data on performance on LHRP measures

- **No fee for submitting data**
- **Fee associated with full participation**

# What's New on the Horizon?



## Physician Quality Reporting Payments

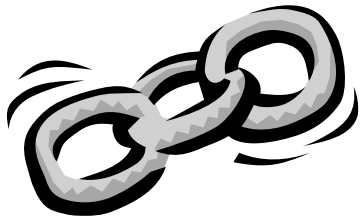
### Physician Quality Reporting Program

- Signed into law by President Bush in December 06
- Physicians will qualify for a 1.5% bonus if they *report* data on quality, using measures specified by the government
- Data used to determine clinical guidelines; no public-reporting
- Program to begin July 1, 2007

## Hospital- Physician Collaboration

### Medicare Hospital Gainsharing Demonstration

- 6 demo projects (including 2 rural markets) to test methodologies and arrangements between hospitals and physicians to improve quality and efficiency of care with sharing of net gains
- 3-year project to begin January 1, 2007



### Physician-Hospital Collaboration Demonstration

- Determine impact of hospital-physician collaboration to prevent complications, avoid duplication of services, coordinate care across settings
- Physician groups and Integrated Delivery Systems to be included
- 3-year project to begin in 2007

# What's New on the Horizon?

## Reducing Payment for Hospital Acquired Infections

- The Deficit Reduction Act of 2005 calls for the reduction of Medicare payments for certain hospital acquired infections beginning October 1, 2008

## Eliminating “Never” Events (serious, preventable, and costly errors)

- On 1/1/05, MN-based insurer HealthPartners required hospitals in its network to report errors to the State Department of Health and not bill its health plan members for a “never” event
- The LeapFrog Group and Midwest Business Group on Health have called on hospitals to commit to a new policy on 28 “never” events
  - Agree to apologize
  - Waive costs related to “never” events



# What's Going on in Pennsylvania?



- PHC4 collects and reports quality indicators for a variety of treatments and conditions by hospital.
- Hospital-related P4P news:
  - Aetna To Pay Doylestown Hospital in Bucks County P4P bonuses
  - Independence Blue Cross has signed an agreement with Univ of Penn. Health System - *One important new component of the agreement is quality-based pay for performance, which provides the opportunity for UPHS to earn additional compensation for delivering increasingly high quality health care to IBC members.*
- Physician P4P:
  - Highmark Blue Shield's (Pittsburgh) Quality Incentive Payment System (QIPS) *rewards Primary Care Physicians (PCP's) physicians for improvements in measures based, in part, on the Health Plan Employer Data and Information Set (HEDIS) for preventive screenings and treatment for chronic conditions.*

# “Prescription for Pennsylvania”



It's coming to a state near you.....

*“The Governor, as CEO of the Commonwealth, will convene a panel of other large **public and private health care purchasers, health care insurers and health care providers to set quality standards and determine how to drive, measure and incent contracted health care providers in a Pay for Performance statewide initiative.**”*

*“The Pay for Performance initiative will be based on proven evidence-based standards for delivering quality care, and will reward providers who successfully implement quality improvement strategies, reduce hospital-acquired infections and effectively manage chronic conditions.”*

# “Prescription for Pennsylvania”



The Administration will implement this Pay for Performance initiative in one or more state-funded programs. For example:

- Those health care providers who meet or exceed the standards and quality and efficiency measures will be identified as “**Preferred Providers**” and will receive preferred compensation for services provided to patients; and patients who use Preferred Providers will have a lower co-payment and cost sharing.
- For all state-funded programs, the Administration will cease paying health care providers for “Never Events”, while ensuring no care is denied or charges accrued to the wronged patient.
- For state-funded programs, the Administration will require all health care providers to participate in the Independent Drug Information Service program.

# P4P Why All The Fuss? ... It Seems to Work

**Premier/CMS demonstration hospitals are responding to financial incentives, resulting in decreased costs of care and improved outcomes**

## Decreased Cost of Care

**Best performers had the lowest costs**

*Pneumonia ALOS in the top decile was 2 days shorter than bottom decile (1<sup>st</sup> year results)*

## Improved Outcomes

**Hospitals raised overall quality by 11.8 percentage points in two years**

	Baseline	Year 1	Year 2
AMI	87% →	91% →	94%
Heart Failure	65% →	74% →	82%
Pneumonia	69% →	79% →	86%
CABG	85% →	90% →	94%
Hip & Knee	85% →	90% →	93%



Analyses suggest that 1,284 heart attack patients were saved over the two-year period as a result of improvements in the AMI focus area

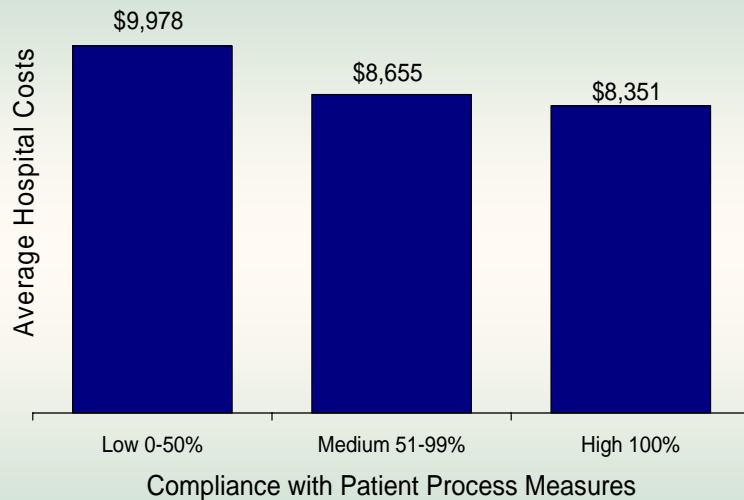
Note: Scores for each measure within a diagnostic group are combined to get the composite score.  
 Source: Premier report "Project Overview and Findings from Year One" issued April 2006; Premier Press Release, 1/26/07.

# P4P Why All The Fuss?...It Seems to Work

The Premier/CMS Demonstration study shows an association between compliance with patient process measures and average hospital costs

## Medical Example:

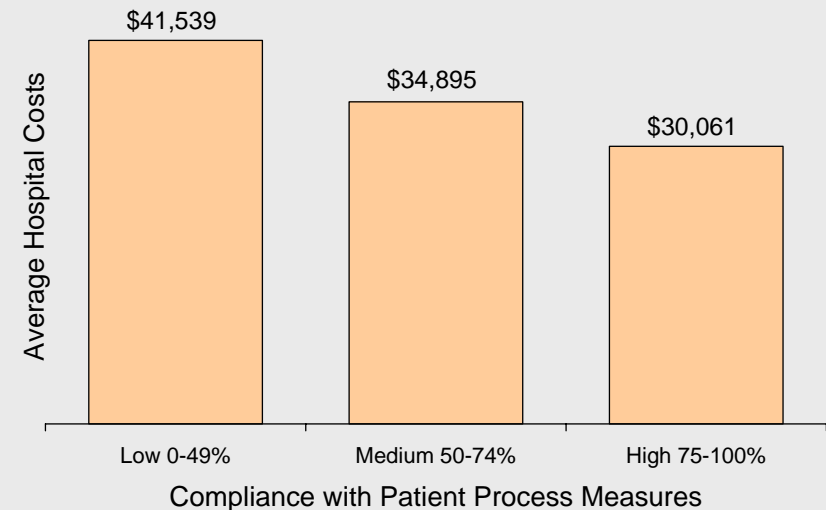
Hospital Costs for Pneumonia Patients



**ALOS (days)**      7.5                  6.7                  6.5

## Surgical Example:

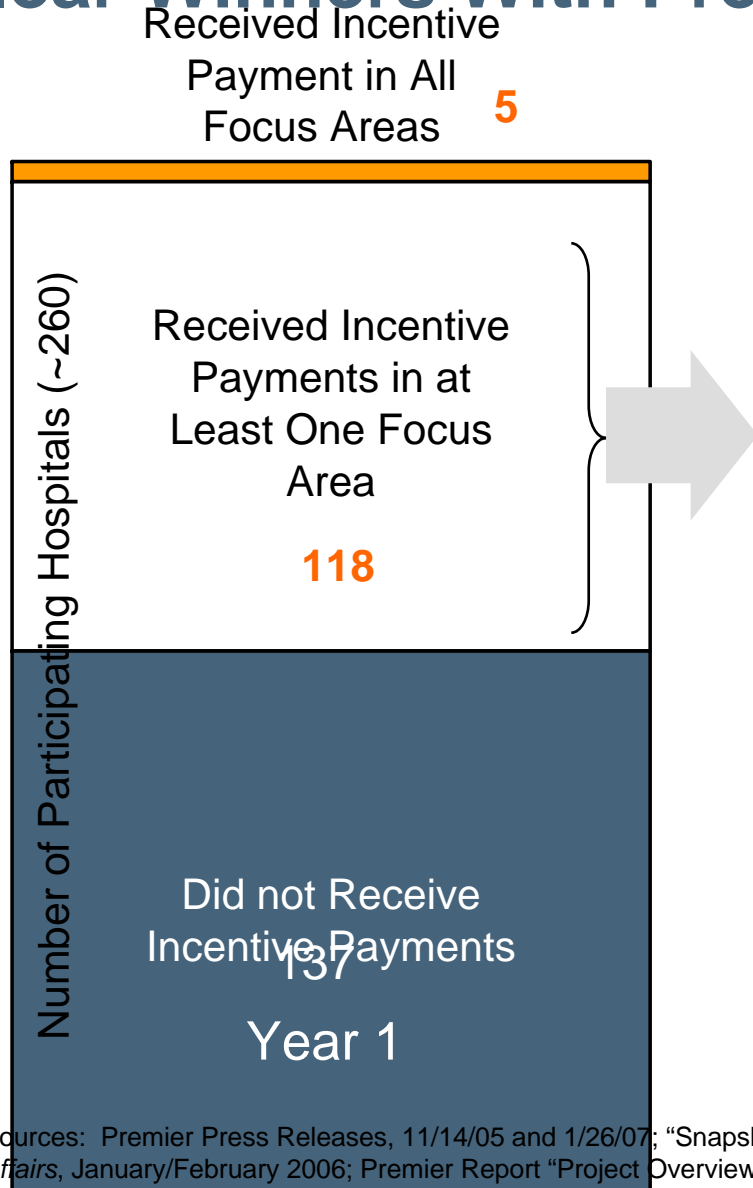
Hospital Costs for Heart Bypass Surgery Patients



**ALOS (days)**      13.5                  11.2                  9.7

Source: Premier report "Performance Pays: Reliable Care Costs Less and Saves Lives," Premier webcast 10/5/06 ([www.premierinc.com](http://www.premierinc.com)).

# Clear Winners With Premier...But at What Cost?



## Year 1 Results:

Total incentive payments were **\$8.85 million to 123 hospitals**

- Equates to an average of approximately \$72,000 per hospital.
- Of the five hospitals receiving incentive payments for all focus areas, Hackensack University Medical Center received a total of \$848,000 in incentive payments
- Focus areas accounted for 15 percent or less of hospital revenue

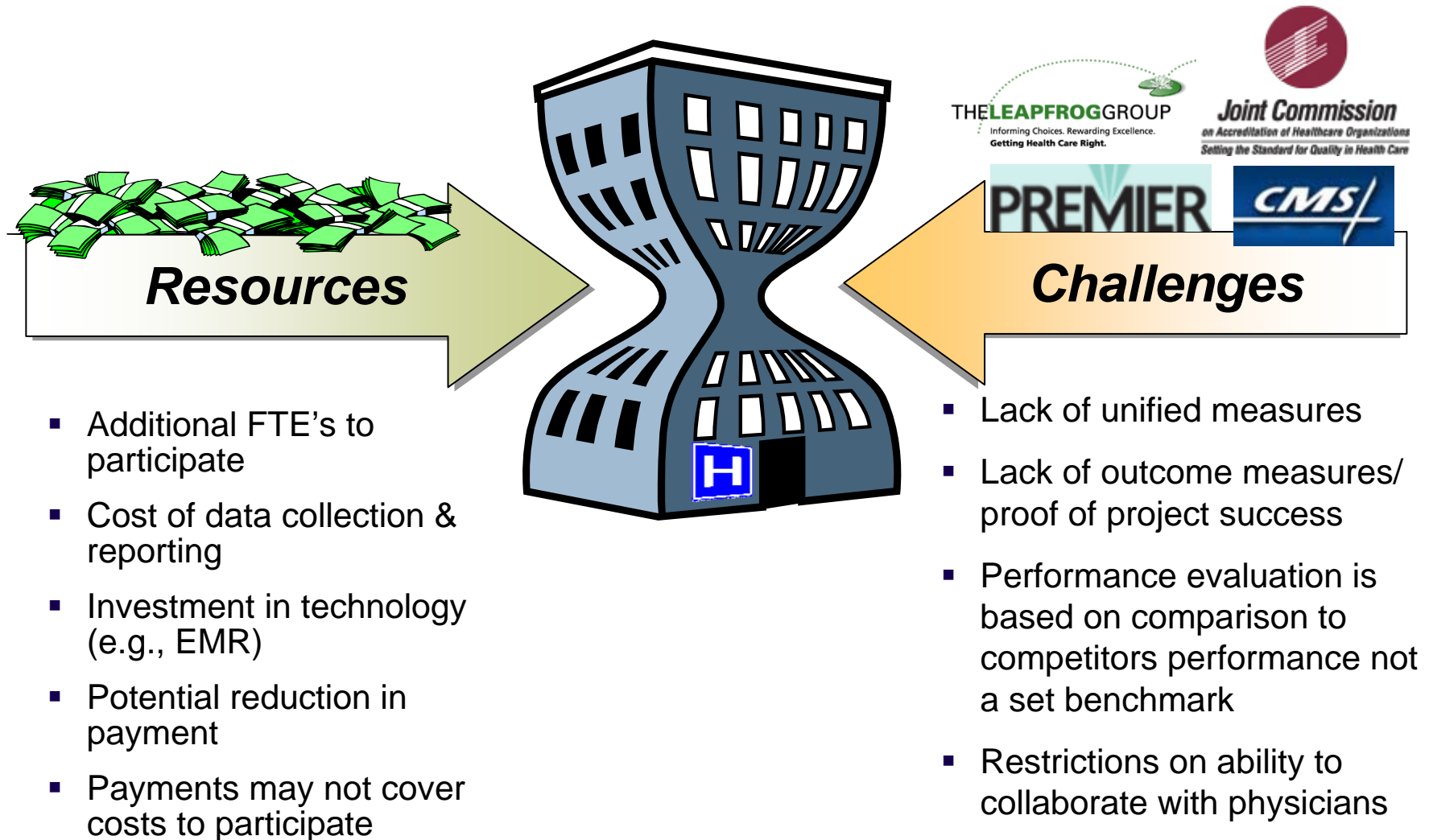
## Year 2 Results:

Total incentive payments were **\$8.7 million to 115 hospitals**

- Hackensack was top winner again, receiving \$744,000 in incentive payments
- Rewards ranged from \$2,829 to \$744,000 per hospital

Sources: Premier Press Releases, 11/14/05 and 1/26/07; "Snapshot of Hospital Quality Reporting and Pay-for-Performance Under Medicare", *Health Affairs*, January/February 2006; Premier Report "Project Overview and Findings from Year 1" dated April 13, 2006; CMS Fact Sheet, Jan 2007.

# The Big Squeeze: Unfunded Mandate or Opportunity for Change?



# What Does the Future Hold?



# Big Unknowns...For Hospitals



- Will hospitals be penalized for poor performance or just rewarded for good performance?
- Will resources for rural and poorer community hospitals be made available to allow/encourage their participation or will pay-for-performance widen the financial gap between the Haves and Have Nots?

# Big Unknowns...Physicians

- Will P4P create a bigger wedge between hospitals and physicians or bring them together?
- Will P4P in hospitals lead to greater tensions or turf battles between PCPs and specialists or lead to more collaboration?

## Big Unknowns...For Employers



- Will pay-for-performance really improve the health of employees?
- Will pay-for-performance control the unsustainable cost increases?

## Big Unknowns...For Patients

- Today, do patients evaluate providers based on clinical quality or more on service and access?
- If patients are more “on the hook” for payment, will quality matter more?

# Some “Nearly Knowns”



- There is clear momentum for P4P programs: It seems safe to say that “it’s coming”:  
*not a question of “if”; more a matter of “how” at this point*
- Pressure for implementing P4P is coming from both private and public payers.
- P4P programs are likely to use and build upon existing measures of quality

# Big Unknowns...For the Audience



- How will pay-for-performance come to Pennsylvania?
- Who do you think stands to benefit the most under a pay-for-performance environment?
- How will pay-for-performance affect you?
- How will a pay-for-performance environment create new challenges for healthcare finance professionals?
- At what percentage of hospital revenue at risk will pay-for-performance move to the forefront?

# How Will P4P Play Out?

P4P Payment Model	Implementation Base	Applicability to Providers	Performance Measures	Use of P4P Information	Timing
<p><b>A-1:</b> Status Quo – P4P not adopted</p>	<p><b>B-1:</b> Scattered local/regional payer-specific programs</p>	<p><b>C-1:</b> Applicable only to acute care hospitals</p>	<p><b>D-1:</b> Payer independently establish measures—limited overlap among payers</p>	<p><b>E-1:</b> Consumers do not utilize performance data to make buying decisions</p>	<p><b>F-1:</b> Implemented by 2009</p>
<p><b>A-2:</b> Bonus payment for superior performance, no penalties</p>	<p><b>B-2:</b> Combination of national CMS program and scattered payer-specific</p>	<p><b>C-2:</b> Applicable only to physicians</p>	<p><b>D-2:</b> Common set of core measures, with some additional payer-specific measures</p>	<p><b>E-2:</b> Consumers differentiate based on performance</p>	<p><b>F-2:</b> Implemented by 2012</p>
<p><b>A-3:</b> Combination of bonuses and penalties</p>	<p><b>B-3:</b> Applicable to all individuals covered by government and private programs</p>	<p><b>C-3:</b> Shared destiny across the continuum of providers</p>	<p><b>D-3:</b> Standard set of measures used by all payers</p>	<p><b>E-3:</b> Payers establish financial incentives for patients to use high performing providers</p>	<p><b>F-3:</b> Implemented by 2015</p>



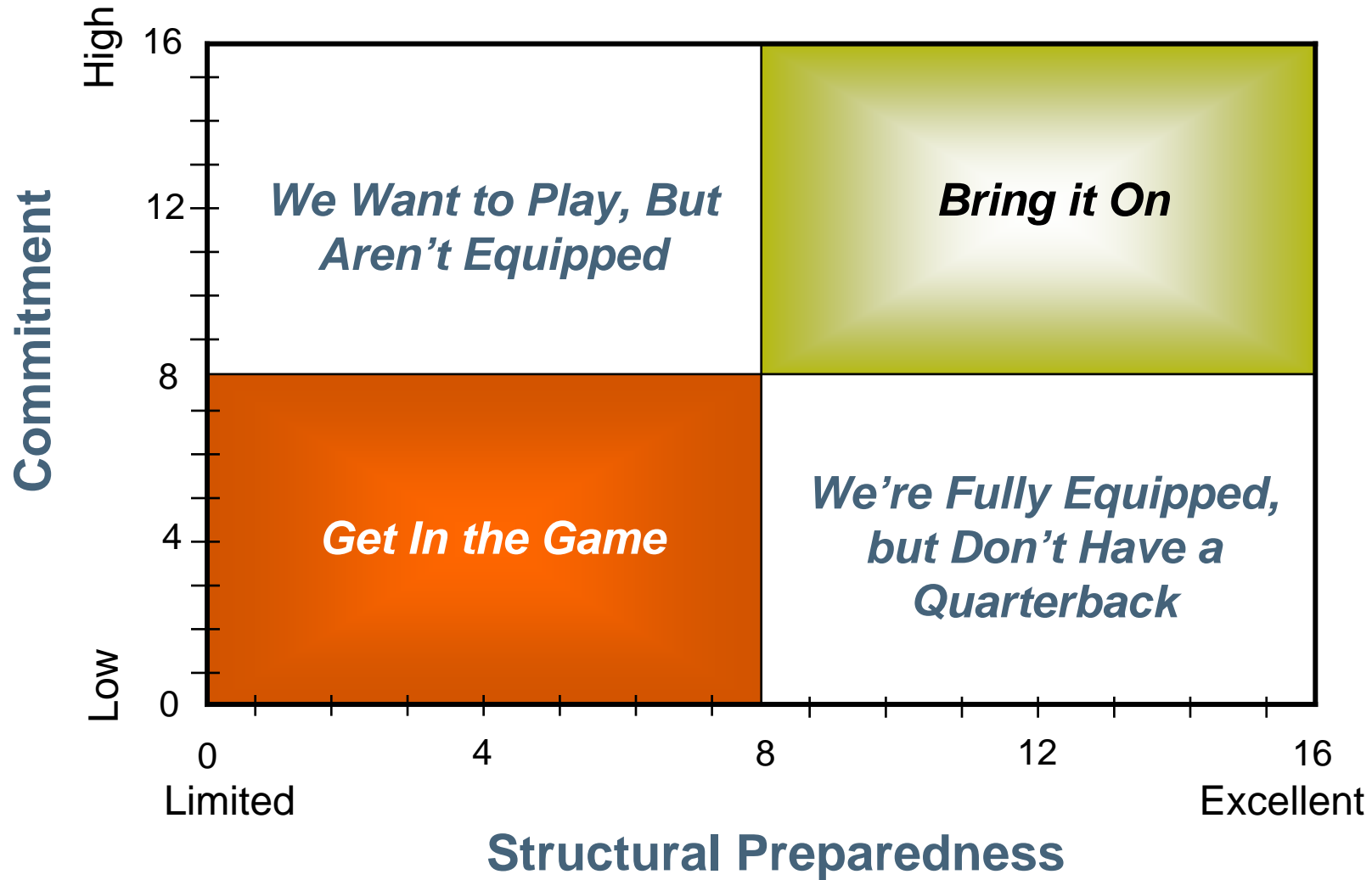
# How *Structurally Prepared* is Your Organization?

Statement	Strongly Agree	Partially Agree	Strongly Disagree
1) Patient safety & quality improvement are an integral part of the our organization's strategic plan	2	1	0
2) All levels of our organization (board, management, clinical staff, and physicians) have a basic understanding of P4P	2	1	0
3) Our clinical and decision support systems can accurately collect and report data	2	1	0
4) Adequate IT and additional non-IT resources (e.g., FTEs, funding, etc.) have been allocated to collect and report data	2	1	0
5) We have a routine process for identifying and collecting clinical guidelines and evidence-based practices	2	1	0
6) We are able to quantify the financial impact of P4P (e.g., understand the potential revenue gains and costs of implementation)	2	1	0
7) We have good mechanisms in place to report issues and errors	2	1	0
8) We have inter-disciplinary teams in place that enable problem identification and collaboration	2	1	0
<b>Total</b>			

# How *Committed* is Your Organization?

Statement	Strongly Agree	Partially Agree	Strongly Disagree
1) Patient safety & quality reporting and improvement are part of my organization's <b>culture</b>	2	1	0
2) Inter-department collaboration and team work is high	2	1	0
3) Effective, open communication is evident across the organization	2	1	0
4) We have a non-punitive approach to dealing with errors that encourages learning and innovation	2	1	0
5) All levels of the organization hold themselves accountable to performance improvement	2	1	0
6) Our clinicians and physicians are strongly compliant with clinical guidelines and evidence-based best demonstrated practices	2	1	0
7) My organization actively spreads improvements across the entire organization	2	1	0
8) We are comfortable with and do report our clinical and cost data to the public	2	1	0
<b>Total</b>			

# Organization Readiness Matrix



# Where Do We Start?

## Culture

- ✓ Non-punitive
- ✓ Accountability at all levels
- ✓ Safety & quality are a priority
- ✓ Continuously increasing capacity for improvement

## Collaboration

- ✓ Open communication
- ✓ Anonymous, user friendly reporting mechanisms to support providers and patients
- ✓ Teamwork across disciplines and departments

## Technology Enablement

- ✓ IT systems for Computerized physician order entry, electronic medical records, medication distribution and recall process
- ✓ Integrated clinical and financial data
- ✓ Data collection, assurance, and dissemination

## Process Redesign

- ✓ Standardized processes in place
- ✓ Clinical redesign
- ✓ Improvement Strategies in Use

# Increasing the Odds of Success

*Leadership, management  
and clinician commitment  
and accountability*

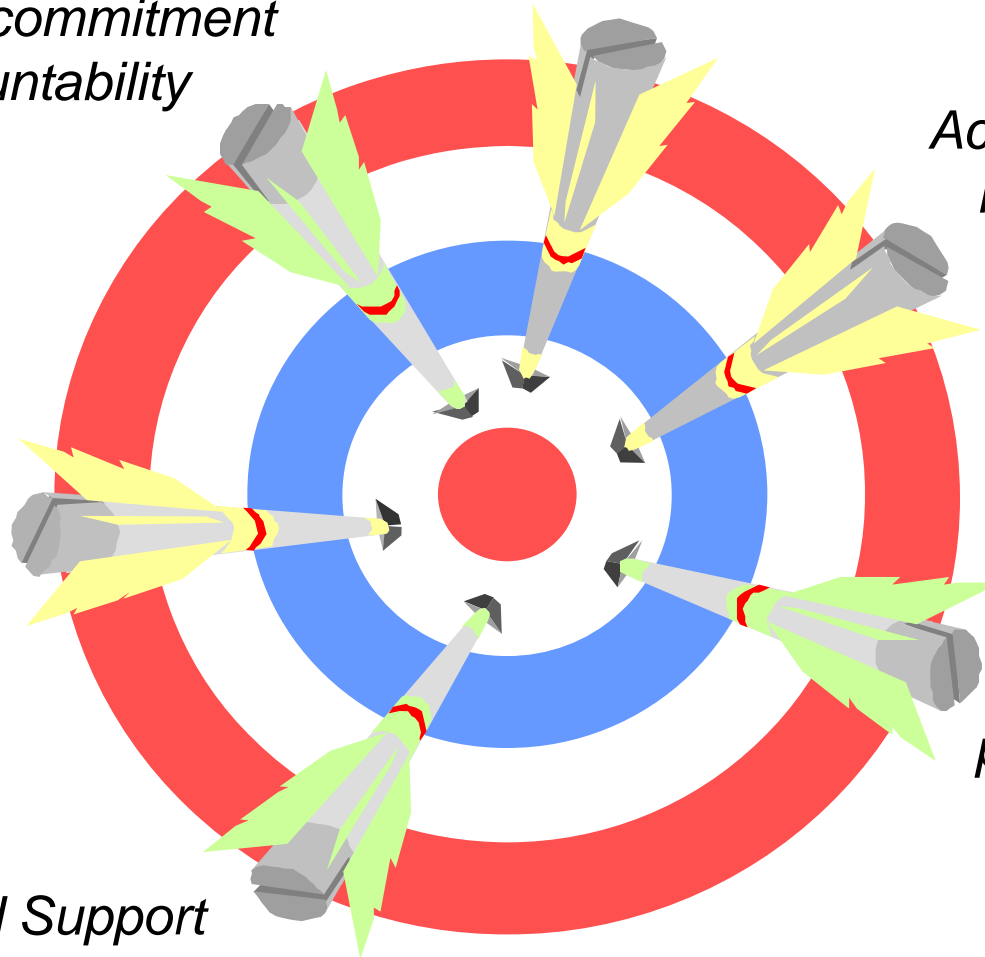
*“Over communication”*

*Active support and  
involvement of  
physicians*

*Allocate  
financial  
human and  
IT resources*

*Organization  
priorities aligned  
with safety and  
quality*

*Board Support  
and involvement*



# P4P The Bottom Line

## P4P...

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- Is more than the payment du jour
- Will change the healthcare delivery system to a far greater extent than prospective payment systems and managed care

**Hospitals that accept this change and position themselves to compete on value will benefit from improved ...**

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- Public Awareness
- Market Position
- Improved Outcomes
- Physician Alignment
- Financial Incentives

# Information Resources

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- CMS MedPac site: [www.medpac.gov](http://www.medpac.gov)
- CMS Medicare Hospital Value-Based Purchasing, Options Paper, 2nd Public Listening Session, April 12, 2007: <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPOptions.pdf>
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- National Quality Forum: [www.qualityforum.org](http://www.qualityforum.org)
- Nursing Home Pay-for-Performance Demonstration Draft Design. CMS Open Door Forum September 20, 2005 [www.cms.hhs.gov/DemoProjectsEvalRpts/](http://www.cms.hhs.gov/DemoProjectsEvalRpts/)
- Physician Quality Reporting Initiative: [www.cms.hhs.gov/PQRI/01\\_Overview.asp](http://www.cms.hhs.gov/PQRI/01_Overview.asp)
- Premier Report: "Project Overview and Findings from Year One" issued April, 2006 <http://www.premierinc.com/all/quality/hqi/resources/HQIwhitepaper-4-13-06.pdf>

# About Noblis' Healthcare Division

## OFFICES

### Atlanta Area

6525 The Corners Parkway  
Suite 450  
Norcross, GA 30092  
404.231.4422 (voice)  
404.231.4423 (fax)

### Austin Area

5838 Balcones Drive  
Austin, TX 78731  
512.342.8815 (voice)  
512.342.8825 (fax)

### Boston Area

1050 Waltham Street  
Suite 500  
Lexington, MA 02421  
781.482.4050 (voice)  
781.863.5657 (fax)

### Chicago Area

211 East Ontario  
Suite 1550  
Chicago, IL 60611  
312.751.8800 (voice)  
312.751.8782 (fax)

### Cleveland Area

Coming soon  
866.882.9007 (voice)

### Denver Area

7720 East Belleview Ave.  
Suite BG-6  
Greenwood Village, CO 80111  
303.779.3003 (voice)  
303.779.2655 (fax)

### St. Louis Area

1034 South Brentwood Blvd.  
Suite 1650  
Clayton, MO 63117  
314.726.4879 (voice)  
314.721.8695 (fax)

### Washington DC Area

F610  
3150 Fairview Park Drive  
Falls Church, VA 22042  
703.610.1001 (voice)  
703.610.2453 (fax)

### West Springfield, MA

80 Capital Drive  
West Springfield, MA 01089  
413.732.3366 (voice)  
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[www.noblis.org](http://www.noblis.org)

## SERVICES

### Strategy Development

- Strategic planning
- Retreat facilitation
- Affiliation assistance
- Market research
- Community needs assessment
- Marketing plan development
- Health system planning

### Governance

- Self-assessment
- Governance restructuring
- Board education and development

### Regulatory Planning

- CON/DON assistance
- Expert testimony

### Post-Acute Strategy

- Strategic planning
- Operational improvement/turnaround
- Compliance

### Information Management

- Strategic information systems planning and business alignment
- Technology planning, design, selection, and adoption services
- Transition planning
- Information assurance and security

### Physician Strategy

- Physician-hospital alignment
- Medical staff development planning
- Physician practice/organization planning

### Service Line Planning

- Clinical service line planning
- Service line business plan development

### Facility Planning

- Master facility planning
- Operational space programming
- Throughput planning
- Facility & technology infrastructure

### Financial Assessment

- Financial forecasts and feasibility
- Strategic financial and capital planning
- Merger, acquisition, and divestiture analysis
- Payer strategy and contracting assistance

### Process Innovation

- Patient safety and quality initiatives
- Care and medical management clinical redesign
- Hospital and health system operational reengineering
- Pay-for-performance systems
- Patient care process innovation