

HOW WE'RE HELPING A LARGE DEPARTMENT OF HEALTH

fight back against avoidable complications.



To improve resident health and the community's finances, we designed a scorecard that bundles a variety of measures into one robust performance assessment.

The challenge

A Department of Health has begun a local and statewide initiative to improve care quality and reduce preventable health complications. The program is designed to help primary care physicians identify patients who need preventive services like cholesterol management and blood pressure control, and take a more active approach to treatment.

The target

One key program goal is to cut preventable hospitalizations by 17%. This would reduce overall medical expenses by many millions of dollars annually.

The population

This is a large, medically underserved population with a range of extraordinary health needs. For example, 25% of residents are estimated to suffer from hypertension, but less than half of the affected residents have blood pressure under adequate control.

Technology's role

To date, more than 1,700 practices have been equipped with electronic health records (EHR) systems. Data from the EHRs help highlight patients' health risks before they cause events like heart attack or stroke. For physicians seeking recognition and incentives, the EHRs also provide automated reporting of clinical quality measures.

Scorecard design

We brought all of our experience to this highly complex challenge, and worked with a multi-stakeholder group to bundle a diverse range of performance measures into a single robust primary care/preventive care scorecard. In doing so, we balanced the needs of all stakeholders, often modifying the measures to reflect local patient populations and give physicians realistic performance targets.

A mix of measures

Some measures, such as HbA1c and LDL numbers, reflect those found in our standard diabetes and hypertension recognition programs. These include "poor control" measures, such as HbA1c less than 9.0. Other adult preventive care measures, such as flu immunizations and body mass index, are based on the program's larger public health goals.

Structuring incentives

The program aims to work with health plans and employers to include these measures and offer substantial rewards for the prevention and effective management of chronic disease. As a result, performance measures focus mainly on clinical outcomes. Incentives are structured to provide higher rewards for measures with the greatest potential to reduce mortality and morbidity. →



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Reducing premature deaths

Over a decade, the program estimates that 500 providers reaching clinical targets for 80% of their patients would prevent 1,900 premature deaths through improved cholesterol control, 1,800 deaths through better blood pressure control, 900 through smoking cessation, and 400 through aspirin therapy.

Engaging local plans and practices

Our role includes encouraging local health plans to use these measures to pay out incentives, or roll them into their other pay-for-performance initiatives. We are also working to engage physicians, and increase the number of participating physicians significantly in the coming years.

Generating feedback

With so many providers using the EHR network, the program can generate meaningful quality benchmarks, track key indicators of overall resident health, and share clinical quality reports. When results are shared with providers, they can compare their performance to peers in their geographical area with a similar practice setting.

What is your community doing to improve the health of its residents—and finances? We have the knowledge and experience to help you design an effective program from the ground up, or get better results from your current one. **Contact us at info@HCI3.org or visit www.HCI3.org, www.BridgesToExcellence.org, or www.PrometheusPayment.org.**



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