

# Partnership for Peak Healthcare Performance

## Mission and Goals

### Mission Statement

Achieve measurable improvements in the quality of outpatient care for prevalent chronic illnesses in the Dallas-Fort Worth metropolitan area by engaging key stakeholders, including physicians, health plans, employers, pharmaceutical companies, patients and consumers, in a collaborative community-wide effort to:

- ◆ Measure, improve and publicly report physician performance regarding implementation of evidence-based treatment guidelines for chronic illnesses,
- ◆ educate and empower patients to proactively participate in effective chronic care management processes, and
- ◆ motivate consumers to demand better quality care for chronic illnesses and act on publicly reported care information.

### Background

A collaborative approach to improving the quality of care for chronic illnesses in the DFW Metroplex will be validated, tested, and documented for diabetes. Diabetes is a prevalent chronic illness diagnosed in an estimated 1.3 million Texans and is the sixth leading cause of death in the United States. Diabetes can be controlled through effective outpatient treatment and lifestyle changes including proper diet, exercise and the use of insulin and/or medication. However, ineffective treatment and failures in patient compliance lead to greater health problems and the need for costly acute care due to related complications, including blindness, kidney failure, heart disease and lower extremity amputations.

The Dallas-Fort Worth Business Group on Health has initiated a community-wide collaborative effort to dramatically improve diabetes care management processes and outcomes in the DFW area. The Partnership for Peak Healthcare Performance brings together decision-makers from key stakeholders, including physicians, health plans, employers, pharmaceutical companies and consumers, to develop a framework and process for measuring performance, providing physician feedback and support, and engaging corporations and consumers in optimizing diabetes care and outcomes.

The Partnership is aligned with the national Value-Driven Health Care initiative outlined in President Bush's August 2006 executive order on health care transparency promoted by U.S. Department of Health and Human Services Secretary Michael Leavitt. Similar collaborative chronic care improvement initiatives have been launched in other communities, including Cincinnati, Detroit, Memphis, Minneapolis, Phoenix and Puget Sound.

## **Goals and Objectives**

- Engage key health care stakeholders in a collaborative planning process to achieve substantial improvements in outpatient diabetes care management, patient compliance, and consumer demand for better quality diabetes care.
- Measure improvements in outpatient diabetes care management over time through a consistent, clearly defined, standardized set of nationally recognized and endorsed performance metrics, which are collected from health plan claims data, aggregated, and reported to physicians and to the public.
- Support physicians' efforts to improve the quality of diabetes care throughout the community by providing regular physician feedback (with performance data aggregated across all five major health plans), CME opportunities, tools and resources to facilitate implementation of evidence-based treatment guidelines, office staff training and support, and the sharing of best practices.
- Measure changes in consumer awareness of appropriate diabetes care, quality measures and likelihood of using physician performance information in making decisions about diabetes care.
- Identify existing valuable and accessible resources and/or create patient and consumer education materials, workshops, and workplace programs to increase consumer awareness of diabetes risk factors, strategies for prevention, and disease management, and to increase patient compliance. Deliver these resources through the physicians, health plans, employers, clinics and other outlets.
- Develop, test and publish a regional multi-plan report card on physician performance to provide consumers information on the quality of diabetes care management on which to base health care decisions.

## **A Ground-Breaking Collaborative in DFW**

- First project on a community-wide scale and involving so many stakeholders in the DFW health care market in a collaborative effort to improve diabetes care.
- Aggregates data across all five major health plans so physicians receive a complete picture of their own performance. Transparency of performance quality data will be achieved with standardized multi-plan public report cards.
- Focuses on demand side of the equation with education of consumers to demand appropriate care and to follow through on the doctor's orders.
- Addresses patient compliance and behavior/lifestyle change challenges through educational programs that include direct mail to diabetes patients via the plans, diabetes education, risk reduction and disease management programs at DFWBGH members' worksites, and diabetes patient education at COPC clinic sites.
- Unlike performance reward projects (financially rewarding physicians meeting certain performance standards), the Partnership for Peak Healthcare Performance does not involve additional financial burden for health care purchasers. Instead, more effective care and improved outcomes throughout the market will lead to lower costs as a result of more effective use of resources, fewer hospitalizations, lower complication rates, reductions in diabetes risk, and informed, value-based decision-making by patients, providers, plans and purchasers.
- In addition to better outcomes for diabetes patients in DFW, the project establishes a basis for physician payment reform that can result in higher reimbursements for high performing physicians and lower reimbursements for poor performing physicians.