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90   Leveraging Information Technology To Implement A Pay-For-Performance Payment Model For Active Surveillance For Prostate Cancer

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Abstract

Objectives

As the U.S. healthcare system shifts from fee-for-service reimbursement to value-based payment paradigms, pay-for-performance (P4P) models have striven to improve the value of healthcare (i.e., improve quality and lower cost). We developed a prostate cancer (PCa) active surveillance (AS) P4P incentive payment model to improve the appropriate adoption and quality of surveillance or watchful waiting (WW) for men with low-risk PCa. Our pilot study develops and tests quality measures, performance thresholds, technology infrastructure and its cost-effectiveness to support the P4P model.

Methods

In collaboration with the national Prostate Cancer Active Surveillance Project (PCASP) consortium, Genesis Healthcare Partners (GHP), developed 4 quality measures: Utilization of an electronic medical record (EMR)-embedded template to capture physician assessed PCa risk and management strategy, Adoption of AS/WW for low-risk PCa, Quality of surveillance with PSA testing, and Quality of surveillance with biopsy procedures. The GHP WizMD® software platform overlays the EMR allowing it to retrieve, organize and report on clinical/pathology data from the EMR-embedded templates. The templates prompt physicians to assess and document the patient's PCa risk category and management strategy. We undertook a pilot study at a centralized location within GHP.

Results

Table 1. Risk stratification

Risk Level	# Patients
To be determined	1
Very Low	3
Low	5
Favorable Intermediate	5
Intermediate	4
High	5
Very High	3
Total Patients	26

Table 2. Management selection

Management Method	# Patients
Not Done	7
AS-Adopted	10
Other	3
Radiation	4
WW	2
Total Patients	26

Table 3: Comparison of cost of manual chart data abstraction versus automated electronic query

	Manual Abstraction	Template Automation
Time/Chart	6 min avg	<1 min
Hours	90	1
FTE Rate	$20/hour	$35/hour
Total Cost	$1,800.00	$70.00

Compared to manual chart review data abstraction, automated template data abstraction resulted in a 26-fold decrease in cost (n=450 patients x2 visits per year). Template use has been well received. A physician

commented: "The template is intuitively easy to use. It takes no more than 1 minute to input the data. While it is an additional step, it is not onerous and appropriate classification and documentation is what we should be doing all the time."

Conclusions

Value-based payment models, including pay-for-performance, require quality measures that can be assessed with a high degree of fidelity to support a payment-incentive method. Our pilot study shows that detailed PCa data on risk stratification and patient management selection can be efficiently, reliably and cost-effectively retrieved from the EMR using information technology to avoid the need for manual chart review.

128 Do Home-Grown Residents and Fellows Make Better Attendings?

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Abstract

Abstract

Background: As healthcare systems examine the increasing expenses for graduate medical education (GME), there remains a question of whether graduates trained internally have measurable differences when compared to hires trained elsewhere.

Objectives: We examine the difference between physicians trained within our GME programs versus physicians trained elsewhere. Our large integrated healthcare system is unique in addressing this objective due to its large physician labor hiring needs and its large GME programs.

Methods: A retrospective review was performed from Jan 2000 to August 2020 of all Kaiser Permanente Southern California (KPSC) physicians who were hired: KPSC GME trained versus non-KPSC GME trained. We examined five variables: retention, leadership (current or historical), physician relations cases, member appraisal of physician and provider services survey (MAPPS) scores, and rate of board certification. Chi-square test of proportions was used for comparison, $p < 0.05$ was considered significant.

Results: From Jan 2000 to August 2020, 2,940 residents and fellows graduated from KPSC GME programs, of which 1,127 (38%) were hired on at KPSC as full time attendings. Across all five metrics (Retention, Leadership [current or historical], Physician Relations, MAPPS, and Board Certification), those who had trained at a KPSC GME program outperformed non-KPSC GME trained physicians to a statistically significant degree.

Conclusions: We have shown that an internally sponsored GME program can represent an opportunity for recruitment of physicians that may have higher retention rates, higher probability of being physician leaders, decreased likelihood of physician relations issues, improved patient satisfaction, and increased rates of board certification.