Piedmont Healthcare

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Executive Summary

A large, well-established healthcare system uses information technology to create a data trust, improve its metrics across the board and build a foundation for a changing healthcare environment.

Background

Piedmont Healthcare (PHC) is a nonprofit health system, founded in 1905, that serves metropolitan Atlanta. It comprises four hospitals; the Piedmont Physicians Group, a 240-member multi-specialty group that includes more than 130 primary-care physicians; the Piedmont Heart Institute, with more than 100 affiliated or employed cardiovascular specialists; and the Piedmont Clinic, a clinically integrated network of more than 700 affiliated physicians working together on population health improvement. In its fiscal-year 2010, Piedmont supported more than 500,000 outpatient visits, nearly 48,000 inpatient admissions and nearly 43,000 surgeries.

Atlanta has multiple health systems competing for the attention of payers, patients and employers. Piedmont is contracted with each of the six major payers: UnitedHealthcare, BlueCross BlueShield (WellPoint), Aetna, CIGNA, Coventry Health Care and Humana. In addition, Piedmont Healthcare works with a number of other smaller payers, as well as several employer-owned or employer-facilitated plans associated with large corporations headquartered in the Atlanta community.

Though there are currently not many financial incentives to do so, PHC continues to prepare for the accountable-care organization (ACO) environment.

"It's interesting that there have been relatively few pay-for-performance initiatives by health plans in Georgia," says Brownsworth. Each insurance plan has a quality-measurement program in place, and some have financial rewards associated with them. PHC does not participate in those because the plans say that, from their perspective, Piedmont Healthcare's negotiated rates are already too high. Top performance has led to high contracted rates, which changes the landscape when it comes to incentive pay. In the last several months, however, some of the more moderate-sized insurance companies—Coventry and Humana, for instance—have proposed ACO-like programs.

A year ago, Piedmont Physicians Group (PPG) entered into a medical-home pilot with CIGNA. The project included PPG's primary-care physicians and their patients, what the organization calls a "light" version of an ACO. Participation in this program helps Piedmont understand the requirements of operating an ACO. "We share information among the primary-care physicians, show improvement and share in cost savings, but it's not as broad as most full cost-of-care models," says Brownsworth. "It's one step past a medical home."

The Piedmont-CIGNA program allows for the funding of several nurse care coordinators, or health coaches. Over time, Piedmont will add 50 to 60 affiliated practices that are part of the Clinic. It has also begun discussions on bundled payments for cardiac services, with plans to consider others in the near future. “The CIGNA pay-for-performance initiative has allowed us to step into the ACO waters,” says Brownsworth. And this type of compensation means that Piedmont Healthcare is receiving incentives, even if they do not come in the form of incentives paid to physicians or the health system.

A repository of clinical, business and financial data has allowed PHC to create a clinically integrated physician network.

As a system, PHC is currently about halfway through implementation of PeopleSoft, an enterprise resource planning program that supports finance, human resources and supply chain. Next spring, PHC will go live with PeopleSoft in its hospitals and employed physicians’ offices. To address the need for an electronic medical record (EMR), PHC is implementing EpicCare across the system over the next three years.

“A truly clinically integrated group, though, must share clinical analytics and business intelligence, not just financial data,” says Brownsworth. To that end, PHC has developed a clinical integration trust (CIT), a data repository for a large amount of de-identified patient data from ambulatory and inpatient settings across the system and among Piedmont Clinic members. Essentially, it includes all claims or billing information from the hospitals and physicians.

Brownsworth says, “It allows us to look at our population of patients and their tests, treatments and diagnoses. We use an attribution model to look at the ones we touch, and which ones are predominantly Piedmont patients.” This creates a subpopulation on which PHC focuses on for the purposes of sharing information, influencing treatment patterns and outcomes and managing population health.

Peer pressure, plus oversight and a little help from a friend, leads the way from good to great.

PHC continuously strives for quality improvement, and it all starts with the data. For example, PHC and its doctors review how many women over the age of 40 in the CIT have received a mammogram in the last two years. By working with the physicians, PHC improves that percentage over time.

PHC physicians are committed to working on quality, safety, service and cost effectiveness. All of the physicians have their own web portals so that they may see treatment and outcome data in relation to their own patient populations and for the clinically integrated network of more than 740 physicians. Once PHC sets targets for its metrics, dedicated quality specialists work with physicians to ensure the data is correct and encourage them to improve. There are also practicing physicians who serve on quality committees and the Boards of Directors that oversee the system as a whole.

Never underestimate the power of peer pressure, though. Every physician can see every other physician's metrics. Transparency among the physicians allows them to gauge where they stand among their peers and engage in conversations that allow all physicians to improve. There are both positive and negative financial incentives. Physicians can lose up to 5% of their contracted rates if they don't meet the metrics, but that decision is made based on the group as a whole rather than on a physician-by-physician basis. "And they're really interested in who has cost them money," notes Brownsworth.

In the end, PHC's information technology moves them down the path toward accountable care and clinical integration. The bar is set high, though. "If our physicians weren't already really good, the plans wouldn't want to work with us," says Brownsworth, who stresses the need to achieve superior performance in order to continue these all-important conversations with payers.