Understanding Patient Choice Insights℠

Patient Choice Insights Network

www.aetna.com

Helping consumers gain better insights into health care costs and quality
Aetna is proud to make available the Patient Choice Insights network, an innovative network option in Minnesota.

The Patient Choice Insights network features a unique open access “tiered” network that can help you make informed choices about your care. In the Patient Choice Insights network, providers are analyzed on cost and quality measures and then ranked into three tiers. The lower the tier, the better they have performed on the measures; making it easy for you to find and choose providers that deliver greater overall value.

With Patient Choice Insights, you have the freedom of choice and the information you need to maximize your health care dollars. You are free to access any provider in the network — in any tier.
Providers are placed into tiers — consumers choose based on value

Tier 1 ($)  
• Higher overall value  
• Provider has performed better on cost and quality measures

Tier 2 ($$)  
Tier 3 ($$$)

Accessing the network

The Patient Choice Insights network is offered in select Minnesota and several bordering counties in North Dakota and western Wisconsin.1 Outside the Patient Choice Insights service area, members have access to Aetna’s National Provider Network.

You can access the Patient Choice Insights Provider Directory online at www.aetna.com/docfind/custom/pcinsights. The online directory includes the most up-to-date information on the physicians, hospitals and other health care professionals and facilities that participate in the network. You can use the directory to search by location, provider name, tier level and more.

What the tiers represent

The tiers offer a quick way for you to identify providers that have demonstrated their ability to deliver value — high quality, cost-effective care. The lower the tier the better the provider has performed on the selected Patient Choice cost and quality measures.

Refer to your coverage document for detailed information about the benefit levels available through your specific plan.

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1The Patient Choice Insights and SelectCare networks are made available to Aetna by Medica® and its affiliates. Medica® is a registered service mark of Medica Health Plans.
How providers are evaluated

Each year, providers in the Patient Choice Insights network are analyzed using an award-winning process that factors in a combination of cost and quality performance measures.²

The process, developed in collaboration with network providers, varies based on the type of provider — primary care, specialty care or hospital.

Calculating costs

Primary care providers

Are grouped with their affiliated health care organizations. Using claims data, the total cost of care is calculated for each organization. The analysis considers the price of all the services they provide to their patients as well as the price of the medications, specialists, hospitals and other facilities they use to care for their patients.

The cost information is then adjusted to account for differences in the patients they treat — such as age, gender and the presence of more than one health condition and/or other complications.³ The process creates a level playing field in which organizations that care for patients with greater medical needs can be compared to other organizations.

²The Patient Choice tiering process was awarded one of the first Driving Value in Health Care Award in 2006 from The Leapfrog Group and the National Business Coalition on Health.

³Patient Choice uses the ACG Risk Adjustment System developed by The Johns Hopkins University.
Specialty care providers
Are evaluated on their quality and cost of care. The quality and cost of care is measured relative to other providers with the same specialty. When applicable, the costs associated with their use of other health care facilities such as ambulatory surgery centers and hospitals are also incorporated.

Hospitals
Are evaluated on the cost of their case-mix adjusted admissions. That means each hospital’s patient demographics, clinical characteristics and mix of treatment opportunities are factored into the equation. The resulting cost information allows hospitals to be compared relative to one another.

Measuring quality
Before joining the Patient Choice Insights network, providers go through a rigorous credentialing process that reviews their education, training and qualifications. This helps to ensure your access to quality care.

Going a step further, Patient Choice Insights providers are grouped with their affiliated clinic or organization and evaluated on a variety of quality measures. The measures are adjusted based on the type of provider.

Primary care providers and specialty providers
Are measured on their quality and service practices. Information is collected about the programs and systems that they have in place that can lead to better quality and improved outcomes including their use of:

• Technology and information systems
• Quality improvement activities and programs
• Service capabilities

In addition, primary care providers are measured on health outcomes and care processes as well as service and satisfaction levels (as reported by their patients) in the areas listed below. Results of this analysis are published in the Patient Choice Insights Clinic Comparison Guide available online at www.aetna.com/docfind/custom/pcinsights.

• Asthma
• Coronary artery disease
• Diabetes
• Preventive care
• Depression
• Hypertension

Hospitals
Are evaluated according to their performance on several national quality and safety initiatives listed below. Results of this analysis are published in the Patient Choice Insights Hospital Guide and Facility Pricing Catalog available online at www.aetna.com/docfind/custom/pcinsights.

• The Leapfrog Group’s Hospital Survey
• Institute for Healthcare Improvement’s 5 Million Lives Campaign/Improvement Map
• The Centers for Medicaid & Medicare Services
• IHI Improvement Map
• Hospital Compare Results

Each quality measure is weighted according to several factors including, potential effect on care processes and/or outcomes and whether it is a nationally accepted guideline or standard. Providers are scored on the quality measures resulting in a corresponding “quality credit.”

For more details about the quality measures used, see the chart on the following page.

Establishing tiers
The tiers are designated at a clinic/facility level. The best performing providers are placed in the best tiers. Here’s how it works:

Primary care providers and hospitals
Each provider’s quality credit is factored into their total cost of care. For hospitals, the quality credit is factored into their case-mix adjusted unit price. The providers are arrayed and preliminary lines are drawn at the 33rd and 66th percentile. The array is then analyzed for natural breaks or clusters. Large breaks that occur either below or above the lines, may result in an adjustment to a tier level. The process is similar for both primary care providers and hospitals.

Specialty care providers
The quality credit results for all providers are analyzed, and quality benchmarks are established relative to other providers within the same specialty. This information combined with the provider’s relative cost are used to determine the tier level. For example, to achieve tier 1 status, a provider must be competitively priced and meet or exceed the established quality credit benchmark.

As a result of this annual review process, a small percent of providers may change tiers. The changes take effect on January 1 of each year.
Helping you choose wisely

Patient Choice Insights helps you understand the differences that exist in care delivery. Considering a provider’s tier designation, enables you to make smart choices about your care and get the best value for your health care dollar.

If you have any questions about either the Patient Choice Insights network, please call the Member Services phone number on your ID card.

Learn more about the quality measures.

Primary care providers

Providers are evaluated in the areas of asthma, diabetes, coronary artery disease and preventive care. The information is collected using a tool developed by MacColl Institute for Healthcare Innovation that has been modified specifically for this program.

The assessment considers:

Outcomes — which refer to measurable evidence of quality care such as lab results, frequency of exams and adherence to known best practices.

Processes — which refer to disease management protocols and tracking mechanisms for identifying patients who need to be screened or seen for follow-up.

Service — which refers to patient satisfaction with their care and accommodation to their special needs.

Primary care and specialty care providers

Providers are evaluated on various aspects of their organization’s infrastructure, programs and capabilities including:

• Use of electronic medical records
• Use of electronic prescribing tools
• Process to electronically track ordered tests until completed and patient notification
• Responsiveness to patient complaints
• Implementation of clinical guidelines
• Active quality improvement committee
• Quality improvement program includes cost-of-care and performance issues
• Metrics used to compare physicians’ clinical performance to one another
• Metrics used to compare clinic’s clinical performance to other clinics
• Process for tracking, analyzing and preventing adverse incidents
• 30-day infection rates (specialty care only)
Hospitals

Providers are evaluated on the following measures:

**The Leapfrog Group’s Hospital Survey Results**

The Leapfrog Group is a coalition of public and private organizations that collects and publishes information about hospital safety and quality in the following categories:

- Physicians enter patient prescriptions and other orders into computers linked to error prevention software.
- Intensive care unit (ICU) is appropriately staffed by trained ICU specialists called “intensivists.”
- Hospital has put in place 13 practices that can have a major effect on the safety of patients in health care settings such as timely clinical information for other caregivers and patients and identification and mitigation of safety risks and hazards.
- Hospital has proven outcomes or extensive experience with several high-risk procedures/conditions.

**The Institute for Healthcare Improvement’s 5 Million Lives Campaign/Improvement Map**

This campaign aims to engage hospitals in implementing 12 changes in care that are proven to improve patient care and prevent avoidable deaths. Patient Choice Insights collects information each hospital’s level of implementation on the following:

- Deploying rapid response teams — at the first sign of patient decline and before a catastrophic cardiac or respiratory event in patients who are progressively failing outside the intensive care unit.
- Preventing adverse drug events — by reconciling patient medications at every transition point in care.
- Delivering reliable, evidence-based care for acute myocardial infarction — to prevent deaths from heart attack.
- Preventing surgical site infections — by reliably delivering the correct perioperative antibiotics at the proper time.
- Preventing central line infections — by implementing a series of interdependent, scientifically grounded steps.
- Preventing ventilator-associated pneumonia — by implementing a series of interdependent, scientifically grounded steps.
- Preventing harm from high-alert medications — initially focusing on anticoagulants, sedatives, narcotics and insulin.
- Reducing surgical complications — by implementing changes in care recommended by the Surgical Care Improvement Project.
- Preventing pressure ulcers — by using science-based guidelines.
- Reducing Methicillin-resistant Staphylococcus Auereus (MRSA) — by implementing scientifically proven infection control practices.
- Delivering reliable evidence-based care for congestive heart failure — to reduce readmissions.
- Getting boards on board — by implementing processes to help hospital board of directors become more effective in accelerating care improvements.
- Prevention of catheter-associated urinary tract infections.
- Linking quality and financial management: Strategies to engage the Chief Financial Officer and provide value for patients.

For IHI Improvement Map — Hospitals are assessed on their level of implementation regarding 70 different processes in 3 areas:

- Leadership
- Support care processes
- Patient care processes

**Centers for Medicare & Medicaid (CMS) Hospital Compare Results**

CMS collects a variety of information about how well hospitals care for patients with certain conditions or procedures and what patients thought about the quality of their care. The following measures were incorporated into the tiering process:

- Heart attack mortality rates.
- Heart failure mortality rates.
- Infection reporting.
- Pneumonia.
- Surgical Care.
- Patient satisfaction: Percentage of patients that would recommend the hospital to friends; HCAPS.
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A tiered network offered by Aetna.