BRIDGES to Excellence®
Rewarding Quality across the Healthcare System

Bridges to Excellence Operations Manual

A Robert Wood Johnson Foundation Grantee

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PROGRAM OBJECTIVE & OVERVIEW

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Objective & Program Overview

The objective of this manual is to summarize the operational processes that Bridges to Excellence (BTE) developed in its dual mission of:

1) Engaging providers to demonstrate that they deliver optimal care that is safe, timely, efficient, effective, equitable and patient centered.
2) Engaging patients to seek evidence-based care and self-manage their own conditions.

BTE's goal for this manual is to provide interested parties with these "best practices" that can be universally deployed in the implementation of Bridges to Excellence or other Pay-for-Performance (P4P) initiatives.

BTE's mission is accomplished by paying bonuses to physicians that meet standardized, expert-based, performance measures. Each set of measurements was developed or co-developed by the National Committee for Quality Assurance (NCQA) and panels of experts. BTE also includes an optional patient component that provides support tools and an incentive model for patients in order to align patient behavior changes with physician standards of care. The success of the program is related to the number of physicians who obtain performance recognition, the number of employer patients who see high performing physicians, and the overall improvement of the quality of care delivered by physicians.

Bridges to Excellence is a grantee of the Robert Wood Johnson's Rewarding Results grant program and a not-for-profit organization with a Board comprised of representatives from employers, providers, and plans.

Organizational Structure

Bridges to Excellence essentially functions as a not-for-profit company with a Board, including structured input from all stakeholders. Below is a description of the overall program organization structure and their roles:

Board - Advisory body comprised of BTE purchaser participants, licensees and stakeholders, that makes decisions on program strategy and direction.

Executive Committee - Acts as the advisory and administrative body with a President, Secretary and Treasurer.

Employer Advisory Board - Advisory body comprised of BTE participating employers that provides broad input into BTE topics and direction.

Administrator Committee – Advisory body comprised of BTE Administrators (licensees and partners) that reviews implementations and operational topics.

Regional Team/Steering Committee - Previous experience has shown that organized regional teams with informal leaders have worked effectively to operate BTE locally; however, regions can establish an operational team structure that best meets their market and customer needs. Overall, the regional team is responsible for regional coordination and market engagement. Led by an identified informal leader, the team includes all participants, stakeholders and allied organizations.

Savings Estimates – The Business Case

Partially due to the rising costs of health care, employers across the nation are becoming more and more interested in P4P programs; however, most businesses need to see a strong case (in terms of ROI) to become engaged in these programs on a larger scale. For the National Committee of Quality Assurance's (NCQA) Diabetes Provider Recognition Program (DPRP), BTE performed a comprehensive actuarial analysis that shows proven savings between 10-15% per patient per year. For NCQA's Heart Stroke Recognition Program (HSRP), Towers Perrin performed an analysis that linked specific costs savings estimates to each HSRP performance measure with savings up to $350 per patient per year. Additionally, BTE's estimates for NCQA's Physician Practice Connections (PPC) measure of primary care physicians' data systems could result in savings up to $110 per patient per year. These savings are attributed to the quality and efficiency of the recognized practices, and are based on reliable information obtained from Medstat on the cost of patient incidents. BTE's clinical literature references come from NCQA and other significant sources (see www.bridgestoexcellence.org).

HSRP – Evaluation Results

The underlined data and assumptions for the HSRP savings estimates come from two measures: Blood Pressure and Low-Density Lipoprotein (LDL). Estimates for other measures are based on similar assumptions and findings regarding the impact of measures related to risk of stroke or myocardial infarction (heart attack) for patients with cardiovascular disease.

For example, the Framingham Heart Study found that risk of stroke and heart attack for patients with hypertension compared to patients with regular blood pressure was 2.5:1.0.

This study also found:

- 82% of patients with cardiovascular disease have hypertension.
- 1 in 1000 cardiovascular disease patients have an incident each year.
- The cost of an incident is approximately $11, 755.
- We could prevent 75 cases per 1,000 cases with an average savings of $11,755.
- The per-patient savings is $547 per year.
- The simple math is the actuarial savings – using clinical research and employer data to calculate the percentage of patients with cardiovascular disease and the average cost of event, related to the employer.

Savings estimates for LDL Control measures run off the same calculation for blood pressure and hypertension. Key assumptions and data came from findings in the New England Journal of Medicine:

- LDL counts were greater than 100 mg/dl.
- At a cost of $11,755 per event.
- With 1 incident per 1,000 cardiovascular disease patients.
- If we can control LDL measures, we can prevent 19.4 cases per 1,000 patients with an average savings of $11,755 per event.
- Only need to meet the measures with 50% of patients to meet the LDL measure and bring costs down to $91 in savings per patient per year.

Findings concluded that it's more appropriate to base rewards on a scale, setting different levels of bonus payments, based on the measures being met. For example, in the HSRP program physicians can receive recognition by meeting only 1 measure, which yields little or no direct savings. Savings for achieving HSRP recognition in this way is $270 per patient; however, by also meeting blood pressure measurements, the amount would increase to $540 per patient. BTE doubles the incentive amount to those physicians who demonstrate that their patients maintain the highest levels of control around LDL and blood pressure.

After the savings analysis is complete, there are three fundamental reward principles:

1. Split the savings with the physicians 50-50.
2. Rewards have to be meaningful and tied to something that is actionable.
3. Critical mass of lives in a market is necessary for the rewards to get the attention of the physicians/practices.

DPRP – Evaluation Results

The underlined data and assumptions for the DPRP savings estimates come from an actuarial evaluation on NCQA's Diabetes Physician Recognition Program (DPRP) performed by Towers Perrin at the request of BTE in 2005. Estimates for these measures are based on assumptions and findings regarding the impact of measures related to risk of myocardial infarction (heart attack), stroke, proliferative retinopathy, ESRD, or partial foot amputation for patients with diabetes.

Findings concluded that it's more appropriate to base rewards on a scale, setting different levels of bonus payments, based on the measures being met. For example, in the DPRP program physicians can receive recognition by meeting only 1 measure, which yields little or no direct savings. Savings for achieving DPRP recognition in this way is about $100 per patient; however, by meeting all HbA1c, blood pressure control, and LDL control measurements, this amount would increase to $1,059 per patient.

Two excerpts from the Towers Perrin report are featured on the following page.

Discussion: Additivity of savings within the Blood Pressure, LDL, and HbA1C measures

- Within the Blood Pressure, LDL, and HbAlC measures, it is unclear whether achievement of both sub-measures (e.g., <20% HbAlC>9.0 and >40% HbAlC<7.0) would yield savings that are completely additive, partly additive, or non-additive
  - Our savings estimate for the HbA1C>9.0 measure is based on the incidence of complications at a range of HbA1C values around 9.0
  - If a physician achieves both the HbA1C>9.0 and <7.0 submeasures, we would expect the actual complications to be less than if only the HbA1C>9.0 measure is achieved
- With the Blood Pressure, LDL and HbA1c, we picked the submeasure that yields the greater savings and assumed no additivity

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Discussion: Additivity of savings between measures

- The results show that the DPRP interventions reduce diabetes complications
- It can be argued that if complications are reduced by one intervention, those same complications may not be "available" to be reduced by another intervention
  - For example, the Steno Study (Art. 46) shows that a program of multiple diabetes interventions similar to DPRP reduced diabetes complications by approximately 50%
  - Beyond the Steno Study there is surprisingly data addressing the rate of reduced complications from a combinatorial intervention approach
- In our study the DPRP interventions *individually* reduce complications by 30% to 50%, but because of the reasons mentioned above, we know that these reductions cannot be completely additive
- Nevertheless, because of the difficulty in determining the appropriate additivity factor, we have presented the savings as completely additive
- **It should be stressed, however, that the actual savings of achieving the 60-point goal with most combinations is largely non-additive**

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Engaging the Market Stakeholders: Employers, Physicians and Other Market Leaders

Engaging the purchasers involves both the commitment of BTE purchaser participants and the attention and support of the community around a common set of P4P principles and reciprocity for measures. This is critically important because you can have the best technical solution, but without engagement, success is greatly limited. For example, GE has found, across a large number of six sigma projects, that:

- 100% of all changes evaluated as successful had a good solution or approach.
- 98% of all changes evaluated as unsuccessful had a good solution or approach.
- **The difference was acceptance or buy-in from the stakeholders.**

The 4 Steps to Market Engagement

Step 1: Lay of the Land - Each market is different and must be approached accordingly.

The BTE Administrators in each market need to:

- Define the market geographically and demographically.
- Understand the strategies and initiatives already in the market.
- Know the market's legislative agendas and current initiatives to leverage BTE.
- Know related market activities and determine how they fit with BTE.

How successful have other initiatives been in this market and what can be learned and leveraged from their progress?

- Example in Cincinnati – the market climate had two huge issues influencing BTE's approach:
  - History with employer driven hospital "quality" initiative in market—providers believe big employers are the cause of their current problems, and
  - Physicians filed lawsuit against the top 4 health plans for Price-Fixing.

Bottom Line: You need to know ALL there is to know about your market!

Step 2: Engaging the Market – Key Stakeholders

The BTE Administrators in each market need to:

- Know who are the "key" players in your market because of their size or reputation.
- Know if the key players will be supportive, neutral, or against the initiative and why.
- Know how important their support is and how much impact they have on the initiative.
- Use a Stakeholder-Analysis Tool to organize this information and make it actionable.
- Know a potential stakeholder's issues, concerns, and the benefits to them before meeting.

Step 3: Building the Team

- Identify what "critical mass" is for the market; How many covered lives do you need?
- Recruit employers by using the business case and…
  - Helping them understand the philosophical reasons and the strength this can give them in responding to the market challenges – and paying for quality.
  - Using the toolkit to show that most of the work has already been done for them.
  - Identifying other businesses that support the initiative.
- Need someone from a captivated employer to lead the market to make things happen.
- Identify others that could be team members and what roles they will play:
  - Contact health plans, coalitions, etc., to take on active roles,
  - …Or ask them to perform communication flow/support roles.
- Recruit a doctor to support the initiative (MD/DO) for credibility when engaging physicians.
- Utilize all the resources available (e.g. local QIO's can be critical).

  Example: Rolling out DCL – At the time of implementation there were no successful processes, no tools, and NCQA's application and recognition couldn't be passed. We received aid from the local QIO to improve processes and practices for success.

Step 4: Getting People on Board

- Have an "elevator speech" prepared –
  - In less than 60 seconds, be able to explain what BTE is & why is it important to the listener.
  - Prepare several versions for different stakeholders (Employers, Physicians, Health Plan Providers, etc.)
- Create a formal plan for communicating with the market that ties in to your stakeholder analysis.

Overall Lessons Learned

- Leverage the market intelligence of the health plans on how to approach key employers and providers.
  - Know the politics and current events in the market.
  - Provider relations teams will know the specifics for your target MD's.
- Look for partners with an "act-now" attitude to create a successful change in the market.
- Leverage all the relationships that you make in the market
- Understand the stakeholders and tailor the message to each one accordingly.
  - If you talk **quality** to physicians – they hear: ***managed care & control***.
  - Instead talk **efficiency & effectiveness** – words that will create an impact and spark action.
- Time and consistency will lead to acceptance and trust in the market
  - Having national credibility helps.
  - Difficulty gaining trust and support in a new market.
  - Credibility is the key but credibility often takes time.

Bottom Line: Keeping people engaged is critically important – If people aren't really feeling the drive, they could lose interest, burn out, and lose commitment.

Performance Measures - Choosing Measures for Paying for Performance

Using Medical Evidence, Guidelines and Measures

All measurement sets used by BTE must be standardized and must contain structure, process, and outcome measures. The measurement sets must also be evaluated by an independent accreditation organization, have accountability for use of resources and outcomes, and be transparent and actionable. BTE also looks for measurement sets that continually raise the expectations for quality.

Evidence-based guidelines must be used to achieve a desired result and measures must indicate if results have been achieved, by asking such questions as, "Have you screened your diabetics?" or "Have you controlled high blood pressure in cardiac patients?" For the purpose of quality, groups will use indicators to measure themselves and, if done consistently and only internally, they won't need to be fully specified. If done nationally, fully developed measures need to be explicitly specified so that the results are comparable with other organizations. Not all measures are feasible to collect, usually due to of lack of administrative data (claims). For example, recognition programs collect richer data than other organizations because they use medical records.

Types of Measures

- **Structure Measures** – PPC looks for certain processes in place and the use of certain tools that apply to ALL patients and are not specific to just selected diseases or patients.
- **Process** – Performance of screenings and use of appropriate measures.
- **Outcomes** – What is achieved via the medical inputs and is difficult to obtain, yet most important, "The Money Measures".
    - For example: What is the actual hemoglobin of diabetic patients – clinical or intermediate outcomes – and what are the actual results?
    - Ideally, ultimate outcome measures would be best, but data is not available. For example: How many days lost from work, activity days, functional status, etc.?
    - Clinical outcome data is more readily available.
- **Desirable Attributes of Measures**
    - Relevance: Are the attributes important enough to require measurement?
    - Are they scientifically sound, reliable, and valid measurements?
    - Feasibility and specification – Is there access to a sufficient quantity of the necessary data?
- **NCQA Recognition Programs**
    - National standards with structured processes and outcomes.
    - Address excellent care management.
    - Used by BTE and many health plans in pay-for-performance.
    - Over 3,000 physicians recognized (and growing).
    - DPRP – developed with ADA.
    - HSRP – developed with AHA/ASA.
    - PPC – done in partnership with/for BTE, now working on Version 2 with national Expert Panel and CMS; measures ready in mid-2005.

Measurement in NCQA recognition programs

- **PPC – has many structural requirements.** (Approximately 37 elements in PPC are for good care management in a physician practice.) For example:
    - Electronic tracking system
    - Point of care tools such as e-prescribing and e-lab results
    - Decision support
    - Processes (electronic or not) and follow up
    - Patient education and support
    - Case management for 1% of very ill patients
- **PPC – process measures,** such as the percentage of:
    - Lab results received electronically
    - Patients with risk factors recorded in medical record

  - Patients with chronic conditions in registry
- **DPRP and HSRP- numeric process measures,** such as:
  - % Patients with eye and foot exams
  - % Patients with lipid profiles and anticoagulants
- **DPRP and HSRP – numeric outcome measures**
  - % Of patients with both good and poor blood sugar control (DPRP)
  - % Of patients with blood pressure controlled (DPRP and HSRP)
  - % Of patients with LDL controlled (DPRP and HSRP)

Physician Practice Connections (PPC)

- PPC has basic and intermediate levels in addition to advanced (EHR). Most practices are at the basic level and use paper processes for care management and follow-up. The most common type of registry: the practice management system using diagnostic codes.
- These are really new concepts, and few practices do any of the processes PPC looks at. It makes the difference between producing a good visit and partnering with patients over time. Doctors are trained to produce good visits.
- Even questions about systematic tracking of lab tests and systematic follow-up for abnormal results, which are important to avoid medical errors and malpractice, had to be developed by some practices.
- There is recognition for practices that use systematic processes and IT.
- Many practices that have qualified have put processes in place to do so.

BTE Administration – Licensing BTE

Bridges to Excellence (BTE) in 2002 was designed as a pay-for-performance program (P4P) independent of a specific Administrator model. While that model continues today, the fact that BTE is a "plug-and-play" design provides Administrators the opportunity to adopt BTE, it's principles, the measures it's based on, the reward structure, and the methodology of physician and patient attribution to expand it into several other market areas. Licensing gives Bridges to Excellence, a not-for-profit provider, a sustainable platform as they work towards harmonization with other national pay-for-performance programs, like CMS. **A sample of the BTE licensing agreement can be found at: http://www.bridgestoexcellence.org/**

Paying rewards or bonuses to physicians is not a new concept; however doing it in a consistent manner, independent of payer, and using national standardized measures is new. The employers that participate in BTE are committed to sending a consistent and universal message around paying for quality. Currently, BTE has been licensed in the following 4 markets, to 8 Health Plans:

Market Area	BTE Administrator(s)
Albany, NY	**CDPHP** **MVP**
Washington, D.C. **Maryland** **Virginia**	**CareFirst**
Georgia	**Aetna** **BCBSGA – Wellpoint** **CIGNA** **Humana** **UHC**
Louisville, KY **Cincinnati, OH**	**Humana** **UHC**

What are the advantages for stakeholders in the licensing arrangement?

- Administrators can meet the requests of their customers – employers and physicians – by implementing a nationally recognized program using well-vetted attribution methodology and standard performance measures. They also gain membership into the Employer-Administrator Leadership Council, use of the trademarked, "Bridges to Excellence" name, and BTE resources to guide the market implementation.
- Employers who want to participate in a pay-for-performance program have the option of having their health plan operate it for them or integrating it within their normal business platform. They also gain transparency in provider performance based on standard measures to share with their employees.
- Physicians can voluntarily participate in a P4P program that has been vetted by other physicians, that uses standard measures consistent with national trends like the CMS Medicare Care Management Program (MCMP), and reciprocity of measures in specific markets to avoid duplication of reporting.

While each stakeholder group can benefit from the licensing arrangement, the actual implementation can be adapted to the market environment, which is exactly what each Administrator has done.

What does Licensing BTE Programs mean for a health plan?

In licensing BTE programs, health plans have the non-exclusive right to implement BTE's programs for their plan members. They do not have the right to implement BTE's programs for non-plan members. Non-plan members can participate in BTE's programs either through another health plan Administrator (if available in that market) or through BTE directly.

The licensing agreement also authorizes the plan to use the BTE brand and associated registered trademarks in promoting and implementing the programs locally. In exchange for these rights an Administrator is required to execute a Licensing Agreement and pay a modest annual licensing fee.

Does an Administrator have to implement all BTE programs?

Administrators have the right, in collaboration with their customers and other BTE participants in the market, to select the programs they wish to implement. They are asked to actively cooperate with other BTE Administrators or Participants in any market to ensure that the Programs' impact will be as significant as possible.

Plan Administrators also have the right and flexibility to incorporate BTE's programs as part of their existing pay-for-performance programs, and to modify the recommended bonus amounts to reflect any rewards they have already built in their current pay-for-performance programs.

What are the obligations of Plan Administrators? There are only a handful of obligations for Plan Administrators, which are based off of the principles that all participants follow. These include:

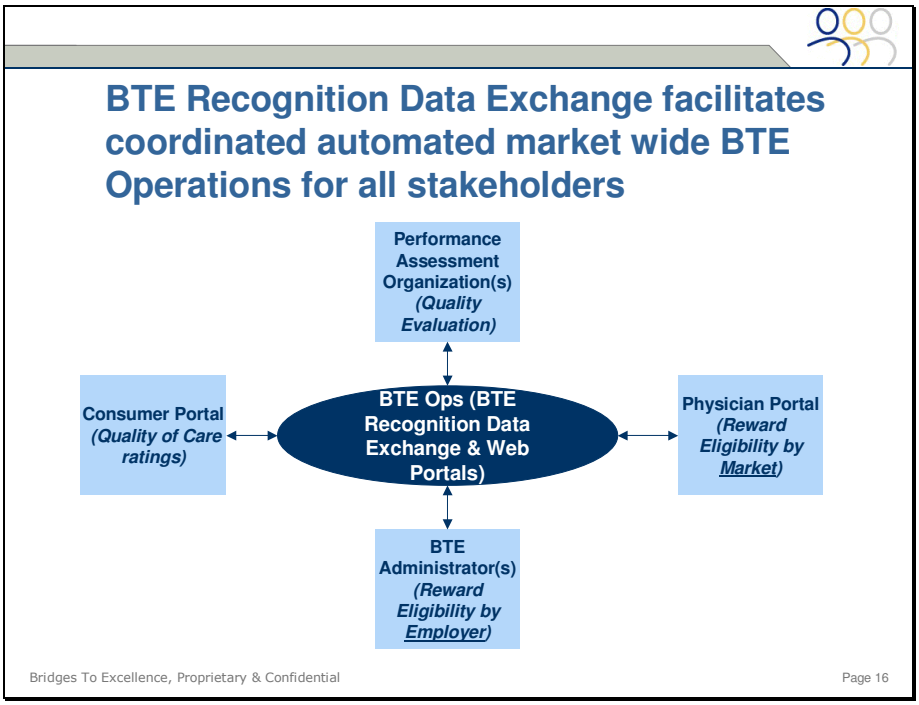
- Rewards paid by the Administrator have to be meaningful and positive, not simply punitive, and aimed at achieving a positive sum outcome for BTE program participants,
- Rewards should be paid after physicians have demonstrated high performance,
- Plan members should be encouraged to seek out recognized providers and plans should create incentives for better member self-care,
- Administrator should use independent national accrediting organization to assess and recognize provider performance community-wide,
- Administrator should continue pushing for ever-tougher standards on provider performance and demand complete accountability for use of resources and delivery of outcomes…

Within the limits of applicable law, Administrator should participate in cross learning with other BTE participants and Administrators on the results of the program.

BTE Operations:

The regional tasks supported by BTE Operations through its Recognition Data Exchange and Web Portals include:

- Overall attribution of patient counts to physicians: Aggregation of data across BTE administrators to create a master attribution list and associated communications of such to physicians through the physician and practice portal.
- Physician and Practice portal: Transfer of data from BTE Operations to BTE administrators including the eligibility of providers for rewards, associated passing of any Performance Assessment Organization fee reimbursement, posting of eligibility for rewards and qualification under the BTE programs to the physician and practice portal and the consumer portal.
- Physician report cards: Engagement of employees through the physician report cards ("consumer portal") by providing physician ratings in their community. Additionally, collecting and showing patient experience of care data, and making said files available to plans.



Administering Physician Rewards for Employer Collaborative

Reward administration is a critical element of BTE program implementation and the reward program itself. There are many details required to ensure that awards are given timely and accurately. Reward administration is done by a BTE Administrator on behalf of their employer customers.

Engaging stakeholders – Administering Physician Rewards

- Tasks include determining:
  - Which physicians are eligible within the market and how they can be contacted.
  - Which physicians are practicing in each office and their patient count associated with each employer/health plan.
  - Whom the actual reward should be delivered to (the practice office or the individual physician) and addressing tax implications.

Data Release Agreements

- Health plans typically will not release any data (even at a summary level) to a third party (e.g., a BTE Administrator) without data-release agreements.
  - For data going from health plans to BTE Administrator for the physician rewards program:

        - The purpose of the data is to count the number of patients per physician associated with each participating employer or health plan.
        - The data does not typically have to include PHI (except some employers that require identifiers for dummy claims).
    - For data going from health plans to the CareRewards program (through the BTE Administrator to the CareRewards vendor):
        - The purpose of the data is to enable outreach to individual patients.
        - The data does typically include PHI (patients' names, addresses, etc.)
- There are typically two types of agreements that may be required before health plans release data:
    - Business Associate Agreements are typically between a self-insured employer and the BTE Administrator to establish the Administrator as a HIPAA-compliant agent of the employer.
    - Data-Use Agreements are typically between a health plan, employer, and Administrator to legally cover the health plans' release of data to the Administrator.
- The process for establishing these data-release agreements can take time. Fortunately, BTE has examples and templates of successful pilot efforts that it can share.

Distributing Rewards – An 8-Step Process

1. The Administrator should immediately congratulate physicians and practices once the recognizing entity sends notification about their recognition. Projected timing of the reward check is provided during this contact.
2. Employers are invoiced for their portion of the rewards.
3. Employer payments can be consolidated into a single check per physician or per practice (as determined by a region).
4. Reward checks are mailed to physicians and/or practices.
5. Physicians fill out a survey pertaining to their impressions of the process and how the reward opportunity influenced their healthcare practices.
6. End of year mailing of 1099 forms to rewarded physicians and practices (compliant with federal income tax requirements).
7. For all 3 programs, practices/physicians can get recognized in Year 1 without being required to submit data each year after to receive rewards.
8. There is a need to monitor rewards per physician, their years of activity, and their reward dates to ensure smooth reward processes each year.

Recruiting and Engaging Physicians

The real savings from BTE is driven by the percentage of patients that see recognized physicians. There are two strategies to increase the percentage – recruit and engage providers and/or encourage patients to switch to recognized physicians. To recruit physicians it is ideal to have a central resource within the market that can communicate to physicians about the reward and fee amounts, and have some level of detail around the recognition requirements. Recognizing entities, such as NCQA, should be used as the expert when there are questions on their performance measures.

Physician Recruitment

- Setting up a specific team of people for engaging physicians is critical.
    - Someone who knows the providers.
    - Someone who is credible and respected (must have at least 1 MD on recruitment).
    - Someone who can champion the initiative & speak to the press.

Choosing Target Physicians

- Attributing the data is time consuming.
    - Even before the data is ready, you can target physician groups who are leaders in the market.
    - Identify who is approachable and most likely to be interested in BTE.
- When data is complete, develop a formal recruitment plan.
    - Sort by patient volume both for individual physicians and group practices.

- Use health plan expertise for identifying groups, getting key contacts, and strategies for effectively communicating with the target physicians.
- Use multiple channels and leverage the toolkit.
- As other activities come up, remember to leverage the opportunity to market BTE.

Active Recruitment

Recruitment is accomplished through a combination of mailings, outreach and training:

Mailing – General mailings (at market launch, after data updates, and ad hoc) are best served as climate-setters and to establish brand recognition.

- Personalized direct mailings to physicians with their reward amounts at the market launch, establish the program's commitment and intent.
- Successive mailings maximize response.
  - For example, BTE sent a customized reward letter, a self-mailer brochure, and a reminder postcard within 3 weeks, which helped to increase interested response by 20%.
- Personalized faxes and letters sent to the practice administrator using the MGMA list. Since practice administrators or office managers are often the "gatekeepers" to the physicians, BTE sent personalized faxes and letters to engage practice administrators.
- The BTE Newsletter was created to increase BTE brand recognition, reinforce the market presence of Bridges to Excellence, and to highlight those practices and physicians who have achieved recognition.
- Consult with engaged practices and physician champions about how they want to handle their own physician communications. Mass mailings and surveys can be distributed internally by the practice and will often have a better response rate than ones sent from the outside.

Person-to-Person Outreach – Assigning recruitment responsibilities early in the initiative is critical to help maximize the exposure and resources across BTE participants.

- Establish a process to coordinate recruitment activity, for example, having a universal contact sheet sent to a central location weekly.
- The best time to contact a practice is soon after an initial communication (mailing/fax) is sent.
- When calling, have all the practice's information available by using the database.
- Use a script, if needed, to describe the mission of the program and rewards.
- If you cannot reach the physician or the office manager, try to establish a follow-up time or ask for to schedule a meeting with the contact.
- Interested practices should be contacted 2-3 times per month (follow-up calls) to offer assistance or to inquire about what potential barriers they are encountering.

Training and Support – The next stage for interested physicians or practices is to get the training and support needed to apply for NCQA recognition (or another approved organization's recognition). NCQA Training can be done through NCQA group training in Washington, D.C., or via Open Call, Workshops, and Web-Ex training sessions which are available online and via teleconference.

- Bridges to Excellence has a registered CME course through the University of Virginia. The ingredients for successful CME's are:
  - Funding provided by pharmaceuticals,
  - Targeted invitees that have expressed interest in the program,
  - Features a well respected physician to share best practices, and
- Follow-up with invitees to get good attendance. NCQA Web-Ex training is an internet-based, distance learning session that is very useful to interested practices for the following reasons:
  - They concentrate resources on the most committed practices.
  - These practices can ask questions.
  - These practices get hands-on exposure to the measures and learn from one another.
  - NCQA gets valuable feedback on their performance assessment process.
- Practices that have had an introduction to BTE and NCQA and have expressed interest in applying, are the ones invited to the training sessions. It is important to encourage these practices to purchase the NCQA tool prior to the training, so they come prepared with baseline familiarity of the program and have

prepared value-added questions; However, anyone can join the web and teleconference training sessions that are offered by NCQA and featured on http://www.ncqa.org/PhysicianQualityReports.htm

Market Intelligence Community Networking – The most critical element of engaging physicians is in-market people who are familiar with the region and the stakeholders, and can promote the program on a community-wide basis.

- Local medical societies can be a valuable ally in certain markets. A successful working relationship can yield access to targeted physicians and specific practice information that can provide insight to physician barriers and/or motivations.
- Quality Improvement Organizations (QIO) can also provide critical linkage for physicians and practices between the tools needed to make quality improvements and the BTE rewards. The QIO's are given a list of the BTE eligible physicians and the customized reward information to distribute during their office visits. The QIO's report back weekly on whom they contacted and what possible next steps would be to engage that practice. BTE and MassPRO (Massachusetts QIO) have developed a successful collaboration to reward eligible physicians BTE rewards for successfully completing MassPRO's quality improvement criteria.
- Physician champions can provide an invaluable perspective to other physicians and practices that are contemplating participation. Early in market implementation, BTE identifies physician champions to whom they could refer to as resources on: the practice level business case, the level of effort required to apply, and general feedback on the program.

Managing the Recruitment Process

- Communication is critical, especially when multiple channels are being used.
- Have regular reviews to share information across the team and leverage each other as resources and contacts.
    - For example, currently on monthly calls the team is able to learn about future events being planned and get BTE into the agenda.
- Issues tend to be similar across a market so working together to find solutions to removing barriers is key.
    - For example, the application process is cumbersome and a common barrier. The Employer Healthcare Alliance, with a grant from Novo Nordisk, was able to offer Certified Diabetic Educators to help with the application process and perform chart extractions. Seven new practices are currently going through the process as a result of this solution.
- Persistence is the key—keep pushing and keep open to new opportunities to promote BTE.

Engaging the Physicians – Lessons Learned

BTE was designed using the underlying principle to make it a win-win situation for everyone and systematically remove the barriers for physicians to participate. Below is a summary of the barriers that BTE encountered engaging physicians and the methods employed to overcome them:

- **Barrier #1:** The per-physician NCQA application fee required for the Provider Recognition Programs is, on average, $450 per physician.
- **Solution:** BTE negotiated a discounted NCQA application fee that is available to all BTE licensees. Additionally, Administrators can reimburse this fee to physicians and practices once they achieve recognition. However, physicians should pay their application fees upfront for two reasons – 1) operational simplicity and 2) it encourages them to complete the NCQA application.

- **Barrier #2:** Physician Recognition Programs alone have not been a market force.
- **Solution:** While the NCQA provider recognition programs are available nationally, all of the growth in the number of recognitions has been in markets where rewards are offered. Initially, BTE educated physicians and practices on the recognition programs and explained why they are so important. Ultimately, the rewards and incentives provided motivated them to become recognized.

- **Barrier #3:** Recognition requires self-reporting & practice level resources. Small to mid-size practices may not have the extra resources to dedicate to the application process for NCQA recognition.

- **Solution:** A grant program was established through a third party to provide extraction services and support for the NCQA recognition programs. There was tremendous response by many practices and physicians and the number of recognitions tripled within a few months.

- **Barrier #4:** Consumers (patients) have not been engaged to the extent that they make choices based on recognized standards of distinction and quality.
- **Solution:** Some employers actively steer patients toward recognized physicians. For example, in the Cincinnati and Louisville markets, practices that are recognized in the area are printed on wallet cards and distributed. Additionally, the Oxford Health Plan actually contacts diabetics in their area and channels them to recognized physicians.

Consumer Engagement

Hannaford – A Case Study in Consumer Engagement

Hannaford's employee population tends to fall into higher cost geographic locations. There is a $2000-$3000 difference in healthcare costs for some of these areas that is not directly attributable to any expected healthcare factors. Consequently, there exists a great opportunity to try to reduce costs. For Hannaford, this could mean a projected savings of up to $319 million by 2013.

One influence on the cost of health care is made by certain high-risk employees, who increase the total cost of care.

2 Examples of High Risk:

1. Depression is a significant cost driver because:
    - Depression is often undiagnosed and/or poorly treated.
    - Anti-depressant medication is one of Hannaford's leading health care costs at $1,000,000; 60% of which may be wasted.
    - 75% of anti-depressant recipients have never seen a mental health provider.
2. Obesity is another one of the leading causes and contributors to preventable health costs.

They key to resolving these 2 health care cost drivers is changing employees (patient) behavior.

The solution is to create a healthcare market with the following characteristics:

- Informed and engaged consumers
- Market Transparency
- Appropriate Treatment Options
- Outcome and Quality Metrics
- Reduced Cost

The Key is TRUST

- A recent survey showed that only 24% of employees and their families would trust their health plan provider to provide them with health information.
- 71% of that same population preferred to use the Internet to other alternatives.
- The imperative solution is to leverage providers and the Internet to provide valuable health-related information to employees.

Hannaford's "Market Based Solution"

As a step forward toward a "Market Based Solution" and engaging the consumer even further, Hannaford has created a benefit for employees using quality-based care. For example: In Maine, 430 primary care practices are creating and publishing "quality" measurements to drive "pay for performance".

Hannaford is encouraging the use of these practices and others by providing:

- Benefits for organ transplants and complex cancers only at designated Centers of Excellence (Medical Care Facilities designated as such by the NCQA).
- Waiving a $250 in-patient co-pay for procedures performed at 3-stars or higher hospitals (based on criteria that includes Leapfrog metrics).
- A 5% higher benefit (via reduced co-insurance %) is used for patients utilizing the top quartile of primary care practices in Maine.
- Health coaches that are available 24/7.
    - At-risk employees (e.g. having chronic conditions, gaps in care, etc.) must participate in Hannaford's health coaching programs and achieve established health goals.
- Ensuring there are nurses on location at every facility.
- $20 per week ($1,040 annual) for a Healthy Behavior Credit.
    - Must be a non-smoker or enrolled in a cessation program.
    - Must complete a Health Risk Appraisal (all adult members).

BTE's Physician Quality Ratings Website

This is a historic initiative – it is the first website where patients share their experiences with individual physicians in a fair and organized manner. It shows:

- High-level roll-up of physician's overall performance.
- Relative performance of physicians within each level.
- Patient satisfaction or dissatisfaction about their primary physician via ratings.

BTE has introduced a new way for patients to find the right doctor for their care. The Physician Quality Rating site allows patients to:

- Research the quality of a specific physician or practice.
- Find qualified physicians in your area, based on your criteria.
- Express your satisfaction or dissatisfaction about a physician experience.
- Learn what other patients have said about their experiences

Physician and practice measures are fed monthly from the NCQA application process. The site gives patients the ability to compare objective (accreditor measures) and subjective measures (Patient Experience of Care survey developed by Dana Safran at Tufts New England Medicine center with MHQP) when selecting a physician. All patients are encouraged to review the performance ratings of the physicians and to use those ratings in selecting a doctor. Featured BTE "certified" physicians, according to NCQA criteria, should distinguish those doctors from their peers, and steer "educated" health consumers to their practices.

Health Care Professionals are invited to visit www.bridgestoexcellence.com/bte/qualityratings to see the progress of this demo site and are encouraged to fill out a survey on their primary care physician while at the site.

Diabetes CareRewards (DCR)

The diabetes care rewards tool was built in response to employer participation in the Diabetes Care Link (DCL) program. For employees, retirees and their dependants the DCR tool offers access to an on-line self-management tool specifically designed for the care of Diabetes.

DCR website promotes the achievement of target diabetes goals to improve a person's health, increase disease awareness and prevent diabetes complications. Eligible employees can earn and redeem points for rewards while simultaneously improving their health by following seven self-care activities, including lowering an unhealthy Hemoglobin A1c level (HbA1c) and/or maintaining healthy levels over time.

The Diabetes CareRewards website is implemented by WebMD and based upon its award-winning personal Health Manager. This website is very customizable and can be integrated with other websites and Internet enabled applications of interest to each BTE Participant.

Evaluation Overview & Key Successful Market Environment Factors

Opportunity for Improvement Exists

- There is a need for a significant market presence of participating employers in: (square bullet vs. round)
  - Volume of total covered lives and clustering of covered lives around physicians and practices.
  - Market leveragability & name recognition.
  - Market intelligence & relationships in the community through coalitions or associations.
- Need to increase buy-in of physician community and acclimatize them to change.
- Need to have active and accessible leadership.
- Need to use aggressive communications and physician recruitment strategy.

Monthly Metrics and Reporting

- The BTE Administrator should produce monthly reports based on the following metrics:
  - NCQA application requests and tool purchases.
  - Number of survey tools submitted to NCQA by program.
  - Number of employees going to recognized physicians.
- If the region is soliciting survey feedback from physicians, BTE has experienced the best response rate when the solicitation comes from the physician group leader that includes a small reward or incentive. For example, including a coupon for a cup of coffee.
- Lessons learned and best practices gathered from various focus groups should continue to be shared across the different markets as well as shared with the different vendors. Information from focus groups containing both recognized and uninterested physicians should be gathered, processed, and disseminated to regional teams for use in future recruitment.
- Additionally, it is important to probe uninterested practices for reasons on why they feel that participating in the program would not be feasible. Need to understand the problems and concerns that physicians have with the program so they can be evaluated and rectified for future program success. Some physician concerns may be easy barriers to overcome but the only way to know is to ask.

CareFirst BlueCross BlueShield Case Study

Case Study Description

CareFirst is performing their case study in the following regional areas: Maryland, District of Columbia, Northern Virginia, and Delaware. The products offered by CareFirst are: Point of Services (POS) plans, Preferred Provider Organizations (PPO's), Managed Care Organizations, and Consumer Direct Health Plans. Currently membership at CareFirst, including Federal (FEP) program members, is at over 3 million with a market share at 39% in this service area. CareFirst is a licensee of the Bridges to Excellence Program and rewards physicians in the Physician Office Link (POL) program. In the first year, a total of $800,000 will be rewarded to physicians.

Engaging Stakeholders

Before starting the Bridges to Excellence program, CareFirst was already rewarding physicians through regionally recognized Pay For Performance programs. However, BTE is a key component of the commitment focusing on initiatives designed to improve quality of care and patient safety. The pilot is consistent with the business strategy and looks to enhance partnerships with physicians and organizations to promote quality and patient safety.

CareFirst has engaged multiple stakeholders in the marketplace to support/endorse the BTE concept prior to the launch throughout the recruitment period. These include the Regional Business Coalition, BlueCross BlueShield Association, Delmarva Foundation (QIO), Medical Societies, Heart Association, and Medical Groups.

Detailed Design

CareFirst launched the $3.6 million pilot for the BTE project in 2005. It's the first health plan (rather than employer) providing financial incentives through the POL program. The pilot program recognizing and rewarding physicians is a 3-year pilot (2005-2007) with approximately 10-15 sites in the service area. A minimum of 15,000 CareFirst members are affected.

Eligible physicians include primary care physicians (PCPs) specializing in internal medicine, family practice, pediatric, or GYN, as applicable. The selections of two practices as "early-adopters" are on-board with the program as it prepares to launch. Selected pilot practices will be required to pass the NCQA Physician Practice Connections (PPC) Assessment Process. CareFirst will assist NCQA, if necessary, and reimburse practice's survey fee if they prove successful and become recognized. If practices have a successful outcome from the NCQA assessment, they will receive PPC Certification. This will include recognition through local media and rewards totaling a maximum of $20,000 per physician and/or $100,000 per practice, per year.

Physician Eligibility and Engagement

Physicians/Practices will go through an initial screening process upon completion of the online application. Screening will be completed by CMO's, Medical Directors, Credentialing, QI, Network Management, Special Investigation Unit, and Care Management services. The selection of physicians/practices will then be done at random selection from a list of successful applications. There will be a maximum payout per applicant calculated and each applicant reviewed in order from top to bottom. Excluded from this list are non-PCP submissions or failed internal screening. Physicians/Practices are placed on a waiting list if there excessive groups/networks or if the pilot project budget has been exceeded. Accepted physicians/practices are all other selected applicants.

Membership Engagement

All network PCPs are invited to apply to the pilot. Multiple forms of invitations were distributed via email, postcard, and personalized letters to practices that were recommended from internal and external sources with an invitation to apply. Phone lines and email accounts dedicated to questions regarding the program were also made available. The application was posted on the CareFirst website. A total of 68 practices completed applications in the service area, which was a total of 214 physicians. In 2005, 20 Practices were PPC recognized with a total of 82 Physicians.

Unique Challenges

- There are no large employer groups to take the lead in the service area.
- CareFirst is the first provider to fund incentives.
- Since it is a pilot there is limited participation and picking practices is completely at random.
- Until there are more engaged physicians/practices, selection to either accept or reject is only being done at a test phase.

BTE Resources and Team Structure

- The BTE Workteam meets every other week. Participants include BTE, NCQA, BCBSA (as moderator), CareFirst QI staff, Provider Relations, Legal Team, Care Management Team, Corporate Communications, the Marketing Team, Medical Directors, and the Informatics team.
- Resources for this project include a dedicated QI staff to assist the selected practices in navigating the accreditation process. The CareFirst Informatics team performs patient attribution. Ongoing Corporate Communications also lends promotional support. Regular reports to the CareFirst Executive staff, QI Committee, Mission Oversight Committee, and Service Oversight Committee, all subcommittees to the Board of Directors, are reported out quarterly to Bridges to Excellence.

National Business Coalition on Health

Case Study Description

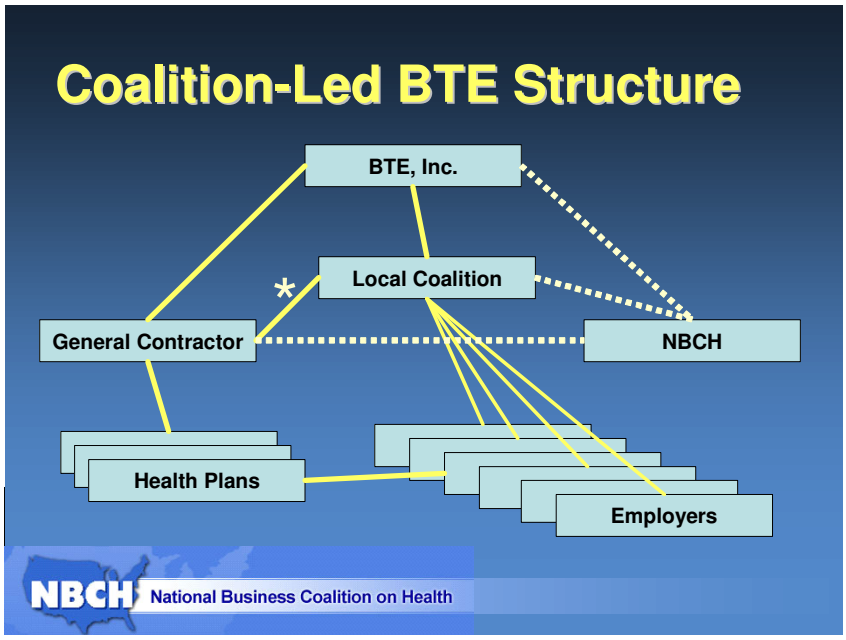
With local knowledge and employer connectivity, business coalitions are ideally positioned to promote the Bridges to Excellence program. NBCH and its member coalitions are working to create a national framework to promote BTE, consistent with NBCH's overall goal to promote value-based purchasing.

The NBCH/BTE initiative was launched in July 2004. The goals of the initiative are to facilitate dialogue among local coalitions and their member employers, promote adoption of value-based purchasing, provide technical assistance through materials on the NBCH website and on-site assistance, and to create a business model for sustained coalition commitment to BTE.

Engaging Stakeholders

Coalition-led implementation of BTE requires a contract structure in which the coalition signs a master agreement with BTE and then becomes the local access point for BTE in its market. In this contracting model, the coalition may engage a BTE Administrator to perform the administrative tasks of BTE such as data processing, rewards payments and program infrastructure. A fee structure for the local market will depend on division of labor between the coalition and the BTE Administrator. Coalitions may be best suited to communications and local market coordination tasks.

The role of NBCH is to coordinate activities among local coalitions and national entities (BTE, BTE Administrators, NCQA, etc.), provide implementation templates to speed process, and provide ongoing technical and liaison support. The diagram below illustrates contracting structure:



Membership Engagement

NBCH is now working with local coalitions to launch BTE in five markets:

- **Direct Purchasing Coalition In Arkansas** – The Employers Health Coalition is working to engage in the BTE initiative for all three programs: POL, DCL, and CCL.

- **Direct Purchasing Coalition In Quincy, IL** – The Tri-State Health Care Coalition seeks involvement in BTE through the CCL program.
- **Direct Purchasing Coalition In Minnesota** – Will be implementing the DCL program and providing rewards to physicians.
- **Traditional Coalition In Colorado Springs** – Colorado Business Group on Health seeks BTE involvement through the DCL program.
- **Traditional Coalition In Heartland, IL** – Heartland Health Coalition seeks BTE involvement through the DCL program.

These markets differ from the original pilot BTE markets, as there was no prior employer commitment to BTE in these areas, leaving the project coordination to start from "square one." In this situation, employer education is the critical first step. To ensure a successful implementation, the coalition needs to have clear vision of the BTE implementation in order to provide information to employers

As of mid-December 2005, NBCH was working on finalizing an implementation infrastructure and employer engagement process that addressed:
- Contracting issues
- Physician communication
- Physician recruitment
- Experience will create templates for quicker launch in other markets

Overall Case Study Lessons Learned

Market Dynamics
- Each market has unique characteristics that should be evaluated at the beginning of the project. There is a need to understand who the key stakeholders are and if they will come to the table. What is the composition of the employer market? Are there one or two key employers or a few large employers or many small employers? Are they mainly public or private employers? Is there a prevalence of self-insurance? Who are the market makers?
- How can the health plans get involved and facilitate the process?
- How is the physician market structured? Are there large group practices, solo practices, and who are the opinion leaders?
- Is the market ready, and if not, what factors need to change to create readiness?
- Local market dynamics will suggest the best implementation model for the market. Is the market Coalition-led, Employer-led, Health Plan-led, or is there some hybrid of the three?

Cost and Benefit Issues
- BTE costs and benefits in the market will depend on implementation choices.
- Therefore, it is important to involve stakeholders in these choices. Implementation choices include: which BTE programs the coalitions are looking to implement (POL, CCL, DCL), the division of labor is between coalition and BTE Administrator, and the physician outreach strategy plan. Identifying these costs and assignments early in the process makes employer recruitment more efficient.

Employer Recruitment Issues
- In some markets, securing the commitment of key "anchor" employers to generate market influence will be critical. Small employers (less than 500 employees) may represent half the employees in a region and may also have challenges implementing BTE. However, small employer participation can augment the efforts of large employers, who otherwise would carry the entire load.

Keys to Success
- Successful BTE implementation requires the coordination of many entities including critical leadership and coordination. It is here that local coalitions can truly demonstrate their value. Local coalitions have the local relationships, know the local players, and are "on the ground".

- BTE can be technically complex to understand, however, there are many resources available in the BTE "network" including, NCQA, NBCH, Medstat, Ingenix, and BTE. Over time, more standardized resources are being developed and will be available to facilitate education and recruitment.

Next Steps for NBCH

- In the immediate future, NBCH will continue implementation in five NBCH pilot markets. Additionally, new coalition-led markets are looking to focus on larger markets, adapt to existing efforts to new environments, and the refinement of the coalition toolkit.
- Cooperate with BTE implementation in "hybrid" markets even where BTE is not led by the local business coalition, the coalition can still play a supporting role. Different models for coalition efforts are certain to evolve.

Additional Information

Please visit our website at www.BridgesToExcellence.org for additional information and resources such as:

- Press Releases
- Newsletters
- BTE Market Locations
- BTE Market Contact Information
- NCQA Program "Quickstart" Guides for Physicians

Contact BTE at 1-800-224-7161 or bridgestoexcellence@thomson.com to request the following materials that are not currently available at www.BridgesToExcellence.org:

- Printed BTE Newsletters
- BTE Reward Administration Toolkit
- BTE Diabetes CareRewards Employer Toolkit
- Stakeholder Analysis Worksheet Template
- Communication Timeline Worksheet Template
- Checklist for Participating Employers
- Physician Recruitment Tools including: Contact sheet, Fax, Script, Process overview
- BTE Overview DVD