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Rewarding Quality across the Healthcare System

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- *Providing tools, information and support to consumers of health care services,*
- *Conducting research with respect to existing health care provider reimbursement models,*
- *Developing reimbursement models that encourage the recognition of healthcare providers who demonstrate that they have implemented comprehensive solutions in the management of patients and deliver safe, timely, effective, efficient, equitable, and patient-centered care which is based on adherence to quality guidelines and outcomes achievement.*

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Rewarding Quality

Physician Newsletter

BRIDGES to Excellence®
Rewarding Quality across the Healthcare System

Issue #3 **August 2005**

Inside This Issue

Adoption and Use of Health Information Technology in a Physician's Practice: Does it Really Help in Delivering Better, Safer Care?

There are currently nine bills in Congress that, in some form or another, create incentives for physicians to adopt and use health information technology (HIT). HIT can take various shapes, but the most commonly referred to (and the one that holds the most promise) is the electronic health record (EHR).

In a recent testimony before the Senate, Dr. Peter Basch from Washington, DC had the following comments:

"The initial impetus for my adoption of an EHR was a response to the pressures of managed care, which required primary care doctors like me to see more patients in less time as well as produce and manage increasing amounts of paperwork. At that time, I saw the potential of EHR quite narrowly—as an electronic filing cabinet—an administrative tool that would help relieve me of some of the paperwork burden and also allow for added productivity; something to automate care.

"Today, after years of using an electronic health record in my own practice, and years of working more broadly in the health information technology field, I believe the analogy of an EHR as electronic filing cabinet is not only inapt, but wrongheaded as well. Advanced EHRs are not and should not simply be about digitizing the information associated with existing care processes. In my view, that would do little more than digitize dysfunction. The real power of an EHR optimally integrated into practice is far greater. Properly implemented, an EHR can be a tool for better informing multiple care processes, and even lead to healthcare transformation, leading to further enhancements in quality, safety and efficiency, and efficacy.

"For example, at the start of each visit, a patient is encouraged to look at his or her medication and allergy list and confirm its accuracy. Patient educational materials are integrated into the system, and soon the EHR will provide clinical decision support for patients, which will allow them to make better decisions about self-care for chronic illnesses. The EHR is also designed to link to new medical information, practice guidelines and even recent reference articles, dramatically shortening the time from discovery of new knowledge to its application into clinical practice. Our EHR is also integrated with electronic prescribing, further increasing safety and efficiency of prescribing. And because the EHR is also available remotely, on-call physicians can view patient records and make care decisions based on the full context of a patient's clinical information anytime and anywhere.

"With our fully integrated EHRs, lab reports flow directly from reference and hospital labs securely into the patient record, showing up on the physician's PC for immediate review. This not only makes report review quicker – it also makes it better; new results can easily be viewed or graphed and interpreted in the context of prior results and the patient's full history. Even digital EKGs can be reviewed and compared with earlier tests.

(cont'd on Pg. 2)

(cont'd from Pg. 1)

Adoption and Use of Health Information Technology in a Physician's Practice: Does it Really Help in Delivering Better, Safer Care?

"EHRs become more powerful when they use decision support tools that not only provide timely information, but also help clinicians turn that information into actionable knowledge. For example, in the case of a diabetic patient, an active decision support tool triggered reminders about clinical management of diabetes such as the need for an overdue test, even though the patient has made an appointment about a sinus infection. Robust uses of decision support tools thus have the power to inform a routine visit into an opportunity to also include and optimize chronic care management.

"But by far the greatest potential for an EHR to improve quality, efficiency, and efficacy comes from its use to transform care. The transformative uses of an EHR include integration of a registry for proactive care and population management; integration with a secure patient portal or personal health record for appropriate use of non face-to-face care or eCare; and use of the EHR to optimize team-based care or care coordination.

"EHR integration with a population or disease registry allows clinicians to proactively review subsets of patients and take affirmative steps to ensure adherence to nationally accepted best practices. For example, my practice, Washington Primary Care Physicians was recently recognized by the Delmarva Foundation, our regional Quality Improvement Organization, for its high rate of pneumonia vaccination in Medicare patients – a process made possible by our use of an EHR with patient registry functions. And when the arthritis medication Vioxx was recently recalled, all of our patients on the medication, among the 25,000 in the practice, were identified within minutes and then contacted."

There is much evidence that adoption and use of EHRs can significantly improve the quality of care in America, and that's why Bridges To Excellence developed the Physician Office Link program. Later in his testimony Dr. Basch was asked how he could afford and sustain such a tool in his practice. His answer: "Bridges to Excellence".

Bridges to Excellence Update

By Jeffrey Hanson
President, Bridges to Excellence

Your Board and Leadership Council have been working hard over the past quarter as BTE continues to be in the spotlight regionally and nationally. We are on the road every week educating interested parties on BTE and supporting the various collaboratives that are coming together to launch the BTE program in their markets. There has also been an increased interest from Congress and various arms of the Federal government in BTE. I, personally, have appeared twice this spring before Congressional groups interested in pay-for-performance and particularly BTE.

As of this June we now have 669 PPC-recognized physicians and 383 DPRP-recognized physicians in our four pilot markets. To date we have distributed $1.9 million in rewards to these doctors. Interest from physicians in these markets continues to grow and we have been working closely with NCQA to be sure we meet the increase in the volume of recognition applications for the various programs. The increase in physician numbers in these markets also means that an increasing number of participating employers' members are now seeing a recognized doctor.

Our health plan licensees have also remained active in launching BTE in targeted markets. This group also continues to grow. We added Capital District Physicians' Healthcare Network in Albany to that group in June. We are in active conversation with numerous other health plans, regionally and nationally, who are interested in assessing a BTE fit for their organizations.

Finally, we partnered with the Leapfrog Hospital Incentives & Reward program at a recent pay-for-performance workshop in Washington, D.C. This "toolkit" event played to a full house and has garnered interest from other parts of the country for repeating. We think this is an exciting vehicle to bringing together inpatient and outpatient P4P.

Pay-for-performance has gained enormous momentum this year. Reportedly, there are now over 100 P4P programs of various kinds across the country. BTE is seen by many as the preeminent ambulatory care program among this list. We have broad support and are producing results. Thanks to all. We look forward to continued success going forward.

NCQA

NCQA Recognition Programs: General FAQs

Q: What is the relationship between the NCQA Recognition Programs and the Bridges to Excellence Reward Programs?

A: BTE has separate programs that reward physicians who achieve recognition through each of the national NCQA physician recognition programs, as shown below:

NCQA Recognition Program	BTE Reward Program
Physician Practice Connections (PPC)	Physician Office Link (POL)
Diabetes Physician Recognition Program (DPRP)	Diabetes Care Link (DCL)
Heart/Stroke Recognition Program (HSRP)	Cardiac Care Link (CCL)

NCQA expects that more Recognition Programs will be available beginning next year, and BTE may subsequently offer additional, corresponding Reward Programs.

Q: How do the NCQA Recognition Programs work?

A: The Applicant (individual physician, or physician group or practice)

1. purchases a Web-enabled Survey Tool (with Excel workbook for DPRP and HSRP)
   - ♦ minimum requirements: Internet access and Excel 2000

2a. for DPRP and HSRP, identifies samples, collects data, and self-assesses using program specifications

2b. for PPC, collects data, attaches supporting information to the Survey Tool, and self-assesses

3. submits Survey Tool, materials, and fees to NCQA
   - ♦ materials include: application forms, agreements and Business Associate addendum, plus for PPC, a Practice Information Workbook

NCQA

1. evaluates documentation, scores the application, and makes a recognition determination within 30 days
2. performs an additional audit of at least 5% of applicant submissions
3. reports only those that pass, provides certificate, and offers press release
4. transmits data feed to BTE, health plans, and directory publishers monthly

Q: How does NCQA know if the data submitted by an applicant are real or accurate?

A: The evaluation by NCQA's trained reviewers includes logic checks and a thorough review of all information submitted. As a result, some applicants need to re-draw samples or collect additional data to meet the specifications. This evaluation, along with the additional random audits of applications, checks the validity of applicant data. For the DPRP and HSRP audits, NCQA generally asks for additional information by mail, but these audits may also result in an on-site review. For PPC, all audits are conducted at the practice site. It is important that applicants keep documentation on any sample of patient records or other data collected, in case they are subject to an audit.

Five Bridges to Excellence Licensees to Expand Program in 2006

Bridges to Excellence (BTE) was originally designed in 2002 as a pay-for-performance program (P4P) that was independent of a specific health plan model. While that model continues today, the fact that BTE is a "plug-and-play" design provides health plans the opportunity to adopt BTE, its principles, the measures on which it is based, the reward structure, and the methodology of physician and patient attribution to readily expand BTE into new market areas.

As of today, five health plans, Capital District Physicians' Healthcare Network (CDPHN), CareFirst BlueCross BlueShield, CIGNA HealthCare, Humana, and UnitedHealthcare have licensed BTE in new markets. Licensing gives Bridges to Excellence, a not-for-profit entity, a sustainable platform on which to continue to build towards harmonization with other national P4P programs, such as is underway by CMS.

Paying rewards or bonuses to physicians is not a new concept; however, doing it in a consistent manner, independent of payor, using national standard measures is new. The employers that participate in BTE are committed to sending a consistent and universal message around paying for quality. The BTE health plan licensing arrangement has a number of advantages for all stakeholders:

- Health plans can meet the requests of their customers – employers and physicians – by implementing a nationally recognized program using a well-vetted attribution methodology and standard performance measures. Health plan licensees also gain membership into the BTE Employer-Licensee Leadership Council, use of the trademarked BTE name, and BTE resources to guide their market implementation.
- Employers who want to participate in a pay-for-performance program can participate in BTE with their health plans operating the program for them, thus integrating BTE within their normal business platform. Employers 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, uses standard measures consistent with national trends such as seen with the CMS Medicare Care Management Program (MCMP), and accommodates reciprocity of measures in specific markets to avoid duplication of reporting.

While each stakeholder group can benefit from the health plan licensing arrangement, the detailed implementation of BTE can be adapted to each specific market environment, which is exactly what the current BTE program licensees have done.

Several other health plans are working towards becoming licensees in the near future. For more information regarding BTE health plan licensing, visit the Bridges to Excellence web site at www.bridgestoexcellence.org.

Capital District Physicians' Healthcare Network (CDPHN), a regional physician-directed health plan, is the latest plan to license BTE. CDPHN is located in a currently running pilot market, the NY Capital Region (Albany-Schenectady area). Alongside the current General Contractor, Medstat, CDPHN will operate BTE for large customers like General Electric, Verizon, and Hannaford Bros. starting in 2006. CDPHN has also committed to assisting physicians and practices in the NCQA application process and has added the NCQA recognition designation to its on-line physician directory.

... five health plans have licensed BTE in new markets.

CIGNA HealthCare, through its work with the Leapfrog Group, the HR Policy Association, and NCHICA is bringing BTE to North Carolina, Phoenix, and Houston. In North Carolina, working with IBM, CIGNA HealthCare is facilitating an all-stakeholder effort, initially focusing on e-prescribing and electronic medication management, ultimately working to meet the standard Physician Practice Connections (PPC) measures. In Phoenix, CIGNA HealthCare has delegated the daily direction of BTE to St. Luke's Healthcare Foundation, a local not-for-profit entity of providers, consumers, employers, and health plans. Ongoing discussions with providers and other health plans and employers continue in Houston.

CareFirst BlueCross BlueShield, a not-for-profit health plan, was the second health plan to license BTE, but the first to fund provider incentives itself and pay up to $50 per patient to reward physicians who meet NCQA's Physician Practice Connections (PPC) criteria, in addition to reimbursing the NCQA fees. CareFirst's demonstration project will cover over 60,000 members in Maryland, Virginia, Delaware, and the District of Columbia.

Humana holds a unique position as a pioneer to the BTE program since its original implementation in Cincinnati and Louisville in 2002, initially participating as an employer. Humana has also become a licensee in Cincinnati and Louisville effective 2006. Humana seeks to encourage the visibility of physicians who are recognized for demonstrating quality care, patient safety, and quality improvement.

UnitedHealthcare, a UnitedHealth Group company, was the first health plan to license BTE and continues its efforts to expand the reach of BTE. UnitedHealthcare is currently partnered with the Tri Rivers Coalition and Ingenix to launch BTE in Dayton, OH and is working with several large employers to bring BTE to Atlanta. UnitedHealthcare also will pay physician rewards for the DCL program on their fully insured members if sufficient employer participation is achieved and the markets are successfully launched.

Massachusetts and New York POL Program Update

Effective immediately, new practices wishing to participate in Year 2 of the Physician Office Link (POL) program in the Boston and New York Capital Region (Albany-Schenectady-Troy) markets will need to complete only 3 of the 9 required NCQA Physician Practice Connections (PPC) modules (instead of 6, as previously required) to become eligible for the maximum POL reward amount.

Existing PPC-recognized practices that have already completed 3 of the required 9 modules will be rewarded based on the same per-patient reward schedule as Program Year 1. **New** practices can submit their PPC applications to be eligible for Year 2 rewards as follows:

- Boston practices until November 14, 2005
- New York Capital Region (Albany-Schenectady-Troy) practices until December 14, 2005

Program Year	Offices Obtaining Passing Scores for PPC in:	Max Possible	Reward	Bonus (25%)*
1 & 2	9 of 9 modules (3 per category)	$50	$40	$10
	6 of 9 modules (2 per category)	$50	$40	$10
	3 of 9 modules (1 per category)	$50	$40	$10
3	9 of 9 modules (3 per category)	$50	$40	$10
	6 of 9 modules (2 per category)	$50	$40	$10
	3 of 9 modules (1 per category)	$20	$16	$4

* Note that for physicians with 5+ diabetes or cardiac care patients, the practice's POL bonus amount is available when the practice obtains DPRP or HSRP recognition.

Existing PPC-recognized practices will already have received notification of this change via U.S. mail. If you are interested in participating in BTE's POL program, please visit www.bridgestoexcellence.org. For PPC application instructions and additional information, please visit www.ncqa.org.

Physicians Newly Recognized for Demonstrating Performance Excellence

March 2005 — June 2005

Louisville, KY Area (DCL Rewards)

1. Nison Abayev, MD
2. Anil Sharma, MD
3. Southern Indiana Diabetes & Endocrinology (SIDE)

New York Capital Region (POL Rewards)

1. CapitalCare Medical Group (4 sites)
   - ◊ Internal Medicine Nott St.
   - ◊ Internal Medicine Balltown Rd.
   - ◊ Family Practice Clifton Park
   - ◊ Pediatrics Clifton Park
2. Cardiology Associates of Schenectady, PC
3. Community Care Physicians (6 sites)
   - ◊ Latham Pediatrics
   - ◊ Latham Internal Medicine
   - ◊ Clifton Park Family Medicine
   - ◊ Schodack Medical Office
   - ◊ Delmar
   - ◊ Pediatrics Saratoga
4. Four Seasons Pediatrics, LLC
5. Prime Care Medical Group (12 sites)
   - ◊ Glenn Falls Assoc. in Cardiology
   - ◊ Amsterdam Assoc. in Cardiology
   - ◊ Albany Assoc. in Cardiology
   - ◊ Troy Assoc. in Cardiology
   - ◊ Primary Care Phys.-New Loudon Rd.
   - ◊ Primary Care Phys.-Wolf Rd.
   - ◊ Primary Care Phys.-4 Palisades Dr. Ste. 250
   - ◊ Primary Care Phys.-2 Palisades Dr.
   - ◊ Primary Care Phys.-Western Ave.
   - ◊ Primary Care Phys.-3 Normanskill Blvd.
   - ◊ Primary Care Phys.-Delaware Ave.
   - ◊ Primary Care Phys.-4 Palisades Dr. Ste. 100
6. Troy Pediatrics, LLP

Boston, MA Area (DCL Rewards)

1. David Gorson, MD
2. Everett L. Seyler, MD

Boston, MA Area (POL Rewards)

1. Bulfinch Medical Group
2. Harbor Medical Group (3 sites)
   - ◊ Harbor Medical Group-Macomber
   - ◊ Medical Treatment Center of Saugus
   - ◊ Harbor Medical Group-Skowronski
3. Pediatric Associates Inc. of Brockton
4. Pediatric Healthcare Associates (5 sites)
   - ◊ Peabody
   - ◊ Lynn
   - ◊ Melrose
   - ◊ Salem
   - ◊ Wakefield
6. Pediatric Specialists of Foxborough & Wrentham
7. Quincy Pediatrics Associates
8. Revere Health Center

Bridges to Excellence Promotes Practice Improvements

PHYSICIAN OFFICE LINK

Submitted by: Robert Fortini, PNP
Community Care Physicians, New York

Community Care Physicians is a physician owned and operated multi-specialty group practice in New York's Capital Region. With over 35 individual practices and 185 practitioners, we deliver healthcare to one of four people in our region.

When we were first approached by the Bridges to Excellence collaborative, we had just begun a Performance Improvement project with a local quality focus group including leaders of our major local healthcare organizations. This group, the Healthcare Quality Roundtable, planned to undertake a quality initiative in 2003 focused on care of the person with diabetes. The timing was perfect. The Roundtable invited a Bridges team representative to introduce the concepts of the collaborative and to explain NCQA recognition standards in each of the three major areas, POL, DCL, and CCL.

Community Care Physicians welcomed this as an opportunity to identify and share best practices within our organization. In our market, the recommendation was to start with Physician Office Link and grow from there. We identified three areas as necessary for compliance with NCQA standards in POL:

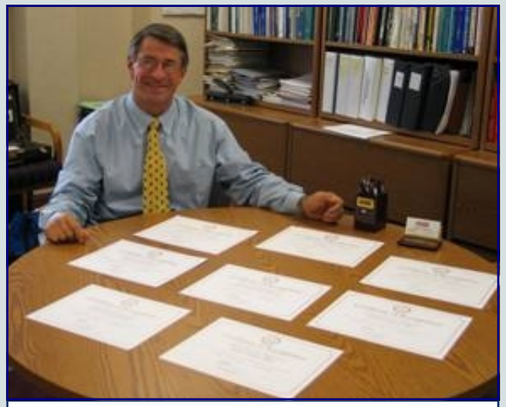
1. Performance Improvement Process
2. Disease/Case Management Process
3. Essential Referral/Test Tracking

The first area was easy. We had already begun a Diabetes Care initiative fostered by participation in the Quality Roundtable. This initially involved five practices, 40 MD's, and a registry of 3,000 patients. The methodology was a cookbook chronic care model: registry development, process measurement, performance analysis, benchmarking, improvement activity, and re-measurement.

Utilizing our new Diabetes Registry, we created an automatic mechanism for referral of high risk diabetic patients into a Case Management program run by a local health plan. Relevant care information now flowed between the insurer and the practitioner, resulting in an average first year A1C reduction of 1.2% for some 150 patients referred to the program.

We also began to use health plan claims data to identify patients in need of care. This project, termed "ProCare", pro-actively reaches out to patients and now also utilizes internal data from our own practice management, lab, and radiology systems.

Across our organization there was consistent use of evidenced-based guidelines in caring for common chronic conditions; however, the methodology employed to track essential tests and referrals varied by practice. We identified a best practice from our two offices that have a fully integrated electronic health medical record (EMR) and layered it with expertise from our IT department. The result was an electronic mechanism based in our practice management system that could be used by our "paper-based" offices for tracking and reconciling ordered tests.



Dr. Thomas Auer, CEO and Medical Director of Community Care Physicians, proudly displays eight NCQA PPC performance recognition certificates

By taking these naturally progressive steps, we were able to meet the criteria established by NCQA for the Physician Practice Connections (PPC) program at eight practices by the year one BTE deadline, and we plan to continue as we roll out our new EMR to all our practices.

Participating in the Bridges to Excellence collaborative and working with NCQA to achieve PPC recognition has allowed us to emphasize the importance of mapping systems and improving efficiency as a way of improving care and patient outcomes.

NCQA has done a great job of setting standards that reflect true quality care and it is a great source of pride to our practitioners to know that we are "measuring up" to that standard.

Diabetes Physician Recognition Program (DPRP) Supports Clinical Medical Care with Improvement of Effort

DIABETES CARE LINK

Submitted by: Jahangir Cyrus, MD
Louisville, Kentucky

The *Advanced Center of Management for Endocrine and Metabolic Disorders* (ACME) is a busy, centrally located office in metro Louisville, Kentucky. Our specialty is adult endocrinology/diabetology and internal medicine. We are proud to have participated in the NCQA Diabetes Physician Recognition Program (DPRP) as part of the Bridges to Excellence project. Over 80% of our total patient population is adult. The racial background is ethnically dispersed with 75% Caucasian, 15% African American, 5% Asian, and 5% other.

Our office's philosophy is that we are in the people business. We have an uncompromising commitment to place patients first. This principle guides formulation and evaluation of all procedures and conduct whether clinical or administrative. This philosophy is coupled with the ADA, AHA, and AACE standards of care.

The Diabetes Physician Recognition Program has helped our practice to become more aware of good clinical care. This awareness has highlighted the importance of patient care in reference to the national performance measures with the proper documentation that supports effectiveness and intervention. Most of all, due to the outcomes of our internal audit, we have been made aware of and encouraged to implement more effective clinical care and more educational programs.

The DPRP program also has been advantageous to our practice in other ways:

- It has been a learning process for everyone involved. Through auditing our data we have found areas where we thought we were implementing ADA recommendations, but we were weak in documentation. Even though we practice by the ADA guidelines, the documentation of annual eye, dental, and foot exams was weak. The correction of this was the development of a comprehensive diabetes/medical history for the chart, as well as updating our daily summary charting record note. We have also developed a "My Diabetes Check List" to encourage the patient to be more responsible for their medical care.
- Recognition has improved our quality of care. We monitor with every visit the "ABCs" of diabetes (A = A1c, B = blood pressure, and C = Cholesterol panel). In addition, we give exercise, nutrition, and updated diabetes education with every visit.

Dr. Jahangir Cyrus (center) shown with Nina Fulkerson, ARNP and Karen Eastridge, NP-C, CDE

- Overall, we realize this program is primarily for physicians. But in reality it takes every member of the practice staff to support the process: the healthcare providers, the educators, the nutritionists, support staff, and last but not least – the patients are all on this team. All of the team members must work together. A wise physician once said that we the healthcare providers are like referees of the ballgame. We are all striving to enforce the rules of this "life threatening game."