

MASSPRO

BTE Physician Practices Testimonials Massachusetts DOQ-IT Practices

Submitted to
Bridges to Excellence

By
Masspro
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EXECUTIVE SUMMARY

Bridges to Excellence (BTE) is a not-for-profit organization that was developed to create significant leaps in the quality of patient care by recognizing and rewarding health care 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 (STEEEP). In order to carry out this mission, BTE authorizes performance assessment organizations to qualify physicians for professional recognition and financial bonuses based on meeting specific criteria in one or more BTE reward programs.

In 2004, BTE partnered with Masspro to provide performance assessment services for eligible Doctor's Office Quality – Information Technology (DOQ-IT) practices in the state of Massachusetts. The DOQ-IT program, funded by the Centers for Medicare and Medicaid Services (CMS), provides advisory services to primary care practices in the implementation of healthcare information technology and use for care management improvement. The goal is to transform practices' operations, management, and IT infrastructure to improve the quality and efficiency of care and implement patient education/support services provided to patients. Twelve practices were qualified for BTE incentive rewards and recognition by Masspro based on these achievements and on the criteria established for the BTE Physician Office Link program. This criteria includes implementing processes in the areas of care management, patient education/support and clinical systems.

BTE is currently involved in performing several large-scale evaluations of their programs to better understand the relationship between care transformation, improved patient care, and decreased health expenditures. As part of this effort, Masspro interviewed representatives from the twelve DOQ-IT practices that were assessed by Masspro and received recognition and financial incentives. The

purpose of this evaluation was to examine the hypothesis that BTE recognition and rewards are the catalysts that inspire physicians to transform the care processes necessary to deliver superior patient care. The information gained by this analysis will be combined with similar data from other BTE markets as part of the comprehensive evaluation of the relationship of incentives as motivation to transform care at the practice level.

Four trends in the relationship between BTE recognition/rewards and transformation of care in the physician office were apparent:

1. Financial rewards are the strongest driver for participation in BTE; professional recognition is less important.
2. The higher the amount of bonus money received, the more that improvement was attributed to BTE participation.
3. Practices actively make process improvements in what they perceive to be a pay-for-performance environment.
4. Transformation of care processes is financially difficult for small practices. The amount of BTE incentives provided was perceived as too small to completely fund most practice improvements.

Given these trends, we can infer that in this subset of practices, BTE financial rewards provide a strong catalyst to transforming care processes when rewards are relatively high. When financial incentives are perceived as low, the decision to make process improvements by the practices appears to be more affected by the pay-for-performance environment, of which BTE is recognized as one small part.

INTRODUCTION

Bridges to Excellence is a not-for-profit organization developed by employers, physicians, health care services, researchers, and other industry experts with a mission to create significant leaps in the quality of care by recognizing and rewarding health care 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. BTE principles are aligned with the 2001 Institute of Medicine (IOM) Report, which recommends that healthcare should be redesigned around these six core principles. In one major recommendation, the IOM said payments for care should be redesigned to encourage providers to make positive changes to their care processes. Ideally, this shift will begin with purchasers and insurers, and filter down through the delivery system to help encourage improvements at all levels. BTE's guiding principles include the hypothesis that BTE recognition and rewards serve as this catalyst for transformation of care, and that this improved care leads to improved patient outcomes and decreasing healthcare costs.

In 2004, Masspro began providing BTE performance assessment services for practices in the state of Massachusetts participating in the Doctors Office Quality – Information Technology (DOQ-IT) program. Participation in DOQ-IT, funded by the Center for Medicare & Medicaid Services, indicates practices' willingness to undergo transformations of care processes using technology. Consulting assistance from Masspro staff help to make this possible and serve to optimize care management improvements. All DOQ-IT practices provide primary care services (internal medicine and/or family practice), and therefore are qualified for BTE's Physician Office Link program.

Through Masspro's physician assessment process, twelve DOQ-IT practices were qualified for BTE recognition for the Physician Office Link program and subsequently received financial incentives. All practices qualified for Year Two of

the three-year Boston cycle and received incentives during that time period. Eleven of these practices continued to receive incentives in Year 3. All practices were qualified for the Basic Level of recognition, indicating that they had implemented specific processes to reduce errors and increase quality. The twelfth practice is no longer part of the DOQ-IT program and did not receive BTE incentives in Year 3.

BTE contracted with Masspro to conduct interviews with participating DOQ-IT practices to evaluate the DOQ-IT assessment process, the relationship between BTE recognition/rewards, and achievement of care transformation.

OBJECTIVES

The objective of the interviews was to further investigate the link between program participation and subsequent practice transformation, as well as the role that BTE incentives play in practice re-engineering.

METHODOLOGY

Each of the twelve practices was contacted and asked to participate in the Physician Testimonials Project. Information from a pre-interview survey was collected by a variety of methods, including direct interview and e-mailed or faxed responses. For an in-person interview portion, four interviews were conducted at the practice and six interviews were conducted via teleconference. One practice filled out the in-person interview questions on paper and was subsequently contacted and interviewed per protocol. Nine of the ten interviews were recorded and sent to BTE.

Data obtained in the pre-interview survey, as well as summaries of the in-person interview, are tabulated in a Microsoft Excel spreadsheet for analysis (Attachment A).

RESULTS

1. Pre-interview survey results

Practice Demographics

There were seven suburban practices, one rural practice and two urban practices. Eighty percent of the practices have less than five physicians. 100% of the practices provided primary care services. The average number of supporting staff per provider is 2.9 (range 2-5.8). The average panel size is 1,178 active patients per provider (range 500-2,273). The average number of patients seen per week by physicians is 94 (range 55-125). 90% of practices estimated that most patients are covered under private insurance. The most prevalent chronic conditions, in decreasing order, are hypertension, diabetes mellitus, coronary artery disease, cardiovascular disease, and peripheral artery disease.

Practice Assessment

Most of the practices are participating in pay-for-performance (P4P) programs through other organizations in addition to their participation in BTE. The most common P4P program is CMS' Medicare Care Management Performance Demonstration (MCMP) (60%), followed by Blue Cross Blue Shield (50%), a local IPA/PHO (20%), Tufts (20%), Harvard Pilgrim (10%), Medicare Preferred (10%) and Partners Healthcare System (10%). In 100% of cases, the practice was participating in every P4P program of which they were aware. For BTE programs, all practices were qualified as part of Physician Office Link (POL) and have participated with an average duration of 32 months (range 27-39). Practices were not aware of having completed PPC modules. Rewards from BTE over the two-year program ranged from \$150 per physician to \$5,000 per physician, with an average of \$1403 per physician.

BTE Care Processes: Pre vs. Post BTE Participation

This table, in which practices were asked to describe the influence BTE participation had on their process improvements, was not filled out completely by

80% of the practices. Therefore, responses gained during the in-person interview were used to supplement this section. Since practices used general statements, rather than specifically addressing each item in the table, data analysis was not done on the table. These results were limited in consistency and completeness. Using the written and in-person interview responses, two practices indicated that BTE was responsible in part for the improvements they made over reward period years. Seven reported that their care improvements were not due to BTE, and one was uncertain as to whether or not changes made were due to involvement in BTE.

2. Interview Results

Decision to Participate

Almost all practices (90%) learned about BTE through Masspro's DOQ-IT program. Reasons cited for participations included financial bonuses (90%), medical professionalism (60%), IPA encouragement (50%) and easy qualification (30%). In all the practices, every physician in the practice participated in BTE, and the decision to participate was made as a group.

Process Evaluation and Changes

While some practices had no recall of the application process (40%), others felt that the application process was either "easy" (40%) or "difficult" (20%). Both of the practices that were dissatisfied with the application process have over 10 physicians. The application process helped 40% of the practices to identify areas of change that were needed in the practice. All of the practices qualified for rewards and recognition the first time that they applied to BTE.

Half of the practices (5) answered the following questions: "Did you have to make process changes", "What changes did you make?", "How did you get people to make them", "Do you feel those changes were helpful?", and "What do your numbers say?". With some prompting from the interviewer, these practices discussed how participation in BTE and the application process impacted

process improvement decisions. Three of these five practices (60%) mentioned that process improvement was implemented as part of an electronic health record (EHR) implementation, making it difficult to “tease out” the direct influence of BTE. The other two practices realized that they needed to make changes to help them conform to performance measures identified by P4P programs. While there was no standard way that practices motivated people to make changes, all felt that the changes that were made were helpful. None of them, however, were able to use data to directly assess that presumption. Only four of the practices answered the question “What do your patients think?” with three feeling that the patients were positive about the changes and the other noticing that patients are “relatively unaffected”. Of the nine practices that answered the question “Are you making new process improvements”, eight of these (88%) responded in the affirmative.

All of the respondents reported that they have internal goals for their patients and their conditions. Most (70%) indicated that they use health information technology in their office to help to address these goals. The practices were equally split among those using health educators and those who are not. Nearly all (90%) of the practices have personal goals for their patients, and each of these practices is using their EHR to help document these goals. Only 40% of the practices have formal quality control meetings about goals for their patient population at the practice level. Another 30% look to their IPA/PHO meetings for this information, and the remaining 30% have no quality control meetings. When asked to report what they are doing differently in 2007 compared to before 2005, 90% have made significant changes in their electronic systems for the purpose of improving patient care.

Bonus Money

Some practices (20%) did not recall how they spent their bonus money, but of those that did remember, 40% of respondents reported that they were dispersing it, 40% reinvesting it, and 20% reported paying bills with their bonus money. One

practice felt that the amount was too low to have any impact, and another solo practice indicated that he did not know he was receiving bonus money. All ten practices felt that bonus money should continue to be provided. 80% of the practices felt strongly that recognition alone was not sufficient to promote information systems in healthcare. Reasons cited included “IT has been a huge investment”, “we need to use IT to drive better care and someone has to pay for that”, “money is better”, and “the practice is closed to new patients anyways”. Two practices felt that practice motivation alone should be the only driver in providing better care, and that high quality should be its own reward.

Feedback

Most practices (70%) reported no problems in working with BTE and were pleased with the process. Of the three practices that reported problems, one felt that the application process was the biggest issue, and the other two reported the difficulty in getting answers to their questions. Two practices felt that there was a need for a single point-of-contact when they enter the BTE program.

ADDITIONAL COMMENTS

The majority of the survey participants are small suburban primary care practices with patient panels heavily represented by private insurances. The most notable exceptions are the two practices with over 10 providers, which indicated that they have additional resources available for quality improvement. The other significant exception is one rural practice, which also has the highest number of Medicare patients (55% of their patient population).

Practices were aware of pay for performance programs administered by Medicare, private insurance companies such as Blue Cross, and their IPA/PHO affiliation. Practices pursued all P4P programs they were eligible for, indicating their interest in receiving all financial awards available to them. All of the practices were qualified as part of the BTE Physician Office Link. Bonus rewards varied widely between practices.

The majority of practices indicated that they could not attribute practice improvements to their participation in BTE. These practices averaged a payment of \$730 per physician over the two years of participation. Over the same time period, the two practices that reported that BTE was important in driving improvements made \$5,000 and \$1,733 per physician, respectively. These two practices include the one receiving the highest per physician payment of the ten practices surveyed and the practice receiving the third highest per physician payment. This data suggests that higher financial incentives resulted in more impact BTE has in motivating practices to improve their processes. This supports the hypothesis that the level of financial bonus must be perceived as high by the practice to achieve a direct impact on practice transformation.

Masspro recruited practices into BTE that were not otherwise aware of the program. The two main factors that drove practices to participate were financial bonuses and medical professionalism, suggesting that these are significant drivers in motivating practices to enter improvement programs. Recognition was

a significantly less important motivator. As evidenced by this evaluation, financial rewards are a powerful influence for participation in performance programs.

The process of becoming involved with the BTE program had an impact on the quality improvement decisions of at least five of the ten practices qualified by Masspro. The exact significance, however, was difficult for practices to recall 2-3 years later. Additional targeted questions will need to be asked to elucidate its impact, if any, on the other five participants. It is important to recognize that primary care practices have influences from many different arenas that affect their decision-making, so it is nearly impossible to assign a rank in terms of importance for one influence over another. Many of the respondents indicated that the trend toward meeting high quality standards for P4P programs was one that they recognized and were actively addressing. Supporting this was the finding that the majority of practices are making new process improvements, no doubt in part due to their desire to be successful in BTE and other P4P programs.

As suggested by their recognition as POL practices, BTE practices qualified by Masspro are using many best practices in care management, patient education/support, and clinical systems. The typical practice has developed internal goals for patients and their conditions and has a mechanism in place for making and documenting personal goals for their patients. As a group, they are using their EHRs and other electronic systems to capture this information. Most of the practices keep abreast of quality control issues in their practice and/or at their IPA/PHO level. Lastly, practices rely heavily on improvements in their technology to meet the goals that they have set for patient care.

The majority of practices were acutely aware of the amount of money that they have received from BTE. A frequently heard inquiry was why the level of reimbursement decreased substantially from Year 2 to Year 3 of the cycle. This can be attributed to a tightening of the POL qualification criteria, which resulted in

the practices automatically moving from higher levels of certification to Basic certification and as such lowering their per patient reimbursement. It was concerning that the level of reimbursement was unknown by one provider, which occurred here because the business functions of the practice operates separately from the clinical function. This could potentially have a negative effect on driving practice transformation if the providers are not using BTE incentives as part of their decision-making. The financial reimbursement received by this provider over the two-year period was \$1200.

It is notable to mention that most of the practices indicated that the amount of money that they had received was helpful, but was not substantial enough to pay for necessary improvements. Comments include “that amount of money won’t make changes”, “the amount we received seems high but it’s only a drop in the bucket”, and “someone ultimately has to pay for better systems”. One practice noted that they had invested \$50,000 in their initial EHR, which they had to abandon and replace with a \$33,000 EHR. The \$5000 that they received from BTE was not significant in helping them achieve their technology goals. While the practices expressed gratitude and support for BTE, they did feel that there was a need for higher incentives to pay for better systems. Overall, however, the practices were pleased with their experience with the BTE organization and Masspro performance assessment organization.

CONCLUSION

There were four trends that were elucidated with respect to the relationship between BTE recognition/rewards and transformation of care in the physician office. The conclusions noted below must be evaluated in terms of the study limitations. The small sample size provides evidence for several trends, though statistical significance would be impossible to achieve. This data is also biased by the fact that the average per physician payment was relatively low (average of \$701 per year).

1. Financial rewards are the strongest driver for participation in BTE.

The data collected uniformly supports the fact that practices are interested in financial incentives. When asked to describe drivers for the application process as well as the importance of financial incentives in BTE, there was strong support for BTE based on delivery of financial bonuses. Professional recognition, while important, was not the primary focus of the practices when evaluating BTE as an incentive program.

2. The higher the amount of bonus money received, the more improvement was attributed to BTE participation.

The available evidence suggests that when practices determine that BTE financial bonuses are significant, they make decisions regarding care delivery improvements partially because of their participation in the BTE program. Practices that perceive that their bonus payments are relatively small did not recognize BTE as directly impacting their process improvement decisions. This suggests a direct correlation between financial incentives and transformation as a result of BTE participation.

3. Practices are actively making process improvements in the context of their pay-for-performance environment.

The majority of the practices, while already maintaining high levels of patient care assisted by the use of information technology, are in a state of continuous process improvement. There is recognition that pay-for-performance programs are influencing practice decision-making on all levels. The exact impact of the BTE program on this decision-making is difficult to elucidate given that many practices tended to include BTE as one part of their discussion around pay-for-performance standards.

4. Transformation of care processes is financially difficult for small practices. BTE incentives provided was perceived as too small to pay for most practice improvements.

In the practices interviewed, most of which are small suburban practices, there was great concern regarding the high cost of implementing new systems of care. The amount of money received by these practices (average of \$701 per physician per year) was welcome, but was not significant in helping most of them to pay for improved processes.

Despite the limitations, this data supports the hypothesis that practices are interested in recognition and reward programs and are considering such programs in making decisions related to care transformation. What is more difficult to determine is the specific impact of BTE participation, as most practices participate in multiple incentive programs and tended to group all pay-for-performance programs in one category when making care-related decisions. Regardless, in this subset of practices, BTE rewards provide a strong catalyst for transforming care processes when financial incentives are relatively high.