QIO Participation Toolkit

With support from the Medical Affairs Section of
The American Health Quality Association

Bridges to Excellence
C/O eHealth Initiative
818 Connecticut Ave., NW, ste. 500
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Rewarding Quality across the Healthcare System

QIO Participation Toolkit

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I. BTE Introduction

• Toolkit Description

The Bridges to Excellence toolkit for Quality Improvement Organizations (QIO) provides a detailed and easy to follow outline of both the BTE program and the roles that QIOs can play in their respective states. This toolkit guides the QIO through the physician/practice performance assessment process, how to effectively convene all the necessary stakeholders, and how to enable practices in the process of practice re-engineering. Communication is a fundamental part of BTE, and this toolkit offers insight based on experience in engaging physicians in BTE and the importance of participating in a performance improvement program.

Prior to implementing the steps outlined in the toolkit, the QIO will need to be approved by and sign an agreement with BTE. For approval, contact Jessica DiLorenzo at 518-355-2893 or Jessica.dilorenzo@bridgestoexcellence.org. For more information about BTE, please visit http://www.bridgestoexcellence.org/.

• BTE's Mission

BTE was developed by its stakeholders with a simple 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 (STEEEP).

• BTE Overview

BTE's mission is accomplished by paying bonuses to physicians that meet standardized, expert-based, performance measures. 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.

In addition, BTE is spreading across markets because we have migrated from "DIY" (do-it-yourself) to "DIP" (do-it-plan) –health plans can execute the implementation and BTE acts as a coordinator, offering one face to the physicians and the consumers. BTE is a model that has a standard operational platform but is adaptable to unique market dynamics. In BTE markets where the QIO seeks to be an active stakeholder, BTE will provide guidance to ensure a smooth market growth, assessment, or implementation.

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

As of April 2006, the operations of BTE are managed and monitored by the eHealth Initiative (eHI) as a result of a shared services agreement that BTE has signed with eHI. eHI provides administrative and management support that further enhances BTE's ability to grow on a variety of levels. The eHealth Initiative is an independent non-profit whose mission is to drive

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improvement in the quality, safety, and efficiency of healthcare through information and information technology. For more information visit www.ehealthinitiative.org.

- ## *Organizational Structure*

Bridges to Excellence is a not-for-profit company with a Board that includes 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.

Employer Purchaser Advisory Board - Advisory body comprised of BTE participating employers that provides broad input into pay for performance, HIT 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.

- ## *Guiding Principles*

BTE is guided by three principles in carrying out its mission:

1. Dedication to transforming care processes to reduce mistakes will require investments, for which purchasers should create incentives
2. Significant reductions in defects (misuse, underuse, overuse) will reduce the waste and inefficiencies in the health care system today
3. Increased accountability and quality improvements will be encouraged by the release of comparative provider performance data, delivered to consumers in a compelling way

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Partners and Operations

Bridges to Excellence participants include large employers, health plans, the National Committee on Quality Assurance (NCQA), HealthGrades, among others. These organizations are united in their shared goal of improving health care quality through measurement, reporting, rewards and education.

eHealth Initiative (eHI)
http://www.ehealthinitiative.org/
eHealth Initiative (eHI) is an independent, non-profit affiliated organization whose mission is to drive improvement in the quality, safety, and efficiency of healthcare through information and information technology. eHI is focused on engaging multiple and diverse stakeholders to define and then implement specific actions that will address the quality, safety and efficiency challenges of healthcare system through the use of interoperable information technology. eHI also serves as BTE's National Program Administrator and overall program operations manager.

HealthGrades
http://www.healthgrades.com
HealthGrades is a healthcare quality ratings and services company. The HealthGrades web portal provides a means for consumers to view physician demographics and recognition status and for physicians to manage their participation in Bridges to Excellence. HealthGrades is also integral to the employee engagement and transparency aspect to BTE.

Leapfrog Group
http://www.leapfroggroup.org/
The Leapfrog Group is made up of more than 170 companies and organizations that buy health care. Leapfrog and its members work together to:

- Reduce preventable medical mistakes and improve the quality and affordability of health care
- Reward doctors and hospitals for improving the quality, safety and affordability of health care
- Encourage public reporting of health care quality and outcomes so that consumers and purchasing organizations can make more informed health care choices
- Help consumers reap the benefits of making smart health care decisions

Michael Pine and Associates
Contact Charles Parrott at 773-643-1700 or e-mail at: mpine@aol.com
Michael Pine and Associates, a consulting firm that specializes in measuring clinical performance, will help participating physicians "risk adjust" their data to account for the relative health of the patients they treat.

National Business Coalition on Health (NBCH)
http://www.nbch.org
202-775-9300
NBCH is a national not-for-profit organization of employer-based health coalitions. NBCH has launched an initiative to help local business coalitions take a leadership role in the implementation by providing set of materials and technical assistance to coalitions moving BTE forward in their markets.

National Committee for Quality Assurance (NCQA)
http://www.ncqa.org
NCQA Customer Support: 1-888-275-7585
NCQA selects which physicians qualify for rewards based on evaluating and verifying their data. NCQA is the leading independent organization providing information that allows purchasers and consumers of health care to distinguish among health plans and physicians based on quality of care.

Towers Perrin
http://www.towersperrin.com
Towers Perrin is a global professional services firm that helps organizations around the world optimize performance through effective people, risk and financial management. The firm provides innovative solutions to client issues in the areas of human resource strategy, design and management; actuarial and management consulting to the financial services industry; and reinsurance intermediary services. Towers Perrin has completed valuable actuarial analysis for BTE.

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- *Programs Overview*

There are three BTE reward programs that are targeted at both MDs and DOs practicing in the areas of primary care, endocrinology, cardiologists, and neurology. These physicians and their office practices are eligible to receive the rewards offered under the BTE programs if they:

- Provide care for eligible patients identified by Bridges to Excellence based on data supplied by the participating health plans for the participating purchasers
- Demonstrate high levels of performance in BTE program content areas by obtaining passing scores either on NCQA's physician performance measures, the DOQ-IT assessment tool for the BTE programs (which we call Office Systems Survey (OSS)/ BTE Version) or other approved Performance Assessment Organizations.

1. Physician Office Link (POL)

Enables practices to qualify for bonuses based on their implementation of specific processes to reduce errors and increase quality. A report card for each practice describes its performance on the program measures and is made available to the public.

BTE has worked in collaboration with the New York state QIO, IPRO, and the Massachusetts QIO, Masspro, to develop the OSS+ assessment tool for BTE POL rewards. This tool is in line with NCQA's Physician Practice Connection Version 2 (PPCv2), and leverages practice participation in the DOQ-IT program.

Physician Office Link Performance Assessment

Practices affiliated with the DOQ-IT program can be eligible for rewards under BTE's Physician Office Link program by completing the following:

- **Office Systems Survey (OSS)/BTE Version:** The OSS, delivered nation-wide to all DOQ-IT practices, is designed to measure practices' adoption of health information technology and implementation of care management improvements. The BTE Version, developed in collaboration with IPRO and Masspro, is designed to add measures in the areas of interest to BTE, including patient self-management, access and communication, and interoperability.

- **Onsite Practice Assessment (OPA):** QIOs often use onsite consultation to provide valuable assistance on the implementation of electronic health records. During these consultations, practices that are applying for BTE rewards will be required to submit evidence of their improved processes through the use of the Onsite Practice Assessment tool. Please refer to Attachments I, II and III.

These tools are attached and will provide comprehensive and defensible evidence that practices have met the requirements of the Physician Office Link program. The OSS tools provide in-depth self-reported data from the practices, while the OPA verifies this information through a visit from a DOQ-IT consultant.

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2. Diabetes Care Link (DCL)

Enables physicians to achieve Basic, Intermediate, Advanced recognition for high performance in diabetes care. The program offers a suite of products and tools to help diabetic patients get engaged in their care, achieve better outcomes, and identify local physicians that meet high performance measures.

Diabetes Physician Recognition Program (DPRP) Performance Assessment

http://www.ncqa.org/dprp/

The American Diabetes Association (ADA) and NCQA have developed the Diabetes Physician Recognition Program (DPRP) to assess physician performance in the care of patients with diabetes, and to recognize physicians who demonstrate a high level of performance. To achieve DPRP Recognition and obtain 3-year recognition, physicians must submit data on outcome and process measures for a sample of their patients with diabetes.

Required Standards (Adult Patients*)	Criteria	Points
CM1A: HbA1c control >9.0% (poor control)	≤20% of patients in sample	10.0
CM1B: HbA1c control <7.0%	40% of patients in sample	5.0
CM2A: Blood pressure control <140/90 mm Hg	65% of patients in sample	10.0
CM2B: Blood pressure control <130/80 mm Hg	35% of patients in sample	5.0
CM3A: Eye exam	60% of patients in sample	10.0
CM4A: Smoking status and cessation advice or treatment	80% of patients in sample	5.0
CM5A: Complete lipid profile	85% of patients in sample	5.0
CM5B: Cholesterol control <130 mg/dl	63% of patients in sample	7.5
CM5C: Cholesterol control <100 mg/dl	36% of patients in sample	2.5
CM6A: Nephropathy assessment	80% of patients in sample	10.0
CM7A: Foot exam	80% of patients in sample	10.0
Total Points		80.0
Points Needed to Achieve Recognition		60.0
Optional Patient Survey Standards	**Criteria**	**Points**
PS1A: Self-management education	90% of patients in sample	10.0
PS2A: Medical nutrition therapy	90% of patients in sample	10.0
Self-monitoring of blood glucose: PS3A: non-insulin treated patients	50% of patients in sample	1.0
PS3B: insulin treated patients	97% of patients in sample	4.0

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Patient satisfaction with: PS4A: diabetes care overall PS4B: diabetes questions answered PS4C: access during emergencies PS4D: explanation of lab results PS4E: courtesy/personal manner of provider	58% of patients in sample 56% of patients in sample 46% of patients in sample 50% of patients in sample 77% of patients in sample	1.0 1.0 1.0 1.0 1.0
Total Points (including Required Standards)		110.0
Points Needed to Achieve Recognition		80.0

*Note: Separate standards also exist for pediatric patients

3. Cardiac Care Link (CCL)

Enables physicians to achieve Basic, Intermediate or Advanced recognition for high performance in cardiac care. The program offers a suite of products and tools to help cardiac patients get engaged in their care, achieve better outcomes, and identify local physicians who meet high performance measures.

Heart/Stroke Recognition Program (HSRP) Performance Assessment

http://www.ncqa.org/hsrp/

The American Heart Association/American Stroke Association (AHA/ASA) and NCQA, have developed the Heart/Stroke Recognition Program (HSRP) to assess physician performance in the care of patients with cardiovascular disease or who have had a stroke, and to recognize physicians who demonstrate a high level of performance. To achieve HSRP Recognition and obtain 3-year recognition, physicians must submit data on outcome and process measures for a sample of their cardiovascular/stroke patients.

Measures	Criteria	Points
Blood pressure control (<140/90 mm Hg)	75% of patients in sample	10
	BP Result Credit Toward Numerator:	
	< 140/90 mm Hg	1
	< 145/90 or <140/95 mm Hg	0.75
	< 145/95 mm Hg	0.5
	<21%145/95 mm Hg	0
Complete lipid profile	80% of patients in sample	10
Cholesterol control (<100 mg/dL)	50% of patients in sample	10
Use of aspirin or another antithrombotic	80% of patients in sample	10
Smoking status and cessation advice or treatment	80% of patients in sample	10
Total Points		50
Points Needed to Achieve Recognition		40

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Suggested Reward Amounts for POL, DCL and CCL:

The suggested rewards associated with each of the BTE Programs are shown in the tables below:

Level of Recognition	Basic	Intermediate	Advanced
Physician Office Link	$15	$30	$50

<table>
<tr><th>The number of reward programs in the market:</th><th colspan="2">Single reward program</th><th colspan="2">Multiple reward programs</th></tr>
<tr><td>Diabetes Care Link</td><td colspan="2">$100</td><td colspan="2">$80</td></tr>
<tr><td>Cardiac Care Link
(Rewards are based on performance tiers)</td><td>$100</td><td>$200
(high performer)</td><td>$80</td><td>$160
(high performer)</td></tr>
</table>

Implementation of More Than One Program

Each of the three BTE programs has its own performance assessment and rewards criteria. We encourage markets to implement more than one program because it will increase the quality of care received as a result of reduced medical errors and improved care management.

Health Plan 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.

The implementation of Diabetes Care Link and Cardiac Care Link will allow the QIO to gather extremely useful disease management data that will help to improve the overall care that is delivered to the market.

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

A physician may be eligible to receive bonuses from more then one program should they meet performance measures associated with the program.

II. Benefits of Participation

• Why a BTE-QIO Relationship Works

The BTE-QIO partnership is a relationship that is beneficial to all parties involved. It allows both organizations to collaboratively achieve their goals of assisting practices in improving care through a recognition process that ultimately rewards physicians who provide high quality patient care. It also enables physicians to receive the help they need in improving their care.

BTE's programs and QIO experiences have demonstrated that once physicians/practices have been engaged in improvement initiatives within their organization, they require assistance from external resources in their quality improvement efforts. QIOs are critical to physicians and practices because they make available the tools necessary for quality improvements that allow qualification for BTE rewards. By working on a collaborative level practices can gain a deep understanding of how to most effectively engage in re-engineering. In addition, because the QIOs are focused on healthcare delivered at the local level, they understand market dynamics and the culture of medicine in their communities, which allows them to operate more efficiently and effectively as catalysts of change.

Furthermore, harmonization of measures within markets is a core BTE principle. This helps reduce duplicative reporting burden on physicians and practices, by rewarding practices that invest in IT solutions and practice change as a means to better patient care.

The QIO can aim to serve a variety of roles in the state:

1) Playing a "traditional" QIO role by assisting practices in the adoption and effective use of health IT, or in practices' quality improvement efforts, specifically in the areas of cardiac and diabetes care;
2) Serving as an independent regional Performance Assessment Organization (PAO) that assesses practices in their quality improvement efforts in order to qualify for rewards through the BTE Physician Office Link (POL) program;
3) Providing guidance and information on how to participate in BTE programs, thereby further encouraging practice re-engineering in the overall market.
4) Serving as a market convener by gathering all necessary parties required to offer pay for performance programs in the particular market.

• What BTE Means to Each Stakeholder

Consumers

Improving quality and safety for consumers is the driving force behind BTE. By encouraging and supporting physician practice transformation, patients receive better, safer care. Consumers can also take a more proactive approach in the care that they receive by researching the quality of a specific physician or practice and choosing to visit high quality physicians in an area. Consumers also have the ability, through the BTE/HealthGrades web site, to express satisfaction or dissatisfaction about a physician experience and learn what other patients have said about their experiences.

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Physicians and Practices

Rewarding physicians for implementing systems of care and providing guideline-based care results in:

- Improvements in care delivery and outcomes (better documentation, patient surveillance, auto follow-up reminders);
- Reduced financial burden to a practice due to lower cost of implementing new processes, and enhanced patient-physician relationship (as more at-risk patients are provided care in a timely manner);
- Voluntary participation in a P4P program that has been vetted by other physicians, uses standard measures consistent with national trends such as DOQ-IT and accommodates reciprocity of measures in specific markets to avoid duplication of reporting.

Employers

Quality care can equate to cost savings for employers. 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. BTE allows employees and their dependents to choose physicians providing higher quality care, which helps lower costs and improve patient safety. Employers also gain transparency in provider performance, based on standard measures to share with their employees. While employers seek to lower their healthcare costs, selecting the least expensive plans based on premiums is not the way to guarantee that employees are receiving quality care. BTE allows employers the ability to encourage their employees to go to quality physicians based on the physicians recognition data. In addition, employers receive positive visibility and publicity, both locally and nationally, for their participation in efforts to improve healthcare quality. Most importantly, employers are helping improve the care that their employees are receiving.

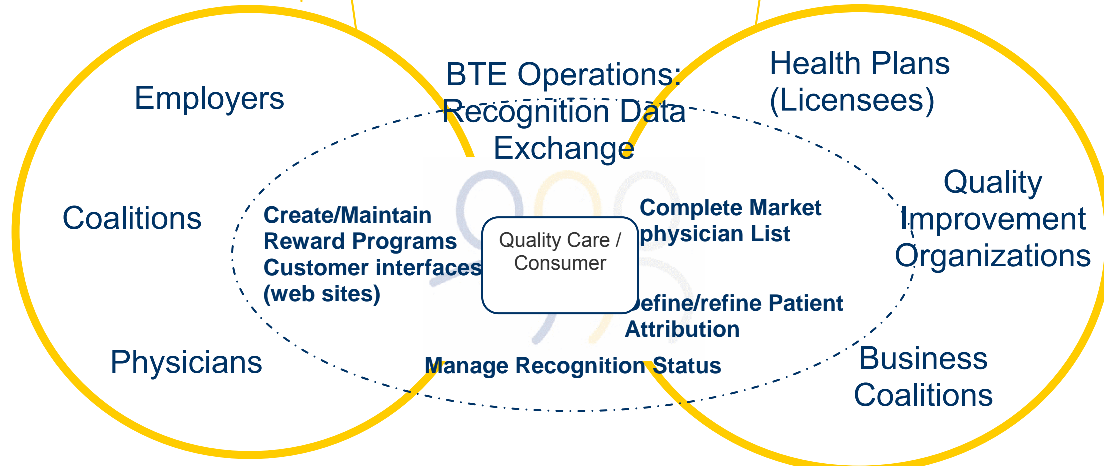
Health Plans

Health plans can meet the requests of their customers– employers and physicians – to ensure that their participating physicians are delivering quality care via the implementation of a nationally recognized program using a well-vetted attribution methodology and standard performance measures. Health plans gain increased confidence that basic treatment processes are in place based on the physician's ability to meet quality measures and the fact that they have engaged in practice transformation to improve the care they deliver to their patients. Health plan licensees also are granted use of the trademarked BTE name and BTE resources to guide their market implementation.

BTE Success Requires Stakeholder Collaboration

Markets Composition:
Determine the market model and engage stakeholders to implement BTE.

BTE Administrators/ Conveners/Enablers:
Ensure proper execution of the BTE program



BTE has participation from physicians, health plans, employers, coalitions and Quality Improvement Organizations. The common thread at the center of each stakeholder's mission is the continued improvement in the quality of healthcare.

- ## *BTE Success*

Thanks to the BTE pilot efforts, BTE has demonstrated success at many levels.

Cost savings: BTE performed actuarial analysis for the National Committee of Quality Assurance's (NCQA) Diabetes Provider Recognition Program (DPRP) that showed proven savings between 10-15% per patient per year. The findings were consistent across three separate analyses.

Towers Perrin performed an analysis on NCQA's Heart Stroke Recognition Program (HSRP) 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) indicate that improvements in primary care physicians' data systems could result in overall savings of up to $110 per patient per year. The evidence behind the POL analysis comes from a compilation of studies referenced on the BTE web site. These savings are attributed to the quality and efficiency of the recognized practices, and are based on reliable information obtained from BTE Operations on the cost of patient incidents.

The studies BTE has conducted to-date on POL have looked at the differential cost of care (on a standard episode basis) between recognized and non-recognized physicians.

The results have been similar to what BTE has found in DPRP:

1. Base PCP costs go up very marginally
2. Specialists costs go down
3. Average patient severity decreases
4. Cost of care varies less

When looking at episodes across different conditions, POL- recognized practices have an average increased efficiency of 5% based on the total per patient per year costs of $2,500. This amounts to a savings of $125 per patient per year. BTE is in the process of refining this analysis with three full years of data and looking at specialists in addition to PCPs.

Additionally, studies from RAND Corp show that physicians deliver appropriate care for patients with diabetes about 55% of the time. Recognized physicians deliver the right care 75% of the time:

	DPRP Physicians	Accredited Plans	Non-Accredited Plans
Comprehensive Diabetes Care - Eye Exams	58%	51%	44%
Comprehensive Diabetes Care - HbA1c Testing	98%	86%	82%
Comprehensive Diabetes Care - LDL-C Screening	90%	90%	86%
Comprehensive Diabetes Care - Nephropathy	86%	50%	45%
Comprehensive Diabetes Care - Good HbA1c Control*	75%	70%	64%
Comprehensive Diabetes Care - LDL Control (< 100)	45%	36%	32%
Comprehensive Diabetes Care - LDL Control (< 130)	75%	63%	56%
Average across all measures	***75%***	***64%***	***58%***

RAND also studied the impact of health IT adoption (featured in a series of recently published articles in Health Affairs) which demonstrates the savings potential generated by the adoption of Health Information Technology. The savings are maximized through effective use of HIT systems. A copy of the RAND report can be downloaded at http://www.rand.org/publications/MG/MG409/

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BTE Lessons Learned

BTE's most important lessons learned during its initial pilots (which lasted three years) can be generalized across the entire P4P market. The outlined lessons below have been presented to members of the Institute of Medicine's committee on payment and benefit reform, as well as to members of Congress through hearings, and have been published in a number of journals and articles:

1. Incentives matter and the size of the incentive is directly related to a physician's decision to participate in care process improvement. In general, incentives have to be greater than or equal to the cost of change, or, at the very least, significantly contribute to the cost of change. For example, a multi-specialty group practice in Albany, NY, was able to defray about a quarter of the $1MM investment in a new clinical information system thanks to the financial incentives received through BTE. The practices, whose care processes were reengineered, achieved significant improvements in the management of patients with chronic conditions.

2. The costs and benefits of participating in an incentive program have to be known up front. Practices or individual physicians that are asked to invest in that practice both time and money to improve their performance must have a good estimate of the benefits they will derive from that effort. For example, physicians in Delaware decided not to participate in a BTE implementation because they estimated that the benefits of meeting the threshold performance required exceeded the investment they would have to make to achieve it.

3. Self-assessment of performance and its validation by an independent third party is a very powerful agent of change. Physicians and physician practices that are asked to participate in a BTE implementation within a market have to perform a self-audit of their current performance. This effort, while time consuming, creates the roadmap for change. For example, a physician in a solo practice in Louisville, KY, discovered through his self-assessment that his compliance with good standards of care for his patients with diabetes was 45%, far below the 80% threshold required for incentives. This discovery motivated him even more than the financial rewards to reengineer his practice of care for those patients and the improvements achieved in under a year were significant both in terms of quality of care for the patients and the cost of care.

4. High quality care can be cost effective care. BTE's analyses of claims data comparing patients that are seen by BTE-recognized physicians and those that go to non-recognized physicians shows conclusively that their average severity-adjusted cost of care is lower by about 10%. For example, patients with diabetes have average yearly costs of about $1,700. Patients going to recognized physicians have costs of about $1,500. The difference comes from lower rates of avoidable hospitalizations or visits to the emergency rooms, which more than offset the increased physician office visits that are the result of the physician delivering more consistent care to patients.

6. Small practices need assistance in the reengineering process. When BTE launched its pilots, there were multiple barriers to success that were anticipated, but we did not anticipate the lack of knowledge and resources for small practice reengineering. This surprised many purchasers. What became clear was that even when financial rewards were sufficient, measures were well accepted, and the practice understood the need to modify care processes to improve the overall quality of care delivered, additional hands-on help with reengineering was needed. There are three types of resources that

emerged from the pilots and are now being used in all BTE implementation areas across the US:

- Quality Improvement Organizations – QIOs help primary care physicians and physician practices as part of their core mission.
- Medical Specialty Societies – the American College of Physicians (www.acponline.org) and the American Academy of Family Physicians (www.aafp.org) have created centers for the transformation of primary care and the creation of the "medical home". Both organizations have state chapters that can help its members to leverage their tools and improve their processes of care.
- State and County Medical Societies – these organizations represent physicians in the state or county and can act as conduits for knowledge sharing or other help. For example, the Jefferson County (KY) Medical Society helped physicians in Louisville to get grants to offset the cost of medical chart abstraction so that they could measure their performance on diabetes care and participate in BTE's rewards.

7. Use standard performance measures of clinical quality, focusing mostly on intermediate outcomes derived from medical chart reviews, not just claims. When selecting performance measures for a program, employers and plans should always default to measures adopted by the National Quality Forum (in the case of QIO implementation OSS+ is another means to achieving POL rewards) to ensure consistency with other programs such as the Ambulatory Care Quality Alliance. However, not all measures are created equal, and findings from experiments in pay-for-performance in England are consistent with BTE's -- that intermediate outcomes should be weighted more heavily than process measures. A study commissioned by BTE and performed by Towers Perrin found that the actuarial value of intermediate outcomes (e.g. blood pressure) in patients with diabetes, coronary artery disease, or cardio-vascular disease were significantly higher than the actuarial value of process measures (e.g. the completion of a lipid profile), as shown on the next page.

Clinical Measure		Annual savings per diabetic patient	Max
HbA1c Control	Poor Control	$177	$279
	Good Control	$96	
Blood pressure control	< 140/90 mm Hg	$166	$494
	< 130/80 mm Hg	$230	
LDL control	< 130 mg/dl	$149	$369
	< 100 mg/dl	$251	
Nephropathy Assessment		$77	
Eye Examination		$1	
Notation of smoking status and cessation advice or treatment		$1	
Completion of Lipid Profile		$0	
Foot Examination		$0	

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BTE will continue to build upon and develop these lessons in a quest for constant improvement in the delivery of care. Collaboration with QIOs will ensure that local markets are receiving assistance and good direction, which is a crucial part of BTE's success.

• *BTE Pilot Markets*

BTE was originally implemented in 4 pilot markets -- Louisville, KY, Cincinnati, OH, Boston, MA and the NY Capital Region beginning in June 2003, with 13 initial participating employers and their health plans representing a combined total of over 200,000 covered lives. The goal was to test the BTE concept and determine if BTE programs encouraged improvement in physician and practice processes. Over the next two-and-a-half years, regional steering committees led extensive physician outreach, recruitment, education and training efforts, resulting in exponential program awareness and growth. It also resulted in CareFirst BlueCross BlueShield of Maryland to independently implement BTE in the Washington, D.C., Virginia and Maryland areas.

At the end of 2005, BTE had:

-Over $4.7M in BTE rewards paid
-Over 1,600 recognized physicians and practices
-Over 71,000 patients receiving care from recognized physicians and practice
-7 states offering BTE programs
-Savings of 10%-15% per diabetic patient
-Close to 100 participating employers

Taken together, the results of the pilot indicate that employer-sponsored incentives drives change in process improvement for high quality care delivered by physicians and practices. For participating employers, preliminary savings estimates mean potential decreases in their overall healthcare spending as more and more of their employees receive their healthcare from recognized physicians. Furthermore, all BTE pilot participants have gained recognition locally and nationally, including presentations to Congress, for their efforts in improving healthcare quality.

The Future of BTE

With the Federal Government recognizing the importance of pay for performance programs, the relationship between QIOs and BTE is fundamental in the drive towards the future success of nationwide recognition of physicians and practices and implementation of BTE programs. As health information technology becomes more prevalent, and with the ever increasing focus on the quality of care physicians are delivering, the future of QIOs and BTE is bright and ever developing. The foundation that BTE provides gives physicians/practices an incentive to measure quality with or without the implementation of information technology, rewards those that do have IT systems in place, and builds a solid ground for future quality improvement. QIOs help give providers the ability to both measure and improve quality. As such, there are obvious roles for the QIO in engaging and assisting providers, as well as helping to ensure that all stakeholders are involved.

BTE is striving to become a benchmark example for many market-driven programs that the Federal Government would like to evaluate. For example, to-date, while the Medicare Modernization Act's Section 649 demonstration is still under development, BTE has demonstrated that practices that adopt health IT can deliver better quality and less expensive care. Government agencies are currently working through how medical record data can be used to augment claims data in measuring physician performance. With this in mind, BTE looks to continue working with Quality Improvement Organizations and Health Information Exchanges in select communities to test various ways of implementing an incentive program that will answer many of the operational questions linked to the merging of medical record and claims data streams.

BTE's vision is to continue to introduce new programs, work with many different organizations to implement them and evaluate their effects on the market. As a fast growing private sector organization that is able to learn quickly, BTE can inform policymakers, as well as private and public sector purchasers, of market trends and best practices. A strong partnership with QIOs, can further ensure that BTE will achieve this goal.

To better meet the needs of stakeholders, BTE is currently working with the American Board of Internal Medicine (ABIM) in a joint effort to develop the measures for the Internal Medicine Care Link program. In addition, BTE is also working with the National Committee for Quality Assurance (NCQA) to develop the Spine Care Recognition Program and a Cancer Care Recognition Program.

Internal Medicine Care Link Program
Comprehensive Care Performance Improvement Module- Proposed

In February 2006, the American Board of Internal Medicine (ABIM) and BTE agreed to collaborate on an effort to recognize internists that deliver good quality care to patients. The assessment of an Internist's quality of care would be performed by the ABIM through its Comprehensive Care Performance Improvement Module (CCPIM).

The Comprehensive Care Performance Improvement Module measures clinical process and outcomes, structural processes and systems of care, and patient experience with the care received. While all the measures have not been finalized, the goal is to adequately assess the breadth of care treated by internists in their practice.

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The CCPIM relies on data stored in medical records in the physician's practice, which the physician must extract from those records and report to the ABIM. As such, the CCPIM will enable the physician to record measures that are significant in terms of their impact on the care of a patient and typically not available other than by looking through medical records (e.g. blood pressure for patients with hypertension).

The ABIM is currently conducting a beta test of the CCPIM in collaboration with BTE. The test is scheduled to be completed by the end of the summer of 2006. The ABIM will use the results of the beta test to refine the CCPIM before its formal release which is scheduled for late fall of 2006.

Employers and plans will therefore be able to roll out the Internal Medicine Care Link in early 2007.

Spine Care Recognition Program

The Spine Care Recognition Program will identify physicians who promote high-value, patient-centered care for patients with back pain. The proposed measures are based on the natural history of back pain and grouped according to the duration of the episode of back pain.

- Acute Phase (back pain duration < = 6 weeks) - Most episodes self-resolve within this period
- Sub-acute & Chronic Phase (back pain duration > 6 weeks)

The potential measures will include: Initial evaluation; Medical assistance with smoking cessation; Patient assessment for functional status, mental health status, pain; Advice for normal activities; Appropriate imaging for acute low back pain; Appropriateness of repeat imaging; Physical activity/exercise; Patient education/decision quality; Surgical alternatives; Appropriate use of epidural steroid injections; Post-surgical outcomes; Treatment re-evaluation/patient experience.

NCQA has posted the proposed measures for public comments and is currently in the process of conducting a pilot study with twenty-six participating pilot sites. A roll-out of the program is anticipated in early 2008.

The Cancer Care/Medical Oncology Recognition Program - Proposed

The Medical Oncology Recognition Program is being developed in collaboration with the American Society of Clinical Oncology (ASCO) and will be based on ASCO's Quality Oncology Practice Initiative (QOPI) measures. The goal is to expand the use of quality measures and indicators into a program that publicly recognizes quality of care in medical oncology practices. The proposed Recognition Program will be built upon the methodology, measures and data collection system of ASCO's Quality Oncology Practice Initiative (QOPI). A roll-out of the program is anticipated in early 2007.

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- *BTE's Alignment- 8th Scope of Work*

Under the 8th Scope of Work, QIOs will continue to promote system changes and encourage the adoption and effective use of information technology, leading to overall process redesign within the practice. In addition, QIOs will continue to work to improve care for disadvantaged populations by focusing on physician office-based care to make sure all Medicare beneficiaries get the right preventive services and appropriate care for chronic diseases, such as diabetes.

All three BTE programs help QIOs achieve the goals established within the 8th Scope of Work.

1. Physician Office Link (POL) - POL enables practices to qualify for bonuses based on their implementation of specific processes to reduce errors and increase quality. A report card for each practice describes its performance on the program measures and is made available to the public. While QIOs are already engaged in practice transformation as a result of engaging practices in the DOQ-IT program, POL is an additional incentive/reward for practices in DOQ-IT because they will:
    - Receive monetary rewards
    - See obvious change in their day to day processes that will result in more efficient care as well as higher quality treatment.
    - Develop the tools necessary to implement care management processes and equip their patients to take a more proactive role in the treatment of chronic conditions.

2. Cardiac Care Link (CCL) and Diabetes Care Link (DCL) - By achieving NCQA HSRP and/or DPRP recognition, physicians self –assess the treatment they deliver to patients that have diabetes, cardiovascular disease or have suffered a stroke. The measures are focused on blood pressure control, Lipid profiles, cholesterol control, administering aspirin or another antithrombotic and proper distribution of smoking information. The measures in both modules mesh with many of the DOQ measures.

    Meeting these measures further enables physicians to self-assess their current treatment processes. This encourages the physician to re-engineer current processes around preventive cardiac and diabetes care treatments. QIOs can provide assistance in helping physicians further understand how to engage in practice transformation to benefit both themselves and their patients. This parallels the QIO's mission to implement care management and patient self-management processes, while promoting the participation in pay for performance programs.

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III. Bringing BTE To Your Market

- *Roles and Responsibilities*

The Role of each BTE Stakeholder

There are five stakeholders that play a critical role in the implementation of a market:

1. BTE Operations
2. BTE Administrators
3. Employers
4. Regional Steering Committee
5. BTE Coordinator
6. Performance Assessor- QIO

BTE Operations

BTE's role in the market is to provide guidance and assistance in implementing the program on the following levels:

1. Data Integration
   - BTE will work with the QIO to ensure that they understand the Master Physician List in order to do a comparative review
   - Consults regarding patient attribution issues
   - BTE will create and provide overall market reports

2. Provider Engagement
   - BTE will ensure that all parties understand BTE best practices and adhere to them to ensure a smooth market implementation for all involved
   - The QIO will receive Physician Online Service training and all necessary documentation required to work with the portal
   - BTE will provide assistance on issues related to provider engagement that are beyond the realm of the QIO knowledge base or network.

3. Regional Engagement
   - It is the responsibility of BTE to negotiate with Health Plans in a market on the licensing agreement.
   - BTE will train designated regional coordinators, where appropriate, to be the market liaison between BTE and all parties involved
   - BTE will maintain updated website/documentation information on the status of the market

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4. Communications

- BTE will work with the QIO to be sure that the outreach strategy for recruitment is in line with the overall national communication strategy
- BTE will provide regional assistance as needed
- Distribute MPL mailing files as needed

Bridges to Excellence operations provides both a foundation for plug and play administration, as well as flexibility for BTE markets to add unique elements into the design (reward amounts, measures, performance assessment organizations etc). BTE's main objective is to make the administration of the program efficient, simple and to see that rewards are paid accurately and timely.

The QIO will need to work with BTE operations to provide performance assessment information and information into its Recognition Data Exchange that allows for standardized and regular data exchanges which are crucial for a successful BTE implementation. BTE will work with the market administrator to ensure that all necessary data being exchanged.

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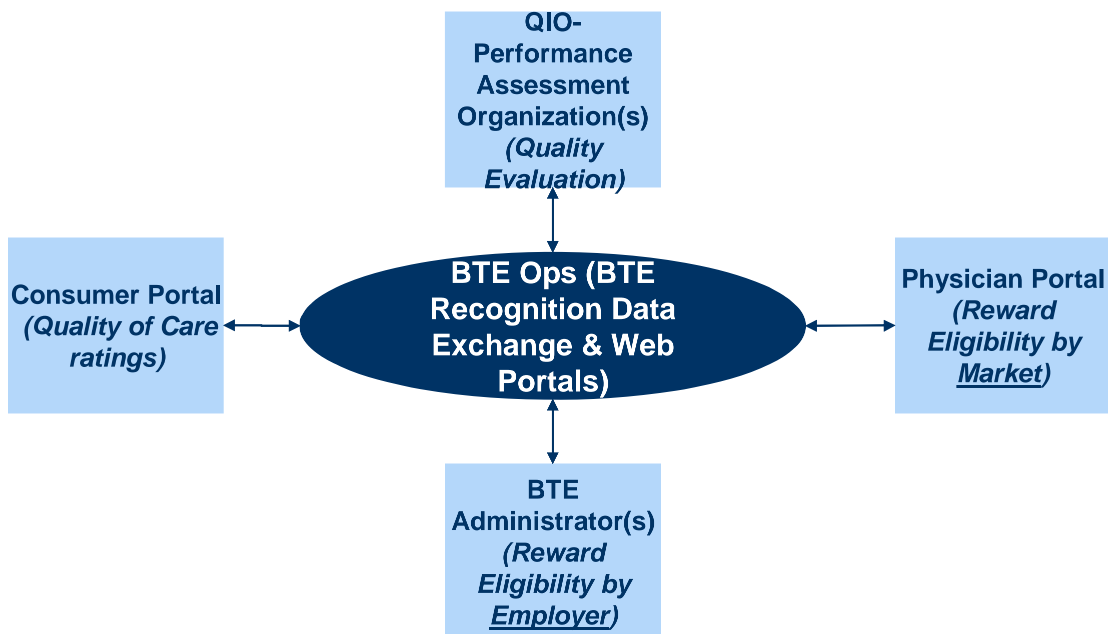
Overall, BTE Operations:

- Provides one platform to introduce multiple program operations in a market
- Provides an appropriate level of coordination among administrators, partners, and stakeholders
- Allows for the potential use of multiple Performance Assessment Organizations in a single market
- Connects as a single link to the Physician Online Service in order to share the Practice composition information necessary for rewards
- Provides a systematic platform to display provider quality ratings to plan members/employees

BTE Recognition Data Exchange facilitates coordinated automated market wide BTE Operations for all stakeholders



BTE Administrators

BTE Administrators are typically health plans which operate the program on behalf of their customers. Their responsibilities are:

- Create employer data files (physician-patient attribution)
- Generate patient counts for physicians (MPL)
- Send out targeted physician communication
- Recruit physicians for participation
- Collect employer reward payments
- Distribute bonus checks to physicians
- Provide employer-specific reports on request

Once a health plan becomes a BTE licensee, the following obligations need to be fulfilled:

- Rewards paid by the licensee 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
- Licensee should use independent national accrediting organization or Quality Improvement Organization (if participating in the POL program) to assess and recognize provider performance community-wide
- Licensee should continue pushing for tougher standards on provider performance and demand complete accountability for use of resources and delivery of outcomes
- Within the limits of applicable law, the licensee should participate in cross-learnings with other BTE participants and Licensees on the results of the program

Employers

Once an employer has decided to participate, the level of activity volunteered to the success of the effort is mostly the decision of the employer. However, the success of the program is directly linked to the collaborative nature of the program and the employer's willingness to engage, not only themselves but the market as well. Employers should participate in Regional Steering Committee meetings and discussions. The Regional Steering Committee is the directing body that influences much of the activity and decisions with regards to BTE in the region.

The basic role of the employer is to ensure that their Administrator is following the right process steps and fulfilling their role as an administrator:
- The Administrator is generating the Master Physician list with the employer's patient counts.
- The Administrators invoice employers and pay physician rewards.

Employers need to pay Administrators for the physician rewards and potential administrative costs associated with the program. In addition, they should help educate their employees about the BTE program in a way that encourages more informed provider selection.

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Regional Steering Committee/ Market Coordinator

Overall, the regional team is responsible for regional coordination and market engagement. Previous experience has shown that organized regional teams with informal leaders and a coordinator have worked effectively to operate BTE locally; however, regions can establish an operational team structure that best meets their market and customer needs. The team includes all participants, stakeholders and allied organizations.

A market coordinator assists with the following types of tasks:

- Coordinating the meetings and agendas
- Following up with employers and administrators on progress the contracts and file development.
- Facilitating questions between the market and BTE operations.

The Role of the QIO

Outlined below are three roles that the QIO can play in a BTE market. Convening is a role for QIOs in new BTE markets, while Enabling and Assessing are roles that can be played in both new and existing markets. Please refer to Appendix D where you will find a case study for each role.

Three Roles the QIO can play

1. Convener
2. Enabler
3. Assessor

1. Convener

As a market convener, the QIO will work with the market as a whole and bring together all necessary parties. BTE recommends first obtaining the support of major health plans, as they are the program administrator, and then bringing in interested employers and providers. The QIO that is already working with practices in the area should discuss BTE with those practices to convey back to plans and employers their interest in BTE participation.

To engage a health plan, it is recommended to start with the regional account manager. Use the information provided in Section II of this toolkit (Benefits of Participation) to support your argument for plan implementation of BTE. It is at this point that initial interest is sparked and the QIO can begin to lay the necessary groundwork. Once there is obvious interest, it is then recommended that the QIO work with the regional account manager to bring together the following individuals within the plan:

- Executive Director of Clinical Affairs
- Director of National Accounts
- Chief Medical Officers/ Medical Director
- Vice President of Quality Improvement

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The individuals serving in positions listed above have the ability to work with BTE to engage in the licensing process. Please visit http://www.bridgestoexcellence.org/pdf/BTE_License_Agmt.pdf for a sample licensing agreement. Additionally, some of these individuals may have prior experience with the implementation of BTE in a market.

Below are four suggested steps that will help in convening stakeholders. While we understand that each market is unique and has its own challenges, these steps should be used as a foundation to build out a more detailed engagement strategy.

The 4 Steps to Market Engagement (Convening)

Step 1: Lay of the Land

QIOs are currently working at a hands on level with local physicians and practices and therefore have a strong understanding of the local market. In addition, QIOs were required to perform an “environmental scan” in preparation for the 8th Scope of Work. This is a great advantage in further developing the existing environmental scan in the context of performance improvement and P4P initiatives such that it may be used to engage all necessary stakeholders.

It is suggested that the QIO be sure that their environmental scan:

- Helps define the BTE market (participating zip codes) geographically and demographically working with employers and health plans
- Reviews the strategies and initiatives already in place to improve the quality of healthcare in the market
- Assesses the market’s legislative, pay for performance, agendas
- Explains related market activities and how they fit with BTE
- Analyzes lessons learned from these initiatives and identifies strategies to leverage their progress

An example from the pilot implementation in the city of Cincinnati:

The market climate had two issues influencing BTE’s approach:

- History with employer-driven hospital “quality” initiative in market—providers believed big employers were the cause of their lower reimbursement rates.
- Physicians had filed lawsuits against the top four health plans for price fixing.

Bottom Line: Know ALL there is to know about your market! QIOs have worked in their health care markets for many years and likely understand market dynamics, but explicitly cataloging historical experiences and current barriers that could impact a BTE implementation is often helpful in avoiding past pitfalls.

Step 2: Engaging the Market – Key Stakeholders

The convening QIO should:

- Know who the “key” players are and what impact their size and/or reputation has on the market because they will likely be a participant in the BTE program.

- Once defined, 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 any meeting.

Step 3: Building the Team

- Identify what "critical mass" could be needed for the market to be successful (e.g. number of covered lives)
- Work with BTE to recruit health plans by using the business case and
  - Help the plans understand the philosophical reasons and the strength this can give them in responding to market challenges – and paying for quality.
  - Identify other businesses that may support the initiative.
- Identify a champion from an engaged employer to lead the market and make things happen.
- Identify others that could be team members and help them further understand what roles they may play:
  - Or ask them to perform communication flow/support roles.
- Recruit a doctor to support the initiative (MD/DO) for credibility when engaging other physicians.

Step 4: Getting People on Board

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

Important Suggestions to Succeed

- Work in collaboration with health plans in approaching key employers.
  - Know the politics and current events in the market.
  - Provider relations teams will know MDs to target.
    - Gather feedback from current DOQ-IT participants to gain insight into how physicians view pay for performance
- 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.
- Time and consistency will lead to acceptance and trust in the market
  - Having national credibility helps.
  - Credibility is the key but credibility often takes time.

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

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2. Enabler

As an enabler, the QIO can engage currently enrolled DOQ-IT participants to participate in the BTE program and enable additional practices to participate in both new and existing markets.

To better accomplish this role, the QIO will receive a Master Physician List (MPL) that will allow them to determine which physicians are eligible for rewards with whom they are currently working with, in addition to those that they should target in an outreach strategy. The MPL will also contain patient counts that can indicate the potential interest of physicians and practices. The QIO can help the health plan target physicians or practices for recruitment based on its current DOQ-IT practices, the BTE market implementation area, and physicians who care capable of meeting or exceeding requirements for recognition and rewards.

QIOs can ultimately help enable transformational change in physician practices by providing direct assistance on practice re-engineering. Serving as a local resource to help small practices prepare and plan for HIT adoption, reorganize workflow and care processes, and perform care management are all key to making sure small practice transformation is supported.

In markets where Physician Office Link is not available the QIO can still participate in the BTE program via the Cardiac Care Link and Diabetes Care Link Program. These programs encourage practice transformation and provide an organized means for performance data to be gathered and assessed. In turn, this leads the way to the improvement in disease management.

The QIO can help physicians adopt tools to better manage patients with chronic conditions which will enable them to meet DCL/CCL measures and qualify for rewards.

Masspro, the Medicare Quality Improvement Organization (QIO) for Massachusetts continues to serve as a facilitator, leader, and key participant in health care performance improvement. The Masspro case study below is a good example of how large a role the QIO can play in the assessment and enabling of physicians/practices in the BTE program.

3. Assessor

Given that QIOs are working with practices through the DOQ-IT program and are involved in quality improvement on a statewide and local level, becoming a BTE performance assessor is a very complimentary fit.

As a performance assessor, QIOs evaluate and verify to BTE that practices qualify for recognition or rewards. QIOs can assess the practices and get them recognized under the BTE program by having them complete the attached survey tool, which is based on the Office Systems Survey (OSS) from CMS. A practice needs to successfully complete all DOQ-IT requirements to receive BTE rewards.

Practices affiliated with the DOQ-IT program are eligible for rewards under BTE's Physician Office Link program by completing the following:

- **Office Systems Survey (OSS+)/BTE Version:** The OSS, delivered nation-wide to all DOQ-IT practices, is designed to measure practices' adoption of health information technology and implementation of care management improvements. The BTE version,

informally called OSS+, was developed in collaboration with IPRO and Masspro, and is designed to add measures in the areas of interest to BTE, including patient self-management, access and communication, and interoperability.

- **Onsite Practice Assessment (OPA):** QIOs often use onsite consultation to provide valuable assistance on the implementation of electronic health records. During these consultations, practices that are applying for BTE rewards will be required to submit evidence of their improved processes through the use of the Onsite Practice Assessment tool.

These tools are attached to this toolkit and, when administered, will provide comprehensive and defensible evidence that practices have met the requirements of the Physician Office Link program. The OSS+ tool provides in-depth self-reported data from the practices, while the OPA verifies this information through a visit from a DOQ-IT consultant.

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Enabling and Assessing- Step by Step Guide

Task 1: Build QIO-BTE Team

The allocation of the appropriate resources is crucial in beginning a BTE implementation through the DOQ-IT program; we therefore recommend that the QIO create an internal BTE team to help with workflow and resource coordination.

The need for these resources will fluctuate depending on the stage of the project and what role the QIO will be playing- be it the convener, assessor and/or enabler. In the beginning of the program, as practices are being recruited and strategies are developed, these resources will be in heavy demand. This will also be true during assessment, evaluation, and sign-up periods.

It is recommended that both the QIO DOQ-IT team and BTE Operations use a project plan to jointly develop collaborative implementation with milestones using input from all team members. We recommend that QIOs utilize the sample work plan in Appendix B to guide BTE implementation in their region.

The following is a description of the various staff resources a QIO will need to supply for implementation of a BTE program:

1. Administrative staff

- Coordinate physician recruitment email / letter distribution
- Analyze relevant practice information
- Field questions from interested physicians and practices concerning program

2. DOQ-IT/BTE project manager (PM)

- Develop strategy, goals and timelines for entire program outreach, analysis, etc
- Attend weekly conference calls
- Train practices on portal registration and use
- Coordinate all data elements with the BTE RDE Manager
- Interview / qualify practices for BTE rewards
- Interface with practices / Field questions concerning program
- Coordinate in-house team; schedules, time allotted, delivery of information, etc

3. IT support

- Receive and send relevant data
- Interpret data, present it to PM in appropriate format
- Coordinate all data elements with the BTE RDE Manager

4. Marketing support

- Coordinate collaborative meetings, establish place for meetings, relevant materials, etc.
- Develop marketing materials
- Perform outreach to physicians when recruiting, training, etc.

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Task 2: Physician Recruitment
Resources needed:

- Administrator/coordinator
- DOQ-IT BTE project manager
- IT support

The first step in the project is to analyze the DOQ-IT Identified Participant Group (IPG) practices to determine potential participants. The QIO should look for practices far enough along through the EHR implementation process that they are eligible for one of the modules, listed later in this document under Task 4. These practices may also be concentrated in geographic areas near one of the participating employers.

Once identified, communicate with the practice. There are a variety of communication outlets that can be used for outreach. Examples include:

1. Informative mailings sent to the practices.
2. Emails can also be effective, although email contact information may not be available, depending on the technology level of the practices.
3. General seminars on pay for performance: Members of BTE present program details alongside DOQ-IT team members. All the communications explain the BTE-QIO partnership, provide qualification requirements, and supplied application materials. Masspro's website contains additional materials and information at: http://www.Masspro.org/HIT.

During the physician recruitment, a QIO must also inform physician practices about the need to identify themselves on the BTE Physician Online Service (POS), such as by providing a training manual and/or any necessary assistance. A practice not identifying itself on the POS will not be eligible to receive BTE rewards. See Task 4 below for further information.

Task 3: Set Up Interface with BTE Recognition Data Exchange (RDE)
Resources needed:

- Systems Analyst
- DOQ-IT/BTE Project Manager
- DOQ-IT/BTE Admin
- BTE RDE Manager (from BTE Operations)

After determining your BTE eligible practices, the QIO should assemble an IT team internally to interface closely with the BTE Recognition Data Exchange (RDE) manager on the BTE side. The BTE RDE is part of BTE Operations. It is an automated system that facilitates the exchange of BTE data files between the BTE administrators and BTE partner/vendor organizations in order to efficiently and accurately provide physician recognition information to the administrators to pay rewards in each BTE market. It provides a common interface for the various partners and administrators and is a stable platform for stakeholders and partners to participate in BTE through standard data formats, data validity requirements, and routine electronic data exchange protocols to receive data from and provide data to BTE partners/vendors on a pre-established data-exchange schedule.

The QIO acting as a Performance Assessment Organization (PAO) should work with BTE to set up access it the RDE and to develop a comprehensive understanding of the processes and expectations of the data file content and formats. A QIO needs to be able to receive, process and send data back to BTE RDE for its BTE implementation. See Task 6 below for additional

information and Appendix A for a detailed RDE overview and separate RDE technical specifications that are needed to develop input and output file exchanges.

Task 4: Practice Assessment
Resources needed:

- DOQ-IT team members
- DOQ-IT BTE project manager

The next step in the process is to assess practices from which the QIO has received applications. The assessment process closely follows the DOQ-IT Roadmap assessment and, indeed, most practices will already have been assessed by a DOQ-IT team member.

The DOQ-IT Roadmap has distinct modules affiliated with EHR adoption: Assessment, Planning, Selection, Implementation, Evaluation, and Improvement. A practice needs to successfully complete all DOQ-IT/QIO requirements to receive BTE rewards.

Once the end of a module draws near, practices will need to be evaluated as to whether or not they met the goals determined in that phase. Meeting these goals will impact whether a practice can receive BTE rewards. The assessment tool would be most efficiently completed by the practice and reviewed by the DOQ-IT team members. As mentioned above, the appropriate evaluation tools will have been provided to each practice during the assessment phase.

It is recommended that the QIO provides a mini-project plan to each eligible practice to help them achieve recognition. At this time, it would also benefit the practice to provide them with a copy of the QIO module evaluation tools.

Task 5: Practice Self-Identification
Resources needed:

- DOQ-IT team members
- DOQ-IT BTE project manager

After DOQ-IT team members provide assessments and work plans for BTE-eligible practices, these practices need to identify themselves to BTE. They will do this through the Physician Online Services (POS) at www.healthgrades.com/physician/bte **.** Here, they will add their practice, associate physicians to the practice, and confirm practice information. Individual physician UPINs are mandatory to complete the rewards process.

QIO staff should proactively remind, follow-up and ask all practices submitting their assessment applications to visit HealthGrades to identify themselves in POS prior to submitting their assessment application (Task 4). Otherwise they will not receive BTE rewards.

Furthermore, a QIO also needs to remind its rewarded practices to visit POS 60-days prior to the end of its recognition anniversary to re-identify itself on POS to continue to receive BTE rewards (in addition to meeting any QIO practice assessment guidelines that might also need to be met).

It is crucial for QIO administrative and project staff to be thoroughly familiar with the practice identification process via HealthGrades site. This is a required step for a practice applying for BTE POL rewards. A practice not identifying/re-identifying itself on the POS will not receive BTE rewards. The process of practice self-identification takes plenty of legwork on the QIO's part. Individual physician offices may require DOQ-IT team member assistance to correctly navigate the POS.

To ensure successful practice identification/re-identification on POS, a QIO must make sure that:

- Practices select 'DOQ-IT' as the qualification vehicle
- Practices return to the portal to associate additional physicians to the practice
- Practices complete the process by confirming data
- Rewarded practices must visit the portal 60-days prior to the end of its recognition anniversary to re-identify itself on POS to continue to receive BTE rewards

Task 6: QIO Recognitions to RDE

Resources needed:

- IT staff
- DOQ-IT BTE project manager
- BTE RDE Manager

Once the QIO determines that the practice has successfully met DOQ-IT criteria by completing the process outlined in Tasks 3-5 of this section, you are required to submit the compiled data to the RDE according to the specifications outlined in Appendix A. This occurs on a monthly basis. During those months when there is no new data to process, a blank file in the standard file format is submitted to the RDE. Close collaboration with technical vendor project manager is required to ensure accurate transfer process and submission/receipt frequency.

After a practice's evaluation/recognition data is successfully received by BTE administrator via the RDE, they will receive awards payment. The schedule for this payment is determined by the BTE regional steering committee. For market specific information, please visit http://www.bridgestoexcellence.org.

Throughout this process, the practice's main job is to improve the quality of care that is being delivered and reengineer their practice. The QIO and BTE work in the background to make sure that the practice's efforts are appropriately recognized and rewarded, thus creating a real business case for quality improvement.

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Appendix A

Recognition Data Exchange Requirements (Overview)

Introduction to the BTE Recognition Data Exchange (RDE)

The BTE RDE is part of BTE Operations. It is an automated system that facilitates the exchange of BTE data files between the BTE administrators and BTE partner/vendor organizations in order to efficiently and accurately provide physician recognition information to the administrators to pay rewards in each BTE market. It provides a common interface for the various partners and administrators and is a stable platform for stakeholders and partners to participate in BTE through standard data formats, data validity requirements, and routine electronic data exchange protocols to receive data from and provide data to BTE partners/vendors on a pre-established data-exchange schedule.

Purpose of RDE Technical Specifications

The purpose of the RDE technical specifications is to describe the data exchange processes, the data file contents, and the frequency of data exchanges so that all BTE partners and vendors will have a clear set of expectations regarding the BTE Recognition Data Exchange system and future BTE data exchanges.

This document is intended for the BTE information systems staff that will be carrying out the necessary preparations for data exchange in each partner organization. Its goal is to describe detailed data file layouts

Data Exchange Flow

BTE partners will submit data to the BTE Recognition Data Exchange electronically, according to the frequency defined below (i.e., monthly), using the Data Submission System. The RDE technical specifications document provides an in-depth discussion of MDSS, including procedural details and features of the system. **NOTE:** The role of a QIO in the RDE process is as a Performance Assessment Organization (PAO).

Input Files to BTE Recognition Data Exchange from Performance Assessment Organizations (PAOs):

- On a monthly basis, PAOs will submit to the BTE Recognition Data Exchange information on any physicians or practices receiving performance recognition (or updating previous recognition) in the prior month.
- Information submitted by the PAOs includes the list of physicians who obtain performance recognition (either individually or as part of a group or practice) for diabetes care or cardiac care.
- The PAO is the sole source of the lists of physicians that comprises each recognition and these lists are used as the basis for the BTE Administrators to calculate rewards for the Diabetes Care Link (DCL) and Cardiac Care Link (CCL) programs.
- This information is critical for the BTE reward administration processes as well as for the physician and consumer web sites that display recognition information.
- Newly (or annually) recognized physicians and practices must be contacted about their rewards, and consumers must have access to current physician recognition information by way of the CRV.

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Output Files from the BTE Recognition Data Exchange to the PAOs:

- On a monthly basis, PAOs will receive new market-level RDE MPL records with the RDE Physician IDs and physician demographic information.
- They will also receive information on self-identified practices, their associated physicians, and any changes to previous information on physicians and practices.
- This information must be updated regularly since it is critical for qualifying program eligibility for physician practices and for matching RDE Physician IDs to newly recognized physicians and practices.

BTE can provide further information on the RDE process including snap shot examples of the file.

BTE Recognition Data Exchange (RDE) File Data Elements
Key points to note:

PAO to RDE Input Exchange:

- The record type (data element 1, i.e., #1) will be either a physician recognition record (#2) or a practice recognition record (03)
- Only recognitions in the BTE markets will be provided
- QIO data feed includes Practice record reflecting recognition
- QIO does not include the physician composition of the practice
- Portal practice ID (41) is valued; RDE Physician ID (#5) and Applicant fields (#s 44 -46) should be blank

RDE to PAO Output Exchange:

- Physician records will include either a RDE Physician ID (#5) or Portal Physician ID (#7)
- Practice records will include a Portal Practice ID (#41)

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Appendix B Sample Work Plan

Project	Task	Action Item	Severity	Status	Start Date	Due/Close Date
	Pre-Work and Education					
Goal:	Outreach to QIO that has already completed assessment	Gain templates, lessons learned and establish ongoing support	H			
-	Outreach w/ Healthgrades	Conference Call to determine action items and timelines, as well as to obtain POS training	H			
	Outreach w/ BTE technical vendor	Initial Conference Call to determine data specifications and transmission requirements	H			
	Explore the possibility of engaging the local IPA					
	Project Plan/Timeline Review w/ Technical vendor & BTE	Conference call to review plan and revise accordingly	H			
	DOQ-IT POS training- potentially include IPA	Train administrative assistants who will register MDs	H			
	Marketing					
	Make table of Rewards					
	Crosswalk BTE MD list with DOQ-IT MD List	Focused list of DOQ-IT MDs to call and introduce BTE to.				
	Review table of rewards & marketing plan for existing DOQ-IT MDs w/ BTE overlap	Prepare marketing package to go out to already recruited DOQ-IT practices				
	Determine BTE outreach strategy					
	Marketing plan for DOQ-IT eligible MDs on BTE list w/o overlap	Confirm plan with BTE				
	Determine outlets that will be used to do BTE outreach					
	Draft outreach letter- Include patient counts	Work w/ BTE				
	Send BTE team outreach letter for review					
	Technical vendor& QIO kickoff	Marketing efforts begin				
	Send marketing package to existing DOQ-IT MDs w/ BTE overlap	Mailing				
	Follow up telephone calls to DOQ-IT MDs w/ BTE overlap	Develop script, make telephone calls				
	Implement marketing plan for DOQ-IT eligible MDs on BTE list w/o overlap	Dependent on plan				

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Physician Registration					
Develop process for admins to follow once they receive interest from MDs	Train admins on process				
Track registration with MD UPINs					
Data Extraction & Transmission					
Received y3 MPL					
Compare currently recruited DOQ-IT physicians against the MPL y3 list to identify those docs that are eligible to receive BTE rewards-					
Place in excel format and send to BTE team for review					
Determine recruitment "universe"- compare current outreach list to MPL and determine which docs are eligible for BTE rewards					
Format/Program Technical vendor file/Link with QIO provider tracking database		H			
Upload DOQ-IT MD list to POS					
Monthly recognition file to POS					
submits sample test file using Excel format currently in place for NCQA and Masspro	Refer to Excel document “Sample Data Feed Template 5-12-06”				
submits sample test file (may have real DOQ-IT recognitions at this time or final test data only)					
submits file with all IPRO DOQ-IT recognitions in Y3 of pilot					
All BTE rewards must be paid to practices					

Appendix C
Glossary of Terms

ABIM – American Board of Internal Medicine

Administrators – Health Plans, Coalitions, Data Aggregators, or Licensees who implement and administer BTE programs in one or more markets.

BTE Recognition Data Exchange (RDE) – An automated data system that accepts standardized data input files from various BTE partners and sends standardized output files to various BTE partners in order to pay rewards to physicians.

BTE Market – A geographic location that is defined by an Administrator, and/or Regional Team as the area where BTE will be implemented by the Administrator.

BTE Operations – The national infrastructure for BTE, staff of BTE Operations provide services such as patient count attribution to physicians, physician and practice web portal support, and physician report cards.

Cardiac Care Link (CCL) – The BTE program that rewards physicians for demonstrating good outcomes in cardiac care as evidenced by passing NCQA's HSRP measures.

Consumers – Also referred to as patients or covered lives, consumers are the people seeking the care from providers.

Diabetes Care Link (DCL) – The BTE Program that rewards physicians for demonstrating good outcomes in diabetes care as evidenced by passing NCQA's DPRP program.

Employer Recruitment – The act of approaching and engaging employers in a market to encourage their support and bring their covered lives into the fold.

Employers – Participating employers that agree to pay rewards through their administrator (health plans) to recognized physicians in a defined market area.

HealthGrades – The organization responsible for developing the interactive, online tools that consumers and physicians use to look up physician and practice information (including NCQA recognition status) and enter and view patient experience of care with their physician ("Consumer Report Card").

Master Physician List (MPL) – A data file generated by the BTE Administrator that lists each BTE-eligible physician along with the physician's address, specialty, and eligible patient count for each BTE program and is sent to BTE RDE.

National Committee for Quality Assurance (NCQA) – One of the Performance Assessment Organizations that determines the performance level of office practices and physicians seeing the participating employers' employees, i.e., BTE eligible physicians. It also provides recognition information to BTE administrators for reward payments.

P4P – "Pay-for-Performance"

Patient Counts – The number of covered lives that an eligible physician sees from participating employers and the number that defines the amount of reward eligibility.

PCP – "Primary Care Physician"

Physician Online Services (POS) – the HealthGrades website that allows BTE participating physicians/practices to add, edit or update physician or practice profile information through a single web-based interface.

Physician Recruitment – The act of recruiting and engaging physicians to pursue recognition, to increase the number of recognized physicians in the market.

Physicians – MD's and DO's only, who have at least 1 patient count from participating employers and who are eligible for rewards.

Performance Assessment Organization – An organization that has developed a systematic and impartial approach to measuring and assessing quality of care.

Regional Steering Committee - 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.

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Appendix D

Case Study 1- Masspro- Assessor & Enabler

Who is Masspro?

Masspro, the Medicare Quality Improvement Organization (QIO) for Massachusetts, has been an independent, objective voice for improving patient care in Massachusetts, and continues to serve as a facilitator, leader, and key participant in health care performance improvement. Our collaborative endeavors include partners such as the Centers for Medicare & Medicaid Services (CMS), the Massachusetts Office of Medicaid, private payers, the full continuum of health care providers, stakeholder organizations, businesses, and legislators. We positively impact our customers' clinical, operational, and financial performance by providing expertise in system and process redesign, the application of information technology, data analysis and utilization, and intervention development, implementation, and evaluation.

What is the Doctor's Office Quality–Information Technology Initiative
CMS funds the Doctor's Office Quality–Information Technology (DOQ–IT) initiative. The project's goal is to expedite the adoption and utilization of electronic health records (EHR) for better patient care through consultation with small-to-medium sized physician practices. These practices provide a majority of the office-based health care to patients.

What is Masspro's Role in the DOQ-IT Pilot
CMS selected Masspro as one of four pilot organizations to utilize its technology and operational expertise to provide end-to-end consulting services to facilitate the adoption of EHRs. During the pilot program, Masspro enrolled over 1,500 physicians, representing over 450 practices sites. Specific services included workflow evaluation, operational redesign, vendor negotiation, implementation assistance, and ongoing practice improvement.

Masspro's participation as a pilot QIO was significant because CMS used the pilot project to develop a task-specific framework for its 8th Scope of Work that extends from August 2005 through July 2008.

Masspro's Role in BTE
Given its active role in the DOQ-IT program, BTE's mission is a logical fit with Masspro's ongoing activities to improve the quality of patient care through the increased adoption and implementation of electronic health records (EHR).

The BTE program serves as an additional motivator for physician practices to become engaged in the DOQ-IT program, thus allowing Masspro to meet its required criteria for recruitment set by CMS.

Benefits of Masspro and BTE Working Together
Masspro focuses on working and assisting healthcare providers at a local level, and BTE focuses on recognizing and rewarding high quality physicians. These goals provide a synergistic partnership opportunity for each party. Masspro provides the critical linkage for physicians and practices between the tools needed to make quality improvements and the BTE rewards.

In addition, this partnership provides harmonization of measures, which helps to reduce the duplicative reporting burden on physicians and practices, by rewarding those practices that invest in IT solutions and practice change as a means of better patient care.

Masspro's primary role is to assist and enable physician practices in their quality improvement efforts. Its secondary role is as an independent performance assessment organization (PAO) to assess practices in their quality improvement efforts allowing DOQ-IT qualified practices to realize the advantages of the BTE Physician Office Link (POL) program.

The Steps to Working Together

Beginning in April 2005, numerous strategy sessions including face-to-face meetings and conference calls were held. It was determined that the best role for Masspro to play in the BTE program was as a performance assessor and practice recruiter.

Masspro took the following steps to succeed:

- develop basic work plan
- analyze existing practice data to determine which practices met eligibility requirements
- obtain Master Physician List (MPL)
- engage allocated staff in practice matching exercise
- develop collaborative environment for all stakeholders
- work with BTE Operations and BTE to ensure all steps involved in the RDE process are correct

The above steps ensured a comprehensive understanding of the processes and expectations of the data provided and returned. Thorough testing of the files submission needed to be done, which included a data feed test by BTE Operations. Listed below are the steps used to complete this process.

1. Download text files from HealthGrades FTP site
2. Import files into Access database
3. Verify UPINs
    a. Provide report of unknown or mismatched UPINs to DOQ-IT Admin
    b. UPIN changes are made in MySQL database
4. Run initial spreadsheet of merged data
5. Audit of spreadsheet done by DOQ-IT/BTE Project Manager
6. Send final spreadsheet to BTE and BTE Operations

Once a comprehensive list of targeted practices was identified and in place, Masspro communicated the benefits of the BTE program via:

- First Class Mail
- Email
- Facsimile
- Cold calls
- Conference calls
- Meetings
- In person office visits by Masspro staff

All communications vehicles provided a detailed explanation of the new partnership, the process by which practices could enter the program and the appropriate contact information should they have further questions or require additional information.

Masspro conducted pay-for-quality sessions for interested practices in collaboration with the CMS Medicare Care Management Performance program and Bridges to Excellence. With assistance from BTE staff, Masspro presented pertinent information that explained the process that needed to be followed to obtain BTE rewards. At the conclusion of each presentation, attendees had the opportunity to engage in a lengthy Q &A session. Masspro found that the Q&A portion of each meeting was the most valuable aspect of the meeting, as attendees were able to obtain numerous take aways and lessons learned. This, in turn, equipped them with the right amount of information to spark interest in BTE.

Once the market was penetrated and interest was established, practices began working in collaboration with their designated Masspro representative on the assessment process. The combined work plan that Masspro had developed ensured all parties involved that target dates for file feeds were met. In addition, through the communications process, Masspro was able to identify and work with physician practices that would meet Year 2 criteria. In working with the identified practices, Masspro assessed 12 practices for the BTE Physician Office Link (POL) program. These practices continue to participate in the program today.

As part of its ongoing efforts, Masspro utilizes the BTE program as part of its general PowerPoint presentation to educate audiences about the importance of practice transformation in the improvement of the quality of care.

Lessons Learned
Successes:

- Weekly conference calls with BTE allowing for ongoing communication amongst team members
- Email communication – rapid response back to practices and the provision of sufficient detail
- Facsimile to reach out to practices
- Relationship building critical – cold call and office visits
- Constant interaction and reinforcement of process and work plan reminders
- Target all areas in state through work with Independent Physician Association (IPA) in state
- Inclusion of BTE message in all communications

Challenges:

- Inclusion in existing BTE payment states
- Timely posting of mailings by physician office staff
- User training
- Review of user documentation and completion of required fields on portal to qualify for rewards
- Confusion related to portal by users
    - Solution: Train internal staff on the portal and all functionalities.
- Add-on requirement for DOQ-IT that was not user intuitive - may have contributed to low application process

Case Study 2 - Ohio KePro – Convener

Ohio KePRO performed an important function in market convening – generating physician awareness and support for the Diabetes Care Link pilot, which was being implemented in the Cincinnati region. The project managers at the QIO knew that pay for performance was the wave of the future and thought that BTE would also be a great opportunity to reach more practices and gain interest in DOQ-IT. Ohio KePRO also realized that once their DOQ-IT practices were recruited, they could help those practices participate successfully in the DCL program.

Ohio KePRO began by designating a strong team that would be able to stay connected with what was going on within the region. The QIO decided to use their full time field representatives from different parts of the state to help educate physicians about DCL.

Once Ohio KePro received the MPL and completed the matching process (this entailed dividing target practices based on zip code and region), they began to develop the outreach strategy. Project leaders verified office information including location, physicians at that location, phone number and office manager. Project leaders then compiled BTE physician letters by office location and put appropriate letters into Physician Rewards Program folders. These folders were from BTE and included:

- Left side: BTE Physicians Rewards Program- Cincinnati and Louisville areas offer Diabetes Care Link (DCL) Program brochure, ADA/ NCQA Are You Recognized Yet? Diabetes Physician Recognition Program for Specialists and Primary Care Physicians, ADA/ NCQA Diabetes Physician Recognition Program Quick Start Instructions
- Right side: BTE Description letter signed by Board President, How to Participate in BTE sheet, BTE business card
- Ohio KePro Field Reps added BTE Recognized Provider listing to folder

Fortunately, there were practice champions in the Cincinnati area -- Queen City and Group Health -- which had success working with the BTE DCL program as well as DOQ-IT. This proved to be beneficial when they began their initial outreach to practices.

The outreach team made sure that their message was clear and that the practices understood why working with the DOQ-IT program and BTE's DCL program would benefit their practice and patients.

1. The team did extensive research on both a national and state level that showed that the state of health care was moving in the direction of pay for performance, and BTE was one of the top P4P programs in the US.
2. The QIO examined data, which indicated that many of these physicians might not be doing as well as they had initially thought. By participating in DOQ-IT, and then working with the DCL program, they would be work to meet the NCQA DPRP measures. This, in turn, would provide them a way to gauge where they needed improvement as well as gaining national recognition and monetary rewards.
3. The team did extensive cold calling and office visits to build a strong relationship with these practices. This also let the practices know that the QIO team was available to support transformation in a hands-on way.

During the visit, the following materials were delivered/ discussed:

- One BTE folder with appropriate itemized letters

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- Ohio KePro Physician Office Toolkit
- Ohio KePro Posters/ Flyers- Diabetes, Immunization, etc
- Ohio KePro Mammography information if applicable
- Ohio KePro IT Readiness Survey

In the end, Ohio KePro found that working in collaboration with BTE was a great success for everyone involved. While they did not play the role of assessor, they both performed a key function of convening – engaging physicians – and they expect that this work will lead to a larger role as an Enabler as well.

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Case Study 3 – Qualidigm - Convener

Qualidigm, located in Middletown, Connecticut, managed to convene all of the Medical Directors from the Connecticut health plans and gained substantial interest in the implementation of the BTE POL program within the state. While Qualidigm has many existing relationships with the Medical Directors at the major plans in the state, the challenge was to bring them all together and have them agree to explore BTE.

Through personalized phone calls placed directly to the health plan Medical Directors, Qualidigm was able to get the Medical Directors to meet on a collaborative level. These meetings entailed extensive strategizing and discussion of various implementation scenarios. The plans began to understand that the ROI that BTE could offer was worth the effort involved in the implementation because BTE would help to improve the quality of health care received in the state of CT. In addition, the POL program would increase the speed of adoption, and use, of HIT.

As a convener, it was Qualidigm's job to bring all the plans together on neutral ground. As highlighted above in Step 2, Qualidigm took into account that Anthem holds the relative market share as the dominant plan in CT. Thus, in turn, making it all the more important to create a neutral environment so as not to create the perception of relative importance of one plan over the other.

As a result of this meeting, the plans came together and are in agreement that it would be beneficial to explore a common implementation of BTE in CT. Qualidigm has begun to build out a work plan that involves the engagement of additional stakeholders and strategizing discussions.

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