Reducing Medical Cost Trend in ACO/AQC Environments: An Innovative Approach to Physician Engagement

AMGA 2013 Annual Conference
March 15, 2013

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Agenda

- MGH initial approach to engaging specialists in managing medical expense trend (2:00-2:20)
- Group activity #1: Dashboards for medical expense trend (2:20-2:50)
- Engaging physicians: MGPO Quality Incentive Program (2:50-3:00)
- Group activity #2: Designing physician incentives (3:00-3:10)
- Wrap up (3:10-3:15)

Learning Objectives

- Learn from each other's experience using data to engage specialists
- Brainstorm tactics for engagement

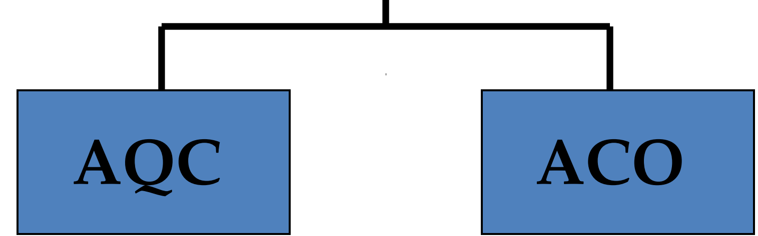
The authors have no actual or potential conflict of interest in relation to this program/presentation.

There are three ways society is combating rising costs

Contain rates through regulation

Implement payment reform

Turn patients into consumers



What we're facing…

- **Constraining the growth of healthcare costs is a national priority**
  - Involvement of physicians through changed incentives is unavoidable
  - PPACA includes several new payment mechanisms – the imperative will persist even if the specifics change

- **The market is using the same play book** – closed networks, budget-based risk, cost sharing, restriction of choice – and this may generate the same backlash as 1990s managed care era

- **But...**
  - The economy is much worse
  - Government is more proactive
  - Rate of change is slower (caps on increases, not cuts)

- **And we have…**
  - Better health IT and data for population management
  - Strategies and tactics that we know will improve care and reduce costs

- **Providers will need a playbook that will be successful under any of the new payment models**

What we're facing…

- **The focus should be on reducing medical expense trend to as close to the rate of general inflation as we can**

- **This means taking risk and changing care models**
  - Shared savings (Pioneer ACO)
  - Bundled payments
  - Global payments (AQC/capitation)
  - Care redesign

- **Challenges**
  - How to make the external incentives internal in a meaningful way, within a complex organization
  - At the right pace
    - Moving *too fast* will lose the docs in the rush to implement – MDs attitude often creates the patient's attitude (managed care backlash)
    - Moving *too slow* will mean not succeeding under the contracts and worsening the regulatory environment

Why Partners/MGH is aggressively pursuing global payment/population management

- Leadership opportunity to bend cost curve

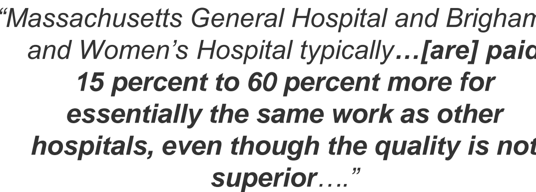
- Efforts to reduce health care spending not going away
  – Government and private sector being proactive

- Lesser of two evils
  - Continued fee-for-service with endless rate cuts
  - Global payments → care redesign, which → decreased utilization, which → (1) shared savings and (2) backfill opportunity

- Partners increased ability to care for populations of patients
  - Universally adopted EHR
  - Successful CMS Demo

We are at the center of the conversation

Media



*"Massachusetts General Hospital and Brigham and Women's Hospital typically…**[are] paid 15 percent to 60 percent more for essentially the same work as other hospitals, even though the quality is not superior**…."*
Boston Globe Spotlight Series, 2008

Payment Reform Commission

"The Special Commission concludes that global payment models….should serve as the direction for payment reform….implemented over a

period of five years….

-Commission Report

Attorney General

*"…points to the **market clout of the best-paid providers as a main driver** of the state's spiraling health care costs…"*
AG Investigation of Health Care Cost Trends and Drivers, January, 2010

Referring Physicians

*"…the organization could **better coordinate care at Beth Israel Deaconess**, partly because the hospital has agreed to send patients back to their primary care doctor or a specialist at Harvard Vanguard after their inpatient stay, rather than keep them in the more expensive hospital system…"*

*"…**About half of Atrius patients are covered by a global payment…**"*
Boston Globe, 2/25/10

Payers

*"We hope this is the beginning of a movement in Massachusetts in which **health plans, hospitals, and physicians work together on a shared agenda to improve care and lower costs**,"*
Andrew Dreyfus, Blue Cross, on the importance of AQC

Partners entered new contracts with our two biggest payers on January 1, 2012

	Alternative Quality Contract (AQC) Blue Cross Blue Shield	Accountable Care Organization (ACO) Medicare Shared Savings
Population	Commercially-insured patients who receive primary care at Partners	Medicare patients with most of their care at Partners
Quality Measures	DM, CVE, HTN, Depression, Cancer Screening, Bronchitis, Patient Experience	DM, CVE, HTN, CHF, Preventative Care, Care Coordination, Patient Experience
Medical Expense Trend	1% less than non-PCHI in cost per member per month from baseline	1% less than comparison group in cost per member per month from baseline

Chiefs Leadership Incentive on Trend

- **Goal**
  - Departments produced a written plan for achieving trend goals, relevant to their specialties
  - Specialists understand contribution to spending trends and key drivers

- **Process**
  - Developed utilization and costs reports for at risk population to help inform divisions on high spend areas and guide possible areas of clinical opportunity

  - From June – Sept 2012, we met with Chiefs and senior administrators from 23 departments total :
    - Provided limited data on utilization and costs for select resource areas
    - Engaged in a focused discussion on clinical opportunities to reduce overall costs of care while maintaining quality

  - **Chiefs receive $$ bonus for turning in trend plan**

Priority areas – trend reduction

Increasing Trend →

Increase in Cost ↑

High cost, flat or decrease trend **Priority Area #2**	High cost, increase trend **Priority Area #1**
Low cost, flat or decrease trend **Priority Area #4**	Low cost, increase trend **Priority Area #3**

Specialty trend matrix

	Inpt Serv	Med Pharm	Pharm	Visits	Amb Proc	Diag Serv	Pathology	Immun
Anesthesia	■				■	↑		
Dermatology			■ ↑	■ ↑	■			
Emergency Services								
Mass Eye and Ear		■ ↑		■ ↑	■		↑	
Medicine - Allergy Immunology					■			
Medicine - Cardiology	■		■	■		■		↑
Medicine - Clin Ed/HospMed/AHS					↑			
Medicine - Endocrine Division			■ ↑	■				
Medicine - Gastroenterology			■	■	■		↑	
Medicine - Hematology Oncology			■			↑		
Medicine - Infectious Disease	↑							
Medicine - McLean Hospital								
Medicine - Nephrology Division								
Medicine - Palliative Care								
Medicine - Pulm & Critical Care								
Medicine - Rheumatology			■		↑			
Neurology Service			■ ↑	■			↑	↑
Neurosurgery Service								
OB GYN Service	■		■	■ ↑	■			
Oral and Maxillofacial Surgery								
Orthopaedic Surgery	■			■	■			
Pathology							■ ↑	
Pediatrics	■		■	■				
Physical Medicine & Rehab				■				
Primary Care			■ ↑	■				
Psychiatry			■	■ ↑				
Radiation Oncology				■				
Radiology Service								
Surgery Service	■			■	■			
Urology Service				■				

For illustrative purposes

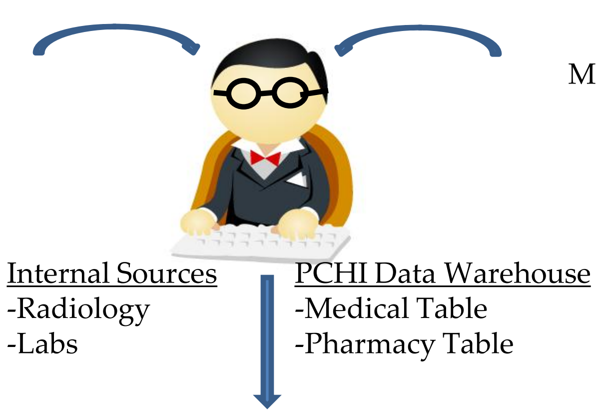
■ Above average medical spend compared with all Department/Resource Area combinations

Below average medical spend compared with all Department/Resource Area combinations

Methodological approach

BCBS Members with an MGH PCP

BCBS MemID	MGH MRN	Eligible Start	Eligible End
1235290	0000001	1/15/11	12/15/11
5903720	0000002	3/15/11	12/15/11
4730434	0000003	1/15/11	7/15/11



MGH Providers eligible for QI Program

MD Name	MD Bucket
Rao	Primary Care
Weilburg	Psychiatry
Weil	Primary Care

Records must meet MGH MRN and MGH Provider criteria for analysis

BCBS MemID	MGH MRN	Eligible Start	Eligible End	Type	Procedure Name	Resource Area	Date of Service	Allowed Amount	MD Name	MD Bucket
1235290	0000001	1/15/11	12/15/11	IP	Subsequent Hospital Care	Inpatient Services	4/1/11	$150	Rao	Primary Care
1235290	0000001	1/15/11	12/15/11	OP	Office/Outpatient Visit	Visits	2/7/11	$230	Weilburg	Psychiatry
5903720	0000002	3/15/11	12/15/11	OP	Emergency Dept Visit	ED Visits	7/30/11	$160	Weil	Primary Care
4730434	0000003	1/15/11	7/15/11	OP	Flu Vaccine, 3 Yrs & >	Immunizations	1/9/11	$15	Rao	Primary Care

Resource Areas defined by trend team

Costs, Utilization and PMPM are summarized by QI Bucket and Resource Area

QI Bucket	Resource Area							
	Inpatient Services	Visits	ED Visits	Immunizations	Ambulatory Procedures	. . .		
Primary Care	$ X	$ Y	$ Z					
Psychiatry								

Data on utilization and costs

Orthopaedic Surgery			
MGPO 2011 Procedures Or Events	Utililtzation	% Of Dept. PMPM Cost	$ PMPM
Ambulatory Procedures	**1570**	**52.35%**	**$2.94**
29881 - KNEE ARTHROSCOPY/SURGERY	81	5.35%	[illegible]
29827 - ARTHROSCOP ROTATOR CUFF REPR	48	5.09%	[illegible]
29999 - ARTHROSCOPY OF JOINT	35	3.10%	[illegible]
29826 - SHOULDER ARTHROSCOPY/SURGERY	68	2.67%	[illegible]
29880 - KNEE ARTHROSCOPY/SURGERY	34	2.42%	[illegible]
20610 - DRAIN/INJECT, JOINT/BURSA	251	2.00%	[illegible]
29823 - SHOULDER ARTHROSCOPY/SURGERY	61	1.93%	[illegible]
64721 - CARPAL TUNNEL SURGERY	42	1.75%	[illegible]0.10
29888 - KNEE ARTHROSCOPY/SURGERY	16	1.68%	$0.09
Other	934	26.36%	$1.48
Visits	**2777**	**23.59%**	**$1.33**
[illegible]CE/OUTPATIENT VISIT, NEW	777	8.05%	$0.45
[illegible]CE/OUTPATIENT VISIT, EST	980	6.65%	$0.37
[illegible]CE/OUTPATIENT VISIT, NEW	157	2.58%	$0.15
[illegible]CE/OUTPATIENT VISIT, EST	194	1.98%	$0.11
[illegible] OFFICE/OUTPATIENT VISIT, NEW	206	1.54%	$0.09
992[illegible]FFICE/OUTPATIENT VISIT, EST	380	1.53%	$0.09
Other	83	1.25%	$0.07
Inpatient Services	**243**	**21.76%**	[illegible]
27130 - TOTAL HIP ARTHROPLASTY	35	5.25%	[illegible]
27447 - TOTAL KNEE ARTHROPLASTY	32	5.01%	[illegible]
23472 - RECONSTRUCT SHOULDER JOINT	7	1.02%	[illegible]
Other	169	10.48%	[illegible]
Pharmacy	**551**	**2.10%**	[illegible]
Opioid Agonists	131	0.52%	[illegible]
Viscosupplements	11	0.47%	[illegible]
Throat Products - Misc.	10	0.27%	[illegible]
Nonsteroidal Anti-inflammatory Agents (NSAIDs)	96	0.24%	[illegible]
Other	303	0.60%	$0.03
Medical Benefit Pharmacy	**392**	**0.19%**	**$0.01**
J3301 - TRIAMCINOLONE ACET INJ NOS	278	0.07%	$0.00
J7324 - ORTHOVISC INJ PER DOSE	4	0.05%	$0.00

"Looks like only way to save $ is to not operate."

"Can I see this by condition?"

"Would be great to see variation by physician by condition."

Imaging variation report example

Imaging Variation

For MGH EVERETT FAMILY CARE

Imaging Orders From: Jan 1, 2011 To: Dec 31, 2011

Provider	Modeled Patients	Observed Exams	Expected Exams	O/E Ratio	Tendency to Image	Intercept p value
	307	83	67	1.23	0.1066	<0.0001
	158	36	26	1.41	0.06165	0.0551
	419	44	63	0.70	-0.03055	0.2017
	498	70	98	0.71	-0.00012	0.996
	715	177	108	1.64	0.09812	<0.0001
	932	141	155	0.91	0.01009	0.6011
	373	50	67	0.74	-0.00555	0.8228
	355	22	57	0.38	-0.06618	0.0085

Color Key:

- Significantly lower intercept than the practice mean
- Not significantly different from the practice mean
- Significantly higher intercept than the practice mean

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Run Date: Nov 14, 2012

2011 Loyalty Cohort, Outpatient CT/MR/Nuc Imaging Performed in 2011. Observed / Expected With Hierarchical Provider Intercept, p-value Delivered Via IPORT And Email

Reports requested: Data by episode and department

	Episodes							
Departments	AMI	CABG	Breast Cancer	Diabetes	Trauma	Screening	Other	Total
Cardiology	$$$	$$$	$$$	$$$	$$$	$$$	$$$	$$$
Endocrinology	$$$	$$$	$$$	$$$	$$$	$$$	$$$	$$$
Surgery	$$$	$$$	$$$	$$$	$$$	$$$	$$$	$$$
Psychiatry	$$$	$$$	$$$	$$$	$$$	$$$	$$$	$$$
Physical Med/Rehab	$$$	$$$	$$$	$$$	$$$	$$$	$$$	$$$
Primary Care	$$$	$$$	$$$	$$$	$$$	$$$	$$$	$$$
Hematology Oncology	$$$	$$$	$$$	$$$	$$$	$$$	$$$	$$$
Radiology	$$$	$$$	$$$	$$$	$$$	$$$	$$$	$$$
Emergency Medicine	$$$	$$$	$$$	$$$	$$$	$$$	$$$	$$$
Other	$$$	$$$	$$$	$$$	$$$	$$$	$$$	$$$
Total	$$$	$$$	$$$	$$$	$$$	$$$	$$$	$$$

Current Data

What Depts Want

Potential Targets

Discussion questions

We asked each group to respond to the following questions:

1. Identify patient populations or episodes in which you believe there are opportunities to reduce overall costs of care without affecting quality or patient experience?

2. Across populations, specific resource areas where you think there is over is overuse or misuse?

3. For those populations or resource areas, what tactics should be deployed to improve efficiency? Which tactics can be employed internally within your department or collaboratively with other departments? (Short or long intervals?)

4. What do you need to move forward with these tactics?

Breakout Session #1- Dashboards for medical expense trend

- Instructions:
  - Break into small groups and discuss how you would develop and implement a similar cost and utilization report at your institution.
  - The handout will provide guidance and focused questions to consider.
  - Identify a team member to report back to the group a brief summary of your approach, methods, anticipated challenges.

Original plan vs actual implementation

Original Plan	What Actually Happened
Show **data** on cost and utilization for all resource areas for past 2 yrs with trend goals	•Data not great – unexpected limitations •Data wasn't a driver for planning/unable to produce specific trend reduction goals across all departments
Identify opportunities to reduce cost standardized medical expense, based on priorities identified in data	1) Many groups didn't need data to generate ideas 2) Many interested in collaboration with other groups 3) Desire for condition/population specific data
Create QI Measure to address 2% reduction in CSME	•Most interventions at system level not MD level •Not developed enough for QI measure •Insufficient data for fair measurement

Department-specific summary for Pathology

Current Initiatives	-Inpatient lab ordering initiative -Ambulatory order sets (e.g. celiac screening)
Specific Populations	High Risk: Cancer Low Risk: Cervical cancer screening, routine labs
Relevant Resource Areas	Labs, biopsies
Variation Report Topics	PCP practice variation lab ordering
Potential Tactics: Internal	-Ordering of additional stains/studies on biopsies -Improved communication with referring physicians
Potential Tactics: External	-Pre-operative testing -Feedback reports to PCPs re: lab ordering and appropriateness -Standard protocol and procedures reflective of clinical guidelines developed for specific conditions (e.g. paps, PSA, HPV, celiac) -Create policy addressing duplicate readings/billings from BWH pathologists;
Potential: QI Measure	Appropriateness guidelines
Potential Targets	Lab testing variation and spending per patient
Potential Collaborations	Primary Care, Surgery, BWH, Derm, GI
Best Practices/Other Areas to Consider	None identified

Emergency Department : Chiefs Plan to Reduce Medical Expense Trend

Emergency Department
Chiefs Plan to Reduce Medical Expense Trend
Due: November 15th, 2012

Background: As of 2012, MGH entered new contracts (commercial insurers and Medicare ACO) that include measures focused on reducing the rate of rise in total per capita medical expense. To assist with this goal, the MGPO has asked all departments to identify opportunities to curb medical expense trend without affecting quality, safety, or patient experience. A plan for each department is due by November 15, 2012.

Below is a plan for reducing per capita spending for **Department of Emergency**.

1. Summary of Current/On-going Efforts:

- Creation of a new 18-bed Short Stay Unit for observation patients. This is in addition to the existing 14-bed ED Observation Unit on Bigelow 12, which increases our observation bed capacity to a total of 32 beds.
- Collaborative effort between the Emergency Department and Partners Continuing Care to reduce unnecessary ED visits for PCC patients
- ED length of stay reduction efforts, specifically in:
  - Screening process redesign
  - Pedi ED process redesign
  - Admission handoff (with the Department of Medicine)
- Multidisciplinary project to reduce ED utilization from our Multiple Visit Patients ("frequent flyers") through improved care management pathway coordination
- Creating decision support for CT for low risk pulmonary embolism
- Creating decision support for CT for mild traumatic head injuries

2. Target Populations:

- High Risk: observation patients who rule in for serious conditions (STEMI, stroke)
- Low Risk: correctly identified low risk PE and head injury patients

3. Relevant Resource Areas:

- Imaging
- Observation units and associated support services (Case Management, Pharmacy, timely imaging services, physical therapy)
- Information Resources (for Multiple Visit Patient care pathways)

4. Identified Collaborations

- Partners Continuing Care
- Department of Medicine
- Pediatrics

5. Potential New Tactics

Internal (within dept)

- Direct to Observation ("DTO") for certain defined conditions, such as chest pain and presumed TIA

External (to dept/system integration)

- TIA protocol w Lee Schwamm
- PCC protocols development for long term care patients

6. What do you need to move forward with these tactics?

- Dedicated project management support
- Process redesign support
- Possible IT/EDIS programming
- Full ramp up of Short Stay Unit staffing and approval of outstanding budget requests

7. Please identify the key initiative (either existing or new) that you plan to focus on the most over the next year.

- Full ramp up of Bigelow 7 Short Stay Unit

8. What is a potential process or outcome measure we could use to track your success? Is there a possible MGPO Quality Incentive measure to engage physicians in this work?

- LOS reduction for discharged patients from the ED. This could be incorporated into a possible MGPO quality metric
- Reduction in the number of patients admitted as inpatients from the ED and who stay only 24 to 48 hours

9. Contact Person: *(Please identify one person to be key representative and report on progress)*

Name: Robert Seger
Email: rseger@partners.org
Title: Executive Director, Emergency Services and Emergency Preparedness

Target populations

High Risk Cost Populations	Low Risk Cost Populations
•Cancer –GYN –Skin –Pancreatic –Colon -Melanoma -Breast -Lymphoma •Critical Care •ALS •Diabetes •HTN •COPD •Patients discharged from psych hospital	•Acne •Warts •UTI •Pneumonia •TIA •Acute appendicitis •Normal vaginal delivery •Cervical Cancer screening •Celiac disease screening •General surgery •Hematuria

Summary of tactics proposed by department

	Care Redesign Initiative, PHS/MGH *	Variation MD-level Reporting	Referral Management	Pre-Op Planning Testing	Standardize Care	Clinical Collaboration	Visits Ambulatory	Site of Care	Patient Engagement	Hospital Admits/Readmissions	OR Efficiency	Imaging	Procedures/Appropriateness	Labs	Pharmacy	ED
Anesthesia	●			●	●			●			●	●		●		
Dermatology		●	●		●	●	●		●					●	●	
Emergency Services		●			●	●		●		●		●				●
Neurology Service	●								●			●	●			
Neurosurgery Service		●		●		●	●			●		●				●
Medicine	● 4		● 1		● 1					● 3			● 4	● 1	● 3	
OB GYN Service	●						●	●		●				●	●	
Oral and Maxillofacial Surgery			●		●		●	●			●	●				
Orthopaedic Surgery	●		●			●		●	●			●	●			
Pediatrics								●							●	●
Pathology		●				●							●	●	●	
Psychiatry		●					●									●
Radiology			●		●							●				
Surgery	●	●		●				●		●	●	●	●		●	
Urology Service			●		●						●		●			●

*Will continue Care Redesign already in progress
Medicine includes the number of sub-divisions for each tactic

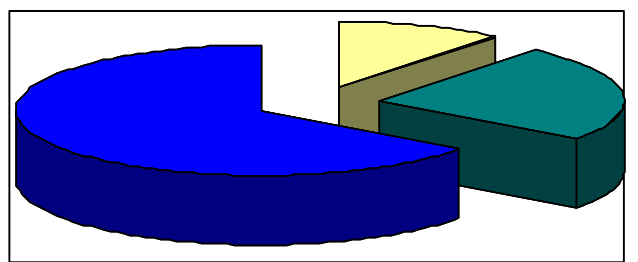
Quality Incentive Program

- **1,700 eligible physicians**
  - Clinically active, non-trainees
  - In at least 2 major managed care contracts
  - Grouped into 3 RVU-based tiers
  - Includes hospital-based and MGPO MDs

- **Incentive payments total $6.5 million/year (~1.5% NPSR)**
  - Started with a bonus check in December 2006
  - Since then, 2 terms, 2 incentive payments per year (July & December)
  - Max of $5,000 per MD per year
  - Plan to pay out ~80% of funds each term

- **3 quality measures per term**
  - 2 are system measures & apply to all docs
  - 1 is chosen by the clinical department in consultation with the QI Program
  - Measurement can be individual, practice group, department or hospital-wide
  - ~140 different measures have been used to date

Eligibility Distribution



Tier 1 ($500)	Tier 2 ($1250)	Tier 3 ($2500)
50-250	250-750	750+
RVUs over 6 months		

Examples of department measures

Care Effectiveness.

- Perioperative antibiotics
- ACE/ARB for CHF and AMI patients at discharge
- Antibiotics to pneumonia patients
- Normothermia in the OR
- Inpatient stroke standards
- Antibiotics at Cesarean delivery
- Complete transition to OPPE
- Psychiatric global assessment of functioning

Coordination/Continuity of Care.

- Pediatric head injury discharge instructions
- Required discharge summary elements
- EMR/operative note timeliness
- Dermatologic pathology report follow-up
- Radiology/pathology report timeliness

Safety.

- MD hand hygiene compliance
- E-prescribing
- Admission note timeliness
- Dating peripheral IVs
- Use of patient identifiers
- Safety reporting
- Surgical handoff policy
- Electronic pathology report sign-out

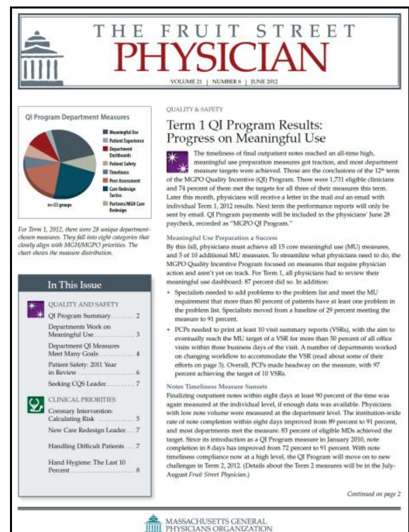
Efficiency.

- PCP list review
- Reduced "red" rate for ROE orders
- Cross cultural training
- Deploy anesthesia charting system
- Structured problem list

These have applied to entire departments or smaller groups of physicians within a department.

Incentives coupled with clear communication

- The *Fruit Street Physician* newsletter announces measures for the term and performance results
- 20-30 emails are sent each term (to explain and remind MDs) and have a high open rate
- The MGPO website has all program details – MDs can see their own performance and that of the group
- Each term a personal results letter/email shows performance



THE FRUIT STREET PHYSICIAN

VOLUME 21 | NUMBER 6 | JUNE 2012

QI Program Department Measures

For Term 1, 2012, there were 28 unique department-chosen measures. They fall into eight categories that closely align with MGH/MGPO priorities. The chart shows the measure distribution.

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QUALITY & SAFETY

Term 1 QI Program Results: Progress on Meaningful Use

The timeliness of final outpatient notes reached an all-time high, meaningful use preparation measures got traction, and most department measure targets were achieved. Those are the conclusions of the 12th term of the MGPO Quality Incentive (QI) Program. There were 1,731 eligible clinicians and 74 percent of them met the targets for all three of their measures this term. Later this month, physicians will receive a letter in the mail and an email with individual Term 1, 2012 results. Next term the performance reports will only be sent by email. QI Program payments will be included in the physicians' June 28 paycheck, recorded as "MGPO QI Program."

Meaningful Use Preparation a Success

By this fall, physicians must achieve all 15 core meaningful use (MU) measures, and 5 of 10 additional MU measures. To streamline what physicians need to do, the MGPO Quality Incentive Program focused on measures that require physician action and aren't yet on track. For Term 1, all physicians had to review their meaningful use dashboard: 87 percent did so. In addition:

- Specialists needed to add problems to the problem list and meet the MU requirement that more than 80 percent of patients have at least one problem in the problem list. Specialists moved from a baseline of 29 percent meeting the measure to 91 percent.
- PCPs needed to print at least 10 visit summary reports (VSRs), with the aim to eventually reach the MU target of a VSR for more than 50 percent of all office visits within three business days of the visit. A number of departments worked on changing workflow to accommodate the VSR (read about some of their efforts on page 3). Overall, PCPs made headway on the measure, with 97 percent achieving the target of 10 VSRs.

Notes Timeliness Measure Sunsets

Finalizing outpatient notes within eight days at least 90 percent of the time was again measured at the individual level, if enough data was available. Physicians with low note volume were measured at the department level. The institution-wide rate of note completion within eight days improved from 89 percent to 91 percent, and most departments met the measure. 83 percent of eligible MDs achieved the target. Since its introduction as a QI Program measure in January 2010, note completion in 8 days has improved from 72 percent to 91 percent. With note timeliness compliance now at a high level, the QI Program will move on to new challenges in Term 2, 2012. (Details about the Term 2 measures will be in the July-August *Fruit Street Physician*.)

Continued on page 2

MASSACHUSETTS GENERAL PHYSICIANS ORGANIZATION

Newsletter announces results at term end

You Are Currently Not Meeting the Visit Summary Report Target (PCP)

There is still time to improve on the MGPO Quality Incentive (QI) Program, Term 2, 2012, meaningful use preparation measure for primary care physicians (PCPs): Provide a visit summary report (VSR) to patients within three business days for 50% of patients.

Based on your July meaningful use dashboard, our records show that you have not yet reached the target of 50 percent. Remember that any staff person in your office can provide the VSR to the patient. Please note, that if you have worked to improve your performance in the last week or so, your efforts will not yet be reflected due to the dashboard data lag. The MGPO will alert physicians by email when the dashboard has been updated.

To track your progress, go to the meaningful use dashboard. Clicking on the measure will give you more information on what needs work.
For more information about VSRs, click here.
For Oncall user information, click here.

For additional meaningful use resources and steps to improve your results, click here. For questions, go to the MGPO QI website, or send an email to the QI Program mailbox.

Sample email to low performer

What are other ways to engage specialists?

Goals

Collaboration vs. Accountability

Actionable vs. Results (e.g process vs. outcome)

Low Risk

High risk

Individual Accountability

	Example	Individual	Practice	Division	Dept	Hospital
Bonus for process measure	*Follow-up discharge calls*					
Bonus for outcome measure	*ED visits /1000*					
% of compensation on value based process/outcome measure	*20% of comp contingent on efficiency measures*					
Sub cap or bundle payment	*Rate per surgery*					
Capitation/shared savings	*AQC*					

Breakout Session #2-Designing physician incentives

- Instructions:
  - Break into small groups and discuss approaches to engaging physicians and senior leadership using the following questions:

    1. How are you currently structuring incentives for your specialists?
    2. Which approach would you choose? What are advantages/disadvantages?
    3. How would you engage physicians and senior leadership? What are some anticipated challenges or barriers? How would you overcome these?
    4. Any key learnings from your group?

Wrap up

- Key points
  - Data is important, but not critical → if you pursue, data driven strategy: physician-level condition-specific variation
  - Engaging physicians is a journey
    Awareness → Accountability