

**Provider Measurement of Small Medical Practices
GMBFH Small Medical Practice Pilot Project**

The Small Medical Practice Pilot Project is a community initiative of the Greater Milwaukee Business Foundation on Health conducted by the Wisconsin Collaborative for Healthcare Quality (WCHQ) and the Wisconsin Medical Society.

The project was designed to determine the feasibility of applying the current measurement methodology of an organization such as WCHQ to practices with less than 20 physicians and identify the role of various stakeholders in obtaining data for calculating the measures, in support of the broader objective of increasing the participation of small physician practices in performance measurement and improvement.

The project concluded successfully in 2007 and included eight family and internal medicine practices located in southeastern Wisconsin. The research results are playing a key role in shaping the Wisconsin Collaborative for Healthcare Quality's strategy to engage small medical practices in quality measurement and improvement.

Small Medical Practice Pilot Project – Final Report

Introduction

The goals of the Greater Milwaukee Business Foundation on Health (GMBFH) Small Medical Practice Pilot Project were to determine the feasibility of applying the current measurement methodology of an organization such as the Wisconsin Collaborative for Healthcare Quality (WCHQ) to small medical practices and identify the role of various stakeholders in obtaining the data for calculating the measures.

This operating activity was selected based on the previous activities of WCHQ (Appendix 1) to identify small medical practices interested in learning about performance measurement. Specifically, this project involved the design and implementation of a strategy to learn the unique challenges and benefits of collecting, reporting, and using comparative performance information within the small practice setting. Ultimately, the goal was that the project will lead to increased engagement by small medical practices in the activity of performance measurement by organizations such as WCHQ or others.

Implementation

Summary

GMBFH contracted with WCHQ, to represent GMBFH in its interaction with the provider community. WCHQ subsequently partnered with the Wisconsin Medical Society for management of the project.

The objectives were to:

- Determine the ability of small practices to apply the WCHQ performance measurement methodology for blood sugar control and breast cancer screening.
- Identify the small practice team member roles in obtaining the performance measurement data.
- Identify the managerial and technical resources required for small medical practices to report performance measures such as that of WCHQ.
- Identify the unique challenges and benefits of collecting, reporting and using comparative performance data in a small practice setting.
- Identify opportunities for quality improvement activities designed to enhance clinical performance.
- Based on the pilot study findings, develop a possible business model to sustain and expand the engagement of small practices with organizations such as WCHQ.

Participants

Study participants included 11 family and internal medicine practices located in southeastern Wisconsin -- each with 1 to 18 physicians. Between April 20 and May 15, 2007, 10 practices received a one-on-one orientation to the WCHQ quality measure specifications and the processes for data collection and reporting. Following the initial face-to-face meeting, 2 practices declined further participation. One group declined because they were without a Medical Director and a Business Manager during the proposed measurement period. Another group declined because they felt the study objectives may be different than the objectives for their patient population, elderly patients with multiple medical problems toward the end of life. Eight practices agreed to implement a methodology used by WCHQ on 3 quality measures and report their results.

Key Finding - Feasibility

Seven of the 8 identified practices participated in the study and collected and reported at least two of the 3 outcome measures. One practice was unable to participate due to lack of time and technical support.

Four out of seven participants collected and reported their data independently, while the other three groups accepted help from the project staff. Among the groups accepting assistance, one out of 3 needed help harvesting the denominator and all

3 groups needed help abstracting the numerator. One out of four groups collecting the data independently had 2 students complete the work.

Unaudited Results

A1c Screening	
2 or more tests (N=6 groups)	46.9% - 74.9%
1 or more test (N=7groups)	70.9% - 97.7%
No test	1.2% - 11.6%
A1c Control	
Good (A1c < 7.0%)	32.7% - 53.9%
Fair to Poor (7.0% ≤ A1c ≤ 9.0%)	32.8% - 46.3%
Uncontrolled (A1c > 9.0%)	8.0% - 22.1%
No Test	1.2% - 11.6%
Breast Cancer Screening	
At least 1 mammogram in 24 months	16.3% - 100%

Key Finding - Denominator Challenges

An early misperception was that the small medical practice pilot was a prospective study. Several groups assumed they would collect the data on patients as they were seen in the practice.

Selecting 'eligible' patients for inclusion in the denominator is dependent on identifying patients:

- 1) with the disease or condition
- 2) managed by the physician group
- 3) currently 'in the system'

An initial challenge for practices that had never done performance measurement was to help them understand that manual identification of patients meeting study inclusion criteria was not required. The expectation was to query claims databases electronically. This was a technical challenge for some practices that lacked computer skills, technical support or were limited by what their practice management systems could be programmed to do.

It appeared to take all of the groups a number of iterations to interpret the specifications used by WCHQ and apply them. This was no reflection on the measure specifications. Three of the groups with experience in performance measurement commented how well the specifications were written. However, practices missed details in applying the specifications. Related to the denominator, one practice applied a more current measurement period (August 1, 2006 – July 31, 2007 rather than July 1, 2005 – June 30, 2006). We did not check the other specifications (e.g. age, diagnosis and procedure code inclusions) to determine if they were correctly interpreted and applied.

Of particular interest is our finding that criterion number 2 could be eliminated for small practices and still have a comparable denominator.

Key Finding - Numerator Challenges

There were subtle challenges in how the groups collected and reported the numerator data. On the A1c measure, the numerator descriptions asked for 'not tested', 'only one A1c test' and 'two or more A1c tests'. Two groups reported patients with 'no test' or 'one or more tests'. One of the groups was able to

provide the correct data while a second group was unable to break down 'one or more tests' into 'only one test' and 'two or more tests'.

One group also had difficulty applying the specifications when it came to reporting the 'most recent' A1c value. They reported all of the A1c values for the entire measurement period. The same group reported a breast cancer screening rate of 100% which appeared to be an outlier when compared to both small and large practice results. It is questionable whether they interpreted the specifications correctly as they also had difficulties on both of the diabetes measures.

Key Finding - Small Practice Team Member Roles

A variety of clinic staff assisted with data collection and reporting including office managers, Medical Directors, IT staff and one Diabetes Program Manager. Four of the practices had Medical Directors interested in IT, and 3 out of 4 of those practices had IT staff that worked on the project. In the other 4 practices, the office manager was solely responsible for the project with one in four having contracted IT support that assisted with data collection.

Key Finding – Managerial and Technical Resources Required for Measurement Calculation

One project manager worked with 10 practices, which was sufficient. However, small practices required more one-on-one resources than (larger practices). The project manager convened three teleconferences (May 21, June 29 and July 12, 2007) to facilitate shared learning across groups. These teleconferences were poorly attended, and the learning community concept failed. It is unclear if the reasons are due to the culture of small groups who are 'used to figuring it out by themselves', a lack of time or other reasons. One issue that emerged was lack of access to the Internet. One practice told us they had only one computer in the practice with Internet access to prevent employees from surfing the web on work time. The Internet was not used routinely to communicate with the practices or with the Project Manager. When the Internet communication and teleconference support strategy failed, the Project Manager phoned each group weekly to inquire about the group's progress and to provide assistance as needed.

Related to technical resources, half of the practices did not have IT staff on site and one practice did not have any IT support. Practices had difficulty querying their claims data due to the limitations of their practice management software. Seven out of eight practices did manual review for at least a portion of the data collection. We estimated it took 8-17 hours per physician to collect numerator and some denominator data for the three performance measures.

Key Finding —Opportunities for Quality Improvement Activities

The WCHQ methodology identifies patients representing those who are cared for by the physician group. The methodology does not include 'frequent flyer' patients or those who seek care infrequently. This was less of an issue for the small practice physicians than (larger practices). When long-standing patients with diabetes were excluded from the denominator because they did not have either a recent office visit or did not have 2 visits during the specified time period, small practice clinicians immediately noticed that those patients were excluded from the denominator.

One unique benefit of a small practice is how quickly a Medical Director can respond to gaps in quality. One practice learned their quality scores were affected by not having A1c results for patients who were managed by endocrinologists. They identified an opportunity to improve their performance by obtaining information from the specialists who manage patients receiving primary care from the small practice.

Another practice learned that women were much more likely to receive a breast cancer screening if they received a referral. They planned to increase their referrals and explore the evidence on whether making appointments when women are in the clinic had been shown to increase breast cancer screening rates.

Summary Lessons Learned

1. In general, an office manager's skill set is not the right match for the activities associated with performance measurement calculation. This may create an opportunity for WCHQ and others to offer consultative performance measurement services when 'the right person/people' are not present in a small practice.
2. The lack of 'in-house' or contracted technical support was a significant impediment ("deal breaker") in terms of a practice's ability to successfully participate in the project.
3. Many small practices may have limited access to the Internet. This presents some important challenges to the use of "virtual" methods for communication and coordination of tasks (as an example, office managers prefer fax correspondence to emails).
4. The learning community experience via group teleconference was not embraced by this group of participants. Further research is required to determine if this is a characteristic of small office practices or if it is idiosyncratic to this group.
5. Whereas large integrated group practices may be able to access hospital, laboratory and other electronic data, small practices may not have access to specialist information (e.g. A1c values when a patient is managed by an endocrinologist). These missing data may affect the physician's performance score. If a small practice physician would be penalized for not having those data, it may be easier to order an A1c when seeing the patient creating an unintended consequence of duplicating laboratory tests.
6. In general, the measurement specifications used by WCHQ were found to be applicable and accessible within the small practice setting. However, the denominator specifications could be simplified for use by small practices.

Implications for Engaging Small Practices

One of the primary objectives of this study was to understand the unique characteristics of small physician offices so as to assist organizations such as WCHQ and others in devising a strategy to encourage practitioners in this setting to participate in performance measurement initiatives. The anecdotal feedback gleaned from participants in a recognition/celebration dinner held at the end of the project suggests that there remain significant barriers to accomplishing this objective.

When attendees were asked their receptivity to joining organizations such as WCHQ at a reduced membership rate (the figures of \$500 or \$1000/year were used as illustrations), the response was not positive; while admittedly a small sample size, this response could suggest that small practices see performance measurement/improvement as a cost and not a benefit. The adoption by CMS of a "pay-for-reporting" incentive – similar to the approach used with hospitals – may be critical to overcoming this barrier. Other purchasers of health care (business coalitions, Medicaid, health plans, and insurers) could assist in making the "business case" for quality through similar incentives or requiring participation as a contractual obligation.

Another model might be one that relies less on membership dues and more on a "fee-for-service" approach based on the degree of technical assistance that a practice needs in order to collect data and calculate measures. While this has the advantage of keeping costs low for those offices that have the requisite technical and system support, it still requires a practice that is either intrinsically or extrinsically (i.e., incited) motivated to engage in quality. Further analysis will be required to determine the economics of providing this service.

Finally, if an organization such as WCHQ attracts an increasing number of small practices to its membership, there may be a need to modify slightly the use of its performance measurement specifications – specifically, the three question algorithm (attribution methodology) – so as to ensure

comparability of publicly reported results between large and small practices. This would have the added advantage of fully aligning such measures with the national standards as endorsed by the NQF.

Summary and Possible “Next Steps”

Seven out of ten small group practices applied the measurement methodology used by WCHQ with some challenges interpreting the specifications correctly. While efficient electronic data capture is the goal, most groups did not have confidence in being able to reliably collect numerator data due to the staggered conversion of their paper charts to electronic systems. Only one group captured all of the data electronically.

It appears the denominator methodology used by WCHQ could be simplified for small practices and still retain comparability to the large medical groups. Retrieving numerator data outside of the practice is more of a challenge for small practices and may be a system reason for the generally lower scores reported by small practices. An audit would have been helpful in understanding how well the small practices applied the required methodology and for determining how much ‘missing’ data from outside the practice affected the study results.

Based on these findings, the following represent areas for further study:

1. Expanding the number of sites to allow for more methodologically robust evaluation of the initial findings presented above, particularly as it relates to the ease/difficulty of quality measurement/improvement in practices with and those without an IT infrastructure.
2. Further experimentation with “virtual” methods of communication so as to overcome inefficiencies in sharing of “best practices” and knowledge transfer.
3. Examining the costs and benefits associated with various models for data audit and validation in the small practice setting.

Appendix 1 Wisconsin Collaborative for Healthcare Quality Small Medical Practice Pilot Project – Phase I

Over the past several years, the demand for publicly reported comparative performance information has become a major area of interest and activity for purchasers, consumers, and providers of health care services. Indeed, information on services provided by certain sectors of the health care industry – such as hospitals, long-term care facilities, and home health agencies -- has become widely available during this period of time. The reporting of information on services provided by physician groups is a more recent phenomenon, largely as a result of the efforts of pioneering groups such as the Wisconsin Collaborative for Healthcare Quality (WCHQ). Notwithstanding this progress, studies have shown that a significant percentage of physicians in the United States do not routinely receive data on their performance or use information to identify improvements in their practice, and that the lack of such use is strongly correlated with the size of the physician’s office practice (Audet, 2005). Thus, there exists a need to study the challenges and opportunities associated with performance measurement and improvement in the small office setting.

The Measures

Data on the following three measures will be collected from the practices in the pilot project:

- **Blood Sugar (A1c) Screening** - The percentage of patients 18-75 years with Type 1 and Type 2 diabetes who had an A1c laboratory test within the last twelve months.

- **Blood Sugar (A1c) Control** - The American Diabetes Association recommends an A1c < 7%. This measure shows the percentage of people with diabetes who were at optimal control, near optimal control, poor control, or were not tested in the measurement year.
- **Breast Cancer Screening** - This measurement assesses women who have had at least one mammogram within the previous 24 months.

Background and Lessons Learned

During Phase I, multiple methods were used to communicate the opportunity to small primary care medical practices. The Collaborative began by securing the active support and endorsement for this project from the Wisconsin Medical Society, Medical Society of Milwaukee County, and Medical Society of Waukesha County. The medical societies sent the project description to its members, announced the project in newsletters and in meetings, or suggested primary care practices that might participate in the project. Similarly, the Wisconsin Academy of Family Physicians mailed the description to its members in the four-county area. In addition, the Vice Presidents of Medical Affairs of the hospital systems in southeastern Wisconsin were contacted and asked to identify independent, small practices that were on the medical staff of the hospitals and / or discuss the opportunity when they could. Two IPAs were contacted about the project and asked to encourage their members to participate. Lastly, two businesses (Suby Von Haden and Kolb & Co.) that work with a large number of medical practices were also contacted and asked to forward the description to potential primary care practices.

After the project descriptions were distributed, follow-up with selected practices occurred and other practices received a phone call about the opportunity. A total of 35 to 40 practices were contacted by phone and nine follow-up meetings were held to provide more detail and answer questions about the project. The most positive responses were achieved where the President of the Medical Society of Milwaukee County sent an email with a cover letter supporting the project to specific independent practices in Milwaukee County known to have an interest in quality measurement.

Some practices were phoned directly; however, the office staff frequently would state that the physician does not participate in projects, or s/he would only return a phone call after seeing a description of the project. For many practices, it could not be determined if the physician actually saw the project description when it was faxed to the office. When interest was expressed and a face-to-face meeting could be scheduled, it was possible to describe the benefits of participation in some detail and respond directly to questions so that the practices could develop a complete understanding of the project.

The primary reasons given when practices declined to participate in the project were, one, that the information might not remain confidential (we have subsequently confirmed that the results can remain blinded) and, two, the uncertainty with regard to how their results might compare with other practices. This suggests a need to develop a compelling case that the intrinsic benefits of comparative information for purposes of quality improvement outweigh the natural concerns about public disclosure.

In addition to the communication and networking activity, a practice profile survey was developed to determine the characteristics of the practice and the methods used to record patient care information. The key contact person at the practice site was sent the survey to complete electronically after the practice made the decision to participate in the project.

In summary, the main learnings from Phase I can be summarized as follows:

1. Many physicians are unaware of the growing momentum for transparency – that is, the collection of data and the public reporting of comparative performance (both quality and cost) information;
2. The process of recruiting the small practice clinics was more effective when the project was introduced by a trusted colleague (physician) or organization (state/local medical society); and,
3. The intrinsic benefits of performance measurement are by themselves an insufficient motivation to engage in performance measurement, thus suggesting that purchasers can play a role by creating incentives for participation.

Participating Practices

We received commitments from eleven (11) small medical practices. The practice sites vary in terms of their capabilities to retrieve clinical and administrative data. Two practices maintain information completely electronically, some practices have a mix of electronic and manual information, and three practices collect information primarily manually. Practices that have agreed to participate in the project have completed the practice profile survey to provide a list of providers, visit volumes, documentation processes, billing processes, and information systems capacity. The practice profile results were used to refine the resource requirements and detailed plan to conduct Phase II of the project.

The practices are as follows:

1. Quad Med
2. Westside Healthcare Association
3. Gerald Ignace Indian Health Center
4. South Center Medical Group
5. Greendale Medical Clinic
6. Westwood Medical Group
7. Community Care Organization
8. Brian McSorley, MD
9. Kumari Chintamaneni, MD
10. Sixteenth Street Community Health Center
11. Madison Medical Affiliates

The participants in the project are enthusiastic about measuring quality and consist of a representative sample of different types of small medical practices in the community.