

# Incentive program for small practices with EHRs results in improvement in CV outcomes

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A pay-for-performance program in electronic-health-records-(EHR)-enabled small practices led to modest improvements in cardiovascular care processes and outcomes, according to a study in the September 11 issue of *JAMA*.

"Most evaluations of pay-for-performance (P4P) incentives have focused on large-group practices," according to background information in the article. Small practices, where the majority of patients still receive care nationally, historically have provided lower-quality care—especially solo practices—and may have greater obstacles to improving care because they lack the scale and organizational structure to do so. It is possible that EHR-enabled solo and small-group practices will be able to respond to P4P incentives and improve quality, but this has not been demonstrated.

Naomi S. Bardach, M.D., M.A.S., of the University of California, San Francisco, and colleagues performed a randomized trial to assess the effect of P4P incentives on quality in EHR-enabled small practices in the context of an established quality improvement initiative. The study randomized small (fewer than 10 clinicians) primary care clinics in New York City from April 2009 through March 2010 to financial incentives and quarterly performance reports or performance reports alone. A city program provided all participating clinics with the same EHR software with decision support and patient registry and quality reporting

capabilities. The program also provided on-site quality improvement specialists offering technical assistance. Incentivized clinics were paid for each patient whose care met the performance criteria, but they received higher payments for patients with co-existing illnesses, who had Medicaid insurance, or who were uninsured (maximum payments: \$200/patient; \$100,000/clinic). Quality reports were given quarterly to both the intervention and control groups.

The primary outcome measures were a comparison of between-group differences in performance improvement, from the beginning to the end of the study, between control and intervention clinics for aspirin or antithrombotic prescription, blood pressure control, cholesterol control, and smoking cessation interventions.

The researchers found that performance improved in both groups during the study, with positive changes from baseline for all measures. The adjusted change in performance was higher in the intervention than in the control group for aspirin or antithrombotic prescription for patients with diabetes or ischemic vascular disease [12.0 percent vs. 6.1 percent]; and for blood pressure control in patients with hypertension but without diabetes or ischemic vascular disease [9.7 percent vs. 4.3 percent]; and smoking cessation interventions (12.4 percent vs. 7.7 percent).

For uninsured or Medicaid (non-HMO) patients, changes in measured performance were higher in the intervention clinics than the control clinics (range of adjusted absolute differences, 7.9 percent to 12.9 percent), for all measures but cholesterol control, but the differences were not statistically significant.

"In this cluster-randomized study of P4P incentives, we found that EHR-enabled small practices were able to respond to incentives to improve [cardiovascular care](#) processes and intermediate outcomes," the authors write. "This provides evidence that, in the context of increasing uptake

of EHRs with robust clinical management tools, small practices may be able to improve their quality performance in response to an incentive."

In an accompanying editorial, Rowena J. Dolor, M.D., M.H.S., and Kevin A. Schulman, M.D., of the Duke University School of Medicine, Durham, N.C., comment on the two randomized trials in this issue of *JAMA* (Bardach et al; Petersen et al) that report the comparative effectiveness of [financial incentives](#) in primary care settings.

"Even though the findings of these 2 studies are encouraging in advancing understanding of the P4P strategy, the reports also raise questions about the solitary focus on clinician performance in achieving these population health goals. Both studies suggest that even with elegant incentives applied at the practice level, gaps in clinical performance still remain. These results suggest that although there is some room for improvement of individual performance, these gaps represent systematic shortcomings rather than an issue with performance at the individual clinician level."

"In a population health model, a variety of strategies is used to achieve success. Some of these strategies would be clinician focused, some technology focused, some community focused, and some patient focused. The appropriate allocation of resources to each of these strategies would be based on economic analysis—how to gain the greatest increase in population health from optimizing interactions across all of these efforts. This type of framework transforms the question from the effectiveness of primary care practice to the effectiveness of primary care service embedded in a community."

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