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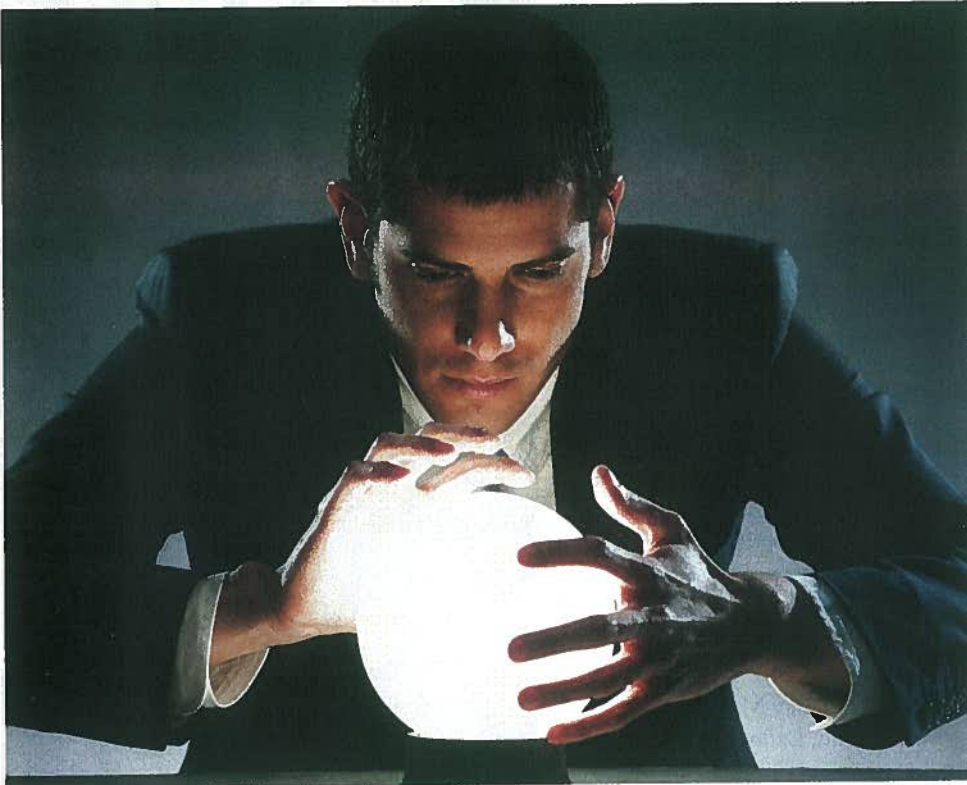
The Sharp Experience: A Journey to Healthcare Excellence

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Envisioning the Quality-Focused Practice of the Future

BY RICHARD GLIKLICH, M.D.



With the recent flurry of political initiatives and legislation surrounding evidence-based medicine and outcomes-based reimbursement, a reform movement has begun to take shape. Although it is being expressed through different models, including accountable care organizations, performance-based care coordination, payment bundling, patient-centered medical homes, and gainsharing, they all touch on the same underlying theme behind all the proposed legislation—improving quality and reducing costs. Elements could be taken from each model to create what politicians are envisioning as the practice of the future.

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The successful practice of the future is emerging as an organization that is focused on quality and measures results across the care continuum from inpatient to outpatient. This organization will be held accountable for demonstrating quality as a requirement for reimbursement for certain procedures

and services, and for collecting, tracking, and reporting outcomes data as a routine part of practicing medicine—leading to an outcomes-based healthcare system. Healthcare policy experts, economists, and many federal and state government officials now believe that an outcomes-based healthcare system, as opposed to a services-based system, will reduce the number of medical errors, infections, re-hospitalizations, etc., and cumulatively reduce the overall amount of government spending on health care.

Despite pushback arising from different stakeholder groups at different times, through investments in technology, research, and other tools, there have been slow but purposeful steps towards a performance-based system. A key question is no longer whether outcomes data will be important in the future, but how practices and health systems can best prepare to be successful as the paradigm shifts.

Investing in Health Care

In February 2009, The American Recovery and Reinvestment Act of 2009 (ARRA) was enacted to serve as a stimulus to the American economy. The act included elements of healthcare reform and an investment of \$147.7 billion in Medicaid, health insurance subsidies, health information technology, health research institutes, prevention and wellness, effectiveness research on healthcare treatments (comparative effectiveness research, also known as patient-centered outcomes research), and more.

ARRA placed emphasis on three key ingredients for a healthcare system based on measuring and rewarding quality: digitization (through electronic health records); payment reform through the strongest association of payment (initially EHR meaningful use payments) with concrete acts to improve quality; and specific funding for comparative effectiveness research (presumably as a prelude to reducing payments for care that is not proven effective). Under ARRA, the largest allocation of resources is for healthcare technology, namely electronic health records (EHRs), as a tool for reducing clinical and administrative errors, linking the inpatient and outpatient realm, and measuring and improving quality of care through integration with other quality improvement programs. As part of this emphasis, ARRA stipulated incentive payments to practices and hospitals for implementing and using EHRs and eventually penalties for those that do not.


In October 2009, the Senate Finance Committee released its healthcare reform bill, America's Healthy Future Act. The act proposed additions to ARRA, including extending the Centers for Medicaid and Medicare Services (CMS) Physician Quality Reporting Initiative (PQRI) incentive payments beyond 2010, implementing a payment penalty for those practitioners who do not report successfully beginning in 2012, and requiring the CMS to integrate PQRI with the standards for meaningful use of certified EHRs (established in ARRA).

The America's Healthy Future Act also proposed the creation of a Patient-Centered Outcomes Research center, which would "assist patients, clinicians, purchasers, and policy makers in making informed health decisions by advancing the quality and relevance of clinical evidence through research and evidence

synthesis ... focus on the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed, and would consider variations in patient subpopulations."

Paying for Reporting and Performance

Pay for performance (P4P) is not a new concept and it has had a somewhat mixed history of success. Some initially dramatic results, such as the general practitioner program in the United Kingdom, are generally associated with the largest at-risk payments. In the past couple of years, more of these programs have been surfacing in the hopes of encouraging physicians to provide improved care. Individual states are increasingly creating their own P4P programs as well. For example, in 2008, Massachusetts implemented the MassHealth Hospital Pay-for-Performance initiative, which has



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set aside more than \$20 million in incentives for Medicaid discharges at Massachusetts hospitals that participate and meet the criteria.

Unlike other initiatives that focus either solely on hospital or ambulatory care, the CMS PQRI crosses the care continuum and affects any provider who sees Medicare patients. PQRI was started with the 2006 Tax Relief and Health Care Act. Today, the program has evolved to include 179 individual quality measures and 13 measures groups. PQRI provides an incentive payment of 2 percent of Medicare Part B billings for reporting on three individual quality measures for at least 80 percent of patients or 30 patients for a defined measures group.

Currently, the program functions as a pay-for-reporting program, as incentive payments are determined solely by meeting the reporting requirements (i.e., correct number of patients entered, reporting on all

measures in a measures group, etc.). CMS's goal over the next couple of years is to shift the program to a P4P program, implement a payment penalty for providers who do not meet the requirements, and require participation in the program as an eligibility criterion for Medicare reimbursement.

PQRI is only a stepping stone towards an outcomes-based performance measurement system.

PQRI can be reported concurrently with claims or through a qualified registry (data collection can take place retrospectively or prospectively). In 2010, there is an option to report a limited subset of measures through a qualified EHR. CMS recently announced its intention to

further modify the program going forward and is testing additional methods for such reporting including through group practices.

PQRI has had several challenges in generating participation, ranging from apathy (too little at stake) to problems with the claims reporting approach (leading to nonpayment of many physicians). Whether the registry approach will yield better results on the payment side is still to be determined. Regardless, what is clear is that PQRI is only a stepping stone towards an outcomes-based performance measurement system. To make substantial payments on the basis of outcomes will require a much more sophisticated performance measurement approach that brings together existing data (e.g., administrative, EHR) with carefully constructed longitudinal measures that reflect meaningful patient outcomes (e.g., patient-reported outcomes) for each condition. Such data

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will need to be carefully collected, checked for accuracy, and adjusted for risk. While it seems we are a long way from that point, much current activity is focused squarely on performance. It will not be too long before longer-term outcomes collection is part of everyday practice.

Connecting the Pieces

The most imposing challenge of this move to an outcomes-based system is the lack of infrastructure to effectively track and collect outcomes data on such a large scale. The use of patient and disease registries could be the key to connecting all of the pieces. Registries are increasingly being used by various stakeholders, including regulators and payers, to monitor safety and minimize risks of medical products; to measure and compare the effectiveness of medical products; and to measure and improve the quality of patient care.

As defined in the U.S. Agency for Healthcare Quality and Research (AHRQ) handbook, *Registries for Evaluating Patient Outcomes: A User's Guide*, a registry is "an organized system that uses observational study methods to collect uniform [clinical or other] data from and evaluate specified outcomes for a defined population, who have a particular disease, condition, or exposure to serve predetermined scientific, clinical, or policy purpose(s)." Registries focus on clinical information in actual practice and can provide a view of quality measures and performance data across diagnoses and procedures. And, as real-world data, they demonstrate how medicines are actually being prescribed and used in the practice setting, which is necessary to accurately measure outcomes.

Registries in heart disease (American Heart Association's Get with the Guidelines), cardiac surgery (Society of Thoracic Surgeons database), or general surgery (American College of Surgeons National Surgical

Quality Improvement Program) are examples of programs that focus on quality or outcomes measurement for specific disease areas. Currently, these programs are generally limited to a few major disease areas and tend to be focused in one care setting (e.g., hospital) rather than crossing between inpatient and outpatient settings as patients do. Even so, these programs and others like them can already generate useful information on quality outcomes and are poised to grow in importance over time.

In addition to the value that registries can bring on their own, they can be integrated with other registries.

In addition to the value that registries can bring on their own, they can be integrated with other registries, databases, practice management systems, and EHRs. Initiatives already underway further demonstrate this capability. For example, in 2009 the U.S. Food and Drug Administration (FDA), in an effort to compile and analyze outcomes data on orthopedic device implants, initiated a project to develop a national network of orthopedic device implant registries that it hopes will serve as an enhanced passive surveillance system.

Preparing for the Future

Outcomes-based performance measurement based on every patient in a practice is not as far off as some might think. Most of the pieces are in place or are in the process of being implemented, and the time has come for providers take notice. Practices have the opportunity to not only participate in these evolving initiatives, but also to help influence their direction. These changes will affect just about every medical group, hospital, practicing physician, and healthcare administrator in the U.S. Practices need to start thinking about adjusting workflow,

technology, and staffing for a future shift to performance and outcomes measurement.

Richard Gliklich, M.D., is president and CEO of Outcome Sciences, Inc. (d/b/a Outcome). He was principal investigator and senior editor of the landmark publication by the U.S. Agency for Healthcare Research and Quality (AHRQ), Registries for Evaluating Patient Outcomes: A User's Guide. Dr. Gliklich developed the American Heart Association's Get with the Guidelines registries in cardiovascular disease, heart failure, and stroke, which involve more than 2,500 U.S. hospitals and more than one million patients. Dr. Gliklich is also a practicing physician and a professor at Harvard Medical School.