HEALTHCARE 20/20: *LEARNING FORWARD*

Quality Improvement Workshop - Pfizer
Webinar #1
April 15, 2013

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QHC is dedicated to improving the quality and safety of health care delivery and reducing costs, utilizing the principles of the Learning Health System and the Triple Aim

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Goals and Objectives: Participants Will Be Able To:

- Define the key elements of payment and system reform
- Understand patient centered outcomes research and how it impacts new product development and payor reimbursement
- Understand the build out of the health information infrastructure today and tomorrow
- Identify the evolution of CME/CE to PICME
- Discuss potential Pfizer strategies to operationalize the transition from CME to PI

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Ten levers, or drivers, are the mechanisms by which the national priorities can be achieved:

1. Payment
2. Quality Improvement/Technical Assistance
3. Consumer Incentives and Benefit Designs
4. Health Information Technology
5. Training, Professional Certification, and Workforce and Capacity Development
6. Public Reporting
7. Certification, Accreditation, and Regulation
8. Measurement of Care Processes and Outcomes
9. Evaluation and Feedback
10. Promoting Innovation and Rapid-Cycle Learning

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Payment Reform

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"You have to expect some cutbacks with the Clinton health plan . . . "

Mike Peters

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Physician Payment Reform

- CMS-driven PQRS
- ARRA-driven Meaningful Use (MU) of HIT
- Efficiency profiling
- Multiple private sector P4P initiatives
- CMS-sponsored Physician Compare
- MOC and PQRS/MOC, Maintenance of Licensure (MOL)

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And…as CMS Aligns & Ratchets Up The Stakes

Provider Support is Not Keeping Pace…Including EMRs

Overview of Physician Programs by Year

Year	Physician Quality Reporting System + MOC Incentive	eRx Incentive Program	EHR Incentive Program	Physician Compare	Physician Feedback Quality Resource Use Reports and Episode Grouper	Value Modifier: Differential Payment Modifier Based on Quality Compared to Cost in Budget-Neutral Manner
2011	+ 1% incentive payment + 0.5% **MOC** More Frequent Incentive	+ 1.0% incentive payment (not available if receiving EHR incentive for 2011)	EHR meaningful use reporting begins Incentive payment Medicare Maximum **$44,000 over 4 years** or Maximum **$63,750** Medicaid **over 6 years**	Launch Physician Compare web site by 1/1/2011; Includes PQRS & eRx participation	Physician Feedback Reports for limited numbers of physicians as authorized by MIPPA	N/A
2012	+ 0.5% incentive payment + 0.5% **MOC** Incentive By 1/1/12 plan to integrate quality reporting EHR incentive program	+ 1.0% incentive payment -1.0% payment adjustment if not successful e-prescriber (regardless of participation in the EHR Incentive	New Medicare 2012 EHR meaningful users may still receive maximum **$44,000** over 4 years or Maximum **$63,750** Medicaid over **6 years**	1/1/2012 earliest reporting period for which performance information can be reported on Physician Compare	By 1/1/2012 develop and establish methodology for use of open source episode grouper to combine closely related items and services into episodes of care and Provide reports that compare resource use beginning 2012 based on claims data, risk-adjusted, cost standardized Coordinate with Value Modifier as appropriate	Value Modifier: Publish by 1/1/2012 measures of quality and cost, implementation dates, & initial performance period for payment modifier implemented in budget-neutral manner

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Only 20 EMR companies qualified for direct reporting for PQRS for 2012

Over 370* currently "certified"

Problem growing as hospitals buy practices…the financial loss burden is magnified

medconcert

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*According to CCHIT 05/2012

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The Emerging Reimbursement Landscape……Challenges & Opportunities

	E/RX		EMR/MU		PQRS			VBP
	E/RX	NO E/RX	EMR/MU (medicare)	NO EMR/MU	PQRS	PQRS+MOC	NO PQRS	VALUE MODIFIER
2009	2.00%	-	-	-	2.00%	-	-	-
2010	2.00%	-	-	-	2.00%	-	-	-
2011	1.00%	-	$18K	-	1.00%	1.50%	-	-
2012	1.00%	-1.00%	$12-18K	-	0.50%	1.00%	-	-
2013	0.50%	-1.50%	$8-15K	-	0.50%	1.00%	Basedon 2013 data	Basedon 2013 data
2014	-	-2.00%	$4-12K	-	0.50%	1.00%		
2015	-	-	$2-8K	-1.00%	-	-	-1.50%	TBD
2016	-	-	$2-4K	-2.00%	-	-	-2.00%	TBD
2017		-	-	-3.00%	-	-	-2.00%	TBD

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System Reform

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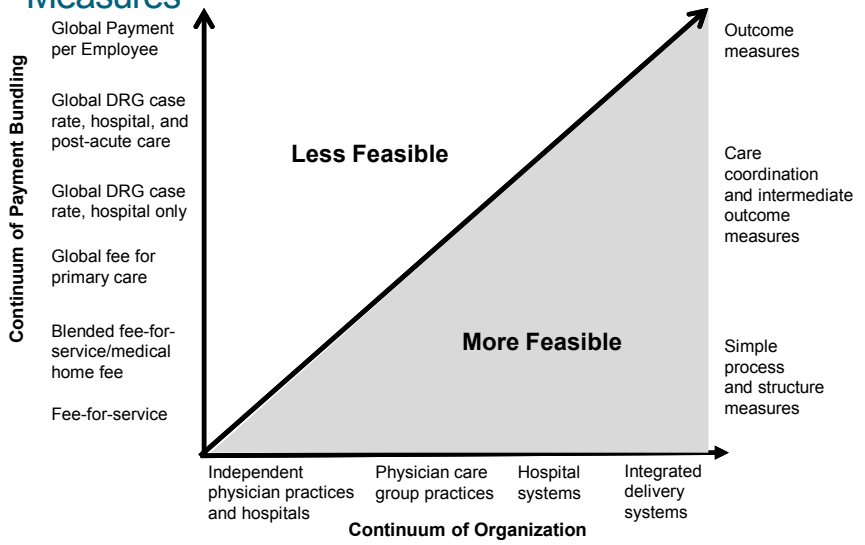
Organization and Payment: Selection of Performance Measures



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Source: Commonwealth Fund, 2009

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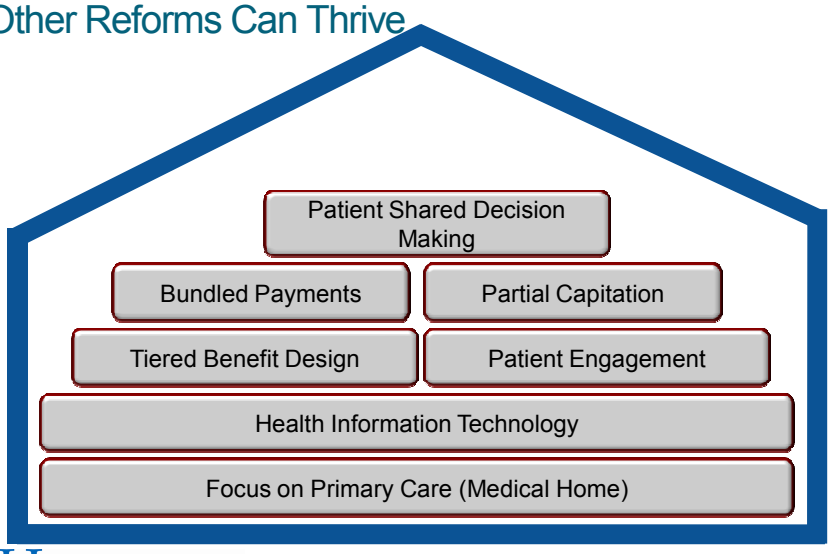
The ACO is an Overarching Structure Within Which Other Reforms Can Thrive



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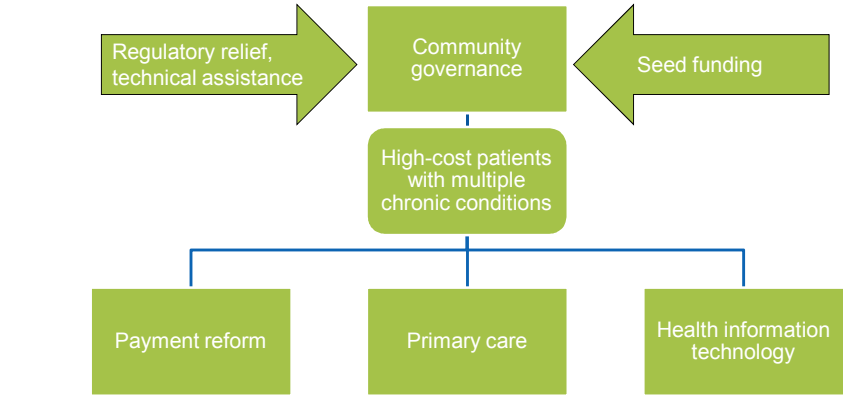
Community-Based Strategy for Improving Care of High-Cost Patients



- Medical home care management fee
- Accountable Care Organizations
- Bundled payment for acute episodes
- Partial capitation
- Shared savings and shared risks
- Gain-sharing
- Value-based purchasing
- Public–private payer harmonization

- Medical homes
- Primary care practice teams
- System of off-hours care
- Transitions in care
- Reduced readmissions
- Care coordination

- Electronic health records
- Electronic prescribing
- Meaningful use
- Support for self-care
- Mobile health applications
- Computerized decision support

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ARRA , HEALTH INFORMATION TECHNOLOGY (HIT) AND FRAMEWORK

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American Rehabilitation and Recovery Act (ARRA)

- Patient Centered Outcomes Research (PCOR)
  - Formerly: Comparative Effectiveness Research
- HIT and Meaningful Use (MU) requirements
  - $30B---$16B in savings
  - $19B in outlays

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Patient Centered Outcomes Research (PCOR)

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Building on the Work of Others

Source	Prevention	Acute Care	Chronic Disease Care	Palliative Care	Care Coordinatio	Patient Engagemen	Safety	Appropriate Use	HIT to improve pt. experience	Impact of New Technology
IOM 2009: Priorities for CER	√		√	√	√	√	√	√	√	√
Federal Coordinating Committee for CER	√	√				√	√		√	
AHRQ National Quality Strategy	√		√			√	√			
AHRQ Effective Health Care Program	√	√	√	√	√			√		
National Quality Forum	√	√	√	√	√	√	√		√	
National Prevention Council	√					√				
National Priorities Partnership	√		√		√	√	√	√		

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Source: PCORI, Apr 2012

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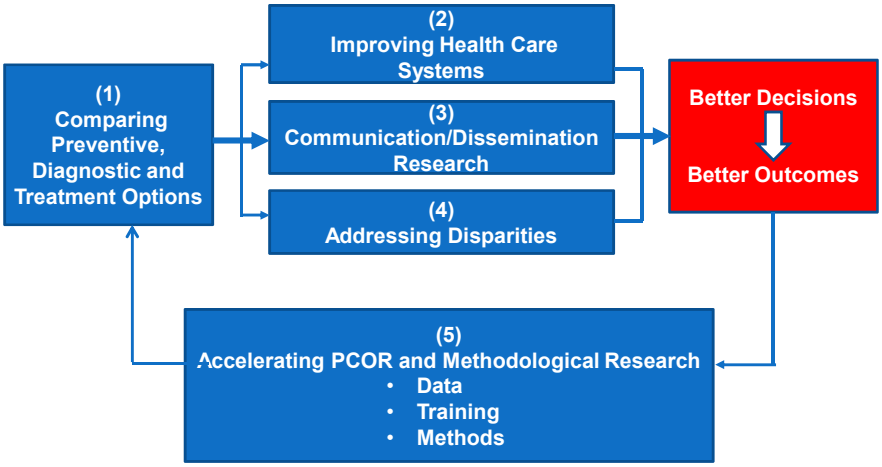
PCORI's Draft National Priorities for Research

Producing and delivering information to support better health care decisions by individuals



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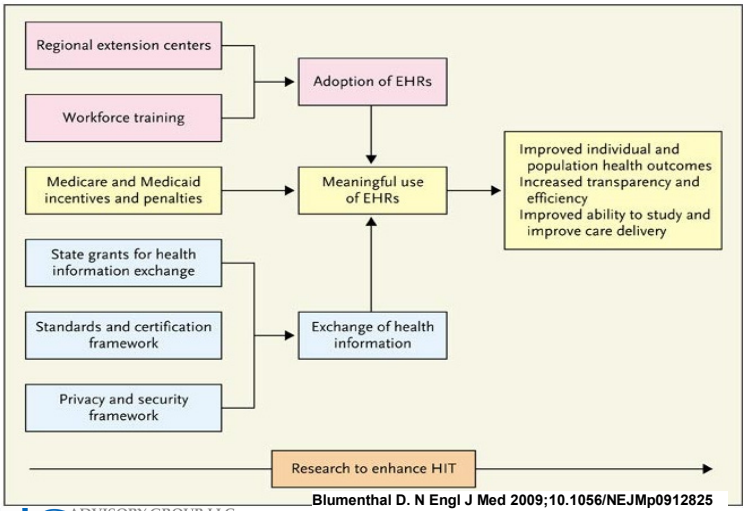
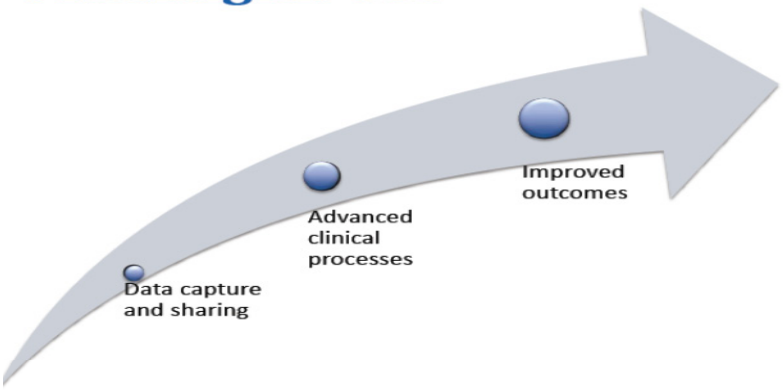
Health Information Technology (HIT)

The HITECH Act's Framework for Meaningful Use of Electronic Health Records (EHRs)



Blumenthal D. N Engl J Med 2009;10.1056/NEJMp0912825

A Conceptual Approach to Meaningful Use



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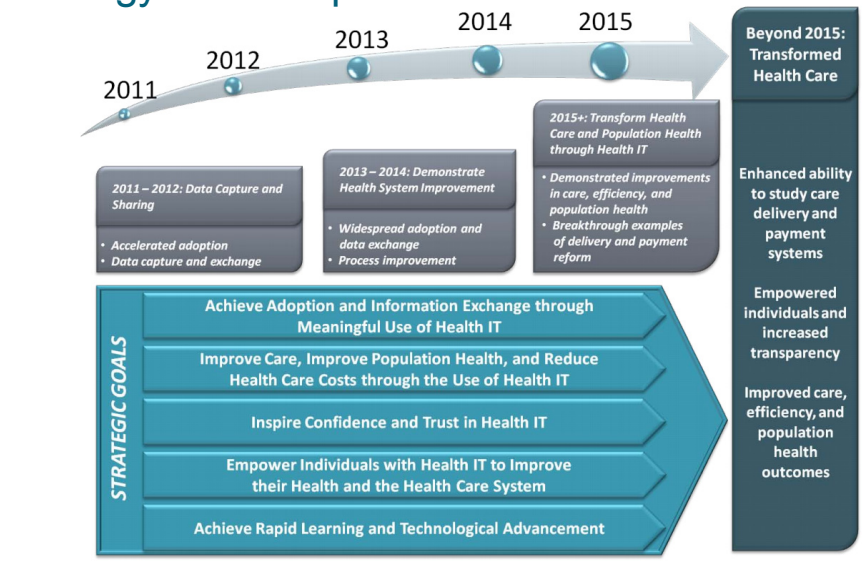
Strategy Road Map



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Source: eHI PSC September 2011 Quarterly Meeting

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MU Requirements: Stage 1 vs. Stage 2 (1 of 2)

- Features:
  - Basic medical record data (demographics)
  - Quality (CPOE, ePrescribing)
  - Engaging patients (share information)
  - Population health (share information with public health)
  - Quality measurement and reporting

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MU Requirements: Stage 1 vs. Stage 2 (2 of 2)

- Escalation:
  - New requirement
  - Menu to core requirement
  - Attestation to doing
  - Higher threshold
  - Fully digital and electronic

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Meaningful Use (MU) Stage 2: Issues

- Need for Stage 1 evaluation
- Usability
- Quality measures – eMeasures - data accessible
- Usable patient information to support engagement
- Time lines

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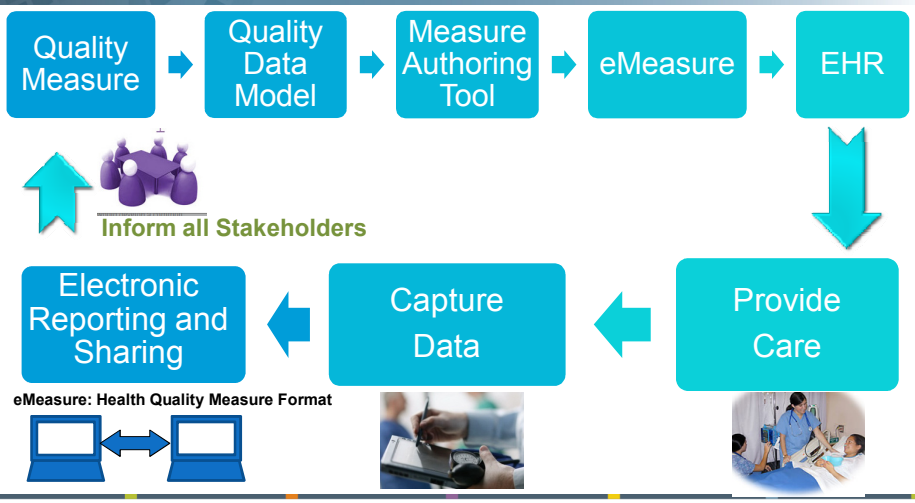
QDM in the Clinical Realm



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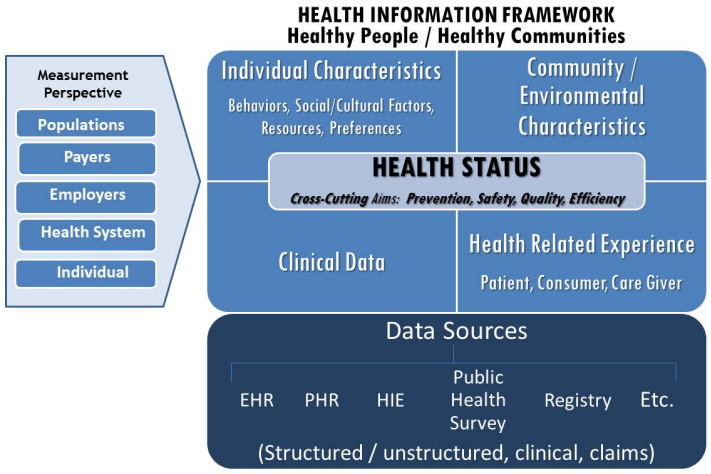
Introduction to the Quality Data Model



mHealth (Mobile Health)

- Increased use by patients and providers:
  - types of use
  - decision making
  - decreased time; collaboration
  - more time with patients
  - communication
- Lots of choices
  - devices
  - operating systems
  - wireless vendors
  - middleware and apps

mHealth (Mobile Health)

- Market share:
  - varies and changing
- Organizations:
  - HIMSS
  - mHealth Alliance, etc.
- Issues:
  - security
  - market moves rapidly vs. the science slowly
- The future – WOW!

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mHealth and Texting

- CMS to facilitate activities
- Conduct research and evaluations
- Partner with the private sector
- Deal with privacy issues
- Note HIMSS efforts and coalitions

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Health Information Exchange – ONC Strategy: Requirements for MU

- Electronic exchange of lab data
- Care and discharge summaries
- Public health reporting
- Quality reporting
- Sharing information with patients

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Ref: Williams and Mostahari. Health Affair

HIT and Patient Empowerment

- The right care, for the right patient, at the right time
- From patient centered care to person centered care
- Physician directed to shared to person directed
- Some issues:
  - health literacy (numeracy)
  - financial
  - social support
  - too sick

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Ref: RTI Report to HIMSS; Sept 2011.

Types of HIT Support for Patients

- Messaging
- Access information
- Creating of communities
- Patient portal – claims, etc.
- Data capture
- PHR

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MU Requirements Adoption (March 2013)

- Eligible professionals:
  - N = 253,427 - - $2.5B = Medicare
  - N = 114,866 - - $1.6B = Medicaid
- Hospitals
  - N = 4,257 - - $8B
- For all groups
  - various uptake in core and menu requirements

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The Sociotechnical System: IOM HIT Report

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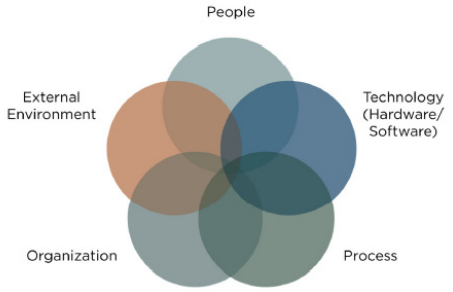

FIGURE 3-1
Sociotechnical system underlying health IT-related adverse events.

SOURCE: Adapted from Harrington et al. (2010), Sittig and Singh (2010), and Walker et al. (2008).

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Current state of health IT

Magnitude of harm and impact of health IT on patient safety is not well known because:

- Heterogeneous nature of health IT products
- Diverse impact on different clinical environments and workflow
- Legal barriers and vendor contracts
- Inadequate and limited evidence in the literature

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Recommendation 7-8

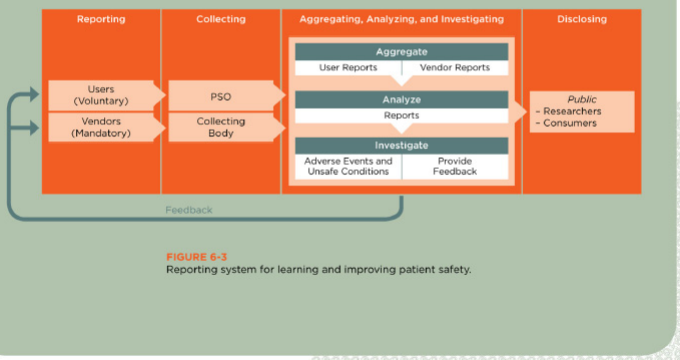

FIGURE 6-3
Reporting system for learning and improving patient safety.

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Evolution of Professional Education (Continuing Professional Development {CPD}) to PICPD

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CME/CE to PICME

- Scientific literature, e.g. Davies
- Reports; Macy; IOM
- ACCME
- Pharma industry shift generally and in funding
- Alliance for CME changes strategy and name

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CME and CPD: Evolution and Change

CME	→	CPPD
Intermittent	→	Continuous
Class room lectures	→	Self learning
Face-to-face	→	Web based
Content unrelated to practice	→	Integrated into work-flow
Medical science only	→	Also management; finances
Focused on individuals	→	Also focused on team
(General) needs assessment	→	Performance based
Evaluation of knowledge	→	Change in performance; ROI

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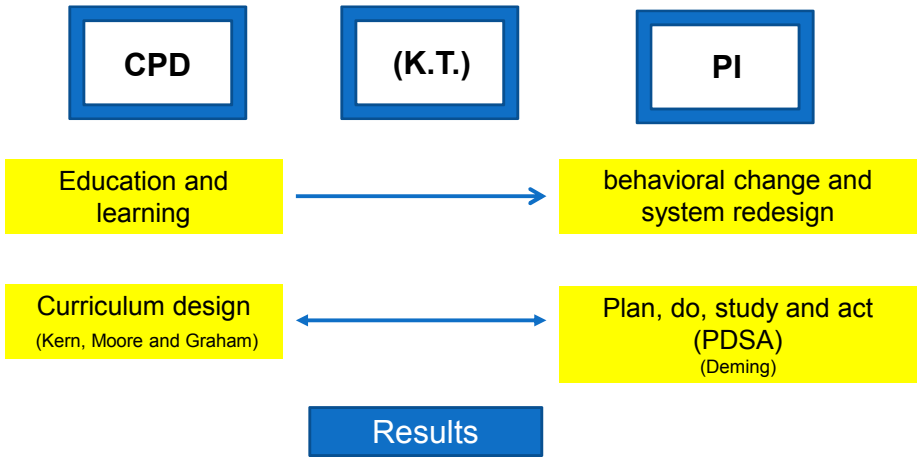
Merging of CPD to PI (1 of 2)



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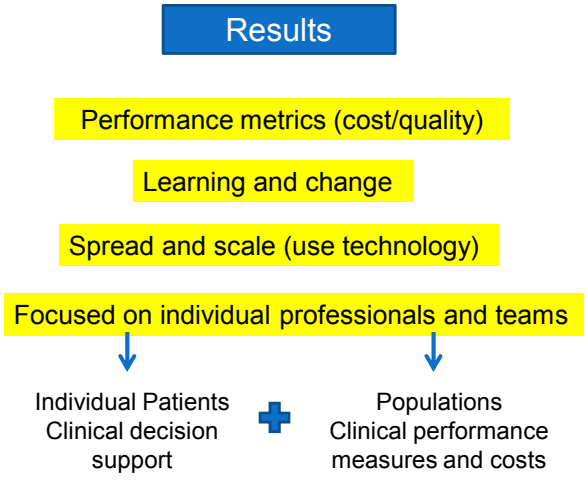
Merging of CPD to PI (2 of 2)



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Conceptual Challenges for the CPD Community (1 of 2)

- Expand the scope, context and focus of CPD:
  - Integrate into practice and achieve results
  - Focus on improving quality and bending the cost curve
- Is research being underutilized (JCEHP: Oslen, Spring 2011)?

Conceptual Challenges for the CPD Community (2 of 2)

- Need for scholarly practitioners in CPD (JCEHP: Oslen, Summer 2011)
  - In both cases:
  - Discovery; innovation, a social process vs. direct linear research to practice models, the act of application, communication; dissemination (KT) and reporting
- Consider utilizing the Squire tool

Strategies to Operationalize the Transition: CME to PI (1 of 2)

- Functional dimensions
- Framework
- Taxonomy
- Awareness of other silos
- Communication across silos

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Strategies to Operationalize the Transition: CME to PI (2 of 2)

- Highlight clinical areas with QI problems (QI skills deficits, etc.; promote attention to gaps)
- Add PI content to clinical content (how to identify gaps and methods to address)
- Supplement with post event deliverables (the conduct of a PI project, MOC)
- Embed CME in PI project (an integrated approach)

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Ref: Shojania; Annals Int. Med; Feb 2012

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Review of Today's Goals:

- Key elements of payment and system reform
- Patient centered outcomes research - how it impacts new product development and payor reimbursement
- Health information infrastructure today and tomorrow
- Evolution of CME/CE to PICME
- Pfizer strategies to operationalize the transition from CME to PI

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Topics for Webinar #2 (May 20, 2013):

- The Learning Health System Model (Institute of Medicine) for transformational health care
  - Science, informatics, incentives, culture - aligned for continuous improvement
  - Best practices seamlessly embedded in delivery process
  - New knowledge captured - an integral by-product of delivery experience
- The Learning Health System and the health care delivery experience

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