EMRlogic™
BUILDING A BETTER PRACTICE

A White Paper for Optometry

Medicare Pay-for-Performance & Value-Driven Health Care

4th Edition (September 2012)

James E. Grue, O.D.

Edited by
Alistair L. Jackson, M.Ed.

Original published June 2007

actiVEHR™

Introduction

Health care reform is upon us like a storm in the night. Portability & interoperability, transparency & value-driven health care, clinical outcomes & evidence-based medicine. What are these concepts and why should optometrists pay attention?

The new realities of pay-for-performance health care are here to stay. Change for eye care is inevitable as we transition from Medicare's voluntary pay-for-performance program, beginning July 2007, to a full-blown value-driven health care system. EHRs and communications technologies are revolutionizing eye care across the nation. Despite a shrinking health care budget, new opportunities exist for those who understand and take action. The optometric voice, to date, only whispers but the profession *will* speak up to raise the bar on optometric best practices.

Herein, we present a series of key understandings and actions for optometrists who want to thrive in the changing environment. The new system, one in which every consumer has access to cost and quality information on every health care provider will challenge the status quo.

When the winds of change have passed, how will your eye care business drive value?

Pay-for-Performance *is* here to Stay

Health care and eye care providers are asking about the Medicare/CMS program going into effect July 1, 2007, wondering if pay-for-performance is here to stay. Is it worth participating in the voluntary reporting project? Will the program stay around or amount to no more than a business annoyance demanding much effort for minimal return? Let us take a brief look at what has led to pay-for-performance.

From an historical standpoint, pay-for-performance and other health care cost-cutting and quality-evaluation measures are not new. They have been studied and proposed for over 20 years. Medicare has funded a number of pay-for-performance initiatives; most have shown that the cost of health care can decrease while quality of care improves. The challenge has been this: changing reimbursement patterns to include quality and cost initiatives is a major undertaking and, to date, the will on the part of Congress has not been sufficient.

However, the Medicare Pay-for-Performance measures seen of late represent a major change in the position of Congress to address this issue. Every sign in the political arena points to rapidly growing support for health care reform as a renewed national priority.

Pay-for-performance is a slice of the bigger pie: value-driven health care. To understand pay-for-performance we must see it in this context, the larger vision. The Secretary of Health and Human Services demonstrates his vision for implementing value-driven health care:

> "Consumers deserve to know the quality and cost of their health care. Health care transparency provides consumers with the information necessary, and the incentive, to choose health care providers based on value.
>
> Providing reliable cost and quality information empowers consumer choice. Consumer choice creates incentives at all levels, and motivates the entire system to provide better care for less money. Improvements will come as providers can see how their practice compares to others.
>
> *Every American should have access to a full range of information about the quality and cost of their health care options."*
>
> HHS Secretary Mike Leavitt

A Brief History of Pay-for-Performance

To understand the significance of what is unfolding in Washington, that has birthed the 2007 Medicare voluntary pay-for-performance project, let us review the steps leading to it.

1. In 2003, President Bush created the **Office of the National Coordinator for Health Information Technology (ONC)**. The initial director of the newly formed office, Dr. David Brailer was given the mandate to create, within 10 years, a health care environment that would provide complete interoperability and portability. ***Interoperability*** means that every piece of equipment and every Electronic Health Record can share information with every other. ***Portability*** means that patient health information can electronically follow the individual and be available anywhere the patient chooses to obtain health care.

2. Dr. Brailer articulated his mandate in two phases. The first was to set standards with which all health care equipment and every health information system would need to comply in order for everything to communicate in a seamless fashion. The second phase was to develop a national system of information-technology software to move patient health information between providers and health care facilities. The completion timeframe for these phases was to be 2014, followed by initiation of pay-for-performance measures and other cost-cutting and quality initiatives.

3. Phase 1 got underway as planned and yielded definitive standards. For example, we now have DICOM for sharing images, XML as an electronically auditable reporting language and HL7 to establish standard medical terminology for the sharing of data and text-based information. These standards have set the baseline for all health care information systems. Phase 1 also set certification standards for electronic health records (EHRs).

4. The second phase of Dr. Brailer's project, to create a national electronic health information sharing system, stalled due to the lack of funding. With national debt increasing dramatically, Congress has not adequately funded the process.

We might easily conclude that the health care reform process has stopped and therefore we need not be concerned with it. On the contrary, the financial crisis in health care is growing rapidly and, with federal funding stalled, insurers and organizations responsible for health care have begun themselves to initiate cost and quality control measures.

Regardless of the fact that the infrastructure to support portability of patient health information is not in place, the Brailer mandate has found a life of its own. Its basic contention was that all patient information would be electronic and the data, therefore, easy to share. Rather than a national system of EHRs with sharing capability established and enforced by the federal government, it has become the responsibility of each individual provider to implement a system that meets these objectives. It is left to the marketplace to provide compliant solutions and to individual providers to adopt them.

We are seeing, therefore, an evolving assumption that health care providers possess electronic health data for their patients. Each provider is also responsible for the selection of an electronic health record that meets the new and future requirements of interoperability and portability and supports the new standards established by pay-for-performance. It will become increasingly difficult and costly for providers to compete who do not make use of EHRs technology.

Is pay-for-performance here to stay? A recent Wall Street Journal article estimated that within seven years Medicare taxes will fall short of Medicare expenses by more than 45%. The same article projected that Medicare and Social Security combined are on track to eat up the entire federal budget. Legislators, without doubt, are well aware of these trends and are compelled to act. Pay-for-performance is just the beginning of a much larger process to address the national health care crisis. There seems little doubt that it is indeed here to stay.

CMS Pay-for-Performance Implications for the Eye Care Provider

Medicare's voluntary program being implemented July through December 2007 is the beginning of a series of quality and cost control programs affecting health care reimbursement, setting the stage for pay-for-performance and value-driven health care. The complex process still unfolding in Washington, DC is leading the way to a new era of health care reimbursements and opportunities. Some practitioners have already initiated business changes.

To understand better the implications of the CMS voluntary program and everything to follow, consider three things that are probably not going to happen.

"Not" Number 1

Health care providers are not going to be able to maintain their traditional impact on the way patients perceive the care they receive. Eye care providers have had the luxury of being able to practice in a rather individualized style. We each have been able to decide what tests, referrals

and level of care we choose to provide for our patient. The patient's perception of the care given has been based largely on their direct experience with us and our office staff. Patients generally have had little ability to compare the quality and cost of the care they receive from us against the cost and quality they would get elsewhere. ***One of the main changes we will see is an increased ability for patients to compare cost and quality of care against published measures.*** In many cases, we will see employers teaching their employees how to shop for the best quality and lowest cost health care.

"Not" Number 2

Medicare will not continue to pay simply for the level of care that the individual Optometrist decides. ***A core concept behind pay-for-performance is to change reimbursement and pay only for what are deemed to be industry and clinical best practices.*** To date, for example, Medicare has paid the optometrist for seeing a diabetic patient regardless of whether a report was sent to the primary care physician treating the diabetes. Medicare has paid for an ocular hypertensive patient visit regardless of our decision to do or not do additional quantitative testing on the status of the nerve head. In the near future, however, Medicare will pay only if we can demonstrate that we have sent a report to the primary care physician on the diabetic patient, or that we have done the appropriate level of specialized testing on the ocular hypertensive patient. Further, payment will be contingent upon making our test results available in an electronic format to any other provider who needs that information.

"Not" Number 3

Optometrists will not likely be required by federal law to purchase electronic health records software. (Note that this does not however preclude *state* legislation of this nature; already there are rumblings from select states.) Many providers, still focused on the original presidential mandate, are awaiting a 2014 regulation that will require them to make the move to EHRs technology. Indeed there is still significant discussion through the ONC and in Congress related to interoperability standards, incentives to promote adoption, and addressing privacy concerns related to EHRs, but other work groups and private health care players have also stepped in to take up the cause. Does this postpone the need for EHRs? On the contrary, it has dramatically reduced the lead time.

Medicare and other insurance carriers see no reason to wait to implement quality and cost savings measures. These measures all *assume* optometrists and other health care providers have electronic health records. They do not *require* EHRs but make it more cumbersome and impractical to meet the requirements of the new measures without electronic records software and the assumed technology platform. The process has already started under the auspices of pay-for-performance.

Let's be clear: no one can predict with certainty the complete implications of pay-for-performance. However, we know there is a process well in place to recreate the reimbursement system so payers can identify health care that meets best-practice standards and pay only for that level of care. Consumers will be more informed and encouraged to shop for the best quality of care at the lowest cost, and will have measures to compare the care they receive.

Pay-for-performance will not be easy. Some changes may have a negative effect. On the other hand, these same changes are creating new opportunities, assuming we understand how to position our practices properly to take advantage of the opportunities while they exist.

The key to best positioning lies in anticipating the opportunities and being the first to take advantage of emerging markets.

Change Agents in Health Care – What's Driving All This?

Executive Order signed August 22, 2006 by President George W. Bush. "Promoting Quality & Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs."

This executive order marked the first federal-level step directly aimed at promoting portability, pay-for-performance and transparency in healthcare. The order was signed at a meeting on health care reform in the state of Minnesota attended primarily by political and industry leaders representing major purchasers of health care. The significance of this should not be underestimated: the forces driving health care reimbursement reform are coming directly from purchasers of health care, which includes the Federal Government. The Physician Quality Reporting Initiative (PQRI) initiated by Congress is a by-product of this Executive Order.

Payers vs. Payees

Out in the marketplace, a new battle plays out between payers and payees. Payers have long warned that the cost of health care is out of control. Significant Medicare deficits are predicted for the near future while businesses are faced with unaffordable increases in health care costs. The tension manifests in the increasing frequency of strike action, largely due to disputes over the cost of health care in the employee benefits package. Individuals with no health care coverage at work must increasingly forego health coverage as they find it more and more difficult to pay the premiums.

Health Care Providers

On the other side, health care providers site advances in technology that allow them to provide improved care, diagnose and treat conditions faster and more effectively than ever. They argue that the health care system in place is able to meet the rising expectations of patients who increasingly view quality health care as a right.

Health Care Payers

From the payer perspective, portability is the way to reduce duplication of testing and drive health care cost and quality monitoring. Issues like pay-for-performance, provider quality scoring and cost reviews have been talked about for years but always presented too many practical issues for effective large-scale implementation.

Portability changes all that. Once patient health information is maintained electronically and requirements are in place for electronic transmission, records reviews for both quality and cost become quick, easy and practical.

Furthermore, it becomes practical for payers to include in provider contracts that reimbursement for specialized testing be contingent upon sending test results in electronic

format to any other provider participating in the care of the patient. This eliminates the need for a second provider to repeat tests already done by another.

The significance of this issue comes to life in a recent example involving a second opinion. A complex problem that resulted in an internal-medicine diagnosis, it had involved approximately $20,000 of testing at hospital A, following which the attending physician gave the patient recommendations for care. The patient decided to seek another opinion at hospital B. The same tests were repeated with no difference in the recommended care, no improvement in care. Mandatory portability of patient health information would have required all test results from hospital A to follow the patient to hospital B. Compared to the actual total cost of $40,000, a second opinion could have been obtained for about $130.

This example provides a compelling argument for portability as a way to reduce health care costs without decreasing quality of care or altering outcomes. Payers, understandably, are becoming more adamant about not paying for cost redundancy. In most cases, patients prefer to forego extra testing. The cost of duplicate services does not make sense to the consumer either.

The result is a concerted effort on the part of health care purchasers, federal and state governments to create an environment in which all patient health information is maintained electronically. Portability then assures the information can follow the patient and be available for clinical care, as well as for quality and cost review.

Two Change Agents Driving Portability

We know that portability is not driven by practitioner demand. The demand stems instead from two sources whose synergy only increases their effectiveness. First, there is a **government movement to create *interoperability*** so health systems may communicate, which will lead to mandatory portability. For example, the above-cited executive order requires that contracts with health care providers arising from government programs and involving software upgrades for EHRs enforce the interoperability standards that drive portability. It is thought that private payers such as BCBS, Aetna and others will follow this lead also requiring portability of patient health information in order for the provider to be paid through their reimbursement programs.

The second movement driving portability is **payer groups** such as Leap Frog. Independently, payers have been ineffective at forcing cost-saving steps. As a coalition of purchasers representing tens of billions of dollars of health care purchasing power, they have found ways to force health care to participate voluntarily in cost-saving steps. ***Although these groups do not have the legislative capacity to force healthcare providers to change and participate in quality and cost reviews, they have the practical ability to do so; they represent a significant portion of health care purchased. They push for portability so they can implement quality review systems to reduce medical errors and facilitate cost reviews.*** A favorite method is to advise the people for whom they purchase health care which providers and facilities have the best record of safety, quality and cost savings. Provider and facility quality scoring is being used right now with hospitals and is planned for private-practice physicians in the near future.

Although there are reasonable arguments why either of these efforts may not be successful, the pooled resources of both groups are very likely to drive successful implementation of mandated

national portability. The federal government can force regulatory implementation. The payer groups, representing tremendous amounts of money spent on purchasing health care, can raise the money necessary to finance legal battles that effect regulatory changes. The money spent on the legal process is considered a long-term investment since they save much more in future health care costs as a result of these changes.

Official government estimates are that portability will directly save $360 billion dollars per year out of the current $1.7 trillion annual healthcare costs in the United States.

Transparency Leads to Change

Transparency is one of the most important concepts to understand in the transition to value-driven health care. It directly affects how patients will perceive the care you provide. Note the following from the Health & Human Services web page.

> "Transparency is a broad-scale initiative enabling consumers to compare the quality and price of health care services, so they can make informed choices among doctors and hospitals.
>
> In cooperation with America's largest employers and the medical profession, this initiative is laying the foundation for pooling and analyzing information about procedures, hospitals and physician services. When this data foundation is in place, regional health information alliances will turn the raw data into useful information for consumers.

Steps to Transparency

1. The federal government, individual private employers and health plans commit to sharing information on price and quality in health care. Together, the government and major employers provide health care coverage for some 70 percent of Americans.
2. The federal government and individual private employers commit to quality and price standards developed with the medical community. This will help guarantee a fair and accurate view of the quality of care delivered by individual providers, as well as providing consistent measures for quality.
3. The federal government and individual private employers commit to standards for health information technology (IT). Health IT will be important for gathering and using the best information for consumers. These standards are also crucial to the goal of achieving electronic health records for all Americans.
4. The federal government and individual private employers commit to offering plans that reward consumers who exercise choice based on high quality of care and competitive price for health care services.

Why Transparency Is Important

For every other purchase they make, consumers can easily get information about price and quality. When consumers have this information they can make better decisions.

> Consumers should share in the savings, in the form of lower premiums and more effective care, when they take an active role in health care decisions.

There is little question that health care providers can expect not only mandatory portability, but also a host of programs specifically designed to drive transparency, reduce health care costs and improve standards and quality of care.

Voluntary Program: "Pay-for-Reporting" leads to Pay-for-Performance

The voluntary Physician Quality Reporting Initiative (PQRI) initiated by Medicare for July through December 2007 is often referred to as pay-for-performance. In reality, it is a precursor, a "pay-for-reporting" project. True pay-for-performance will compare what a provider did against an expected outcome. The current Medicare program simply requires a provider to report on activities not yet correlated to clinical outcomes.

Congress passed the Tax Relief and Health Care Act (TRHCA) in December of 2006 that authorized the establishment of a physician quality reporting system by the Centers for Medicare & Medicaid Services (CMS). Medicare had only a few months to develop and release this program. As a result, the 2007 program only touches on steps that will lead to a true pay-for-performance system. We can expect to see further changes in the 2008 version of this program.

Participation in the voluntary project involves reporting on a specific set of criteria. For example, the optometrist must confirm the number of times a diabetic patient letter was sent to the referring primary care physician. Again, while these may contribute to a better outcome they are simply reporting activities, not outcomes *per se*.

An outcome in eye care would be, for example, the percentage of cataract surgery patients with a subsequent diagnosis of endophthalmitis. Or, the percentage of refractive surgery patients who had 20/25 vision after 3 months. These are measurable clinical outcomes.

Through true outcomes we can see how all other components of value-driven health care fit into the process. When pay-for-performance is based on true outcomes we can apply quality measures, cost measures, patient satisfaction measures, and understand why ***transparency*** (the ability for the public to have access to this information) is important. Together, supporters of value-driven health care argue, they result in a health care system capable of providing the best care at the lowest cost.

In the example of cataract patients who develop endophthalmitis, the percentage of patients is a quality measure. A cost measure will show it is less expensive to provide care to a patient with a good cataract surgery outcome than to one with endophthalmitis as a complication. A patient satisfaction measure, we expect, will show the patient without endophthalmitis is more pleased than the one with it. In addition to decreasing cost, patients want to know that of the two cataract surgeons they are considering, one has a quality history of 1 patient per 1000 that develops a complication vs. the other that has 10 patients per 1000.

Even this overly-simplified example starts to show the rationale on the part of health care purchasers for implementing pay-for-performance and the benefits it can have on the delivery of health care. ***The challenge, of course, is to select as measures the outcomes that truly represent delivery of the best quality care and, for providers to embrace transparency as a change agent driving best practices system-wide as well as in their own practices.***

What is Value-Driven Health Care?

The following paragraph is taken from ***Value-Driven Health Care - A Purchaser Guide,*** available through the Leap Frog Group to members and all companies that purchase health care for employees.

"Value-driven health care employs standardized methods for measuring health care quality and pricing information and then puts this information into the hands of consumers, empowering and motivating them to make informed decisions about their health care. Informed consumers are able to seek the best available care, which stimulates the entire health care system to provide better quality, more efficient care. High quality, efficient health care translates into savings in terms of both lives and dollars."

Four Cornerstones of Value-Driven Health Care

1) Utilizing health information technology to ensure that all patient health information is electronic and can be efficiently and effectively moved anywhere the information is needed
2) Measuring and publishing health care *quality* information
3) Measuring and publishing health care *pricing* information
4) Creating incentives for high-quality, efficient health care

The quest for value-driven health care is currently led by purchasers of health care, especially large companies and the federal government whose resources are stretched by the rapidly escalating cost of health care. Ultimately however, the quest will be led by consumers who expect the benefits of value-driven health care to be available to them.

It is no surprise that health care providers are generally against the initiation of value-driven health care, and for a plethora of reasons. Despite the need for change and its potential advantages, there are also problems with this kind of system.

Nevertheless, like pay-for-performance, value-driven health care is here to stay. The average person has plenty of examples to draw from to know that technology today can make information available wherever society chooses. We also realize the tremendous benefit we receive from rapid access to information. An example from the banking industry will serve to illustrate.

Value-driven banking – an everyday example

Most consumers today expect they can walk up to an ATM almost anywhere in the world, see the balance in their bank accounts, and withdraw cash. Everyone has the ability to make good decisions about their choice of financial institution since they know exactly the interest rate or what they will earn on a 6 month GIC. This information is available to consumers today because the banking industry initiated "value-driven banking" years ago.

Likewise, purchasers of health care are employing a strategy to make value-driven health care the culture of health care in America. As seen above, they are making it their business to educate employees, enrollees and the general public about the benefits of value-driven health care.

Lest our efforts amount to holding back a storm, convincing others to look for a bank that doesn't use computers, where tellers sit behind the counter with a ledger book, eye care providers must get on board with a new reality: value-driven eye care. It's here to stay.

Optometry's Pay-for-Performance Outcomes - Who Decides?

In a mature pay-for-performance model, quality and cost of care will be measured against outcomes not by simple reporting of clinical activity. As we have seen, the current voluntary Medicare pay-for-performance program does not yet utilize outcomes. However, future expansion of the program is likely to do so. Selection of clinical outcomes is still in progress. ***The question before us now is how and by whom should the outcomes for Optometric pay-for-performance be determined?***

While the Federal government is the primary coordinator and force behind the pay-for-performance movement in health care, it does not pretend to have the ability or resources to set standards or outcomes. The government turns to private enterprise and professional organizations to set industry standards. Washington wants input from the eye care industry.

The eye care measures included in the 2007 PQRI program reveals wording taken directly from the American Medical Association (AMA) Physician Consortium for Performance Improvement (PCPI). The publication is the Eye Care Physician Performance Measurement Set. Understandably perhaps, no optometrists were part of the AMA PCPI Eye Care Work Group that developed these measurements. The AOA provided comment on the initial measures during the public comment period and became further involved later in the process when the measures were being considered for endorsement by the National Quality Forum.

The American Optometric Association, however, recognized the need for optometric input earlier in the development process and was able to place two optometrists on the AMA PCPI Eye Care Working Group for future development of additional eye care measures. Getting members onto this board may be one of the most significant actions the AOA has ever taken. Selection of outcomes will be critical to the future o**f** our profession. This action on the part of the AOA is an example of why every optometrist must support our national association.

Few if any in the optometry profession would argue against the need for an optometry voice in this new era of health care where ophthalmology has already set the initial criteria by which eye care will be evaluated. Looking deeper into the criteria used for the PQRI, we glean some insight into why the criteria most beneficial to ophthalmology may not be the criteria most beneficial to optometry or the public as a whole. This has the potential to develop in a way not favorable to the vast majority of patients who see an optometrist and not an ophthalmologist. Keep in mind, a key concept behind pay-for-performance is *transparency,* reporting health care experience, quality and cost to the public so patients may decide how we stack up against other, in our case, eye care providers from whom they could seek care.

The 2007 Physician Quality Reporting Initiative (PQRI) Physician Quality Measures represent the current pay-for-performance criteria on which health care providers will be reporting. (See www.cms.hhs.gov/pqri/. Select Measures/Codes, then Downloads, 2007 Physician Quality Report. Measures that apply to eye care are numbered 12 through 19.) Due to a recent clarification, optometry will be reporting on six of these eight eye care measures. Two of the cataract measures are intended to be reported by the surgeon to require that he/she is in possession of the documentation of pre-op services prior to performing the cataract surgery.

After reading these eight eye care criteria, note first that all relate to the four most common eye pathologies: Glaucoma, Age-Related Macular Degeneration, Cataracts, and Diabetic Retinopathy. A similar pattern emerges for other specialties: initial measures, at least, are based on big-volume pathologies. Reporting volume will be high on these conditions versus less common conditions. Note also that the reporting criteria do not start at the onset of the condition, rather somewhere further along in its development. For eye care, this could be reflective of the ophthalmology roots of the criteria since ophthalmologists generally see patients with more advanced pathologies than optometrists. For example, measure #12 is Primary Open Angle Glaucoma: Optic Nerve Evaluation. The measure starts at the point that the patient has a diagnosis of Open Angle Glaucoma. The selected measurement criteria was not the ocular hypertension stage where evaluation of the optic nerve head is just as important.

Measure #19 covers only diabetic patients with diabetic retinopathy. From an optometry perspective, it is equally important to communicate the results of the eye exam to the managing physician before the diabetic patient shows signs of retinopathy. However, this was not selected as the starting point for reporting purposes. ***Without intervention from optometry, outcomes that reflect an earlier stage of pathology are even less likely to appear.*** Development of quality measures depends on the review of evidence-based literature and the existence of known gaps in care.

We see a pattern, therefore, of initial reporting criteria - the baseline for future development of the pay-for-performance program – that reflect conditions already quite advanced. ***Since an important goal of reporting progress is transparency to the public, it is significant that optometric involvement in all these conditions would favor earlier detection, prevention and care.*** Optometry represents primary care while ophthalmology moves toward secondary or tertiary care.

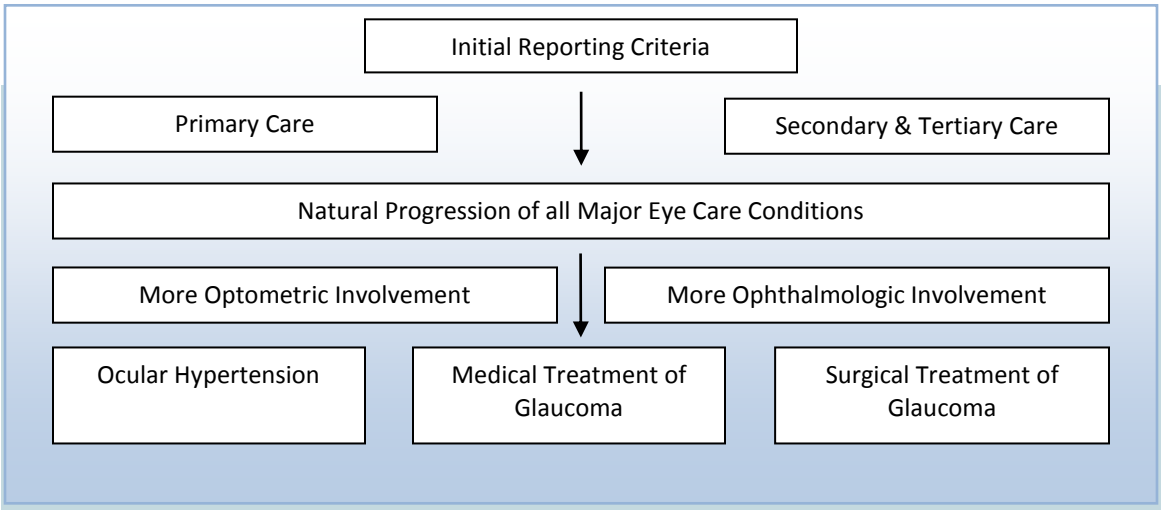

Figure 1. Glaucoma Management.

In Figure 1, the initial reporting criteria are balanced. Both optometry and ophthalmology have a level playing field and the patient has a balanced way of evaluating the care given. Will balance be maintained as we move through the process? What happens is critical to the patient.

The purpose of value-driven health care is to make cost and quality measures for every provider available to patients, thus motivating them to select providers who deliver the highest quality care at the lowest cost. Continuing with the glaucoma management example in Figure 1, true clinical outcomes will be required, versus simple reporting criteria.

Assuming there may eventually be ten clinical outcomes for glaucoma management, the question is this: where on the line of natural disease progression will those outcomes fall and how will that look to the patient selecting an eye care provider?

New clinical outcomes could fall anywhere on the disease-progression continuum but, as a general rule, it is easier to identify outcomes once symptoms are more obvious and treatment becomes more complex. In glaucoma progression, outcomes in the surgical arena can be identified easily. E.g. percentage of patients who develop endophthalmitis after stent insertion, or percentage of patients who meet target IOP after trabeculoplasty, and so on. On the other hand, primary care outcomes are more difficult since actions taken in this area tend toward long-term preventive effects not measurable short-term results.

As already stated, the initial selection of reportable measures by Medicare is inclined toward common pathologies likely to yield high-volume reporting. Natural evolution in the forthcoming selection process will likewise yield outcomes predominantly in surgical and advanced-treatment areas. We know that such outcomes are easier to identify and more quickly produce qualitative measures. Yet these are the areas where optometrists have little involvement.

If only one or two of the pay-for-performance outcomes represent areas where optometry can report and the remaining majority is reportable by ophthalmology, a bias in the evaluation

process is inevitable. It is conceivable that patients, unclear about the optometry-ophthalmology continuum and viewing transparency reports for eye care will be unknowingly biased toward the *advanced* treatment of each condition.

Is it in the best interests of either the patient or the health care system itself to emphasize surgical and advanced-treatment methods over early intervention and preventive methods? Clearly not! Yet this is the natural course of the current pay-for-performance implementation. Optometry must position itself to gain input into the outcomes selection process.

The Value of Well-Selected Outcomes

Pay-for-performance clinical outcomes will revolutionize medicine. Already, the process to implement pay-for-performance is putting in place the technology infrastructure to create a whole new vision for the practice of eye care.

New technology, fully implemented, will electronically store every byte of patient health data then provide a way for information from every patient's record to be extracted at any time for any purpose. The implications are enormous. Having already discussed how outcomes can be measured as we drive toward value-driven health care, let us explore other ways outcomes can be used to enhance our knowledge and improve the way we care for patients.

Consider the potential behind selecting outcomes for the practice of optometry. We know many things affecting thousands, sometimes millions of patients remain yet a mystery to us. The diagnosis of myopia, for example, is one of the most common diagnoses made by an optometrist. Even with millions of myopes in America, there remains much controversy in our professional literature as to whether bifocal or contact lenses are effective in slowing or stopping the progression of myopia. Why? Essentially, because myopia is a low-risk condition and putting children in bifocals is not appealing to many providers. Therefore, the incentive to fund a valid study has never been strong enough. Given our current paper system, gathering data for this kind of study requires significant personnel and financial resources.

By contrast, with electronic data readily available and portable, the costs and constraints of such a study all but disappear. The process is called data mining. We decide the information to extract from electronic records throughout the country, create an algorithm for the analysis, and vast amounts of data can be available almost immediately. Portable electronic health records will provide quick access to data for the analysis of virtually any medical mystery.

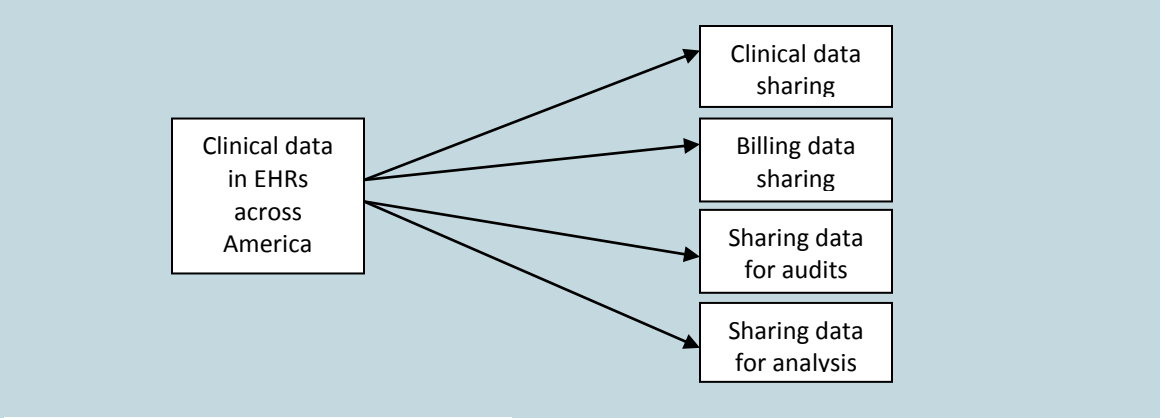

Figure 2. Data Mining & Portability.

Data mining is already an accepted part of health care but companies will emerge that specialize in high-quality HIPAA-compliant studies to support evidence-based medicine. Most data needed even for complex analysis will be contained within EHRs in every office across the country. With only slight modification to a given EHR, specific studies on the effects and side effects of new medications can be done on every patient to whom the medication is prescribed. Adverse side effects will become more quickly recognizable as well as side benefits often missed today due to the difficulty in analyzing paper-based data.

Indeed, given these new health care realities, we are not far from answering the question about bifocals for the seven-year-old myope. Specific statistics based on a large population of patients treated with conventional minus lenses can be compared to a population prescribed bifocals and contact lenses. The mystery will be resolved due to the relative ease of mining and analyzing the data. This same scenario will occur time and again with the technology of EHRs.

Selecting Optometric Pay-for-Performance Outcomes.

We have discussed the relative ease of identifying measurable outcomes at the secondary and tertiary levels of care. Emphasizing clinical outcomes only at these levels, however, means we are paying attention to the *advanced* condition rather than to early detection and intervention**.**

Admittedly, when we consider early-phase outcomes of eye diseases, results take longer. However, ***best practices that slow or prevent early stages of disease progression are clearly in the interest of the patient. For the health care system as a whole, it is obviously less expensive to care for the patient whose condition does not progress.***

The optometry profession today finds itself in a unique and important place. The domain of our expertise and best practices – early detection and preventive care of eye disease – is one that the developing pay-for-performance system seems to have overlooked and that the public needs.

Optometry must engage in the process and point to the benefits of early-stage outcomes. Our intervention will not only enjoy support by administrative agencies tasked with developing outcomes but will also position optometry better to contribute to the overall success of the

current health care reform process. Without question, Optometric organizations and associations are the only source from which such critical insights may come.

We now have the opportunity to select outcomes that will enhance our knowledge of the care we provide. It is important to remember that an outcome does not require 100% success in order to be legitimate. In fact, outcomes with a lower expected success rate may be more representative of true quality of care. For example, consider the percentage of patients with elevated IOP and demonstrated early nerve-fiber layer dropout who progress to changes in the optic nerve head over 1, 3, or 5 years.

In this example, we would expect evidence-based medicine to recommend a treatment for this type of patient and also specify an expected outcome. This measure could, therefore, be used as a Medicare outcome since each provider could be compared against published outcomes. We in the profession could also use this outcome to improve our knowledge of how to treat patients.

Measurable Outcomes & the Opt-Out Clause

Every measureable outcome will need an opt-out clause, a statement that makes allowance for the patient not best-served by the evidence-based medicine approach. There may be a variety of reasons for a patient opt-out but we know that sufficiently large sample groups for any condition will contain patients not best served by evidence-based medicine. In such cases, the attending provider could employ a variety of treatment alternatives. Comparing alternate approaches will normally confirm the evidence-based approach but, in some cases, another approach may prove superior. Properly selected outcomes can result in this type of information becoming available to eye care providers with very little additional monies spent for analysis.

Properly selected outcomes can be useful for assessing quality and cost but also for providing long-term information beneficial for patient care. It is the responsibility of the optometry profession to ensure that such an approach is used in the selection of eye care outcomes in the Medicare program.

Pay-for-Performance Cost Measures & Evidence-Based Medicine

Predictive cost analyses that employ different methodologies and which are subject to many variables, such as the duration of care, will obviously yield varying results. It is not the purpose of this paper to look in-depth at health care or eye care cost predictions. For simplicity, let us assume that pay-for-performance cost measures will rest primarily on the *actual costs* of providing care.

In view of such *actual costs*, we believe, ***one of the most important things a practicing optometrist can do at the present stage of pay-for-performance development is to begin working towards in-office procedures and methods (internal best practices) supported by evidence-based medicine.*** Given that we are early in the process of incorporating evidence-based medicine into standard optometric practice, this may be more difficult than it first

appears. In fact, some of the most engrained procedures in health care may not actually have any evidence-based studies to support those practices.

To be sure, there are examples of standard practices not supported by evidence-based medicine, which are as effective as those processes with evidence supporting them. Unsupported practices may even be clinically easier to achieve or have other perceived benefits. Or, it may simply be that evidence-based literature and studies have not been produced. It is important to identify such practices and make sure that the evidence supporting them is documented by practitioner groups.

Let us consider, for example, the evidence-based literature for following nerve head changes in glaucoma. The accepted standard of care compares stereo images over time; ample literature supports this activity. Technology now offers an alternative to the time-consuming visual comparison process with other ways of analyzing and following the nerve head. The technologies include GDX, OCT and HRT among newer instruments. Some eye care providers no longer compare stereo photos, rather track changes using technology. These tests are considered adjunct tests by Medicare, not diagnostic tests and there exists no evidence-based literature that shows they are more effective or even as effective as comparing stereo photos for detecting changes in the nerve head.

A number of potential questions may be raised about the old versus new practices. Currently, each provider decides which method or combination of methods is best. Medicare pays for the tests regardless. In the new pay-for-performance world, reimbursement will be scrutinized more closely. There will be a definite trend toward higher reimbursements for evidence-based procedures over alternative procedures. We will also see direct cost comparisons of the two methods. It is unlikely Medicare would stop paying for adjunct tests but in reporting cost/quality comparisons, if the technology approach lacking supporting evidence turns out to be more expensive than the image-comparison method, we may expect a substantial effect on the cost/quality assigned.

A coming change in the domain of specialized testing is that the pattern of ordering tests will enter into the cost/quality assessment of each provider. Groups leading cost-measures assessment are well aware of the escalating cost to health care arising from new technology. One of the goals of cost analysis is to eliminate everything that does not contribute to improved care for the patient, therefore, patterns of specialty test ordering will become a targeted activity. Under Medicare regulations, all diagnostic tests must be ordered as a direct result of an indicator in the clinical exam.

In our current system, a provider decides what specialized tests to order and, generally, is reimbursed for them. The new pay-for-performance system will see outcome-based criteria that ask not only if a test was done when indicated, but also, if tests were done that were not indicated. So, for example, for an ocular hypertensive patient, the clinical record would need to specifically indicate some type of change in order to justify additional specialty testing. Without visible change in the nerve head, it may be justifiable to order a GDX since one cannot adequately visualize the nerve-fiber layer but with no change evident after the GDX, it may be difficult to justify ordering an HRT or OCT.

Medicare may not initiate audits to assess specialty testing at the level described but the care provided will certainly be compared against that of other eye care providers. So if a provider orders tests not indicated, the cost of care will increase over a provider who orders tests appropriately, since the outcomes will likely be the same. Transparency dictates that the cost difference will be reported to the public.

This is a good example of why optometric input is critical in the selection of clinical outcomes. Evidence-based literature indicates clearly that early treatment of nerve-fiber layer drop out yields fewer changes to the optic nerve head. One of the strengths of optometry is early detection of glaucomatous changes. We have already shown that the baseline outcome already established for glaucoma is *after* a diagnosis of glaucoma. Optometric input into outcome selection could ensure that, since the best patient care is achieved by slowing or stopping progression of the condition at the earliest possible stage, indicators emphasizing early detection should be the most important to put in place. Optometry must ensure this approach is reflected in the final outcomes selected by eye care payers.

In the pay-for-performance world, tests and other activities that do not contribute to improved outcomes will only augment the cost of care and reflect negatively on transparency reports of providers who order unnecessary tests. On the other hand, procedures with proven positive outcomes become critical to do and, when not done, will reflect poorly on the quality outcomes of the provider. Pay-for-performance will require eye care providers to be more aware of proper evidence-based indicators so they may consistently do the things that have a positive effect on outcomes and avoid doing the things that drive up the cost of care without positively affecting outcomes.

The Eye of the Storm

We began by stating that health care reform is upon us like a storm in the night. Storms occasionally take us by surprise but that is rare now, given the technology and communications systems of our times. Predictability does little to lessen the severity of a storm, but our preparations can make a significant difference to the impact we feel. What impact will the storm of health care change bring for you?

We have presented many new terms and concepts, revisited some known ones and generally given you much to consider. It is not helpful to have so much information that we don't know where to start. The final section will summarize some key concepts and provide several clear, achievable action steps. Here, in "the eye of the storm", we bring it all down to a single big idea.

Value-driven health care is, naturally, about driving value – value for payers, value for practitioners and value for patients. Transparency, as we have seen on page 8, is the window through which consumers, your patients, will assess the value they perceive in the services you offer. Transparency reports will emerge but your patients' assessments will not be read as individual evaluations, rather seen in their individual choices to remain in your care or to seek services elsewhere.

Our core idea, our storm test, therefore, is this: in everything you do to prepare for value-driven health care, see your practice through the eyes of your patients. Think Transparency.

Summary of Key Understandings & Actions

Understand …

1. Understand that most of what we have considered above is here to stay and *will* affect your eye care practice.
2. Understand that we have written about health care and eye care reform, about changes taking effect now, being careful to avoid alarmist tones. We do not believe pay-for-performance and value-driven health care are to be feared, only that being involved in the change process and prepared for it is the prudent course of action.
3. Understand that if value-driven health care becomes a reality you are already building your quality and cost reporting profiles through your insurance billing.
4. Understand the value of identifying the new opportunities and being the first in your area to position your practice for those opportunities.
5. Understand that health care reform will affect you but also your patients. They will look to you as a trusted advisor.
6. Understand that clinical (or external) best practices will be, for the most part, determined and dictated to you through prescribed outcomes, programs and contracts. Internal best practices, however, are yours to control and can have a significant impact on how patients perceive the care you provide.
7. Understand the importance of utilizing EHRs and that they will be critical in helping you position your practice to take advantage of new opportunities. Understand that your EHRs software will not operate in isolation from the rest of your practice; you need an integrated solution.
8. Understand that *interoperability* is not a feature on the screen, rather a technical platform "under the hood" of your software solution. *Portability* likewise. You can see signs of it but the most important aspects of the technology cannot be seen. (You've heard of *Intel Inside* but you probably haven't seen it!)
9. Understand that successful transitions arise out of planned, incremental change. Change requires not only planning, but good leadership as well. Transitions should be led by someone not heavily involved in the learning curve who can continue taking care of business.
10. Understand the storm test. Times change. Rules change. The winds of change pass. As you consider policies and procedures, resources and acquisitions to meet the demands of a new environment, the storm test is to see your business through the eyes of your patients. Think Transparency.

Do …

- ❑ **Take a position**. Promote discussion among your colleagues and staff. Spend time reading and participating in programs so you can decide for yourself if the move to value-driven health care is real. View the following links used as source material for this white paper:
  www.leapfroggroup.org/media/file/Employer_Purchaser_Guide_05_11_07.pdf
  www.hhs.gov/transparency/index.html
  www.whitehouse.gov/news/releases/2006/08/20060822-2.html
  www.cms.hhs.gov/PQRI/Downloads/PQRIMeasuresList.pdf
  www.hhs.gov/transparency/fourcornerstones/quality/
- ❑ **Help create a voice for optometry** in Medicare's outcome selection process. Understand the terminology so you can identify and support significant legislation that affects optometry. Speak up for your profession locally and nationally.
- ❑ **Get involved** with the CMS Pay-for-Performance voluntary program starting July 2007. Make it your training ground for the next steps coming January 2008.
- ❑ **Educate your patients**. Give them reasons to come to you and not to look elsewhere. Start with transparency about your own quality measures and cost of care.
- ❑ **Discuss internal best practices with your staff**: what do they look like for your practice?
- ❑ **Start your search for EHRs**. Look for yourself at exam forms and communications functionality but engage IT professionals in looking "under the hood" at the solution's technical platform for compliance with interoperability and portability standards.
- ❑ **Plan your transition in phases**. Allocate resources, including your own time and energy.
- ❑ **Read our white paper follow-up series, *Optimizing your Eye Care Practice for a New Era of Information Technology & Value-Driven Health Care***
- ❑ **Remember the storm test**. Think Transparency.