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The Road Ahead

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Roadmap to the FUTURE of PRACTICE

Podcast interview: www.gastro.org/cghpodcast. Also available on iTunes.

With the July 2012 issue of *Clinical Gastroenterology and Hepatology*, the responsibility for the "Practice Management" special section changed, in conjunction with overall editorial responsibility, to a new group led by Hashem El-Serag, MD, MPH. Joel Brill, MD, AGAF, whose knowledge is unparalleled in our specialty about health care reform, reimbursement, and practice management, has edited this section with admirable care since its inception. Having assumed the role of special section editor, I will bring experience from 10 years in academic gastroenterology, 20 years in private community practice, a first-hand perspective of current gastroenterology practice business models, and extensive experience in quality improvement and development of both performance measures and the Digestive Health Outcome Registry.

For this initial article in the renamed section now called "Practice Management: The Road Ahead," I have outlined 5 overarching concepts that will likely alter our practices in the coming decade (The Road Ahead). Next, I will discuss a new, coordinated and proactive initiative of the American Gastroenterological Association (AGA) designed to help gastroenterologists in both community and academic practices meet the considerable challenges created by these concepts (Roadmap to the Future of GI Practice) and finish with a brief outline of articles to come (Practice Management: The Road Ahead).

The Road Ahead

The future of gastroenterology is spelled "PPACA." Actually, I am not referring to the Patient Protection and Affordable Care Act signed into law on March 23, 2010, by President Barack Obama. This is the health care act that has generated so much controversy and whose central tenet, compulsory financial participation in health insurance (also known as the individual mandate), is under constitutional review by the Supreme Court of the United States. A decision will likely be known by the time this article is published.

The PPACA that I will discuss refers to 5 concepts that are the foundation for current health care reform—all of which have bipartisan political support and are currently being implemented by both federal and commercial payers. Ramifications emanating from these 5 concepts will determine how we practice gastroenterology in the coming decade and what infrastructure will be needed to support our practices. This will hold true for large integrated delivery networks (IDN) including academic medical centers (AMC) and for practices that wish to remain physician-owned and independent of health system employment. Established IDNs may be in the best position to accomplish the health care imperatives of these 5 concepts because of their integrated business model (Figure 1). The major issue for independent gastroenterology groups will be whether they can successfully coexist with (and support) the overarching health care mandates for care integration for which IDNs are suited and equal the health outcomes and resource efficiencies of established IDNs. If they cannot or if they are unable to integrate their health information systems with regional hospital systems, then they likely will be left with little choice but to enter into employment within an IDN. Five concepts that will be both our greatest challenge and greatest opportunity are as follows:

- Performance measures
- Population management
- Aggregation
- Cost
- Accountability

In some form or another, all of these concepts are contained within the health care reform law. They support a nationally agreed-upon agenda to enhance value by improving health of both individual patients and larger patient populations while reducing cost.[1,2] This triad has been termed the "Triple Aim."[3]

Performance Measurement

Over the last decade, virtually all stakeholders have agreed that strategies to improve health care value must include public reporting of clinical outcome measures and linking such measures to reimbursement.[4] Hence, enormous efforts have

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Abbreviations used in this paper: AASLD, American Association for the Study of Liver Disease; ACG, American College of Gastroenterology; ACO, accountable care organization; AGA, American Gastroenterological Association; AMC, academic medical center; ASGE, American Society for Gastrointestinal Endoscopy; CCFA, Crohn's and Colitis Foundation of America; CMS, Centers for Medicare and Medicaid; EMR, electronic medical record; GI, gastroenterology; IDN, integrated delivery networks; NPMS, National Performance Measure Set; NQF, National Quality Forum.

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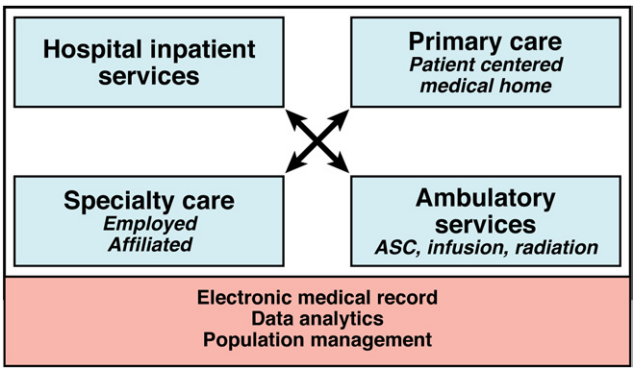

Figure 1. This figure illustrates the components of a typical IDN. IDNs usually include 4 parts of health care: hospital(s), primary care, specialty care, and ambulatory services. Specialists can either be employed or belong to an affiliated but independent single or multi-specialty group. The IDN is supported by robust infrastructure, including an electronic medical record and data analytics. Many IDNs are positioning themselves to be able to accept financial and performance risk for patient populations. Reprinted from Gastroenterology 2012, volume 143, pages 5–9.

been expended to develop valid clinical metrics to improve internal operations, develop process efficiencies, and report results externally. Thanks in part to the foresight of Martin Brotman, MD, AGAF, AGA, President in 2002, the AGA got ahead of the quality trend and began creating guidelines and measures to support quality efforts. Words written by Dr Brotman 7 years ago still ring true today: "The entire American health care delivery system (physicians and hospitals) must be motivated to lead the new approach to defining and improving quality rather than becoming passive recipients of mandates based on unpredictable objectivity."[5]

Until passage of the 2010 health reform law, the quality agenda in the United States was uncoordinated and confusing for providers, health systems, payers, purchasers, and patients. The new law addresses this confusion directly by calling for pertinent stakeholders to join together under a single national strategy. This effort now is coordinated by the National Priorities Partnership, an initiative overseen by the National Quality Forum (NQF), an entity that works under contract to the Centers for Medicare and Medicaid (CMS).[4]

In 2011, NQF, in conjunction with the Department of Health and Human Services, created the first National Quality Strategy that shaped infrastructure to build a National Performance Measure Set (NPMS). The NQF 2012 Report to Congress[4] states that the measure set will be a parsimonious collection of rigorously validated metrics that relate to health outcomes, patient experience, or resource use. Eighty-five percent of measures now used in public and commercial reimbursement programs have been endorsed by NQF and are contained in the NPMS; most others are pending review and endorsement.

Process and outcome measures differ in their focus and intent.[6] Process measures now are used primarily for internal quality improvement. Most measures related to "quality" of endoscopy are in fact process and not outcome measures, including adequacy of colonic preparation prior to exam, completeness of procedural documentation, or whether the colonoscopy included an examination of all areas of the colon. When the AGA, American Society for Gastrointestinal Endoscopy (ASGE), and American College of Gastroenterology (ACG) together recommended to NQF a composite measure concerning complete colonoscopy documentation, it was rejected because it did not correlate closely to a patient health outcome.

As described by Dorn,[7] the National Committee for Quality Assurance has been responsible for measures aimed at hospitals, health systems, and insurance companies and has created the Healthcare Effectiveness Data and Information Set Measures aimed at individual providers or provider groups, typically developed by the AMA-sponsored Physician Consortium for Performance Improvement, an entity that includes over 100 medical organizations, including AGA, ASGE, and ACG. Once measures are developed, they go through an evaluation, public comment, and endorsement process directed by NQF that typically requires about 18–24 months from point of inception to endorsement. Once endorsed, measures can be used in government or commercial incentive programs including the CMS Physician Quality Reporting System. Within this broad set of measures are a group of measures directly related to the practice of gastroenterology. Since 2006, the AGA has provided substantial staff and volunteer physician support in leading the effort to develop a gastroenterology-specific set of measures to include in the NPMS (GI-NPMS). Payers have indicated their need for endorsed measures that relate to both procedural and cognitive aspects of gastroenterology for use in value-based reimbursement. Current measures in the GI-NPMS are listed in Table 1. The development of GI-NPMS has been a result of close cooperation among the AGA, ASGE, ACG, American Association for the Study of Liver Disease (AASLD), plus the Crohn's and Colitis Foundation of America (CCFA) for measures related to inflammatory bowel disease. As a result of this cooperative effort, we have avoided creation of duplicative or competitive accountability measures for our specialty.

Within a few years, Physician Quality Reporting System measures and those used in commercial payer incentive programs will be consolidated into the NPMS and will form the basis from which measures specific for specialists or primary care will be derived and used for value-based payments from the federal level to regional accountable care organizations (ACO). Persistent attention to this evolving infrastructure by our societies has been important to assure development of measures that are fair, reasonable, and important to gastroenterologists and their patients.

Population Management

The coming decade in health care will be characterized by intense cost pressure and a demand for clinical coordination, especially for patients with complex or chronic diseases. This has given rise to ideas to build ACOs, patient-centered medical homes and medical neighborhoods where specialists assume principle care for patients with chronic illnesses related to their practices.[8] Gastroenterologists, who traditionally served as consultants to patients as individuals, may be confronted by a request to demonstrate success at improving the health of a population of like patients.[9] The emergence of large IDNs willing to assume responsibility for population-based clinical outcomes[10] or willing to contract for "total cost of care"[11] has set a high bar for other health care systems to meet. As large employers begin to steer their patients toward high-performing IDNs, independent GI groups will be challenged to develop business infrastructure to demonstrate similar results.