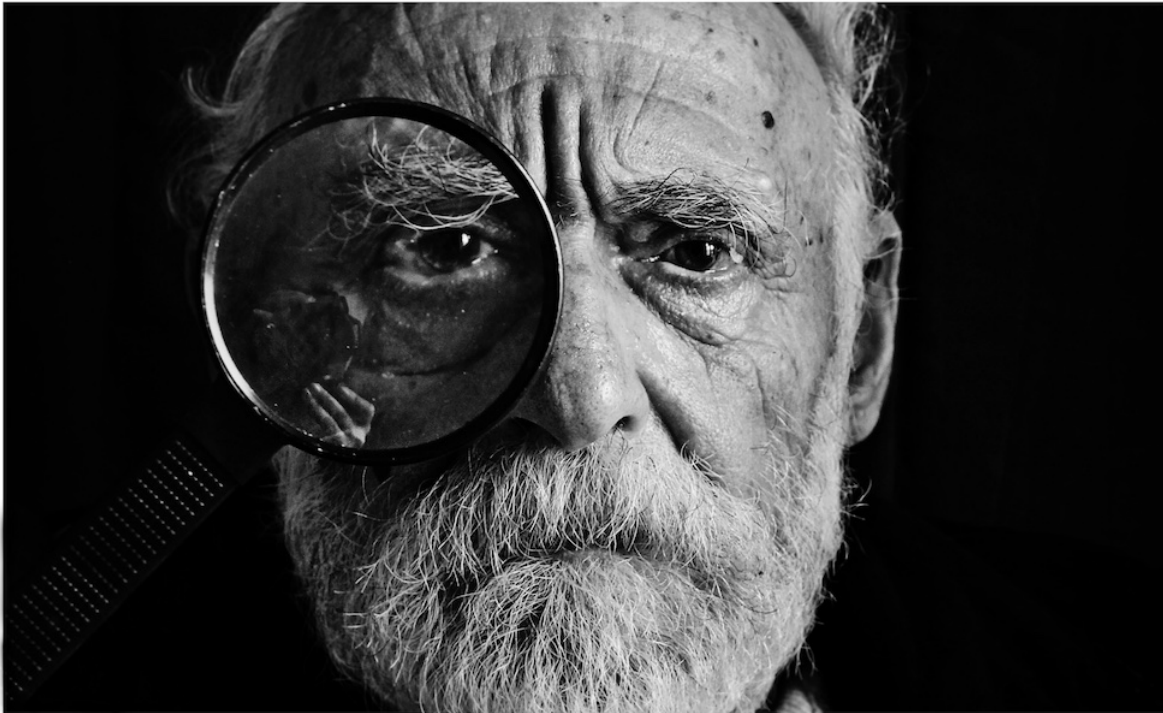


# How to Improve Patient Outcomes with a Multi-Specialty QCDR

written by Dave Halpert | June 1, 2017



Care coordination and HIT interoperability are touted throughout the healthcare world as “must haves” for any provider, practice or health system. The reason is simple: information from multiple sources helps providers and patients to make informed clinical decisions and provide better care.

A key pillar in any program that quantifies whether providers are “meaningfully using” their EHRs is the ability to send and receive information on a specific patient. If that’s true at the point of care, doesn’t it make sense that performance measurement and improvement would benefit from the same treatment?

Qualified Clinical Data Registries (QCDRs) were created specifically to go beyond the administrative task of quality reporting in order to help providers improve care. A [QCDR that can take in data from multiple sources and multiple specialties](#), including data from hospitals, ambulatory practices (for both private and employed providers) and others (e.g. patient satisfaction survey vendors), can track patients and populations across the spectrum of care, creating a global view of outcomes and costs.

This view of the whole patient sheds light on the “why” behind health episodes. Those using Specialty-Centric QCDRs can track specific outcomes in detail and gain insight on where they stand compared to others who perform similar services. The drawback to this approach is that opportunities for improvement are only apparent when you attempt to see the bigger picture. Specialty-Centric QCDRs significantly benefit the evaluation of specialty-specific outcomes and results. But if you’re in an academic or multi-specialty setting, they may not satisfy all the needs of the entire organization to meet cost and value goals.

## Locus of Focus: The Difference Between Multi-Specialty and Specialty-Centric QCDRs

Specialty-Centric QCDRs pool data from specialists across the country, enabling them to aggregate and benchmark information related to specific conditions, procedures and settings. Ideally, specialists who utilize these systems can continually raise the bar in each setting. As each specialty improves its own care, better outcomes and lower costs will follow. Certainly, there are benefits to this approach, such as comparative studies of the efficacy of specific techniques, long-term disease- or procedure-focused studies, and resulting improvement of existing treatment outcomes.

The drawback to an exclusive specialty focus is the narrowly focused setting. In a Specialty-Centric Registry, poor outcomes are a reflection of the provider, and to [improve outcomes](#), the burden sits exclusively on that provider’s shoulders.

Multi-Specialty QCDRs, in turn, draw from a larger dataset of both primary care and specialty contributed data, and the patient issues can become clearer. By looking at all specialties in the network, a multi-specialty QCDR can follow the patient across the spectrum of care. In so doing, the QCDR can integrate data from outside of one specialty group, adding context to patient outcomes. In other words, a multi-specialty QCDR assumes that measurement and improvement cannot occur in a vacuum.

Both types of review have their purposes. Ideally, data should be shared between specialty and multi-specialty organizations to perform both specific and multi-factor review of patient outcomes.

## Episodic Costs: An Illustrative Benefit of Multi-Specialty QCDRs

Episodic care—treatment provided before, during and after a hospitalization—has gained significant attention over the last several years. Programs like [Bundled Payments](#) (whether

voluntary or mandatory) and the distribution of Supplemental Quality and Resource Use Reports (SQRURs) highlight how tracking patients across specialties is critical to understanding patient experience and outcomes.

For example, if a surgeon hits all marks during a procedure, but the episode produced astronomical costs (e.g. the patient did not follow up with a primary care provider and developed a subsequent complication), who benefited? It certainly is not the patient, and unless the reasons behind those costs are examined, other patients are similarly at risk.

By looking at the underlying causes of [high episodic costs](#), a multi-specialty QCDR can help you address them, benefiting both the provider and the patient. Understanding episodic cost is critical—not because of the pending scoring in MIPS, but because the episodic costs are indicative of whether complications have occurred, and with what frequency. If your costs per episode are out-of-sync with what’s expected, you need to know why.

## Next Steps: Develop System-Wide Improvement Techniques with a Multi-Specialty QCDR

Using a Multi-Specialty QCDR, you have the ability to look across the network. The specialty-specific data is still there, with a rich context. Indeed, the right Multi-Specialty QCDR can act as a hub between Specialty-Centric QCDRs. This benefits all providers—and their patients. Here are just a few examples of how a Multi-Specialty QCDR can facilitate improved outcomes and decreased costs:

### Track follow-up visits following a surgical procedure, a “scary” diagnostic, or post-discharge.

At these visits, providers can identify early signs of complications, investigate other providers’ concerns, answer patient’s questions, clarify discharge instructions, and customize treatment plans—all of which can facilitate a quicker recovery or slow the progression of disease. An advanced Multi-Specialty QCDR can track patients across the network, whether in the hospital or in the ambulatory setting—even if that means matching patients between separate EHRs (and even if patients do not share medical record numbers across data sources). This facilitates improved care coordination, as well as reduced costs.

## Provide mechanisms for improving rates of screening and/or early detection.

In systems where [screening](#) is lacking, potential concerns become real concerns. What could have been a simple screening and follow-up becomes a high-cost—and sicker—patient who needs specialty care. Specialty-Centric QCDRs recognize that complex or advanced cases are more likely to result in poor outcomes. Providers won't necessarily be penalized in these situations, as these patients will be risk-adjusted during scoring; but, once again, while this process attempts to compare providers fairly, patient information may not receive enough attention because care extends beyond the specialists.

A Multi-Specialty QCDR can engage certain specialists and primary care providers in collaborative projects and screening activities designed to keep patients healthy. Determining, for example, which patients are overdue for screening and quantifying improved screening rates following outreach puts the emphasis back on improving patient care.

## Obtain clinician feedback to identify underlying causes.

In cases where an unexpected outcome has occurred, feedback from clinicians can provide insight into why. For example, a high re-admission rate alone is not actionable. The Multi-Specialty QCDR may also allow for providers to submit feedback on contributing factors, and these may be related to something outside of a provider's control. A Specialty-Centric QCDR may be able to identify that a set of providers have high re-admission rates, but a Multi-Specialty QCDR can show that this may be due to poor discharge instructions or excessive admissions through the emergency department.

Multi-Specialty QCDRs can [strengthen your network](#) for patients and providers alike. A patient who requires specialty care is not likely to select a practice that's a thousand miles from home, even if that practice's outcomes are better than a local group. The flip side is true, too—the specialty group has limited control over their patient pool, as referrals are going to come mostly from local networks. Therefore, it's in both patients' and providers' best interest to improve care at the system level. By partnering with a QCDR that can look across the spectrum of care, you can provide excellent care as a unified network while still collaborating with Specialty-Centric QCDRs to improve their outcomes.

*Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through [Solutions](#) that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.*

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