

Premier Embarks on 3-Year 'Quest' for Quality

BY MARY ELLEN SCHNEIDER
New York Bureau

Over the next 3 years, more than 100 hospitals will collect quality data on mortality, appropriate care, efficiency, harm avoidance, and patient satisfaction with the aim of improving care and controlling costs.

The Quest: High Performing Hospitals project, which was launched by Premier Inc., a hospital performance improvement alliance, is also designed to test performance measures that will likely be included in future pay-for-performance programs.

"It's an opportunity to learn but also to guide the industry," said Stephanie Alexander, senior vice president and general manager of Premier's informatics division.

In the short term, the program is aimed at preparing hospitals for a world of value-based purchasing and pay for performance. Over the long term, it should help hospitals improve quality and safety while safely reducing costs. "It's really a laboratory," said Dr. Richard A. Bankowitz, vice president and medical director for the informatics division.

Premier began recruiting hospitals for the program last summer and in January started collecting quality data. Over the course of the project, Premier will collect data on the following:

► Mortality, by using a risk-adjusted ratio to measure progress toward the goal of eliminating all avoidable deaths.

► Evidence-based care, via a measure of the percentage of patients receiving "perfect care" based on nationally recognized quality measures.

► Efficiency, through a measure of total inpatient cost per case-mix-adjusted discharge, including all of the costs associated with each episode of acute care.

► Patient experience, as measured using the Centers for Medicare and Medicaid Services' Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient satisfaction measures. The program will also study how patient satisfaction can relate to cost, quality, and safety.

► Harm avoidance, via measures of the prevention of health care-associated infections and adverse drug events. Premier is working with the Institute for Healthcare Improvement to develop automated measures of harm that can be reported without having to perform a manual chart review.

The first year of the program will focus on mortality, evidence-based care, and efficiency. The hospitals will take on harm avoidance and patient satisfaction during the second year.

Premier will analyze the data from each hospital, disseminate best practices among the facilities, and provide financial incentives to the top-performing hospitals at the end of the 3-year project. The amount of the reward pool has yet to be determined. However, there are no penalties for hospitals who don't meet the goals.

There was no cost for hospitals to participate, Ms. Alexander said, but they needed to have a commitment at both the

executive and board levels to meeting the quality goals. They also had to commit to data collection and sharing best practice knowledge, she said. Premier also encouraged hospitals not to make Quest a "special" project but to incorporate it into the everyday business of the facility.

The project builds on the success of the Hospital Quality Incentive Demonstration project, a pay-for-performance initiative performed in collaboration with the Centers for Medicare and Medicaid Services

that showed significant improvements in quality and reductions in the cost of care.

The Medicare demonstration showed that hospitals can improve both quality and cost and that there is no reason to think the lessons learned can't be applied beyond the conditions in the pilot project, said Dr. Stephen Schoenbaum, executive vice president for programs at the Commonwealth Fund and a member of the Quest advisory panel.

North Mississippi Health Services in

Tupelo didn't participate in the Medicare demonstration project, but they matched its progress on their own; this time around they were the first to sign up for Quest.

It's obvious that both the government and private payers are moving forward with pay for performance, said Dr. Ken Davis, chief medical officer for North Mississippi Health Services. He and his colleagues want to ensure that when the payers move forward, the measures used are valid, fair, and clinically relevant.

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Are certain patients at greater risk for rapidly progressing RA?

Joint damage is responsible for much of the disability associated with rheumatoid arthritis (RA).¹ Early diagnosis and effective treatment may play a critical role in preventing functional decline and loss of quality of life—especially in patients with poor prognosis.²

The course of radiologic damage in RA is not completely understood. The amount of damage seen on radiographs of RA patients can vary widely. It remains unclear whether erosions and joint space narrowing are equally important in determining degree of radiologic damage. In addition, there is little detailed information on the rate of progression of radiologic abnormalities from disease onset. Some studies suggest a nonlinear, first-order kinetics model with most of the damage progression occurring in the initial years; other studies suggest a linear, stable rate of progression throughout the course of the disease.³

Despite these questions, there is little doubt about the correlation between radiologic damage and disability in RA.¹ Data from 10 prospective, longitudinal studies indicate significant correlations that become more obvious as disease duration increases.¹ It has been suggested that physical disability in early RA is largely determined by disease activity, while in late RA, joint damage plays a more important role.⁴ In addition, patients at risk for long-term disability are those with seropositive erosive disease and high initial average Health Assessment Questionnaire scores.¹

There is a clear case for identifying and treating RA patients early. Finckh, et al, conducted a meta-analysis of 12 studies to examine the correlation between late therapeutic initiation and joint damage. An average delay in treatment start of 9 months altered disease progression over the long term. However, early initiation of therapy reduced radiologic damage, resulting in a dramatically altered disease progression curve. (See Figure 1.)⁵

Despite the evidence that rapidly progressing RA benefits from early and aggressive treatment, early diagnosis has proven difficult in many patients. In many cases, American College of Rheumatology criteria may not be met in patients who nevertheless will deteriorate rapidly.⁶

There are measurable variables at initial visit that can identify patients at high risk for rapid radiologic progression. (See Table 1.) Of particular interest is arthritis of the large joints, especially the knee.⁷ In a Linn-Rasker, et al, regression analysis of 1009 patients, arthritis of the knee at initial presentation was revealed to be a strong predictor of a more destructive course of disease.⁷ Also compelling is a study by Taylor, et al, that demonstrated a clear relationship between sonographic measurements of synovial thickening and vascularity at baseline to magnitude of radiologic joint damage at Week 54.⁸

These markers may present a means to identify rapidly progressing RA patients early in the course of the disease, rather than risking unsuccessful treatment with less aggressive therapies. Early and more aggressive treatment for appropriately identified patients has the potential to reduce further radiologic joint damage and functional decline.²

Figure 1. Early therapeutic initiation alters RA progression over time⁵

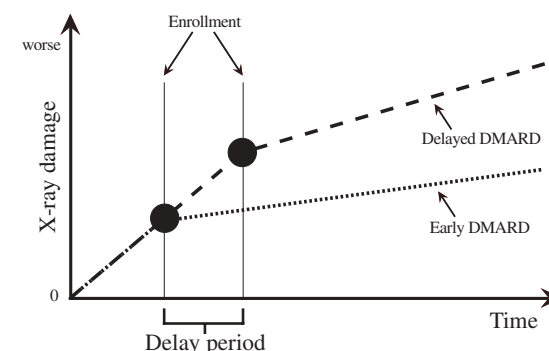


Table 1. Measurable variables at initial visit to identify high-risk patients^{4,6-9}

- Swollen joint count
- Erythrocyte sedimentation rate
- Serum IgM rheumatoid factor
- Arthritis of the large joints, particularly the knee
- Anti-cyclic citrullinated peptide antibodies
- Synovial thickening and vascularity at baseline

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inc

800 Ridgeview Drive
Horsham, PA 19044
USA

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