



This article is based on a presentation by Heather Smith, PT, MPH, Director of Quality, American Physical Therapy Association, at the 2017 FSBPT Annual Meeting.

PT Outcomes Registry and Continuing Competence

In February of 2017, the American Physical Therapy Association (APTA) launched the Physical Therapy Outcomes Registry, a clinical data registry, which it hopes will increase patient safety, improve continuing competence, and take the guesswork out of payment for services.

Many medical associations and other professional associations have registries. One key use of registries in years past has been on issues related to patient safety. Medical devices and pharmaceutical registries many times track events that can cause harm in an effort to stop them beforehand.

Clinical data registries are a bit different. While they can also track those types of issues, clinical data registries can also provide more insight into clinical practice. They can provide information about how many times a patient is seen for a particular diagnosis and what typical clinical practice patterns might be expected for certain patient populations.

The Physical Therapy Outcomes Registry is patient-focused across the care continuum and across care settings. It will help the profession and key stakeholders better understand what clinical practice looks like. That, in turn, will improve efficiency and patient care and safety.

Understanding clinical practice is essential moving forward. Healthcare is shifting from a traditional volume-based payment structure to more of a value-based payment structure. Providers will need to have data to be able to articulate the value they bring and navigate some of the new payment models. Additionally, payers are beginning to look for the kind of data contained in the outcomes registry.

Key Components in the Registry

The registry contains several key components: quality, research, and payment.

Quality measures are used in a variety of programs. Historically, quality measures have been, for the most part, measures that look at care process. Did you do something that's part of evidence-based practice? Did you assess pain on the first visit? Do you have a full list of medications in a chart? For patients who are at risk of falls, did you do an appropriate fall

screening?

Broadly collecting data on those quality measures across a wide spectrum of practices will allow the profession to gain metrics around issues important from a patient harm perspective. It will allow researchers to pinpoint national benchmarks on how many therapists screen for patient falls and how many do a standardized pain assessment and intervene on that when there's a risk. In the past, most of APTA's quality measures have been developed by payers. The Physical Therapy Outcomes Registry will allow the profession, for the first time, to start to develop measures that are meaningful and important to practice from a patient-harm perspective. It also will ensure the profession is better able to assess and control for variation in practice.

Research is a long-term goal. Obviously, a lot of data needs to be in the registry to be able to look at research, but this is a changing dynamic in the healthcare environment. In years past, research was driven by randomized control trials. These scientific, rigorous studies took years to conduct and years to bring to publication. That research is now being complimented by clinical registries collecting real-time data. The data sources are different, but complementary. Clinical practice guidelines is an area in which the ongoing collection of data will be able to help the profession make adjustments to best evidence-based practice without waiting 17 years for peer reviewed research to come to publication.

Payment is another important area. This is a way to start to empower the profession to think about how it can better understand the value brought, and be appropriately paid for, by physical therapy in new models of care that are much more episodic-based and patient-centered than they have been in the past. Payers are also probably interested in this data. From a professional standpoint, therefore, one of the things the profession must quickly develop is a comprehensive set of measures representative of some of the value the profession brings. They can include measures that look at the average number of visits for certain episodes of care, but also look at clinical aspects, like changes in function over an episode of care or other integral pieces in the care continuum for very specific patient populations.

How It Works

The registry works on a sophisticated information technology structure that extracts clinical information from a clinical record, electronic health records, or electronic medical records. The information is imported into the registry and visual reports are created to make the data more meaningful to the typical provider. Those reports can show up in a variety of ways. For example, it may be the registry's typical red light, green light score card on a quality measure. If the national benchmark is 70% and the provider is performing at 80%, they're in the green. If the provider is performing at 70%, they're still in the green. A little less than that, they will be in the yellow. Further down the scale, they will be in the red. It's a quick snapshot for that provider to be able to understand the data.

Types of Data Collected

The registry first identifies where the facility or practice is located geographically and the type of facility. Some basic information about providers is collected at the National Provider Identifier (NPI) level. In addition, the registry collects detailed information about whether the providers have completed a fellowship or residency, when they graduated, and information on their terminal degree and specialization.

The registry's primary mission is to collect data across the care continuum and across the life span for patients, which is a little different from the way the profession traditionally has approached data collection. The focus here is to understand more clearly what happens in practice. It's not just recording a patient in one episode in one setting, but better understanding what happens as practitioners treat and manage chronic disease. With the registry, caring for patients who have multiple sclerosis, or who've sustained a stroke at some point and need ongoing care, can be better understood. There can be a better understanding about what pediatric patients look like across the life span as they move into adulthood.

The registry will allow the profession to ask questions about more proactive care, preventative care, and how that may impact the care continuum, with a goal of changing overall practice.

What We Can Learn from the Data

The data contained in the registry can help a therapist identify that their treatment variation for the stroke population is 10 to 32 visits. The therapist can then analyze why a patient would need to be seen for the high end of 32 visits and explore if treatments are available that can lower that number. The clinician can also compare their average to another clinician.

The registry's clients will be able to look at the data to see what their overall business looks like. They can determine the average number of visits for that stroke population in their clinic and also identify potential variations between their clinic sites. If the client has three locations and there is variance, they can look at potential causes, such as patient demographics, experience of the clinician, or more complex ailments at one clinic over another. The goal is to take the data generated at the clinical level and seamlessly provide that back to the provider in a way that is actionable, intuitive, and meaningful.

Benchmarking is key to the registry. The goal, when enough data is collected, will be to establish national benchmarks, and ultimately regional and state benchmarks, where appropriate. The registry would look to define specific measures of clinical practice quality measures that are evidence-based and critical to success, taking practice setting into account.

Some measures may be overall measures that APTA believes are important, such as risk screening for falls in high-risk patient populations, which could cross multiple diagnoses and multiple patient populations, versus something that's very specific. Or ensuring the best evidence-based care is delivered to a stroke population. The evidence may show this population needs a certain intervention at a certain time and that therapists need to make sure they're not doing a different intervention. It may be a must do versus a not do.

The data will help the profession understand where there might be risk or where there may be a need for better education. The registry's clients may look at the data and see they're doing an amazing job with their orthopedic patients, but really struggling with their neurologic patients. The goal here would be to help them to find the solutions to improve their practice in that area and then go back in and re-assess.

Benefits for Medicare and Other Payers

Under Medicare Part B's newest quality payment program, physical therapists may

voluntarily participate in the Merit-Based Incentive Payment System (MIPS). When physical therapists are required to participate in MIPS, which will potentially occur in 2019, the registry will be very useful because MIPS reporting can be incredibly complex.

Most of the data currently available to payers is simply utilization data. It cannot explain the variation in practice. For example, difficulty with walking or knee pain can represent a variety of different patient conditions. Difficulty with walking for somebody who comes in with a mild ankle sprain is going to look incredibly different from a patient who has multiple comorbidities, is older in age, and has had a significant stroke. Right now, it is very difficult to discern those two patients. What the data says is they both have that diagnosis. But one patient is seen for four visits and the other one for 22. That's difficult to explain to the payers.

From a practice standpoint, the post-acute care setting is under tremendous pressure currently to begin to ask questions about whether a patient should go to inpatient rehab versus skilled nursing versus home health. As the payment structure in this country changes, the profession is beginning to make it patient-centric and to better understand how the patient should flow through the care continuum. Practitioners will need to answer those questions. And the only way to do that is to collect data across care continuum and payers and to be able to bring that data together in different ways.

Registry has a Long Way to Go

Since the registry was launched in early 2017, some 250 to 500 practitioners have signed on. Some are contributing to the registry now, some have undergone contracting but have not yet connected their electronic data, and others are a little earlier in that contracting process. APTA is spreading the word by going to professional meetings, everything from physical therapist-specific such as the Federation of State Boards of Physical Therapy, to organizations like the National Association of Housing and Redevelopment Officials (NAHRO), which is more of a rehab association. APTA plans to intensify its efforts over the next year.



Heather Smith, PT, MPH, currently serves as Director of Quality for the American Physical Therapy Association. In her current role, Heather leads and coordinates quality initiatives for the Association and develops key member resources related to quality for programs under Medicare that impact PTs. She serves in a consulting role for the Physical Therapy Outcomes Registry, with a focus on measure development and compliance with quality reporting regulations. She has presented nationally on quality related topics that impact PTs.