



# ABCs – Alphabet Soup

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# Conflict of Interest

**I am a paid consultant who provides guidance on compliance and quality metrics with AIMS.**



# Objectives

- To better understand the myriad acronyms confronting our profession
- Understand the rationale for shift from 'pay for volume' to 'pay for value'
- Understand the definitions of Quality Metrics
- Understand the implications of NOT reporting Quality Metrics

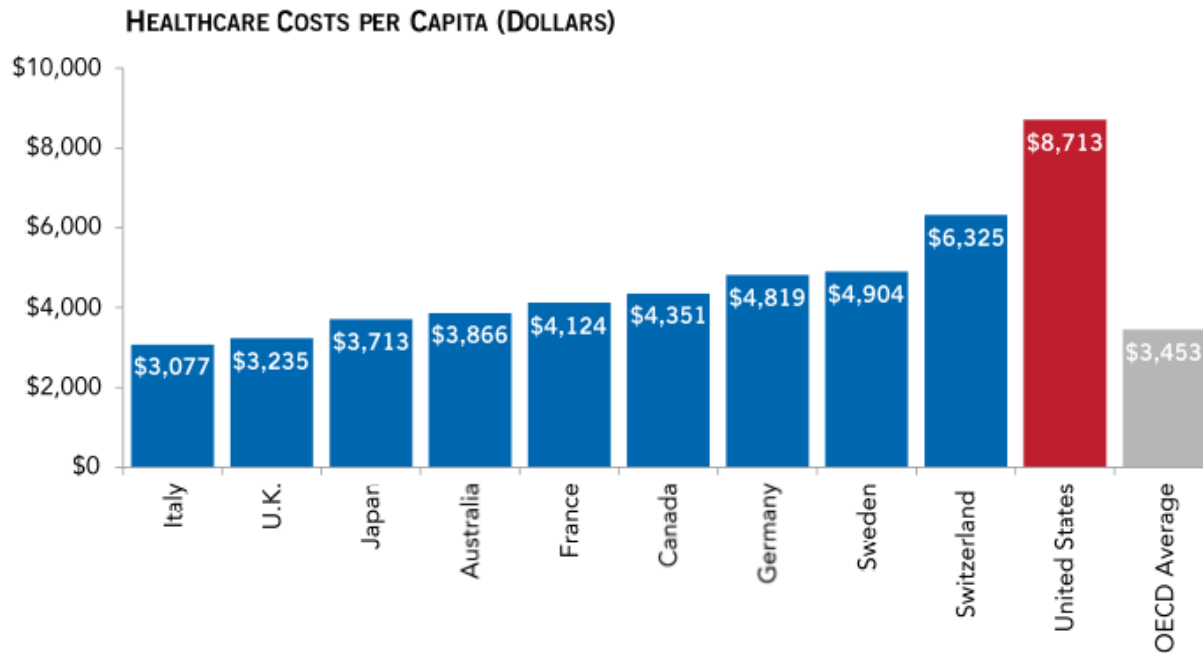
# Alphabet Soup

- ACA
- EP
- PQRS
- QCDR
- MACRA
- MIPS
- VBM
- APM
- NPA
- OMG

# Per capita spending in HC



United States per capita healthcare spending is more than twice the average of other developed countries



SOURCE: Organization for Economic Cooperation and Development, *OECD Health Statistics 2015*, November 2015. Compiled by PGPF.

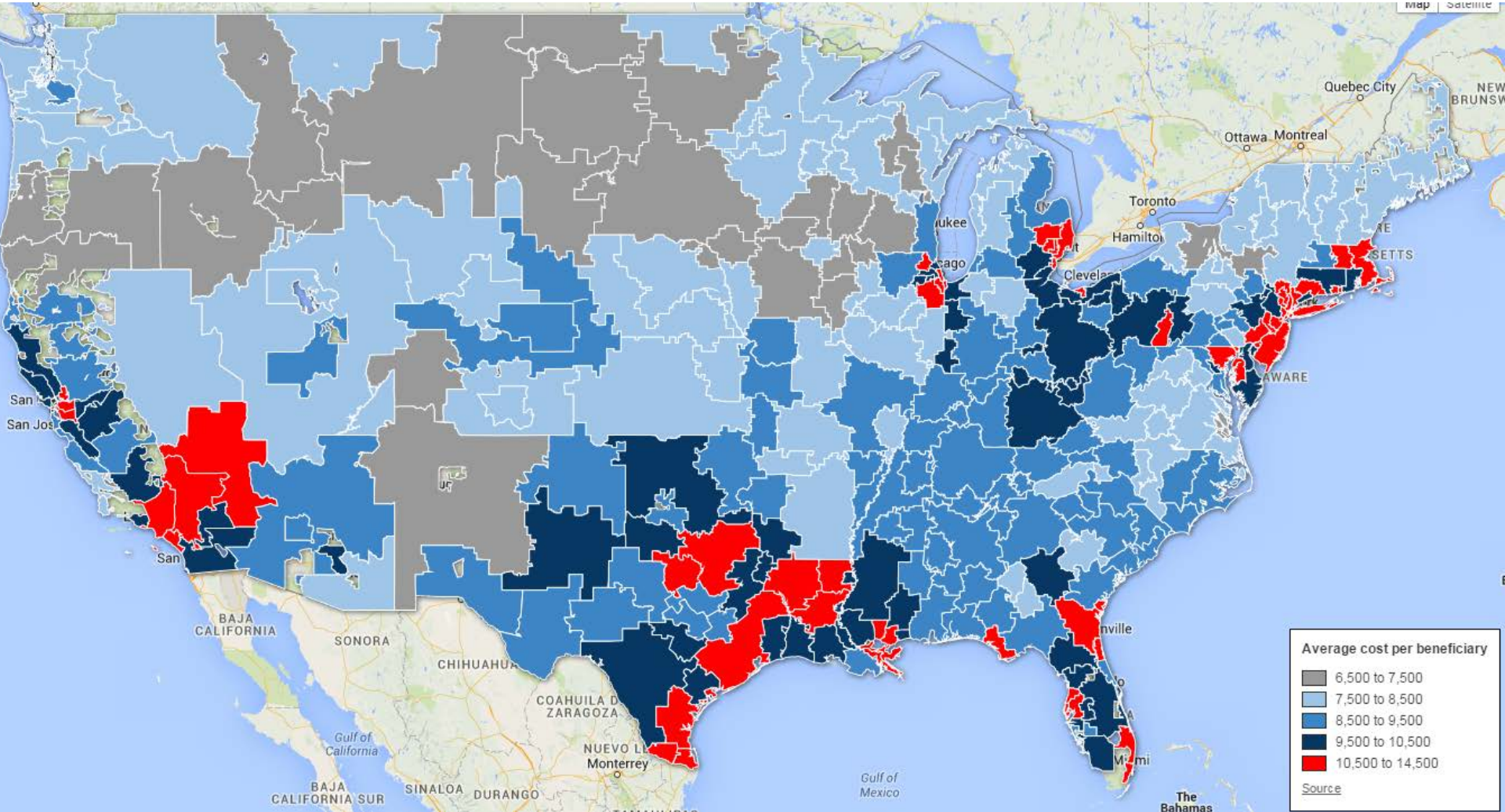
NOTE: Per capita health expenditures are for 2013, except Australia for which 2012 data are the latest available. Chart uses purchasing power parities to convert data into U.S. dollars.

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PGPF.ORG

[http://www.pgpf.org/chart-archive/0006\\_health-care-oecd](http://www.pgpf.org/chart-archive/0006_health-care-oecd)

# 2011 Cost per Medicare Beneficiary – US Interactive Map

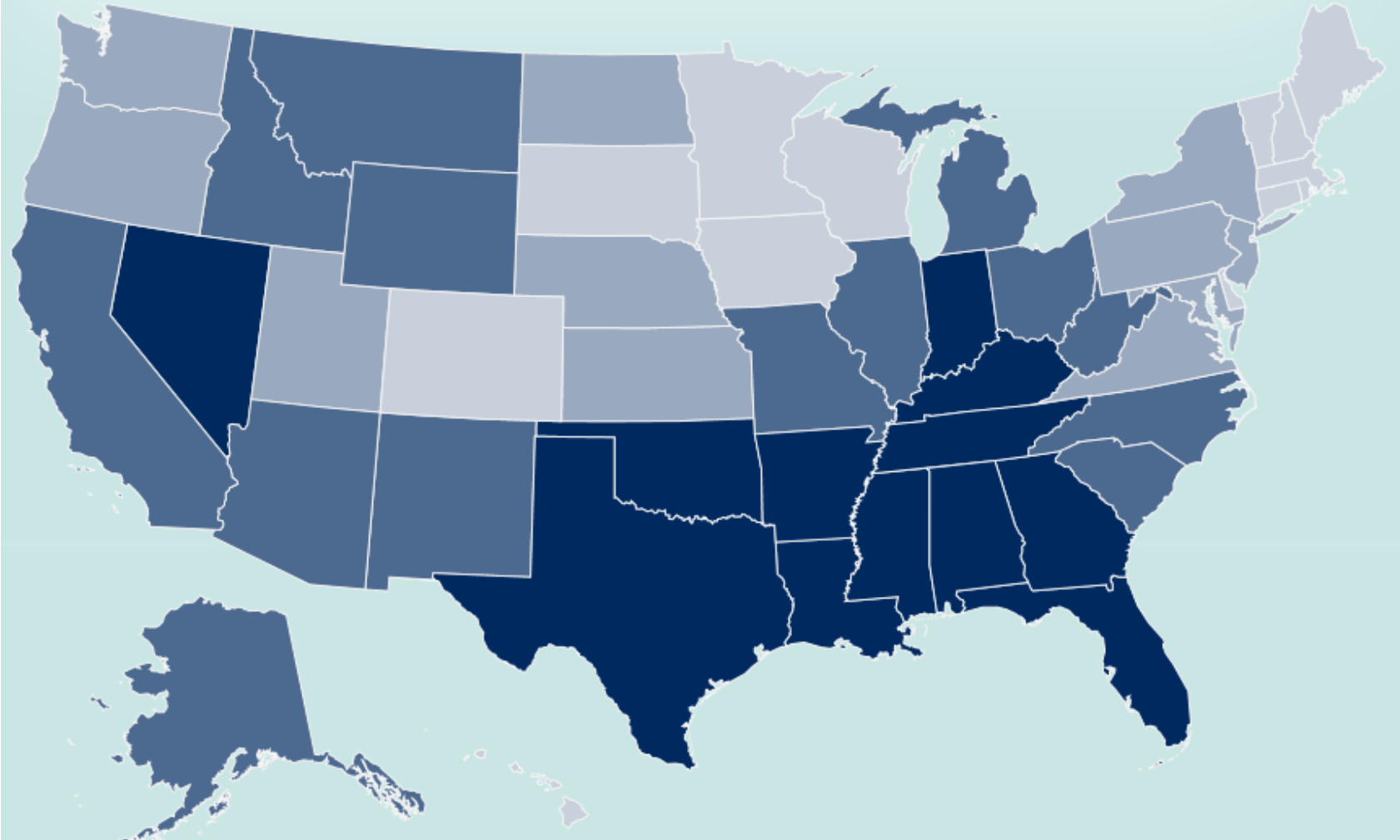


<http://pgpf.org/issues/health-care/2013-medicare-map>

Source – Peterson Center on Healthcare

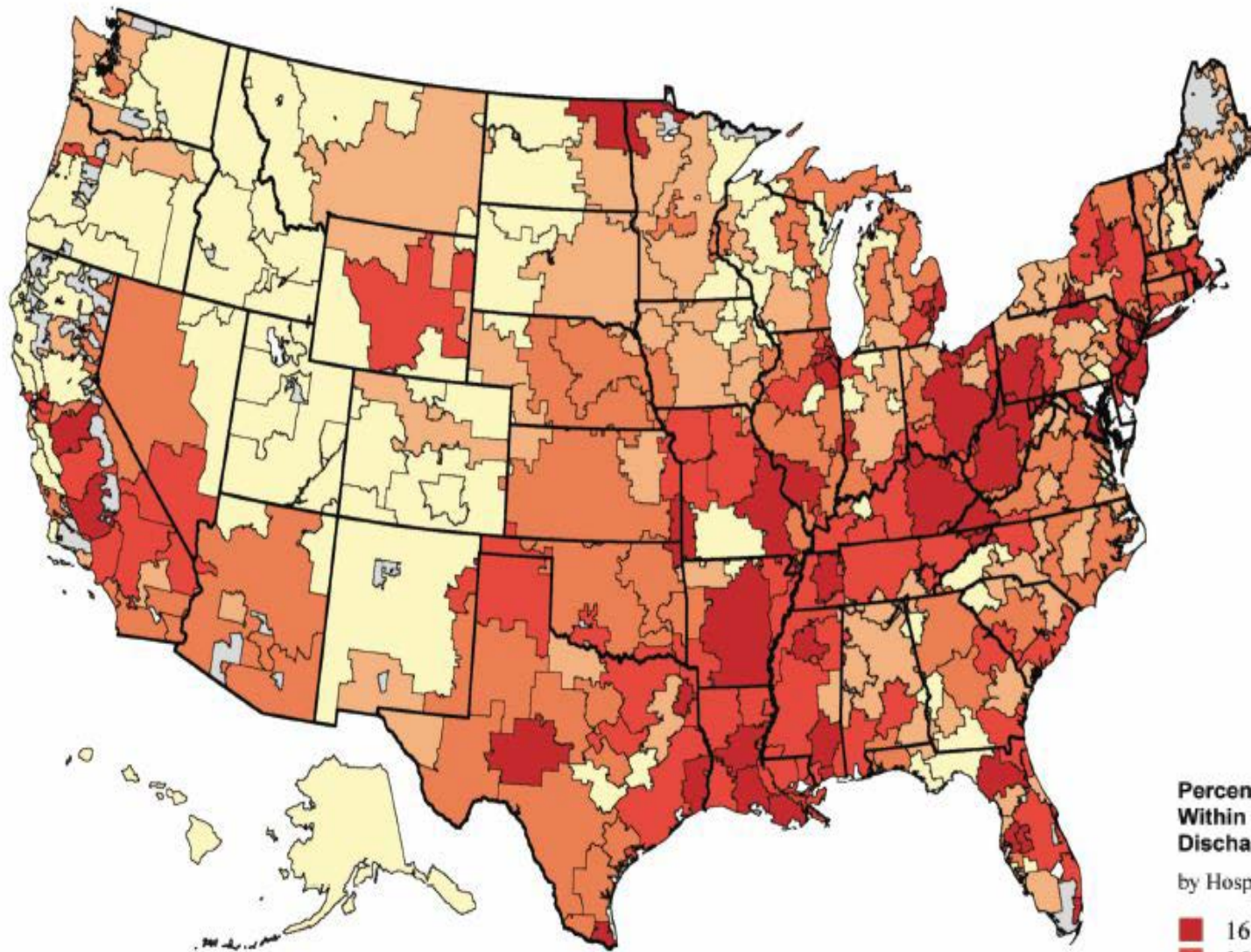
## Overall Ranking, 2014

○ Top Quartile    ● Second Quartile    ● Third Quartile    ● Bottom Quartile    ○ No Data



**US map all Quality Indicators**

<http://www.commonwealthfund.org/publications/fund-reports/2014/apr/2014-state-scorecard>



**Percent of Patients Readmitted  
Within 30 Days of Medical  
Discharge**

by Hospital Referral Region (2009)

■	16.7 to 18.9	(57)
■	16.1 to < 16.7	(59)
■	15.6 to < 16.1	(61)
■	14.8 to < 15.6	(63)
■	11.4 to < 14.8	(63)
□	Data suppressed	(3)
■	Not populated	



# Pursuing the Triple Aim

- CMS provides coverage for 100 million patients
  - Nearly 1/3 of all US citizens
- Institute of Medicine's six aims
  - Safe, Effective, Patient-centered, Timely, Efficient, Equitable
- Institute for Healthcare Improvement's Triple Aim
  - Better care, Better health, Reduced costs
- Patient Protection and Affordable Care Act (ACA)

# Healthcare Reform

Reforming health care

**This is going to hurt**



# Quality Metrics

## Hospital Reporting:

### 1. Core Measures

- Acute MI
- Pneumonia
- CHF

### 2. SCIP Measures

- Surgical Site Infection Reduction
- VTE Reduction
- Beta Blockers

## Surgical Care Improvement Project Core Measure Set

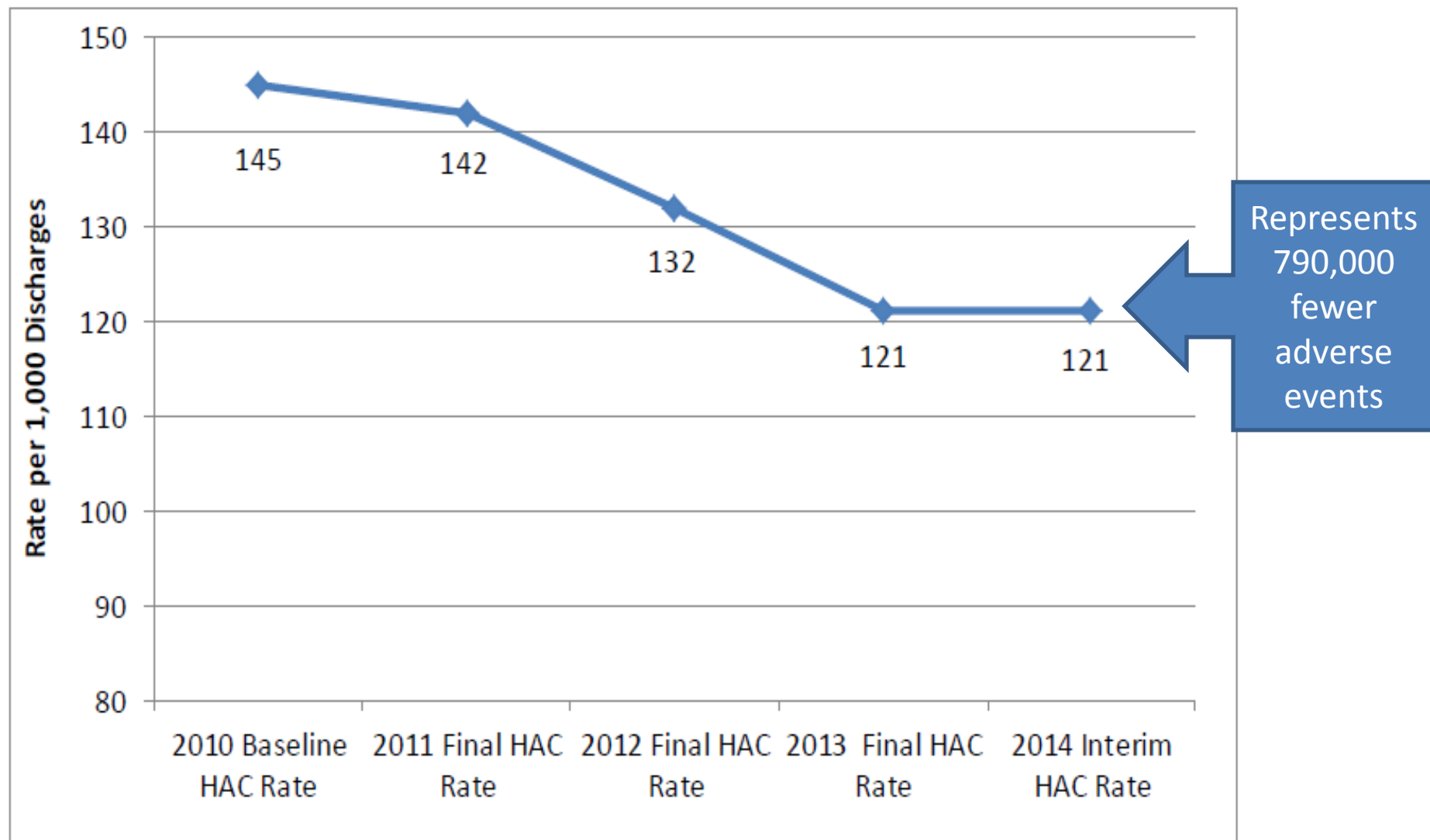
Set Measure ID #	Measure Short Name
<b>SCIP Inf-1</b>	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision
<b>SCIP Inf-2</b>	Prophylactic Antibiotic Selection for Surgical Patients
<b>SCIP Inf-3</b>	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
<b>SCIP Inf-4</b>	Cardiac Surgery Patients With Controlled 6 A.M. Postoperative Blood Glucose
<b>SCIP Inf-6</b>	Surgery Patients with Appropriate Hair Removal
<b>SCIP Inf-9</b>	Urinary catheter removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with day of surgery being day zero <sup>@</sup>
<b>SCIP Inf-10</b>	Surgery Patients with Perioperative Temperature Management <sup>@</sup>
<b>SCIP Card-2</b>	Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period
<b>SCIP VTE-1</b>	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
<b>SCIP VTE-2</b>	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery

# Compliance with Surgical Care Improvement Project for Body Temperature Management (SCIP Inf-10) Is Associated with Improved Clinical Outcomes

- 45,000 inpatients
- Lower incidence hospital acquired infections [7.5% vs 12.9%]
- Lower ischemic cardiovascular events [1.4% vs 3.1%]
- Lower hospital mortality [1.4% vs 4.8%]
- Median hospital length of stay reduced [4 vs 5 days]

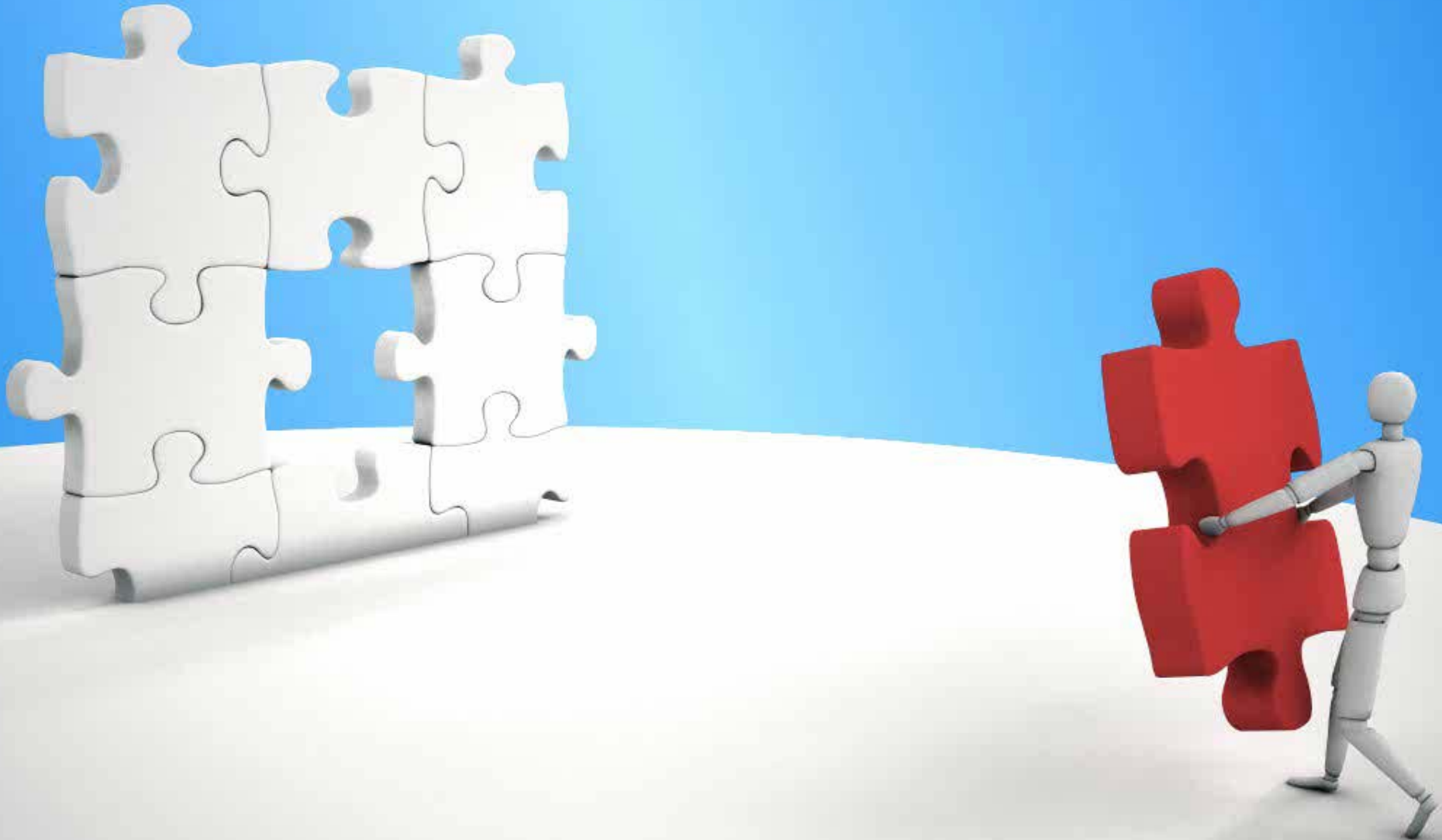
Scott A, Stonemetz J, Wasey J, Johnson D, Rivers R, Koch C, Frank S  
Anesthesiology 2015; 123:116-125

**Exhibit 1. HAC Rates, 2010 to Interim 2014**



<sup>1</sup> AHRQ Partnership for Patients Web page for methods and data: <http://www.ahrq.gov/professionals/quality-patient-safety/pfp/index.html>.

# How do we integrate physicians in healthcare?



# Metrics

- Quality Metrics
  - PQRS
  - Patient/Physician Satisfaction
- Performance Metrics
  - Waste reduction
  - Elimination of Variation
- Productivity Metrics
  - Case Counts
  - RVUs



# Anesthesia Scorecard - March 2012

	Quality						Service	
	On-time Administration of antibiotics (PQRI 30) <sup>1</sup>	Prevention of Central Blood Stream Infection <sup>1</sup>	Normothermia <sup>1</sup>	Medication Management	Professionalism <sup>2</sup>	SCIP Measure	Surgeon Satisfaction (one to five scale) <sup>3</sup>	Anesthesia Delay % <sup>4</sup>
<b>Benchmarks Internal</b>	90.0%	90.0%	90.0%	95.0%	90.0%	See Below	3.25	<5%
<b>HCAPS Employed</b>								
West Florida	97.4%	100.0%	97.9%	N/A	96.6%	99.5%	4.20	1.25%
Ft Walton Beach	99.5%	100.0%	99.0%	N/A	91.0%	100%	4.90	1.10%
Redmond	97.3%	96.8%	97.8%	N/A	91.3%	99.6%	4.79	0.00%
Ocala/West Marion	99.3%	90.9%	99.9%	N/A	91.7%	100%	4.57	0.53%
San Antonio <sup>5</sup>	98.3%	95.0%	99.3%	N/A	N/A	N/A	4.88	0.12%
<b>Total</b>	<b>98.4%</b>	<b>96.5%</b>	<b>98.8%</b>	<b>N/A</b>	<b>92.6%</b>	<b>99.8%</b>	<b>4.67</b>	<b>0.53%</b>

NR Data not reported

N/A Not available

<sup>1</sup> Aboe

<sup>2</sup> Hospital Medical Record

<sup>3</sup> Hospital Survey

<sup>4</sup> FL Hospitals - Meditech, Redmond - OR Metrics reports from Division

<sup>5</sup> Anesthesia delay % includes Tejas Anesthesia which handles 40% of the cases

Q Reported Quarterly

SCIP Measure

98.8% & above Green

97% - 98.79% Yellow

less than 97% Red

## Physician Quality Reporting System

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### **Physician Quality Reporting System (Physician Quality Reporting or PQRs) formerly known as the Physician Quality Reporting Initiative (PQRI)**

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#### **About PQRs**

The Physician Quality Reporting System (PQRS) is a quality reporting program that encourages individual eligible professionals (EPs) and group practices to report information on the quality of care to Medicare. PQRS gives participating EPs and group practices the opportunity to assess the quality of care they provide to their patients, helping to ensure that patients get the right care at the right time.

By reporting on PQRS quality measures, individual EPs and group practices can also quantify how often they are meeting a particular quality metric. Beginning in 2015, the program will apply a negative payment adjustment to individual EPs and PQRS group practices who did not satisfactorily report data on quality measures for Medicare Part B Physician Fee Schedule (MPFS) covered professional services in 2013. Those who report satisfactorily for the 2015 program year will avoid the 2017 PQRS negative payment adjustment.

# Physician Quality Reporting System (PQRS)

- Defining PQRS
  - “Paid under or based on the Physician Fee Schedule”
  - Eligible Professionals (EPs)
- Common Measures Reported by Anesthesiologists
  - #30 (NQF #0269): Timing of Prophylactic Antibiotic
  - #44 (NQF #0236): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery
  - #76 (NQF #0464): Central Venous Catheter (CVC) Insertion Protocol
  - #193 (NQF #0454): Perioperative Temperature Management

# Measure # 30 – Abx

- Demonstration of administration of prophylactic abx within 60 minutes of incision (except for Vanc/Fluoroquin).
- Category II code 4047F denominator (was abx ordered? – part of standing orders)
- Category II code 4048F – we gave them on time. Needs to be on claim form as non charged CPT code.
  - 4048F – 1P (Medical reasons)
  - 4048F – 8P (no reason specified)

# Value Based Modifier (VM)

CY 2015 is the performance period for the Value Modifier that will be applied in CY 2017. In order to be eligible for upward, downward, or neutral payment adjustments under the Value Modifier quality-tiering methodology and to avoid an automatic negative two percent (“-2.0%”) (for physician groups with between 2 to 9 EPs and physician solo practitioners) or negative four percent (“-4.0%”) (for physician groups with 10 or more EPs) Value Modifier payment adjustment in CY 2017, EPs in groups and solo practitioners **MUST** participate in the Physician Quality Reporting System (PQRS) and satisfy reporting requirements as a group or as individuals in CY 2015, as described below. We note that quality-tiering is mandatory for groups and solo practitioners subject to the Value Modifier in CY 2017. Additional information about quality-tiering is provided below.

# Quality-tiering Approach

- Each group receives two composite scores (quality and cost), based on the group's **standardized performance** (e.g. how far away from the national mean.)
- Group cost measures are adjusted for specialty composition of the group.
- This approach identifies statistically significant outliers and assigns them to their respective quality and cost tiers.

Quality/cost	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Medium quality	+1.0x*	+0.0%	-1.0%
Low quality	+0.0%	-1.0%	-2.0%

\* Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores.

# Value Based Modifier (VM)

Also based on the PQRS measure set

Requires 9 measures

- 3 domains

- at least 1 outcome ...

- ...or hardship exemption

PQRS in 2015 – penalties in 2017; -2% plus up to -4% VM for groups >10 providers.

Total of 6% penalty for NOT participating by June 30, 2015

Losers pay for winners!

# New PQRS 2016

Based on the PQRS measure set

Requires 9 measures

3 domains (OUT OF 6 POSSIBLE)

at least 1 outcome ...

...or hardship exemption

Requires at least ONE 'Cross Cutting measure'

“... a measure that is broadly applicable across multiple providers and specialties.”




# Domains

- **Communication and Care Coordination**
  - Medication Reconciliation (discharges)
  - Care Plan
  - Pain Assessment and Follow-Up
  - Falls: Plan of Care
  - Functional Outcome Assessment (needs care plan)★
  - Closing Referral Loop (receipt of specialist report)


# Domains

- **Community/Population Health**
  - Influenza Immunization
  - Pneumonia vaccination
  - BMI Screening (with follow-up plan)★
  - Screening for Depression (with plan)
  - Tobacco screening and cessation intervention
  - Childhood Immunization status
  - Screening for High Blood Pressure (with plan)
  - Screening for unhealthy alcohol use (with plan)

# Domains

- **Effective Clinical Care**
  - % of pts with HbA1c > 9.0% 
  - % of women aged 50 – 74 who have had mammograms
  - % of pts with diagnosis of HTN with adequate controlled BP
  - % of pts with HCV screening

# Domains

- **Patient Safety**
  - **Documentation of Current Medications** 
  - **Falls: Risk Assessment (aged 65 or older)**
  - **Screening for Falls**

# Domains

- **Person and Caregiver-Centered Experience**
  - **CAHPS for Clinician/Group Survey**
    - **Timely care/appointments; provider communication; access to specialists; Health promotion and education; Shared decision making; courteous office staff; care coordination; taking medication as directed; stewardship of patient resources**

# Domains

- **Efficiency and Cost Reduction**
  - No Cross Cutting Measures for this domain

# PQRS Measures 2016

PQRS #39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older
PQRS #44	Pre-operative Beta-Blocker in Patients with Isolated CABG Surgery
PQRS #46	Medication Reconciliation Post Discharge
PQRS #47	Care Plan
PQRS #76	Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections
PQRS #109	Osteoarthritis (OA): Function and Pain Assessment
PQRS #110	Preventive Care and Screening: Influenza Immunization
PQRS #111	Pneumonia Vaccination Status for Older Adults
PQRS #128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
PQRS #130	Documentation of Current Medications in the Medical Record
PQRS #131	Pain Assessment and Follow-Up
PQRS #134	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
PQRS #145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy
PQRS #154	Falls: Risk Assessment
PQRS #155	Falls: Plan of Care
PQRS #181	Elder Maltreatment Screen and Follow-up Plan
PQRS #226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
PQRS #342	Pain Brought Under Control Within 48 Hours
PQRS #404	Anesthesiology Smoking Abstinence
PQRS #408	Opioid Therapy Follow-up Evaluation
PQRS #412	Documentation of Signed Opioid Treatment Agreement
PQRS #414	Evaluation or Interview for Risk of Opioid Misuse
PQRS #424	Perioperative Temperature Management
PQRS #426	Post-Anesthetic Transfer of Care Measure: Procedure Room to a Post Anesthesia Care Unit (PACU)
PQRS #427	Post-Anesthetic Transfer of Care: Use of Checklist or Protocol for Direct Transfer of Care from Procedure Room to Intensive Care Unit (ICU)
PQRS #430	Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy

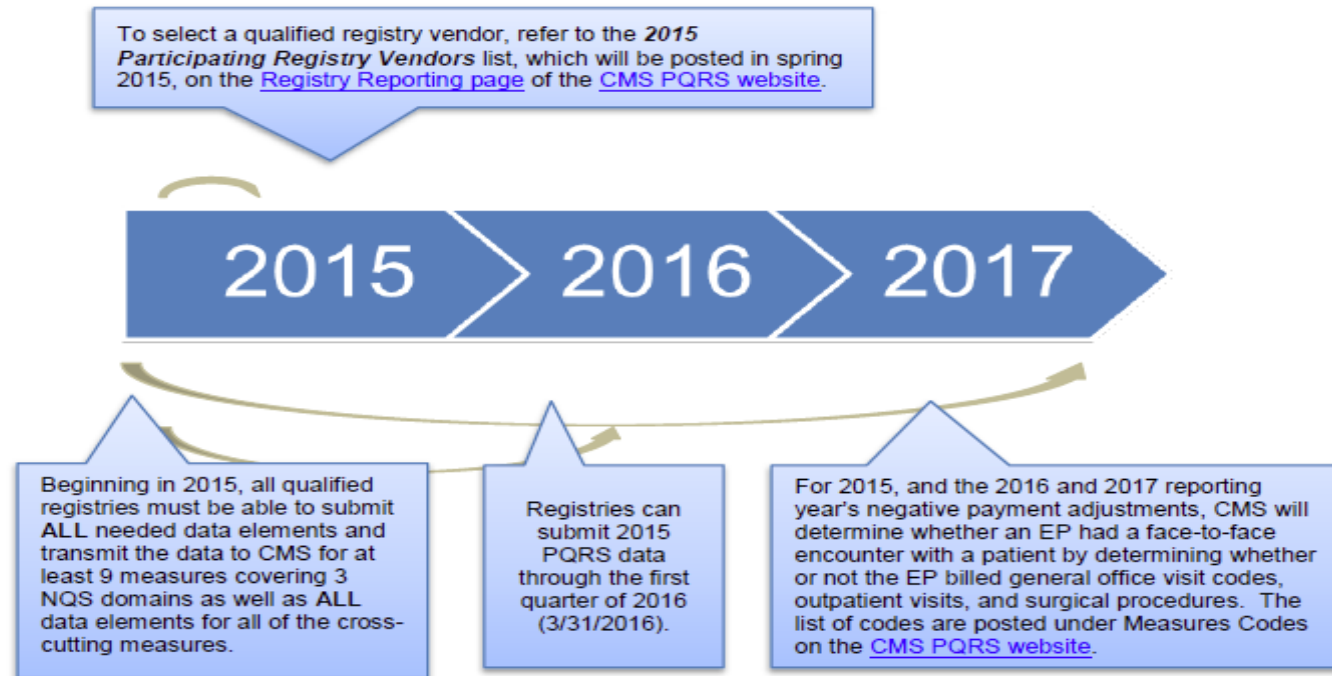
# PQRS 2016

PQRS Measure	Domain
#44 – Preoperative Beta Blockers/Isolated CABG	Effective Care
#76 – Sterile Technique Central Line Placement	Pt Safety
#128 – <u>BMI (with plan) (Cross Cutting)</u>	Community health
#130 – <u>Current medications (Cross Cutting)</u>	Pt Safety
#131 – Pain Assessment and Follow-Up	Community health
#342 – Pain Under Control within 48 hours	Pt Centered
#404 – Anesthesiology Smoking Abstinence	
#424 – Perioperative Temperature Management	
#426 – Handoff Checklist for PACU	
#427 – Handoff Checklist for ICU	
#430 – Prevention of PONV	



## Qualified Registry Vendors

A qualified registry is an entity that collects clinical data from an EP or PQRS group practice and submits it to CMS on behalf of the participants. EPs and PQRS group practices participating should work directly with their chosen registry in order to submit data satisfactorily on the selected measures or measures groups.



## Reporting Criteria for Individual EPs

EPs wanting to satisfactorily report 2015 PQRS data to avoid the 2017 negative payment adjustment can do so by meeting one of the following criteria:

- 1. Report on at least 9 individual measures covering at least 3 NQS domains for at least 50% of the EP's Medicare Part B FFS patients.**

EPs who submit quality data for **less than 9** PQRS measures covering 3 NQS domains for at least 50% of the EP's Medicare Part B FFS patients **OR** who submit data for **9 or more** PQRS measures covering **less than 3 domains** for at least 50% of the EP's Medicare Part B FFS patients eligible for each measure **OR** who do not report on at least 1 cross-cutting measure if had a face-to-face encounter will be subject to Measure-Applicability Validation (MAV). (See <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html>)

# Options for PQRS

Claims based

Group PQRS via GPRO Web Interface

*Group Practice Reporting Option – Must all use same TIN*

QCDR (NACOR)

Other Registries

# More about the QCDR

- New method for satisfactorily reporting PQRS
- a CMS-approved entity that collects clinical data for patient/disease tracking for quality improvement
- QCDRs are typically specialty society registries like AAI's National Anesthesia Clinical Outcomes Registry (NACOR)
- Measure data across multiple payers, not limited to Medicare beneficiaries
- Allowed to report “non-PQRS” and PQRS measures for successful PQRS reporting

# Anesthesia Perspective

The National Anesthesia Clinical Data Registry is certified as a QCDR

Available measures for perioperative care increased from 26 in PQRS to 48 measures

Includes 22 ASA Measures

4 domains, multiple outcome measures

# ASA Quality Measures 2016

Measure Number	Measure Title	Qualified Registry	QCDR
ASA #8	Prevention of Post-Operative Vomiting (POV) - Combination Therapy (Pediatrics)		X
ASA #10	Composite Anesthesia Safety		X
ASA #11	Perioperative Cardiac Arrest		X
ASA #12	Perioperative Mortality Rate		X
ASA #13	Postanesthesia Care Unit (PACU) Re-intubation Rate		X
ASA #14	Assessment of Acute Postoperative Pain		X
ASA #15	Composite Procedural Safety for Central Line Placement		X
ASA #16	Composite Patient Experience		X
ASA #19	Perioperative Use of Aspirin for Patients with Drug-Eluting Coronary Stents		X
ASA #20	Surgical Safety Checklist – Applicable Safety Checks Completed Before Induction of Anesthesia		X
ASA #23	Coronary Artery Bypass Graft (CABG): Prolonged Intubation		X
ASA #24	Coronary Artery Bypass Graft (CABG): Stroke		X
ASA #25	Coronary Artery Bypass Graft (CABG): Post-Operative Renal Failure		X
ASA #28	Rate of Post-operative stroke or death in asymptomatic patients undergoing Carotid Artery Stenting (CAS)		X
ASA #29	Rate of Post-operative stroke or death in asymptomatic patients undergoing Carotid Endarterectomy (CEA)		X
ASA #30	Rate of Endovascular aneurysm repair (EVAR) of small or moderate non-ruptured abdominal aortic aneurysms (AAA) who die while in the hospital		X
ASA #31	Total Knee Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation		X
ASA #32	Total Knee Replacement: Preoperative Antibiotic Infusion with Proximal Tourniquet		X
ASA #35	Day of Surgery Case Cancellation Rate - Adult		X
ASA #36	Day of Surgery Case Cancellation Rate - Pediatric		X
ASA #37	Unplanned Transfer or Admission to Hospital		X
ASA #38	New Corneal Injury Not Diagnosed in the Postanesthesia Care Unit/Recovery Area after Anesthesia Care		X

# Physician Quality Reporting System

## Preparing for the Future

- Learn and Understand PQRS
  - CMS PQRS Website ([www.cms.gov/pqrs](http://www.cms.gov/pqrs))
  - CMS QualityNet Help Desk (866-288-8912 or [qnetsupport@hcqis.org](mailto:qnetsupport@hcqis.org))
- Member Resources
  - Quality and Regulatory Affairs ([gra@asahq.org](mailto:gra@asahq.org))
  - Anesthesia Quality Institute (<http://www.aqihq.org/qcdr>)
- Prepare for PQRS Reporting in 2016

# MACRA

## Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), H.R. 2, Pub. Law 114-10

[http://www.acr.org/~media/ACR/Documents/PDF/Economics/Medicare/APM/AMA\\_MACRAsummarybranded.pdf](http://www.acr.org/~media/ACR/Documents/PDF/Economics/Medicare/APM/AMA_MACRAsummarybranded.pdf)

- Repeals SGR
- Replaces ALL Quality programs with MIPS (Merit-based Incentive Payment System)
  - 2019 – bonuses for positive performance
  - Penalties under PQRS; MU; VBM will end at close of 2018
  - Composite scores based on four categories:
    1. Quality (PQRS/ 30%)
    2. Resource use (VBM/30%)
    3. MU (25%)
    4. Practice Improvement Activities (15%)

Participation in a qualified data registry qualifies as PIA

# Advantages of MIPS

- Sliding scale vs 'all-or-nothing' metrics
- Flexible weighting – adjusted for those in practices or specialties at disadvantage
- Credit for CPI and improvement
- Risk adjustment – health status/socio-economic factors
- Exemptions for APM
- Timely feedback and Performance targets
- Quality measures built on existing metrics
- Telehealth and Remote Patient monitoring (PIA)
- QCDRs



# Maximum Positive and Negative Adjustments as a Percentage of Medicare Payments

2019	+4%	-4%
2020	+5%	-5%
2021	+7%	-7%
2022 onward	+9%	-9%

# Alternative Payment Models (APM)

- Qualified Medical Homes NOT required to assume downside financial risk
- 5% bonus (2019-2024) to join new models
- Only subject to Quality of APM; exempt from MIPS
- MACRA creates Advisory Panel to consider proposals

# Great Philosopher

- Wayne Gretsky



Skate to where the puck is going to be

# QCDR Metrics

- PQRS measures
- PONV prophylaxis
- ICU/PACU Handoffs
- Normothermia
- PACU Reintubation rate
- ASA for pts with coronary stents
- Corneal injury

# Quality Metrics

- Costs implementing data capture significant, especially if you don't have an AIMS
- Potential 'Negative Payment Adjustment' in 2019 6-9%
- Ability to show your hospital that you are measuring Quality – PRICELESS!

# Actual Cost of Quality

Primary Care; Cardiology; Orthopedics; Multispecialty

- Average physician spends 2.6 hours/week dealing with metrics
- Staff spend additional 12.5 hours/physician/week
- Time spent translates into >\$40,000/physician/year
- Annualized yearly cost > \$15 billion for 4 specialties
- 27% felt measures represented quality care
- 28% are using measures as basis for QI
- Data entry most time consuming task

Health Affairs; March 2016

# How Measurement Fails Doctors and Teachers

- Robert Wachter – Chair of Medicine UCSF
- Contributes EHRs to the > 50% burnout by physicians
- Described the Donabedian Triad for Quality
  - Outcomes – how pts fared
  - Processes – what was done
  - Structures – how work was organized
- Defined the Secret to Quality

Sunday Review Opinion; NY Times January 1, 2016