## Quality and Regulatory Affairs

# Prioritizing Measures and Indicators Beyond a Payment Program

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Much attention has been placed upon participation in the Quality Payment Program (QPP), including reporting quality measures for the Merit-based Incentive Payment System (MIPS) or joining an Alternative Payment Model (APM). But for many anesthesiologists, the need to participate and do well in those programs often comes at the expense of reporting measures that mean something to somebody else – your fellow anesthesiologists, surgical colleagues, facility leadership, your patients, and most importantly, you.

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Let’s first take a look at what most hospitals and your surgical colleagues are concerned about – the bottom line. Just like anesthesiologists and their groups, a portion of Centers for Medicare & Medicaid Services (CMS) payments to hospitals and ambulatory surgical centers is tied to the hospital’s performance in four key areas. First, hospitals are scored each year on outcome measures like 30-day mortality after heart failure and coronary artery bypass (CABG) surgeries, the total hip and knee arthroplasty complication rate, and pneumonia. Second, hospitals are assessed on infection rates and patient safety issues like central line-associated bloodstream infections (CLABSI) and surgical site infections (SSIs). Patient satisfaction and experience figure into the third piece of hospital payments as well. Last, hospitals share a common cost measure with anesthesiologists and other physicians – the Medicare Spending Per Beneficiary measure (MSPB).

For anesthesiologists, gaining access to a hospital’s internal benchmarks might prove a challenge. However, in seeking to contribute to your facility’s priorities and goals, anesthesia groups should identify available measures that anesthesia controls and that lend themselves to their facility meeting its quality goals. For instance, if your facility wants to decrease its SSI rates, an anesthesia group may want to collect and benchmark their data on prophylactic antibiotic administration, antibiotic redosing, perioperative temperature management, glucose testing, and hyperglycemia control. These measures do not have to be used for payment purposes, but rather to show that a change in anesthesia performance can improve a facility’s performance overall.

When considering your patients, we have often heard from physicians that the AQI and ASA should develop measure sets based upon a patient’s condition or procedure. For anesthesiologists looking at general patient satisfaction and experience, the Committee on Performance and Outcomes Measurement (CPOM) produced a white paper on best practices, while the AQI maintains a patient satisfaction quality measure. Anesthesiologists may wish to combine that patient satisfaction measure with process measures that have been linked to better patient experiences, like the prevention of postoperative nausea and vomiting measures, multimodal pain management, and acute assessment of postoperative pain. Of course, your patients would most likely want you to also do well on your cardiac arrest and mortality scores.

Patient-centered care measures can also be organized based upon you or your group’s interest in a certain patient population in collaboration with your surgical colleagues. For instance, groups seeking to improve their geriatric care may look at collecting and reporting data on frailty screenings and geriatric consultations. Obstetric patients, those undergoing CABG surgeries, and even diabetic patients can have measures assigned to them. Tracking these measures via AQI’s National Anesthesia Clinical Outcomes Registry (NACOR) not only allows the anesthesia groups an opportunity for quality improvement, but also to demonstrate to patients and hospitals that you care about and are doing something to improve patient safety, quality, and clinical effectiveness.

The consistent push among health care leaders that future measures must address “patient outcomes” oftentimes serves as a blanket argument rather than a specific and actionable task that each specialty can meet. Of course anesthesiologists contribute to patient outcomes, but the overall outcome of the patient also rests with how other physicians, nurses, and clinicians have engaged with the patient. It is impossible for any entity, whether CMS, hospitals, anesthesia groups, or patient advocacy groups, to feasibly assess every single process of care that contributes to a patient’s individual outcome. However, by prioritizing measures based upon surgical procedure or patient need, anesthesia groups can move beyond using measures for payment purposes and refocus on why many anesthesiologists chose their profession – to provide safe, quality care that is focused on patient needs and outcomes.

Each of the anesthesia measures described above is maintained by ASA and reportable via NACOR. Measures are publicly posted and AQI has identified a list of vendors who can help you collect and report those measures. In general, AQI and the ASA Quality and Regulatory Affairs staff maintain a set of nearly 40 quality measures each year.

Yet there are limits to the number of quality measures available and their meaningfulness to patients, anesthesiologists, and hospitals. Groups may want to combine available quality measures with outcome and adverse event indicators. AQI provides ASA members and registry participants with the opportunity to record dozens of more rare events such as burn injury, cardiac arrest, I.V. infiltration, and failed intubation. Similar to quality measures, these indicators, paired with quality measures, might prove beneficial to some departments and individuals working on local initiatives.

Regardless of your participation in quality programs, ASA and AQI offer groups an affordable and meaningful process to track the measures and indicators through its benchmarking service line. AQI benchmarking subscription by an ASA member costs $50 per physician to submit and benchmark data on any combination of quality measures and outcome indicators.

It is impossible for an anesthesia group of any size to track all the available measures and indicators. However, anesthesiologists and their groups may focus their quality improvement goals using specific measures and indicators. At the same time, linking an anesthesia group’s performance on specific measures with larger hospital goals of patient care, patient satisfaction, and cost can open additional doors for increased collaboration in the facility. ■

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