

Quality Measurement: A Primer for Hand Surgeons

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As the government and payers place increasing emphasis on measuring and reporting quality and meeting-specific benchmarks, physicians and health care systems will continue to adapt to meet regulatory requirements. Hand surgeons' involvement in quality measure development will help ensure that our services are appropriately assessed. Moreover, by embracing a culture of quality assessment and improvement, we will improve patient care while demonstrating the importance of our services in a health care system that is transitioning from a fee-for-service model to a fee-for-value model. Understanding quality and the tools for its measurement, and the application of quality assessment and improvement methods can help hand surgeons continue to deliver high-quality care that aligns with national priorities. (*J Hand Surg Am. 2016;41(5):645–651. Copyright © 2016 by the American Society for Surgery of the Hand. All rights reserved.*)

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THE CONTINUED RISE IN HEALTH CARE COSTS has impelled private and governmental payers to change the financial incentives for care providers. These changes are based on evidence that the behavior of physicians and health systems corresponds with economic incentives (behavioral economics).¹ The transition is from payment for service (fee for service) to payment for quality.^{2,3}

This shift towards measuring the method care is delivered, evaluated, and reimbursed in shaping the

practice of hand surgery through reimbursement models such as the Value-Based Modifier from the Centers for Medicare & Medicaid Services⁴ (CMS) and the Merit-Based Incentive Payment System.⁵ As oversight and transparency continue to expand,^{6,7} the incentives are meant to transition hand surgery from practice based on the maxim “this is how I trained” or “this is what works in my hands,” to practice that delivers measurable, high-quality care resourcefully. Moreover, it is hoped that as we begin to embrace a culture of continuous quality assessment and improvement, hand surgery will evolve as evidence from quality improvement efforts will inform clinical practice over time. Working knowledge of quality and its application in reimbursement models will allow hand surgeons to be active drivers in quality measure development, and ensure that we measure what matters.²

QUALITY

“Quality” in health care is defined by multiple organizations including the National Health Services⁸ and the Institute of Medicine.⁹ The Institute of Medicine's definition of quality is widely accepted in the literature.

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They define quality as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”⁹

Several factors influence quality. First, there is a focus on both the individual and the population: quality care must be patient-centered while also addressing public health concerns.¹⁰ An example of these competing interests is voluntary childhood immunization, where respect for individual preferences allowed a resurgence of a previously well-controlled vaccine preventable disease (measles).

Second, the focus on “desired health outcomes” and “clinical effectiveness” requires that the outcome must be measured to ensure what is desired is indeed achieved (eg, hemoglobin A1C levels in diabetics). For many conditions treated by hand surgeons, the outcome varies based on the surgical procedure (eg, fracture or nerve decompression), how “outcome” is defined (eg, objective = healed fracture vs. subjective = improved pain or quality of life), and who is being questioned (the patient or the surgeon). Given that a substantial percentage of hand surgery consists of discretionary procedures intended to improve pain, hand function, and quality of life, we can expect some of the future quality measures developed for hand surgery to be based on patient-reported outcomes measures. There is no value, for instance, in a trapeziometacarpal arthroplasty that is technically perfect, with no adverse events, and adequate radiographic alignment, if the patient does not feel that his or her pain is diminished and function and quality of life are improved. Measures that evaluate satisfaction, return to work, pain intensity, and magnitude of disability may become standard in addition to objective measures such as motion, sensibility, and alignment on radiographs.¹¹

Third, the definition of quality care is dynamic, as it depends on “current professional knowledge,” which continues to advance based on knowledge gained from basic, translational, clinical, and comparative effectiveness research. Thus, quality as it relates to specific diagnoses will change as hand surgeons adapt treatments to improve outcomes and decrease cost.

In spite of the complexity in measuring quality, public and private payers will continue to look to steer patients towards high-quality providers¹² and adjust payments based on quality of care.⁴ Using the tools for quality assessment and quality improvement, hand surgeons can help ensure that evidence reaches practice efficiently and effectively: improving patient care and satisfying quality initiatives.

HOW TO ASSESS QUALITY

Avedis Donabedian, a pioneer of quality improvement in health care, considered quality assessment in 3 domains: structure, process, and outcomes.¹³ All 3 domains can be used as mechanisms for quality assessment through quality measures. Quality measures are tools that help quantify health care structures, processes, or outcomes associated with the ability to provide high-quality health care.¹⁴ A quality measure, in essence, is an evidence-based tool used to evaluate the quality of care.¹⁵

Structural quality measures

Structural measures are based on the capacity and characteristics of delivering care. This includes the provider, the hospital, facilities and infrastructure, and the health care system^{13,15} as well as surgical expertise, and volume.¹⁶ The acquisition of a certification by the provider (eg, Certification in the Subspecialty of Surgery of the Hand) can be a structural quality measure. In colorectal surgery, for example, certified colorectal surgeons have less local recurrence and longer survival.¹⁷ Structural measures also include measures of hospital staff expertise or coordination.¹⁶ For example, there is evidence that patients treated by board-certified intensivists in intensive care units (rather than by a general internal medicine doctor) have lower mortality.¹⁸ Another example is that hospitals with high nurse-to-bed ratios have lower mortality rates after certain procedures.¹⁹ In addition, resources such as the presence of certain technology in the intensive care unit may reduce mortality.²⁰

Structural measures use readily available data, are inexpensive,²¹ and—as seen in the previous examples—are often correlated with clinical outcomes.¹⁶ Outcome measures have typically been based on and collected through administrative claims (eg, mortality rates, 30-day readmission rates, 30-day reoperation rates). On the other hand, there is a paucity of literature correlating structural quality measures with outcomes not collected from administrative claims.¹⁶ Furthermore, structural measures are often composed of factors the physician does not have the direct ability to change, such as hospital infrastructure, accreditation, and patient volume.²²

Process quality measures

Process measures address the encounter between provider and patient.^{13,15} The majority of current quality measures for musculoskeletal care are of process nature.²³ Examples of process measures include routine influenza vaccination,²⁴ use of perioperative antibiotics,²² surgical site marking,²² osteoporosis

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