

Quality Metrics in Urology

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Abstract

Introduction: The focus of quality metrics is to ensure that physicians provide and practice within a standard of care, and to maximize patient benefit and safety. Several quality reporting programs in urology such as SCIP (Surgical Care Improvement Project, PQRS (Physician Quality Reporting System) and OPPE (Ongoing Professional Practice Evaluation)/FPPE (Focused Professional Practice Evaluation) have been used to review and monitor standards of care and improve medical care quality. Urological databases are emerging with the main focus of reviewing and assessing health care delivery quality and patient outcomes. Such data will likely influence future quality improvement measures and standards. Awareness and understanding of these programs and measurements are vital to continued successful urological practice.

Methods: AUA (American Urological Association) and CMS (Centers for Medicare and Medicaid Services) documents were used. We reviewed program specific requirements, including minimal required data, timeline requirements, and specific incentives and penalties.

Results: Quality measures and programs in urology aim to monitor, standardize and improve medical care delivery in the United States. Since the implementation of electronic health records, the ability to review individual and group medical practices has become available and reviewable by outside agencies. Universal practice standards and government monitoring of individual and group achievement of those expectations are the current direction of health care. This is exemplified by the United States DHHS (Department of Health and Human Services) announcement of transitioning Medicare to a value based reimbursement model and the 9 HCTTF (Health Care Transformation Task Force) principles for accountable care organization footprint expansion.

Conclusions: The quality era has arrived. Its continued impact on health care delivery will be noted as public reporting and payment modifications based on quality indicators and performance metrics.

Key Words: urology, health care reform, accountable care organizations, quality control, registries

Abbreviations and Acronyms

AQUA = American Urological Association Quality Registry

BCBSM = Blue Cross Blue Shield of Michigan

E&M = evaluation and management

MUSIC = Michigan Urological Surgery Improvement Collaborative

QCDR = Qualified Clinical Data Registries

VTE = venous thromboembolism

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The concept of quality measurement is not new or revolutionary in the field of medicine. Its presence and impact on daily medical practice rapidly became apparent in the last decade. Quality measurements have been touted as the underlying mechanism by which health care delivery in the United States can emerge from a pay for quantity focus to a desired pay for quality paradigm.

New ideas and strategies to monitor and evaluate health care services are continuously being tested and implemented. As a health care practitioner it behooves one to not only stay abreast of these changes but also be proactively aware of the implications and potential negative consequences.

Quality measures are the tools that enable the measurement and quantification of health care processes and outcomes. Patient perceptions and organizational structure may also be reviewed to provide a higher quality level of health care. These measures allow for the identification of quality goals for health care by providing common ground for discussion. Quality goals include effective, safe, efficient, patient centered care in timely and equitable fashion.¹

The idea of reporting health care performance information is hardly a new concept. Dating back to 1754 the Pennsylvania Hospital had programs in place to collect and tabulate patient outcome data.² The person first credited with having a significant impact upon health care performance assessment was Dr. Ernest A. Codman, a surgeon at Massachusetts General Hospital. In 1910 he proposed an “end result system of hospital standardization” in which patients were followed after discharge home to evaluate the efficacy of treatment.² ACS (American College of Surgeons), which was founded 3 years later, incorporated the Codman system into its objectives. JCAH (Joint Commission on Accreditation of Hospitals), which was formed 33 years later, set standards and expectations for hospital care.²

In 2003 the SIP (Surgical Infection Prevention) project was started.³ It was refined and later became SCIP, a national quality partnership of organizations with an interest in the common goal of improving surgical care by significantly decreasing surgical complications.

SCIP quality indicators are multifocal, encompassing areas such as prophylactic antibiotic selection and administration (within 1 hour preoperatively and discontinuation within 24 hours postoperatively), hair removal technique, minimization of Foley catheter indwelling time (removed within 48 hours of the surgical procedure) and perioperative temperature management. Documentation of continuance of β -blocker therapy postoperatively as well as VTE therapy 24 hours preoperatively and postoperatively are also components of the SCIP core measures. Data using these measures are recorded and reviewed with the interest of minimizing

surgical complications/length of hospital stay and decreasing postoperative hospital readmissions.

The decision to retire individual measures is based on the following accrual of sufficient collection of data combined with achievement of the individual core measure expectation. Starting on January 1, 2015 the joint commission has no longer required documentation of several core measures, including antibiotic selection, 24-hour postoperative antibiotic discontinuance, hair removal, and β -blocker and VTE therapies.³ To date there has been no announcement of any replacement for the discontinued measures.

PQRS, originally known as PQRI (Physician Quality Reporting Initiative), was established by CMS to encourage and promote the reporting of quality information by eligible professionals. This initiative uses financial incentive bonuses and penalties based on the timeliness of physician reporting. The number of eligible professionals participating in PQRS in 2012 increased 62% since 2010. The 2012 participation rate more than doubled to 36% since 2007.⁴

Financial incentives are paid under the physician fee schedule. They are available to eligible professionals who meet certain reporting criteria on specified quality measures for Medicare Part B services. This incentivized data reporting, which is equal to 0.5% of each individual/practice total estimated Medicare Part B PFS (Physician Fee Schedule), ceased in 2015. A 2% penalty will be assessed for unsatisfactory reporting. One nuance of the program is a 2-year lag from clinical reporting until analysis. For the 2015 reporting year the assessment will be based on data submitted to the program in 2013 (Appendix 1).⁵

Specific measures are reviewed and evaluated on a yearly basis. The 2014 reportable measures include 3 registry options, that is measures groups, measures clusters and 9 individual measures that span 3 domains. If fewer than 9 measures are submitted, the provider will have to pass the MAV (measure applicability verification) to insure that no additional measures must be submitted to avoid a noncompliance penalty.

As defined by CMS measures groups are a subset of 4 or more PQRS measures that are related by a particular focus or clinical condition.⁵ Individual measures in a measures group have a common denominator definition and coding mechanism.

Specific to urology, PQRS clusters addressing preventive care documentation are organized according to demographics that define the denominator. PQRS Measures 48 to 50 (urinary incontinence assessment) apply only to female patients 65 years old or older.

The prostate cancer cluster includes 2 measures, that is PQRS 102 (avoidance of overuse of bone scans to stage patients with low risk prostate cancer) and PQRS 104

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