

Performance Measures in Radiology

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Performance measures in radiology play an increasingly significant role in health care quality assessment and now form the basis for a variety of pay-for-performance programs, including those administered by CMS. This article introduces the measure development process, beginning with topic selection, followed by measure development and testing, National Quality Forum endorsement, and implementation. Once implemented, measures may undergo further testing and be re-endorsed, modified, or retired. Radiologists should familiarize themselves with the measures relevant to their practice, develop ways to collect and report data efficiently, and implement the necessary practice changes to meet measure criteria and improve the quality of their practice.

Key Words: Imaging, radiology, quality and safety, performance measure, pay for performance, American College of Radiology

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INTRODUCTION

Landmark reports from the Institute of Medicine in the 1990s and 2000s revealed considerable gaps in the quality and safety of health care in the United States [1-3]. Since that time, public and private organizations and governments have increasingly focused on quality improvement, including the development of performance measures in medicine. A performance measure is a specific quantifiable indicator of an aspect of health care, expressed as a proportion or percentage of patients who are treated according to a specified standard. Performance measures typically focus on structures, processes, or outcomes of care [4,5]. With appropriate benchmarks, performance measures allow health care practitioners to identify areas within their practices that could be improved [4,5]. For example, the ACR National Radiology Data Registry provides benchmark information on numerous measures, allowing radiology practices to compare their performance measure data with other practices to determine performance gaps [6]. A sound methodologic approach to measuring these

aspects of care should result in higher quality and more efficient care, as well as improved patient outcomes.

Although the primary intent for using performance measures is to improve health care quality, public and private payers also increasingly use them as a mechanism to establish a financial incentive for practitioners to improve quality and reduce costs [7]. Performance measures are now used in a variety of programs that adjust payments on an individual practitioner, group, or institutional level. These include several programs administered by CMS, such as the Physician Quality Reporting System (PQRS) with the PQRS Maintenance of Certification Program Additional Incentive, the Physician Value-Based Payment Modifier, the Hospital Outpatient Quality Reporting Program, and the Inpatient Quality Reporting Program with the associated Hospital Value-Based Purchasing (Table 1) [8-14].

The growing emphasis on pay-for-reporting and pay-for-performance programs, along with the need to identify radiologist-provided value-added aspects of care and services, spurred the ACR in 2004 to gather a group of quality-focused radiologists in Sun Valley, Idaho, to discuss a road map for improving quality in radiology [15]. Soon thereafter, CMS began to develop a physician quality reporting program and encouraged medical specialty societies to develop quality measures for use in the program. In 2006, the ACR evaluated the need for measure development, and the ACR Metrics Committee was then established to develop radiology performance measures [16,17]. The Metrics Committee began collaborating with the AMA's Physician Consortium for Performance Improvement (PCPI) for that purpose [18]. This collaboration resulted in several measure sets with imaging-related measures, many of which are currently used in the CMS PQRS [19]. In this paper, we focus on

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Table 1. CMS (selected) quality reporting and value-based purchasing programs

Incentive Program	Level of Application	Incentive/Year	Penalty/Year
PQRS	Physician/Group	0.50% (2013, 2014)	1.50% (2015)* 2.00% (2016, 2017) [†]
PQRS+MOC	Physician/Group	1.00% (2013, 2014)	1.50% (2015)* 2.00% (2016, 2017) [†]
VBPM	Physician/Group	+ TBD based on aggregate amount of downward payment for low-scoring groups (in 2015, groups of 100+; in 2016, groups of 10+)	–1.0% (in 2015 for groups of 100+ not participating in PQRS 2013, or low performing) –2.0% (in 2016 for groups of 10+ not participating in PQRS or low performing)
HOQR	Outpatient Facility	N/A	2.00% (FY2013) and beyond [‡]
HIQR	Inpatient Facility	N/A	2.00% (FY2013) and beyond [§]
HVBP	Inpatient Facility	Hospitals may earn an incentive payment % that is <, =, or > the applicable reduction % for that program year (shown as penalties in next cell)	Reduction in DRG payments, withheld: 2013: 1.0% 2014: 1.25% 2015: 1.5% 2016: 1.75% 2017: 2.0%

Note: DRG = diagnosis-related group; FY = fiscal year; HIQR = Hospital Inpatient Quality Reporting; HOQR = Hospital Outpatient Quality Reporting; HVBP = Hospital Value-Based Purchasing; MOC = Maintenance of Certification; NA = not applicable; PQRS = Physician Quality Reporting System; TBD = to be determined; VBPM = Physician Value-Based Payment Modifier.

*Based on 2013 data.
[†]Based on 2014 and 2015 data, respectively.
[‡]Hospitals must participate in data collection, submission, and public reporting of performance rates to receive the annual payment update on Hospital Outpatient Prospective Payment System services the following year.
[§]Hospitals must participate in data collection, submission, and public reporting of performance rates in order to receive the annual payment update on Hospital Inpatient Prospective Payment System services the following year.

the typical process for the development of performance measures frequently used in such programs.

OVERVIEW OF MEASURE DEVELOPMENT

Performance measure development and implementation is a multiple-step process, beginning with identifying a clinical area that warrants dedicated attention. The project scope may include general imaging and radiology considerations and more specific topics such as radiation exposure and the appropriateness of certain imaging studies. Typically, once a focus area is selected, an environmental scan is conducted to gather relevant clinical practice guidelines and data to provide evidence that an improvement in the focus area is needed. After such a review, a multiple-stakeholder work group is established, composed of experts in various fields pertinent to the focus area. On the basis of the evidence and guidelines collected, the workgroup considers potential measures to draft, begins to develop and refine measure statements, and identifies numerator and denominator populations with any appropriate exclusion criteria. Technical specifications for refined measures are drafted, and data sources and data collection feasibility are assessed, potentially resulting in modification of the draft measure. After specification, candidate measures are tested for feasibility, reliability, validity, and unintended consequences.

Multiple variables carry weight in the final approval, endorsement, use, and sustainability of a measure. These include organizations involved in the measure

development process (eg, medical specialties, payers, and consumer representatives), the intended purpose of the measure (eg, quality improvement, accountability, public reporting), and defined settings or levels of care (eg, physician, group, hospital, or system). A developed measure may proceed to the National Quality Forum (NQF) for endorsement consideration, or in some cases it may be implemented before endorsement. Measures may be used for public pay for reporting or pay for performance (such as with the various CMS programs), private payer pay for performance or quality tiering, hospital credentialing, or internal quality improvement initiatives.

Since the initial implementation of radiology measures in PQRS in 2007, requirements for endorsement and successive maintenance have become increasingly stringent. Measure testing is intended not only to ensure that measures can improve clinical structures, processes, and outcomes but also to improve the effectiveness of the measures. Measures fully endorsed by the NQF must be maintained over a 3-year cycle, with annual updates required. At each juncture, performance measures are reevaluated for continued relevance. A performance measure may conclusively remain as is, undergo modification, be harmonized with related measures, or be retired. The purpose of this article is to describe a measure's "life span," emphasizing key elements particularly relevant to measures intended for radiology (Fig. 1).

Part 1: Topic Selection

Currently, nearly 700 measures have been endorsed by the NQF through the innovation and commitment of

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