



ELSEVIER

Selection, implementation, and interpretation of patient-centered shoulder and elbow outcomes

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The movement toward a value-based health care market requires comparison of physicians, hospitals, and health systems. Traditionally, process-based measures such as infection and readmission rates have been used. However, these events are uncommon in shoulder and elbow surgery, thus limiting their utility. Patient-reported outcomes (PROs) are a promising measure of quality and have been proposed as a potential metric to compare surgeon performance. However, there are over 25 different PROs for shoulder and elbow conditions. Therefore, the American Shoulder and Elbow Surgeons Value Committee was established to recommend shoulder and elbow PROs in an effort to align their implementation for quality assessment. The committee developed criteria for assessing the outcome measures including that each measure should be patient reported, not requiring clinician input; have published validation and psychometrics; and be standardized and demonstrate ease of use for the patient and clinician. Two sets were suggested: one set for clinical implementation and a more robust set for research purposes. The final recommendation was that all patients should complete the Veterans Rand 12 for general health and the Single Assessment Numeric Evaluation for the specified body region. For patients with shoulder complaints, the American Shoulder and Elbow Surgeons score was recommended, and for those with elbow complaints, the Quick Disabilities of the Arm, Shoulder and Hand score was recommended. More robust disease-specific measures were provided for research purposes. Continued efforts should be made to align these measures across orthopedics to facilitate use of patient outcome measures as a component of value-based health care assessment.

Level of evidence: Narrative Review

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The American Shoulder and Elbow Surgeons (ASES) Value Committee established a subcommittee on outcomes charged to make recommendations regarding selection, implementation, and interpretation of patient-centered shoulder and elbow outcome scores. In this report we will define quality; establish why we measure outcomes, as well as how they are measured; describe the process of outcome collection; and make recommendations back to the ASES Executive Committee.

The outcomes subgroup members consisted of Bernard Morrey, John (JT) Tokish, Guido Marra, Scott Steinmann, Ted Schlegel, and Charles Thigpen. Ex officio members were Rob Bell and Bill Mallon as Past Presidents.

We are aware of the drive to move toward value-based compensation for physicians, where maximum value is the best outcome at the lowest cost. Although cost remains the primary target of improving value in the US medical system, most attempts to measure quality have aimed to reduce expensive cost drivers associated with orthopedic procedures, such as complications, readmissions, or reoperations. However, proponents of value-based medicine such as Michael Porter and Robert Kaplan from Harvard University suggest physicians will be defined by quality measured as patient-reported outcomes.^{9,11,12} To date, patient-reported outcomes have not tended to be included in value-based payment models.

Why should we collect outcome scores?

1. Physicians will be judged on quality in the future.
2. It is helpful to know the outcome of treating our own patients.
3. If we do not do it, others will do it for us.
4. Payers and agencies, such as the Centers for Medicare & Medicaid Services (CMS), will demand it.
5. We need to get ahead of the government and other agencies (CMS) with what we, as surgeons, perceive as appropriate scores to measure the outcomes of the treatment of our patients.

Presently, there are many agencies and programs on which physicians are graded from consumer sites such as healthgrades.com, RateMDs.com, and Yelp. For the transition to pay for performance for hospital systems and office practices, surveys such as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and Consumer Assessment of Healthcare Providers & Systems (CAHPS) are used to assess the consumer perception of care. Reporting programs such as The Joint Commission's Surgical Care Improvement Project (SCIP) and the CMS Physician Quality Reporting System have financial implications for reporting and meeting thresholds related to surgical treatment. However, these approaches include patient-reported outcomes that have the potential to assess changes in patients' function based on their treatment. As emerging payment models move away from fee-for-service and toward performance-based reimbursement, accurate assessment of patient outcomes is crucial to a comprehensive strategy to deliver on the value proposition.

The committee on researching, defining, establishing, and recommending outcome scores to ASES decided that there should be 2 packages: a basic package for the community at large and a more robust research package. To accomplish this, the subgroup agreed on criteria by which to rank the available shoulder and elbow outcome tools. The outcomes subgroup members reviewed applicable papers and reports with particular attention paid to the psychometrics of shoulder

and elbow scoring systems including reliability, validity, and responsiveness of each tool. Outcome tools with better psychometrics, especially regarding precision, such as the minimal clinically important difference, were ranked higher, given the desire to eventually use them to determine value.^{1,10,16,18,20,24}

The committee, following many phone calls and meetings, established the following guidelines for selection:

1. Patient-reported outcomes
2. Validated scores
3. Good psychometrics
4. Ease of use for patient (ie, brief)
5. Ease of scoring and understanding for physician
6. Standardized use nationally
7. Consideration of cost

Shoulder

There are approximately 25 shoulder scores used worldwide. These were narrowed to a few following our guidelines for selection. The group agreed a generic quality-of-life score would be required; a joint-specific score would be required; and for research, more sophisticated scores would be needed. The committee debated whether we should include more than 1 score for these different areas or settle on just 1 score.

Generic quality of life

Generic health-related quality-of-life measures such as the Short Form 36 (SF-36), Short Form 12 (SF-12), EuroQol-5 Dimension (EQ-5D), Veterans Rand 12 (VR-12), and Patient-Reported Outcomes Measurement Information System (PROMIS) 10 are important for establishing baseline health status and function beyond comorbidities and have been shown to influence orthopedic outcomes. These measures are also the primary outcome tools that have been used for value calculations, such as quality-adjusted life-years, providing the ability to compare total shoulder arthroplasty with total hip arthroplasty or breast cancer treatment.^{2,13} This is thought to be meaningful to payers such as CMS to aid in the allocation of dollars to treatments that offer the most improvement in patient health status over time. In addition, these scores can be used at baseline for purposes of risk adjustment and stratification as emerging payment models are developed.

The SF-36, SF-12, EQ-5D, PROMIS 10, and VR-12 (Fig 1, A) were all discussed, and our committee settled on the VR-12 as the generic quality-of-life score. The primary advantages of this tool are that it has US population norms, is a part of the Medicare Health Outcomes Survey and is directly comparable with the SF-12, and is in the public domain and therefore available at no cost. The VR-12 consists of 12 questions with a Likert response system. The SF-36, SF-12, and EQ-5D all carry financial implications. The PROMIS 10 is available in the public domain at no cost, but its use is not widespread at this point. The EQ-5D, although widely used

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