How Anesthesia Helps ASCs Maximize Value-Based Purchasing Performance

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YOUR PRESENTER

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• VP, Quality Assurance, Somnia Inc.
• Executive Director, Somnia Patient Safety Organization
• >20 years hospital/anesthesia practice management; military, academic, tertiary, community hospitals/ASCs
• 100% in Anesthesia / Surgical / Perioperative/OR
• 8+ yrs. Perioperative/OR management (operational)
• 10+ years anesthesia practice management (financial)
• 6+ years anesthesia quality management (quality)
• Member, Anesthesia Quality Institute Advisory Council
Disclaimer

The opinions expressed in this presentation are that of the presenter and do not necessarily reflect the opinions of Becker’s or Somnia Anesthesia, Inc.

The presenter is employed by Somnia Anesthesia Inc.

There is no financial interest related to the content or delivery of this presentation.
What is “Value Based Purchasing”?

\[
\text{VBPP} = \frac{\text{Quality (Outcomes)}}{\text{Payments}}
\]
ASCQR = Baseline “Value Based Purchasing”

<table>
<thead>
<tr>
<th>Number</th>
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<th>Data Submission Dates</th>
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<tbody>
<tr>
<td>ASC-1</td>
<td>Patient Burn</td>
<td>Claims submitted for services furnished between January 1, 2016 and December 31, 2016</td>
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<td>Patient Fall</td>
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<tr>
<td>ASC-3</td>
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<td>All-Cause Hospital Transfer/Admission</td>
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- **CY2015**: 98.9% of the ASCs subject to ASCQR program requirements met the requirements and received the full annual M’Care payment update.
- ASCs that met the criteria for CY 2015 ASCQR program reporting receive a full payment update of 1.4%.
- The few ASCs that did not meet the criteria for CY 2015 ASCQR program received a 2% reduction in their M’Care payments.
Anesthesia impacts 50% of ASCQR Measures

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How to maximize Value Based Purchasing?

• **Quality requirements:**
  - Defining “quality” beyond ASCQR
  - Infrastructure, systems, and resources
  - Leadership/Management
  - Daily emphasis and prioritization
  - Staff awareness, engagement, feedback and incentives!
  - Continuous data gathering, reporting and P.I. activities

• **Payment requirements:**
  - Ensure compliance with ASCQR measures/reporting
  - Use quality data to increase commercial payer rates
CMS Conditions for Coverage requires “QA/PI”

• The CMS CfC provide the compliance standards and *Quality Assessment/Performance Improvement* (QA/PI) requirements to contractually participate with (bill) Medicare.

• **CMS Conditions for Coverage; QA/PI section, 416. 43**
  • “The ASC **must develop, implement, and maintain an ongoing, data-driven quality assessment and performance improvement (QA/PI) program**”
  • “The ASC **must measure, analyze, and track quality indicators, adverse patient events**, infection control, and other aspects of performance that includes care and services (**including anesthesia**) furnished in the ASC.”
  • “The ASC **must set priorities** for its performance improvement activities that
    • Focus on high-risk, high-volume, problem-prone areas
    • Consider incidence, prevalence and severity of problems in those areas
    • Affect health outcomes, patient safety, and quality of care
CMS Conditions for Coverage/QAPI (cont’)

• CMS Conditions for Coverage; 416. 43
  • “The ASC has many choices of indicators to use when assessing and improving quality and performance to include:
    • **Outcome Indicators**: Complication rates, Mortality rates, HAI rates, LoS, Re-admission rates, etc.
    • **Process Indicators**: Prophylactic Antibiotics timing, pre-surgical timeouts, syringe labeling, medication safety and security, infection control compliance, etc.
    • **Patient Perception Indicators**: Measure a patient’s experience/satisfaction with the care and services he/she received

• “The ASC must track and report all patient adverse events”

• CMS recommends at a minimum, that ASC’s track and report National Quality Forum (NQF) quality/patient safety indicators to include **Prophylactic Antibiotic Timing, Hospital Transfers**, and **Wrong Patient/Site/Side/Procedure** events. Facilities may choose to track and report other indicators as needed.
Who should lead, and ensure daily success with your value-based purchasing initiatives?
Anesthesia!

- Daily Physician/CRNA medical leaders
- Involved in every operational aspect of care
- Responsible for safe throughput and outcomes
- Already responsible for 50% of ASCR measures
- Impacts your bottom line!
6 common ASC challenges with anesthesia

1. Leadership/Management
2. Dedicated/Consistent Staff
3. Practice compliance/standards
4. Quality/safety
5. Patient & Surgeon satisfaction
6. Financials (Costs & Revenues)
The risk/impact of those anesthesia challenges

1. Surgeon Satisfaction
2. Patient Satisfaction
3. ASC Staff Satisfaction
4. Competitive Advantage
5. The Bottom Line!
VBP begins with effective Anesthesia leadership

The OR is a “team sport” and requires daily team leadership!

Are your anesthesia leaders interdisciplinary “connectors” or “dividers”? Are they effective and dedicated to your ASC, or the local hospital?

Who are they accountable to??!!
VBP requires Anesthesia staff consistency

Revolving door of Anesthesia providers??

Inconsistent anesthesia staff = inconsistent standards, inconsistent safety, inconsistent quality

Anesthesia often torn between Hospital vs. ASC
VBP requires “Quantified” Anesthesia Quality

Is your Anesthesia group quantifiably demonstrating and validating:

• **Compliance**: CMS CfC (QA/PI), Accreditation, ASA, etc.
• **Clinical Outcomes**: occurrence reporting, review, feedback
• **Patient Satisfaction**: Anesthesia-specific surveys/questions
• **Clinical Effectiveness**: PONV, Pain Management, etc.
• **Emergency Preparedness**: Mock Drills for MH, Codes, etc.
• **Surgeon & ASC Staff Satisfaction**: Surveys to solicit feedback
• **Anesthesia Clinician Evaluations/Review**: Critical staff feedback
Anesthesia Challenge: Translate “Know How” into “Can Do”

Menu
- Effective Leadership
- Consistent Staff
- Operational Efficiency
- Compliance
- Quantified Quality
- Financial Stewards

Accountability and Ability to Execute???
Somnia Case Study: Kentucky ASC, Lexington, KY

Demographics:
Multi-Specialty ASC
Annual Cases: + 8,000
ORs: 7
Anesthesia Care-Team

Quantified Quality:
• ACCQR & SCIP: 100% compliance annually
• Adverse Event Rate: .2% (occasional PONV, Pain, Difficult Airway)
• Clinical Effectiveness: post-op pain study to standardize effective pain protocols
• Patient Satisfaction: > 98% annually
• Surgeon Satisfaction: > 95% annually
• Emergency Preparedness: Mock Drills, Cognitive Aids, etc.
• Accreditation Surveys: 100% success
• Anesthesia Peer Review/Evaluations: 100% annually
Current/Future VBP Risk for Anesthesia (and You!)

Shared Risk:
1. VBP evolution (PQRS/VBPM, MACRA, etc.)
2. Commercial payers adopting VBP models
3. Bundled Payments (shared risk!)

Shared Impact:
1. Risk to Anesthesia bottom line, solvency, recruit and retain staff, and fund infrastructure and resources needed for quality.
2. ASC risk to financially support Anesthesia
3. ASC risk in not maximizing payer rates
2016 = Big changes for Anesthesia VBP (PQRS-VBPM)

• **2007 – 2015**: Anesthesia could meet PQRS reporting requirements by **reporting >80%** of eligible cases via Medicare paper/electronic **claims reporting** using the Measure Application Validity (MAV) process; essentially reporting up to **3 measures** (Prophylactic Antibiotics, Normothermia and Central Line sterility); plus 1 cross-cutting measure (advance directive) in 2015.

• **2016**: CMS requires anesthesia, and all other medical specialties, to **report >50%** of eligible cases via **registry reporting** (qualified registry (QR) or a qualified clinical data registry (QCDR)).

• CMS now requires anesthesia to successfully report a minimum of **9 measures**, across 3 national quality forum (NQF) domains, including 1 outcome measure.
## 2016 Anesthesia PQRS Registry Reporting Requirements

| General Overview: Qualified Registry (QR) vs. Qualified Clinical Data Registry (QCDR) |
|-------------------------------|-----------------|-----------------|
| **QR** | **QCDR** |
| Types of Measures | Reporting is **limited to the CMS PQRS measures** only | Available PQRS **and QCDR measures, ie:** ASA, ABG, etc. |
| Types of Patients | Reporting is limited to Medicare Part B FFS patients | QCDR participants must report on **all patients** |
| Reporting Requirements | Reporting criteria: 9 or more PQRS measures across 3 NQS domains, **where 1 measure must be a PQRS cross-cutting measure for face-to-face encounters** | Reporting criteria: 9 or more PQRS or ASA measures across 3 NQS domains, where 1 or more ASA measures should be outcome measures **(*No Cross-Cutting Measure!* )** |
| Additional Considerations | EPs who do not meet reporting criteria are subject to MAV | EPs will **NOT be subject to MAV** given that additional non-PQRS measures are available to report on |

* More reporting & risk!  
* Less reporting, more options, & less risk!

* American Society of Anesthesiologists web site (April 2016)
Ambulatory Anesthesia CMS PQRS Measures

- **Smoking Abstinence** DoS: Anesthesia discusses w/ patient before surgery
- **Safe Surgical Checklist** before surgery used and documented
- **Periop. Temperature Management** (> 60min. Case); future ASCQR measure?
- **PACU patient transfer** protocol used for all patients
- **Patient transfer to hospital/ICU**
- **PONV combination therapy** used; if GA is used

Additional possible QR/QCDR (ASA, etc.) measures:
- **Anesthesia adverse events**; from dental trauma through cardiac arrest
- **Post-op pain assessment**
Anesthesia financial risk under CMS Value Based Purchasing

**PQRS**

- Individual provider (NPI#) based
- Binary (Y/N/NA) compliance
- ≥ 9 measures; 3 NQF domains
- ≥ 50% of eligible cases
- Compliant = neutral
- Non-compliant = 2% penalty

**VBPM**

- PQRS data is aggregated
- Group TIN# based
- Group level “reporting” compliance
- Not rate/outcome based; ie: mortality rate, adverse events, etc.
- Quality “tiering” against national mean

**Illustrative Example**:

<table>
<thead>
<tr>
<th>PQRS Measure</th>
<th># Eligible</th>
<th># Reported</th>
<th>% Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking Abstinence</td>
<td>1,000</td>
<td>850</td>
<td>85%</td>
</tr>
<tr>
<td>Periop. Mortality</td>
<td>1,000</td>
<td>875</td>
<td>88%</td>
</tr>
<tr>
<td>Adverse Event Rate</td>
<td>1,000</td>
<td>800</td>
<td>80%</td>
</tr>
<tr>
<td>Corneal Injury</td>
<td>1,000</td>
<td>900</td>
<td>90%</td>
</tr>
<tr>
<td>PONV Combo Therapy</td>
<td>1,000</td>
<td>950</td>
<td>95%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>5,000</strong></td>
<td><strong>4375</strong></td>
<td><strong>88%</strong></td>
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* If Care Team; both providers (Physician/CRNA) involved in the most amount of case time, will be responsible for, and receive credit for, the PQRS reporting.

**Value Based Physician Modifier (+/- 6%)**

- Group reporting compliance: 88%
- National quality mean: 80%
- Group above mean = VBPM incentive
- Below mean = penalty
- At mean = neutral

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<th>Average Quality</th>
<th>High Quality</th>
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<tbody>
<tr>
<td>Low Cost</td>
<td>0.0%</td>
<td>+2.0%*</td>
<td>+4.0%*</td>
</tr>
<tr>
<td>Average Cost</td>
<td>-2.0%</td>
<td>0.0%</td>
<td>+2.0%*</td>
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<td>High Cost</td>
<td>-4.0%</td>
<td>-2.0%</td>
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**PHYSICIANS, PAS, NPS, CNSS AND CRNAS IN GROUPS OF 10+ EPS**
6 key questions about your Anesthesia

1. Is your Anesthesia leadership engaged, effective and accountable to you and the ASC leadership; operationally, qualitatively, and financially?

2. Does Anesthesia have the invested infrastructure and resources to keep up with healthcare reform challenges; VBPM, etc.?

3. Do you have dedicated and consistent anesthesia staff or a revolving door?

4. Is anesthesia flexible in adjusting to your surgical schedule?

5. Does anesthesia help you market/recruit surgeons and develop new service lines?

6. Do you have the right anesthesia partner for now and the future?
Questions?

Thank You!

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