Value Based Medicine: Quality Metrics and the Future of Hospital and Physician Payment

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Value-Based Care: NYULMC-HJD Experience

- Overall, our research initiatives are improving our understanding of
  - How to maximize safety
  - How to minimize complications
  - How to control the cost of care through consistent use of evidence-based medicine and clinical practice guidelines
- This overall effort is providing the industry with valuable guidance on optimizing performance under value-based payment initiatives

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Hospital Acquired Conditions (HACs) The Bundle Buster

- As government and private payers expand bundled payment arrangements for orthopedic surgery, hospitals must focus on controlling the factors that lead to poor outcomes and high costs. High on the list of controllable factors are healthcare-acquired conditions (HACs).

- HACs are complications that could reasonably have been prevented through the application of evidence-based guidelines.
- When present as a secondary diagnosis, HACs result in the assignment of a case to a more expensive DRG.
- The federal government's HAC Reduction Program penalizes hospitals in the bottom quartile for risk-adjusted HAC quality measures. In the context of bundled payment programs, HACs increase episode costs and represent a poor outcome.

- Hospital-acquired infections (HAIs) drive the bulk of HAC costs.
- Despite widespread implementation of quality improvement initiatives to reduce infections, U.S. providers spend an estimated $9.8 billion annually to treat HAIs.
- Most expensive HAI is central line-associated bloodstream infection (CLABSI), $45,814 per case.
- Reducing HACs requires multidisciplinary effort with strong leadership from nurses. As the first line of defense against these conditions, nurses generally have the most powerful influence over HACs of all the patient care team members. For instance, the nurse is often the first provider to notice the earliest signs of infection and skin breakdown. This speaks to the importance of organizational fluidity and interdisciplinary communication.

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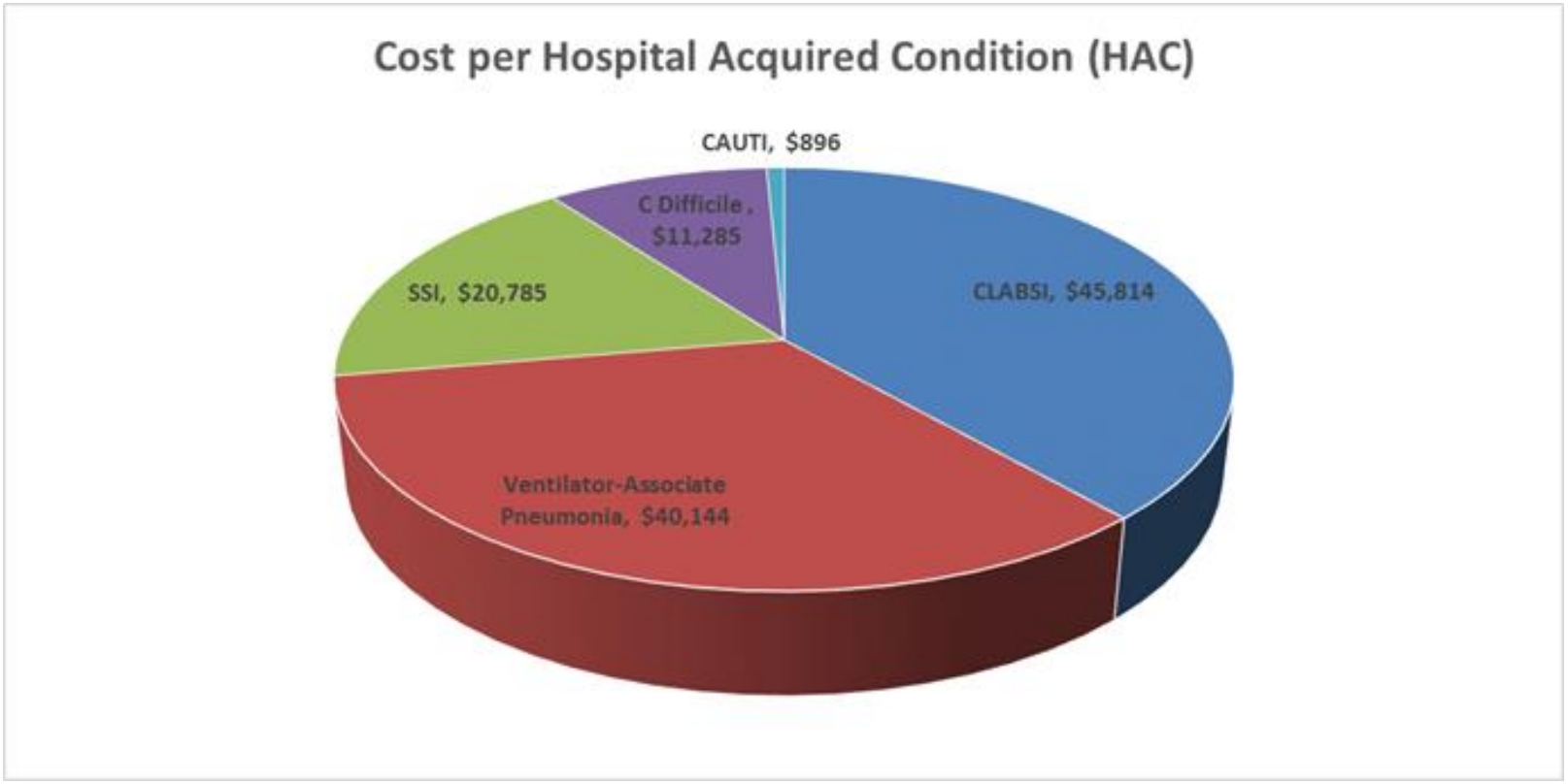
Hospital Acquired Conditions (HACs)
The Bundle Buster



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Measuring Quality Metrics

- Improving metrics involves detecting and correcting errors
- Vital to properly identify where improvements should be made in the process of care delivery
- Objective nature of internal metrics simplifies their measurement and allows straightforward calculations regarding improvement
- Identify appropriate indicators such as HACs, VTEs, SSI, LOS, readmissions, patient experience
  - First, look at overall numbers (department level, division level)
  - Then, look at numbers on a procedural or physician level
    - Where are the outliers?
    - What do you do with them?
    - Is there a trend?
    - What do GME trainees know about quality, patient experience, and value-based payment models?

GME = graduate medical education; HAC = hospital-acquired condition; LOS = length of stay; SSI = surgical site infection; VTE = venous thromboembolism.

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MEASURING QUALITY METRICS

Metrics we oversee

- Quarterly vs. Monthly and Real Time
  - Patient Satisfaction
  - Readmissions
  - Length of Stay
  - CLABS Infection Rate Non-ICU
  - Infections
  - Case Times
  - Discharge Disposition
  - PE/DVT Cases
  - Surgical Site Infections
- Bundled Payments Data

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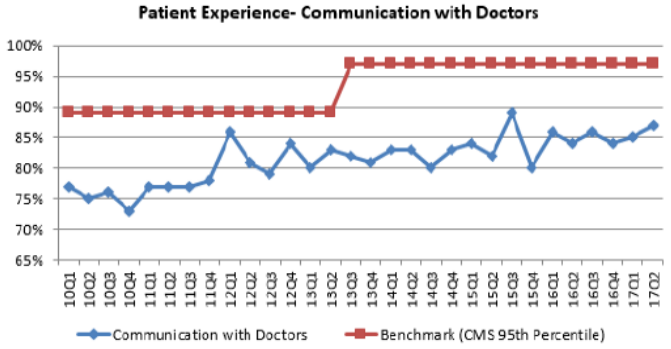
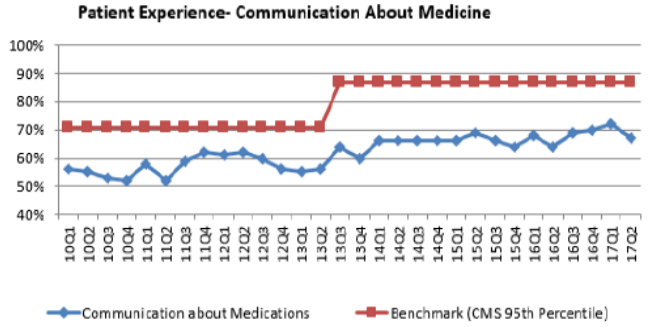
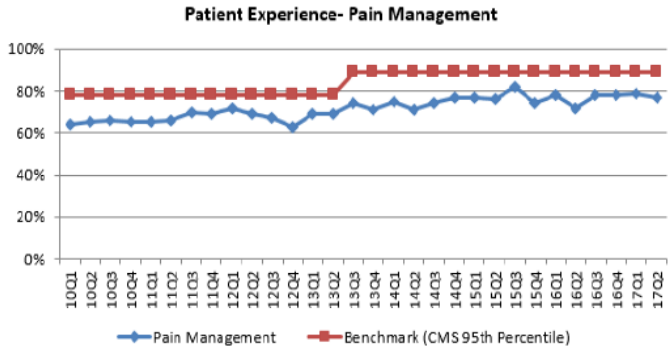
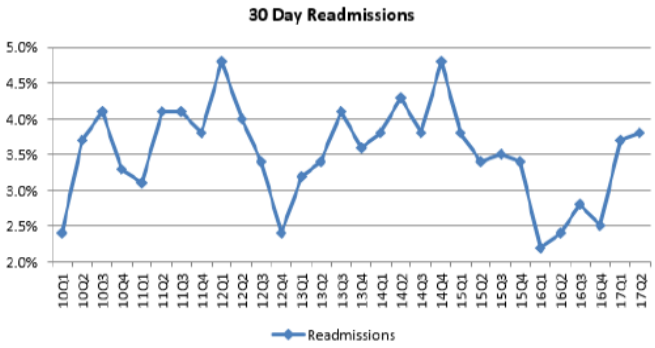
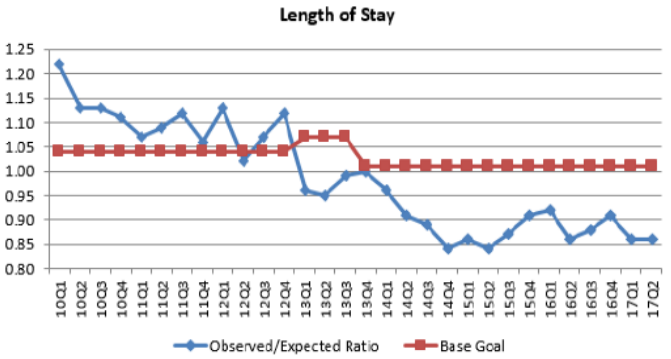
Metrics: Patient Experience, 30-day Readmissions, LOS, and CLABSI

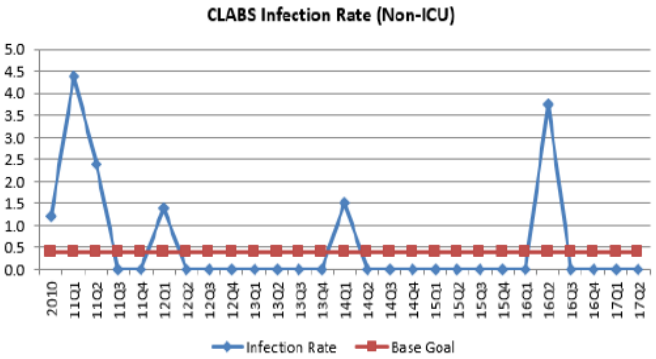












CLABSI = central-line-associated bloodstream infection.

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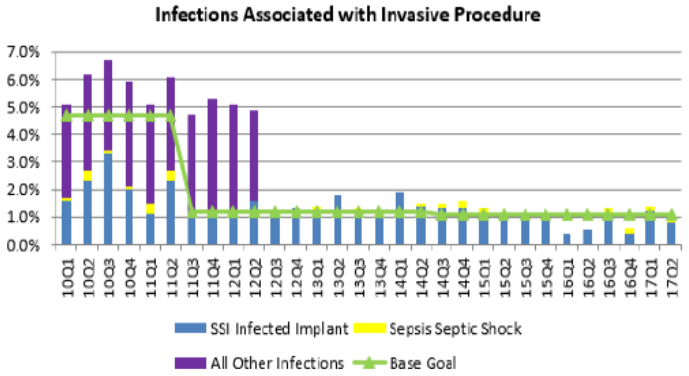
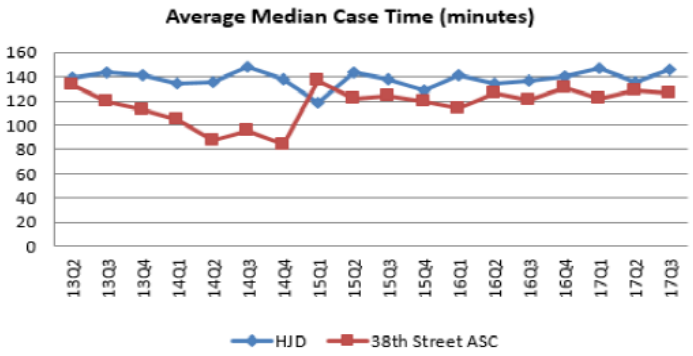
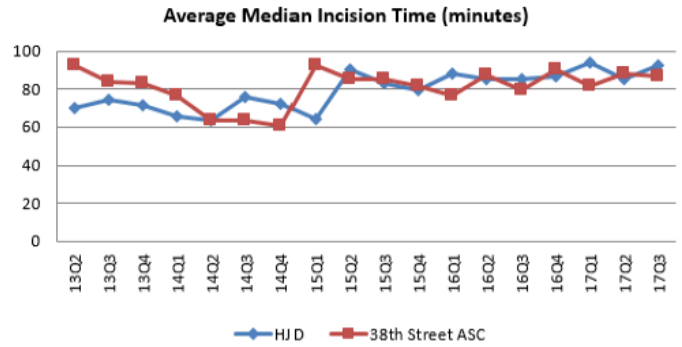
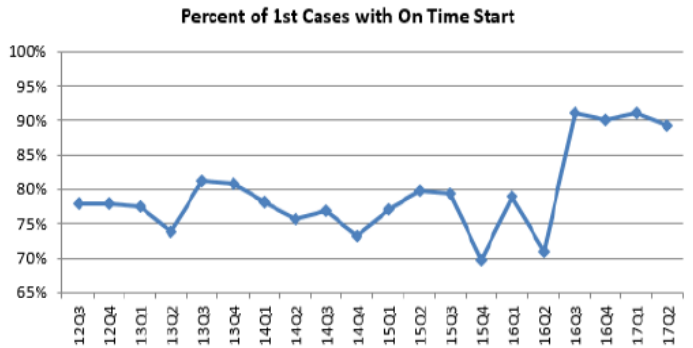
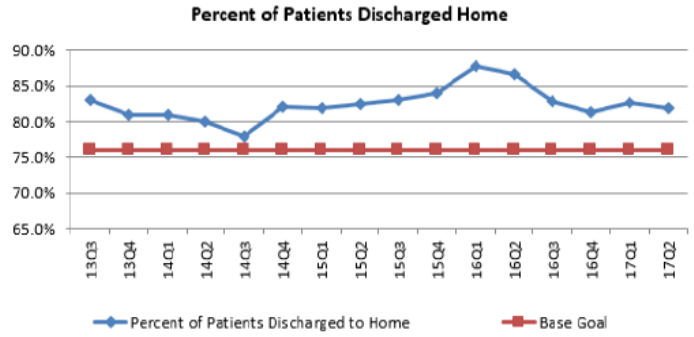
Metrics: Infections, Case Time, Incision Time, On-time Start, Patients Discharged to Home











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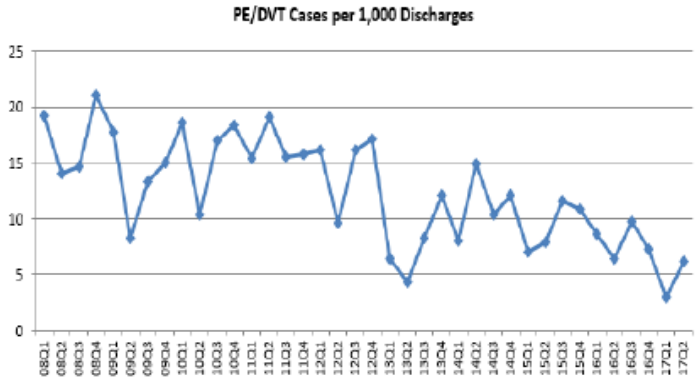
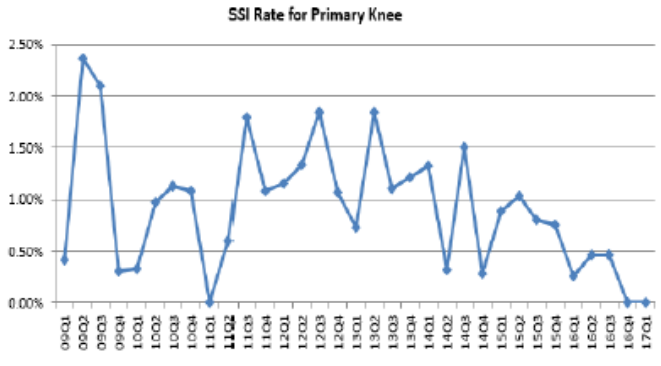
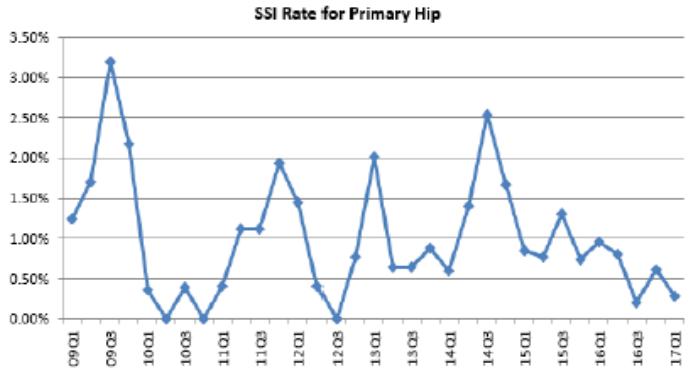
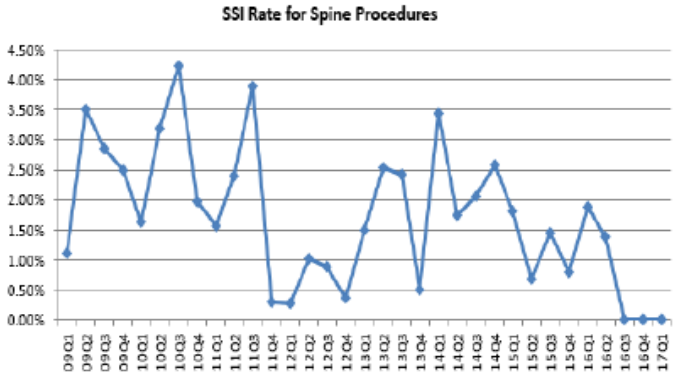
Metrics: PE/DVT and SSI Rates









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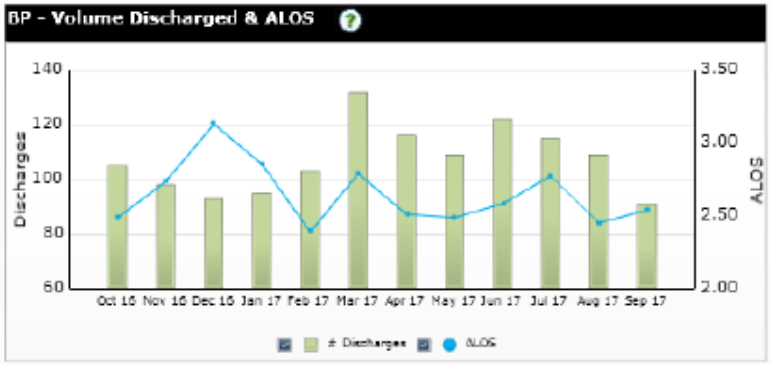
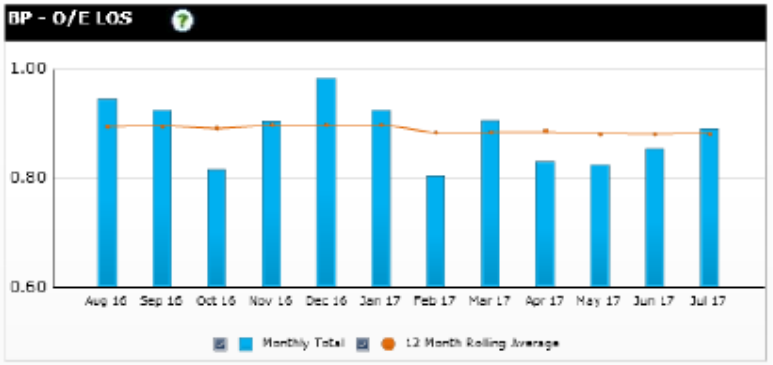
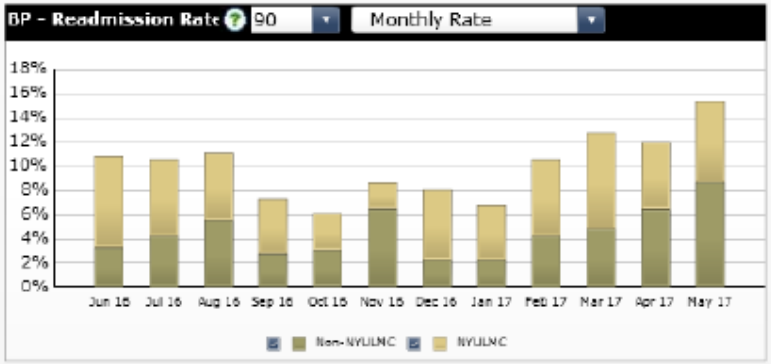
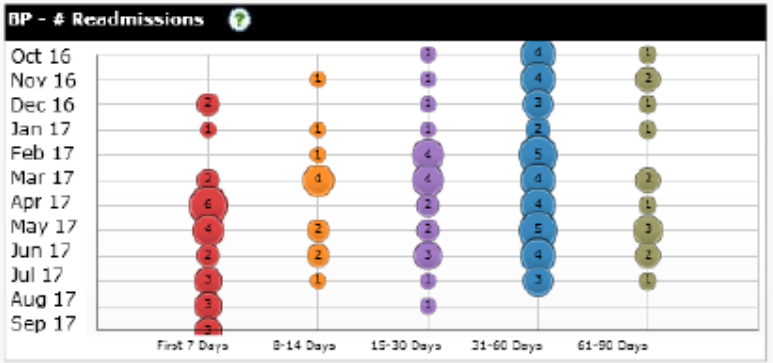
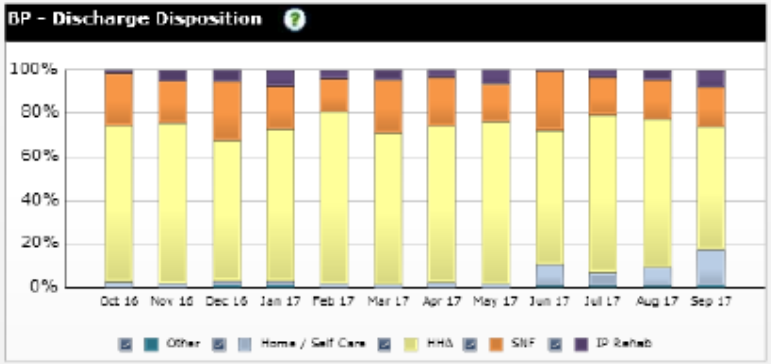
Bundled Payment Metrics

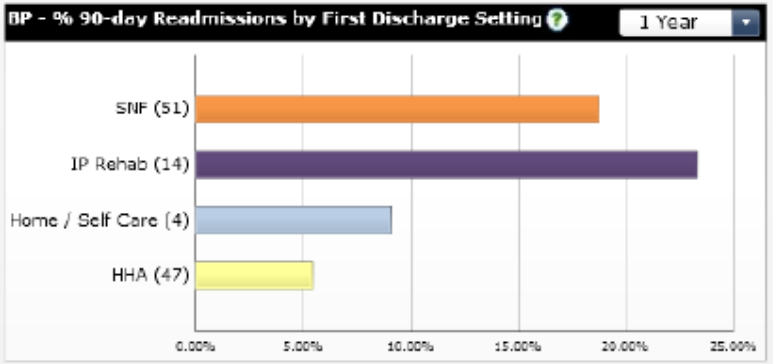












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NQF 1550 and NQF 0166

- In the final CJR ruling two quality measures were adopted
  - **NQF 1550:** Hospital level risk standardized complication rate following elective primary total hip and/or total knee arthroplasty
  - **NQF 0166:** Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Measure

- Voluntary reporting of PRO data will be used in a composite quality score methodology to link the quality of total hip and total knee arthroplasty procedures in participant hospitals to payment

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NQF 1550: Hospital Level Risk Standardized Complication Rate Following Elective Primary Total Hip and/or Total Knee Arthroplasty

- This measure is implemented under CJR
- Assesses a hospital's risk standardized complication rate
- This is the rate of complications occurring after elective primary THA and TKA surgeries
- The measure outcome is the rate of complications occurring after THA and/or TKA surgical procedures during a 90-day period beginning with the date of the index admission for a specific hospital
- An index admission is the hospitalization to which the complications outcome is attributed

One or more outcomes of the following measures are considered complications:

- Acute Myocardial Infarction
- Pneumonia or Sepsis within 7 days of admission
- Surgical site bleeding, pulmonary embolism or death within 30 days of admission
- Mechanical complications, periprosthetic joint infection, or wound infection within 90 days of admission

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NQF 0166: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Measure

- This measure is implemented under CJR
- HCAHPS is a national, standardized, publicly reported survey of patients' experience of hospital care
- It is an instrument and data collection methodology for measuring patients' perceptions of their hospital experience
- The survey asks recently discharged adult patients 32 questions about aspects of their hospital experience
- The core of the survey contains 21 items that ask "how often" or whether patients experienced a critical aspect of care
- It also includes four items to direct patients to relevant questions, five items to adjust for the mix of patients across hospitals, and two items that support Congressionally mandated reports
- Currently 11 HCAHPS measures are publicly reported on the Hospital Compare website (7 composite measures, 2 individual items, 2 global items

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PAIN AS THE 5th VITAL SIGN

- In 2001 The Joint Commission rolled out its Pain Management Standards
  - Pain as the “Fifth Vital Sign”
  - Required healthcare providers to ask every patient about their pain
  - Perception at that time was pain was undertreated

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LINK BETWEEN PATIENT SATISFACTION AND OPIOIDS

- Patients using prescription opioids for pain management are 32% more likely to report higher patient satisfaction scores (Sites BD, et al. *Ann Fam Med*, 2018 16:2-3).
  - Among adults with musculoskeletal conditions 13.1% were opioid users
  - Opioid users were more likely to report high satisfaction with care
  - Stronger association was noted with moderate and heavy opioid use

The Issue:

- Pain management questions currently factor into value based reimbursement rates for hospitals
- As of November 2016 CMS removed pain management and opioid prescribing questions from the reimbursement formula
- Effective 2018 HCAHPS questions on pain management were reformulated

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LINK BETWEEN PATIENT SATISFACTION AND OPIOIDS

Patient Satisfaction Questions Prior to 2018:

- During this hospital stay, how often was your pain well controlled?
- During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?

Patient Satisfaction Question Changes Beginning in 2018:

- During this hospital stay, how often did hospital staff talk with you about how to treat your pain?
- During this hospital stay, how often did hospital staff talk with you about how much pain you had?

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CLINICIANS NEED TO RE-EVALUATE PRESCRIBING PATTERNS

- Drug overdose is now the leading cause of accidental death in the United States, and opioid addiction is driving this epidemic.
- A majority of heroin users started by using prescription narcotics, often switching for reasons related to cost or availability.
- Orthopedic post-surgical patients represent a large cohort that receives opioid prescriptions, often in substantial quantities.
- Prudent use of these medications is important in diminishing the overall number of narcotics in circulation.
- Several initiatives have been put into place over the last few years to this end in New York State:
  - October 2015- electronic prescribing of controlled substances became mandatory.
  - July 2016- a state law was passed limiting prescriptions of opioid medications for acute pain to seven days or fewer.
  - July 2017- a three-hour educational requirement was put into effect for all opioid prescribers.

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DEPARTMENTAL INITIATIVE

- Each of our Divisions has analyzed their opioid prescribing patterns by physician and procedure type.
- They have been instructed based on these analyses to implement new protocols for reducing prescribing patterns.

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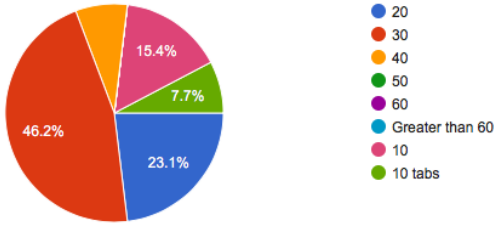
Overview: Number of Pills Prescribed

Meniscectomy

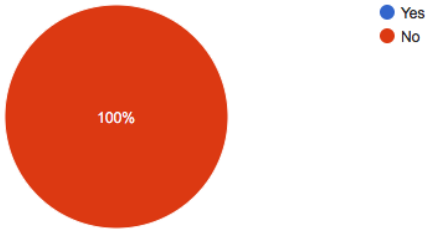
How many tabs?

13 responses



Do you give refills?

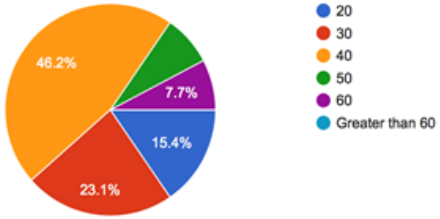
13 responses



ACL Reconstruction

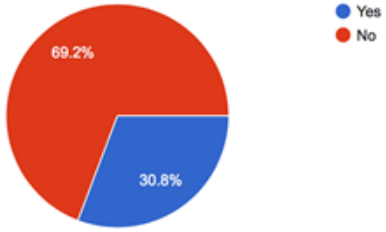
How many tabs?

13 responses



Do you give refills?

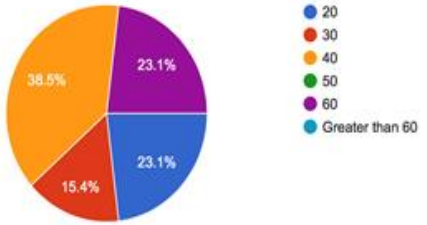
13 responses



Rotator Cuff Repair

How many tabs?

13 responses



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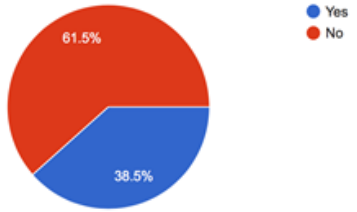

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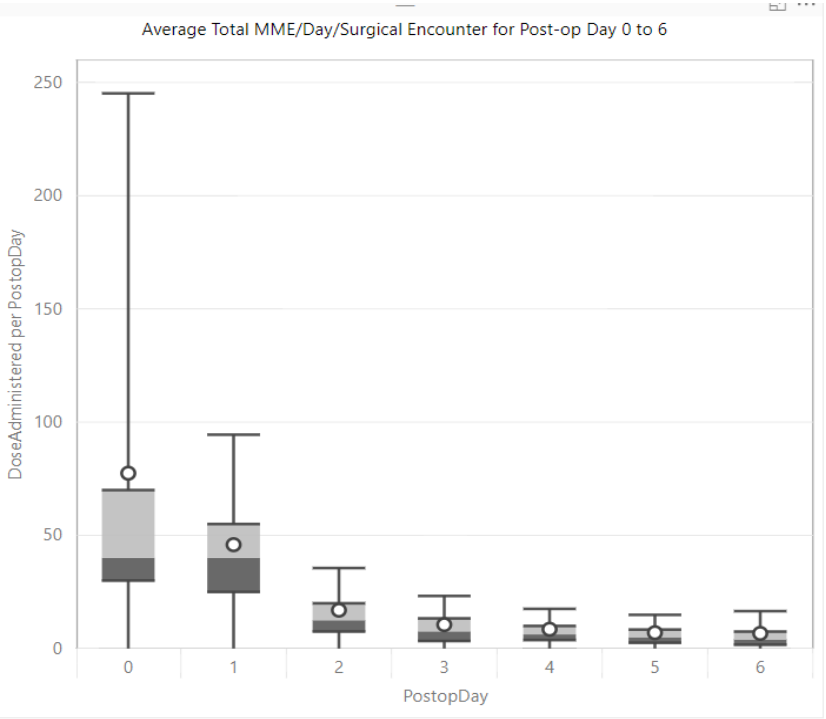
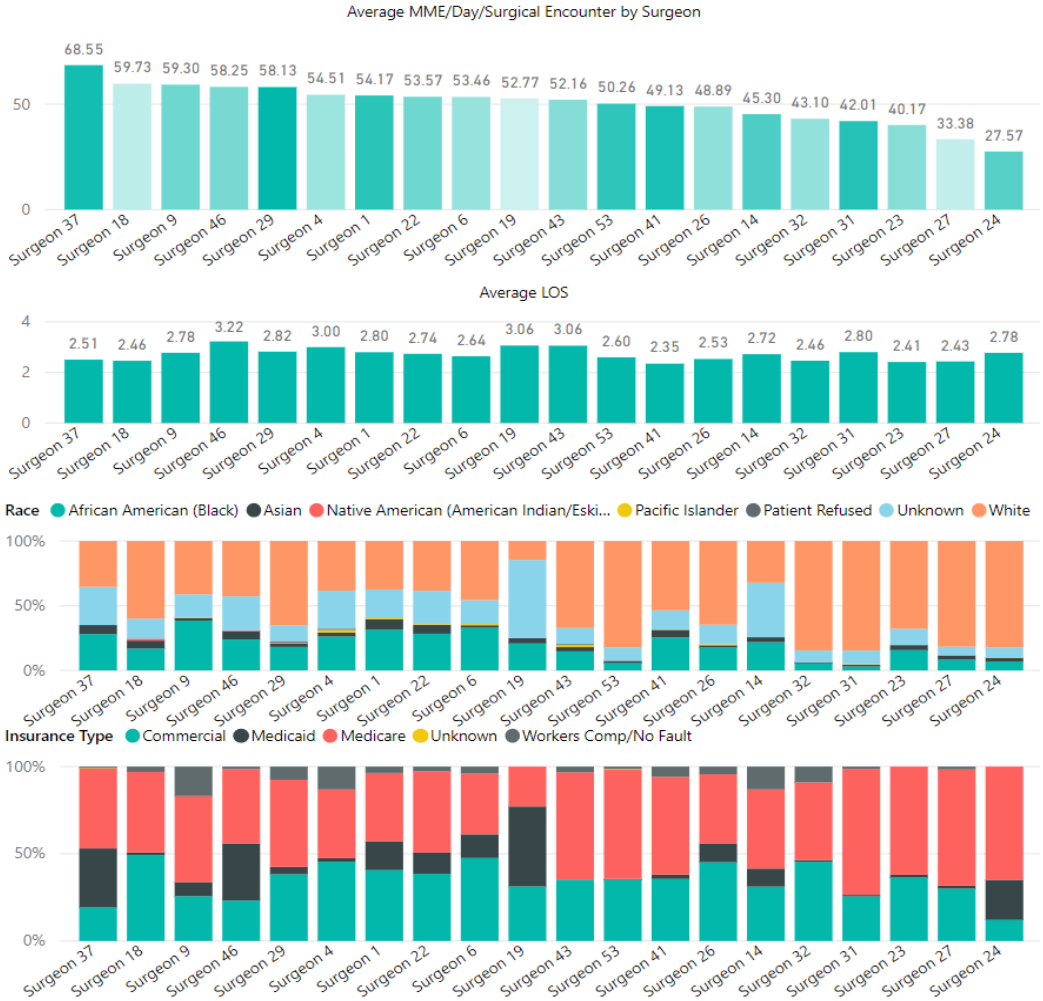


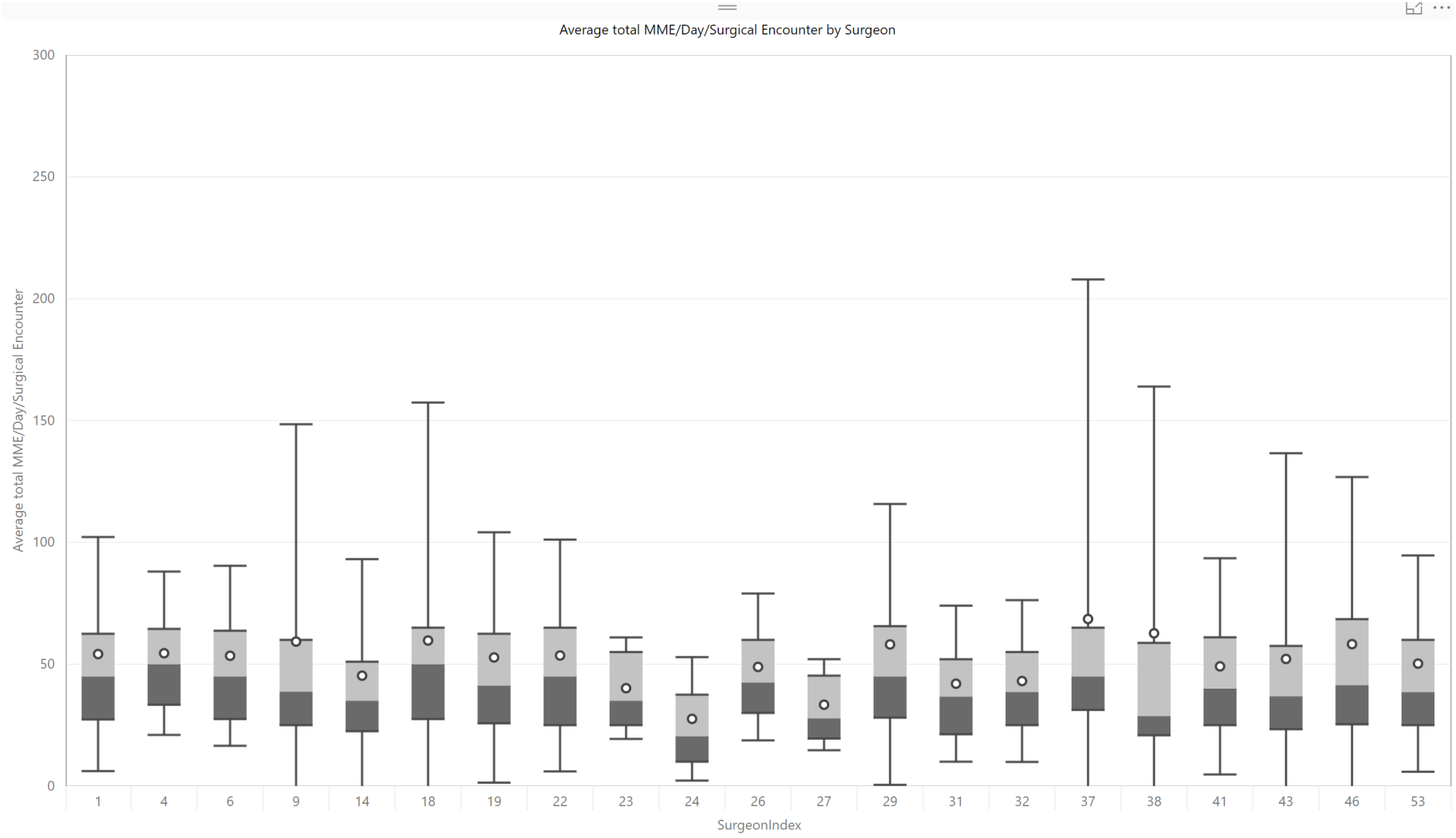
50.88

Average total MME/Day/Surgical Encounter

63.68

Standard Deviation of Total MME/Day/Surgical Encounter





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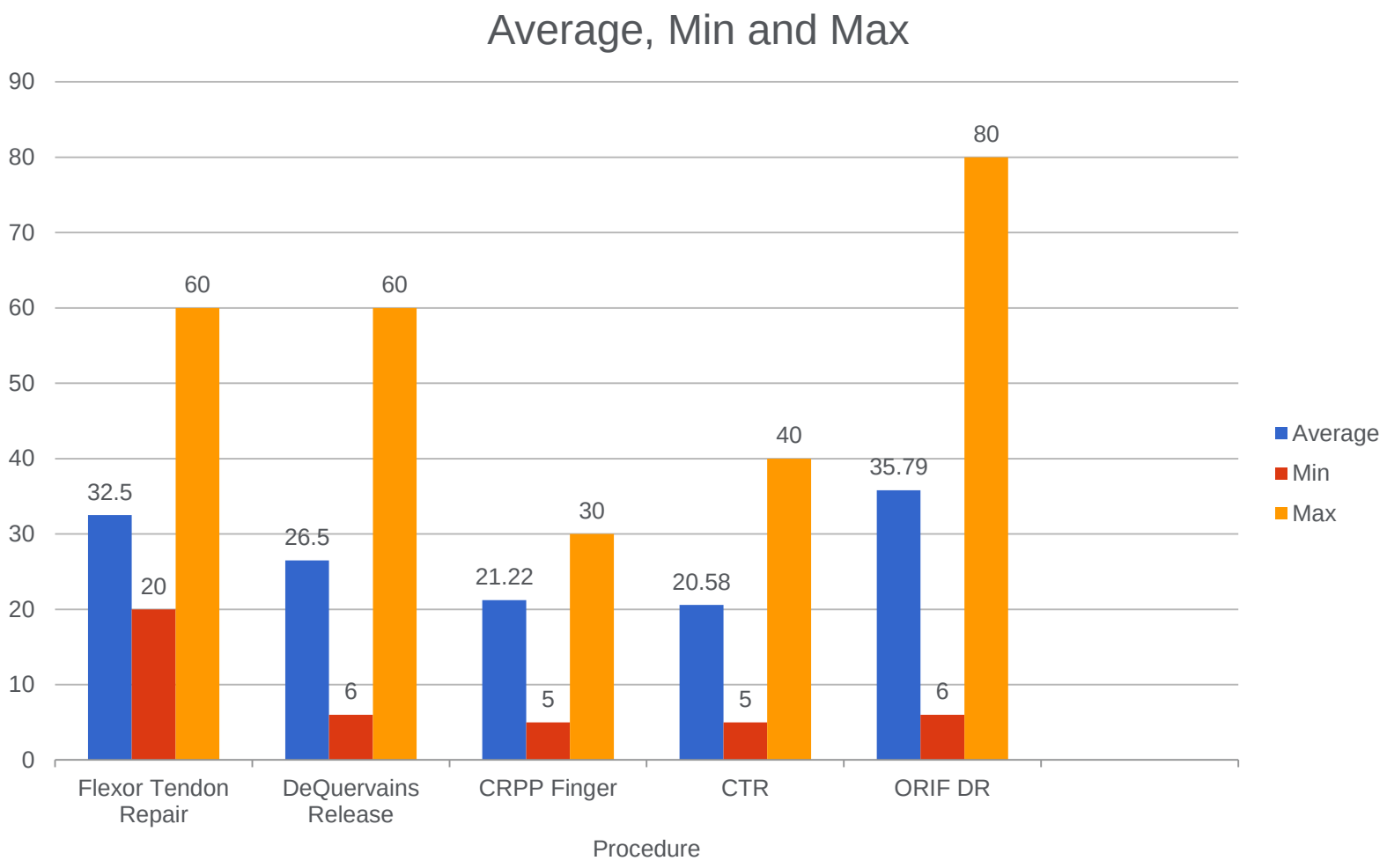
Average, Min and Max
90
80
70
60
50
40
30
20
10
0
32.5
20
60
26.5
6
60
21.22
5
30
20.58
5
40
35.79
6
80
Flexor Tendon Repair
DeQuervains Release
CRPP Finger
CTR
ORIF DR
Procedure
Average
Min
Max

How Many Pills could we get out of circulation?

Procedure	Number of Pills Saved	Per 10 Procedures	Per 100 Procedures
Trigger Finger	26	260	2,600
DeQuervains	20	200	2,000
Flexor Tendon Repair	26	260	2,600
CTR	14	140	1,400
CRPP FINGER	11	110	1,100
ORIF DR	25	250	2,500
total	122	1,220	12,200

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The Future

- Physicians can expect greater public reporting and transparency
  - ProPublica Report
  - CMS Hospital Star Ratings
  - Hospital Compare→ Physician Compare

  - Value based payment for physicians in Medicare is no longer an elusive goal
    - The actions in 2017 will determine 2019 payment.
    - Any organization operating or managing physician services of any size need to decide how they will respond, and, in particular, if it is feasible to get to QP status.
  - The cost burden of compliance, in the context of overall Medicare payment increases over the next four years that will be substantially less than the rate of inflation
  - It will become increasingly difficult for smaller practices to survive
  - The number of physicians who opt out of Medicare in some high end urban markets may increase.
  - Hard and important decisions need to be made soon.

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Moving Forward

- Increasing pressure to provide value presents a new set of challenges to current healthcare practices
- The goal of obtaining the best clinical outcome has always guided and will continue to guide medical decision making; physicians have never been forced to document quality because the focus had been on maximizing clinical volumes
- Monetary pressure to cut costs while improving outcomes represents a new force in the marketplace
- Applying principles of quality management is vital to comply with the changing structure of healthcare reimbursements and to provide the best care for an aging population
- Regardless of political landscape, priorities for the next era of healthcare reform include
  - Accessibility
  - Reliability
  - Affordability

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THANK YOU!

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