



Advancing Female Pelvic Medicine
and Reconstructive Surgery

**Everything You Wanted to Know about Quality Reporting and Were Afraid to Ask
Developed by the AUGS Quality Outcomes Committee**

Important measures and standards as they relate to FPMRS Practitioners:

Outline:

- PQRS (CMS)
- VBM (CMS)
- PSI's (AHRQ)
- SCIP (Joint Commission)
- FPPE, OPPE (Joint Commission)

- Attachments: (1) Selected PQRS Measures
(2) AHRQ PSI List
(3) SCIP Core Measure Set
(4) OPPE FAQ

PQRS

Physician Quality Reporting System (PQRS) is a Centers for Medicare and Medicaid Services (CMS) reporting program of quality measures. It uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs). While this is currently a voluntary incentive-based program through CY2014, it transitions to a penalty-based program for non-participation, beginning CY 2015. Beginning in 2015, the program also applies a 1.5% payment adjustment to EPs who do not satisfactorily report data on quality measures for covered professional services. The program uses physician data reported to Medicare with a 2-year lag (i.e. CY 2015 will utilize CY2013 data)

Currently there are a total of 203 measures available for reporting. An EP may choose from the following methods to submit data to CMS: claims-based, registry-based, qualified Electronic Health Record (EHR), or the Group Practice Reporting Option (GPRO). For individual providers, 3 measures need to be reported. See selected PQRS Measures handout.

The AUGS Quality Outcomes Committee is currently developing measures directly relevant to our subspecialist practice for future use.

Value-Based Payment Modifier (VBM)

Value-based payment modifier is used to adjust a physician's Medicare payments up or down based on participation/performance. Performance is based on data collected via the PQRS program with a 2-year lag (i.e. CY2015 will be calculated based on CY2013 performance data).

The VBM will adjust 2015 Medicare payment rates through a scoring system that would initially raise payment by as much as 2% or cut payment by as much as 1%. Physicians deemed to deliver high value care will receive Medicare reimbursement increases, while those considered to be lagging behind in cost and quality will receive decreases in Medicare reimbursement.

The 3-year rollout applies to all physicians practicing in medical groups with at least 100+ practitioners starting CY2015, expanding to all practitioners by CY2017.

Patient Safety Indicators (PSIs)

PSIs are a set of indicators providing information on potential in hospital complications and adverse events following surgeries, procedures, and childbirth. The PSIs were developed and maintained by the Agency for Healthcare Research and Quality (AHRQ). Some indicators are area-specific while others are provider-specific (e.g. PSI 15 Accidental Puncture or Laceration Rate is a provider-level indicator, while PSI 25 is the same outcome rate tracked for the population in a metropolitan area or county). See enclosed list of provider-specific indicators which are reported as rates and often compared to national benchmarks.

Surgical Care Improvement Project (SCIP)

The SCIP is a set of surgery-specific measures that are part of JCAHO's larger hospital Core Measures which are designed to significantly reduce surgical complications. Through the Joint Commission SCIP represents a set of quality measures that are tracked institutionally as well as individually. Looking at the list of measures, they cover an array of processes that should be done for every patient to help prevent infections including timing and choice of antibiotics, ensuring perioperative glucose control, timely removal of a transurethral catheter and perioperative temperature control. Other measures deal with processes designed to reduce cardiac and thromboembolic events in surgical patients. Some measures are universal whereas some are specific to the type of surgery being done. (see attached SCIP Core Measure Set and antibiotic selection handout)

OPPE and FPPE

In 2008, The Joint Commission (TJC) implemented a new standard with the intent that organizations

look at data on performance for all practitioners with privileges on an ongoing basis rather than at the two year reappointment process, to allow them to take steps to improve performance on a more timely basis. Processes should be clearly defined as to who is responsible for reviewing, how often the data will be reviewed, how the data will be used to make decisions on individual privileges (see enclosed OPPE FAQ sheet)

Ongoing Professional Practice Evaluation (OPPE) is intended as a means of evaluating professional Performance within an organization on an ongoing basis (more frequently than once a year; once a year or less frequent is considered periodic review) to serve three potential functions: 1) as part of the effort to monitor professional competency; 2) to identify areas for possible performance improvement by individual practitioners; and 3) to use objective data in decisions regarding continuance of practice privileges.

Focused Professional Practice Evaluation (FPPE) involves more specific and time-limited monitoring of a provider's practice performance in three situations: 1) when a provider is initially granted practice privileges; 2) when new privileges are requested for an already privileged provider; and 3) when performance non-conformance involving a privileged provider are identified (through the OPPE process or by any other means such as complaints or significant departure from accepted practice.)

SELECTED PQRS MEASURES

Incontinence measures (PQRS measures 48-50)

Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older: Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months

Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older: Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was characterized at least once within 12 months

Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older: Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months.

Additionally, reportable are SCIP-derived measures regarding perioperative timing, selection and discontinuation of prophylactic antibiotics as well as perioperative VTE prophylaxis. (PQRS Measures 20-23, 193):

Perioperative Care: Timing of Prophylactic Parenteral Antibiotic – Ordering Physician: Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours), prior to the surgical incision (or start of procedure when no incision is required)

Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin: Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis

Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures): Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic, which have an order for discontinuation of prophylactic parenteral antibiotics within 24 hours of surgical end time

Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients): Percentage of surgical patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time

Perioperative Temperature Management: Percentage of patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer, except patients undergoing cardiopulmonary bypass, for whom either active warming was used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time.

AHRQ Provider-Level Patient Safety Indicators

- PSI 02 Death Rate in Low-Mortality Diagnosis Related Groups (DRGs)
- PSI 03 Pressure Ulcer Rate
- PSI 04 Death Rate among Surgical Inpatients with Serious Treatable Conditions
- PSI 05 Retained Surgical Item or Unretrieved Device Fragment Count
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 07 Central Venous Catheter-Related Blood Stream Infection Rate
- PSI 08 Postoperative Hip Fracture Rate
- PSI 09 Perioperative Hemorrhage or Hematoma Rate
- PSI 10 Postoperative Physiologic and Metabolic Derangement Rate
- PSI 11 Postoperative Respiratory Failure Rate
- PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
- PSI 13 Postoperative Sepsis Rate
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Accidental Puncture or Laceration Rate
- PSI 16 Transfusion Reaction Count
- PSI 17 Birth Trauma Rate—Injury to Neonate
- PSI 18 Obstetric Trauma Rate—Vaginal Delivery With Instrument
- PSI 19 Obstetric Trauma Rate-Vaginal Delivery Without Instrument

Surgical Care Improvement Project Core Measure Set

Set Measure ID #	Measure Short Name
SCIP Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision
SCIP Inf-2	Prophylactic Antibiotic Selection for Surgical Patients
SCIP Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
SCIP Inf-4	Cardiac Surgery Patients With Controlled 6 A.M. Postoperative Blood Glucose
SCIP Inf-6	Surgery Patients with Appropriate Hair Removal
SCIP Inf-9	Urinary catheter removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with day of surgery being day zero [@]
SCIP Inf-10	Surgery Patients with Perioperative Temperature Management [@]
SCIP Card-2	Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period
SCIP VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
SCIP VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery

[@] denotes Accountability evaluation pending

The Joint Commission- Standards FAQ Details

http://www.jointcommission.org/mobile/standards_information/icfaqdetails.aspx?StandardsFAQId=213&StandardsFAQChapterId=74 (Accessed 10/12/2013)

Ongoing Professional Practice Evaluation (OPPE)

Updated | March 15, 2010

Q. What is the intent of the requirement for Ongoing Professional Practice Evaluation?

A. 1. The intent of the standard is that organizations are looking at data on performance for all practitioners with privileges on an ongoing basis rather than at the two year reappointment process, to allow them to take steps to improve performance on a more timely basis.

2. A clearly defined process would include but not be limited to:

- who will be responsible for reviewing performance data. For example, in smaller organizations the department chair or the department as a whole at their department meetings might be able to review all department members. In larger organizations it could be the responsibility of the credentials committee, the MEC, or a special committee of the organized medical staff.
- how often the data will be reviewed. The frequency of such evaluation can be defined by the organized medical staff, e.g., three months, six months, nine, months, etc. However, as noted in the teleconferences during 2007, twelve months would be periodic rather than ongoing.
- the process to be implemented to use the data to make decision as to whether to continue, limit or revoke privileges. This could include defining who can make and approve a recommendation for action, e.g., the department chair when no action is required, the MEC and governing body for limitation or revocations.
- how data will be incorporated into the credentials files. There needs to be a defined process for the data to be in the record and for the review to occur. This can include storing the data out of the record and making it available with the record at the time of the review. There is no requirement that the data be continuously stored in the credentials file.

The decision resulting from the review, whether it be to take an action or to continue the privilege would need to be documented along with the supporting data.

3. The type of data to be collected would need to be defined by individual medical staff departments and approved by the organized medical staff. The standards require an evaluation for all practitioners not just those with performance issues. The departments will know best what type of data will reflect both good and problem performance for the various practitioners in their departments. The organized medical staff will then determine if the correct type and amount of data is being collected.

The standard's rationale outlines suggested data that the organization may choose to collect along with the following suggestions for methodologies for collecting information:

- periodic chart review
- direct observation
- monitoring of diagnostic and treatment techniques
- discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel.

While some types of data apply to all practitioners, since performance is different for different practitioner, e.g., cardiologist vs orthopedists, vs obstetricians, there may need to be specific data.

In addition since most practitioners perform well, there would need to be data on their actual performance as well as those with performance issues. The fact that a practitioner doesn't fall out on pre-defined screening criteria, is not sufficient to meet the requirement for performance data on every practitioner.

It is also important to remember that zero data is in fact data. Zero data can actually be evidence of good performance, e.g., no returns to the OR, no complications, no complaints, no infections, etc.

It is also important to know when someone is not performing certain privileges over a given period of time. It would not be acceptable to find at the two year reappointment that someone has not performed a privilege for two years.

4. The information resulting from the evaluation needs to be used to determine whether to continue, limit, or revoke any existing privilege(s) at the time the information is analyzed. Based on analysis, several possible actions could occur, including but not limited to:

- determining that the practitioner is performing well or within desired expectations and that no further action is warranted
- determining that issue exist that require a focused evaluation
- evoking the privilege because it is no longer required
- suspending the privilege, which suspends the data collection, and notifying the practitioner that if they wish to reactivate it they must request a reactivation
- determining that the zero performance should trigger a focused review (MS.4.30 EP 5) whenever the practitioner actually performs the privilege.
- determining that the privilege should be continued because the organization's mission is to be able to provide the privilege to its patients.

Evidence of these determinations would need to be included in each practitioner's credentials files at the time of each review of the data.