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Quality Measurement & Urology

Christopher Tessier, MD
Chair, Quality Improvement & Patient Safety Committee

QM and urology

- **Healthcare quality overview**
- Quality measurement overview
- AUA knowledge portfolio
- Current status of quality reporting in urology
- Future directions

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Paradox of American Healthcare Quality

- Highly trained practitioners, widespread state-of-the-art technology, unparalleled biomedical research, unequaled expenditures
- Overuse, underuse, and misuse problems are common, serious and systemic in nature
- Medical errors exist

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Some HC Quality Stakeholders

- Patients (PCORI)
- Payers
  - CMS (PQRS, Value Modifier, Meaningful Use)
  - Private insurers (company-based measures)
  - Employers (Leapfrog group)
- Hospitals (internal QI, ACO's)
- Professional medical societies (AUA,AMA, ACS, Alliance of Surgical Subspecialties)
- Regulatory (latest-ACA via HHS, AHRQ, JCAHO, NQF)

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Value Based Medicine

- Variation in quality and outcomes is substantial and is driven (at least somewhat) by provider behavior
- Suboptimal health care quality and outcomes contribute to excess costs
- Higher quality is not generally associated with higher overall costs, but improving quality often reduces provider revenue under current payment systems

Patrick S. Romano, MD MPH
UC Davis Center for Healthcare Policy and Research
AHRQ Annual Conference
Bethesda, MD; September 14, 2009

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Today's Goals

- Healthcare quality overview
- **Quality measurement overview**
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Quality Measurement

- Quality Indicators (aka Quality measures) - active tools to improve healthcare quality
- Catalyzed by:
  - financial incentives and penalties (PQRS & Value modifier)
  - EHR documentation and reporting capabilities
- Historically "siloed" approach
  - Different measures within each quality program
  - Different reporting criteria for each program

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Quality Indicators – Donabedian

- Donabedian paradigm – Structure, Process, Outcomes measures.
  - Structural Measures : infrastructure and resources of the provider or facility
    - ex. Intensivists in ICU, operative procedure volume
    - Pros: easy to report, often with administrative data
    - Cons: link with outcomes tenuous (confounding variables), often not actionable, not typically related to individual provider performance

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Donabedian (cont'd)

- Process Measures: actual care patients receive.
  - ex. Adjuvant hormonal therapy in high risk CaP pts
  - Pros –
    - actionable
    - linked to individual provider performance
    - based on high-quality data
    - no need to risk-adjust patient factors
    - Short-time frame evaluation period
      - » Ex. Stroke patient receiving right medication (process measure) vs 30 day mortality (outcome measure but difficult to interpret cause)
  - Cons –
    - need to accurately identify denominators of pt. populations for accurate assessments,
    - may not always be appropriate for pts with multiple diseases (potential for adverse drug reactions or therapies)
    - Process measurement does not signify quality unless validated by demonstrating relationship to desired outcomes ("outcome validated")

Mainz, J. Defining and classifying clinical indicators for quality improvement. International Journal for Quality in Health Care 2003; Volume 15, Number 6: pp. 523–530

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Donabedian (more)

- Outcome measures:
  - Pros:
    - actionable, provider-level
    - can include patient-level parameters (QOL),
    - often familiar to providers as a previous generation process measure (asking about substance abuse <process M> can be extended to an <outcome M> assessing whether pt attended abuse Rx program
  - Cons:
    - Outcomes may depend on pt variables beyond provider's control
    - May not reflect quality of care (poor outcome doesn't always occur when there is a quality problem)
    - Subject to statistical validity re: sample size
    - Potential for gaming the system (ex. Selectively referring sicker patients), though risk-adjustment system can mitigate
    - limited outcome data on most GU diseases

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Quality Indicators – Functions

- Quality assurance
  - MOC – Board certification / recertification
- Quality improvement (+/- payment incentives)
  - PFP programs
  - Individual, group and hospital based QI
    - Federal , state, and private payers
    - ACO, health system, facility, group, individual level

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Quality Indicators - Attributes

- Relevance to selected problem
- Understandable
- Achievable
- Changeable by behavior
- Measurable with high validity
  - Content = evidence-based
  - Construct = strong correlation with with actual care provided
- Reliability
  - Evaluation of intra- and inter-observer reliability
- Plus, EHR related issues

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EHR's and Quality Indicators

- EHR's can facilitate QI representation and reporting.
- Electronic QI reporting can overestimate and underestimate quality
  - Some existing measures not suited to the documentation patterns of EHR's :
    - lack of consideration of workflow issues, and
    - data element representation

Bridging Informatics and Implementation Science: Evaluating a Framework to Assess Electronic Health Record Implementations in Community
Richardson, J., AMIA Annu Symp Proc 2012; 2012: 770–778

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AUA Divisions dealing with QI

- Science and Quality
  - Practice Guidelines Committee
  - Quality Improvement & Patient Safety Committee
  - Data Committee
- Coding and Reimbursement
- Public Policy and Practice Support

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GETTING THE 'RIGHT INFORMATION' INTO CLINICAL PRACTICE

IN THEORY, STRAIGHTFORWARD:

- Evidence → Guidelines
- Guidelines → Changes in clinical practice
- Changes in practice → **Improved quality of care**

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AUA Knowledge Portfolio

Current AUA Knowledge Portfolio [21]

- Guidelines – evidence-based guidance on topics with explicit clinical scope and purpose. Development is based on systematic literature review, data extraction and meta-analysis.
- Best practice statements – evidence-based guidance in addressing the principles of a specific issue. Based on a literature review without formal data analysis
- Policy statements – policy/opinion documents relating to declarations on a particular topic as dictated by government or similar agencies. Based on a cursory literature review.
- Consensus statements - policy/opinion documents, representing the collective opinion of an expert panel.
- Technology assessment statements – use of the guidelines process directed at a specific intervention
- White Papers – collaborative committee research using outside resources to provide a position or philosophy document.

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Evidenced-Based Medicine: Urology Perspective

- Tools:
  - AUA Knowledge portfolio-paper & electronic form
  - Informatics tools – clinical decision support (CDS) (order sets, documentation templates, static and interactive guidance)
- Incentives via Quality Indicators:
  - Financial incentives (Meaningful Use, PQRS, Value-modifier, other PFP)
  - Comparison reports (CMS Physician Compare, SQA public reporting, institutional reporting, state/regional collaboratives)

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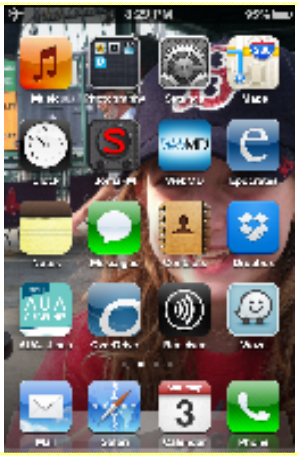
AUA Guidelines app

AUA Guidelines app icon



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Current reporting

- SCIP measures
- PQRS

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Example

Measure #48: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

DENOMINATOR:
All female patients aged 65 years and older

Denominator Criteria (Eligible Cases):
All female patients aged ≥ 65 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

RATIONALE:
Female patients may not volunteer information regarding incontinence so they should be asked by their physician.

CLINICAL RECOMMENDATION STATEMENTS:
Strategies to increase recognition and reporting of UI are required and especially the perception that it is an inevitable consequence of aging for which little or nothing can be done. (ICI)

Patients with urinary incontinence should undergo a basic evaluation that includes a history, physical examination, measurement of post-void residual volume, and urinalysis. (ACOG) (Level C)

Health care providers should be able to initiate evaluation and treatment of UI basing their judgment on the results of history, physical examination, post-voiding residual and urinalysis. (ICI) (Grade B for women)

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PQRS cont'd

- For the urologist, the measures most commonly reported are:
  - Perioperative & postoperative measures (#20, 23 & 46)
  - Incontinence measures (#48, 49 & 50)
  - Prostate cancer measures (#102 & 104)

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Need for harmonization

- Measure publishers do not harmonize measure content
- Ex. – Prostate biopsy antibiotic selection
  - AUA Antimicrobial Best practice statement (2012 revision)
  - SCIP INF-2 – generally in line with AUA BPS
  - PQRS #20 -Ceftriaxone not on list

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CMS' Vision for Hospital and Physician Quality Reporting Programs: "Report Once"

- Reports once to CMS to "receive credit" for their ACO quality measures, Meaningful Use, PQRS, and Value Modifier and aligns with private payer reporting
- Implement a unified, aligned set of electronic clinical quality measures (eCQMs) and e-reporting requirements to synchronize and integrate CMS quality programs which will reduce provider reporting burden and maximize improvement on patient outcomes
  - Hospitals: Inpatient Quality Reporting Program (IQR), Hospital Value-Based Purchasing (HVBP), and the EHR incentive program for Meaningful Use.
  - Eligible Professionals: Physician Quality reporting System (PQRS), Physician
  - Value Modifier (PVM), EHR Incentive Program for Meaningful Use, and Medicare Shared Savings Program (ACOs)

Kate Goodrich, MD MHS
Director, Quality Measurement and Health Assessment Group
Center for Clinical Standards and Quality July 10, 2013

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Need for Urology Measures

- More urology-pertinent reportable measures for CMS' PQRS / VBM program
  - Current pathway (AMA-PCPI & NQF) – unpredictable, expensive $$
  - Alternative pathways to CMS measure adoption ??
    - Direct to CMS submission
    - Registry-level and hospital-level measures
      - Prostate Cancer Registry (AQUA) in development (Data Committee, AUA)
      - Existing urology collaboratives - USQC, MUSIQ, and UroSCOAP
      - Developing collaboratives – ASCO's (QOPI registry), Committee on Cancer /NCDB (hospital level measures)

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Focus and perspective