American Society of Anesthesiologists®

# Measurement Milieu

ASA Processes Today, Meeting Practice Needs Tomorrow

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## Disclosures

Matthew Popovich works for the American Society of Anesthesiologists (ASA).

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## Learning Objectives

At the conclusion of this activity, participants should be able to:

- Discuss why ASA quality measure development, from a regulatory standpoint, is necessary
- Describe the quality measure development cycle at ASA
- Understand how individuals and practices can participate in measure development at ASA

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## Regulatory Issues Influencing Measure Development

The Centers for Medicare & Medicaid Services (CMS) maintains multiple documents governing quality measurement.

- CMS Measures Inventory
  - 26 programs that use quality measures
  - 1,950 quality measures in use or under development
- CMS Measures Management System Blueprint (Vol. 12.0)
- CMS Quality Strategy
- MACRA Measure Development Plan (Updated Annually)

 

## Regulatory Issues Influencing Measure Development

Federal legislation and regulation over the past 20 years have allowed for the proliferation of quality measures.

- Federal legislation on Eligible Professionals
  - PQRS in 2006 under TRHCA (penalties under ACA, budget neutral)
  - EHRs in 2009 under HITECH Act part of ARRA (stimulus)
  - VM in 2010 under ACA (budget neutral with PQRS)
  - Quality Payment Program in 2015 under MACRA legislation

 

## Regulatory Issues Influencing Measure Development

Federal legislation and regulation over the past 20 years have allowed for the proliferation of quality measures.

- Federal legislation on Hospitals/Facilities
  - HVBP in 2003 under Medicare Prescription Drug Act
  - EHRs in 2009 under HITECH Act part of ARRA (stimulus)
  - Ambulatory Surgery Center Quality Reporting or “ASCQR” Program has legislative history dating to the last century

 

## Regulatory Issues Influencing Measure Development

CMS and other drivers of quality measures realize the over-abundance of quality measures.

- Initiatives to find parsimony among measures
  - AHIP, Specialty Societies and CMS have worked to develop "Core Measures" for certain clinicians
  - National Quality Forum (NQF) requires measure harmonization when available (facility and individuals, similar measure concepts)
  - QCDRs required to harmonize similar measures
- Initiatives to limit "low-bar," "topped-out" or "process" measures
  - Greater emphasis on outcome, care coordination, and patient-reported outcome measures
  - "Retirement" of quality measures

 

## Regulatory Issues Influencing Measure Development

Consensus on quality measures ensures physician anesthesiologists and other clinicians are fairly assessed.

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
  - Common measure reporting leads to Benchmarking
  - Quality component of MIPS scoring is based on performance

TABLE 16: Example of Using Benchmarks for a Single Measure to Assign Points With a Floor of 3 Points

| Benchmark Decile | Sample Quality Measure Benchmarks | Possible Points with 3-Point Floor | Possible Points Without 3-Point Floor |
|---|---|---|---|
| Benchmark Decile 1 | 0.0-9.5% | 3.0 | 1.0-1.9 |
| Benchmark Decile 2 | 9.6-15.7% | 3.0 | 2.0-2.9 |
| Benchmark Decile 3 | 15.8-22.9% | 3.0-3.9 | 3.0-3.9 |
| Benchmark Decile 4 | 23.0-35.9% | 4.0-4.9 | 4.0-4.9 |
| Benchmark Decile 5 | 36.0-40.9% | 5.0-5.9 | 5.0-5.9 |
| Benchmark Decile 6 | 41.0-61.9% | 6.0-6.9 | 6.0-6.9 |
| Benchmark Decile 7 | 62.0-68.9% | 7.0-7.9 | 7.0-7.9 |
| Benchmark Decile 8 | 69.0-78.9% | 8.0-8.9 | 8.0-8.9 |
| Benchmark Decile 9 | 79.0-84.9% | 9.0-9.9 | 9.0-9.9 |
| Benchmark Decile 10 | 85.0%-100% | 10 | 10 |

 

## Regulatory Issues Influencing Measure Development

Many anesthesiology measures are nearing topped-out status – putting both measures and MIPS scores at risk

| | Measure_Name | Decile 3 | Decile 4 | Decile 5 | Decile 6 | Decile 7 | Decile 8 | Decile 9 | Decile 10 | Topped Out |
|---|---|---|---|---|---|---|---|---|---|---|
| 23 | Smoking Abstinence Measure | 76.56 - 88.93 | 88.94 - 97.51 | 97.52 - 98.83 | 98.84 - 99.38 | 99.39 - 99.87 | 99.88 - 99.99 | -- | 100 | No |
| 24 | Prevention of Post-Operative Nausea and Vomiting (PONV) - Combination Therapy (Adults) | 86.41 - 95.07 | 95.08 - 97.93 | 97.94 - 98.94 | 98.95 - 99.52 | 99.58 - 99.99 | -- | -- | 100 | Yes |
| 28 | Prevention of Post-Operative Vomiting (PONV) - Combination Therapy (Pediatrics) | 80.77 - 95.64 | 95.65 - 98.99 | 99.00 - 99.99 | -- | -- | -- | -- | 100 | Yes |
| 29 | Anesthesiology Post-Anesthetic Transfer of Care Measure: Procedure Room to a Post Anesthesia Care Unit | 97.00 - 99.46 | 99.47 - 99.99 | -- | -- | -- | -- | -- | 100 | Yes |
| 30 | Composite Anesthesia Safety | 90.40 - 99.58 | 99.59 - 99.72 | 99.73 - 99.81 | 99.82 - 99.90 | 99.91 - 99.99 | -- | -- | 100 | Yes |
| 31 | Immediate Perioperative Cardiac Arrest Rate | 0.13 - 0.13 | 0.14 - 0.18 | 0.19 - 0.24 | 0.25 - 0.33 | 0.32 - 0.50 | 0.51 - 0.81 | 0.82 - 1.49 | >= 1.50 | No |
| 32 | Immediate Perioperative Mortality Rate | 0.10 - 0.13 | 0.14 - 0.16 | 0.17 - 0.19 | 0.20 - 0.23 | 0.24 - 0.28 | 0.29 - 0.34 | 0.35 - 0.60 | >= 0.61 | No |
| 33 | PACU Reintubation Rate | 0.19 - 0.23 | 0.24 - 0.28 | 0.29 - 0.36 | 0.37 - 0.50 | 0.51 - 0.69 | 0.70 - 1.18 | 1.19 - 2.27 | >= 2.28 | No |
| 34 | Short-term Pain Management | 96.89 - 98.46 | 98.47 - 99.19 | 99.20 - 99.56 | 99.50 - 99.83 | 99.84 - 99.99 | -- | -- | 100 | Yes |
| 35 | Colloid use limited in cases with no indication | 97.24 - 97.56 | 97.57 - 97.75 | 97.76 - 98.11 | 98.12 - 98.45 | 98.46 - 98.73 | 98.74 - 99.02 | 99.03 - 99.56 | >= 99.57 | Yes |
| 36 | Avoiding intraoperative hypotension | 91.67 - 92.72 | 92.73 - 94.41 | 94.42 - 99.54 | 99.55 - 99.72 | 99.73 - 99.85 | 99.86 - 99.88 | 99.89 - 99.99 | 100 | Yes |
| 37 | Avoiding gaps in systolic or mean arterial pressure measurement | 72.59 - 80.74 | 80.75 - 90.44 | 90.45 - 91.11 | 91.12 - 92.21 | 92.22 - 92.89 | 92.90 - 93.73 | 93.72 - 94.86 | >= 94.87 | No |
| 38 | Avoiding myocardial injury | 99.87 - 99.98 | 99.47 - 99.63 | 99.42 - 99.38 | 99.37 - 99.28 | 99.27 - 99.02 | 99.01 - 98.83 | 98.82 - 98.49 | >= 98.48 | No |
| 39 | Train of Four Monitor Documented After Last Dose of Non-depolarizing Neuromuscular Blocker | 78.96 - 80.94 | 80.95 - 82.72 | 82.73 - 83.47 | 83.48 - 84.42 | 84.43 - 86.07 | 86.08 - 88.08 | 88.09 - 90.33 | >= 90.34 | No |
| 40 | Avoiding medication overdose | 90.76 - 99.70 | 99.69 - 99.85 | 99.64 - 99.51 | 99.50 - 99.39 | 99.38 - 99.32 | 99.31 - 99.30 | 99.29 - 98.92 | <= 98.91 | No |
| 41 | Administration of Neostigmine before Extubation for Cases with Nondepolarizing Neuromuscular Blockade | 80.03 - 90.25 | 90.26 - 93.55 | 93.56 - 96.79 | 96.80 - 97.96 | 97.97 - 98.41 | 98.42 - 98.89 | 98.90 - 99.30 | >= 99.31 | Yes |
| 42 | Avoiding excessively high tidal volumes during positive pressure ventilation | 89.66 - 91.38 | 91.39 - 92.67 | 92.68 - 94.06 | 94.07 - 95.28 | 95.29 - 95.66 | 95.67 - 95.97 | 95.98 - 96.54 | >= 96.55 | No |
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## Quality Measurement Development at ASA

Quality measure development is a priority for the American Society of Anesthesiologists® (ASA).

- Previous quality measure development was inadequate
- Physician anesthesiologists:
  - Know their priorities in patient care
  - Understand where gaps in care may exist
  - Should be assessed and scored on measures under their control
  - Should be assessed on practices and actions that reflect current clinical guidelines and practice parameters

## Quality Measurement Development at ASA

The ASA has physician leadership, staff and the Anesthesia Quality Institute (AQI) to execute a measure development.

Physician leadership and contributions are key to measure development
- Committee on Performance and Outcomes Measurement (CPOM)
  - Subgroup: Core Measure Development Group
- Anesthesia Quality Institute (AQI) Committees
- Coordination with subspecialty and component societies

## Quality Measurement Development Cycle at ASA

The ASA has physician leadership, staff and the Anesthesia Quality Institute (AQI) to execute a measure development.

ASA and AQI staff are highly-trained and knowledgeable in measure development and maintenance
- Quality and Regulatory Affairs (QRA)
- Anesthesia Quality Institute (AQI)
- Analytics and Research Services (ARS)
- Payment and Practice Management (PPM)

## Anatomy of a Measure

Physician anesthesiologists and practices must understand the basics of a quality measure.

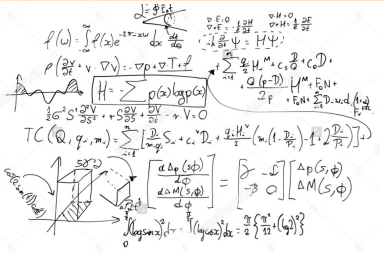
A quality measure consists of at least a denominator and a numerator.

- **Denominator**: A statement that describes the population evaluated by the quality measure
  - Often includes CPT® Codes, ICD-10 codes or other patient population elements (age, condition, anesthesia type)
  - The lower part of the fraction used to calculate a percentage or ratio
- **Numerator**: A statement of the measure's target process, procedure, clinical action or outcome
  - The upper part of the fraction used to calculate a percentage or ratio

## Anatomy of a Measure

This is what you're thinking:



## Quality Measures - Basics

This is what I'm saying:

3 (numerator)

4 (denominator)

## Anatomy of a Measure: MIPS #076

Measure =

**Numerator**

Patients for whom CVC was inserted with all elements of maximal sterile barrier technique, hand hygiene, skin preparation, and, if ultrasound is used, sterile ultrasound techniques followed

—

**Denominator**

All patients, regardless of age, who undergo CVC insertion

**Denominator Exception**

Adherence to aseptic technique would cause an unsafe delay in CVC insertion

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## Measure Development Process: An Overview


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## Quality Measurement Development Cycle

In January 2017, CPOM, along with the ASA Department of Quality and Regulatory Affairs (QRA) launched a Call for Measure Concepts.

The Call for Measure Concepts includes:

- Performing targeted outreach to ASA Subspecialties and Committees
- Identifying subject matter experts and formulate initial workgroups
- Narrowing potential measure topics for consideration for measure development

* Future call for measure concepts will include pain measures.

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## Quality Measurement Development Cycle

Once measure concepts are identified, physicians and staff conduct an environmental scan to ensure measures are not duplicative or reflect a standard of care.

The environmental scan process includes a review of relevant practice parameters and known measures.

- Search for supporting evidence from literature
- Identify supporting clinical guidelines or practice parameters
- Review of CMS Measures Inventory and AHRQ Measures Clearinghouse

Staff makes recommendations and a "business case" to CPOM and physician leaders on whether a measure(s) has merit.

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## Quality Measurement Development Cycle

Draft measure specifications are developed and honed by physicians, methodologists and others.

CPOM (and its Core Measure Development Group) draft measure specifications.

- Outreach to subject matter experts on measure topics
- Physician anesthesiologists
- Methodologists
- Implementation experts (measure feasibility, where data can be gathered)
- Informaticists (data source experts, feasibility and availability of data elements)
- Possible outreach to payers, consumer groups and patients

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## Quality Measurement Development Cycle

Member and public comments are used by CPOM and workgroups to hone and finalize the measure, incorporating appropriate comments and considerations.

Quality and Regulatory Affairs staff sort and highlight comments.

- CPOM and relevant workgroups discuss comments
- Changes to measures are reviewed and approved by consensus
- If feasibility issues have been discovered or determined, CPOM may recommend additional measure testing take place.
- Draft final report with the measure is included in CPOM correspondence to the ASA House of Delegates

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## Quality Measurement Development Cycle

Quality measures used in payment programs and in quality improvement activities must be appropriately maintained.

ASA staff works with physician leaders to perform measure maintenance.

- Annual reviews include, but are not limited to:
  - Measure specifications
  - Practice guidelines
  - Member and participant measure use and inquiries
  - Feasibility testing and review
  - Reliability and validity testing

ASA staff routinely communicates with CMS on measures.

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## Quality Measurement Development Cycle

This is what you're thinking:

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## Quality Measurement Development Cycle

This is what I'm saying:

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## Participate in Measure Development

Participation in the AQI may also mean allowing your practice to trial or test measures before implementation.

CPOM, AQI and ASA staff are developing mechanisms for practices to trial and test measures.

- Data benchmarking is necessary for MACRA scoring
- Measures must be tested for feasibility (data collection)
- Measures must reflect clinical workflows
- Measure testing can identify appropriate patient populations and necessary exemptions
- Registries can help you identify gaps in care, regardless of regulation

 

## Questions / Comments

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