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Pay for performance: what the urogynecologist should know

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Abstract

As urogynecologists, we should educate ourselves about pay for performance and be proactive in the development of outcome measures.

Keywords

Pay for performance; Outcome measures; Healthcare quality; Urogynecology

Introduction

In the USA, healthcare providers have traditionally been paid for services without reference to the quality of the services provided [1]. An idealistic view of the healthcare market in the USA is that the consumer's desire for information on performance and quality of their providers and the services they receive will ultimately guide their healthcare choices, but this view is not the current reality. Pay for performance (P4P) is a reimbursement scheme adopted and supported by the Center for Medicare and Medicaid Services with the support of the US Congress in 2005, which is currently utilized by more than half of health maintenance organizations (HMOs). [2,3] The goal of P4P is to invoke speedy and radical change in the current US healthcare system to ultimately foster higher performance standards, support innovation, and encourage comprehensive system-wide improvements. [2] P4P is a “catchphrase for a management tool that establishes incentives for clinicians and institutions that deliver health care services to deliver care that third parties deem is... appropriate to achieve the highest-quality standards and best outcome” [4].

The attempt to foster revolutionary changes in the US healthcare system by changing the reimbursement scheme for providers is not new. When Medicare changed reimbursement schemes in 1982 to be based on diagnosis-related groupings instead of the fee for service, the average hospital length of stays immediately decreased. The drive for decreasing hospital length of stay sparked the development of many minimally invasive surgical techniques and an increase in outpatient surgery to benefit of our patients and our subspecialty.

As a subspecialty, we should educate ourselves about P4P, make recommendations on how to apply P4P to our subspecialty, and be proactive in the development of outcome measures.

Defining and measuring quality

Although the ultimate goal of improving quality is laudable, defining what quality “is” becomes elusive. Even more difficult is the implementation of restructuring the entire payment system for healthcare in the USA around the concept of reimbursement for quality care. Quality can be measured in many ways. Currently, quality is measured in three main ways: use of medical care, outcome measures, and patient satisfaction.

Use of medical care

Errors in the use of medical care can be categorized in three ways: underuse, overuse, and misuse. Misuse is most impressively demonstrated by the 1999 Institute of Medicine report stating that as many as 98,000 Americans die each year from medical mistakes [5]. However, problems of underuse (e.g., women not receiving appropriate screening tests in a recommended and timely fashion) and problems of overuse (e.g., inappropriately ordered radiologic imaging studies or unindicated antibiotic use) are also highly prevalent throughout the current healthcare system creating inefficiency and wasted resources. The majority of P4P measures currently utilized by HMOs are related to underuse, although addressing problems of overuse may ultimately provide cost savings to insurance companies [3].

Outcome measures

Surgical procedures in urogynecology and female pelvic reconstructive surgery are unique compared to many surgical specialties. The desired outcomes of these procedures are not to save lives but rather to produce a noticeable and measurable improvement in the quality of women's lives. In most urogynecology procedures, unexpected complications are morbid but rarely fatal. Therefore, the quantification of what outcome measures to use within the field of urogynecology becomes problematic. Although 30-day mortality or 5-year survival rates may be applicable to other surgical specialties, reporting mortality as the sole outcome measure is not adequate in elective surgery.

National Committee for Quality Assurance—The National Committee for Quality Assurance (NCQA) is a not-for-profit organization established in 1990 and works toward accreditation, certification, and physician recognition of quality in the USA [6]. One of the ways this organization measures and reports on healthcare quality is through the Healthcare Effectiveness Data and Information Set (HEDIS) tool. HEDIS measures are then utilized by P4P reimbursement systems. In 2004, urinary incontinence was added to the annual reported HEDIS measures [7]. Urinary incontinence data are collected through questions answered on the Medicare Health Outcomes Survey. These questions focus mainly on (1) the proportion of members in an insurance plan who have experienced urinary incontinence in the last 6 months, (2) the proportion reporting urinary incontinence is bothersome to them, (3) the proportion reporting the discussion of these issues with their healthcare provider, and (4) the proportion receiving any kind of treatment for urinary incontinence [8].

Clavien complication scheme—Some quality measures are universal throughout many surgical specialties. In 2004, Dindo et al. proposed an evaluation tool to grade surgical complications, later named the Clavien Complication Scheme [9]. Minor Clavien complications include grade I or II. Grade I complications are defined as any deviation from the expected normal postoperative course with grade II complications defined as the need for pharmacologic or medical interventions including blood transfusions and total parenteral nutrition. Major Clavien complications include grades III to V. Grade III complications require “surgical, endoscopic, or radiological intervention.” Grades IV and V complications include life-threatening complications, organ dysfunction, and death. This graded

complication scheme could be applied to any organ system and specific surgical procedures, including urogynecological surgeries.

Internal reporting with NSQIP—The National Surgical Quality Improvement Program (NSQIP) is a standardized model for surgical quality assessment and improvement currently utilized by over 121 hospitals nationwide originated at Veterans Affairs (VA) hospitals in the 1990s. In 1999, a pilot program to involve non-VA hospitals was successful, and in 2001, the American College of Surgeons (ACS) partnered with the VA to offer NSQIP participation to all American hospitals. Participation is currently mandatory for VA hospitals and voluntary for other institutions [10]. NSQIP utilizes the Clavien complication scheme with preoperative morbidity adjustments to calculate adjusted 30-day morbidity and mortality ratios. Quality improvements as a result of the NSQIP program have included a 9% decrease in 30-day mortality and a 30% decrease in 30-day morbidity throughout the VA system in a 3-year period [11]. Reporting is voluntary; data for the institution and the individual surgeons are currently kept confidential. NSQIP does not encompass procedures commonly performed exclusively by gynecologists because of its primary association with the ACS. In the 2007 Telinde lecture at the annual scientific meeting of the Society for Gynecologic Surgeons, Dr. William Cliby made convincing arguments for the specialty of gynecology to push toward the involvement in this successful quality improvement program [12].

In addition to the NSQIP, other quality measures are currently reported to CMS on a voluntary basis that will move toward mandatory reporting, including: correct antibiotic prophylaxis administration, documentation of thrombo-embolic prophylaxis, and completion of the surgical pause on every surgical patient. In addition to these measures, insurance companies are moving toward zero tolerance, refusing to reimburse, on certain misuse complications including wrong site surgery and blood transfusion reactions.

Patient satisfaction

Another dimension of quality being used in P4P reimbursement schemes is patient satisfaction. Patient satisfaction is easy to ask but harder to interpret. Patient satisfaction measures generally follow a skewed distribution; the majority of patients report being very satisfied with a few outlying dissatisfied patients. Some measures of patient satisfaction currently being collected include patient reports of their doctor: (1) always knowing important information about medical history, (2) always explaining things so that you can understand, (3) always spending enough time with you, and (4) always discussing treatment options and involvement in decision about treatment [13].

Developing P4P measures in urogynecology

In 2007, the 110th Congress of the American College of Obstetricians and Gynecologists (ACOG) listed the maintenance of high-quality patient care as a top legislative priority [14]. All members were encouraged to urge Congress to implement P4P as a voluntary reimbursement system based on performance measures developed by ACOG. In 2006, ACOG began including “proposed performance measures” in ACOG practice bulletins. Some of these performance measures include: documentation of indication for episiotomy, percentage of women taking combination contraceptives with history of venous thrombo-embolic event, and percentage of women undergoing vaginal or abdominal hysterectomy who receive antibiotic prophylaxis.

When developing P4P measures, it is important to distinguish between quality measures and clinical practice guidelines [15]. Practice guidelines are intended to be recommendations to be applied prudently to an individual patient or certain population based on clinical

experience while acknowledging the flexibility in the practice of medicine. Quality measures are rigid tools. Practice guidelines are sometimes based on expert opinion compiled with the best available clinical knowledge recognizing that results of randomized controlled trials (RCTs) do not exist for many aspects of clinical practice. Providers should be cautious of accepting flexible practice guidelines as rigid quality measurements tied to reimbursement schemes. Unfortunately, very few aspects within the field of urogynecology can be based on evidence from RCTs. In the absence of solid data, practice within the specialty needs to be flexible and patient directed.

The biggest challenge urogynecology faces as a subspecialty in the implementation of P4P is the development of feasible and high-impact performance measures that can be adhered to rigidly. Unlike flexible practice guidelines that can be tailored to unique patients, P4P measures are not adjustable. Some performance measures discussed, such as antibiotic prophylaxis prior to incision, documentation of thromboembolic prophylaxis, and documentation of the surgical pause, can be universally agreed upon. However, other P4P measures specific to the field of urogynecology are more problematic to implement, as the definition of quality, a successful outcome, and what measures to use in our subspecialty still need to be determined.

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