Value Measurement in Orthopaedic Surgery

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Impact on the Profession and Surgeon
Orthopaedic surgeons have been at the forefront of medical innovation over the last 50 years, developing and now routinely providing interventions that change lives for the better. Payers for that care, however, are well-aware that those interventions have a real-world range of costs and outcomes, and they have been pursuing strategies to reduce variability for several decades. Parallel to those efforts has been the growing consensus among patients, payers, and the body politic that the relative cost of health care has reached a limit in terms of share of gross domestic product, percentage of the federal budget, and cost of premiums and taxes for the individual.

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Surgeon income also will be tied to value measurements. The former Physician Quality Reporting Initiative (PQRI) is now known as the Physician Quality Reporting System (PQRS), which requires the reporting of process and outcomes metrics from the outpatient arena; failure to report will soon mean a withhold. Physicians also will soon be measured by the average cost of the care delivered for their Medicare populations. Their cost profiles, with geographic comparisons, will be sent to them in the form of a Quality and Resource Use Report (QRUR).

This data will be combined with patient satisfaction scoring and outcomes to determine withhold versus additional payment from CMS through the Value-Based Payment (VBP) program.

The outcomes and risk adjustments will be dependent on CMS claims data that has historically not been as accurate as other sources, in part because of the variability of the codes given. There was a provision in last winter’s “fiscal cliff” bill that allows for alternative, approved registry outcomes data to be used for reporting; this is an option in development. The implementation of better data collection, metrics, and risk adjustment will be best accomplished with input from our specialty, as has been the case with the initial instruments developed for the total joint readmission and complications processes. The AAOS board has just approved a plan to develop processes, support, and committee structures to generate relevant PQRS-reportable metrics that are developed by surgeons for their own specialties.

As hospitals and groups become more involved with accountable care organizations and bundled payment plans, surgeons will find their costs and outcomes under local scrutiny. When all parties are part of a common payment for a particular patient population or individual patient care intervention, the same parties will inevitably exert their influence on surgeons to reduce the incidence of adverse events and costs. Surgeons need tools to be able to deliver appropriate evidence to support their interventions. Specialty-driven development of evidence-based clinical guidelines and appropriate use criteria will become even more critical.

Certain groups of patients with known, but not fully accounted for, higher risks of complications will be at risk for marginalization, especially given the usual relatively lower incidence of complications in orthopaedic surgery. It will not be long before hospitals and surgeons with larger pockets of such patients become value-based payment outliers; this will lead to pressure from hospitals, groups, and partners to avoid or curb access to such patients. Ideally, given the uncertain experience with current risk-adjustment formulas, higher-risk patients would be excluded from analysis or carved out of bundle/Accountable Care Organization (ACO) agreements, allowing apples to be compared to apples.

Conclusions

The value of what we contribute through our interventions as a specialty is going to be under increased scrutiny, with implications for the national “triage” of limited resources, hospital and surgeon reimbursement, and patient access. It is a critical time for orthopaedic surgeons. Collectively, we need to support our national organizations in the development of the tools and evidence to best support our ongoing care of patients and their access. Individually, we need to become involved leaders at the local level to improve accurate data collection, guide the selection of registries and metrics, and continue to protect the most vulnerable patients from becoming “value refugees.”

References

