

## Value-based purchasing

# SCIP measures to weigh in Medicare pay starting in 2013

**T**he dawn of hospital pay for quality has arrived. Hospitals have been reporting Surgical Care Improvement Project (SCIP) measures and other quality measures to Medicare for public display. Now starting in fiscal year 2013, how well they perform on 7 of the SCIP measures and 18 other measures will determine in part how much they are paid by Medicare.

In a proposal for value-based purchasing issued January 7, 2011, the Centers for Medicare and Medicaid Services (CMS) asked for comment on its plans to start tying Medicare DRG payments to hospital scores on 25 quality measures. Comments are due March 8.

The Joint Commission is also raising the stakes on quality reporting. In January, the commission announced its plans to tie scores on core measures, including SCIP, to hospital accreditation (related article, page 6).

Under the CMS proposal for FY2013, which starts October 1, 2012, DRG reimbursement will be tied to:

- 17 clinical measures, including 7 SCIP measures
- 8 patient experience measures (HCAHPS scores).

Scores for the individual measures would be rolled into a composite score. Hospitals would be scored both on their achievement (compared to a benchmark) and their improvement. The higher of the 2 scores would be used to calculate the incentive payment amount. At risk would be 1% in Medicare inpatient payments, gradually rising to 2% by FY 2017. The program will gather momentum, with 20 more measures planned to be added in FY 2014 (sidebar).

The hospital outpatient quality measures are not included in this plan. The health care reform act also requires CMS to develop a value-based purchasing plan for ambulatory surgery centers, with a report due to Congress by January 1, 2011. That report had not been issued by press time.

### Change is immediate

Change is coming immediately—the period for measuring hospital performance for FY 2013 payments would start July 1, 2011, and run through March 31, 2012.

CMS says the plan will be “budget neutral.” That is, the program will be funded by reducing DRG payments to hospitals overall and having them earn that back through their performance scores.

“Value-based purchasing in Medicare is the beginning of a transition away from paying hospitals on the basis of the volume of activity and cost to paying them based on clinical outcomes and patients’ experiences with care,” says Jeffrey A. Peters, presi-

dent of Surgical Directions, Chicago-based consultants.

“The SCIP measures and patient satisfaction are all things hospitals have measured—now it’s going to affect the bottom line.”

Regardless of how health care reform fares in Congress, he says, private payers are already experimenting with similar approaches.

### Preparing for value-based purchasing

“Most hospitals are already on board with most of these measures, but now it is a matter of consistency and accountability 24/7,” notes Mary Jane Edwards, MHSA, RN, CNOR, FACHE, specialist leader, Strategy & Operations, Deloitte Consulting, McLean, Virginia. Close collaboration with surgeons, anesthesiologists, and hospital administrators will be important, she adds.

Advice for perioperative directors:

- **Build awareness.** Explain to the Surgical Executive Committee and the staff “that the paradigm has changed,” Peters advises. “We’ve talked about the need to create a safe environment with good outcomes. Now we will be measured by it.

“The hospital’s financial viability is no longer involved just in increasing our surgical volume; now it is also the outcomes of surgery.”

- **Assess for gaps.** With the July 1 evaluation period coming up, “it is a good time to evaluate your hospital,” says Edwards. “These measurements are concrete: prophylactic antibiotics delivered on time, the right antibiotics delivered, and so forth. Where does your hospital stand?”

- **Check your status.** Pay attention to where you are on the measures. Compliance on SCIP measures is already high. “Develop corrective action plans for any measure for which you’re below a national benchmark,” Peters says.

- **Make current scores visible.** Post current performance scores on an internal surgical services dashboard, publish them in the department newsletter, and take other steps to make sure your scores are known to the staff and physicians.

- **Elevate quality as a priority.** “So many ORs focus on turnover time and on-time starts,” says Randy Heiser, MA, president and CEO of Sullivan Healthcare Consulting, Ann Arbor, Michigan. The same emphasis needs to be placed on quality measures, he suggests. “Think of quality as a day-to-day operational metric tied to the individual patient.”

- **Give feedback to individual providers.** Progressive hospitals Heiser knows of

### Hospital SCIP data, 2nd quarter 2010

Measures in red are proposed for value-based purchasing in FY 2013

Complete data (100% eligible sample)

Performance measure

Rate (%)

**SCIP-1:** Antibiotic within 1 hr before Incision (2 hrs if vancomycin or quinolone is used) 97.1

**SCIP-2:** Received prophylactic antibiotic consistent with recommendations 97.6

**SCIP-3:** Prophylactic antibiotic discontinued within 24 hrs of surgery end time (48 hrs for cardiac surgery) 95.5

**SCIP-4:** Controlled 6 am postoperative serum glucose-cardiac surgery 93.9

**SCIP-6:** Appropriate hair removal 99.6

**SCIP-CARD2:** Perioperative period beta-blocker 93.8

**SCIP-VTE1:** Recommended VTE prophylaxis ordered during the admission 94.7

**SCIP-VTE2:** Received VTE prophylaxis within 24 hrs prior to or after surgery 93.1

**SCIP-9:** Urinary catheter removed on postoperative day 1 or day 2 91.2

**SCIP-10:** Surgery patients with perioperative temperature management 98.8

Source: Data from Centers for Medicare and Medicaid Services, 2010.

have incorporated the SCIP measures into their perioperative information systems.

"They collect the data, and it is reviewed by the OR Committee. If it looks like they have an issue, the chief of surgery and the medical director speak with the surgeon who has the problem. That is happening within a week to 10 days.

"These are the hospitals that are not going to have a problem with value-based purchasing."

- **Align incentives.** Peters recommends aligning hospital and anesthesia group incentives. "You need to incorporate these expectations into the anesthesia agreement," he says, noting most contracts now include criteria for meeting or exceeding SCIP measures as a condition for the anesthesia group's continued exclusive relationship with the hospital.

"If your anesthesia group receives a stipend, which 75% of all anesthesia groups nationally receive, you need to tie the stipend to compliance with these measures."

- **Anticipate FY 2014 measures.** Most will involve surgical patients, Edwards points out. An example is postoperative pulmonary embolism or deep-vein thrombosis. This is an outcome connected to the SCIP measure for venous thromboembolism (VTE) prophylaxis, she notes. It's an opportunity to look at the whole process: "First, are you ordering it? Then are you applying it? And then what is the result?"

Among other measures for FY 2014 that involve surgery are retained foreign objects, blood incompatibility, Stage 3 and 4 pressure ulcers, falls and trauma, vascular catheter-associated infections, and catheter-associated urinary tract infection.

Falls and trauma, for example, include injuries that could happen in the OR, such as dislocations, crushing injuries, and burns. A patient's hand might be crushed between the gurney and OR bed, or a patient might suffer an electrosurgical burn.

"These are all things everyone knows you should address—but there will be dollars attached to these now," Edwards observes.

### **Some SCIP measures not included**

Several of the current SCIP measures are not proposed to be included in value-based purchasing for FY 2013.

CMS proposes not to include SCIP-Inf-6, appropriate hair removal, saying it is "topped out," meaning nearly all hospitals have achieved high performance, and there's not much room to improve. The latest available data shows compliance with SCIP-Inf-6 to be 99.6%.

Also not included would be SCIP-Inf-9 (urinary catheter removed on postoperative day 1 or 2) and SCIP-Inf-10 (surgical patients with perioperative temperature management) because they have not met the requirement that value-based purchasing measures be posted to the Hospital Compare website for at least 1 year prior to the performance period.

CMS proposes to reclassify the surgical infection-related measures, SCIP-Inf-1 through 4, under health care-associated infection (HAI) measures rather than surgical care measures to align with the Health and Human Services Action Plan for Health-care-Associated Infections.

### **Looking beyond SCIP**

Are SCIP measures the best measures? There is some skepticism.

A study published in 2010 found hospitals' adherence with individual SCIP infection prevention measures didn't affect patient outcomes (Stulberg J J, et al. *JAMA*. 2010;303:2479-2485). But all 6 SCIP infection measures taken together were linked to lower infection rates. The study was based on administrative data, which experts say is not the ideal way to assess outcomes.

CMS says it is already looking beyond SCIP and other process measures and plans to adopt other types of measures “as quickly as possible.” These would include more measures for outcomes, efficiency, and patient experience.

### **Surgical outcomes measures**

The American College of Surgeons (ACS) says it is working with CMS to develop outcome measures based on its National Surgical Quality Improvement Program (NSQIP).

“The SCIP measures are evidence-based process measures, and in that regard, ACS supports them,” Clifford Ko, MD, MS, FACS, professor of surgery at UCLA and director of the ACS Division of Research and Optimal Patient Care, told *OR Manager*. “But I think we all recognize that the quality movement needs to move forward, either with additional process measures or outcomes measures.”

NSQIP, which involves abstracting clinical data, requires more resources than using administrative data to measure outcomes, Dr Ko acknowledges. The program requires a dedicated surgical nurse reviewer and captures 135 variables according to the NSQIP website ([www.acsnsqip.org](http://www.acsnsqip.org)).

Dr Ko points out, however, that abstracted clinic data is more robust than administrative claims data for evaluation and quality monitoring. He says ACS is working with CMS to refine the data collection process.

“We know how much data is needed for the SCIP measures. Our intent was to have as much or less data collection for the outcome measures,” he says.

In the future, the necessary data could be collected through the electronic medical record. “We are working toward an EMR. Until then, if you want the best data, that needs to be clinical data,” Dr Ko says.

### **Opportunity to do the right thing**

Edwards advises OR leaders not to view value-based purchasing as something negative. Rather, she says, “This can be a great incentive for hospitals and OR directors to examine closely any deficits in their performance and make corrections.

“This is the opportunity not only to do the right thing—providing safe care, accountability, and responsibility—but gaining back some the financial reward or payment you would have lost under the Patient Protection and Affordable Care Act.” ❖

—Pat Patterson

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## **Value-based purchasing FAQs**

### **What is value-based purchasing?**

Value-based purchasing is a Medicare program that for the first time will tie hospitals’ Medicare DRG payments to their performance on quality measures. The program applies to acute care hospitals paid under the Inpatient Prospective Payment System, with some exceptions.

The new program, required under the 2010 health care reform act, will provide incentive payments to hospitals beginning in fiscal year 2013, which starts October 1, 2012. A proposed rule was issued January 7, 2011 by the Centers for Medicare and Medicaid Services (CMS).

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### **When does value-based purchasing start?**

- The first performance period for FY 2013—during which hospital performance will be evaluated—is July 1, 2011 through March 31, 2012.
- Hospital payments will be adjusted for discharges starting October 1, 2012.

### **What will the quality measures be?**

Proposed quality measures for FY 2013 are:

- 17 clinical process measures, including 7 SCIP measures
- 8 measures on the patient's experience of care based on the HCAHPS survey.  
The clinical measures would be weighted at 70% and HCAHPS measures at 30%.

### **Measures to be added**

For FY 2014, CMS proposes to add:

- 3 mortality outcome measures: acute myocardial infarction, heart failure, and pneumonia.
- 8 measures for hospital-acquired conditions (HACs):
  - Foreign object retained after surgery
  - Air embolism
  - Blood incompatibility
  - Pressure ulcer Stages 3 and 4
  - Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)
  - Vascular catheter-associated infections
  - Catheter-associated urinary tract infection
  - Manifestations of poor glycemic control.
- 9 measures: Agency for Healthcare Research and Quality patient safety indicators, inpatient quality indicators, and composite measures.  
To be included, measures must have been posted on Hospital Compare for at least 1 year.

### **How will performance be scored and linked to payment?**

This is basically what CMS proposes:

- Each hospital would be scored on its achievement and improvement for each measure. Its performance would be based on the higher of the achievement score or improvement score, which compares the hospital's score during the performance period with its baseline.
- A hospital would be scored from 0-10 for achievement and 0-9 for its improvement on a measure.
- CMS would then calculate a total score for each hospital using a formula.
- The hospital's total score would be translated into a value-based incentive. CMS proposes to notify each hospital of its FY 2013 estimated incentive payment at least 60 days before October 1, 2012, with notice of the exact amount by about November 1, 2012.

### **Where can I learn more?**

A fact sheet on value-based purchasing is <http://www.cms.gov> Look under Newsroom.

The proposed rule is at <http://edocket.access.gpo.gov/2011/pdf/2011-454.pdf>.