PRINCIPLES FOR QUALITY INCENTIVE PROGRAMS IN ANESTHESIOLOGY

Committee of Origin: Performance and Outcomes Measurement

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The American Society of Anesthesiologists has extensive experience in the development of practice standards, guidelines, advisories and statements, all intended to advance patient safety and the practice of anesthesiology. Since the publication in 1986 of "Standards for Basic Anesthetic Monitoring," ASA has published 53 practice parameters, documents initially consensus-based, but after 1991 evidence-based as well. The goal of each of these documents has been to promote quality practice and to enhance patient safety. The Institute of Medicine continues to cite Anesthesiology as the leading medical specialty to effect meaningful and sustained improvements in its practices, which in turn have led to remarkable improvements in patient safety.

Encouraging and facilitating ASA members' engagement in programs and processes which enhance quality and patient safety continues to be a major goal of the ASA. The establishment of the Anesthesia Quality Institute (AQI), continued development of pertinent, meaningful measures, ongoing analysis of evidence-based practice parameters, review and updating of older practice parameters and retirement of parameters no longer applicable are all part of ASA's process to realize its vision for the future. ASA's objective is to assist anesthesiology practices and individuals in benchmarking their practices to allow them to continue to improve, as well as to compare one practice to another. ASA's ultimate goal is to identify strategies which are most beneficial and valuable, to measure outcomes associated with their use, and to accumulate data to allow for further evidence-based changes in clinical practices.

When incentives are to be deployed to stimulate changes in the behavior of anesthesiologists, ASA believes that these quality incentive programs must adhere strictly to principles of equity and fairness, be evidence-based, and be directly attributable to those practitioners who demonstrate the improvement in patient safety. ASA believes that the following principles are crucial to ensuring that such quality incentive programs are effective in advancing patient care.

Demonstrable Relevance to Quality of Perioperative Care

- Incentives should encourage only those practices that have been recognized to improve patient outcomes. Performance incentive measures, analogous to practice parameters, are legitimate only if supported by analysis of the current literature and by synthesis of expert opinion, open forum commentary, clinical feasibility data and consensus surveys.

- The responsibility for developing, maintaining and revising performance measures that relate to quality of care must reside with the specialty organization(s) representing the practitioners in whose scope of practice the clinical process(es) resides.

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- The validity of all performance measures must be monitored on an ongoing basis and measures must be eliminated or revised, as scientific knowledge dictates. Adoption of any performance measure confers an obligation to monitor for unintended, adverse consequences of the measure.

- Performance incentive measures intended to promote quality patient care may be structural, process-associated, or outcome-determined. The first two may stand on their own, but outcome-determined measures are critically dependent upon risk adjustment. The methods for how to risk-adjust outcomes is still evolving, and hence incentive measures or programs of this kind should be advocated with caution unless appropriately tested, including determination of the risk of unintended consequences.

Inclusive of Practice Styles & Settings

- The ASA should develop and promote performance measures, which may be used by others in incentive programs relevant to a broad range of anesthesia practice settings, styles and specialties to make the opportunities available to as many anesthesiologists as possible.

Meaningful Incentives

- Incentives of whatever type must be of sufficient magnitude to induce most practitioners to modify their individual practices to achieve the goals of the measure. Costs of implementation, including those of data collection and reporting, cannot overshadow the magnitude of the incentive.

Collaboration and Teamwork

- Perioperative efficiencies and improved patient safety and quality of care benefit dramatically from cooperation, collaboration and teamwork amongst a variety of practitioners, e.g., anesthesiologists, surgeons, nurses, administrators, physician extenders, etc. To achieve the greatest positive impact, developing performance measures should involve relevant professional groups with whom we share responsibility for patient care, in order to work to align programs and processes across specialties.

- The multidisciplinary nature of healthcare that affects patient outcomes is significantly influenced by anesthesiologists. Recognizing that measures developed and advanced by other organizations have relevance to quality improvement within anesthesiology, ASA through CPOM will evaluate and potentially recommend endorsement of such measures.

Relevant Recipient

- Incentives must reflect that individuals or groups of practitioners are documenting successful incorporation in their practice of measure(s) that have been shown to improve patient care. Incentives for measures requiring multi-disciplinary teamwork for successful implementation must be fairly and equitably distributed amongst participants.

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Viable Economic Environment

- Incentive programs can exist only in a payment environment capable of sustaining medical practice. Such an environment must provide baseline payment rates that cover practice costs, including necessary updates to account for inflation, administrative requirements and other economic factors outside the control of the practitioner. This principle applies whether baseline payment rates derive from fee-for-service, capitation, episode-based payments or other payment methodologies. To promote real change, incentive funds must be over and above baseline payment rates, as the goal is to raise the quality of care, not to economically disadvantage those providing care.

- Incentives should rely on measurements which are valid and evidence-based, demonstrated to produce clinically relevant improvements in quality, and are administratively straight-forward and cost-effective to implement, track and report. As anesthesiologists work individually and as members of the surgical team, payments at the individual, team, and organizational level should appropriately reflect the role of anesthesiologists in providing high-quality care. Incentives should recognize both improvements in quality as well as sustained high quality care. Accurately adjusting for patient risk is essential so as not to penalize practitioners who provide care to patients at high risk for adverse outcomes.

Requisite Low Burden of Implementation

- Any performance incentive program must be designed to be adopted with minimal administrative burden and cost. Documentation requirements should not be burdensome. Going forward, electronic clinical records should be considered as a means to minimize reporting costs including the use of the Anesthesia Quality Institute as a means of reporting to the appropriate agencies.

Disclosure

- Physicians must have the opportunity to understand the measures, analytical methodology applied to the performance data, criteria for achieving incentives, and any use of performance data for public reporting before participating in a quality incentive program.

- Physicians must have timely access to the comparative performance database to which they have contributed data, including the ability to compare their own performance to the pooled benchmark data of their peers.