GUIDING PRINCIPLES FOR MANAGEMENT OF PERFORMANCE MEASURES BY THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Committee of Origin: Performance and Outcomes Measurement

(Approved by the House of Delegates on October 15, 2000, and last amended on October 19, 2011)

BACKGROUND AND PURPOSE

The American Society of Anesthesiologists (ASA) recognizes the importance of collecting relevant data in today's health care environment. Benchmarking of performance using defined measures or metrics is essential to improving patient care. Furthermore, the continued yet evolving political focus on the delivery of medical care has increased public awareness of the issues of patient safety and quality of care. Hospitals, insurers, regulatory bodies, and patients increasingly expect that physicians demonstrate their competence and ability to render high-quality and cost-effective health care.

As the voice of the specialty of anesthesiology, the ASA should develop and maintain performance measures and feedback mechanisms to allow anesthesiologists to benchmark their own outcomes and to facilitate quality improvement. These same tools and mechanisms will also be used to track resource utilization and to establish health care priorities. Measures developed by the ASA will be used, for example, by the Anesthesia Quality Institute (AQI) as part of the foundation upon which to build the National Anesthesia Clinical Outcomes Registry, and by other stakeholders with an interest in processes and outcomes in anesthesiology.

This document describes guidelines for data management (technical standards and organizational oversight) that will allow the ASA to pool performance measurement data into a comprehensive relational database. This collection of clinical data should have the potential to improve rather than merely to document a significant dimension of patient care. Such data should include but not be limited to processes of care, clinical outcomes, patient satisfaction, and resource utilization. Equally important is the collection of organizational or structural data that will permit identification of relationships between practice characteristics and clinical outcomes.

RESPONSIBILITIES OF CPOM:

1. Develop and maintain performance measures

    a. Define the principles for developing outcome measures in anesthesiology.

        i. Methodology used for validating performance measures should be similar to the ASA strategy for developing practice guidelines. Because of the analogous methodology, performance measures or indicators could be developed routinely as part of ASA development of clinical practice parameters

    b. Prioritize which measures are needed as determined by ASA leadership, regulators, evolving clinical progress or other.
    c. Develop specific measures and definitions.

i. Data sources may include, but are not limited to, paper medical records, electronic medical records, clinical information systems, administrative and claims data, quality management programs, and patient surveys

ii. All performance measures will be periodically assessed and updated as needed to assure continued quality and consistency with other components of this ASA relational database. NACOR will be a constantly-evolving database, with the inclusion of newly developed indicators and variables, and the exclusion of those that are no longer applicable

d. Evaluate and potentially recommend endorsement by other organizations of measures developed by CPOM and approved by ASA HOD.

e. Facilitate the identification, assessment and adoption of risk-adjustment models.

2. Disseminate defined measures to interested stakeholders

a. Provide an analysis of the strengths, limitations and potential unintended consequences of proposed performance measures from the perspective of both public and private reporting

b. Given both the public demand for accountability and transparency, and the limitations of performance and outcome measurement, CPOM will play an advisory role for the ASA and AQI in deciding which ASA performance measures are best suited for public reporting, and which measures should be reserved for confidential non-public reporting

c. Educate anesthesiologists on the methodological basis of performance measurement, including a discussion of the strengths and limitations of various quality metrics

i. CPOM will comment on the inherent limitations of both process measures (the quality of the evidence base linking specific medical practice and outcomes is frequently limited) and outcome measures (different risk adjustment models can lead to discordant conclusions regarding individual hospital and physician quality)

ii. CPOM will comment on the potential unintended consequences from public reporting.

d. Demonstrate to anesthesiologists how to use performance measures to improve patient outcomes

i. CPOM recognizes that that non-public reporting (e.g. VA NSQIP) can lead to large reductions in morbidity and mortality, and serves to achieve the primary objective of performance measurement – improved quality of care.

3. Guide AQI regarding relevant structures, processes, and outcomes of care and whether specific performance and/or outcome measures should be presented for public or nonpublic reporting.

    a. The design and ongoing evaluation of ASA performance measures will be the responsibility of CPOM. Implementation of the National Anesthesia Clinical Outcomes Registry (NACOR) will be the responsibility of the Anesthesia Quality Institute (AQI), with consultation from CPOM. The role of CPOM will be advisory, seeking to ensure the consistent content of all databases and the appropriate focus of the AQI and NACOR in the area of performance and outcome measurement as detailed in a separate memorandum of understanding between CPOM and AQI.

        i. Indicators may include but are not limited to the following:

            1. Clinical indicators
                a. processes of patient care (e.g., adherence to standards. incorporation of other applicable practice parameters
                b. outcomes of care
                c. perceptions of care (e.g., patient satisfaction)
                d. population level-based medical care issues, public health, and outreach education (e.g.., obesity, smoking cessation-based assessment, post anesthetic discharge or other follow-up calls

            2. Administrative indicators
                a. resource utilization and costs (e.g., use of drugs and disposable resources, operating room utilization)
                b. personnel management (e.g., staff numbers and qualifications, case types)

4. Assist with the formulation of a research agenda for improving the quality of perioperative care

5. CPOM supports AQI's concept that NACOR may also serve as a final repository for preexisting data contributed by large consortiums of practitioners, information technology vendors, or subspecialty societies. No data should be included in NACOR without identification of its originating source and context of collection, such that future queries of the database can be confined to sets of data with sufficient accuracy to provide a valid answer. This will allow for use of administrative data to answer administrative questions, but will not compromise more sensitive reporting of clinical outcomes or

research questions that will require more precise (detailed) data collection or risk adjustment.

6. CPOM strongly encourages but does not require participation of a practice in NACOR

    a. That relationship may be constant or intermittent (for finite periods) depending on the needs of the practice

    b. CPOM believes that the ASA should not require participation in any aspect of the AQI or NACOR, but should strive to make participation an efficient avenue for improving patient care and meeting multiple regulatory requirements

    c. CPOM believes that with time, it is likely that external forces will encourage practice participation. For example, national, regional or local organizations may demand evidence of participation in a clinical outcomes database system or require the comparison of the outcomes of groups or individual providers with national benchmarks