Quality Measures in a Group Retina Practice

If retina specialists monitor quality, they may help prevent outside organizations from attempting to regulate doctors.

By Brian C. Joondeph, MD, MPS

In our practice, we set up a project designed to demonstrate and measure quality within a large retina practice. When we were thinking about quality, we took it to refer not only to surgical outcomes, but also to patient satisfaction, both of which are components of the “patient experience” piece of the “triple aim.” (Safety is the third component.) At the start of our assessment, we estimated that the benefits of quality measurement would include cost savings, improved value of provided services, and a greater likelihood of financial viability under future health care payment systems.

WHAT WAS MEASURED

The assessment project was performed within Colorado Retina Associates (CRA), a 12-physician retina-only practice. Patients with a diagnosis of retinal detachment (RD) or macular hole (MH) who received surgical repair by a CRA physician and who presented to the practice in 2012 were identified. Complex cases, such as reoperations and cases related to trauma, diabetic retinopathy, or other confounding factors, were excluded. The one-operation success rate was noted, defined as successful RD repair or MH closure 2 to 3 months after surgery. Anatomic, rather than visual, success was used as a metric because it represents an all-or-nothing metric without confounding variables.

Patient satisfaction was measured via a two-statement survey conducted in all offices among approximately 400 patients, representing 0.7% of total patient visits to CRA in 2012. The first statement was, “I would recommend this practice to a friend or family member if they needed this type of medical service.” The second statement was, “The physician is good about explaining my test results, my treatment or medications, and what I need to do next.” Responses were given based on a five-point scale: strongly disagree, disagree, neutral/no opinion, agree, or strongly agree. The latter two responses were considered positive.

Serious reportable events (SRE) or “never events” were also assessed, focusing on intravitreal injections. Approximately 16,000 injections were performed by CRA in 2012. An SRE was defined as either the correct medication injected into the wrong eye or the wrong medication injected into the correct eye. These events were self-reported by the physicians.

WHAT WE FOUND

After excluding complicated cases and cases with insufficient follow-up, 230 of 286 eyes (80%) with RD were successfully repaired with a single operation. For uncomplicated MH repair, 105 of 120 (88%) were successfully repaired with a single operation (Figure 1).

A total of 400 patients answered the patient satisfaction survey. With a positive answer being “agree” or “strongly agree” with the statement, 95% and 93%, respectively, gave positive responses to statements 1 and 2 (Figure 1).

CRA physicians performed 16,000 intravitreal injections in 2012, with only two SREs reported: one wrong...
medication and one wrong eye, for an incidence of 0.0125% (Figure 2).

Success rates by physician varied from 62% to 100% for RD repair and from 44% to 100% for MH repair (Figure 3). Physician surgical volume also varied considerably during the measurement year. Excluding the author, only four of the 12 physicians requested their individual results when these were offered upon completion of the study.

WHAT IT MEANS

There were two phases to this project: collecting data on the actual quality measures and attempting to create a cultural shift within the organization. The cultural shift was proposed, but met with only lukewarm acceptance, leaving the original culture mostly intact. Aside from financial incentives or penalties, such as those in the Physician Quality Reporting System (PQRS) or meaningful-use programs, it remains challenging to create an organization-wide cultural shift toward self-assessment and measurement.

The single operation success rates for the repair of routine RDs and MHs were consistent with published series. This suggests that CRA physicians are meeting the standards of their peer practices. The variability is due to case selection, what is considered routine, and definitions of success.

The two patient satisfaction measures scored in the 93% to 95% range, favorable and in the expected range. This suggests that CRA patients were overwhelmingly satisfied with the care they received, as measured by the survey questions. Many potential questions that can be asked to measure patient satisfaction could result in a higher or lower rating depending on the question and how it is worded. Although there is always room for improvement, any organization is unlikely to achieve 100% satisfaction for a variety of reasons, such as patients being dissatisfied with their office experience. It is important to monitor these measures, noting any downward trend in these scores and instituting corrective actions that address the decline.

Interestingly, both SREs were in my patients. Therefore, this outcome may be influenced by selection bias, as the author had a personal interest in this measurement for this study. There is no way to retrieve these events from an electronic health record (EHR) system; thus, there is a reliance on self-reporting, which can lead to underreporting. These events may not be reported for fear of liability risk or if there is no negative consequence to the patient—“no harm, no foul,” as one might say. Some SREs can be captured only if the SRE leads to a malpractice claim or reduced reimbursement, both easily identified and tracked. Fewer than one-and-a-half of the CRA physicians asked for their individual success rates at the end of the project. This was surprising yet consistent with the fact that no one asked about the project when it was initially presented. Physicians think and practice in their own silos and are only roughly aware of their own outcomes; they are generally unable to quantify them. Most believe they are above average, also known as the Lake Wobegon effect. The incurious physician, believing his or her outcomes are above average, may avoid seeking any information that may contradict this impression.

Future directions for our organization include embracing rather than passively accepting the need for measuring quality. Many organizations resist change, and individual physicians may be fearful of publically disclosing their clinical outcomes to avoid the scrutiny and judgment of their patients and peers. One driver of the need for measuring quality is the concept of consumer-driven health care, in which patients utilize both cost and quality data when choosing their health care providers. Another external driver is PQRS measures. Initial bonuses for meeting PQRS reporting requirements followed by penalties for nonreporting will almost certainly create a sense of urgency, perhaps serving as a catalyst for cultural shift.
Quality measures can be continued and expanded to include other common disease states, such as diabetic retinopathy or age-related macular degeneration. Measuring success in these conditions is more challenging, as it could be defined as improved vision, prevention of vision loss, reduction in the number of treatments, or other measures. The challenge lies in identifying metrics that are both easy to measure and truly indicative of quality, rather than simply process measures.

As medical practices become more proficient and comfortable with their EHR systems, extracting data will become easier. Having quality measures available will provide advantages under new payment mechanisms when distinctions can be made in terms of networks and preferred providers.

It is better that we in the retina specialist community proactively define and measure quality rather than have the government do it for us with less meaningful metrics. One example is Retina PractiCare, a benchmarking tool developed by the American Society of Retina Specialists. Another is the IRIS Registry, a clinical data registry through the American Academy of Ophthalmology, “the nation’s first EHR-based comprehensive eye disease and condition registry.”

Ultimately, if cost is attached to these quality measures, then quantification of “value” is obtained, which is one of the goals of value-based health care under the Patient Protection and Affordable Care Act. Once value is defined economically and measured as such, treatments and procedures can be compared, yielding a preference for high-value (ie, low cost) procedures and avoiding low-value (ie, high cost) ones. On the one hand, cost is not necessarily indicative of value if value is assumed to mean the benefit to the patient (which should be the ultimate benchmark of quality health care). However, tying value to cost also has implications for reimbursement: Payers will assign higher reimbursement for higher value care activities if they save money for payers, patients, and society.

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