

WHITE PAPER
CLINICAL PRACTICE
IMPROVEMENT ACTIVITIES

AAOE EDUCATION COUNCIL
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EXECUTIVE SUMMARY

AAOE distributed a survey to all member practices of the organization to collect information concerning the clinical practice improvement activities (CPIA) AAOE members were preparing to attest to for the Medicare Quality Payment Program (QPP) in 2017. Approximately 10% of practices who received the survey returned responses to the CPIA inventory. Although the response rate is lower than necessary to be considered representative of all AAOE members, the results do provide an indication of the CPIA that members will be attesting to in 2017.

There were 19 measures, out of 89 potential measures, that respondents indicated they would be attesting to or are currently performing. These measures encompass the subcategories of care coordination, beneficiary engagement, patient safety and practice assessment, expand practice access, achieving health equity, behavioral and mental health, and population management.

AAOE then took these measures and compared responses with three variables, practice size, geographic location, and practice setting. We found that there were no noticeable measure selection trends across the three variables. We did find a moderate correlation between a “expand practice access” measure and practice size but without more data that correlation is difficult to generalize.

For any questions regarding research methodology, analysis, etc. please contact AAOE’s Government Affairs Manager, Bradley Coffey, MA at bcoffey@aaoe.net or 317-749-0629.

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INTRODUCTION

On November 4, 2016, the Centers for Medicare and Medicaid Services (CMS) published a final rule implementing the Merit-based Incentive Payment System (MIPS). MIPS will be comprised of four categories, quality, resource use, clinical practice improvement, and Advancing Care Information. Clinicians will be graded on their performance in these categories and CMS will determine whether, based on their scores, the clinician is entitled to receive a positive, negative, or neutral payment adjustment.

Of the four categories of MIPS, three are programs that the healthcare community is already familiar with. Clinical practice improvement activities (CPIA), however, are new to many in the industry including the members of the American Alliance of Orthopaedic Executives (AAOE). To assist members with selecting their measures for 2017, the first year of reporting, AAOE created a survey of the entire CPIA inventory and asked members to indicate the measures to which their practices were planning to attest.

The survey was open for three weeks. During these three weeks, 123 practices responded to the survey. Of these 123 respondents, 32 were either not preparing their practice to attest to the CPIA category or did not know enough about their practice's compliance plans to take the survey. This left us with 90 respondents, or about 10% of potential respondents.

The results of this survey are meant to assist practices in determining the best CPIA for their practices based on a number of factors however, we caution that due to the low number of responses, the results are not representative of all of the practices represented in AAOE's membership. We urge readers to use their best judgement while reviewing our analysis of the survey findings and while implementing a CPIA action plan in their practice.

DEMOGRAPHICS

90 practices responded to AAOE’s request for data. Practices represented different practice sizes, different geographic regions, and different practice settings. Figure 1 shows the count of respondents by practice size.

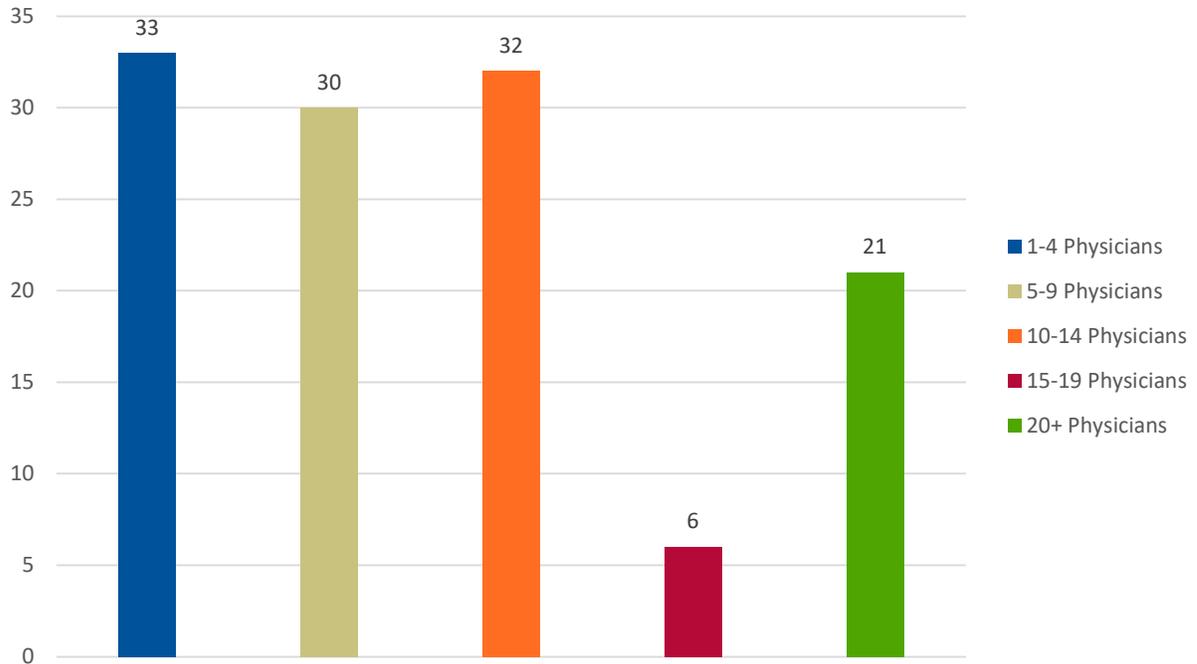


Figure 1

We were interested in determining the geographic distribution of participating practices and asked respondents to indicate the state in which their practice was located. In order to group the data appropriately, we then grouped respondents by United States Census Bureau Divisions (see below).

East North Central:	Illinois, Indiana, Michigan, Ohio, Wisconsin
East South Central:	Alabama, Kentucky, Mississippi, Tennessee
Middle Atlantic:	New Jersey, New York, Pennsylvania
Mountain:	Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
New England:	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Pacific:	Alaska, California, Hawaii, Oregon, Washington
South Atlantic:	Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia

West North Central: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
West South Central: Arkansas, Louisiana, Oklahoma, Texas

Figure 2 displays the regions of respondents.

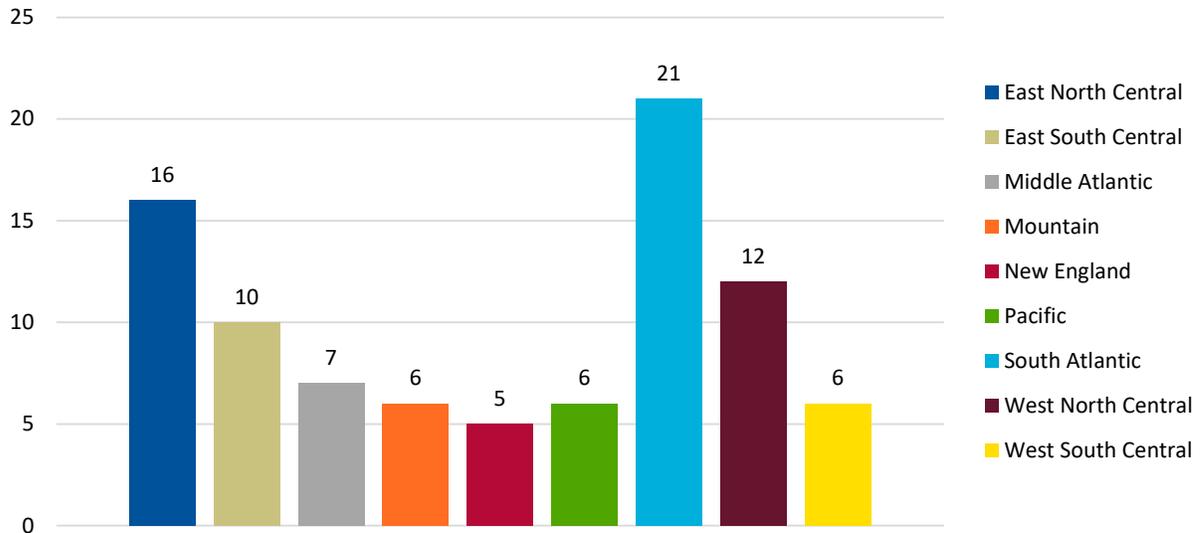


Figure 2

Respondents were then asked to indicate their practice setting. As the reader will see in Figure 3, the overwhelming majority of respondents were independent orthopaedic practices.

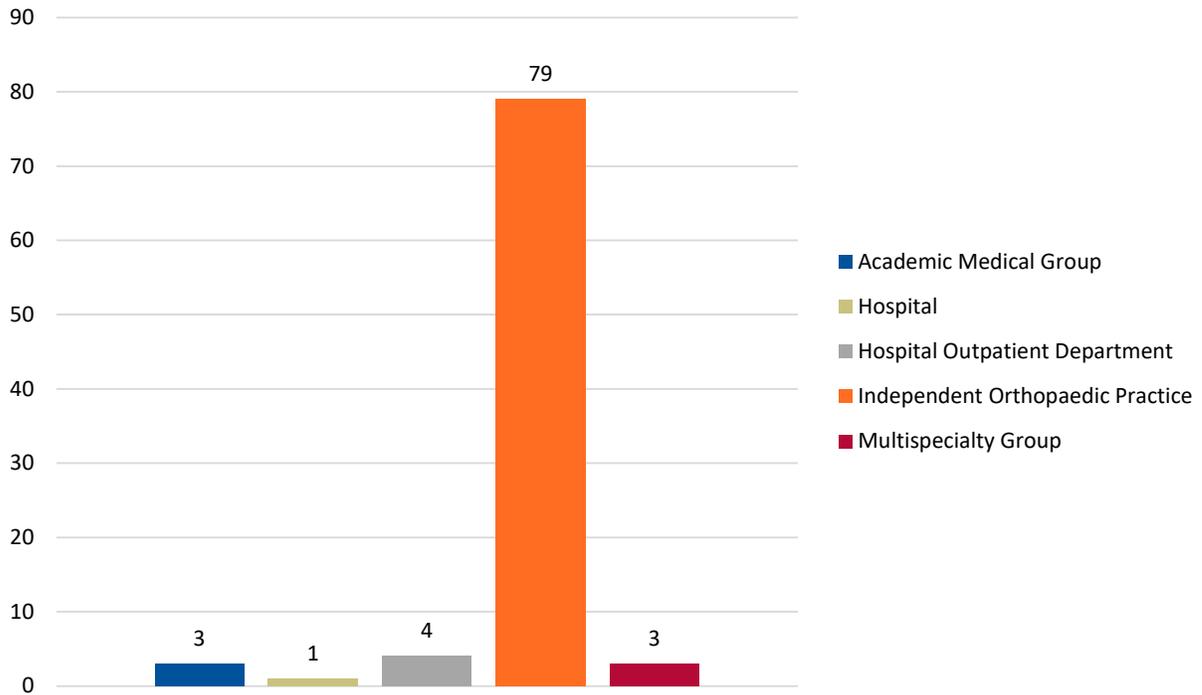


Figure 3

We were also interested in finding out how many respondents had been reporting to the Physician Quality Reporting System (PQRS) and the Electronic Health Records Incentive Program (meaningful use) in 2015 and 2016. Results for these questions indicated that most respondents reported to CMS' quality programs in 2015 and 2016.

When asked whether the practice was expecting to receive a negative payment adjustment in 2017 for 2015 reporting, 90% of respondents indicated that they were **not** expecting to receive a negative payment adjustment in 2017, while 10% indicated they are planning to receive a negative payment adjustment in 2017. These numbers change only slightly for the 2018 payment adjustment for reporting in 2016, where 88% of respondents indicated there are **not** expecting to receive a negative payment adjustment in 2018, while 12% indicated they are planning to receive a negative payment adjustment in 2018. 1-4 physician practices were the largest group indicating that they were expecting to receive a negative payment adjustment in 2017, whereas the largest group that indicated they are expecting to receive a negative payment adjustment in 2018 is the 10-14 physicians group. Practices in the South Atlantic and East North Central divisions tied for most negative payment adjustments in 2017. The Mountain division has the most practices expecting a 2018 negative adjustment. Independent orthopaedic practices overwhelmingly expect to receive negative payment adjustments in 2017 and 2018 over their academic, multispecialty, hospital outpatient department (HOPD), and hospital colleagues. Charts can be found in the Appendix.

Respondents were then asked to identify their method of reporting data to CMS for PQRS in both 2015 and 2016. In both years, an electronic health record was the most

popular method of reporting, with registry second and claims third. Figure 4 shows respondents' reporting selection.

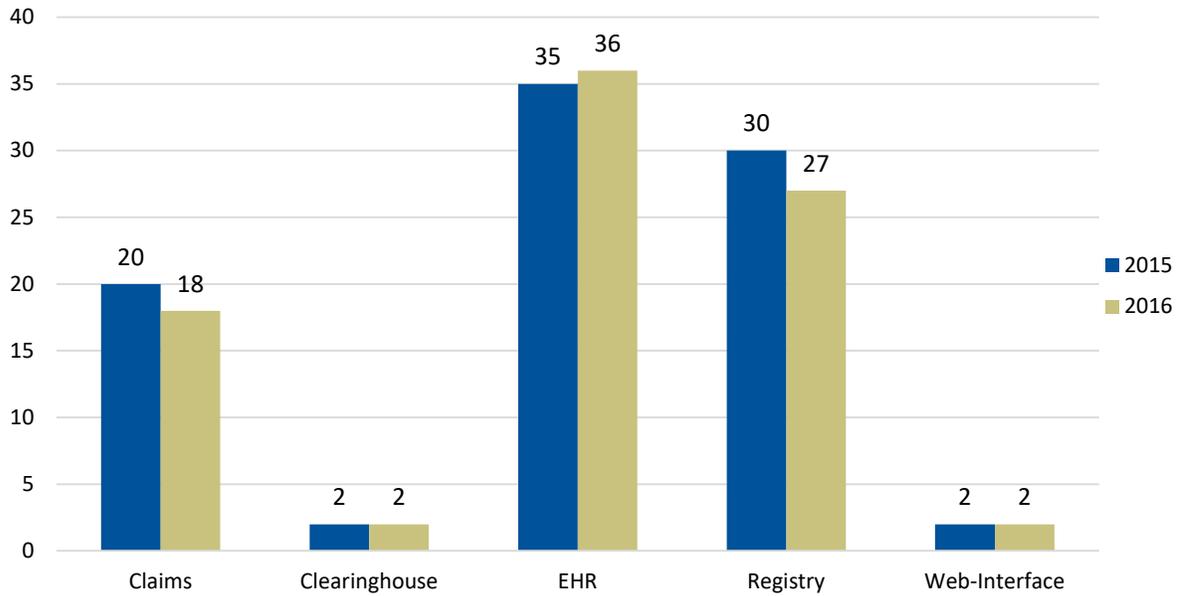


Figure 4

We then surveyed respondents on the inventory of CPIA measures and asked the respondent to indicate if their practice intended to use the measure for CPIA reporting in 2017 or are currently performing the measure. There were 19 measures in which a majority (50% plus one) of respondents indicated they were either already performing or planning to perform in 2017. Table 1 shows these measures, including the measure priority, the CMS measure subcategory, as well as the measures' popularity among survey respondents.

#	Measure Description (Measure Priority)	Subcategory	Number Indicating Measure is or Will Be Used	Number Not Utilizing Measure
1	Timely communication of test results defined as timely identification of abnormal test results with timely follow-up. (Medium)	Care Coordination	46	7
2	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan. (High)	Beneficiary Engagement	52	13

#	Measure Description (Measure Priority)	Subcategory	Number Indicating Measure is or Will Be Used	Number Not Utilizing Measure
3	Performance of regular practices that include providing specialist reports back to the referring MIPS eligible clinician or group to close the referral loop or where the referring MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the certified EHR technology. (Medium)	Care Coordination	36	15
4	Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms. (Medium)	Beneficiary Engagement	35	14
5	Annual registration by eligible clinician or group in the prescription drug monitoring program of the state where they practice. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and groups must participate for a minimum of 6 months. (Medium)	Patient Safety & Practice Assessment	52	22
6	Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs. (Medium)	Expand Practice Access	45	19
7	Access to an enhanced patient portal that provides up to date information related to relevant chronic disease health or blood pressure control, and includes interactive features allowing patients to enter health information and/or enables bidirectional communication about medication changes and adherence. (Medium)	Beneficiary Engagement	39	20
8	Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare. (High)	Achieving Health Equity	38	21
9	Tobacco use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including tobacco use screening and cessation interventions (refer to NQF #0028) for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence. (Medium)	Behavioral and Mental Health	31	18
10	Implementation of fall screening and assessment programs to identify patients at risk for falls and address modifiable risk factors (e.g., Clinical decision support/prompts in the electronic health record that help manage the use of medications, such as benzodiazepines, that increase fall risk). (Medium)	Patient Safety & Practice Assessment	31	22

#	Measure Description (Measure Priority)	Subcategory	Number Indicating Measure is or Will Be Used	Number Not Utilizing Measure
11	Implementation of practices/processes that document care coordination activities (e.g., a documented care coordination encounter that tracks all clinical staff involved and communications from date patient is scheduled for outpatient procedure through day of procedure). (Medium)	Care Coordination	30	23
12	Provide self-management materials at an appropriate literacy level and in an appropriate language. (Medium)	Beneficiary Engagement	29	22
13	Manage medications to maximize efficiency, effectiveness and safety that could include one or more of the following: Reconcile and coordinate medications and provide medication management across transitions of care settings and eligible clinicians or groups; Integrate a pharmacist into the care team; and/or Conduct periodic, structured medication reviews. (Medium)	Population Management	29	22
14	Establish effective care coordination and active referral management that could include one or more of the following: Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and MIPS eligible clinician or MIPS eligible clinician group expectations between settings. Provide patients with information that sets their expectations consistently with the care coordination agreements; Track patients referred to specialist through the entire process; and/or Systematically integrate information from referrals into the plan of care. (Medium)	Care Coordination	40	34
15	Engage patients and families to guide improvement in the system of care. (Medium)	Beneficiary Engagement	30	26
16	Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the certified EHR technology. (Medium)	Beneficiary Engagement	31	27
17	Ensure that there is bilateral exchange of necessary patient information to guide patient care that could include one or more of the following: Participate in a Health Information Exchange if available; and/or Use structured referral notes. (Medium)	Care Coordination	26	23

#	Measure Description (Measure Priority)	Subcategory	Number Indicating Measure is or Will Be Used	Number Not Utilizing Measure
18	Establish standard operations to manage transitions of care that could include one or more of the following: Establish formalized lines of communication with local settings in which empaneled patients receive care to ensure documented flow of information and seamless transitions in care; and/or Partner with community or hospital-based transitional care services. (Medium)	Care Coordination	33	31
19	Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care); Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management. (High)	Expanded Practice Access	25	24

ANALYSIS

We were interested in determining how these measures would be reported across several divisions within the AAOE membership. Practice size, geographic locality, and practice setting are all important determinants of measure selection. For example, an independent orthopaedic practice employing 1-4 surgeons and located in a rural or sparsely populated census division is unlikely to choose a measure that requires the practice to provide patient access for 24 hours, seven days a week. There is unlikely to be a need for that kind of access in the practice’s market and the practice is likely not staffed for that kind of activity. Figures 5, 6, and 7 show the survey results filtered by possible external variable.

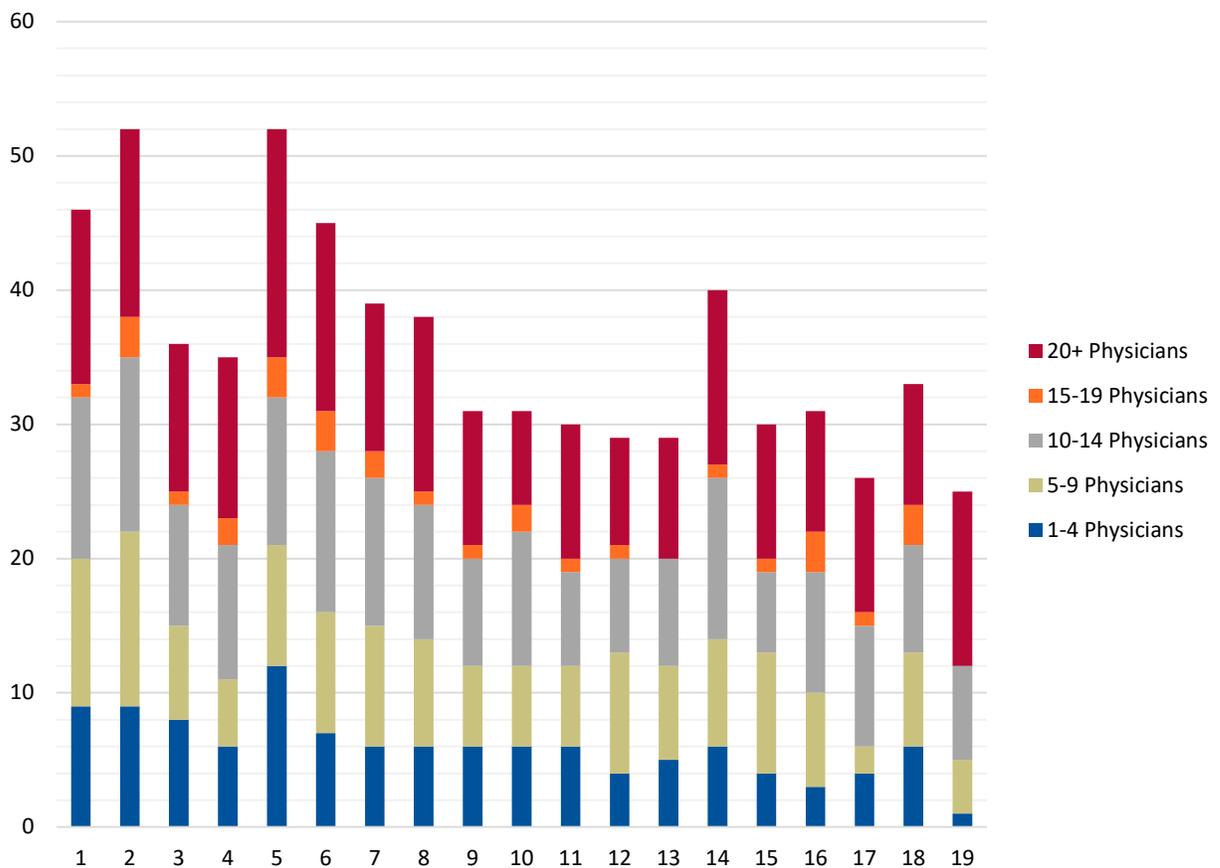


Figure 5

Figure 5 shows the number of respondents indicating that they either currently use or are planning to use one of the 19 measures in 2017. The graph also illustrates that small practices (1-4 physicians) are more likely to choose measures relating to patient engagement and care coordination while larger practice sizes (5-20+ physicians) exhibit greater variation in their selected measure subcategories.

Practice size does appear to have an effect on at least one measure, Measure 19:

Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care); Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management.

According to survey responses, practices employing 1-9 physicians are unlikely to choose to report to this measure likely because this measure is one of the more labor intensive measures and smaller practices have fewer resources with which to implement it.

To test this, we ran a correlation test using practice size as the independent (or predictor) variable and the individual measure as the dependent (or outcome) variable. We found two weak negative correlations and one moderate negative correlation. Table

Table 2		
Measure	Variable	r
Measure 17	Practice Size	-0.28461492
Measure 19	Practice Size	-0.54260853
Measure 4	Practice Size	-0.23952738

2 shows the measure and its correlated variable as well as the correlation coefficient (r). The full tables are available in the Appendix. A negative correlation indicates, in this context, that either as practice size increases the number of practice sizes reporting the measure decreases, or vice-versa. This runs in direct opposition to what

we would expect to see, particularly for Measure 19; that is as practice size increases, the number of practices reporting the measure would increase. We believe the reason for this is the small sample size. Had a representative sample been obtained, the results may be different. With a full data set, it may be possible to further explore the relationship between these variables and the measures utilizing binomial linear regression.

We stress that correlation does not equate to causality (i.e. small practice size does not cause the practice to select a particular measure) but these numbers are helpful in explaining to us respondent's measure selection behavior. Because region and practice setting are categorical variables rather than ordinal variables, the correlation coefficient is not a good measure of the relationship between the variable and the measure however, we have included these correlation test results in the Appendix for the reader to review as supplemental data.

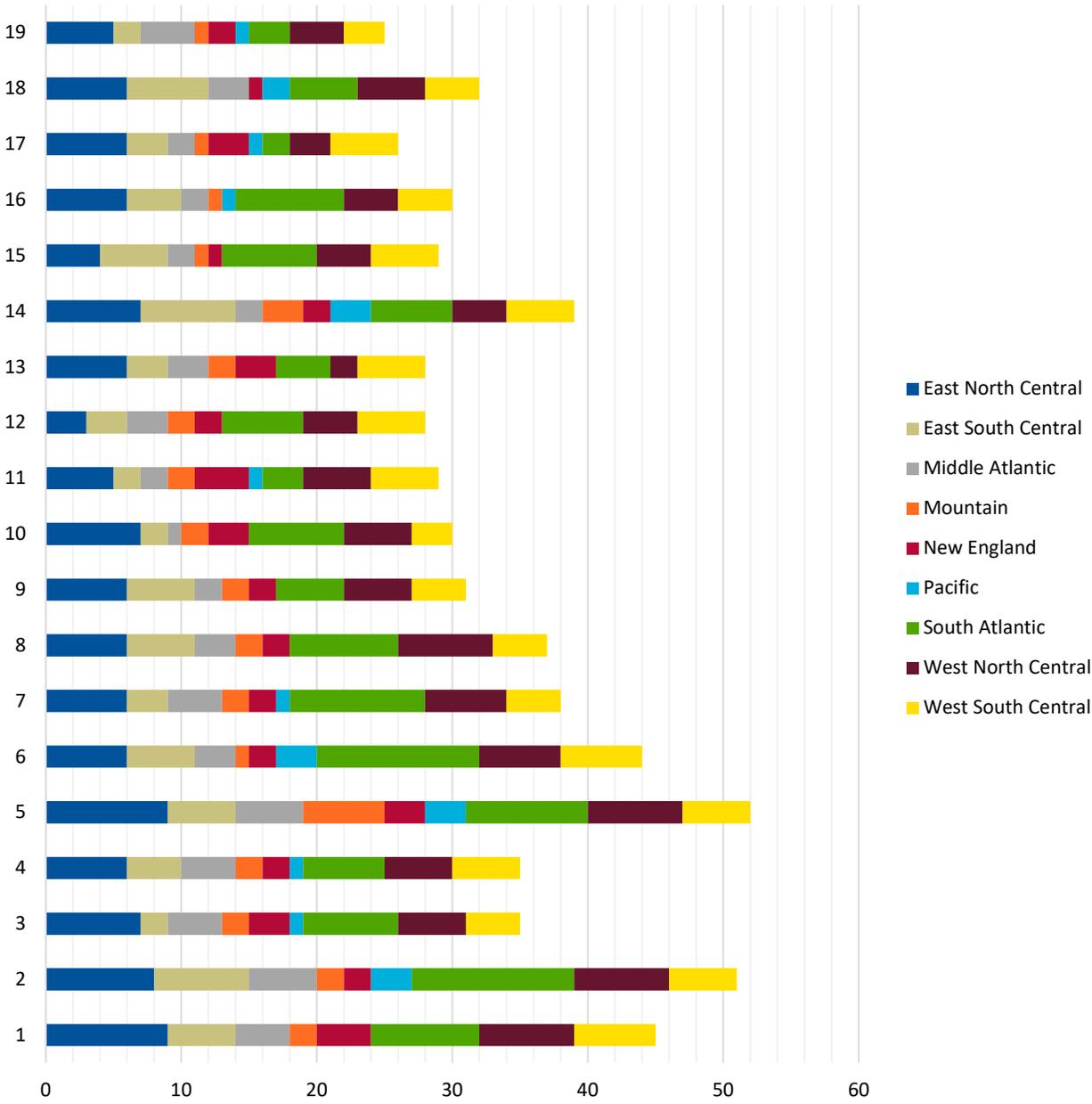


Figure 6

Figure 6 does not provide us with any noticeable trends based on geographic location.

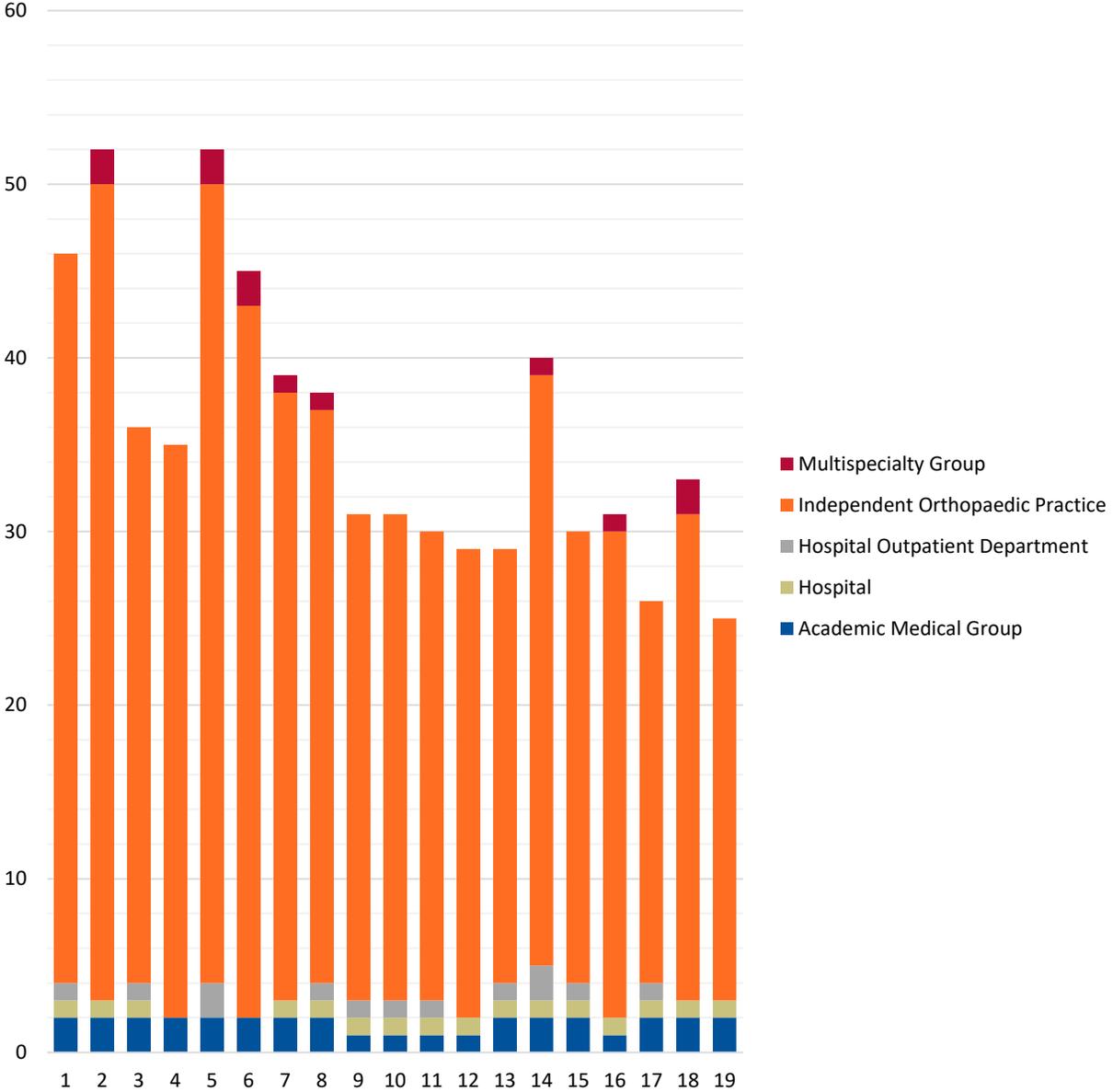


Figure 7

Figure 7, like Figure 6 does not show any strong trends when practice setting is taken into account.

CONCLUSIONS

Of the three variables under consideration here (practice size, geographic location, and practice setting) only one has been seen to be moderately correlated with any of the measures. Practice size has a moderate effect on whether a practice elects to report to Measure 19.

Unfortunately, our study was hindered by a low response rate which limited the analyses we could accomplish. Despite the limited data, this study should provide the reader with an understanding of how practices similar to their own are planning to report for 2017 and future years.

Despite the lack of data, these results are helpful for the reader to see which measures are most popular among orthopaedic and musculoskeletal practices in general. Ultimately, this study was successful in narrowing down the number of CPIA categories from a potential 87 (with activities not relevant to orthopaedics removed) down to 19 activities that a majority (50% plus one) of respondents indicated they were preparing to report to. It is also important to note that with CMS' "Pick Your Pace" reporting structure for 2017, many practices may not be planning to report to the CPIA category in 2017. We anticipate performing this study again at the end of 2017 as practices are planning for the 2018 reporting period.

For more information about the CPIA inventory and the entire Medicare Quality Payment Program, visit gpp.cms.gov.

FOR MORE INFORMATION

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