



# THE CHANGING FACE OF WOUND CARE: MEASURING QUALITY

*Value-based payments are the future for wound care providers. What does that mean right now?*

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**T**he validity of the Mayan calendar, which predicts the end of the world this coming December, is certainly a questionable debate. However, had the Mayans originally set forth to try their hands at predicting the end of the wound care industry as we know it today, they might have been spot on. The future of wound care is coming quickly in the form of quality measures, but many providers haven't prepared for their respective apocalypse with the same fervor their colleagues have shown across other healthcare specialties. Depending on how you calculate the effects of the Affordable Care Act (ACA), Medicare will go bankrupt in 2024 or 2016, according to the 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, which also acknowledges that the current "volume based" business model for delivering healthcare is unsustainable. The "fee for service" (FFS) system, which pays physicians for each individual service provided, has resulted in what many could consider an expensive yet mediocre delivery of healthcare. Reimbursement based on number of services can actually reward substandard quality, and it could be argued that the least-skilled practitioners are compensated the most, since the more tests or interventions they perform and the longer their patients remain in their care results in more revenue earned. This is set to change, however, as health reform legislation will dramatically change the way providers are paid, giving payment

bonuses and/or penalties based on the achievement of patient outcomes.

Section 3007 of the ACA includes a Senate provision that would pay for individual physician services based on a "value index," creating a new value-based payment modifier that will be used to provide differential payments to physicians based on quality and cost of care beginning in 2015.

Since the payment adjustments are to be budget neutral, some physicians will receive bonuses while others will face penalties under this provision. Current pay-for-performance programs, known as "value-based purchasing," will be expanded. It is likely that payment based on quality measures will soon represent a substantial portion of a wound care physician's income.

However, the movement away from FFS began in earnest in 2006, when then President George W. Bush signed the Tax Relief and Health Care Act (TRHCA), which authorized the Centers for Medicare & Medicaid Services (CMS) to establish and implement a physician quality reporting system — the Physician Quality Reporting Initiative (PQRI). Participating in PQRI (now called PQRS [Physician Quality Reporting System]) has been challenging for wound care clinicians. Also known as Pay for Performance (P4P), the initiative has not been living up to that name so much as it is "paying for reporting" without requiring physicians to "pass" or "fail" on any quality measures reported. The Medicare Improvements for Patients and Providers Act (MIPPA)

of 2008 authorized a 2 percent bonus for physicians who successfully reported quality measures. Bonuses increased to a total of 4 percent in 2011 (2 percent for PQRS reporting plus 2 percent for electronic prescribing). In 2011, there were 173 measures applicable to primary and specialty physicians. Most of the measures were designed to evaluate whether a clinician provided the "right" care, not whether the patient's outcome was favorable. Today, both the focus of the measures and the voluntary nature of PQRS are changing.

## **GUIDELINES VS. QUALITY MEASURES**

Crucial to adjusting to the changes ahead for the wound care industry is having an understanding of the difference between clinical practice guidelines (CPGs) and quality measures. CPGs are a way of describing what ought to be done, while quality measures are a test to determine what kind of care was actually performed.

Imagine that, as a member of the American Heart Association, a series of CPGs existed to reduce the likelihood of cardiac disease among adults. These CPGs might include controlling blood pressure, optimizing the patient's weight, and helping patients to stop smoking.

How would these CPGs compare to quality measures? A good way to illustrate this is to visualize patients as a numeric value (just this once). In the case of tobacco use, all patients who used tobacco become the denominator (number of eligible patients). The numerator would then be all smokers whom the

## Meaningful Use and the \$44,000 Provision

Among the many provisions included in the American Recovery and Reinvestment Act signed by President Obama is a piece of legislation known as the HITECH (Health Information Technology for Economic and Clinical Health) Act, a mandate funded by more than \$20 billion to incentivize clinicians and hospitals to adopt health information technology. The Medicare Electronic Health Record (EHR) Incentive Programs (part of this mandate) pay up to \$44,000 in bonuses to each eligible provider (EP) who adopts and “meaningfully uses” an EHR. “Meaningful use” is determined, in part, by the reporting of certain quality measures, including 3 core measures and 3 “clinical quality” measures from a set of 38 each year (for a total of 6 core). Physicians who report their data are to be compensated by taking away money from those who don’t report. Beginning in 2015, non-reporting physicians will lose 1 percent of their Medicare revenue; in 2016 they will see a 2 percent deduction, and in 2017, a 3 percent deduction can be expected. Separately, as part of the Physician Quality Reporting System (PQRS), there are 265 quality measures defined for 2013, of which physicians must submit at least 3 in order to qualify for a 0.5 percent bonus or avoid a 1.5 percent “adjustment.” The Centers for Medicare & Medicaid Services (CMS) worked with the National Quality Forum, whose membership includes a variety of healthcare stakeholders such as consumer groups, hospitals, accrediting and certifying bodies, and healthcare research and quality improvement organizations, to retool 113 of the 265 PQRS measures into “electronic measures.” Of those, CMS selected 51 to be part of the US Department of Health and Human Services’ EHR Direct program, which has established a secure, scalable, standards-based method for participants to send authenticated, encrypted health information directly to trusted recipients over the Internet (<http://wiki.direct-project.org/file/view/DirectProjectOverview.pdf>). Given that those 51 EHR measures contain all 44 HITECH measures (6 core + the 38 aforementioned), physicians can use EHR Direct to meet both the HITECH Meaningful Use requirements and those of the PQRS. When a physician submits measures through EHR Direct, a 0.5 percent PQRS bonus is awarded, a 1.5 adjustment (the reduction in total Medicare billing for not reporting) is avoided, and part of the requirement for HITECH adoption money is met. Unfortunately none of the wound care measures are electronic, so these physicians cannot take advantage of the EHR Direct program in this way.

*For more information on Meaningful Use, see the Feature Article “Making Wound Care More Meaningful” on page 18.*

clinician counseled to stop smoking (a quality measure). Naturally, the goal would be to counsel all smokers to quit and have a measurable to report, as in 200 of 200 (200/200).

Remember, the measure to assess counseling for smoking cessation did not specify how many patients actually quit; the measure was designed only to determine how many were counseled. Also, remember that the incentive money was awarded merely for reporting on said measure, regardless of whether or not it was met.

Could a physician simply have counseled only 1/200 smokers and have gotten a bonus just for reporting data? Conceivably. (In reality, calculating measures is much more complicated because there

are exclusion criteria for numerators and denominators of particular measures.) For more details on quality measures, visit [www.qualitymeasures.ahrq.gov/content.aspx?id=32560](http://www.qualitymeasures.ahrq.gov/content.aspx?id=32560).

## WOUND CARE’S QUALITY MEASURES

There were no measures relevant to wound care when PQRS launched, but there is now a measure directly applicable to our industry: the percentage of patients with venous ulcers who were prescribed any type of compression 1 time during the year in which they were treated. Since all physicians had to report at least 3 measures successfully to qualify for a bonus, wound care physicians have been forced to report on measures that aren’t directly applicable to the industry

(eg, screening for fall risk, tobacco cessation counseling, diabetic blood pressure control, etc.).

In 2000, officials with the American Medical Association (AMA) decided to focus on wound care as part of their Physician Consortium for Performance Improvement® (PCPI) project, an effort intended to enhance quality and patient safety while fostering accountability in healthcare by developing, testing, and implementing evidence-based performance measures for use at the point of care.

For guidance, they went to the American Academy of Plastic Surgery (ASPS). (Since “wound care” is not a recognized medical specialty and is hindered by not having representation within these types of organizations, the ASPS stood as a viable ally with its voting members by having seats on the AMA House of Delegates.) A multidisciplinary working group came up with 7 measures, and CMS has announced its intention to add 2 of these measures to PQRS.

These measures include the “overuse” measures that require physicians to “pass” a measure by not performing swab cultures or using wet-to-dry dressings. There are also some measures that are indirectly relevant to wound care such as hemoglobin A1c measurement and smoking cessation. (See Table 1 on page 14 for a brief summary of the 5 current PQRS measures relevant to wound care.)

Initially (in 2007), physicians were to report measures using their “claims” (a paper-based charge document to track these “quality measure” interventions). This method was not successful because it was complex and required a lot of work.

In April 2008, CMS expanded the data collection process from the laborious claims-based reporting method to include reporting data via qualified patient registries. However, registry reporting was always meant to be temporary, with a goal to eventually have all physicians report their measures directly from their electronic health records (EHRs).

Theoretically, there are four different ways that an eligible provider can submit data to CMS. These approaches are: claims-based, registry-based, directly from

**Table 1: Physician Quality Reporting System Measure Specifications**

| Measure Number | Measure Title   | Description  | Instructions   |
|----------------|---|--|--|
| 126            | Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation. | Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months.                 | This measure is to be reported a minimum of 1 time per reporting period for patients with diabetes mellitus seen during reporting period.                                  |
| 127            | Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention - Evaluation of Footwear.       | Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing.  | This measure is to be reported a minimum of 1 time per reporting period for patients with diabetes mellitus seen during the reporting period.                              |
| 186            | Chronic Wound Care: Use of Compression System in Patients with Venous Ulcers.                     | Percentage of patients aged 18 years and older with a diagnosis of venous ulcer who were prescribed compression therapy within the 12-month reporting period.                        | This measure is to be reported a minimum of 1 time per reporting period for patients with venous ulcer(s) seen during the reporting period.                                |
| 245            | Chronic Wound Care: Use of Wound Surface Culture Technique in Patients with Chronic Skin Ulcers.  | Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer without the use of a wound surface culture technique.                 | This measure is to be reported at each visit occurring during the reporting period for patients with a diagnosis of a chronic skin ulcer seen during the reporting period. |
| 246            | Chronic Wound Care: The Use of Wet-to-Dry Dressings in Patients with Chronic Skin Ulcers.         | Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer without a prescription or recommendation to use wet-to-dry dressings. | This measure is to be reported at each visit occurring during the reporting period for patients with a diagnosis of a chronic skin ulcer seen during the reporting period. |

an EHR, and group practice reporting. However, since neither the group practice nor the EHR direct options include any of the 5 wound care measures, wound care clinicians can, by default, use only claims-based or registry-based reporting.

To become eligible for an incentive, an eligible professional must submit each measure on 80 percent of eligible beneficiaries, and no measure or measures group can have a 0 percent performance rate.

It seems unlikely that these measures will significantly improve the outcome of patients living with chronic wounds or decrease the cost of caring for these patients. Clearly, practitioners of advanced wound care need to develop better measures that reflect the care they provide to patients. However, if quality measures are a large component of physician payment, it could be argued that substandard measures would be better than none at all.

## MEASURED QUALITY IN WOUND CARE

Aside from improving the quality of care for patients in the US, this initiative is also about developing a nationwide program of data transmission to CMS regarding clinician adherence to practice standards.

That means wound care practitioners need to consider the types of quality

measures by which they would like to be measured. The industry needs to determine measures that would improve patient outcomes, decrease costs, and reflect the quality of care provided. Most would probably agree that the current measures do not suffice. Improving upon them would require large-scale participation, namely in the form of industry members supporting development of better electronic measures.

However, development and testing of improved measures for the industry overall will be key. For instance, consider measures like offloading diabetic foot ulcers during each patient visit, or conducting vascular screening with nonhealing leg ulcers. Imagine a measure for adequate compression of venous ulcers at each visit, or placing all pressure ulcer patients on an appropriate support surface. These are among the measures proposed by stakeholders with the National Alliance of Wound Care ([www.nawccb.org](http://www.nawccb.org)), a non-profit organization governed by a voluntary board of directors.

As wound care providers, we must begin to act like the specialists we know we are if we want to continue to care for patients in the face of healthcare reform. The measure development and testing process to meet CMS standards is not a

simple process. Wound care organizations and manufacturers need to combine their resources to create and test electronic measures for wound care.

This will require substantial funding, potentially from a coalition of industry and specialty societies. If we begin working together as an industry now, we might have wound care quality measures ready by 2015, when value-based purchasing becomes a reality.

If we do not create and test wound care quality measures within the next 12 months, the wound care industry may not exist in order to even be considered a specialty within the next decade. Consider that a Mayan-like prediction. ■

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## RESOURCES

1. American Medical Association. Physician Consortium for Performance Improvement. [www.ama-assn.org/ama/pub/physician-resources/physician-consortium-performance-improvement/about-pcpi.page](http://www.ama-assn.org/ama/pub/physician-resources/physician-consortium-performance-improvement/about-pcpi.page)
2. 2012 Physician Quality Reporting System Medicare Electronic Health Record Incentive Pilot: Quick Reference Guide. [www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/downloads//2012pqrs\\_medicareehr-incentpilot\\_final508\\_1-13-2012.pdf](http://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/downloads//2012pqrs_medicareehr-incentpilot_final508_1-13-2012.pdf)