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Did You Know?

A new study reveals that gastroenterologist-administered sedation during colonoscopy could lead to unsafe levels of respiratory depression.

True or False?

The abdominal pain which became a bleeding ulcer found during surgery does not necessitate an update to my records?

T or F?

Check next month's issue for the answer!

Last month's answer is: **False.**

Asking the surgeon is the best source.

CMS Gives Providers More Ways To Enroll in Alternative Payment Models

The Obama administration is reporting continued progress in achieving its goal of tying half of all healthcare spending to alternative payment models by end the of 2018. HHS Secretary Sylvia Mathews Burwell added that CMS would give providers more opportunities to become involved in Medicare's alternative models. "That's incredible progress. It's historic," she said. "But it's just a start. We have a long road ahead."

Contracts in place at the beginning of 2016 put 25% of healthcare payments through APMs, and the actual amount will be higher because of contracts negotiated throughout the year. The report surveyed 72 health plans covering more than 128 million Americans, about 44% of the covered population in Medicare Advantage, Medicaid, and commercial plans.

Burwell said CMS will reopen the Next Generation ACO and Comprehensive Primary Care Plus (CPC+) models to applicants for the 2018 performance year. Both models qualify as an advanced APM in the new framework for paying physicians established by the Medicare Access and CHIP Reauthorization Act. She said the report shows 23% of all healthcare dollars from Medicare Advantage, Medicaid and private health plans went through APMs in 2015. Patrick Conway, CMS chief medical officer and director of the innovation center, said the agency now wants to work with the private sector.

Provider groups and lawmakers have expressed concern, meanwhile, that CMS is pushing too many experiments too quickly for proper evaluation, but administration officials continue to laud the efforts of the CMS Innovation Center, which is continuing to create and test new models. Some studies have suggested that value-based payment systems and pay-for-performance schemes often fail to achieve significant improvements in quality and efficiency because of overly complex designs and conflicting incentives.

Less Hospitals Earn Medicare Bonuses With Value-Based Purchasing

More than 1,600 hospitals will see bonuses from Medicare in 2017 under the Hospital Value-Based Purchasing program, according to federal data released November 1st. The number earning positive pay adjustments is about 200 fewer than last year. This program affects approximately 3,000 hospitals, which are penalized or rewarded based on how well they perform on certain quality measures. These hospitals performances are assessed in comparison to their peers, as well as to their own performances over time. The results are "somewhat concerning," said Francois de Brantes, executive director of the Health Care Incentives Improvement Institute. One reason was the fact that fewer hospitals are being rewarded. Another was hospitals' lack of movement in rankings.

The number of hospitals whose payments were docked grew from 1,236 in 2016 to 1,343 in 2017, according to an analysis of the data. Last year, 59% of hospitals received bonus payments; this year 55% did. More than half of the 2,879 hospitals in the program both years will see lower payment adjustments in 2017 than in 2016. Payments improved for 1,388 of those hospitals. CMS also announced several changes to the program for fiscal 2018. The four domains on which hospitals are scored—clinical care; patient and caregiver-centered experience and care coordination; safety; and efficiency and cost reduction—will be weighted equally. Also, CMS removed two measures from clinical care and added a care transition dimension.

The results show "how progress on quality can be accelerated when pay-for-performance programs reward both achievement and improvement," said Nancy Foster, the American Hospital Association's vice president of quality and patient safety policy. "However, CMS must continue to refine the program to ensure that it effectively drives quality forward for hospitals and the patients they serve," she added.

Risk Factors Differ For Acute vs. Chronic Pain In Patients After Breast Cancer Surgery

Among patients who have undergone breast cancer surgery, risk factors for acute pain differ from those for persistent pain. New research shows that while acute pain immediately after surgery correlated with surgical injury, chronic post-mastectomy pain showed no association with surgical extent or duration. Instead, chronic pain was more closely correlated with patients' physical sensitivity to pain, as well as their psychological response to pain.

Researchers believe that these results could aid in patient stratification ahead of surgery to better deliver pain medicine in the future. "By more extensively phenotyping individual differences in pain processing in the preoperative period, we may differentially identify those at greater risk of acute versus chronic postsurgical pain and design preventive therapies accordingly," said Kristin L. Schreiber, MD, PhD, an anesthesiologist and clinical neuroscientist at Brigham and Women's Hospital, in Boston. Dr. Schreiber reported at the 2016 annual meeting of the International Anesthesia Research Society (abstract S-161), retrospective studies have cited an approximately 30% incidence of chronic pain after mastectomy, with putative risk factors including younger age, type of surgery, anesthetic technique, genetics, and more recently, psychosocial and psychophysical factors (*Pain Manag* 2014;4:445-459; *Anesthesiology* 2010;112:1494-1502; *Pain* 2001;90:261-269; *J Pain* 2011;12:725-746).

For this study, Dr. Schreiber and her colleagues prospectively measured an array of risk factors in women (18-85 years old) undergoing partial or total mastectomy. These risk factors included validated psychosocial measures (anxiety, depression, catastrophizing, sleep disturbance) and psychophysical responses (quantitative sensory testing including pressure pain tolerance and threshold, pinprick temporal summation and aftersensation pain). Surgical and anesthetic variables, opioid requirements and verbal pain ratings were assessed on the day of surgery. Patients' degree of surgically related pain was then assessed at two weeks, three months, six months and 12 months using the Breast Cancer Pain Questionnaire, which measures frequency and severity of pain in four surgically related areas (breast, axilla, arm and side) and from which a Pain Burden Index was calculated.

Patients undergoing more extensive surgery reported higher levels of acute pain (on postoperative days 0 and 1), Dr. Schreiber said, with pain severity correlating with surgical extent. Three and six months after surgery, the Pain Burden Index was no longer associated with surgical variables but still correlated with preoperative psychosocial factors, as well as heightened baseline sensory processing (higher temporal summation of pain and painful aftersensations).

"People who scored high on psychosocial tests like catastrophizing were much more likely to go on to have persistent postmastectomy pain," Dr. Schreiber said. "The temporal summation of pain test also correlated with the amount of pain experienced at six months." "This is an interim analysis," she added, "but we're beginning to get a sense of how acute pain and chronic pain differ in terms of which variables may predict them."