

Speaking Out Against Measuring “Quality”

PQRS. For the last decade, the most maddening 4 letters in medicine. Now another 4-letter acronym—MIPS—threatens to take their place. In November, I wrote an op-ed critical of PQRS for the medical website KevinMD.com, titled “The Medicare Boondoggle That’s Wasting Tax Dollars

and Infuriating Doctors.”¹ It quickly went viral in the health care community, and it was clear that I’d struck a nerve. Among the many physicians who left comments or contacted me, 2 themes emerged.

First, it was surprising to see how many doctors simply refused to participate in PQRS or EHR meaningful use programs. Second, it struck me that doctors hunger for solutions but feel powerless to effect change. Because these programs were mandated by Congress and the solutions are obviously political, medical societies like the Academy and the American Medical Association are best poised to oppose them. Hence, we should continue supporting our societies, telling our leaders that these issues bother us, and supporting medical PACs and physicians who run for office.

What would a solution look like? I would like to see the entire quality-reporting program dismantled (PQRS has rolled over into the Merit-Based Incentive Payment System, or MIPS), and the EHR and accountable care organization

requirements eliminated. There is no evidence that these government initiatives improve patient care. When a new drug is developed, it must be shown to be effective before

WRITE TO US. Send your letters of 150 words or fewer to us at *EyeNet Magazine*, American Academy of Ophthalmology, 655 Beach Street, San Francisco, CA 94109; e-mail eyenet@aao.org; or fax 415-561-8575. (*EyeNet Magazine* reserves the right to edit letters.)

it’s approved—yet Medicare created these costly, disruptive programs without any evidence of efficacy. There’s a reason why we don’t skip over phase 1 studies and go directly to mass marketing of a drug.

Of course, efforts to measure outcomes and quality are not going away. But these ideas should be implemented first in smaller, local markets to see if they improve care or

reduce costs (think of a health system like Kaiser Permanente in California, for example). Seeing what works and what doesn’t in smaller settings will be not only more efficient and cost-effective but also more likely to result in changes that physicians will accept and adopt.

Most important, physicians must become more engaged in the political process at all levels of government. Many of us continue to jump through the hoops imposed by government or insurance companies. Though these tasks annoy us, we’re generally more focused on simply making it through our busy days. However, there comes a point when government programs grow so onerous and detrimental that we, as a profession, must speak out. If we do not, we risk losing far more than a mere PQRS or MIPS payment penalty.

*Andrew Lam, MD
Springfield, Mass.*

1 www.kevinmd.com/blog/2016/11/costly-medicare-boondoggle-thats-wasting-tax-dollars-infuriating-doctors.html.

Response from the Academy: The frustration you express is indeed shared by many, including the Academy. We agree that banding together in support of our advocacy efforts will help us bring about much-needed change. With Republicans in control of the White House and Congress and the appointment of Rep. Tom Price, MD, to Secretary of Department of Health & Human Services, there is a unique opportunity for simplification and for regulatory relief for physicians. Not only is the Academy helping shape the American Medical Association’s development of relief ideas, but we have also initiated our own effort.

To read the rest of the Academy’s response, see this article online at aao.org/eyenet.

Editor’s note: Reducing your regulatory burden is an Academy priority. What can you do? Help the Academy in its advocacy efforts (aao.org/advocacy) and take advantage of the Academy’s MIPS reporting tools (aao.org/iris-registry/medicare-reporting).

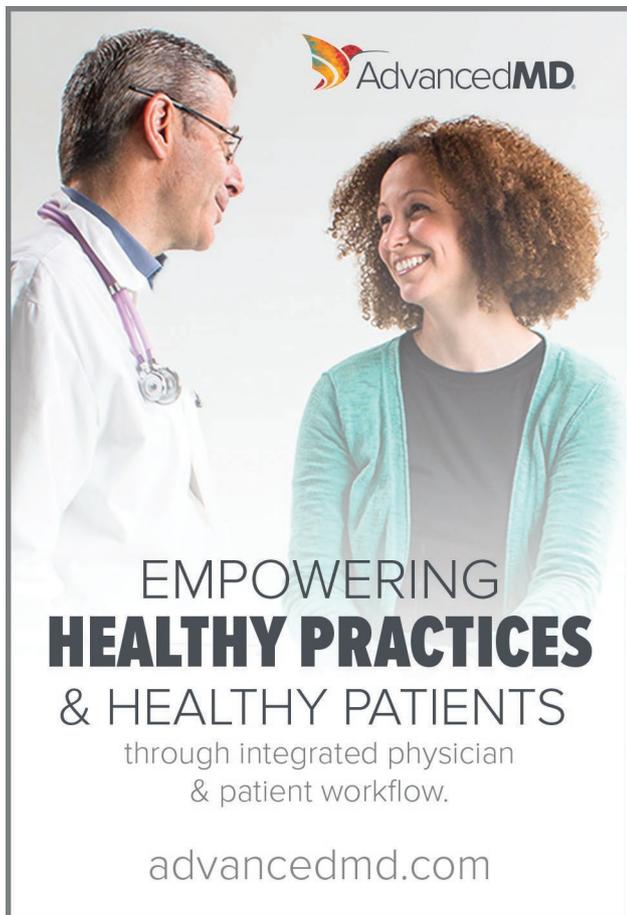
Continuing the Discussion on Concussion Care

As noted in Annie Stuart’s excellent article “Concussion Care” (Feature, December 2016), the importance of related visual dysfunction is becoming increasingly apparent. Neglected in most concussion discussions is an evolving understanding that idiosyncratic responses by the migraine brain are often contributory. As with headaches, slowed thinking, and sleep disturbances, postconcussion visual symptoms are similar to those occurring with migraine. These include photophobia, convergence insufficiency, accommodative

The 16th Annual Downeast Ophthalmology Symposium

SEPTEMBER 15-17, 2017

Bar Harbor, Maine



AdvancedMD

**EMPOWERING
HEALTHY PRACTICES
& HEALTHY PATIENTS**
through integrated physician
& patient workflow.

advancedmd.com

insufficiency, chronically blurred vision, and vestibular migraine with vestibulo-ocular dysfunction.

Posttraumatic headache (PTH) is the most frequent post-concussion symptom.¹ PTHs are associated with a variably disabling postconcussion syndrome (PCS) in a small percentage of those concussions that remain symptomatic for more than 1 week.² Preinjury primary headaches represent a significant PTH risk factor. Migraine and probable migraine (as classified in ICHD-3 beta) are the most frequent primary headaches identified, and there are no symptoms that distinguish trauma-triggered migraine from concussion. The presence of the migraine comorbidities of depression and anxiety are risk factors for developing persistent PTHs and PCS.^{3,4} Familial migraine is a biomarker for postconcussion migraine.⁵⁻⁹

Researchers are beginning to find explanations for these responses in the migraine brain. Cortical spreading depression is induced by brain trauma and is also the pathophysiologic correlate of migraine aura.^{10,11} Nitric oxide synthase, pain-signaling molecules, and calcitonin gene-related peptide (CGRP) are common to the pathophysiology of both migraine and PCS.¹² Possible contributory postconcussion cerebral alterations include neuroinflammation; augmented pain perception from malfunction of the intrinsic pain modulation system; and elevation of the level of comorbid depression, anxiety, and sleep disturbances.¹³ The mapping of task-specific cortical activity using brain network activation analysis is different in migraine patients who are expected to develop PTHs.¹⁴

By including an accurate migraine history in concussion data collection, the significance of the relationship between migraine and the visual symptoms of PCS will be better appreciated and lead to improved concussion care. I agree with Dr. Galetta's comment, "We need ophthalmology involved." We may even consider prospective identification of young athletes at risk for developing more severe postconcussion symptoms due to migraine.¹⁵

Alfred J. Cossari, MD
Port Jefferson, N.Y.

1 Heyer GL et al. *Cephalalgia*. 2016;36(4):309-316.

2 Morgan CD et al. *J Neurosurg Pediatr*. 2015;15(6):589-598.

3 Morgan CD et al. *Neurosurgery*. 2014;61(suppl 1):196.

4 Kerr HA. *Pediatr Ann*. 2014;43(12):e309-315.

5 Abu-Arafeh I et al. *Pain Manag*. 2014;4(4):303-308.

6 Lucas S. Characterization and management of headache after mild traumatic brain injury. 2015. www.ncbi.nlm.nih.gov/books/NBK299177/. Accessed Feb. 13, 2017.

7 Pinchefskey E et al. *Pediatr Neurol*. 2015;52(3):263-269.

8 Lucas S. *Curr Pain Headache Rep*. 2015;19(10):48.

9 Lords Q et al. *Sports Health*. 2014;6(5):406-409.

10 van der Veek EM et al. *Neuropediatrics*. 2015;46(2):116-122.

11 Tang YT et al. *J Neurophysiol*. 2014;112(10):2572-2579.

12 Daiutolo BV et al. *J Neurotrauma*. 2016;33(8):748-760.

13 Ruff RL et al. *F1000Res*. 2016;5.

14 Kontos AP et al. *Brain Imaging Behav*. 2016;10(2):594-603.

15 Anderson K et al. *Behav Neurol*. 2015;2015:693925.