NATIONAL QUALITY FORUM

# Meeting Summary

## Surgery Standing Committee – September 2017 Off-Cycle Webinar

The National Quality Forum (NQF) convened a public webinar for the Surgery Standing Committee on Monday, September 18, 2017. An online archive of the webinar is available for playback.

### Welcome, Introductions, and Review of Webinar Objectives

Kathryn Goodwin, Senior Project Manager, National Quality Forum (NQF), began by welcoming participants to the webinar. Ms. Goodwin explained that the off-cycle webinars represent an opportunity to bring the Standing Committee together during a time in which there are no measures being reviewed, to continue the Committee's important work in surgery performance measurement. Ms. Goodwin reviewed the meeting objective, which was for fellow Committee members to share and discuss their innovated work related to surgery performance measurement.

### Measure Madness and Electronic Clinical Quality Measures

Mark Jarrett, MD, MBA, Chief Quality Officer, Associate Chief Medical Officer, North Shore-LIJ Health System, stated that measures are important because improvement of care requires metrics. There are many stakeholder groups who are interested in measures such as "non-performance improvement" audiences, Centers for Medicare and Medicaid Services (CMS), insurers, regulatory agencies (e.g New York State Department of Health Cardiac Database), patients and families. Dr. Jarrett noted that one of the problems in what has resulted in "measure madness", is a proliferation of measures. To expand upon his point, Dr. Jarett provided examples such as CMS had over 33 different programs with 850 unique measures in 2014, and that over time, NQF has endorsed over 650 measures. In addition, commercial payers use their own measures.

Reiterating the abundance of measures, Dr. Jarrett summarized the Institute of Medicine's Vital Signs Report that indicated a need to integrate measurements with electronic health record (EHR) capabilities. He also summarized a recent viewpoint in the Journal of American Medical Association on the cost of quality, as well as an article in Health Affairs that stated United States physician practices spend more than $15.4 billion annually to report quality measures. Additionally, he cited a John Hopkins study from 2016 that showed the potential unintended consequences of measures if they are not informing measure implementers or users accurately.

Dr. Jarrett then pointed to "report card madness", citing Leapfrog as an example. The Leapfrog Group is a national non-profit organization that collects and publicly reports information about the safety and quality of inpatient hospital care. Dr. Jarrett noted that more than 1,750 hospitals participate in Leapfrog's report program, but there are some scientific problems with it, such as the results can't be normalized and self-selection. Hospitals with less than optimal results may be less likely to report them. He stated other issues such as combining risk and non-risk adjusted data and combining multiple timeframes for different measures which threatens the validity of the measures. Dr. Jarrett noted the importance of sharing metrics with the public, but there are problems with the scientific merits of this particular reporting program.

Dr. Jarrett summarized a response provided by the American Association of Medical Colleges (AAMC) in reference to the CMS Stars for Quality. CMS Stars for Quality is how CMS rates hospitals based on seven categories: mortality, safety of care, readmissions, patient experience, effectiveness of care, timeliness

of care and efficient use of medical imaging. According to the AAMC, the CMS Stars for Quality rating system misrepresents hospital quality, and includes quality measures that are flawed and disproportionately impact teaching hospitals. Also noted by the AAMC is that the methodology used has no socio-demographic risk adjustment and the lack of transparency around data used to calculate results.

Dr. Jarrett then referred to a report by the Hospital Association of New Year State that suggests how to move more towards "Measures that Matter". According to the report, measures should reflect clinical reality – that what is being measured is important and really makes a difference in a patient's outcome. There should be a smaller number of measures because the measurement community can only effectively work on a small number at a time. It was also recommended that data collection should be part of the normal workflow and providers need to focus on the most serious safety concerns. Measures need to be actionable and meaningful.

Dr. Jarrett discussed how electronic clinical quality measures (eCQMs) help to minimize human coder variability and cost. eCQMs could be used for improving patient care in real time – not just the measure report or scorecard. Dr. Jarrett however, pointed out that there are some problems or "landmines" with eCQMs. Electronic health records (EHRs) aren't always well designed for eCQMs. There are multiple places for documentation that can be entered by multiple providers, which can result in clinical workflow mismatch. Another issue is that eCQMs often don't correlate with claims, which could result in a potential compliance issue.

### Committee Discussion

Lee Fleisher, MD, Committee co-chair, thanked Dr. Jarrett for highlighting the above issues, noting that these important issues have been discussed by the Consensus Standards Advisory Committee (CSAC); the NQF Board of Directors, The NQF Intended Use Committee, and the Measure Applications Partnership (MAP). Dr. Fleisher stated that Dr. Jarrett's presentation nicely outlines a framework by which the Surgery Standing Committee should be looking at measures and ensuring they're useful. Dr. Fleisher asked the Committee to think about how the group could think differently as they evaluate measures, as well as how the Committee and/or NQF can reach out to different specialty societies, because in the end, all stakeholders want measures that matter. Other Committee members agreed that the presentation was a nice summary of a very difficult issue.

Committee members noted the need for a tiered system or hierarchy for measure prioritization, so that hospitals, providers, and other stakeholders have guidance on which measures to be concentrating on most. Prioritizing measures is improvement in reducing effort and resources, and in reporting measures that aren't meaningful. The Committee agreed that measure prioritization would be helpful for the MAP, which advises CMS, on which measures to put into the different federal programs. Barbara Levy, MD, FACOG, FACS, noted that a challenge with regards to accountability is to pick really meaningful outcome measures and just a couple of them that can be used for public reporting. It was suggested that shifting towards fewer but more meaningful measures will require a policy change, but perhaps NQF could advocate for policy change that supports the ultimate goal of the measurement community being continuous quality improvement. Dr. Levy would rather see a system judged and given it a star rating for working hard on quality improvement in one or two areas than to give them five stars for spending an abundance of resources to report things that aren't meaningful.

### Current Practices and Management Gaps: Perioperative Care

Richard Dutton, MD, MBA, Chief Quality Officer, United States Anesthesia Partners, discussed current practice and measurement gaps in perioperative care. Dr. Dutton stated that it would be great if there could be measures that cover multiple different kinds of surgical cases that span the world of surgery. Dr. Dutton stated that from the patient's point of view, they don't necessarily understand specialization, and the very specific things that the different specialties, practices or hospitals are looking at. There is also a need for measures that capture important long-term outcomes of surgery such as, when does the patient go back to work, was their pain reduced, did their cancer reoccur, is their cognitive function okay. Specifically related to anesthesia, there is concern about this at both ends of life such as, the effects of anesthesia on babies could have long-term neuro-cognitive consequences, older patients with the risk of post-operative delirium, and cognitive dysfunction after surgeries. Dr. Dutton noted that this is what is important to patients. The measures span across a lot of different kinds of operations, and they're desperately needed. Dr. Dutton noted other gaps including, reduction in opioid prescriptions or pain management and surgical patient satisfaction.

Dr. Dutton highlighted additional measurement gaps that specifically include both surgical and anesthesia components such as, survival after cardiac surgery, uncomplicated screening colonoscopy, transfusion rates, and enhanced recovery. He noted that there is also a need for measures related to surgical procedures that are performed outside of the traditional operating room such gastrointestinal laboratory, surgery centers and cardiac electrophysiology. Lastly, Dr. Dutton indicated that when looking at the portfolio of NQF endorsed measures, there are very few measures in the following disciplines: neurosurgery, otolaryngology, urology, trauma, plastic surgery, gastroenterology, and transplant.

### Committee Discussion

Dr. Fleisher noted the importance of developing joint accountability measures, where both anesthesia and surgery specialties can both take accountability with such measures. Dr. Dutton agreed that the measurement community should be thinking about accountability more broadly as measures are developed and endorsed, and the importance of discerning how to apply them across specialties. Ideally, both physicians and the facility would be measured on the same broad outcomes. Dr. Fleisher asked if there are measures being developed related to anesthesia that could involve surgery to encourage "co-development" with surgical subspecialties. Frederick Grover, MD, noted that there is already some collaboration on measure development between with the cardiac anesthesiologist and thoracic surgeon groups. Dr. Fleisher stated that perhaps one of the goals of this committee to communicate to the measure development community a need to develop the measures that matter to patients. It was suggested that the next in-person meeting the Committee could have this discussion and identify avenues to share the recommendations with specialty societies who may be developing measures. It was also suggested that NQF and/or a subgroup of committee members could possibly offer consultative services to assist measure developers, particularly the underserved subspecialty groups, who are developing new measures. The type assistance provided would be less about the technical aspects of measure development and more about an overall framework to support meaningful measures.

### Performance Measure Proposals: American Academy of Orthopaedic Surgeons (AAOS) Surgical Management of the Knee Performance Measurement Committee

A.J. Yates, MD, Associate Professor and Vice Chairman for Quality Management, Department of Orthopedic Surgery, University of Pittsburgh Medical Center, presented on performance measures that are currently in development through AAOS. Dr. Yates pointed out that these measures are different

than the majority of the measures that the Committee has evaluated over the last three years, in that these are for the Merit-based Incentive Payment System (MIPS). They present a slightly different issue in that MIPS measures are voluntarily reported. Dr. Yates provided an overview of the Medicare Access and CHIP Reauthorization Act (MACRA). The MIPS process within MACRA requires numerous performance measures to determine quality, and orthopedics is a high priority for CMS.

Dr. Yates stated that the most likely process for meeting the quality metrics within MACRA is going to be through the MIPS process with fewer doctors being able to meet the requirements for advance alternative payment models. These measures need to be harmonized with those measures used in Advanced Alternative Payment Models (APMs) and Comprehensive Care for Joint Replacement (CJR). Dr. Yates' group has identified gaps that are considered to be high priority in measurement related to orthopedic surgery that they feel meet the needs of MIPS. Dr. Yates suggested that orthopedics was probably selected as one of the high priorities by CMS because of high costs related to hip and knee surgical procedures.

Dr. Yates described four process measures that are in development by AAOS. The measures are based on level one evidence for best practice with strong recommendations in clinical practice guidelines and are intended to be deliverable through EHR/registry. The measures require the provider to develop/initiate protocols for best practice. The measures all share accepted harmonized exclusion criteria such as tumors and fractures for being excluded from the denominator during primary procedures. Dr. Yates stated that ideally these measures would all be readily crossed over to total hip arthroplasty. The four process measures that are in development are:

- Reversible risk reduction for patients with a high body mass index otherwise indicated for primary total knee arthroplasty (TKA);
- Use pre-operative risk assessment tool as part of pre-operative counseling/shared decision;
- Utilization of Early Mobilization Protocols; and
- Utilization of Multimodal Pain Management Protocols.

Next, Dr. Yates described two structural measures that are in development by AAOS:

- Participation in a joint registry for patients undergoing TKA; and
- Use of a Patient Report Outcome tool in Patients Undergoing elective TKA.

Lastly, Dr. Yates described two outcome measures that are in development by AAOS:

- Patient-acceptable system state (PASS) 9-12 months post TKA; and
- The measurement of those patients that expect to go home after TKA that do go home and stay home without readmission, transfer to skilled nursing facility, or return to emergency room (Expectation of Home Measure).

The measures are being assessed via AAOS' Surgical Management of Osteoarthritis of the Knee Performance Measure Workgroup and have preliminary approval from the American Association of Hip and Knee Surgeons. The University of Pittsburgh Medical Center has offered to help with preliminary testing of the measures. It is hoped that the group will be able to show data to support performance gaps, reliability, validity, and usability this calendar year or early 2018.

### Committee Discussion

Dr. Fleisher applauded the AAOS' effort in developing the new measures and reiterated the need for measures of both accountability and quality improvement. Committee members agreed that this effort shows how AAOS is thinking about measurement in a very holistic way from multiple endpoints and is very patient oriented.

Amy Moyer, MS, PMP, raised a question about the structural measures using a patient-reported outcome (PRO) tool. Dr. Moyer pointed out that there is already an existing endorsed measure (*NQF# 2653: Average change in functional status following total knee replacement surgery*) that uses the improvement and functional status which is obtained by using a PRO and wondered if a structural measure would be in some ways less advanced. Dr. Yates clarified that the reason for being more broad and accepting of any number of PROs that could be captured and reported as having been collected, is because it has to be something that is voluntary and selected by the surgeon. He stated that the vast majority of surgeons in private practice aren't currently collecting this information. The measure is starting point to getting universal collection because if it is readily done, then the next step would be to provide a score. The intention is to keep it simple and let the surgeon choose.

Allan Siperstein, MD, noted that the measures under development are the type of measures that are applicable for the entire span of health care providers of both large institutions and private practice. These are the type of metrics that need to continue being developed in the future. Dr. Siperstein also suggested that the presentations today show that measurement can be a "team score". Dr. Siperstein concluded that there are various outcome measures that aren't showing only how well the surgeon is performing, but how well the team is performing. It is important when developing quality programs to be multidisciplinary in how those are constructed, but also on how the attribution is in terms of good outcomes.

### Opportunity for Public Comment

Ms. Goodwin opened the call for public comment and no comments were offered.

### Next Steps

Ms. Goodwin adjourned the call by stating the meeting summary and transcript would be posted to the project webpage next week, and thanked the presenters, the Committee, and the attendees for their participation