

## **NATIONAL QUALITY FORUM**

**Moderator: Alexis Forman**  
**March 1, 2012**  
**11:00am CT**

Operator: Good day everyone and welcome to today's conference. Please note today's call is being recorded.

At this time, I'd like to turn things over to Alexis Forman. Please go ahead, ma'am.

Alexis Forman: Thank you. Good afternoon and good morning and welcome to the Surgeon Endorsement Maintenance 2010 Steering Committee conference call and today the committee will be reviewing the submitted measures or the submitted comments in regards to the nine measures from our phase two addendum.

And just before I turn the call over to Drs. Morris and Torchiana, I just wanted to go over a few housekeeping things for today's call. Today's call, what we're going to do is start with the major themes, and discuss those comments and the measure available responses and the proposed committee responses.

And then after we go through the major themes, we'll ask the committee members if they have any additional comments or responses that they would like to pull out for discussion that weren't discussed within the major themes. Also we do have in addition to our agenda SVS for the two measures that are on today's call, 1523 and 1534.

They have made minor revisions to their specifications and have removed the word "small" from the measure title and the specifications. And we do have the developer on the call today to go through that with the committee.

So now, I'd like to turn the call over to Drs. Morris and Torchiana.

Dr. David Torchiana: Arden, why don't you kick off, and then I have one comment to make.

Dr. Arden Morris: Okay. Welcome everybody and thank you for joining us for this anticipated final telephone conference for the Surgery Endorsement Maintenance. Hello? Can you hear me okay?

Alexis Forman: Yes. I got distracted for a second.

Dr. Arden Morris: Okay. Let's see. So this is to be our final call. I'm anticipating that everybody received the agenda. We'll be reviewing the comments received. We'll go through the themes based on our steering committee deliberations, and we'll determine whether or not the committee would like to revote on any of the measures at the end of our conference, joining other comments and issues. And David, did you want to start with a comment?

Dr. David Torchiana: I - well, yes. My comment really was just an overview of the agenda that you and I were on a pre-meeting call with Alexis, and I think it's important to think of these themes across the multiple measures that have been clustered together, and I think this is a wonderfully useful way to do this rather than tackling each theme individually for each measure.

So my hope would be, I think a couple of themes are a little bit more complex than others, but I guess our hope for this call is to be able to have a agreed upon committee response to each of these themes that we can sort of pass on and let this then go forward.

And to do that, I think we ought to try to think of these not at the specific level of detail of the measures themselves, but rather at the aggregate level of the theme. So I think once we get into the first one, this will get a lot easier if we keep that in mind.

Alexis Forman: Yes.

Dr. David Torchiana: I hope that made sense. I'm sorry if it didn't. So how do we want to do this? Alexis, do you want to sort of describe the theme, or do we just read it off the page? How should we start to engage in these?

Alexis Forman: It's up to you and Drs. Morris if you - we can just start with the first theme. I can give a brief overview about the theme if you would like me to.

Dr. David Torchiana: I think that would be helpful, and then the - you know, when applicable is the rationale behind our response, or the proposed response.

Alexis Forman: Okay, sure. The first theme was related to the related and competed triple A measures as well as the pancreatic measures, and we did get some comments from commenters expressing concern that those two sets or two topic areas, those two groups of measures should have been competing measures and not related.

The committee decided that the triple A measures, measures 357 and 359, those two ARC measures were considered best in class, and indicated that the measures were superior to the leapfrog measure. And I think the reason why we didn't necessarily remove endorsement from

that leapfrog measure was because this leapfrog measure was not under maintenance review in the project, so the committee did not have the authority to provide that recommendation to our membership.

So I think what we need to do here is probably provide additional language within the report to indicate if the committee agrees that they do feel that the triple A measures are best in class and are superior to the leapfrog measure.

(Heidi): Right and this is (Heidi). If I could just add, I think as Alexis and I went to write off a summary of your discussion of the triple A and then also the pancreatic, we had some limited information, but I think the membership is just asking for a little bit more information that's why - what the thinking was.

So for triple A, I think it was because the ARC measures are risk adjusted, that was our takeaway as the primary reason, but if there's anything more than that, I think that'd be very helpful and we'll include that in the report.

Female: Alexis, is this supposed to be showing up on our screen? It's not on my conference call screen, but I'm looking at it from the materials you sent earlier.

Alexis Forman: It should be just us.

Female: It just keeps saying "loading screen, may take up to 30 seconds" but it says that - it showed me the agenda, and now it doesn't show anything else.

Alexis Forman: Can anyone else see the screen, or does...?

Female: No, I'm having problems with the screen, too. It wouldn't load at all. It's just continuously saying it's about to load.

Male: Same here.

Alexis Forman: Okay. All right. I will try something else. Thank you.

Female: The agenda was on mine originally, but then since we've started talking about the comments, it has not been - oh, there - now the agenda's back up again.

Alexis Forman: Okay, good.

Female: Sorry. It may be systems are slow here. I'm not sure. But that's just the agenda. It's not what we're talking about.

Alexis Forman: Right. Jessica will work on fixing it, but I guess for right now if you could just use the materials that I sent you via email, that should be fine.

Dr. Arden Morris: My memory of the talk on the triple A measures was that not only was the ARC measures risk adjusted, but they were kind of the same things looking at it from the opposite perspective - you know, so like, on the flip side of the coin. But it generally gave the same information, and that the ARC measures had more information and more separated out into the various categories of endovascular versus open and ruptured versus non-ruptured, since ARC had updated their measures.

Alexis Forman: Okay.

Dr. David Torchiana: I remember exactly the same thing, so I think there's two things that Alexis is asking us for here. One is just to acknowledge we did not pick one over the other, because technically we don't have the authority to remove the leapfrog measure. But then secondly, the reasons that you just described are the reasons why we considered the ARC measure to be superior. And I'd like to not spend too much more time on this, because I think that's pretty cut and dried.

Dr. Arden Morris: And I forgot what happened with the SVS ones, but I think we considered them to be different information.

Female: Right. Those showed the other, kind of the other side of what you were looking at with the ARC measures, correct?

Dr. Arden Morris: Right. Well, now, the SVS ones were more related to sort of small aneurysms and making sure that there's not over-utilization and that people are doing small - you know, small aneurysms where the indications for surgery is kind of borderline, that they're doing it for the appropriate reasons and they're not over-utilizing the procedure.

Female: Right. Correct. And do we have (Chris Vagle) on the line, who introduced the SVS measures?

Dr. David Torchiana: Do we have the SVS developers on the line also? I think Alexis, you said they might have a change in the description of the measure?

Alexis Forman: Right. We can - that, I'm going to save later for the call.

Dr. David Torchiana: Okay.

Dr. Arden Morris: Okay. At any rate, this is also my - this is exactly my memory of the - our discussion earlier, which was I thought very thorough, that we were really in some ways talking about two

different animals, two different major concerns with regular triple A's versus the small triple A's.

But if they are taking out the word "small" that changes things a little bit.

Female: I don't know that they're taking out the word "small", but - so we'll see.

Tim Kresowik: This is Tim Kresowik. I'm from SVS, and we definitely are taking out the word "small". But I'll just comment briefly because I'm going to have to - I'm supposed to start a procedure in ten minutes, but I'm going to try to be on and off as best I can. And I can explain that at any point if you want us to explain the justification why we're doing that. But I am going to be trying to do a procedure in the midst of this call at the same time, so I can either do it now or try to sign back in at the appropriate time.

Alexis Forman: Well, I - you know, now, I'm sorry. I didn't know - I wasn't aware that you weren't going to be on the entire call.

Tim Kresowik: Yes. I'll just briefly - and part of the problem, and I apologize for this, but the original drafting took place a long time ago, and it was by different people than are involved now.

And the issue is that we're not really changing the specifications as written in terms of the size that we're talking about, but there was quite a bit of concern, which I think is very valid, that using the word small associated with aneurysms that could be up to six centimeters in men and 5.5 centimeters in women sends a message that many people are uncomfortable with.

Our issue, what we're really trying to do with the exclusions is to exclude large aneurysms, which - excuse me - we've done. So it's really just semantics. We're not really changing that - the intent of the measure. The idea is that if you're talking about measures that aren't - aneurysms that aren't large, they are ones where which the risk adjustment should be part of the surgical discussion.

So that's the main intent. So while we want to remove the word "small", because that has raised a lot of concern, especially among the vascular surgeons.

Dr. Arden Morris: Okay, is that because they were thinking really small, like three centimeters, versus say 5.1 centimeters?

Dr. David Torchiana: I think it raises ((inaudible)) appropriateness, and is kind of a right way to reflect the measure. I think it's a very wise decision to do that, but you've basically kept the criteria the same so that the rationale over not needing risk adjustment is the same, and that seems like a very appropriate modification.

Tim Kresowik: Correct, and that's all we're trying to do. It's just that for some people small would imply that, well, it should never be done at all. And that's not our intent. Our intent is to capture the majority of aneurysms that are being considered, which fall into a range for which there's still some - there's still an option of observation, but it's certainly a good - there's nothing wrong with doing them at that size, you know, 5.5 and to six in men, and five to 5.5 in women. So just what we just wanted - that's why we wanted to remove the word small.

Alexis Forman: Okay. So that's a good rationale. Anybody on the committee have any other comments or questions about this?

Male: No. I think you've captured it.

Dr. David Torchiana: And I think thematically this is not - doesn't sort of add to the cacophony of competing measures. This is an innovative and thoughtful and interesting way of introducing a new measure that is not risk adjusted that incorporates decision making into the surgical outcome.



And I don't think that it is competitive or confusing when you line it up against the ARC measures.

So I think we're on the right ground approving all of these.

Vivienne Halpern: I agree.

Dr. Arden Morris: I agree as well. Do we need to talk about the leapfrog - about whether or not we recommend that endorsement be reviewed when the leapfrog measures are under consideration?

Alexis Forman: Yes, you can if you would like to make the recommendation for when that leapfrog measure does come up for maintenance. If you do believe that the other measures are superior and that endorsement should possibly be removed, you can make that recommendation.

(Heidi): Right. This is (Heidi). It will eventually be reviewed by steering committee, but I think it's helpful for you to provide that input for the future.

Dr. Arden Morris: Vivienne, did you have any particular thoughts about that?

Vivienne Halpern: Again, I think the - now that the ARC adjusted their measures to separate out those categories, I as a vascular surgeon think it's a superior measure, because of that, and they are so similar, you know. One's sort of looking at who dies and one's looking at who survives, but it's essentially the same data.

Dr. Arden Morris: Anybody else agree or disagree that we should recommend endorsement be removed?

Dr. Richard Dutton: This is Rick. I think we should make that recommendation, that the leapfrog measure be retired.

Female: I would agree with that.

Dr. Arden Morris: Okay. Let's go ahead and make that recommendation, unless anybody else on the committee wants to talk about it further.

Alexis Forman: Okay, great. Part two of scene one is looking at the pancreatic surgery measures, and here again is dealing with two measures, measures 0365 and 0366 from ARC, as well as the leapfrog measure 0738. The committee did say that the leapfrog measures and the ARC measures were complementary and not competing, but the committee noted that they did like the ARC measures because it was stratified by the non-malignant disease as well as risk-adjusted. So here I think we really need to provide additional information regarding the committee's rationale to view these measures as related and complementary and not competing.

Dr. Arden Morris: Rick, do you want to start off the discussion of this?

Dr. Richard Dutton: I think I was just trying to go through the documents and remember our thinking from before, but I believe that one of these was based on administrative data, and one of these is based - the one we liked better is based on clinically - clinical registry data. So I think one of the reasons we viewed them as complementary is that we recognized that different institutions would be gathering the data in different ways or would have different data to look at.

Alexis Forman: Dr. Dutton, they're actually both - all three of them are facility level measures, as well as administrative claims.

Dr. Richard Dutton: Okay.

Alexis Forman: I think the main difference was the ARC measures were risk-adjusted and stratified.

Dr. Richard Dutton: So why did we say we still liked the other ones? Do you recall?

Alexis Forman: Yes, we went back through the transcripts, and we couldn't find...

(Heidi): Yes, this one was a hard one for us to try to summarize. And so if it's the will of the committee, I think you could consider this to be a similar issue as what you just talked about with the triple A, and you might consider them actually competing. But again, the ARC measures provide additional detail rather than - it sounds like you may be headed toward deciding they're competing rather than complementary. But I don't want to put words into anyone's mouth, so...

Dr. David Torchiana: So since we don't have the computer screen up, does anyone know what page in the print-out we could look at the notes from the discussion previously?

Alexis Forman: Sure. If you're looking at the draft report that I sent you that was a part of the PDF packet, it starts on page four for measure 0635 and let's see. Actually if you scroll down to page six, which would be nine of the PDF, we did provide the rational and discussion regarding the related and competing discussions.

Vivienne Halpern: Is there a number on the left, Alexis, for that? You know how there's an ID number all the way to the left of the spreadsheet, on the comment - are we working on the comment report?

Alexis Forman: We're actually at the draft report.

Vivienne Halpern: So what is the number on the left?

Dr. Arden Morris: It's not the Excel one. It's the other one. It's part of the agenda.

Vivienne Halpern: Oh, okay. Got it, sorry.

Dr. Arden Morris: It's the rest of the agenda set.

Vivienne Halpern: Oh, I see. It's coming up on my screen now. Got it.

Dr. Arden Morris: Yes, mine still won't load. I don't know why.

Vivienne Halpern: Yes, mine all of a sudden appeared, so I'm excited.

Dr. Arden Morris: Okay. My memory of this is that we really struggled with this one.

Alexis Forman: Right.

Vivienne Halpern: And the comments are on page six?

Alexis Forman: If you scroll - it depends on how you're looking at it. If you're looking at it in the view of the entire PDF it's on page 13. If you're looking at it, just looking at the draft report document, it starts on page five into page six.

Vivienne Halpern: Okay.

Dr. Arden Morris: And we considered these to be...

Vivienne Halpern: I see the steering committee follow up, just for everybody who's on pick, the bottom of page seven of the draft, which is page 15 of the whole thing. It said there was one of three measures considered for potential harmonization. It said after some discussion the members agreed that because measures 0365 and 0366 are risk adjusted and measure 0738 is not, that

recommended related to harmonization of numerator and denominator should not be advanced at this time.

Dr. David Torchiana: So the thinking there that - was that there would be some value in reporting the measure without risk adjustment or places or programs or institutions that couldn't gather their risk adjustment data.

Dr. Arden Morris: And the reason that they should be - that they - so let's just go over what the arguments are that they should be complementary versus the argument that they should be competing. And we are trying to think broadly here, and we're thinking that this is similar to the triple A measures, but let's just review this.

We thought that they were complementary because there - because we thought that there was data in measuring both the volume, which is actually more predictive of mortality than mortality is. And we thought that we should - that there should be measurement of mortality because we know that mortality is important, and then - and what else?

Dr. Richard Dutton: So - and I'm picking up some of the pieces of this. There's also the issue of separation of benign and malignant.

Dr. Arden Morris: Right.

Dr. Richard Dutton: And I guess in my mind then the answer is that the ARC measures were separated by benign and malignant and separated by volume and mortality, but that the leapfrog measure which aggregated all of these together might still have some utility as an aggregate measure bringing everything together, possibly as a measure that had more ability to discriminate because it had a larger - and I'm sort of grasping at straws here, because if this is administrative data, it shouldn't be a matter of being able to collect the information needed for risk adjustment.

Dr. Arden Morris: I think part of the issue here is that volume tends to be so low with some hospitals doing one every other year, or even fewer than that, that risk adjustment wasn't as meaningful.

Patrick Romano: This is Patrick Romano. Can I say something?

Dr. Arden Morris: Yes.

Dr. David Torchiana: Yes.

Patrick Romano: Yes, so I'm obviously not representing leapfrog. I'm representing AHRQ along with

Patrick Romano: This is Patrick Romano. Can I say something?

Dr. Arden Morris: Yes.

Dr. David Torchiana: Yes.

Patrick Romano: Yes, so I'm obviously not representing leapfrog. I'm representing AHRQ along with John Bott. I'm not sure if anybody else on the call is representing leapfrog. But I think one thing that's important to remind the committee is that the leapfrog measure is collected through a survey of hospitals, in which an external organization such as leapfrog just asks hospitals on an annual basis to report their volume and to report their mortality experience.

So it doesn't actually involve collecting any administrative data. The hospital runs its own internal data to generate the information for leapfrog. But it doesn't require any patient level data to be transmitted to the organization that reports the measure.

So I think that's kind of the fundamental difference. The ARC measure of course does require a user to have an administrative data set based on the clients or hospital reporting to the state government or the federal government. Hopefully that helps.

Dr. Richard Dutton: Yes, it does. Thank you. That was the difference between the data reporting mechanisms that I was trying to get at.

Dr. Arden Morris: Okay.

Dr. Richard Dutton: And I didn't state it well before. But the other question I had for Alexis is the leapfrog measure is already approved, so once again we don't have jurisdiction over it, although we could make a recommendation that it be harmonized or retired later. Is that correct?

Alexis Forman: Yes.

Dr. Arden Morris: Do we have anybody from leapfrog on the line who could talk about the other measure?

(Heidi): I don't think they're on the phone.

Dr. Arden Morris: Okay.

Dr. Richard Dutton: So I think on this - and I think where we're getting to is we think that the ARC measure is a better measure both in terms of how the data is collected and how it's analyzed, and we would recommend that that is the stronger measure, and if the hospital or the institution has the ability, that's what they should report. That leaves the question of whether we think the leapfrog measure should be dropped or whether it should be retained for those hospitals and institutions that that's the only way they can do it.

Dr. Arden Morris: I would argue against that. If we were determining whether or not to keep the leapfrog measure, I would - I am against the possibility that that's the only way that the hospitals would be able to do it, because I would think that basically collecting claims data is a lot more straightforward than responding to a survey.

Dr. David Torchiana: Well, I think it's fair to say that most hospitals who respond to the leapfrog survey use their administrative claim status to deliver the information on it. That's certainly the way my institution does it. But I guess, you know, we've taken now over a quarter of the call on the most straightforward of these themes.

And I don't see any reason not to address the - this theme the way we addressed part A, which is to say that the ARC measures seem to be a superior definition of the issue at hand, and that we recommend that the leapfrog measure be retired when the time arises. I - that would be my position.

Dr. Arden Morris: I agree.

Dr. Richard Dutton: I agree.

Dr. Arden Morris: Yes, I agree with that.

Alexis Forman: Anybody disagree with that? All right. Time to move on. Okay, great. Moving on to theme two, commenters had concerns as far as mainly with the ARC measures and looking at the level of measurement, and it not including clinician level of measurement. And this is some comments that we've been receiving from phases one and two as well.



They're similar comments and similar concerns. So we would like to know - staff would like to know if you're okay with the committee's proposed response, if there's anything that you would like to add or remove from that response, as well as if this issue, since it's becoming an overarching issue, if it should be included in our draft report.

Dr. Arden Morris: I'd like to go first on this. I strongly think it should be included in the draft report, and I do believe it is an overarching issue which will continue to arise, so we need to make sure to keep it on the radar to sort through, and it's not going to be easy.

I would say that quality improvement needs to come both at the systemic level, at the hospital level, and then also at the individual clinician level, but the biggest problem that we have here is that individual clinician measures are not very often meaningful. I think that, you know, if there is particularly, sort of historically if there's a grass roots change in practice, grass roots based change in practice, then quality improvement can certainly occur.

But trying to promote quality improvement through measuring individuals is going to be tricky. Having said that, it can't be ignored. So I think it - I don't think that we're going to resolve within this committee - we're certainly not going to resolve this balance, but I think that we need to pay attention to it. I think bringing it up has value.

Carol Wilhoit: I think the wording in the draft is really quite good in that it talks about where appropriate, because there's a lot of measures where the numbers are just too small to be appropriate at a clinician level. And it also puts in to think about the issues from the particular measure, and I think that's very relevant too. So I really like the way this was worded.

Dr. Arden Morris: I agree.

Dr. Richard Dutton: I agree with Carol and with Arden. I feel very strongly that some of these measures do not have the statistical power to assess the measure at the individual physician level.

Dr. Arden Morris: I agree.

Dr. Richard Dutton: Like pancreatic mortality.

Dr. Arden Morris: Right.

Dr. Richard Dutton: But perhaps we could add another sentence that strongly encourages examination of individual performance within the facility or institution.

Dr. David Torchiana: Yes, and I think the other - the argument which is in many of our discussions when this has come up on individual measures is how much the attribution of an outcome can be fairly laid at the feet of one individual when tens if not hundreds of times have physicians interfaced with the care of a patient through a complex hospitalization.

And it - you know, kind of defining the attending physician on a procedure that's part of a complex hospitalization is not necessarily warranted, so some kind of wording around that as well and the response - I think the three key issues are statistical validity, you know, the fairness of attribution to an individual.

And then the third one is the legitimate consumer desire. Those are the three things that have to be balanced to do this in a reasonable and thoughtful way.

Dr. Arden Morris: And I like what you just said, too, about the fact that - because I think it's - you know, the surgeon's always the captain of the ship, but there are many people who get that patient, and I speak as a vascular surgeon with many sick patients. The post-operative care and all the people

who are involved in the post-operative care can make or break, no matter how technically good the case is.

Female: Well I think consumers probably expect that the surgeon is able to control that and is responsible. I think your last point about consumers looking for something to help them make these decisions is an important one. I mean, somebody has to be responsible for the care of the patient.

Carol Wilhoit: Yes, but you're not - you can't - that's - that is true, and the surgeon is the captain of the ship, but there are things that are out of our control in terms of what happens at any given time, because we are not standing at the bedside 24/7.

Female: That's true.

Carol Wilhoit: I mean, you're not standing at each patient's bedside 24/7. Otherwise you can't see any - you know, you're not taking care of any other patient.

Female: And that's true. But I guess - I'm just reflecting on how difficult it is for a consumer to make a decision and would it not be true that some surgeons would have less complications than others throughout the whole hospital stay, just by the way they manage the patient and manage the - just that whole environment?

Dr. David Torchiana: To a degree though, but there's a lot of literature on this, and I've contributed a little bit of it. You probably don't want the surgeon with zero mortality and zero complications, because the shortest pathway to that is to operate on healthy people. So you actually want a surgeon who is conversant with caring for complex patients. They kind of hit the tip of the pyramid of expertise.

And so the problem with this kind of measurement and the appetite for this kind of measurement is that you know, technically what you're seeking is you're seeking the best surgeon, and what's best for the public, but you're encouraging kind of medical practice that is not necessarily best for the public.

So it's a very, very much a two-edged sword, and in many respects, it's I think limited really as a legitimate discussion by the concept of statistical validity, and so that can be kind of the leading argument against individual procedure - profiling of individual operators. But this other issue is a hugely profound issue, is that the surgeon or actually for that matter, the institution with zero mortality is oftentimes in fact not the best one.

Dr. Richard Dutton: I agree with the point he's making. That's an important point. The outcomes are the result of the whole systems, and trying to attribute them to the individuals, even if we see the individual as the captain of the ship, I think is inappropriate. I think it would be much better to educate the public in the regard that what really matters is the system of care.

Dr. Arden Morris: Well, I guess what I would say is that I think that the system of care probably matters the most, but I think that - this is Arden - the individual surgeons - I think that we all know that the individual makes a difference as well.

That shouldn't be completely ignored, so I think that all of these points are basically encapsulated within the proposed committee response, as Carol pointed out, in the language, and we could make it more explicit to capture more of this discussion.

You know, we could sort of take another run at drafting this to just explain in a little bit more detail exactly what where appropriate and carefully considered really mean.

Carol Wilhoit: One other thing that could be added, and again I like what's there, but is the notion that for accountability purposes, certain things, you know, may make sense reported at facility level. But for quality improvement purposes...

Dr. Arden Morris: Yes.

Carol Wilhoit: ...even a denominator of one, you can look at, at a clinician level, and you know, for quality improvement purposes.

Dr. Arden Morris: I think probably the best way to formulate it in the response is to take that and use it. Sorry for interrupting, Carol.

Carol Wilhoit: No, that's okay. Just - you know, I think that there is that difference between accountability and quality improvement, and a measure could be broken down by clinicians, even with a small denominator for quality improvement.

Dr. Arden Morris: So let's take another stab at the proposed committee response to - not to change it, but just to add a little bit more of the - to expose a little bit more of the underlying thinking.

Alexis Forman: Okay. Will do. We'll then view the updated language for any revisions.

Dr. Arden Morris: Okay.

Alexis Forman: Okay.

Dr. David Torchiana: And if I might just have a quick comment, I think ARC of course would agree with everything that's been said, and I think it's important to really align the locus of measurement with the content and the purpose of the measure, and for all the reasons that you described, we think

of mortality measures as being more appropriately reported at the hospital level, but for example, measures of patient selection for surgery might be more appropriate for reporting at the physician level.

Dr. Arden Morris: That would be a good example to put into the proposed committee response.

Alexis Forman: Okay. Are there any more comments on theme two? Okay, before we go to theme three, the measure developers from ARC, you have to leave the call early, so at this time if there are any other comments or responses for the ARC measures that we did not discuss in themes one and two that the committee would like to pull out for discussion while we do have the developers on the call. We can do so now.

Female: I would like to make a comment about the cap survey, but I don't know if this is a good time, or if it should be later. That's theme four.

Alexis Forman: Yes, that's theme four, and that's an ACS measure, not an ARC measure.

Dr. David Torchiana: We have 20 more minutes, so then I think the discussion should proceed.

Alexis Forman: Okay, theme three is looking at the lack of support for process measures, and these comments were really geared toward measures 128, and measure 529, and there are some concerns as far as the measures, or the committee endorsing process measures instead of looking at the importance of outcome measures.

So the committee did recommend these two process measures because of the performance rates and the current performance rate is below 9%. And the committee felt that these two measures should maintain endorsement until they become topped out and the performance rate has been increased.

Dr. Richard Dutton: This is Rick. I like the proposed committee response. One thing that might add to it is to note that the outcome measure in this question, which might be the development of antibiotic resistance, is very difficult to measure, and relatively low risk and diffuse, so it would be very hard to capture an outcome measure that was patient-specific in this area, whereas we do know the process correlates with that, and there is good evidence supporting the linkage between this process and that outcome.

Alexis Forman: Are there any other comments regarding theme three?

Dr. Arden Morris: There is one other comment that I have that doesn't necessarily need to take up much of our time. For surgical measures, the outcomes are appropriate because we can determine what they are. For other measures, for example, measures of the quality of medical care, processes are more appropriate because those are - those sort of reflect longitudinal care rather than cross-sectional care more. Because we're the surgery steering committee, I don't think we need to necessarily bring that up, but I wanted to see if anybody else thought that it was relevant to talk about where outcome measures versus process measures are more appropriate.

Alexis Forman: Okay.

Dr. Arden Morris: Okay, so let's not do that.

Alexis Forman: Any other comments regarding theme three? Okay. Also, before we move on to theme four, STS, a measure developer, does have to leave early. The only STS measure in these phase two addendum was measure 128. Does any of the committee members have any other comments or want to pull out any comments or responses to comments for that measure before the developer leaves the call?

Okay, I guess we can go on to theme four. Theme four is related to the ex-cap measure, measure 1741, and we did receive several comments regarding the recommendation that the committee made to endorse this measure. We did have comments indicating that they disapproved of the committee's recommendation ((inaudible)).

For this measure we should go by comment instead of looking at the overall theme. We'll just go comment by comment, review the comments that came in as well as the measure developer response and come out with a committee response for each of those comments.

Dr. Arden Morris: Alexis, I just wanted to make one comment, and that is when I read all the different viewpoints on this particular measure, and some of them are from nursing organizations, but there were also some from I think the neurosurgeons and others, I was reflecting, because everybody kind of came at it from a different perspective, and I was reflecting on how we had dealt with some of the earlier discussions we had on for example the STS measures and we had really taken a different position and recommended that rather than prescribing a specific tool that - and I wonder if we couldn't do that for this and then resolve some of the concerns, because the concerns are quite varied.

I wonder if we wouldn't want to consider requiring participation in a patient satisfaction database with broad state, regional, or national representation that provides regular performance reports based on benchmark data. And I just got that language from the language when we addressed the STS, you know, endorsement, and we switched it from saying STS to using this language.

So I guess that seemed to me something just to throw out there that would maybe be an umbrella approach and would be consistent with what we had done in our previous approaches, and not endorsing just one type of a tool.



Carole Wilhoit: Oh, you know, I think that that is actually a very good idea, because with the STS with our response to that STS registry measure, we're moving at it from a division that probably most people just use STS, but some may use others. And that could be the way that we approach the SCAP as well.

Dr. Arden Morris: And most people might use ex caps, but I think this would address - all the comments I thought, this would address it, plus I think it's consistent that we are taking the approach. And so as I said, this language I guess specifically from what we substitute for the STS, except like the second patient satisfaction survey, rather than whatever we said for STS.

So this measure requires participation, a patient satisfaction database with broad state, regional, or national representation that provides regular performance reports based on benchmark data, and that was the language we used before. It was measure 0113 we had used that for.

Carole Wilhoit: Yes, I don't see a downside. Let's think about whether or not - because I think the upside is very clear, but is there any downside to doing this, to saying that?

Dr. Arden Morris: One concern is the use of the word patient satisfaction survey. I think a lot of the questions in CAPS, for example, aren't really satisfaction questions, but they're experience questions, which are a little bit more objective. And granted, it's the patient's perspective, and you might say the patient is right or not right in their perception, but I think the term patient experience survey has real advantages.

Carol Wilhoit: That sounds good.

Dr. David Torchiana: It's the right wording.

Dr. Arden Morris: We could say, you know, in caps, they call it consumer assessments, we could call it patient assessment survey.

Carol Wilhoit: ((inaudible)) whatever. I think that's the whole idea.

(Heidi): So this is Alexis and (Heidi). I'm sorry. I'm not sure that we're tracking your thinking here, so if one of you can perhaps summarize, or maybe a couple for me to see what I think you just said.

Dr. Arden Morris: Christine, are you willing to do that?

Christine Zambricki: Oh, certainly. What I would - after reading all of the - all the comments on this particular issue and this theme, it seemed to me people were coming at it from different perspectives, and people had concerns about it for different reasons.

So I was reflecting on that before this call, and then I remembered that we had, when we had talked about the STS tool, said that we really didn't want to endorse one tool, but rather we wanted to look at the content that we were looking for and leave it up to individual organizations to select what tool would meet their needs.

And so it seems to me that for this SCAP issue, that we could address all the letters that were submitted to us by taking the same approach, and so I went back and looked at measure 0113, which was participation in a systematic database for cardiac surgery, and so I just wrote down that language for this call because I thought it could be appropriate that we would maybe modify this measure to say that the measure required participation in a - and we have to pick the word.

I put patient satisfaction database, but maybe it's consumer assessment database or patient experience database, whatever we feel captures it the best with broad state, regional, or national representation that provides regular performance reports based on benchmark data. That's the

language we used to indicate that the facility can pick a survey, but it has to be state, regional, or national.

It can't just be their own, you know, Joe Smith Hospital Survey. And it has to provide regular performance reports, and it has to give benchmarking data. Those were the criteria that we set before. And then people may choose to use ex caps. They might choose to use Press Ganey. They might choose to use the ACF, or you know, or the neurosurgeons, sounds like they have a tool that probably meets this criteria, national representation regular performance reports. So does that make sense?

Dr. Arden Morris: Well, I see where you're going. I think there are a couple challenges because of in part what you have ((inaudible)) so with the STS measures, the way they have that - the data specified, and I'd have to go back to be sure, 100% sure, but the way it's specified, it could be used by other individuals using different registries or something else.

It was - it had the specificity needed but it was generic enough that you didn't - it didn't require the use of that specific registry. For what we're looking at here with the ex cap, though, that is different because what you have in front of you is the measure scores that are a result of use of that one specific survey tool.

And they don't think that they tested the use of other survey tools like Press Ganey or other - if it's neurosurgery or whatever other ones. I'm concerned that if you use that survey, you would get the same results that would allow comparability, ensure reliability and validity.

So I think - I'm not - I think you could recommend that you'd like to see the measure potentially be expanded to use other tools or that type of thing. But the measure before you right now really only uses ex cap.

Carol Wilhoit: So we would like to do is to ask them to change the measure to include the use of other tools.

Dr. Arden Morris: Right. I agree.

Christine Zambricki: I'm not sure that's such a great idea, and the reason I say that is a couple things.

One is that this survey tool makes a huge difference, and if all you're asking about is, you know, was the room pretty and were the decorations nice and was the food good, does not necessarily get at the items of interest, and I think you know the point is the items that are in it.

Another thing is that in many other arenas, there is one standard survey that's the one that is used for quality purposes. For health plans it's HCAP or it's the health plan version of CAP. For hospitals it's HCAP. There's you know, a number of other areas where there is a standardized survey.

And the other thing is that CAPS is in the public domain, whereas something like the STS database is not in the public domain. And I think that that makes a difference as well.

Joann Sorra: This is Joann Sorra with Westat, and has Jill Shelli been able to get on from ATS? Are you on the speaker line?

Jill Shelli: Yes, I just got in.

Joann Sorra: Okay, great.

Jill Shelli: ((inaudible)).

Joann Sorra: The one thing I do want to say as far as reaching a conclusion that is being proposed, I don't think the comments actually are very - that would lead to that conclusion. The comments are actually fairly easily addressed, and most of them I think the first thing that comes out is that some of the commenters are saying it doesn't apply to their specific specialty.

And CAPS is aware of that, right? The developers are aware of that. The purpose was actually to create a standardized instrument that could be used across specialties, and the way that the CAPS instruments are developed is there's a core set of items that - and the purpose of those items is for standardization and comparing.

And then developers, other individuals can develop supplemental item sets that are specific to areas that are not measured by that core. So on the clinician and group survey, there are a number of different supplemental items that measure health literacy, cultural competency, use of health information technology, so that - because those items aren't specifically in the survey.

So what we - in the response we're saying that we're aware that the survey may not be specific to neurological surgeons, but that's not the purpose, is to develop an instrument that completely captures the dimensions across every specialty, but does get at the core across the specialties.

Dr. Arden Morris: I guess when I hear some of the comments, I - my reaction is I don't think that we would want to conclude that other surveys just ask about curtains and the things that you were saying. I think that there are other legitimate surveys of patient experience that would be equally useful in accomplishing a measure of what the patient satisfaction about that whole result is, of people explaining things to them and seeing them postoperatively. So I guess I don't agree that it's not CAPs, that people are just asking about decorating. I just don't think that's an accurate representation.

Carla Zema: Well - and this is Carla Zema from the CAPS ((inaudible)) as well. I just wanted to comment from the survey development perspective. The survey measures are wholly dependent on the surveys from which they are administered.

So you could not say that this would be a valid measure if you didn't actually use the full survey as it was in the context of the questions that made the measure have to be in the context of the full survey, or else the validity that you were looking at is not the same.

Dr. Arden Morris: I don't think anybody's suggesting using only part of the survey.

Christine Zambricki: I think it's perfectly appropriate that there would be other perhaps patient experience measures that would be appropriate, and then those should be submitted to NQF for review and approval as well.

Dr. Arden Morris: You know what I'd like to do here, Christine, is to back it up a little bit and explain what I thought you were suggesting. Let me just explain what I thought you were suggesting. I thought that you were suggesting comparing to the issue that we had with the measure that required participation in the STS registry.

And the problem that we had with that was that it forced places to pick only the STS registry to - or to - that they would have to belong to the STS registry. And in this situation, this would essentially force institutions to use the SCAP survey, which I think is a perfectly good and valid survey, but it would force the use of that survey to the potentially to the exclusion of another survey, if they only had the resources to use one patient satisfaction or patient assessment survey.

That's where I thought you were coming from, Christine, and that's why this seemed like a good idea to me, because if we're trying to deal with a plethora of specialty groups' issues with this

particular survey that we could say, okay, use a validated survey that you've identified that's used in a regional way instead of this, if that's your choice. But just use a survey. Is that - Christine, is that what you were essentially talking about?

Christine Zambricki: But you said it so much better than I did. Thank you. I'm sure that everybody understands this better now. But I think that what we're after here is not forcing actually the use of the SCAP survey, which I think is a perfectly good survey.

And part of the way that we were thinking about this analogously in terms of the registries is that at some point we all talked about how we anticipate that at some point, everybody really will be participating in the same registry, but that we're not at that point right now.

And then I think it's certainly quite likely that at some point everybody will - really will be participating, using the same patient assessment survey as well so that we will be able to compare across specialties, across institutions, or even across regions, but that it's not clear that we're at that point right now based on the many responses to our approval of SCAPs.

I think part of the problem is, as indicated by many of the comments, is that each specialty has a little bit different flavor that they need to assess in their patients' satisfaction. And that's I think what the concern of all the specialties are, so it maybe need to be, like you said, a survey that we don't have yet that you can extract what data you need for your specialty, or potentially this survey, when everybody has accepted the fact that we're going to be using a patient satisfaction survey. But Carol, I'd really like to hear what you have to say as well in response to what I just laid out.

Carol Wilhoit: Well, it seems like - I mean, the whole - this whole committee has been looking at specific measures. There's a lot of measures out there that nobody's submitted to NQF and weren't reviewed. What we're looking at is with individual measures, whether they're ARC measures or

STS measures or whoever the developer is, we've looked at specific measures and said we think this measure should be approved.

We think this measure should be changed a little and then we'll think about approving it. We think this measure shouldn't be approved. When we're looking at specific measures with specific specifications and either approving, requesting modification, or disapproving, basically, and so the notion of saying we think everybody should use a survey - you know, it's a nice notion, and there's probably nothing wrong with it.

But that's not really a measure to endorse. I think what we're looking at here are specific - a specific survey with - that's looking at specific things, and saying we approve it, we think it should be modified, or we don't approve it and saying we think everybody should do a survey doesn't really get at what we're doing with the measure.

And I think as I said before, I think CAPS is a bit different for a number of reasons than STS, not that it's the only survey method. There may not be other good surveys, but then they should come through the endorsement process, and if there's a sense that they're better, then you go through the, you know, competing measures and you know, process them and so on and so forth. But at this point, this is the one we're looking at.

Joann Sorra: And this is Joann Sorra from Westat again, and if we're looking at a patient experience survey for surgical patients, then any survey will have the same limitation that you're identifying about the SCAPs that...

Dr. Arden Morris: Actually, it's the people who wrote in comments that were identifying surveys. What I'd like to do is to have the committee discuss this first and then what I'd like to do is to ask you for questions and comments second from the developers.



Joann Sorra: Okay.

Dr. Arden Morris: I'm sorry to interrupt you like that, but I want to make sure that the committee has an opportunity to speak and think through this together. Christine, do you have any particular response to Carol's comments?

Christine Zambricki: I do. You know, I was reflecting on what Carol said about having the other survey developers have to present their surveys and have them validated and have the NQF committee look at their questions. And we really didn't do that when we proposed an alternative to STS. As I recall there was a, like a Northeastern consortium or some type of...

Male: Northern New England.

Christine Zambricki: Northern New England, and we didn't say, well, now they have to come in. Otherwise we're not going to allow people to use their survey. We set criteria that it had to be state, regional, or nationwide; it had to provide benchmarking data, and it had to provide regular reports. So we really did not get into the weeds with other surveys. And so I'm just trying to be consistent when I look at how we dealt with these issues before.

Dr. Arden Morris: What we were looking at there was a particular measure, and I don't remember which exact one it was, but a mortality rate or a volume rate...

Carol Wilhoit: No, no. It wasn't. It was use of the registry. It was belonging to a registry.

Christine Zambricki: Okay, you're right. That one was. Okay.

Carol Wilhoit: Yes.

Dr. Arden Morris: So that does make it a different kind of a measure than the very specific measures that we also assess. David, what are your thoughts about this?

Dr. David Torchiana: You know, I think this is a - it's an interesting and I think potentially fruitful response to what is otherwise obviously a bit of a contentious question given the input that we received. I mean, most of the input that we received as I read it was to reject the measure as being too narrowly conceived or not something that the various constituencies felt was an accurate - you know, an accurate way to look at the activities that it's purported to.

So it does seem to me that this is I think the analogy to the decision to, you know, approve a registry as opposed to approving registries that meet certain criteria. I think that analogy is pretty well done, so if you ask me to kind of vote at this moment, that would be my leading response, because I think it neither denies the - you know, the value and the validity of the SCAPs survey, nor does it endorse it. It simply endorses the validity of doing such a survey on surgical patients. And I think that might be the right place to come out.

Dr. Arden Morris: What if we ask for the measure developers to reword the measure to include participation in a patient assessment survey that was both validated and also in the public domain as SCAPs is?

(Heidi): So - and this is (Heidi) - just from a staff perspective...

Dr. Arden Morris: Is that too much? Yes.

(Heidi): ...I think that is beyond the scope of what you can do.

Dr. Arden Morris: Okay.

(Heidi): I mean, what you're looking at, at this point in time is a measure that is specified using that survey. If they come forward and say that they've identified other surveys that they've tested and found that they, you know, yield comparable results and they are indeed...

Dr. Arden Morris: That's not what I'm suggesting. I'm suggesting that if they rework the language in their measure, how would we feel about including in that language that any other surveys in the measure that they're proposing, that they say that any other surveys that hospitals or institutions would participate in would also be validated and in the public domain.

I'm not suggesting that people who put together SCAPs go out and find other surveys, potentially competing surveys, and study them, validate them, etcetera. I think that would be totally inappropriate to ask of them, but if we're asking for them to rework the language of the measure, then I'm thinking that it may be valuable to have that in the new language of the measure. We did this - (Heidi), I'm not sure if you were involved in that or not when we did this with a STS measure.

(Heidi): Yes, I do, and I guess I from my perspective, I see - I do see that registry piece being different than what we're talking about here, because that - this is actually yielding not just - it's not a yes/no structural measure, which that other measure was, from what I remember. But this one is talking more - the actual results out of the survey.

And so when this goes to say feedback and then the board, the question that will come up - and I mean, the SCAP folks will have to be okay with making the changes anyway - but widening the door and not showing what tools could actually, and surveys could actually demonstrate that will raise some concerns, because what is in fact before you at least shows what they've identified using that one survey, and if you widen it and say there's others, the question always becomes, well, how do you know which ones are actually okay unless they've tested it.

And that's where I'm struggling. I'm not sure how you would do that now. It's something they could do potentially in the future. I'm just not sure if they could do it now.

Dr. Arden Morris: So what you're saying is that if you just make it a general statement, how do - and NQF is endorsing it, do you really know that these other surveys have been validated and are in the public domain.

(Heidi): You got it. That's it. Yes.

Christine Zambricki: Also looking at the specifications for 1741, there are seven specific measures, and you know, with - many of the measures are composites of more than one item, so it's a very - it's not just participation in a registry that's measure 1741 is describing. It's describing particular indicators with data collected in a particular way.

I guess I would propose that other surveys exist that describe patient experience with information to help you prepare for surgery, how well the surgeon communicated with you, surgeon's attentiveness. These are not wholly owned questions by SCAPs, and they are common questions that are asked of patients when asking about their peri-operative experience.

So the measure could even if we wanted to say the survey answer must include information about how well the surgeon communicated with patients after surgery. Or it could be as simple as just saying that it has to address communication - surgeon communication. This is really our first foray into this domain, and I think it's really important to do it in a way that people embrace it and that we are able to get meaningful results.

Dr. Richard Dutton: This is Rick. I'll support Christine's idea here. The problem is we want to be in this domain, I agree. We want to suggest that measuring patient experience is important. It's obviously something the public values. It would be great to have an endorsed measure in this

area. But if we - as all of the comments illustrate, if we do it with too narrow a measure, that's not valid for different populations, then we're shooting ourselves in the foot.

Dr. Arden Morris: Any other comments from the committee?

Christine Zambricki: So I think then we have to decide if it's - I think it would be bad to completely reject this measure, but is there a way that it can be - like, somebody was - I think Arden, you were saying earlier, can it be reworded in such a way to be more inclusive of other surveys by asking them to sort of have this same kind of requirements as this one does.

Dr. Arden Morris: Well it's like (Heidi) was saying that we can't really do that, that we can't really ask them to reword the measure they've proposed. I also would like to give the measure developers an opportunity to respond to any other comments that we have, if there are any additional - to these comments and any additional comments that we have.

(Bob Jasek): Joann and Carla, this is (Bob) from the ACS, so I'll go first and then I can turn it over to you guys if you want.

Dr. Arden Morris: Before you proceed, anybody else on the committee that would like to bring up any new thoughts with regard to this?

Howard Barnebey: Hi, this is Howard. I do have a question. Am I understanding this correctly that the questionnaire, the survey, needs to be taken in a complete context the way it was developed, and that no particular one question can be changed or deleted?

Dr. Arden Morris: Yes, it's validated as it stands.

Howard Barnebey: Okay, so it kind of is intact as a whole item and not...

Dr. Arden Morris: That's right.

Howard Barnebey: Okay.

Dr. Arden Morris: All right. Anybody else before we proceed to letting the measure developers speak?

Christine Zambricki: Yes, this is Christine. I just wanted to mention one thing that we haven't talked about that we may want to have some discussion on is the concept of the percent of responses. And as I recall at our committee meeting we had concerns about that expectation, and some of that came out in the comments. So just to put in the parking lot, I think that as part of this whole discussion we want to have some conversation about that.

Dr. Arden Morris: Okay. Yes, I think that's an important point. (Bob), did you want to go first?

(Bob Jasek): Yes, this is (Bob Jasek) with the college of surgeons, and I just wanted to touch on a couple points, and the first one was, you know, and part of this is incumbent on us getting it in front of you, but that this was submitted by the ACS in conjunction with the surgical quality alliance. And everybody except - within the surgical quality alliance, all the surgical specialties within the alliance except for the neurosurgeons are supportive of this and were involved in the development.

That's something that we need to get to you so that you have that, but in terms of the concern about the specialties and the application to it, it's isolated to the comment that you've received, at least as far as the groups in the surgical quality alliance go.

The other part is going back to I think part of what (Heidi) was mentioning, and I think on our end, it's a little - it's a little confusing to us what our role would be at that point, because part of what

I'm hearing is changing this from a specific measure into a structural measure. If that were to be the case, I'm not sure that we'd be the appropriate steward, even if we were willing to change the submission. And so that part is - I'm sort of getting tripped up on that trying to figure out how to process this.

Dr. Arden Morris: Are there other comments from the developer?

Carla Zema: This is Carla. I just wanted to echo what (Bob) said. I think you're talking about two very different measures. One is a structural measure of using or implementing a patient experience survey. In that case then I think you could say that there are lots of patient experience surveys that are out there for - you know, let this - for me to say not differentiate between proprietary and public domain that could in essence be the equivalent of the STS do you participate in a registry.

And any would be the equivalent of participating in STS. However, this is a specific patient - set of patient experience measures that are based on the CAP surgical survey. So if the goal of this measure is to get comparable results in information to help you prepare for your surgery for example, the only way that you can get comparable results is if you start with the same standardized instrument, and that was the purpose of this measure.

And I would add that the pilot test was done with nine different surgical specialties, and again reiterate the point of the different specialties that were involved in the development.

Dr. Arden Morris: Maybe - because some of the comments - a lot of comments seem to be based on how things are - I don't even know how to say this, because you know, they like - it's like somebody was fixating on the use of anesthesiologist instead of anesthesia team. So...

Christine Zambricki: You mean one of the commenters?

Dr. Arden Morris: Yes.

Alexis Forman: This is Alexis. Would it help to go to the individual comments, and after reviewing those comments, make a committee decision on how to proceed with this measure?

Dr. Arden Morris: Sure. I think that that - you know, that was our original plan, so I think that's not a bad idea. Can you lead us through those comments?

Alexis Forman: Sure. Does everyone have the Excel comment table?

Dr. Arden Morris: Yes.

Alexis Forman: Okay. So the first comment is 278, and this comment is from (Aheb) and (Aheb) generally supported the measure, but they did recommend additional testing on reliability and validity. And we do have the ATS measure developer response, which indicates that they will continue to revise and update the measure.

This comment along with the next comment, ID 2088, does get into some concerns about the validity testing, so I think maybe we should take a moment to discuss that. The measure developer did respond to the validity testing concern, and I don't know if they want to go in more detail to provide the committee some more intellect about their validity testing.

Carla Zema: This is Carla. I think that we interpreted this as being again a more of a broader framework for how the measure was designed in terms of this was not intended to get at every nuance of every different subspecialty, and so I understand where that comment was coming from.

The approach that this measure takes is that we are going to measure aspects of surgical care that can be measured and compared equivalently across all different types of surgical care, so in



terms of communication before your surgery, that's something that is applicable regardless of your surgery subspecialty, so the approach is that you start with what is common across surgical care and then you add supplemental items to drill down into things that are specific to the subspecialty.

Dr. Arden Morris: It sounds to me like some of these people are concerned about how this is going to be used and reported in terms of how patients view a specific surgeon or hospital or whatever, experience.

Christine Zambricki: Are you talking about for example, are you talking about a specific comment or this comment?

Dr. Arden Morris: Well, the neurosurgery comment about like, you know, doesn't really apply and where was this? I think I just skipped past this. Comment 2080, yes. They mentioned concerns that patient satisfaction measure had not been validated with any other process or clinical outcomes measures.

That's because nobody measures patient satisfaction, even though patient-centeredness is an established outcome. It just doesn't get attention. So this is something new. And of course there won't be many related outcomes that have been linked to it.

Female: Patient experience has been shown to be its own distinct aspect of quality, so...

Dr. Arden Morris: Yes, no arguments. So I think that neurosurgery concerns are basically - I could almost summarize it as we don't like this new thing because it's not traditional, that is, it's not linked to established outcomes. And even though patient-centeredness or patient experience is an institute of medicine, established outcome, it just hasn't been - it hasn't been widely measured.

(Heidi): Did neurosurgery - it looks like they have their own quality outcomes database, and 2QOD, I thought that was perhaps another one of their...

Carla Zema: ((inaudible)) participation and SCAPs may decrease the proportion of patients participating in their survey.

Dr. Arden Morris: Well, Carla, I think, and it's brought up actually by the hospital - there was the one from hospitals, and one from nurse anesthetists that looked like also that said this similar concern. And so if you keep throwing a million patient satisfaction surveys at the patients, it's going to decrease what they want to look at too.

So I think you know, we all agree that we should have something that encourages people to look at their patients' status - you know, survey - you know, their patient experience and how the patients feel they're being - what their perception of care is. There's no doubt about that. But the question - you know, I guess we have to just decide, is making CAPS - it's the same discussion that we keep coming back to, is do we choose a winner.

(Heidi): The question before the committee whether this is the best surgical patient experience survey, or whether this one meets the criteria for being reliable and having evidence, so I guess I'm wondering what the question is before the committee.

Christine Zambricki: Well, we have...

Dr. Richard Dutton: My take on that would be that this was a subjective topic. The very notion of patient-centeredness means that no survey will ever be valid or specific for everybody. So I think we are on the broader concept here, but that might also lead us to conclude that we need a broader vendor, rather than a specific product.

Dr. Arden Morris: I think the concern is of these other societies is that if you choose a winner, then everybody's forced - they feel like they may be forced into using a specific one, or dilute their own surveys that may be more helpful to them in improving their patient satisfaction.

Dr. Richard Dutton: Yes, I talked to a lot of anesthesia practices now that are feeling very constrained by these surgical CAP things. Like their hospital tells them you have to do this. You can't use any other mechanism for measuring patients' satisfaction. And the fact that this isn't very specific for the anesthesia is a problem, and the - so it's the specificity of CAPS is what most of the commenters are objecting to, and that's what I think I'd like to see us get around.

(Bob Jasek): This is (Bob) from the ACS too, just to pull the history into it, if we back up though, that's one of the reasons that this was created, because otherwise the CAPS survey that's out there that's NQF endorsed that stands as the clinician and group survey, and that didn't - and we found that that didn't apply to surgical practices, so this was an attempt to find that broad-based standardized survey that would apply more directly to the surgical practices, because if not the clinician and group was the only thing out there.

Christine Zambricki: What is exactly the title of your - I'm trying to find the exact title.

Dr. Arden Morris: Of the measure?

Christine Zambricki: Yes. Where is that title?

Carla Zema: Patient experience...

Dr. Arden Morris: The measure is Patient Experience with Surgical Care Based on the Consumer Effects on Health Care Providers, CAPS Surgical Care Survey. So I think it - the measure could just be patient experience with surgical care based on consumer assessment.

I mean, I've listened to the conversation and I'm still feeling like this measure is not quite right, and there's a lot of reasons, one being that it's requiring one particular survey, and when you look at the survey questions, it's really a lot of question to get at whether the patient felt that their health care provider was supportive and communicating.

And then there's the issue about the actual logistics of it that we talked about, that people are concerned about, especially for small practices or subspecialty practices, getting these numbers and this response rate and then the follow up. I'm just concerned that for a first step into patient experience, that this might not be quite where it needs to be.

(Heidi): I'm liking the idea of introducing this. I think this is a really important domain to measure, and maybe it is a first step to do more of a participation in a consumer assessment survey of health care providers, and I guess I keep going back to the language we've used before, statewide, regionwide, nationwide.

Those are not going to be Mickey Mouse instruments. There's going to be benchmark. They're going to have frequent reports, and maybe that's our first step so the patients can see, do their surgeons participate in some type of patient satisfaction survey. They could ask to see their results.

Dr. Arden Morris: So it sounds like what you're suggesting is instead of having it be patient experience, but - to make it more like what the STS was participation in a patient experience survey, or you know, participating in collecting data on a patient experience, whatever. I don't know exactly how to word it.

Female: Right. ((inaudible)) and health - consumer assessment of health care providers.

Dr. Arden Morris: Right. But if the measure developers are not interested in changing - and that does to an extent change the spirit of this measure. And if they're not interested in shepherding this or stewarding this measure with the change in the spirit of the measure, then we're a little bit stuck. We voted to approve the measure and it - maybe we should have another vote.

(Heidi): This is (Heidi). I think I'm - I think that's probably the best solution, because it sounds like you all need to just revisit and sit back and think, does this measure as it currently stands before you, because that's based on what I'm hearing from college of surgeons ((inaudible)), what's in front of you - does it continue to meet the criteria, and we'll provide all that information and then you continue - do you want to continue to recommend this measure. It sounds like you might need to revisit that, unless people disagree with that, but...

Christine Zambricki: Okay.

Dr. Arden Morris: I agree that we should revote. You know, we've been discussing this for some time. It brought up a few new concerns, or more deeply explored some of the concerns, and also brought up some of the old concerns.

Christine Zambricki: I think part of the problem is we didn't anticipate such a negative response.

Dr. Arden Morris: Right, such a - so many comments.

Christine Zambricki: Yes.

Dr. Arden Morris: You know, I think...

(Heidi): Also - this is (Heidi). I mean, seeing a lot of the other responses on these types of measures that are somewhat new, I mean, there's a lot of CAPS measures within the NQF portfolio now. This is actually not unusual, the way the response is, if that's helpful. I'll just let you know.

Dr. Arden Morris: All right, well my sense is that we should - in some ways, we're not going to be able to resolve some of these problems like the developers proposing the measure are not interested in changing the measure, they've said. We're - we are to some extent picking a winner, because there is some competition for patient time.

There is this, you know, burden to the patients in terms of filling out surveys is real, and it's very likely that this will decrease that proportion of patients participating in every single survey that comes their way, if we add more surveys to it.

On the other hand, the whole committee is excited about the idea of paying attention to patient experience, and using this as a quality improvement tool. What other - we mentioned that there's a bunch of surveys out there. Is it - there are already NQF approved. Do we have access to those to see how they compare?

(Heidi): Sure. I - we can send it to you. I mean, the current set of CAPS surveys, I think almost all of them are endorsed. So it's the hospital CAPS, HCAPS, CG Clinician Group CAPS, nursing home. There's one for dialysis facilities. I can't remember if that one's CAPS or different. We can send that to you if that's helpful. We're happy to.

Dr. Arden Morris: Yes, I think particularly the hospital one, because they were one of the people who raised the concern that if there's this one also, that they will have less of a response on the patient's hospital experience.

(Heidi): Yes, we'll send you the information on that.

Dr. David Torchiana: And then the idea would be to send out another vote?

Dr. Arden Morris: Yes.

(Crosstalk)

Dr. Arden Morris: ...how that evolves on the hospital pass side. There was a concern that by having hospital CAPS endorsed and by CMS basically sort of mandating it that it would obviate the proprietary questions that other survey vendors had been administering for many years, and basically what happens is they administer the hospital CAPS and then they also administer their proprietary questions alongside. Again, the supplemental items concept.

Christine Zambricki: Well, I am saying is, do they become competing measures, then? If you have a patient going through surgery and you're presenting them with two different surveys...

Dr. Arden Morris: They're integrated. The surveys tend to be integrated so they can...

(Crosstalk)

Dr. Arden Morris: I think your question is, are you pulling from the same sampling frame, and the answer is no because the surgical care survey is an ambulatory based survey, so the sampling frame is based on ambulatory visits. So it's - we don't even consider it a facility survey. It doesn't get sampled like HCAPS does.

Christine Zambricki: So you would expect all surgeons throughout the country to do this in their office?

Dr. Arden Morris: No. It is administered by mail, telephone, email, with mixed mode with email follow-up.

Christine Zambricki: Who does it?

Dr. Arden Morris: I think what I'm hearing is that the process or how this measure will be implemented is where all the questions are.

Christine Zambricki: Yes.

Dr. Arden Morris: And from an ARC perspective, from a CAPS consortium perspective, we get these types of questions all the time. But we don't - we're responsible for developing the survey. We don't implement the survey. We don't require the survey. So for example, we just worked with NCQA to develop the patient-centered medical home version of the CAPS survey, very similar questions.

They have chosen to implement it, so there are lots of different ways that you can implement it if you're seeking NCQA, you know, certification as a medical home. You can choose to use the survey; you can choose not to use the survey, but that's the survey answer decisions. And we see that as separate from is this a valid measure of patient experience. So we don't really get involved in the - in how the survey will be implemented.

Christine Zambricki: But I think that's the concern. If you - if NQF endorses this measure, the expectation is that people will have to implement it, and what the concerns that seem to be raised by these other societies is, if we're forced to implement this one, will that dilute our ability to tell us how we're really doing in terms of our specific specialty, and what is the time - you know, will it take away from, you know - patients - I mean, I'm in the VA system, and I can tell you that they very tightly control surveys because patients don't want to get a hundred surveys either.



Dr. Arden Morris: Absolutely. That - I completely understand that concern, and I would just say that our - what we see happening is absent you having something like this survey is you might have survey sponsors that are just going to say we have to use the clinician group because it's the best - you know, it's the closest thing that you can use.

Christine Zambricki: Right.

Dr. Arden Morris: And so the surgeons said that they would rather have something that's at least more specific to surgery than have - than be forced to use the clinician in group one because it's endorsed.

Dr. Richard Dutton: Well, that's great for the surgeons, but I'm hearing from a lot of anesthesia practices that are told by their institutions, no you can't do a survey about anesthesia experience because our patients are getting too many surveys. And yet they need something that actually gives them some information.

Dr. Arden Morris: So what you're hearing is that there are more than one aspect to these surgical satisfactions.

Christine Zambricki: Oh, absolutely. Absolutely, and that's not what this is - survey is intended to do, so we know and we recognize that this is not a survey to evaluate the anesthesia team, or you can get very high level information about the anesthesia process, but our - the way that this survey was developed, the patients can't tell you who - you know, what part of the - you know, specifically what that person's role was on the team.

They just see it as anesthesiology, and they recognize the term anesthesiologist, but they don't equate that to be what we consider anesthesiologists. And so I absolutely agree with you that that's going to continue to be a problem from the anesthesiologists' perspective, because patients

can't - we would say that that may not be the - they may not be the best and reliable source of information if you want to measure a focal anesthesiologist.

Jill Shelli: And I think we should go back to the idea that we need to rethink this and kind of get all the information together.

Christine Zambricki: I would support that.

Jill Shelli: And one other question was on the last call, there was some reference to a patient experience call for measures, and there was some suggestion even last time about perhaps placing this survey in that larger call. I don't know if that's still something that NQF is planning, or whether that would be a consideration in the context of a patient experience call for measures. Other developers of surgical instruments could submit theirs as well.

Dr. Arden Morris: (Heidi), do you have any response to that?

(Heidi): So we do have a project on patient experience and engagement coming forward where there will be an open call. So anyone who has a measure that would be applicable is welcome and actually encouraged to submit. I think you have this CAP measure in front of you now, and as it won't hold together then information, and then I think it goes out for vote and we determine next CAPS after that, if I understood everything Jill said.

Jill Shelli: And would that exclude ACS from submitting it to a larger call for patient experience measures?

(Heidi): So Jill, your measure's still in play here, so I would - I think we need to see how the committee feels and then we'll go from there. But we'll pull everything together for them. They'll revote it, and then it should go through the rest of the endorsement process and then we'll figure out the rest.

So based on this I think the committee's not yet decided. They need to get a little more information and then they'll make their decision.

Jill Shelli: Okay and just so - the one concern that if it's not endorsed, if it's endorsed or not endorsed, I'm assuming decision. If it's not endorsed, just wondering whether that means it will - that makes it not possible to become endorsed under a different call or something like that.

(Heidi): Jill I would suggest we take that conversation offline and let's figure that out when we get there, if we do. Okay?

Jill Shelli: Thank you.

(Heidi): Yes. Arden or David?

Dr. Arden Morris: Once we get it, it'll go out for a vote. I'm not sure if you want to - if there's anything else or if there's anyone on the...

Jill Shelli: What I'd like to ask you is when you say put everything together, can you tell me, are you talking about putting together the comments and response to the previously endorsed measures, and also the committee response and measure developer response so that we can review basically how these same issues were handled previously? Is that what you're thinking?

(Heidi): Yes, we'll try to pull that together. What we can do at a minimum is the last time that the CAPS and several of the CAPS measures went through review, we'll try to pull that report and get you that summary.

Jill Shelli: Okay.

(Heidi): And perhaps we'll pull another, if we've got a form that's recent that would be helpful, we can pull that for you. But if nothing else we'll give you a summary of this discussion. We'll pull together what we can from previous reports and then again, we'll pull together at least the list of the measures. If nothing else, you'll have that as well.

Jill Shelli: Okay. In that situation then would we do an electronic vote?

(Heidi): Yes, we'll have you do a vote by Survey Monkey, yes.

Jill Shelli: Okay. I think that sounds good. We haven't said too many favorable things about this particular measure, but it's - I think it's important to pay attention to the fact that it was developed by a large variety of surgery subspecialties within SQA, that a tremendous amount of thought went into it, and they were working hard to get that common - the commonalities in the experience of surgical care to be part of this - to encompass this particular survey, and in addition that it has been validated. All of those things are really, really hard to achieve.

So I think it's important for us to keep that in mind, and also the fact that even though everybody agrees, that the patient's individual experience is very important. It gets very little attention, because it's so hard to measure, and that's what this survey attempts to do, so we're trying to promote doing something that everybody agrees is important, but it's essentially somewhat new because it's so complicated.

But I think it's also important to say that we - I think the survey is good, but we have to - you know, it would be good if we could find a way to make it - more people buy into the whole concept.

Dr. Arden Morris: I agree with you. I think that we have a problem, though, because we know what surgery subspecialists are like because we are them...

Jill Shelli: Yes.

Dr. Arden Morris: And it's a tremendous number of different societies came together for making this, so even though every single society doesn't necessarily buy in, it was a very broad effort. I just want to make sure that we put out there, that everybody kind of keeps that in mind as well.

Okay, are there any other measures that we need to talk about revoting on? Alexis, you, David, and I had talked about whether or not we wanted to revote, and we discussed that with regard to this measure.

Christine Zambricki: I'm sorry. I was going to say, do we need to talk about it with regard to any other measures? My perception is now.

Alexis Forman: Yes, my perception is no as well, but we can ask the entire committee if there are any other measures that they would like additional information on, or they would like to revote.

Dr. Arden Morris: Okay.

Alexis Forman: I guess that's a no.

Dr. Arden Morris: Yes.

Alexis Forman: Okay. So we've gone over the four major themes, and at this time before we go to public and member comment, this is the opportunity for the committee to pull out any other measures that they felt weren't discussed under the four major themes or any other comments or responses that weren't discussed out of those four themes.

Christine Zambricki: Hello?

Alexis Forman: Yes?

Christine Zambricki: Sorry, it's Christine. I got cut off somehow and I just got back in.

Alexis Forman: Oh, okay.

Christine Zambricki: I wasn't sure if the call was still going, it was so quiet.

Alexis Forman: So Drs. Torchiana and Morris, it doesn't look there are any other measures that the committee would like to pull for discussion. So I think we can now move to NQF member and public comment, if that's okay with you.

Dr. Richard Dutton: If I could just make a comment, I'd like to compliment you for organizing this in this way. I thought it made for a much more coherent discussion than trying to do it sort of one item at a time, so I think that was a very good way of cleaning a lot of material up and wrapping this up. So I just wanted to say thanks.

Dr. David Torchiana: I think we're ready to open it up to the public. I think that's great.

Alexis Forman: Yes, (Jim), it's - you can give us the details on how the public and members can now question or have any comments or any questions for the committee.

Operator: Certainly. That is star one for the phone audience if you'd like to ask a question or make a comment. Again, that is star one. Again that is star one and again for our hosts who are on an open line, you do not need to press star one. Again, for only those who are muted, that is star one.

Jill Shelli: Hi, this is Jill Shelli from the American College of Surgeons. Can I go ahead and comment? I don't know if there's a queue.

Dr. David Torchiana: Please go ahead.

Jill Shelli: Okay, this is in regards to measure 529, prophylactic antibiotics if continued within 24 hours after surgery, and I just wanted to submit a comment on behalf of our fellows. They believe the measure needs clarity about when prophylaxis shifts to empiric therapy.

And this is - within the exclusions on their exclusions for patients who have pre-op infections, patients who started on antibiotics prior to surgery, as well as patients who have reason to extend antibiotics. However, there is nothing that deals with when contamination is discovered during surgery. So I just wanted to communicate on behalf of the ACS fellows.

Dr. David Torchiana: So is there data that could be brought to bear on that question? Does the ACS intend to bring data forward that demonstrates that that's a situation in which discontinuation of - discontinuing antibiotics is appropriately done at a different interval? I would guess if data were brought forward, it would kind of make the case for that, that that would be a reasonable exception. But is there any such case to be made?

Jill Shelli: I think that if you find contamination, particularly in certain operations, like let's say you're doing an open triple A and there's lots of adhesions and you know, you get a little spillage of small mil, I don't think any - you know, the question - I don't think there is specific data out there as to when to stop that, but you might feel uncomfortable, you know.

Dr. David Torchiana: Yes, I guess the range - that would be a good range of severe contamination. I guess if your medical student's sleeve brushes against the eyeglasses of the second assistant,

whether that justifies continuation of antibiotics in the same way - it just seems like something that would require a little more definition than just the word contamination.

Jill Shelli: Okay. I can work on getting something back to the committee. I also - I don't know if the developer could provide any information on what the rationale was for not excluding patients. That's another question I guess we could raise.

Dr. David Torchiana: We should try to figure that out.

Jill Shelli: Yes, okay.

Dr. Arden Morris: May be that they didn't think about it.

Dr. David Torchiana: That's a very good possibility.

Dr. Arden Morris: Yes.

Operator: And as a reminder to the phone lines, that is star one if you'd like to ask a question or make a comment. And it appears there are no question or comments from the phone audience at this time.

Alexis Forman: Okay, thank you, (Jim). So moving along, next steps. (Heidi) and I and Jessica will prepare additional materials for the SCAPS measure, and we'll get that out to you as soon as we possibly can to provide you with guidance.

When you do revote on the measures, we will also be preparing for NQF member voting, which is scheduled to launch no later than March 15th, and if it does open to ((inaudible)) we'll definitely



let the committee know, and we will revise the committee responses to the comments and then send that out to the committee for final review.

And just a last note, this should be the committee's last conference call. And NQF staff, we greatly appreciate your continued participation. I know this project started back in September 2010, and it's - it was unfortunately extended a little bit. We appreciate you continuing to participate on these calls and continuing to review the measures and do your role. So we greatly appreciate that.

Dr. Arden Morris: We're almost done.

Christine Zambricki: Alexis, this is Christine. I was wondering, there is a comment while we were discussing that patient satisfaction measure about the logistics of conducting the work and who would do it and how it would go. I wonder if somehow in the materials you've sent out to us, if we could address that in some way, just get a better idea, just refresh our minds as to the number of surveys, what percent have to have a response, and kind of where they would come from, who would do it and what form it would be, if that's possible.

Alexis Forman: Sure. And I think some of that information is currently in the measure submission form. We'll make sure you have...

Christine Zambricki: Yes, I think it was in the original materials. I think we talked about it at our committee meetings.

Alexis Forman: Yes. So we'll make sure you have that information again. Are there any other questions from the committee or concerns or comments? Okay, Drs. Torchiana and Morris, did you have any closing remarks?

Dr. Arden Morris: I'd just like to thank the committee for providing really genuine and careful thought to - and discussion to each of these measures. I think it's - you know, it's been a lot of work. We've really - in some ways it may seem from time to time that we've gone in some circles, but I think that ultimately, that we really tried to work through each of these in a careful way. So I want to thank everybody for that, for what they've done for the committee.

Dr. David Torchiana: Yes, because I think this is a terrific group, really nice to get to have known you, albeit mostly over the phone.

Dr. Arden Morris: Yes.

Dr. David Torchiana: It's a very valuable experience for me.

Dr. Arden Morris: Me as well.

Male: As the medical student whose eyeglasses brushed Dr. Torchiana's sleeve 25 years ago, I want to thank you and Arden for your leadership.

Christine Zambricki: Yes, really. Thank you for being good leaders.

Dr. Arden Morris: All right. Thanks very much. I think that's it then.

Alexis Forman: Yes.

Dr. David Torchiana: Bye-bye, now.

Operator: Thank you. That will conclude today's conference. We thank you for your participation.

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