NATIONAL QUALITY FORUM
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Meeting Summary

Surgery Standing Committee – Topical Web Meeting

During the spring 2021 cycle, no measures were submitted for the Surgery Standing Committee to evaluate. Therefore, National Quality Forum (NQF) convened the Surgery Standing Committee for a topical web meeting on August 11, 2021.

Welcome, Introductions, and Review of Meeting Objectives

Amy Moyer, NQF senior director, welcomed the Surgery Standing Committee and participants to the web meeting. Alex Sox-Harris, PhD, MS, Surgery Standing Committee co-chair, provided welcoming remarks. Ms. Moyer reviewed the meeting objectives and conducted the Standing Committee roll call. The purpose of this topical web meeting was to discuss gaps in surgery performance measurement and to review and discuss the current state of social risk adjustment in performance measurement.

Measure Gap Discussion

Ms. Moyer began the discussion by noting that an extended portfolio of Surgery measures (i.e., all measures related to surgery across all NQF portfolios) was included in the meeting slides and posted as a spreadsheet on the project website. Ms. Moyer initiated the discussion by prompting the Standing Committee to suggest aspects of surgical care that are important contributors to high quality care and to think about how these aspects of care might be measured. Dr. Sox-Harris emphasized the importance of this discussion, noting that the Standing Committee brings expertise and a multistakeholder perspective that could encourage the development of measures to fill identified gaps.

A Standing Committee member indicated that patients desire a coordinated process and communication both before and after surgery. They emphasized that this process should include the primary care team. Another Standing Committee member agreed and noted that pre-surgical considerations are different for elective and emergent surgery. This Standing Committee member also recommended considering a whole new measurement area of preparation for surgery and optimizing the pre-surgical patient condition in order to reduce adverse outcomes and disparities and not merely clearance for surgery.

Another Standing Committee member asked how to encourage developers to integrate this current gap discussion into their work, as many developers have their own methods of collecting and assessing data for measure development. A Standing Committee member noted that the measures in the Surgery portfolio are necessarily focused on existing concepts and data, such as mortality and readmission. However, there are other important concepts to measure that are essential elements to quality, such as change in function over time, patient-reported outcomes (PROs), patient decision making, communication, and patient education. The Standing Committee co-chair noted that it would be interesting to understand the challenges with measures focused on these concepts. Furthermore, the following question was considered: If there are successful measures in these areas, then how can that success be replicated to other measure areas? Ms. Moyer noted that this has been an ongoing discussion for the Core Quality Measures Collaborative (CQMC) Implementation Workgroup: How can we reach innovative measures when the infrastructure is not well developed, and how do we achieve a well-developed infrastructure without using measures that require that infrastructure?

A Standing Committee member stated that the real question is whether the portfolio is representative of the most important surgical quality issues that need to be solved. This Standing Committee member suggested looking at surgical care areas with high mortality and/or morbidity and focusing measure development in those areas that offer the greatest opportunities for improvement. The Standing Committee member observed that the Surgery portfolio currently has measures for procedures with high volume but low risk, such as orthopedics, and procedures with low volume but high risk, such as pediatric heart surgery. The Standing Committee acknowledged that the Surgery portfolio has a significant number of outcomes measures, including composite outcomes, which indicates that the Surgery portfolio is relatively well developed compared to other topic areas. The Standing Committee noted that work still needs to be done to reduce morbidity and mortality and that focusing measure development on areas/procedures that are high volume and high risk could help with this reduction.

The Standing Committee discussed more specific measure gaps and emphasized the need for measures focused on general surgery, noting that most of the measures in the Surgery portfolio are focused on specialty areas. The Standing Committee co-chair noted further gaps in areas such as opioid use and multimodal pain management. A Standing Committee member observed that the portfolio does not consider the value of care, which they defined as quality divided by cost. The co-chair then mentioned a gap in measures of low-value care, further noting a need to identify and set de-implementation targets for suboptimal interventions. Another Standing Committee member noted capturing "never events", such as putting the wrong implant in a patient or operating on the wrong side of the body, contributes to additional gap areas for further measure development.

A patient representative on the Standing Committee shared their story of surgical care that was not aligned with their pre-surgical instructions. They spoke to the patient's perspective and questioned who is ultimately responsible for deciding whether the patient is receiving good care because it is often not a shared decision between the provider and the patient. In response, a Standing Committee member noted that quality care could potentially be measured by assessing whether the care delivered was appropriate to the diagnosis. Ms. Moyer added that it is essential to have a clear understanding of patient goals and expectations, which may differ from the goals of the care team, in order to deliver high quality care. Another Standing Committee member noted that this aspect of care may only be possible to capture through PROs. The Standing Committee co-chair noted that the ultimate goal would be to address a patient's goals of care and that an intermediate step could be determining whether a patient's goals of care were assessed. Developing a measure in this area that captures the quality of care versus one that checks the box (i.e., whether care/service was delivered or not) is a challenge.

Dr. Sox-Harris recapped the themes and discussion. He noted that the existing surgery measures, such as mortality, complications, and infections, could add value through expansion to other specialties that have yet to develop measures in these areas. He also noted the need for measure development in areas such as patient experiences and the full episode of care, including communication, decision making, pain management, and postoperative care. Dr. Sox-Harris stated that although it may be difficult to obtain scalable data, the need for metrics in these areas is still important.

Dr. Sox-Harris closed the discussion with two questions to the Standing Committee, specifically what measures they wish they had, and what measures they wish would be removed. A Standing Committee member responded to the question by stating that their organization is focused on what will be on the radar in the future, as the Centers for Medicare & Medicaid Services (CMS) increasingly moves to a bundled payment model. The current models assess small areas that have elective bundle enrollment, such as knee and hip orthopedic surgery. Bundle programs examine the entire episode of care, from pre- to post-surgery. Programs that have been voluntary to date are going to become mandatory and

expand in scope. The Standing Committee member noted that healthcare systems will need to change how they assess patients' care preoperatively and during transitions of care in order to perform well on these new models.

Social Risk Discussion

Dr. Matt Pickering, NQF senior director, presented a comprehensive overview of NQF's recent CMS-funded work on developing and testing risk adjustment models for social and functional status-related risk within healthcare performance measurement. Dr. Pickering noted that during the base period of the current project, NQF conducted an environmental scan of data sources available for social and functional risk adjustment. Many of these sources focused on social risk adjustment, including the American Community Survey, Medicare Enrollment Database, and Medicare administrative claims. NQF also researched the approaches to designing a conceptual and statistical rationale for risk adjustment in the context of quality measurement. The Environmental Scan Report and input from the Technical Expert Panel (TEP) informed the development of a Technical Guidance report for developers focused on emerging and best practices on risk adjustment. These best practices have been structured as minimum standards or recommendations to apply while performing risk adjustment. Dr. Pickering noted that NQF will work on operationalizing this technical guidance during the option period, if awarded. The final Technical Guidance Report will be posted on September 15, 2021, and the Draft Technical Guidance Report is currently posted on the project page.

The Technical Guidance Report spells out the minimum standards for social and/or functional risk adjustment. The steps for social and/or functional risk adjustment include conceptualizing the model, identifying potential data sources, empirically testing risk factors, empirically testing the adequacy of the model, and identifying considerations for determining the final risk model. The report also includes a series of appendices, which provide examples of testing approaches that developers may choose to incorporate to supplement their conceptual model. Dr. Pickering discussed NQF's objectives in the case that an option year is awarded. These objectives include reconvening the TEP, conducting key informant interviews (KIIs), and updating the Technical Guidance Report. The KIIs would be conducted with measure developers, and the focus group will consist of members from different NQF Consensus Development Process (CDP) Standing Committees.

A Standing Committee member noted that this work is increasingly important to gain insight into areas of disparity in care. This Standing Committee member also indicated that discussion is taking place within the field regarding whether to risk-adjust or not, especially when measures are used in incentive programs. Some patients have more identifiable risk factors; however, even after a multivariate risk assessment is conducted, there may be additional risks not yet recognized. In response, Dr. Pickering stated that the TEP has considered this possibility throughout the course of their work. The TEP wanted to emphasize more of the stratification approach with these measures. While this type of approach is recommended in the Technical Guidance Report, questions remain regarding the use of component and payment approaches that the TEP was aware of outside endorsement: How are the payments arranged within programs to provide incentives to providers for mitigations for specific patient populations? While NQF's purview is endorsement, implementation considerations are important and were included within the Technical Guidance Report.

David Nerenz, NQF Scientific Methods Panel (SMP) co-chair, presented on social risk adjustment for healthcare performance measures. Dr. Nerenz reviewed the history of the point at which the discussion started when the first CMS hospital readmission penalties were initiated. Dr. Nerenz discussed the concerns regarding negative bias in safety net providers. Unadjusted performance scores could give the

impression of worse quality than what is actually present in care. Absent of adjustment, providers and plans may be less willing to serve vulnerable patients, resulting in reduced access to care.

Dr. Nerenz provided a brief history of social risk adjustment, beginning with an NQF Expert Panel Report conducted in 2014 titled *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors*. Dr. Nerenz noted that prior to the Expert Panel Report, the standing NQF policy prohibited adjustment for social or economic factors. After the report was published, the recommendation was changed to suggest that under certain conditions, adjusting quality measures for social demographic factors makes sense, particularly for outcome measures. The report included other recommendations, such as stratification. Dr. Nerenz noted that the report resulted in more public comments than any other report developed by NQF and that most comments were in support of the recommendations. The Expert Panel Report also resulted in the Social Risk Trial period. NQF's Consensus Standards Approval Committee (CSAC) agreed to change the policy and to track what happened during the trial period. Key findings from the trial period indicated that 96.0 percent of risk-adjusted measures submitted to NQF for review had a conceptual rationale for social risk adjustment. In addition, 30.4 percent of the risk-adjusted measures included social risk factor(s) in their final risk adjustment approach. Dr. Nerenz noted that this does not necessarily translate to how measures are used in the field; nevertheless, it does indicate whether there is a conceptual rationale for including social risks.

The Standing Committee co-chair prompted a discussion about the intended use of quality measures and whether the conceptual model for risk adjustment changes for different intended uses. In response, Dr. Nerenz explained that the two classes of use that are usually brought into this discussion are often pay for performance and public reporting. Dr. Nerenz viewed the technical quality of measurement as the most important issue. Dr. Nerenz also noted a need to see accurate, unbiased, and fair quality measurement. Dr. Sox-Harris noted that another use would be quality improvement. In response, Dr. Nerenz indicated this could be a factor in large-scale, national, or statewide improvement, as risk adjustment assists with valid comparisons. A Standing Committee member asked how to determine whether risk adjustment or intervention support is the more effective route for addressing social determinants of health (SDOH). Dr. Nerenz answered, explaining that it depends on the resources available and how to deploy them most effectively as well as the boundary conditions (i.e., they can address individual patient issues, but addressing broader underlying conditions is more challenging). Dr. Nerenz also noted that providers can only address current problems and not historical issues.

Public Comment

No public or NQF member comments were provided during the topical webinar.

Next Steps

Ms. Moyer noted that NQF will draft a summary encompassing today's discussion, which will be posted to the web on September 22, 2021. Ms. Moyer also reminded the Standing Committee that the intent to submit deadline for the fall 2021 measure review cycle was August 1, 2021. NQF received five new measures for the Surgery Standing Committee to review. The Standing Committee will receive more information regarding the fall 2021 measure review meetings in the upcoming weeks. Ms. Moyer thanked the Standing Committee for their time and thoughtful conversation.