Meeting Summary

Core Quality Measures Collaborative

Gastroenterology Workgroup: Measure Selection Approach and Evaluation Meeting

The National Quality Forum (NQF) convened a closed session web meeting for the Gastroenterology Workgroup on May 22, 2019.

Welcome and Review of Web Meeting Objectives

NQF staff and Workgroup co-chairs welcomed participants to the meeting. NQF staff read the antitrust statement and reminded the Workgroup of the voluntary nature of the CQMC and the obligation of all participants to comply with all applicable laws. NQF staff reviewed the following meeting objectives:

- Provide an overview of the CQMC and workgroup charge,
- Discuss the CQMC measure selection principles,
- Review past work and current measure set, and
- Identify potential sources for additional measures.

Decision-making Process

Voting and Quorum

NQF staff gave an overview of quorum and voting process. The Workgroup was informed that voting and non-voting participants could take part in discussion, but only voting participants would participate in the voting process. Quorum is defined as representation from at least one health insurance provider representative, at least one medical association representative, and at least one representative from the remaining voting participant categories (i.e., consumers, purchasers, regional collaboratives).

NQF staff advised that the Workgroup will thoroughly discuss each item and all views will be heard. Items for which the co-chairs determine that a consensus and quorum has been reached may be approved or disapproved by a voice vote. Items for which voting participants express dissenting opinions or when a quorum has not been reached, the Workgroup co-chairs will subject the applicable item(s) to an electronic vote. In the event that reaching consensus is not possible, the measure will be presented to the Collaborative for additional discussion. The Collaborative will be responsible for the final decision to approve a core measure set.

Principles for measures included in the CQMC core measure sets

1. Advance health and healthcare improvement goals and align with stakeholder priorities.
    a. Address a high-impact aspect of healthcare where a variation in clinical care and opportunity for improvement exist.
2. Are unlikely to promote unintended adverse consequences.
3. Are scientifically sound (e.g., NQF-endorsed or otherwise proven to be evidence-based,

reliable, and valid in diverse populations).
    a. The source of the evidence used to form the basis of the measure is clearly defined.
    b. There is high quality, quantity, and consistency of evidence.
    c. Measure specifications are clearly defined.
4. Represent a meaningful balance between measurement burden and innovation.
    a. Minimize data collection and reporting burden, while maintaining clinical credibility (i.e., measures that fit into existing workflows, are feasible, and do not duplicate efforts).
    b. Are ambitious, yet providers being measured can meaningfully influence the outcome and are implemented at the intended level of attribution.
    c. Are appropriately risk adjusted and account for factors beyond control of providers, as necessary.

Principles for the CQMC core measure sets

1. Provide a person-centered and holistic view of quality, including consideration of Social Determinants of Health (SDOH) and experience of care.
2. Provide meaningful and usable information to all stakeholders.
3. Promote parsimony, alignment, and efficiency of measurement (i.e., minimum number of measures and the least burdensome measures).
4. Include an appropriate mix of measure types while emphasizing outcome measures and measures that address cross-cutting domains of quality.
5. Promote the use of innovative measures (e.g., eMeasures, measures intended to address disparities in care, or patient-reported outcome performance measures, or PRO-PMs).
6. Include measures relevant to the medical condition of focus (i.e., "specialty-specific measures").

Discussion on Current Measures in Core Set

NQF staff reviewed the current core set for gastroenterology. NQF staff highlighted that clinician-level measurement is the focus of the core sets and explained that some workgroups did include measures at the facility level of analysis due to the importance of a measure's focus and paucity of measures available.

NQF#	Measure	Steward	Level of Analysis	Endorsement Status
0658	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	AGA	Clinician	Endorsed
0659	Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	AGA	Clinician	No longer endorsed
PQRS #343	Screening Colonoscopy Adenoma Detection Rate Measure	ASGE		Not endorsed
PQRS #439	Age Appropriate Screening Colonoscopy	AGA	Clinician	Not endorsed
PQRS #271	IBD: Preventive Care: Corticosteroid Related Iatrogenic Injury – Bone Loss Assessment	AGA	Clinician	Not endorsed
PQRS #275	IBD: Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy	AGA	Clinician	Not endorsed

PQRS #401	Screening for Hepatocellular Carcinoma (HCC) in Patients with Hepatitis C Cirrhosis	AGA	Clinician	Not endorsed
PQRS #400	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	AMA-PCPI	Clinician	Not endorsed

NQF staff reviewed the eight current Gastroenterology core set measures. NQF staff noted that #0659 is no longer NQF endorsed and that there was previously discussion around whether there is still a performance gap for this measure. There are currently two Hepatitis C measures in the gastroenterology core set (which align with those in the HIV/Hepatitis C core set). A Workgroup member added that the focus areas for the current set (e.g., endoscopy, IBD, Hepatitis C) were selected based on availability of measures; these areas are not entirely inclusive of all potential key measurement areas for gastroenterology.

There was discussion that the CQMC selected clinician measurement as a starting point and based on the need for alignment across payers for measures at this level of analysis. There was discussion that there may be a potential in the future to expand beyond clinician level, but that the CQMC should ensure the clinician sets are updated and effective before considering expanding scope. A co-chair noted that AGA has revised PQRS #271 to shift focus from DXA scans for patients who received steroids months to vitamin D and calcium treatment.

Measures Previously Reviewed but Not Selected
NQF staff briefly shared measures that were reviewed by the Gastroenterology workgroup in 2016 but were not selected for inclusion in the core set.

- NQF #0727: Gastroenteritis Admission Rate (PDI 1)
- NQF #2065: Gastrointestinal Hemorrhage Mortality Rate (IQI #18)
- NQF #1617: Patients Treated with an Opioid who are Given a Bowel Regimen
- NQF #0622: GERD: Upper Gastrointestinal Study in Adults with Alarm Symptoms
- PQRS #269 IBD: Type, Anatomic Location and Activity All Documented
- PQRS #270 IBD: Preventive Care: Corticosteroid Sparing Therapy
- PQRS #272 IBD: Preventive Care: Influenza Immunization
- PQRS #273 IBD: Preventive Care: Pneumococcal Immunization
- PQRS #274 IBD: Testing for Latent Tuberculosis (TB) Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy

Previously Identified Gastroenterology Measure Gaps

- 0635: Chronic Liver Disease - Hepatitis A Vaccination / Proof of prior vaccination
- 0034: Colorectal Cancer Screening - measure needs to retooled for GI specialists as they don't take care of a general population
- Adverse events related to colonoscopy screening
- Assessing the quality of the colonoscopy:
  - Patient Safety measure: #2539 Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
  - Consideration of CMS measure under development for Post Colonoscopy Complications
  - "Quality colonoscopy" AGA set of measures
- GERD and cirrhosis measures
- Barrett's Esophagus

Evaluation of New Measures

NQF staff shared findings from the environmental scan of gastroenterology measures, which included

NQF-endorsed measures and measures used in MIPS and other federal programs with specifications publicly available.

Review of Potential Gastroenterology Measures
Highlighted in the scan were measures discussed in 2016 that the Workgroup recommended to revisit, new measures endorsed since 2016, measures used in MIPS, and eMeasure versions of current core set measures.

Hepatitis
0635: Chronic Liver Disease - Hepatitis A Vaccination (no longer NQF-endorsed)
The Workgroup discussed that the measure is not currently being maintained. The Workgroup expressed that Hepatitis A vaccination is an important aspect of care, but data collection and tracking vaccination records when patients switch providers or plans is challenging. The Workgroup decided to remove this measure from consideration.

3059e: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk (eMeasure version of MIPS 400, already in core set; not yet NQF-endorsed)
This measure and the next five measures were also discussed by HIV/Hepatitis C Workgroup. NQF noted that the Workgroups should aim for alignment when measures are used in multiple sets, unless there is a rationale supporting otherwise. The Workgroup agreed to continue to discuss this measure for inclusion, noting the push towards eMeasures and their potential to reduce burden.

3060e: Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users (not yet NQF-endorsed)
This measure will be reviewed for NQF endorsement during the spring 2019 cycle. The measure uses EHR data and is used in MIPS. There was some concern that this measure may be more appropriate for the HIV/Hepatitis C or ACO core set versus the gastroenterology core set as gastroenterologist are less likely to see this population. One gastroenterologist noted the importance of this measure, but stated patients he sees present following these screenings. The Workgroup expressed there may be a volume problem for the denominator for this measure if measuring gastroenterologists. Despite some concerns, the Workgroup decided to keep the measure for further discussion.

3061e: Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection (not yet NQF-endorsed)
Some Workgroup members felt this measure was more related to population health than gastroenterology. A co-chair suggested a hepatologist should be invited during the discussion of these measures on subsequent calls. Workgroup members were interested in discussing more detailed specifications for this measure. The Workgroup agreed it would be best to consider the body of Hepatitis C measures on the next call to determine which ones can have the greatest impact on patients and are most influenceable by gastroenterologists. The Workgroup agreed to continue to consider this measure.

Hepatitis C: Discussion and Shared Decision Making Surrounding Treatment Options (MIPS ID 390)
Members agreed with the HIV/Hepatitis C Workgroup that this measure should be removed from consideration. Workgroup members noted that treatment options are constantly changing and other measures are higher priority.

Treatment of Chronic Hepatitis C: Completion of Therapy
There were concerns that gastroenterologists have limited access to prescription claims data and determining completion of therapy is problematic as there are many variables for which to account. The Workgroup agreed that sustained virologic response is the preferred outcome measure. This measure was removed from consideration.

Colorectal Cancer

0034: Colorectal Cancer Screening (COL)

This measure was previously discussed in 2015/2016 by the gastroenterology Workgroup, who suggested that this measure be retooled for use by GI specialists. This measure was developed at the health plan and population levels; however, it is being used in MIPS at the clinician level. A gastroenterologist shared that specialists are usually not the first line of evaluation for patients (patients are usually referred after this screening has already been completed). The Workgroup agreed that this measure should be removed from consideration.

3510: Screening/Surveillance Colonoscopy (not yet NQF-endorsed)

This cost measure is currently undergoing NQF endorsement review. There was discussion that gastroenterologists usually perform procedures at their hospital or health plan affiliate locations, and therefore, are not in control of where these procedures are done or their associated cost. Another Workgroup member acknowledged that costs are easier to measure for Medicare but determining and attributing costs on the commercial side is far more complex. The Workgroup decided to remove this measure from consideration and reconsider it in future when value-based care expands.

Photodocumentation of Cecal Intubation (MIPS ID 425)

This measure was considered but not included by the 2015/2016 Workgroup. The Workgroup noted that other colonoscopy measures are more valuable, specifically citing their preference for the adenoma detection rate measure. While this measure appears to be topped out based on MIPS benchmarking, a considerable gap was previously identified. At least one Workgroup member expressed that it would be useful to gather additional performance data (e.g., from registries like GIQuIC) to better understand the gap. The was interest in a suite of colonoscopy measures, a composite measure, and/or, ideally, measures assessing the quality of colonoscopy. The Workgroup agreed to keep this measure for further discussion and potential inclusion.

Safety

2539: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

The Workgroup agreed that this measure evaluates an important clinical issue, but it is not practical for measurement at the clinician level. The measure was removed from consideration.

Anastomotic Leak Intervention (PQRS #354)

The Workgroup emphasized this measure is applicable to surgery but not gastroenterology and removed the measure from consideration.

Other

1854: Barret's Esophagus

The Workgroup agreed this measure is appropriate for pathologists but not gastroenterologists and removed the measure from consideration.

The Workgroup also discussed ten AGA measures that are specified and in the process of beginning testing.

- Endoscopy/ Barrett's esophagus surveillance: Esophagogastroduodenoscopy (EGD) interval for patients with non-dysplastic Barrett's esophagus
- Endoscopy/ Barrett's esophagus surveillance: Systemic biopsies during surveillance esophagogastroduodenoscopy (EGD) in patients with Barrett's esophagus
- Inflammatory bowel disease: Thiopurine methyltransferase (TPMT) testing (enzymatic activity or genotype) in all patients that was performed and results interpreted prior to starting azathioprine or 6 mercaptopurine

- Inflammatory bowel disease: Postoperative monitoring for recurrence of Crohn's disease at six to 12 months after surgical resection in patients with Crohn's disease
- Inflammatory bowel disease: Percentage of patients diagnosed with extensive mild-moderate ulcerative colitis that receive a high (>3g/d) or standard-dose mesalamine (2-3 g/d) or diazo-bonded 5-aminosalicylate (5-ASA) rather than low dose mesalamine (< 2 g/d), sulfasalazine or no treatment
- Sustained Virological Response in the treatment of hepatitis C infection
- In patients with acute pancreatitis, AGA recommends early (within 24 hours) oral feeding rather than keeping the patient NPO
- In patients with acute pancreatitis and inability to feed orally, AGA recommends enteral rather than parenteral nutrition
- In patients with acute biliary pancreatitis, AGA recommends cholecystectomy during the initial admission rather than following discharge
- Colorectal Cancer Screening: Testing of all patients for potential cases of Lynch syndrome with colorectal cancer using immunohistochemistry (IHC) or microsatellite instability (MSI) by polymerase chain reaction (PCR)

The Workgroup acknowledged the strong clinical basis for these measures and was interested in various concepts presented. The Workgroup expressed that SVR, Barrett's esophagus, and IBD are priorities. The Workgroup noted that the pancreatitis measures may be less relevant to the CQMC gastroenterology set since their setting is inpatient. A Workgroup member stated there is too much surveillance being done for Barrett's esophagus. A co-chair explained that more information about the measures will be provided prior to next meeting. Since these measures have not yet undergone testing or NQF-endorsement, the group suggested it would be best to keep these in mind for future iterations of the core set. The Workgroup will note the current gap areas and continue to discuss these measures in the future.

Workgroup members also suggested that they might want to consider measures related to Non-alcoholic fatty liver disease (NAFLD) (if any measures with this focus exist) and that it would be beneficial to consider patient-reported outcome performance measures (PRO-PMs) for inclusion in the core set.

Next Steps

NQF staff shared that the focus of the next Workgroup meeting is to vote on measures for addition to the core set, continuing discussions as needed, and to identify and discuss potential measures for removal. NQF staff requested members who have not submitted DOI forms, send the completed DOIs to the CQMC email: CQMC@qualityforum.org.