Meeting Summary

Core Quality Measures Collaborative

Gastroenterology Workgroup Meeting #3: Measure Evaluation

The National Quality Forum (NQF) convened a closed session web meeting for the Gastroenterology Workgroup on July 15, 2019.

Welcome and Review of 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 notified Workgroup members that the meeting is being recorded for the purpose of accurately capturing the discussion for meeting minutes and to allow CQMC members to listen to the meeting for a limited time only. The recording will be destroyed as soon as reasonably practical. NQF staff reviewed the following meeting objectives:

- Review previous discussions on candidate measures and have additional discussion
- Finalize recommendations for new measures for the set
- Identify measures for removal from the core set

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 would thoroughly discuss each measure and all views would be heard. Measures for which the co-chairs determine that a consensus and quorum has been reached may be approved or disapproved by a voice vote. Measures 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.

NQF staff informed the Workgroup that, while quorum was reached during the call, voting for measure for addition and removal from the core set would be done electronically through a survey link that would be emailed to voting members following the meeting.

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”).

Overview of Current Core Set Measures

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 specified at other levels of analysis (e.g., facility) due to the importance of a measure’s focus and paucity of measures available. NQF staff reviewed the eight current Gastroenterology core set measures. NQF staff noted that measure 0659 is no longer NQF endorsed.

Consensus Core Set: Gastroenterology Measures				
NQF #	**Measure**	**Measure Steward**	**Level of Analysis**	**Consensus Agreement / Notes**
Endoscopy & Polyp Surveillance Measures				
0658	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	AGA	Clinician	**Consensus to include in core set.**
0659	Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	AGA	Clinician	**Consensus to include in core set.**
PQRS #343	Screening Colonoscopy Adenoma Detection Rate Measure.	ASGE		**Consensus to include in core set.**
PQRS #439	Age Appropriate Screening Colonoscopy	AGA	Clinician	**Consensus to include in core set for measurement at the group level.** **Note:** Programs utilizing this measure are not looking for 100% performance.
Inflammatory Bowel Disease				
PQRS #271	IBD: Preventive Care: Corticosteroid Related Iatrogenic Injury – Bone Loss Assessment*	AGA	Clinician	**Consensus to include in core set.**
PQRS #275	IBD: Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy*	AGA	Clinician	**Consensus to include in core set.**

* Note: For 2015 PQRS, a "global denominator" was added to the IBD Measures Group. AGA intends to submit its IBD measures for NQF-endorsement consideration after there are adequate testing data to meet NQF measure evaluation criteria.

Hepatitis C Measures for the Gastroenterology Core Measure Set				
NQF #	**Measure**	**Measure Steward**	**Level of Analysis**	**Notes**
N/A	PQRS #401: Screening for Hepatocellular Carcinoma (HCC) in Patients with Hepatitis C Cirrhosis	AGA	Clinician	**Consensus to include in core set.**
N/A	PQRS #400: Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	AMA-PCPI	Clinician	**Consensus to include in core set.**

Evaluation of Measures for Potential Addition

NQF staff shared information and provided a recap of the discussion for the four measures the Workgroup chose to continue to consider for addition. After a brief introduction of each measure, the Workgroup had additional discussion as needed. Below is a summary of the Workgroup's discussion for each of the measures.

Hepatitis C

3059e: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk (eMeasure version of MIPS 400, already in core set)

During the previous meeting, the Workgroup seemed to reach consensus to add this measure to the core set, as it promotes alignment with measures already in the core set and has the potential to reduce reporting burden. This measure is currently NQF endorsed for trial use. This designation is assigned specifically to eMeasures that are ready for implementation but cannot be adequately tested to meet NQF endorsement criteria. Measures approved for trial use are usually not widely used, however, the measure specifications and evidence have been reviewed and approved by the relevant NQF Standing Committee. 3059e is currently going through full endorsement and being reviewed by the Primary Care and Chronic Illness Standing Committee in the Spring 2019 cycle. The measure has been recommended for endorsement by the Standing Committee but has not yet undergone commenting or CSAC review. A Workgroup member shared support for adding eMeasure options to the core set when available,

however, questioned if there are issues with comparability for individuals who report using eCQM specifications versus other data sources. Another Workgroup member who is a developer clarified that during implementation, agencies, like CMS for example, provide separate benchmarks for different reporting options to ensure that groups are compared appropriately. A Workgroup member inquired if those benchmarks are available to the public, and the developer responded that CMS measure benchmarks are published yearly and publicly available. Workgroup members agreed that in cases where eMeasures are included as reporting options, it is imperative to add a note that separate benchmarks are needed for comparison purposes. Workgroup member stated that for voting purposes, an "approved with modification/note" voting option should be added. NQF staff responded that they would update the survey to reflect the request.

3060e: Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users
During meeting #2, Workgroup members stated this measure might be more suited for the HIV/Hep C or ACO core sets and that GI specialists might not have enough patient volume for this measure; however, the group acknowledged the importance of focusing on this topic area. Like measure 3059e, this measure is currently approved for NQF trial use and is currently going through full endorsement in Primary Care and Chronic Illness project for Spring 2019 cycle. The Standing Committee did not reach consensus on the reliability criterion for this measure. Concerns were raised about the representativeness of the sample and challenges getting patients to self-report IV drug use. The Standing Committee also expressed some feasibility concerns. A member shared that it may be difficult to capture data for these patients appropriately and questioned if gastroenterologists see enough of these patients for this measure to be a core measure. Another member added that this measure is more suited for a provider taking care of a person longitudinally, instead of the gastroenterologist. Workgroup members generally agreed this is an important care process and good clinical practice but not the best measure for this particular core set.

3061e: Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection
This measure is currently approved for trial use but has not been submitted for full endorsement. During the previous meeting, Workgroup members stated this may be more appropriate for the ACO core set and as it relates to care coordination. The Workgroup discussed that measures, such as this one, not formally tested should generally not be included but re-discussed for potential inclusion in the future. The developer stated that they were unable to get data from test sites in time for this measure to go through the endorsement process. A co-chair emphasized that for consistency in decision making, it is important to make similar decisions regarding all measures without appropriate testing. NQF staff shared that while NQF endorsement is not a requirement for inclusion in a core set, measures should be tested for reliability and validity. The Workgroup inquired if the HIV/Hep C Workgroup is interested in including this measure in their core set. NQF noted that like this Workgroup, the HIV/Hep C Workgroup is interested in this measure, but they may choose to reconsider in the future post testing data and/or endorsement.

Colorectal Cancer
Photodocumentation of Cecal Intubation (MIPS ID 425)
The Workgroup previously requested additional information about performance as the measure appeared "topped out" according to MIPS data. In response, GIQuIC shared that performance for 2016-2018 reflects a wider performance gap than that seen in public reporting. GIQuIC also noted that for 2019, providers will need to document two cecal landmarks; previous data was based on documenting one cecal landmark. Following this change, a wider performance gap is anticipated. Workgroup members stated this is an important and challenging quality indicator to measure. Workgroup members discussed that software to collect these images, which would make reporting easier, are not widely implemented. Workgroup members also discussed potential discrepancies if charts have to be manually reviewed. Workgroup members discussed potential financial and resource challenges of getting two landmarks. A Workgroup member expressed that these challenges to assessing

photodocumentation can be solved by random auditing to ensure that photodocumentation is completed. Although beyond the Workgroup's scope, members suggested cecal photodocumentation should be required for all providers who perform colonoscopy. This measure is gastroenterologist specific, thus limiting the number of providers who could report on the measure.

Evaluation of Measures for Potential Removal

0658 Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

This is an AGA measure that is NQF endorsed and currently used in multiple federal programs. Performance is high for this measure in MIPS. A member expressed support for keeping measure as part of core set, noting widespread use and that high performance in MIPS does not necessarily indicate there is no room for improvement. Another Workgroup member reiterated that this is an important measure and that multiple studies show there is overuse of colonoscopies. Another Workgroup member disagreed, stating that this measure does not measure adherence to colonoscopy and follow up, but rather it measures that the report states "next colonoscopy in 10 years" (not whether a patient has a colonoscopy in that time). A member discussed the ability to "game the system" but refocused the conversation on the fact that the measure is written and specified for follow-up in 10 years. Workgroup members explained that providers could recommend shorter follow-up intervals to assess for cancer or improve on colonoscopy prep quality in order to conduct a good colonoscopy and assess for polyps. Some providers state 50% of their patients' bowel preps are inadequate. Frequent, low quality exams are risky and costly to patients and health plans.

0659 Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use

This measure is no longer NQF-endorsed, as it was not submitted for maintenance since the developer thought it was no longer going to be used for public reporting. Data from 2009 and 2012 indicated a gap, while MIPS benchmarking data indicated the measure is topped out in this reporting platform. A Workgroup member stated that surveillance recommendations are undergoing revisions and will be released before the end of next year. The new recommendations may or may affect measures in the current core set. Workgroup members inquired if this measure will be removed from the core set, since it lost NQF endorsement. NQF staff advised that NQF endorsement is not a requirement, but that it should be taken into consideration. A Workgroup member stated that although this is a good measure, their organization has never used it because it is difficult to measure. Workgroup members agreed unanimously that this measure addresses an important topic.

PQRS #343 Screening Colonoscopy Adenoma Detection Rate Measure

This measure is currently used in MIPS, NQF provided decile performance data for this measure. The Workgroup discussed that the measure is not expected to get higher than 40-50%, but gastroenterologists are concerned about the proportion of people who are under 30%. Workgroup members explained that if 99% of groups are submitting numbers of people over 30% then that would be an example of the measure possibly being topped out. There was discussion that 35% for men and 25% for women are the current recommended benchmarks identified by the various GI societies. A co-chair explained that overall reporting on GI-specific measures is low. The Workgroup discussed that this is the best colonoscopy measure at this time and is linked to cancer incidence and mortality. A Workgroup member stated that their association has been in conversations with CMS about this measure because it does not accurately calculate how adenoma detection rate is captured in the entire population as the methodology created to calculate deciles is not appropriate. Workgroup members explained that CMS will re-benchmark this measure to reflect changes in coding and that accurate benchmarking for this measure is needed. Another Workgroup member explained that benchmarking is helpful, but not absolutely necessary as health plans may use this information to assess performance over time rather than against benchmarks. The member encouraged the

Workgroup not to let current CMS benchmarking be a limitation to keeping this important measure in the core set.

PQRS #439 Age Appropriate Screening Colonoscopy
NQF staff reported there is no publicly available performance data for this measure. The Workgroup generally agree this measure is important in preventing overuse of colonoscopy in elderly patients. Changes to measure specifications discussed include removal of modifier codes 52, 53, 73, and 74 because if patients over 85 years should not have colonoscopies then it should not matter if the colonoscopy is recorded as incomplete. Workgroup members stated that current USPSTF recommendations include no colonoscopies for persons above 85 years.

PQRS #271 IBD: Preventative Care: Corticosteroid Related Iatrogenic Injury – Bone Loss Assessment
NQF staff reported there is no publicly available performance data for this measure which uses registry data. Per the developer, a revised form was submitted to CMS for this measure (for use in MIPS) to focus on Calcium and Vitamin D optimization rather than DXA scans, given concern that the measure as currently written could result in overuse of DXA scans in younger patients. NQF staff asked about the timeframe of changes made to the measure specifications, and the developer responded that these changes, if approved, would be reflected in 2020 MIPS. Workgroup members raised concerns that focusing on Calcium and Vitamin D might not be adequate in assessing bone health. A Workgroup member stated there were gaps within their medical systems regarding DXA scan use, and it would be good to review literature from bone health experts to understand if measuring calcium and Vitamin D optimization is interchangeable with use of DXA scans. NQF staff advised that the Workgroup should keep the updates in mind but vote on the measure as currently specified. A note should be added to this measure to reflect specification changes when they occur.

PQRS #275 IBD: Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy
NQF provided an overview of the measure specifications. No data on current performance was available, however, this measure is currently used in MIPS. A member expressed support for keeping this measure. Another member stated they do not use this measure because pre-certification is required for anti-TNF therapy so an HBV check is conducted before medication is ordered. No Workgroup members stated objection to keeping this measure in the core set.

PQRS #401 Screening for Hepatocellular Carcinoma (HCC) in Patients with Hepatitis C Cirrhosis
No performance data was publicly available for this measure. This measure and PQRS 400 are also included in the CQMC HIV/Hep C core set. A member stated this measure is valuable and indicates high-quality clinical practice, but also wondered how often this measure is being used and if there are difficulties using this measure.

PQRS #400 Hepatitis C: One-Times Screening for Hepatitis C Virus (HCV) for Patients at Risk
This measure and measure PQRS 401 are also included in the CQMC HIV/Hep C core set. A member stated this measure is valuable and indicates high-quality clinical practice. This measure uses registry data (versus being an eMeasure) but is otherwise the same as 3059e, which is currently being considered for inclusion in the Gastroenterology core set.

Next Steps

NQF staff shared that voting members of the Workgroup would be sent an online survey to vote on whether each of the four measures should be included and if any current core set measures should be removed. NQF staff advised that the next meeting would focus on implementation strategies and measure gaps.