

## QUALITY IMPROVEMENT

**Quality Improvement Workgroup Activities.** As quality improvement related activities continue to grow, QIW members and staff remain very busy. We are currently reassessing the structure and function of the QIW, including the appointment of new members and the assignment of members to quality improvement organizations (e.g., AQA, NQF, PCPI, etc.).

**Quality Improvement Organizations.** Since last October, the following meetings of various quality improvement organizations have taken place:

- **AMA Physician Consortium for Performance Improvement (PCPI)**, a physician-led group that develops evidence-based measures, held one full meeting since October. The PCPI has approved 174 measures to date through on-line voting and three in-person meetings annually. The specifications (i.e., CPT-II codes) for each measure are now available online. Dan Resnick (with the support of Katie Orrico and Rachel Groman) continues to represent neurosurgery on the PCPI. A new Spinal Stenosis workgroup recently formed, but has yet to meet. Neurosurgery remains a co-lead organization of the workgroup, but our nominee (Resnick) was not selected to co-chair the group. Instead, two orthopaedic surgeons were chosen: William Watters of the North American Spine Society (NASS) and Robert Haralson of the American Academy of Orthopaedic Surgeons (AAOS).
- **National Quality Forum (NQF)**, which endorses quality measures that are ready for public reporting, held one full meeting and multiple workgroup meetings since October. The AANS and CNS are not members of this multi-stakeholder group (dues are \$15,000 per year), but Rachel Groman participates in NQF meetings that are open to the public. Neurosurgery is working with other surgical societies to secure approval of the PCPI-approved perioperative measurement set, which is now under NQF consideration. Neurosurgery also recently supported the nomination of two surgeons to the NQF Board of Directors (Bill Rich of the American Academy of Ophthalmology and Fred Grover of the Society of Thoracic Surgeons)
- **Surgical Quality Alliance (SQA)**, which acts alongside the AQA to ensure the unique perspective of surgeons is preserved in quality conversations, has been working to strengthen its position both within the AQA and as an independent quality alliance. The group held multiple phone calls and two in-person meetings since October. The group's focus is now on registry reporting collaboration among surgical specialties, ensuring a due process and a defined voting structure at the AQA, and coordinating meetings with federal officials, payers and plans. Bob Harbaugh, Gary Bloomgarden, and David McKalip (with staff support from Rachel Groman) continue to represent neurosurgery within the SQA. Elana Farace and John Cowan also participate in the newly formed Data Registry Workgroup.
- **Ambulatory Care Quality Alliance (AQA)**, a multi-stakeholder group lead by health plans and primary care physicians, continues to approve measures that are ready for implementation. The group continues to develop principles on issues related to data aggregation, reporting, test measures, appropriateness measures, and harmonization of measures. Two full meetings have been held since October. At the most recent meeting, multiple measures were rushed forward for consideration due to the newly passed quality reporting legislation. A contentious prioritized list of conditions that should be targeted for cost of care measurement was also voted on at this meeting. "Lumbar spine" was included on the final list, despite tireless efforts by neurosurgery and others to highlight the flawed voting process and the lack of concurrent, valid quality measures. The events at this meeting underscored ongoing concerns about the AQA's failure to follow a defined process and the fact that payers are more interested in cost than quality.

Neurosurgery, represented by Robert Harbaugh, David McKalip, and Gary Bloomgarden (with staff support from Rachel Groman) continue to demand due process within the AQA by insisting the AQA must: define "consensus;" who is eligible to vote; how votes are recorded; what defines a quorum; a governance structure and selection process for leadership; and a system for balancing interests (health plans/employers should not outnumber the votes of physician groups). The last meeting was a huge step forward in that the AQA Steering Committee promised to develop recommendations on how best to define a voting process and, for the first time, insisted on one vote per organization and took an actual hand count, rather than a visual estimate.

- **Pay-for Performance Summit.** Rachel Groman represented neurosurgery at the February 2007 P4P Summit in Los Angeles. The Summit was sponsored by the Integrated Healthcare Association, a non-profit statewide healthcare leadership group composed of key California stakeholders. The Summit focused on primary care/chronic disease management and was overtly dominated by plans and payers. The unbalanced attendance resulted in lots of negativity towards physicians, particularly surgical and other acute care specialties, who were portrayed as obstructionists. This served as a reminder that critical decision-makers require an enormous amount of educating. On a positive note, there was general consensus that P4P should not be applied on top of the current flawed payment system.

**Neurosurgery Quality Projects.** Members of the QIW are involved in the following two activities:

- **AANS Lumbar Spine Surgery Outcomes Pilot.** As a result of the registry language in the TRHCA 2006, neurosurgery has increased efforts to promote the AANS lumbar spine surgery outcomes database pilot and to work with other surgical groups to evaluate which outcomes reporting models are most effective and which can be easily adapted across the surgical spectrum. To gain support and possibly funding for our own registry, the AANS and CNS leadership recently invited NASS and AAOS to participate in the AANS lumbar spine outcomes reporting pilot project. Both organizations responded favorably and recently participated in an online demonstration of the registry's capabilities.

In February 2007, Robert Harbaugh and Elana Farace met with CMS officials to discuss the pilot and how this registry may be useful for reporting quality data under the PQRI. They also made the case that prospective outcomes reporting produces better quality indicators in surgical care than process measures and spoke about the use of CPT modifiers that would indicate whether a physician reported to a quality database. CMS was impressed with the pilot and CPT proposal, but unable to commit to anything. Upon recommendation, some of the process measures approved for use in the PQRI were added to the AANS registry.

The AANS and CNS will continue to work with CMS to discuss issues related to outcomes and registry reporting. We will stress the need to implement pay for participation programs, and to ensure no public release of individual data, which should be used for internal education and quality improvement processes. We will also continue to invite other surgical and medical device groups to participate in our spine outcomes registry and to set up meetings with third party payors (United HealthCare, BCBS, others) to talk about the value of outcomes registries, how some of our members have been adversely affected by their programs, and to seek possible funding/support.

**ACTION TAKEN: The lumbar spine pilot project will continue throughout the remainder of 2007, at which time currently budgeted funds will end. At that time, the AANS and CNS will evaluate whether or not this approach is viable for future expansion.**

- **National Committee for Quality Assurance (NCQA) Back Pain Recognition Program (BPRP).**  
On January 18, 2007, the NCQA released the 2007 requirements for its newly renamed program (formerly known as the Spine Care Recognition Program). The program will identify high-quality physicians and chiropractors who take a patient-centered approach to back pain using 16 evidence-based criteria. Over the last year, AANS and CNS, with input from the Spine Section (Charlie Branch, Dan Resnick and Chris Shaffrey) registered serious concerns about the program, particularly its breadth and complexity and its disregard for new guidelines. NCQA adequately addressed these concerns and also appointed Dr. Branch to the BPRP Physician Advisory Committee, which has been working to further refine the quality measures based on public comments and pilot tests.

NCQA will begin accepting applications for the BPRP in April 2007. In the interim, NCQA is working with stakeholders, including organized neurosurgery, to finalize the data collection tool and the application instructions and forms. While the program is voluntary, it is anticipated that many private health plans may require physicians to participate in order to qualify for reimbursement for spine care services. For example, Bridges to Excellence (BTE), a nationally recognized program, will be launching a Spine Care Link that will provide bonuses and other financial incentives for those who become recognized under the NCQA Back Pain Recognition Program. AANS and CNS will recommend that members participate only if the benefits outweigh the costs.