

QUALITY IMPROVEMENT

Medicare Physician Quality Reporting Initiative (PQRI)

Reporting PQRI Participating Physicians

As required under Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), CMS recently began to post on its web site the names of professionals who reported quality information (successfully or unsuccessfully) under the 2007 PQRI. Under this initiative, known as “Physician Compare,” Medicare beneficiaries who search for a physician or other Part B provider on Medicare.gov will also find out if the provider participated in the 2007 PQRI. While the AANS, CNS and other medical specialties feel that the public posting of this information was premature and that this information is of little value to patients, we are pleased that CMS honored our request to include a disclaimer on the web site that explains that there are many reasons why a physician may not be participating in the PQRI, including that available measures may not be applicable. Neurosurgeons are encouraged to visit the CMS website to confirm whether their listing is accurate.

2008

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), extended the “voluntary” PQRI through 2009. For 2008, there were 45 additional reportable measures, bringing the total to 119, all of which have either been endorsed by the National Quality Forum (NQF) or adopted by the Ambulatory Quality Alliance (AQA). The bonus payment was 1.5%, with no cap, and funded through the Medicare Part B Trust Fund. Alternative reporting options were also available in 2008, including reporting of measures over a 6-month or 12-month period, reporting individual measures or groups of clinically related measures, and reporting measures through the claims system or via designated clinical data registries. In late August, CMS selected 32 self-nominated registries qualified to submit quality claims data on behalf of their participants for 2008. This list includes Outcome’s TotalQuality registry, the American College of Cardiology’s National Cardiac Data Registry, and the Society of Thoracic Surgery’s registry. CMS plans to distribute individual feedback reports to 2008 PQRI participants by October 2009. Around that time, CMS will also publicly post the names of physicians who attempted to participate in the 2008 PQRI on its Physician Compare website.

2009

The MMSEA 2007 required CMS to use a rulemaking process to select quality measures for the 2009 PQRI and the MIPPA legislation extended the program, and 2% bonus payments, through 2010. For 2009, CMS will maintain the basic claims-based reporting option, as well as most of the alternative reporting mechanisms authorized last year, including registry reporting and the reporting of individual or group measures over either a 6- or 12-month reporting period. For registry-based reporting, CMS will continue to rely on the 32 registries selected in 2008, and will consider other registries self-nominated through January 31, 2009.

For 2009, there are 52 new quality measures, bringing the total number of measures to 153. Eighteen of the new measures will be accepted exclusively via registries due to their complex specifications, which require multiple diagnosis codes. CMS also added four new measure groups, which simplify reporting by aggregating several measures that address similar clinical conditions. The new measure groups include encounters pertaining to Perioperative Care and Back Pain. While the measures that comprise each group can be reported as a group or individually, the four Back Pain measures are only reportable as a group due to their simplicity. Physicians need only to report a single G-code to indicate he/she met all the individual process measures included in a group. Detailed specifications for both individual and group measures are available on the CMS Web site at:

http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage

In 2010, CMS plans to use its Physician Compare website to publicly identify *successful* participants of the 2009 PQRI (not simply those who attempted to participate), and has stated its desire to eventually make performance information public, as well.

Neurosurgery's Reaction to PQRI Expansion

The AANS and CNS have been working with the Alliance of Specialty Medicine to voice its concern about the expansion of the PQRI, its burden on physicians, and its failure to improve quality of care. The following concerns were expressed through various sign-on letters and meetings with both Congress and CMS:

- Concern about the proliferating number of quality and efficiency measures imposed on physicians without evidence of improved health outcomes and reduced system costs;
- Concern about the lack of interim feedback reports during the course of the PQRI, which prevents participants from knowing whether they are successfully complying with program requirements; and
- Concern about CMS's proposal to move forward with public reporting before conducting a formal evaluation of the PQRI to date, before correcting the program's many technical flaws, before having a mechanism in place to risk-adjust or otherwise validate data, and before testing which public reporting formats are most accurate and user-friendly.

In the late fall of 2008, the Alliance for Specialty Medicine also asked Rep. John Dingell (D-MI), former Chair, Energy and Commerce Committee, and Rep. Frank Pallone (D-NJ), Chair, Energy and Commerce's Health Subcommittee, to hold hearings on the PQRI. As a first step, Rep. Pallone sent a letter to Kerry Weems, MD, Acting Administrator, CMS, relaying the Alliance's concerns.

Physician Pay-for-Performance

There is increasing interest in Congress and among CMS to transition quickly from the current physician pay-for-reporting (P4R) system to a pay-for-performance (P4P) system. In November 2008, CMS, as required under MIPPA, released a paper titled, "Development of a Plan to Transition to a Medicare Value-Based Purchasing Program for Physician and Other Professional Services." The paper discusses options for transitioning from physician P4R to physician P4P, with the stated goal to "improve Medicare beneficiary health outcomes and experience of care by using payment incentives and transparency to encourage higher quality, more efficient professional services." In pursuit of this goal, CMS has defined the following objectives:

- Promote evidence-based research through measurement, payment incentives, and transparency;
- Reduce fragmentation and duplication through accountability across settings, alignment of measures and incentives across settings, and better coordination for smoother transitions, and attention to episodes of care;
- Encourage effective management of chronic disease by improving early detection and prevention, focusing on preventable hospital readmissions, and emphasizing the importance of advanced care planning and appropriate end-of-life care;
- Accelerate the adoption of effective, interoperable HIT, including clinical registries, e-prescribing, and electronic health records.

In response to CMS's transition plan, the AANS and CNS have drafted its own *Blueprint for Quality Improvement*, which outlines its own vision for meaningful quality improvement.

In early January 2009, CMS reported to the House Ways and Means Committee on the progress of its transition plan. Taking the public's feedback into consideration, CMS is now working to design various

approaches for performance-based payment that will address its stated goals and objectives for different practice arrangements. CMS will consider approaches that: 1) overlay the current physician fee schedule, such as differential fee schedule payment based on measured performance or for providing a medical home; 2) address multiple levels of accountability, including individual professionals as well as larger teams/organizations; and 3) promote more integrated care through shared savings modes and bundled payment arrangements. CMS is currently testing these approaches through various demonstration projects, including the Physician Group Practice demonstration of a shared savings model, medical home and other care coordination/disease management demonstrations, and the Acute Care Episodes demonstration of bundled payments.

Physician Resource Use

Following recommendations by MedPAC and the GAO, the MIPPA legislation included a provision that requires CMS to establish a confidential Physician Resource Use Feedback program to improve efficiency and to control costs. Under the program, which must be implemented by January 1, 2009, CMS will use Medicare claims data to provide confidential reports to physicians that measure the resources used in furnishing care to Medicare beneficiaries. In the 2009 MPFS final rule, CMS outlined current efforts to test ways to measure physician resource use (e.g., episodic versus per capita cost measurement, benchmarking, risk-adjustment, feedback report formats, etc.) in three communities across the nation. CMS will present more formal findings in the spring of 2009, but in the interim is collecting public comments on the initial phase of its implementation plan. CMS will then present a plan for the next phase of this project in the FY2010 MPFS proposed rule. Under MIPPA, the GAO is also required to conduct a study of the feedback program and make recommendations to Congress by March 2011 regarding appropriate legislation and/or administrative action. As CMS continues to provide updates on its progress, the AANS and CNS will work with other specialties to analyze and comment on the utility of this project.

Health Information Technology and E-Prescribing

HIT Provisions in Stimulus Package

Ensuring that the nation's health system moves toward an electronic system is a key component of the Administration's health care platform. In that vein, the American Recovery and Reinvestment Act (ARRA) of 2009 includes various provisions to spur adoption and use of HIT, including:

- Codifies Office of the National Coordinator for Health IT (ONCHIT) to promote the development of national interoperable HIT infrastructure and help develop electronic health record (HER) certification standards
- Establishes a HIT Policy and Standards Committee, a group of public/private stakeholders that will provide recommendations on HIT policy, standards, implementation, and certification criteria
- HHS will adopt through rule-making an initial set of standards, implementation specifications, and certification criteria for EHR adoption by December 31, 2009;
- Competitive grants to states for HIT advancement
- Creates Broadband Technology Opportunities Program to provide education and support for providers
- \$19 billion in Medicare payment incentives/penalties to spur use of EHRs
- Physicians must adopt /use in a meaningful manner certified EHRs within 5 yrs
 - ONCHIT will certify eligible EHRs that meet certain standards and provide a government-sponsored EHR for nominal fee
 - "Meaningful use" to be defined by HHS, but will include e-Rx, information exchange standards, and reporting quality measures to CMS

- Bonus payments available over 5 yrs on a sliding scale starting in 2011, followed by penalties for non-adoption starting in 2015. Maximum incentive for early adopters is \$44,000 over 5 years. Penalty starts at -0.1% of total annual Medicare charges in 2015. The reduction phases up to -0.3% for 2017 and could be higher after that, since HHS has authority to increase the penalty up to 5% if physician uptake is low.
- Rural health professional shortage areas eligible for higher bonus
- Physicians may qualify for hardship exemption to avoid penalties (up to 5 yrs)

In late January, the Alliance of Specialty Medicine sent the House and Senate leadership a letter expressing appreciation that both stimulus packages include funding to support HIT adoption. However, we expressed concern about the ambitious timeline; the lack of federal HIT standards and certified products; new privacy regulations that have yet to be clarified; the failure to account for the ongoing cost of implementing HIT infrastructure (in December 2008, the Congressional Budget Office estimated that in addition to any initial investments, annual costs can average from \$3,000 to \$9,000 per physician); and most importantly, the use of penalties for those who fail to adopt HIT in future years given that most physicians cannot afford the upfront and ongoing costs associated with adopting HIT.

Hospital Quality Reporting

Hospital P4P

In November 2008, Senate Finance leaders Baucus (D-MT) and Grassley (R-IA) released a bipartisan discussion draft of legislation to implement a Medicare value-based purchasing (VBP) program for inpatient hospital care in 2012. The draft legislation, the Medicare Hospital Quality Improvement Act, would provide hospitals with either an increase or a decrease in their Medicare payments depending on how they perform on standard quality measures. The proposal suggests starting with an initial set of inpatient measures, including those that focus on surgical care, selected from a list of measures representing the best practices in inpatient hospital care, such as those endorsed by the National Quality Forum (NQF). The program would be phased in over the course of five years, starting in FY 2012, with full implementation beginning in FY 2016. Payment levels would gradually increase from 1.0% in FY 2012 to 2.0% by FY 2016. The proposed VBP program would be budget neutral, so any savings from reduced payments to certain hospitals would be used to increase payments to other hospitals.

Legislative action is necessary to implement any VBP policy. However, it's likely that this latest Senate Finance proposal will be folded into another large piece of healthcare legislation, such as universal healthcare or a Medicare physician payment fix, especially since the Administration's Budget Blueprint also indicated support for hospital P4P. The AANS and CNS distributed to Congress and CMS its *Blueprint for Quality Improvement*, which warns about the unintended consequences of prematurely transitioning to P4P.

Present on Admission (POA) Reporting and Non-Payment for Hospital-Acquired Conditions (HACs)

As of 2008, hospitals receive lower Medicare reimbursements if inpatients suffer from "hospital-acquired conditions" that are not documented as "present on admission," such as SSIs following spine and joint procedures. The AANS and CNS were critical of this program since it targets infections that may sometimes occur despite adherence to best practices. Furthermore, the policy's all-or-nothing approach to non-payment does not include case-mix adjustments or provide a mechanism to flag cases where an infection occurred despite adherence to evidence-based guidelines. We are also concerned that by defining what is and what is not preventable, CMS may expose providers to increased med liability risks.

In preparation for the FY 2010 rulemaking process, CMS held a listening session in December 2008 to solicit stakeholder input on expanding its inpatient HAC policy to other providers and settings (e.g., outpatient, physician practices). The AANS and CNS submitted comments outlining the flaws of the current inpatient HAC policy, the challenges associated with applying a similar policy to other provider payment systems, and the irrationality of expanding a policy that has not yet been adequately tested.

Surgical Error National Coverage Determinations

In January 2008, CMS announced three final national coverage decisions under which Medicare will not pay for the following errors resulting from surgical or other invasive procedures:

- Wrong Surgery Performed on a Patient
- Surgery Performed on the Wrong Patient
- Surgery on the Wrong Body Part

Overall, the AANS and CNS support this effort to target truly egregious errors. We had initial concerns about how intra-operative changes in the surgical plan, common in spine surgery, would be treated under this policy. However, we believe the final language is written in a way that will not adversely affect those making a good faith effort to provide high quality care. The policy places strong emphasis on the consent form, which puts more control in the hands of physician, and excludes emergent situations that preclude a provider from obtaining informed consent. Nevertheless, this is a policy we'll continue to monitor closely for unintended consequences as it is implemented.

Hospital and Outpatient Reporting Programs

Under the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program, hospitals must report 30 quality measures to qualify for a full update to their FY 2009 payment rate. For FY 2010 payment, CMS has added 13 new quality measures and will retire one existing measure. The new measures include:

- Additional Surgical Care Improvement Project (SCIP) measures related to hair removal [**see section on Surgery Patient with Appropriate Hair Removal Measure**] and cardiovascular surgery;
- Various AHRQ composite outcome measures; and
- Participation in a systematic database (i.e., STS's registry) for cardiac surgery.

Hospital outpatient departments must report 11 quality measures in 2009 to receive a full payment update in 2010, including four new imaging efficiency measures. Hospitals that fail to report will get dinged two percentage points in their annual Outpatient Prospective Payment System (OPPS) inflation update, as mandated under the Deficit Reduction Act of 2005. Many stakeholders, including the AANS, the CNS, and the American Hospital Association voiced major concern over the inclusion of the imaging measures, since many were not endorsed by the Hospital Quality Alliance (HQA) and two were rejected by the National Quality Forum (NQF) due to "substantial technical problems."

Surgery Patient with Appropriate Hair Removal Measure

Recent efforts at the federal level to reduce Surgical Site Infections are quickly leading to the removal of razors from the operating room. Due to the NQF's recent endorsement of a measure originally developed under the Surgical Care Improvement Project (SCIP), organizations like the Joint Commission and CMS have adopted guidelines that state that razors are "never appropriate" for surgical skin preparation. In 2008, CMS, under its inpatient hospital reporting program, will publicly report on hospital compliance with this measure and in 2009, link hospital payments to compliance with this measure. Starting in 2010, the Joint Commission will similarly seek to ban razors from the operating room through its hospital inpatient certification program. As pointed out by the Florida

Neurosurgical Society, with the assistance of the CNS Plante Public Policy Fellow, Joseph Hsieh, there is little to no literature demonstrating that adherence to this practice guideline improves SSI in neurosurgical procedures such as brain and spine surgery. The AANS and CNS are now working to reverse this policy. In February 2009, the Surgical Quality Alliance (SQA) voted to send a joint letter to CMS and The Joint Commission requesting that: 1) it only use quality measures that are based on solid evidence; and 2) when there is not reliable data to compel one practice over another, mandatory compliance with a measure is inappropriate and a surgeon's clinical autonomy should be preserved.

Establishing a Comprehensive Neurosurgery Clinical Data Reporting System

The AANS and CNS have initiated a project to create a single system that will allow practicing neurosurgeons to satisfy MOC case reporting and Medicare and other third-party payers' P4P/quality requirements. In late 2008, the NeuroPoint Alliance, LLC (NPA) was formally incorporated and continues to meet regularly to discuss the functions and scope of the registry, the structure and governance of the system, reporting relationships, data access and ownership, applications/software, and funding. The NPA has decided to contract with Outcomes Sciences, Inc., the vendor that AANS used for its earlier Lumbar Spine Outcomes Data Collection pilot, to operate the registry. The NPA is currently working with Outcomes to finalize a business plan, which will include cost estimates of setting up and maintaining a website portal and a PQRI reporting system. It will also include a proposal for any profit sharing generated by the use of the system. The NPA is also working to finalize an agreement with the ABNS to share Key Case data.

The QIW, working with the clinical subspecialty sections, will assist in developing data collection instruments (i.e., standardized measures of patient characteristics, processes and outcomes) to evaluate neurosurgery's most commonly used CPT codes, which will then be added to the data fields currently used for Neurolog and Key Case reporting. Once the registry is deployed and tested, a Research Committee also will be formed within the LLC to review various uses of the reported data.

In January 2009, the NPA made the following appointments:

- Tony Asher, President-Elect
- Paul McCormick, Treasurer
- Chris Wolfla, Secretary

Neurosurgery's leaders believe this system, which will eventually allow us to refine care processes that lead to better outcomes, will be of considerable value to neurosurgeons and payers alike, and many private payers have already expressed interest in providing incentive payments for participation in such a registry.

Private Payer Quality Recognition Initiatives

Over the last few months, the AANS and CNS have been contacted by various health plans-- including Aetna, BlueCross Blue Shield, and CareFirst (the Blues plan that serves DC-MD-VA)—that have expressed interest in collaborating with neurosurgery to develop specialty-specific recognition programs. Over the last few months, Dan Resnick and Jack Knightly helped BCBS develop a program that recognizes multidisciplinary facilities that deliver high quality spine care. While the BCBS program is far from perfect and does not warrant AANS/CNS endorsement, we are pleased to have been given a seat at the table early on in the development process.

In late January, WellPoint also notified the AANS and CNS that it is interested in developing a Low Back Pain Center of Excellence-type program, which would encourage the formation of multi-stakeholder collaborations to encourage care coordination and increase quality/efficiency for managing LBP patients. While WellPoint claims flexibility in terms of protocol setting, it would require

minimum standards. It is still unclear how this program would be implemented, and we have remaining concerns about it benefiting primary care providers at the expense of surgeons' time and resources. Separately, WellPoint also proposed to work with neurosurgery to develop interactive CME to educate providers on the main tenants of quality care (e.g., adherence to EBM guidelines, use of shared decision-making tools, use of pain/functional status assessments). WellPoint recently granted the American College of Physicians a nonrestrictive grant to develop didactic, interactive, cross-specialty CME that the American Board of Internal Medicine will incorporate as a requirement of Part 4 MOC. The AANS/CNS noted that it already offers interactive CME courses and that it would be equally interested in working with WellPoint to assist with the development of an educational component that cuts across various relevant specialties.

Consumer Checkbook vs. HHS

On January 30, 2009, the US Court of Appeals for the D.C. Circuit Court reversed a federal district court's decision on Consumers' Checkbook vs. HHS Freedom of Information Act. The court's refusal to grant Consumers' Checkbook's request for physician billing records represents a momentous victory for physician privacy rights.

In 2007, a federal district court ordered CMS to release, under the Freedom of Information Act (FOIA), individually identifiable physicians' claims data to Consumer's Checkbook, a non-profit group that rates everything from plumbers to health clubs. Consumers' Checkbook planned to use the data to provide consumers with information on Medicare physicians' "quality." The 2007 decision was in conflict with a Florida district court ruling, which prohibited release of Florida Medical Association (FMA) member data due to privacy concerns.

Both the AMA and the American College of Surgeons (ACS) sent letters to HHS Secretary Leavitt urging HHS to appeal the 2007 ruling on the grounds that it posed significant privacy risks to patients and physicians and could undermine current concerted efforts to ensure meaningful, accurate health care performance data is available to patients. HHS subsequently filed an appeal, but continued to emphasize its commitment to transparency by referring to initiatives such as the Hospital Compare Web site, which offers consumers unprecedented access to Medicare data on facilities and the conditions they treat.

In May 2008, the AANS and CNS, along with 16 other medical societies, filed a "friend-of-the-court brief" in the FOIA case brought by Consumers' Checkbook. The medical societies' brief argued that disclosure of the requested information would violate the privacy rights of physicians and would harm patients and the public interest. Among other things, the brief showed that claims data alone cannot be used to assess accurately the quality of physician services or develop reliable physician rankings, which are among the purported goals behind Checkbook's request. Disclosure of the requested data would therefore mislead patients about the quality of their physicians' services and incomes from Medicare and thereby interfere with the physician-patient relationship.

In related news, another case – Alley v. HHS – has recently emerged on the same topic. The AANS and CNS also joined this amicus brief initiative. Given the outcome of the Consumer Checkbook case, we are relatively confident (although you never know) that the 11th Circuit Court of Appeals will not contradict the findings of the D.C. Circuit Court.

Comparative Effectiveness Research

The ARRA 2009 included \$1.1 billion for Comparative Effectiveness Research (CER), which is projected to result in \$6 billion in system-wide savings. This funding includes:

- \$400 million for NIH

- \$300 million for AHRQ
- \$400 million allocated at discretion HHS for efforts that:
 - Compare clinical outcomes, effectiveness, and appropriateness of care
 - Encourage development and use of clinical registries, clinical data networks and other forms of electronic health data used to generate outcomes data
 - \$1.5 million: IOM development of recommendations on national CER priorities based on public feedback.

Leaders from the Spine Section will be submitting an NIH Challenge Grant proposal to obtain CER funds to support a clinical data registry for spine. The proposal will use the NeuroPoint Alliance as the data collection system.

The AANS/CNS will also submit written comments to the IOM that highlight the lack of high quality evidence and subsequent clinical uncertainty surrounding many neurosurgical procedures and the important role clinical outcomes registries could play in obtaining data needed to guide clinical practice. We will offer specific CER research questions related to common spinal disorders, but we will frame them in a way that does not pit one procedure against another or potentially limit treatment options for individual patients. Instead, the AANS/CNS will highlight the need for prospectively obtained clinical data to identify patient profiles that more accurately predict an outcome following a given procedure.

The legislation also creates a Federal Coordinating Council that:

- Includes 15 federal employee members appointed by president (at least 1/2 must be physicians)
- Will coordinate CER among the various government agencies, limit duplicative efforts, and encourage coordinated use of resources
- Will advise President/Congress on CER priorities and funding needs (report due June 2009)
- Does not have the authority to use the research for payment, coverage, or treatment decisions.

There is still debate about whether CER could be used to restrict coverage and to what extent it will include cost-of-care analyses. An earlier version of the legislation, which the AANS/CNS supported, specifically referred to the policy as comparative “clinical” research and specifically prevented cost-analyses from being included in such studies. Unfortunately, the final version of the legislation does not make those distinctions. The only language that explicitly prohibits the use of this research for coverage determinations is 1) the provision related to and limited to the Council, and 2) report language that accompanied the final bill stating that such research should not be used to mandate coverage and that research should not limit patient access to individualized treatments. While the AANS/CNS supports this report language, it represents Congressional intent, but holds no statutory force. As a result, there is lingering concern that HHS, or CMS specifically, may still have discretion over whether the research should be factored into coverage decisions.

Details regarding CER will be worked out through the rule-making process and during broader health reform discussions over the next few months. Senate Finance Chair Baucus and Budget Chair Conrad also plan to reintroduce legislation that would create a public-private CER entity financed by both the federal government and an assessment on the insurance industry. Throughout the fall and winter, the Alliance of Specialty Medicine met with Baucus’ and Conrad’s staff to request that they strengthen the bill’s language to make it more difficult for researchers to exclude subpopulations from such research; ensure that the leadership include adequate representation by board certified clinicians who are involved in treating the disease or disorder under consideration; and that they reconsider funding the initiative with Medicare Part B funds, given the payment cuts facing physicians.

In the fall of 2008, the AANS and CNS also became a founding member of the Partnership to Improve Patient Care (PIPC), a newly formed multi-stakeholder coalition that advocates for well-designed CER. It is currently underwritten by BIO, AdvaMed and PhRMA, but the governance structure is not weighted towards the industry.

As the stimulus package was debated, the PIPC urged Congress to keep in mind that CER should:

- Enhance information about treatment options; close gap between care known to be effective and care patients receive
- Preserve patient/physician choice and support medical innovations
- Provide information on clinical value and patient health outcomes, not cost-effectiveness
- Ensure studies are valid and appropriate and reflect diversity of patient populations
- Require open and transparent processes; ensure all stakeholders have input into research priorities and design

Quality Improvement Organizations

AMA Physician Consortium for Performance Improvement (PCPI)

The AMA PCPI organizes cross-specialty work groups to develop physician-level performance measures from current evidence-based clinical guidelines. Working with the AMA's CPT panel, the PCPI also develops standardized codes to allow for the reporting of such measures. The PCPI has approved over 200 quality measures to date through on-line voting and three annual in-person meetings. CMS recently renewed for a year its contract with the PCPI, the National Committee for Quality Assurance (NCQA), and Mathematica to develop physician-level measures. Starting in 2009, Jeff Cozzens and Peter Angevine will replace Dan Resnick and Mike Kaiser as the AANS/CNS representatives to the PCPI.

The PCPI is now focusing on the following activities: testing of previously adopted measures; developing new measures of outcomes and appropriateness (including overuse); bundling of certain measures; fostering the use of clinical registries; and increasing the involvement of key stakeholders (e.g., consumers, American Board of Medical Specialties (ABMS)). The PCPI is also exploring the development of measures that assess episodes of care across care settings (rather than individual measures). In a Robert Wood Johnson Foundation-funded project titled, "Characterizing Episodes and Costs of Care," the PCPI is working with the ABMS and the NQF to define episodes of care and related cost measures for three targeted areas, one of which is low back pain [**see section on NQF**]. Zohar Ghogawala is representing the AANS and CNS on the newly formed Low Back Pain Cost of Care Workgroup. At the workgroup's first meeting in November, Dr. Ghogawala convinced the panel that surgery is not the real problem in dealing with the variable cost of spine care. The group has subsequently decided to develop measures that focus on the cost of treating low back pain among primary care physicians. Over the next few months there will also be a call for nominees to a Stroke Cost of Care Workgroup. AANS/CNS CV Section leaders have nominated Greg Zipfel for this activity.

National Quality Forum (NQF)

The NQF is a federally-defined voluntary consensus standards-setting organization. This multi-stakeholder group's role is to ensure that measures are scientifically sound and meaningful and to standardize performance measures used across the health care sector. NQF endorsement is viewed as the "gold standard" for health care performance measures by other stakeholders, including consumers, employers, and purchasers. Due to its legal status, the federal government is obligated to use NQF standards, where they exist, rather than creating its own. To date, the NQF has endorsed over 200 performance measures.

The NQF currently has a broad membership (over 350 members, including at least 30 medical and specialty societies) representing every sector of the health care system. Membership is organized into

eight councils, including a “Health Professionals Council.” The NQF is also a member of the National Priorities Partnership (NPP), a coalition of 28 key healthcare stakeholders including the AMA’s PCPI, AFL-CIO, Consumers Union and the CDC.

The NQF meets twice a year and holds monthly member conference calls, quarterly member council calls, and smaller workgroup meetings throughout the year. Gail Rousseau and John Kusske represent neurosurgery on the NQF. The QIW recently appointed Jack Knightly (Spine), Aaron Cohen-Gadol (Tumor, CV), Fernando Diaz (Spine, CV), Gary Bloomgarden (Spine), Jeff Cozzens (Tumor, Functional), Monica Wehby (Peds), and Kevin Cockroft (CV) to also assist with the increasing demands of the NQF.

- **NQF Recommends Linking Performance Measurement to Health Reform.** In January 2009, the NQF, in consultation with the National Priority Partnership, finalized a position paper titled, *Building a Foundation for High Quality, Affordable Health Care: Linking Performance Measurement to Health Reform*, which it recently sent to the new Administration and Congress. The paper calls on the federal government to build on the collaborative quality coalition work accomplished to date and to expand public investment in performance measurement and public reporting in order to improve care and lower costs. While the final paper contained many supportable elements regarding QI, the AANS/CNS felt it placed too strong of an emphasis on the role of performance measurement and public reporting, implying that these two elements are the “be all, end all” of quality improvement. As a result, the AANS/CNS decided not to sign on to this document and instead sent Congress its own *Blueprint for Quality Improvement*, which advises against a one-size-all approach to quality improvement [**see section on Physician P4P**].
- **Characterizing Episodes and Costs of Care.** As part of the RWJF-funded project, Characterizing Episodes and Costs of Care, [**see PCPI section**], the NQF recently developed a document titled, *Evaluating Efficiency Across Patient-Focused Episodes of Care*, which is available at: <http://www.qualityforum.org/projects/ongoing/episodes/voting-materials.asp> This framework for evaluating efficiency is structured to aggregate care across sites and providers, as well as over time, in order to promote shared accountability for a patient’s care. It incorporates multiple measurement domains, including health outcomes, cost and resource use, and processes of care. At the end of the document, the Committee theoretically applies the framework to two chronic conditions, including acute myocardial infarction and low back pain.

The NQF addressed many of the AANS/CNS concerns regarding this paper. However, significant concerns still remain. While a commendable framework, it is hard to imagine how it can be implemented without first addressing the multitude of current barriers (e.g., the current payment system, which stands in the way of achieving many of the goals outlined in the paper. The framework also relies on a far more robust set of measures for quality and cost than currently exists. Finally, the NQF failed to take action in response to our request to clarify that consensus-based standards should only be relied on when evidence-based standards do not exist. Although this document is simply a “living” blueprint for examining models of shared accountability that will evolve over time, its failure to address critical obstacles regarding implementation is concerning. The AANS/CNS therefore abstained from supporting this document.

Surgical Quality Alliance (SQA)

The SQA acts alongside the AQA to ensure the unique perspective of surgeons is preserved in quality conversations. Gary Bloomgarden and Elana Farace represent neurosurgery on the SQA, with staff support from Rachel Groman. The group is now focusing on registry reporting collaboration among surgical specialties, developing a surgical patient experience survey, and coordinating meetings with federal officials, payers and plans.

Frustrated by current public and private performance measurement programs that rely largely on poor indicators of quality surgical care, the SQA has begun to explore the feasibility of developing a common surgical data registry that would allow for the collection of more meaningful data across surgical specialties. The hope is that the data could be combined and used for internal quality improvement purposes; standardized reporting to the government and private health plans; MOC reporting; coverage/reimbursement decisions; and general specialty-specific and cross-specialty research, including device-tracking (similar to the goals of neurosurgery's NeuroPoint Alliance (NPA), but on a much broader scale). While few details have been worked out, the group agrees that a hub and spoke model would most appropriately fit the varying needs of the different surgical specialties. Under this model, specialties with existing specialty-specific registries, such as the NPA, could maintain their own registries and simply funnel data to the collaborative surgical database as needed. Those surgical specialties who do not yet have a registry would be able to use the collaborative surgical database as their primary data collection tool.

The first real movement on this effort came in the fall of 2008, when the SQA began working with a contractor to issue a RFP to solicit feedback from vendors on possible strategies for collecting meaningful data across surgical specialties. After reviewing various proposals, the SQA decided that Outcomes Science, Inc. was the most appropriate and qualified vendor for this project (this is the same company that the NPA contracted with to build/manage the neurosurgical registry). The consulting services used to vet and select the vendor cost the SQA about \$20,000. Since the SQA is not a dues paying organization, but rather a voluntary coalition, the ACS asked surgical societies to contribute to this cost. The AANS/CNS together contributed \$1,000 in "seed money," which we felt would allow us to track this important, but somewhat overly ambitious initiative from the sidelines while we focused on the more important task of getting our own registry off the ground.

We've now reached the next phase of this project, during which Outcomes Sciences, Inc. will conduct a more in depth design study to further refine the scope of this effort, the functions of the registry, and the needs of each society. To cover the costs of this study, each surgical specialty is now being asked to contribute an additional \$6,000. Societies that contribute to this phase will be considered "charter" members of the joint surgical registry and will have input into some of the more critical (and controversial) details, such as the governance structure, ownership and use of data, and the role of the Boards. To date, 8 surgical societies have contributed funding, some of which have existing registries (American College of Surgeons, American Society of Plastic Surgeons) and some who do not (American Academy of Ophthalmology, American Academy of Otolaryngology). The American Academy of Orthopaedic Surgeons is still wavering, since it's currently trying to revamp an earlier effort to create its own Joint Procedures Registry. The Society of Thoracic Surgeons also has not yet contributed, despite its support for this effort, which is likely due to the specialty's indifference about being a "charter" member given its unparalleled experience with registries.

The Boards are also interested in this effort. The American Board of Medical Specialties (ABMS), under the leadership of Kevin Weiss, supposedly recently signed off on partnering with the surgical specialties to collect cross-specialty data. However, the ABMS' intentions are still unclear. For example, we do not know what level of involvement they envision as this collaborative relationship moves forward. In previous discussions, the ABMS seemed to indicate in that they would demand a 50% stake in the governance of the joint surgical registry. We also do not know what the ABMS intends to do with the collected data. Kevin Weiss continues to heavily advocate the ABMS' "public trust" duty when it comes to physician accountability in the quality movement, which raises red flags about his desire to make data collected through this registry widely available to the public. We also heard that ABMS intends to move forward with collecting and reporting this data with or without collaboration from the surgical specialties.

In assessing this project, the AANS and CNS will consider the following pros and cons:

Pros

- Opportunity to steer this ship and ensure the collaborative registry is in synch with neurosurgery's registry, that data goes only where we want it to go, and that the ABMS doesn't inappropriately use or prematurely release surgical data to the public. Few details have been worked out yet and becoming a "charter" member would allow us to influence some of the more controversial aspects of this project.
- Opportunity to be involved with a project that is starting to gain more attention from public and private stakeholders. The FDA, NIH, and CMS have all expressed interest in this collaborative effort, as have multiple private health plans, such as BCBS, WellPoint, and Aetna (which could mean more money for physicians who participate in the registry). Some of these groups have also expressed interest in funding some of the costs of the registry.
- Neurosurgery's involvement in this effort shouldn't affect our independent effort to collect meaningful data through our own specialty-specific registry other than at some point requiring that we standardize some mutually common surgical data points so that they can be easily aggregated across other relevant surgical specialties.
- The fact that the NPA has contracted with Outcomes Sciences, the same vendor that would manage the joint surgical registry, means that the data flow between neurosurgery's registry and the joint registry should be easier and the long-term costs lower for neurosurgery.
- Opportunity for surgery to take back the medical profession by coming together and showing meaningful dedication to quality improvement and patient care (which is especially critical at a time when there's talk of cutting payments to surgery to benefit primary care).

Cons

- Diverting resources away from our main priority, the NPA.
- The fact that the NPA could probably achieve some of the same goals, but on a smaller scale, by inviting other neurosurgically-relevant specialties to participate in our registry (e.g., other surgical and non-surgical spine care providers, such as orthopods, physiatrists, etc.).
- Concern that this initiative is overly ambitious. Will it ever get off the ground? And even if it does, will enough surgeons opt to participate? A registry is only as meaningful as the data entered.
- Will this effort disproportionately benefit those specialties that do not yet have a registry? Unlike neurosurgery, many of the societies that have already pledged funding don't have their own registry and are looking to the joint surgical registry to fill that role.
- Current lack of financial commitment from some key stakeholders, such as the orthopods and STS. Although this may soon change, it is nevertheless concerning, especially since there is a lot of cross-over between orthopaedic and neurosurgical procedures.

Ambulatory Care Quality Alliance (AQA)

This multi-stakeholder group, led primarily by health plans and primary care physicians, continues to evaluate whether measures are ready for implementation and develop principles on issues related to data aggregation, reporting, and harmonization of measures. The AQA does not develop measures, but instead evaluates measures to see if they are suitable for implementation. Gary Bloomgarden and Elana Farace represent neurosurgery on the AQA, with staff support from Rachel Groman. The AQA meets in-person three times a year and holds numerous conference calls in between.

As the NQF grows in size and responsibility, the AQA has begun to focus on more general issues related to quality and accountability, rather than evaluation of specific measures. These include: improving the leverage of quality measures; identifying attributes of high bar vs. low bar measures; aligning quality improvement activities and measures across disciplines of care; and identifying how board certification/MOC, state licensure, clinical registries, and outcomes data can be used for quality improvement purposes.