Quality & Regulatory

Thinking Outside of the Box for Choosing Quality Measures

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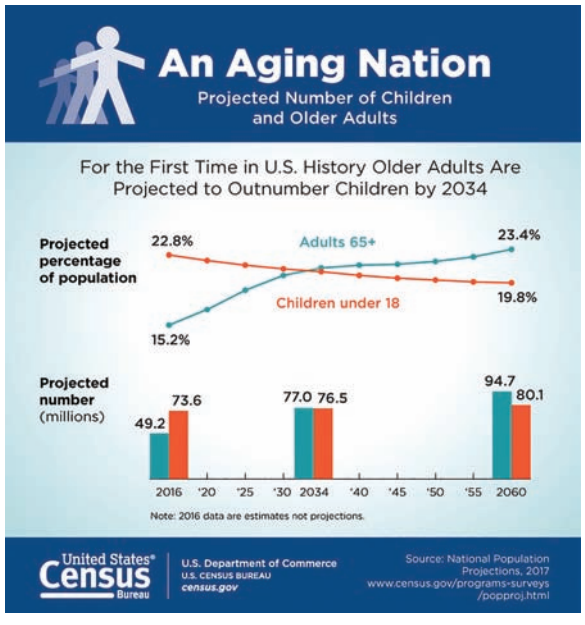
The Committee on Performance and Outcomes Measurement (CPOM) is tasked with creating meaningful measures for anesthesiologists to use in quality programs and, more specifically, for use in the Centers for Medicare & Medicaid Services (CMS) Quality Payment Program (QPP). The life cycle of a quality measure is built on a defensible measure development process, including (but not limited to) identifying a performance gap, conducting feasibility testing, and implementing the measure for use. The most important aspect to keep the measure alive in any program is ensuring its adoption and reporting by a significant number of physicians and groups. Without adoption and measure data, it becomes nearly impossible to create a case to CMS that this measure is valuable to the physicians who do use the measure.

The Merit-based Incentive Payment System (MIPS) is built on CMS assessing and paying physicians and their groups for the delivery of quality and cost-effective care. If quality measures are not reported by eligible clinicians (ECs) and groups in significant numbers, CMS cannot use the data to score (or rather, differentiate) the care that a patient received from one physician that another patient may have received from a different physician. ASA and the Anesthesia Quality Institute (AQI) understand that ECs and groups, including those who report quality data for internal quality improvement purposes, report on measures that are not just meaningful to their practice but can be easily collected. This logical measure selection process by groups has left several ASA measures being under-reported and in danger of retirement in 2022. This process eventually becomes problematic for the future of a measure.

Before a measure is rejected by CMS, the agency allows for a Qualified Clinical Data Registry (QCDR) to implement a participation plan to encourage physicians and groups to report that measure. This CMS-approved plan allows QCDRs to promote the measure to their participants. CMS believes these measures are well-established and evidence-based but struggle with low adoption and reporting rates.

For ASA measures, we encourage physicians and their groups to consider collecting and reporting data on these lesser-used measures. These measures include a cardiovascular anesthesia measure set of AQI18 (Coronary Artery Bypass Graft [CABG]: Prolonged Intubation), AQI49 (Adherence to Blood Conservation Guidelines for Cardiac Operations using Cardiopulmonary Bypass [CPB]) and AQI65 (Avoidance of Cerebral Hyperthermia for Procedures Involving Cardiopulmonary Bypass), as well as one critical care measure, AQI55 (Team-Based Implementation of a Care-and-Communication Bundle for ICU Patients), a pain medicine measure, AQI57 (Safe Opioid Prescribing Practices), and a measure for older patient populations, AQI67 (Consultation for Frail Patients). Please take another look at those measures and consider reporting a few of them in 2021.



The second part of this article focuses on AQI67: Consultation for Frail Patients, a measure that had low adoption among reporters for the 2019 Performance Year. The 2019 Performance Year data on this measure was unique among other measures in that, while there was a lower number of physicians reporting this measure, there was a large case volume that showed physicians reporting the measure in large numbers.

AQI67: Consultation for Frail Patients: Percentage of patients aged 70 years or older, who undergo an inpatient procedure requiring anesthesia services and have a positive frailty screening result who receive a multidisciplinary consult or care during the hospital encounter

The United States population is aging, and anesthesiologists must be aware of the perioperative implications of this phenomena. According to the U.S. Census, adults over 65 years old will outnumber children by 2034 (asamonitor.pub/35bVxD6) (Figure 1). Frailty is a measure of decreased physiological reserve that results from impairments in multiple organ systems (*J Clin Anesth* 2018;47:33-42). This makes a patient less resilient and particularly vulnerable to stressors such as surgery. Among elderly surgical patients, frailty has been well-associated with postoperative complications and mortality (*JAMA Surg* 2018;153:160-68).

There is agreement that preoperative assessment and identification of frailty is an important first step to ensure coordinated and patient-centric care for the frail patient throughout their perioperative course. Preoperative identification of frailty and appropriate multidisciplinary consultation allows for the care team to provide appropriate counseling regarding the anticipated outcomes of surgery, better anticipate postoperative complications, and better prepare patients and families for their postoperative course. Several organizations, including the Society for Perioperative Assessment and Quality Improvement, American Geriatrics Society, and American College of Surgeons' NSQIP have endorsed this concept (*J Clin Anesth* 2018;47:33-42; *JAMA Surg* 2018;153:160-68).

Overall, this measure encompasses team-based care and highlights our role as perioperative physicians. AQI67: Consultation for Frail Patients allows anesthesiology departments to embrace this issue. Essentially, this measure seeks to determine the percentage of patients aged 70 years or older who undergo an inpatient procedure requiring anesthesia services and have a positive frailty screening result who receive a multidisciplinary consult or care during the hospital encounter. Frailty can be screened using an established tool, including but not limited to the following tools:

- Fried Frailty Phenotype Criteria
- Modified Frailty Index
- The Vulnerable Elders Survey
- Initial Clinical Impression ("First Minute Impression")

Performance is met on this measure when a multidisciplinary consult is conducted or initiated by the anesthesiologist. A multidisciplinary consult should include documentation of a discussion of the frailty screening result and can include a consultation initiated by the anesthesiologist or other qualified anesthesia provider with surgery, geriatrics, hospital medicine, palliative care, or other appropriate specialty to help manage the perioperative care of a frail patient.

The adoption of the measures will not only sustain the life of a measure, it will in some instances allow the new adopters of the measures to set the benchmarks for the coming years. For more information on QCDR measures, please reach out to the Quality and Regulatory Affairs team at **qra@asahq.org**. ■

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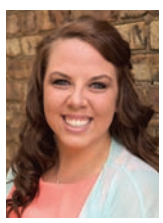

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