Surgical Phase of Care (SPC) Measure 7 – ACS21: Post-Acute Recovery Composite

National Quality Strategy (NQS) Domain: Patient Safety

Meaningful Measure Area: Care is Personalized and Aligned with Patient's Goals

Measure Type: Composite; Process

Inverse Measure: No

High-Priority Measure: Yes – Communication and Care Coordination

Risk-Adjusted: No

Number of Performance Rates: 1

Proportional Measure: Yes

Continuous Variable Measure: No

Ratio Measure: No

2019 QPP MIPS QUALITY OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients age 18 or older who are taken to the operating room for an elective intervention under regional, MAC, and/or general anesthesia who have been documented for having all two post-acute components addressed at the beginning of the post-discharge phase of care:

1. A post-discharge review of the patient goals of care that were expressed preoperatively and updating those goals of care as appropriate occurring after discharge up until 30 days following discharge date.
2. A post-discharge follow-up encounter within 30 days updating patient improvements in mobility, pain control, diet, resumption of home medications, wound care, and management of cutaneous/invasive devices (drains, IV lines, etc).

INSTRUCTIONS:
This measure is to be reported each time a patient is taken to the operating room for an elective intervention under regional, MAC, and/or general anesthesia. There is no diagnosis associated with this measure. This measure may be reported by eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

DENOMINATOR:
All patients, aged 18 years and older, who undergo an elective procedure under regional, MAC, and/or general

anesthesia who have a post-discharge communication regarding the goals of care discussion documented as one of the following:

1. Living as long as possible
2. Living independently
3. Keeping comfortable, symptom relief
4. Establishing a diagnosis or treating/curing a condition
5. Other (single sentence)

Denominator Criteria (Eligible Cases):

All patients aged 18 years and older

AND

Patients who undergo an elective procedure under regional, MAC, and/or general anesthesia

AND

Patients who have postoperative and/or post-discharge communication regarding the goals of care discussion documented as one of the following:

1. Living as long as possible
2. Living independently
3. Keeping comfortable, symptom relief
4. Establishing a diagnosis or treating/curing a condition
5. Other (single sentence)

AND

One of the following CPT codes for the patient encounter during the reporting period: (see appendix 1)

AND NOT

Patients who are inpatient at an acute care hospital at the time of their current operation

OR

Patients who are transferred from the Emergency Department (ED)

OR

Patients who are transferred from a clinic

OR

Patients who undergo an emergent/urgent surgical operation

OR

Patients whose admission to the hospital was on any date prior to the date of the schedule surgical procedure for any reason

NUMERATOR (All or Nothing):

All patients age 18 or older who are taken to the operating room for an elective intervention under regional, MAC, and/or general anesthesia who have been documented for having all two post-acute components addressed at the beginning of the post-discharge phase of care:

COMPONENT 1: A post-discharge review of the patient goals of care that were expressed preoperatively and updating those goals of care as appropriate occurring after discharge up until 30 days following discharge date.

COMPONENT 2: A post-discharge follow-up encounter within 30 days updating patient improvements in mobility, pain control, diet, resumption of home medications, wound care, and management of cutaneous/invasive devices (drains, IV lines, etc).

Numerator Instructions: Each component should be reported in order to determine the reporting and performance rate for the overall percentage of patients that meet ALL targets represented as the numerator. There must be documentation for all two post-acute recovery ***components*** listed.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

COMPONENT 1:

Documentation of a post-discharge review of the patient's goals of care that were expressed preoperatively and who has had those goals of care updated as appropriate occurring after discharge up until 30 days following discharge date.

Component Options:

Performance Met:	Documentation of a post-discharge review of the patient's goals of care that were expressed preoperatively and who has had those goals of care updated as appropriate occurring after discharge up until 30 days following discharge date.
OR	
Performance Not Met:	No documentation of a post-discharge review of the patient's goals of care that were expressed preoperatively and who has had those goals of care updated as appropriate occurring after discharge up until 30 days following discharge date.

AND

COMPONENT 2:

Documentation of a plan during a post-discharge follow-up encounter that takes place within 30 days of discharge updating patient improvements in mobility, pain control, diet, resumption of home medications, wound care, and management of cutaneous/invasive devices (drains, IV lines, etc.).

Component Options:

Performance Met:	Documentation of a plan during a post-discharge follow-up encounter that takes place within 30 days of discharge updating patient improvements in mobility, pain control, diet, resumption of home medications, wound care, and management of cutaneous/invasive devices (drains, IV lines, etc.).
OR	
Performance Not Met:	No documentation of a plan during a post-discharge follow-up encounter that takes place within 30 days of discharge updating patient improvements in mobility, pain control, diet, resumption of home medications, wound care, and management of cutaneous/invasive devices (drains, IV lines, etc.).

RATIONALE:

COMPONENT 1: There is substantial literature supporting the need to align appropriate care with patient goals. With better alignment of patient care and patient goals, there will be better appropriateness of care, better satisfaction, and likely cost savings. Furthermore, revisiting the patient's goals of care will facilitate care coordination and communication with the patient's other providers.

COMPONENT 2: It is expected that there will be better coordination of care between the surgeon and the patient's other providers thereby increasing patient satisfaction and well-being.

SUPPORTING EVIDENCE:

COMPONENT 1:

Steffens NM, Tucholka JL, Nabozny MK, Schmick AE, et al. Engaging patients, health care professionals, and community members to improve preoperative decision making for older adults facing high-risk surgery. JAMA Surg. 2016. doi: 10.1001/jamasurg.2016.1308

Kelly KN, Noyes K, Dolan J, Fleming F, et al. Patient perspective on care transitions after colorectal surgery. J Surg Res. 2016; 203(1):103-12

Gussous Y, Than K, Mummameni P, Smith J, et al. Appropriate use of limited interventions vs extensive surgery in the elderly patient with spinal disorders. Neurosurgery. 2015; 77 suppl 4:S142-63

Kim Y, Winner M, Page A, Tisnado DM, et al. Patient perceptions regarding the likelihood of cure after surgical resection of lung and colorectal cancer. Cancer 2015; 121(20):3564-73

Paul Olson TJ, Brasel JH, Redmann AJ, Alexander GC, et al. Surgeon-reported conflict with intensivist about postoperative goals of care. JAMA Surg. 2013. 148(1):29-35.

COMPONENT 2:

Henderson PW, Landford W, Gardenier J, Otterburn DM, et al. A simple, visually oriented communication system to improve postoperative care following microvascular free tissue transfer: development, results and implications. J Reconstr Microsurg. 2016; 32(6): 464-9

Salzwedel C, Mai V, Punke MA, Kluge S, et al. The effect of a checklist on the quality of patient handover from the operating room to the intensive care unit: A randomized controlled trial. J Crit Care. 2016;32:170-4

Streeton A, Bisbey C, O'Neill C, Allen D, et al. Improving nurse-physician teamwork: a multidisciplinary collaboration. Medsurg Nurs. 2016; 25(1):31-4

Agarwal HS, Saville BR, Slayton JM, Donahue DS, et al. Standardized postoperative handover process improves outcomes in the intensive care unit: a model for operational sustainability and improved team performance. Crit Care Med. 2012; 40(7):2109-15

Segall N, Bonifacio AS, Schroeder RA, Barbeito A, et al. Can we make postoperative patient handovers safer? A

systematic review of the literature. Anesth Analg. Jul; 115(1):102-15

Joy BF, Elliott E, Hardy C, Sullivan C, et al. Standardized multidisciplinary protocol improves handover of cardiac surgery patients to the intensive care unit. Pediatr Crit Care Med. 2011; 12(3):304-8