

Division of Advocacy and Health Policy

Statement of the American College of Surgeons

to

Health Information Technology Policy Committee

by

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RE: Hearing on Meaningful Use Measures Related to Specialists, Smaller Practices and Hospitals, and Providers of Underserved Populations

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Dr. David Blumenthal, Dr. Paul Tang, and distinguished members of the Health Information Technology Policy Committee, thank you for the opportunity to testify today on behalf of the 74,000 members of the American College of Surgeons. My name is Frank Opelka. I practice colorectal surgery in New Orleans, and serve as Professor of Surgery, Vice Chancellor for Clinical Affairs at Louisiana State University School of Medicine. I also serve as the Chair of the Surgical Quality Alliance.

SPECIALTY PANEL QUESTIONS

We are appreciative and encouraged that the Committee is facilitating dialogue with specialists regarding including more specialty-focused measures in the meaningful use definition, and we agree that, as currently drafted, the quality measures in the meaningful use matrix are too heavily focused on adult primary care. There is concern among our members that it will not be feasible for specialists to meet the meaningful use definition, but refining the list of measures to include measures that are specialty-focused is one significant step toward making the meaningful use definition more inclusive for specialists. In addition, we believe that finalization of the interoperability standards would be a major step toward utilizing the quality measures that currently exist. We address these issues in greater detail below in our responses to the six questions relevant to the specialty panel.

Question 1: In the context of the policy priorities, care goals, and objectives that are part of the definition of meaningful use, what is the best way for specialists to be integrated into that framework?

With respect to the policy priority of improving care coordination, we recommend that the Committee explore the use of the measures that are part of the current National

Quality Forum (NQF) project, Care Coordination Practices. Although this project is not yet complete, these measures could potentially be included in the meaningful use matrix for 2013.

Regarding the policy priority of improving quality, safety, efficiency, and reducing health care disparities, we believe that requiring specialists to participate in registries for their specialty is an appropriate goal for 2011. Registries generate high quality complex data that is used to track outcomes and to improve surgical patient care. These data programs give healthcare providers a model for organizing and managing their networks to ensure multidisciplinary, integrated, and comprehensive services. The results are system wide cost savings and improved patient care. Registries also serve as a deep reservoir for researchers interested in clinical trials and outcomes research, and they provide a means to obtain population data, which are not available outside the context of a registry. We discuss specific registries in detail in Question 2, below.

The definition of meaningful use should be realistic and scalable to accommodate practices with varying IT adoption levels and with different capabilities. As currently drafted, it is unclear exactly where the bar will be set, e.g., too low or too high. For example, it should consider the technical capabilities of solo practitioners or rural practices, among other considerations. Flexibility is particularly important for surgery because most surgeons have not yet adopted or implemented EHR systems. At the same time, those surgeons who were early adopters of EHR should be supported so that their EHR products can be brought into conformance with certification requirements. We strongly believe that the requirements for 2011 should be “achievable” so as not to result in a barrier to surgeons aspiring to be meaningful users of EHR.

In order to efficiently measure and manage the quality of care for surgical patients, EHRs should be capable of tracking pre-, peri-, and post-operative data across settings, and should allow surgeons to obtain data from and coordinate effectively with referring physicians. Currently, registries are an invaluable aid in this process because they provide a means to track and make such data available. Although this type of data will be more accessible once EHRs are adopted and once the interoperability standards are in place, most surgeons are unwilling to purchase and implement EHRs until the criteria for interoperability have been determined. For most of our members, the cost of purchasing and implementing EHR software is high, and many are unwilling to risk purchasing software that could later be determined not to meet interoperability standards.

We appreciate that the Committee is open to continued dialogue regarding the inclusion of more specialty-focused measures in the meaningful use definition. The measures that are currently included in the meaningful use matrix are oriented toward adult primary care, and much of the data identified are not routinely collected, measured, or managed by surgeons, or the details of the data are not directly relevant to surgery. We believe that it is unrealistic to hold specialists accountable for quality measures that are completely unrelated to their specialty, and specialties should be exempted from compliance with non-relevant measures. We discuss our recommendations for specific specialty measures below in Questions 4 and 5.

Question 2: Are there relevant national registries in your specialty? Would participation in those registries be a good measure of meaningful use for the HIT incentive?

Several national surgery-related registries exist, and we strongly believe that participation in such registries is an excellent measure of meaningful use for the HIT incentive for 2011 and beyond. Examples of such registries include the following:

- The ACS National Cancer Data Base (NCDB) is a nationwide oncology outcomes database for more than 1,400 Commission on Cancer Accredited Programs in the United States and Puerto Rico. Some 75% of all newly diagnosed cases of cancer in the United States are captured at the institutional level and reported to the NCDB. The data is used to explore trends in cancer care, create regional and state benchmarks, and serve as the basis for quality improvement.
- The ACS National Trauma Data Bank (NTDB) is the largest aggregation of North American trauma patient data. NTDB annual reports characterize trauma care in North America for both adults and children, and NTDB benchmark reports compare hospitals to similar institutions on patient demographics, raw mortality, injury type, injury severity, length of stay, and other pertinent measures. Trauma centers use the benchmark reports and the research dataset to create extensive comparisons to other centers and gauge their own performance.
- The ACS Trauma Quality Improvement Program (TQIP) provides risk-adjusted benchmarking of designated/verified Level I and II trauma centers to track outcomes and improve patient care. TQIP relies and builds upon the existing trauma infrastructure of data collection, reporting, and performance improvement through extensive trauma registrar training opportunities, rigorous data validation, and risk adjusted outcomes models. TQIP uses a systems approach to improving trauma care in participating centers.
- ACS Bariatric Surgery Database Approved centers of the ACS Bariatric Surgery Center Network Accreditation Program report bariatric surgical outcomes data to the ACS Bariatric Surgery Database. The data is complete, uniform, encrypted, and de-identified to protect the confidentiality of patients, surgical facilities, and surgeons. This longitudinal database requires a 100% capture of all cases and data points. Participating Bariatric Centers receive an annual report of their non-risk-adjusted outcomes data collection.
- The ACS National Surgical Quality Improvement Program (ACS NSQIP) is the first nationally validated, risk-adjusted, multi-specialty, outcomes-based, systems focused program to measure and improve the quality of surgical care. As a clinically based program, ACS NSQIP detects and averts, more complications than administrative QI programs, resulting in improved patient care and significant return on investment for participating hospitals. Certified surgical clinical reviewers collect, validate, and submit data, including preoperative risk

factors, intraoperative variables, and 30-day postoperative mortality and morbidity outcomes for patients undergoing major surgical procedures in both the inpatient and outpatient setting. Data is presented to hospitals enrolled in the program via comprehensive semiannual reports and real-time, continuously updated, online benchmarking reports.

- ACS Practice Based Learning System (Case Log) The ACS Practice Based Learning System (PBLs), also known as the Case Log, is used for quality/performance improvement, quality reporting, and maintenance of individual certification. The Case Log data registry collects about 30 data points, including patient demographics, diagnosis, co-morbid conditions, procedures, complications and outcomes. The database now contains over 1,000,000 patient records with almost 2,000 participants. Launched in 2005, the Case Log is growing at a rate of almost 100% per year. Reports available to participants include procedure lists, outcomes reports, and benchmarking reports.
- The American Society of Plastic Surgeon's (ASPS) Tracking Operations & Outcomes for Plastic SurgeonsSM (TOPS)SM Program TOPS is a web based data collection process that captures plastic surgery procedures, clinical outcomes and patient satisfaction results. TOPS is available to all ASPS members, and currently includes approximately 420,000 cases. TOPS is unique because it is physician focused, rather than facility focused. The TOPS registry stores cases a surgeon performs at each facility where he/she is on staff. Data entered through the web based TOPS interface are used by the surgeon in a variety of practice situations such as comparing cases and outcomes across facility type (in-patient, out-patient hospital, ambulatory surgical center, and office-based surgery facility) and to benchmark patient surgical outcomes, patient satisfaction results and practice patterns against their peers. ASPS uses the de-identified data for multiple purposes including: compilation of the National Clearinghouse of Plastic Surgery Statistics and monitoring clinical outcomes and emerging trends. The TOPS registry was created in 2002.
- The Society of Thoracic Surgeons (STS) National Database This registry is the premier clinical data registry for cardiothoracic surgery. It includes three component parts: the Adult Cardiac Surgery Database, the General Thoracic Surgery Database, and the Congenital Heart Surgery Database. More than 90 percent of all adult cardiac surgery centers nationwide participate in the Adult Cardiac Database and 70% of the congenital heart surgery programs participate in the STS Congenital Database. Surgeons add new patient data on a continuous basis thereby providing a highly dynamic, up-to-date picture of cardiothoracic surgical practice.

Surgical data registries typically collect more complex data compared to the data obtainable from EHRs. As a result, until the appropriate interoperability criteria have been determined, reporting data to the registries will be an added burden for surgeons, but

we maintain that participation in such registries is an important measure of meaningful use from the outset.

Question 3: How can specialists and the societies that represent them help accelerate the development of HIT-enabled quality measures that are appropriate for the definition of meaningful use?

Market forces are already at work to accelerate the development of HIT-enabled quality measures that are appropriate for the definition of meaningful use, and the determination of the interoperability standards would be a major step forward in utilizing the quality measures that currently exist. Data related to surgeons' practices are currently measured on multiple levels and collected by more than one method. For example, data on an individual practitioner level is captured by certain data registries such as the STS National Database, TOPS and the Case Log; data on a facility/system level is captured by other types of data registries such as the ACS NQSIP; and data on patient experience of care is captured through tools such as the Surgical Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Currently, each of these types of activities are siloed, but with effective interoperability, the data could be shared. The College supports greater interchange of data and the facilitation of risk adjustment, and the College has worked extensively to advance methods of risk adjustment and to combine data from multiple sources to develop meaningful composite measures of surgical care. Interoperability will also improve efficiency and reduce duplication of reporting efforts in light of new rules requiring participation in a registry for purposes of maintenance of certification.

Question 4: What other measures would you propose to be considered to assess the meaningful use of EHRs by specialists? Are there any cross cutting measures that could be added to the meaningful use definition today?

We are appreciative and encouraged that the Committee is facilitating dialogue with specialists regarding including more specialty-focused measures in the meaningful use definition. Including such measures will make it more feasible for specialists to be eligible for the ARRA incentives. The measures that are currently included in the meaningful use matrix are oriented toward adult primary care, and much of the data identified are not routinely collected, measured, or managed by surgeons, or the details of the data are not directly relevant to surgery. Accordingly, we recommend including the following cross-cutting measures in the meaningful use definition:

NSQIP Measures

These three risk-adjusted outcomes measures apply across specialties, and were recently submitted to NQF for endorsement. Although these are facility or system-level measures, they represent cross-cutting measures that collect data from both inpatient and outpatient settings, and track 30-day outcomes data that are obtained from physician office records. Of note, the Surgical Site Infection (SSI) Outcomes Measure highlights the value of data registries because SSIs generate an average of \$28,211 in extra costs per case and comprise 38% of all morbidities; therefore, reducing SSIs leads to lower costs and

morbidity. In general, however, we caution against automatically applying facility-based measures to individual providers.

- Risk Adjusted Urinary Tract Infection Outcome Measure;
- Risk Adjusted Surgical Site Infection Outcome Measure; and
- Risk Adjusted Case Mix Adjusted Elderly Surgery Outcomes Measure.

Physician Quality Reporting Initiative (PQRI) Measures

- Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician;
- Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin;
- Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures);
- Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients); and
- Perioperative Care: Timing of Prophylactic Antibiotics – Administering Physician.

Surgical Care Improvement Project (SCIP) Measure

- Ventilator-assisted Pneumonia (VAP)

Imaging Measures

We support the development, endorsement, and inclusion in the meaningful use definition of measures that would incorporate guidelines on imaging services and provide clinical decision support at the point of care.

Eventually, we need to move toward greatly enhanced “meaningful **use**,” e.g., shifting from performance measurement to performance improvement through relevant decision support via “just-in-time, just-for-me” knowledge for providers and patients that incorporates the knowledge we have gained from data-mining. To accomplish this will require decision support relating to identified quality metrics in computable language. This will require an interfacing of the informatics and quality communities within and across specialties. To accomplish this requires specialty societies within medicine as well as nursing, pharmacy, dentistry and perhaps others to create structures that link NQF, the specialties, the Agency for Healthcare Research and Quality (AHRQ) and others so that EHRs will be able to maintain currency of practice and improved outcomes through use of “high performance” decision-support.

Question 5: Which measures could be incorporated in the definition of meaningful use that would help drive more communication and coordination between specialists and primary care?

The College agrees that driving communication and coordination between specialists and primary care is an important component of the meaningful use definition, however, few appropriate measures exist at this time. We recommend that the Committee consider some of the measures that are part of the current NQF project, Care Coordination Practices. Although this project is not yet complete, these measures could potentially be included in the meaningful use matrix for 2013. We also support the development and use of medication reconciliation measures. Also, to further drive communication between specialists and primary care, we support the development of two complementary measures, one for the primary care/referring physician, and one for the specialist. This type of measure would promote effective communication in the form of a feedback loop.

In addition, we support the development and use of measures related to the ongoing care of the surgical patient. In general surgical care is not strictly limited to performance of the surgical procedure. Rather, it involves many providers in addition to the surgeon. For example, in the treatment of cancer, a surgeon will perform the necessary surgery, but treatment of the patient could also include care provided by a radiologist, pathologist, primary care physician, and others. Communication with the tumor registry is also a critical component to effectively managing the care of the surgical cancer patient. Surgeons must be able to communicate and coordinate with each of these other providers and entities, and appropriate quality measures would improve such communication and coordination.

Question 6: Does your specialty participate in primary care, and how should that be measured?

Typically surgeons do not participate in primary care; however, a surgeon often acts in the capacity of the team leader in the care of a patient. In addition, in some cases, rural general surgeons are primary care providers for their patients.

ADDITIONAL COMMENTS

In addition to the specialty panel questions above, we would like to take this opportunity to comment on the measures generally. The College appreciates the Committee's efforts to promptly issue a proposal for meaningful use objectives and measures, but we do have some additional concerns, as described in more detail below, regarding the measures.

Objectives and measures should be well connected: Once the specialty measures are developed and included in the meaningful use definition, those measures should correspond closely with the meaningful use objectives. For example some of the

objectives and measures in the meaningful use recommendations document, as currently drafted, are not intuitively connected. I.e., it is unclear how the 2011 measure of “percentage of smokers offered smoking cessation counseling” will achieve any of the 2011 objectives. Conversely, it is also unclear how the 2011 objective of “Record vital signs including height, weight, blood pressure” is directly addressed by any of the 2011 measures.

Tailor meaningful use criteria appropriately: The definition of meaningful use must accommodate physicians who do not engage in all the core functionalities as described by ARRA, namely e-prescribing, exchanging information for the purpose of care coordination, and reporting clinical measures. For example, low volume prescribers, physicians who do not issue prescriptions to his/her patients, or physicians who do not review and/or exchange certain health data should be acknowledged, as should physicians who are low prescribers of non-controlled substances.

Account for situations beyond a physician’s control: Although the surgical community intends to make every effort to comply with measure reporting, there must be mechanisms built into the process for demonstrating meaningful use that account for situations where it is impossible for a physician to comply with the meaningful use definition. For example, some physicians may not have an adequate number of quality measures available for reporting for their specialty or subspecialty, or may practice in areas with inadequate information exchange. In addition, some physicians may experience significant practice interruptions due to unforeseen circumstances like natural disasters.

Ensure adequate technical implementation support: Reengineering workflow takes time, and extensive technical and implementation support will be critical to ensure overall success of incorporating new technologies into current practice workflows. Physicians will need substantial technical support to assist in the significant changes that accompany the incorporation of new technologies into practice workflow. Funding to support education and training should be part of the overall program.

Thank you, again, for the opportunity to provide testimony regarding meaningful use measures related to specialists, and for your efforts to refine the definition of meaningful use for the purposes of the ARRA incentive in a way that is more inclusive for specialists. If you have any questions about our testimony, please contact Vinita Ollapally in our Washington office. She can be reached at vollapally@facs.org or at (202) 672-1510.