Meeting Summary

Core Quality Measures Collaborative Gastroenterology Workgroup Meeting

Under its Partnership for Quality Measurement (PQM), Battelle convened the Core Quality Measures Collaborative (CQMC) Gastroenterology Workgroup on Tuesday, June 25, 2024, to discuss potential measure additions or measure removals to the Gastroenterology core set.

Welcome and Opening Remarks

Kate Buchanan, MPH, Battelle CQMC Lead, welcomed Workgroup members to the Gastroenterology meeting to discuss core set updates. Ms. Buchanan reminded Workgroup members that Battelle now holds the Centers for Medicare & Medicaid Services (CMS) consensus-based entity (CBE) contract, which was formerly held by National Quality Forum (NQF). She reviewed the anti-trust compliance statement and said that CQMC is a membership-driven and -funded effort, with additional support from CMS and AHIP. Ms. Buchanan gave an overview of the meeting agenda.

Ms. Buchanan introduced the Workgroup co-chairs, Kenneth I. Freedman, MD, MS, MBA, FACP, AGAF, DFASAM, and Jenny Maratt, MD, MS, and then provided a list of voting and non-voting members.

Dr. Freedman and Dr. Maratt each provided opening remarks to the Workgroup, and Ms. Buchanan then outlined the core set maintenance process, noting the intent of the core sets, CQMC principles for core set measure selection, and the process for maintenance for the core sets.

2022 Maintenance Review Recap

Ms. Buchanan provided a high-level recap of measures under review and results from the 2022 cycle. During the 2022 cycle, the Workgroup removed one measure and added one measure. The Workgroup removed Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Related Iatrogenic Injury – Bone Loss Assessment (MIPS ID 271) as this measure is no longer active in federal programs and is no longer being maintained. The Workgroup chose to add CBE #0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention with the rationale that screening and tobacco use cessation counseling can reduce the risk of tobacco-associated gastrointestinal injury. The Workgroup also discussed key updates to American Gastroenterological Association (AGA) measures and added a few gap areas: infectious hepatitis, screening for Clostridium difficile colitis (C. diff colitis), upper GI infection, hypertrophic pyloric stenosis, chronic pancreatitis disease, celiac disease, and the

correlation between smoking and Barrett's esophagus.

The Current Core Set

Ms. Buchanan provided an overview of the current Gastroenterology core set, noting that it has eight measures: four measures on endoscopy and polyp surveillance, two measures on hepatitis C, one measure on irritable bowel syndrome (IBS), and one cross-cutting measure.

Measures for Consideration – Addition

Ms. Buchanan reviewed the process to assess potential additions to the core set, indicating that Battelle requested feedback from Workgroup members and conducted an environmental scan with a three-year lookback period. The sources for the scan include: CMS Measure Inventory Tool (CMIT), CMS Measures Under Consideration Entry/Review Information Tool (MERIT), PQM Submission Tool and Repository (STAR), measures discussed in previous meetings, CQMC analysis of Measurement Gap Areas and Measure Alignment white paper, Quality Payment Program (QPP), and Healthcare Effectiveness Data and Information Set (HEDIS).

The Workgroup considered nine measures for addition to the core set:

1. Hepatitis C Virus (HCV): Sustained Virological Response (SVR)
2. Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users
3. CBE #0034 Colorectal Cancer Screening (COL)
4. CBE #3661 Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma
5. CBE #1717 National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure
6. CBE #3688 CDC, NHSN Healthcare Facility Onset, Antibiotic Treated Clostridiodes Difficile Infection Outcome Measure
7. CBE #2539 Facility Seven-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy
8. Screen Positive Rate for Social Drivers of Health
9. Screening for Social Drivers of Health

Ms. Buchanan introduced Hepatitis C Virus (HCV): Sustained Virological Response (SVR), an AGA-stewarded measure. A Workgroup member proposed the measure because it addresses infectious hepatitis, a core set gap area, and treatment and monitoring for Hepatitis C is an equity concern. Ms. Buchanan added that AGA submitted the measure to the 2024 Measures Under Consideration (MUC) List, and the HIV/Hepatitis C Workgroup voted to include it. A co-chair voiced support for this measure addition because it identifies patients with Hepatitis C and takes them through a full referral and treatment process. A Workgroup member asked for more information around the numerator and denominator. The developer clarified that the numerator is patients who have been treated and have a subsequent negative ribonucleic acid (RNA) test at 20 weeks to 20 months after the first detected positive test. The denominator includes all patients aged 18 years or older who are eligible for the encounter with a positive Hepatitis C RNA test. The measure does account for patients who decline. The developer worked with CMS and Mathematica to ensure this measure provided needed linkage care. This measure will be included on the voting ballot.

The Workgroup next discussed Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users which is also stewarded by AGA. Similar to Hepatitis C Virus (HCV): Sustained Virological Response (SVR), the measure addresses the infectious hepatitis gap area. The CMS CBE approved this measure for trial use in 2017 but it is not fully endorsed. The co-chairs noted this measure does not include patients with a history of chronic Hepatitis C; this is important because most substance use treatment programs conduct initial screenings for viral hepatitis for all incoming patients, regardless of whether they have a history of Hepatitis C. This approach is treatment agnostic: the treatment does not change based on the patient's Hepatitis C history. This

measure attempts to capture those who have not been positive for Hepatitis C in the past.

During the measure discussion, a Workgroup member raised a question about whether the clinician is obliged to supply laboratory data that confirms screening. The developer clarified that this measure is specifically for outpatient providers. Another question was whether the measure differentiates between active and past drug use. In response, the developer explained that the measure's specifications identify active injection drug users as those who have used any injectable drug within the last 12 months. Members were concerned regarding the feasibility of implementing this measure.

A Workgroup member asked if this measure had benchmarks to allow for evaluation of performance. In their response, the other co-chair mentioned that there is likely a benchmark specific to active substance use treatment, but they are not aware of benchmarks existing outside of treatment settings. This measure could be used to create benchmarks moving forward to measure treatment settings and allow for comparison. Ms. Buchanan mentioned Battelle will see if benchmarking data are available and if so, will include them on the ballot.

The Workgroup discussed CBE #0034 Colorectal Cancer Screening next. It is stewarded by the National Committee for Quality Assurance (NCQA) and is part of the CMS Universal Foundation for quality measures. Ms. Buchanan noted that NQCA now requires reporting by race and ethnicity. A co-chair noted that this measure excludes patients with a history of colorectal cancer and colectomy. The measure developer added they also changed the age range for patients from 50-75 to 45-75 years to reflect updated clinical guidelines and stratified from 45-49 and 50-75. A Workgroup member noted that American College of Physicians released a guidance statement that in average-risk patients aged 45-49, harms of early screening outweigh the benefits and thus they do not recommend early screening during this age range.

While a Workgroup member noted that gastroenterology normally picks up after the screening and subsequent surveillance is complete and proposed that this may be more suited for a primary care measure rather than gastroenterology, the Workgroup agreed to include CBE #0034 Colorectal Cancer Screening on the ballot.

The Workgroup next reviewed CBE #3661: Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma. A Workgroup member expressed concerns around the importance of this measure in the Gastroenterology core set. A Workgroup member asked if the Workgroup chose to include this measure if they would then be scored on reporting metrics that are outside of their scope as gastroenterologists. Ms. Buchanan clarified that the core sets are voluntary reporting on suggested measures agreed upon by the Workgroup. Their aim is to promote alignment but there are no reporting or payment requirements for inclusion to the CQMC. The Workgroup agreed that this measure relates more to pathology, not gastroenterology. This measure will not be included on the ballot.

Ms. Buchanan introduced the next two measures: CBE #1717 National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure and CBE #3688 CDC, NHSN Healthcare Facility Onset, Antibiotic Treated Clostridiodes Difficile Infection Outcome Measure. Both are stewarded by the Centers for Disease Control and Prevention (CDC). They are proposed for addition because the Workgroup previously identified screening for Clostridium difficile colitis as a gap area in the core set. A co-chair asked if CBE #3688 had been considered by any of the other CQMC Workgroups. Ms. Buchanan noted these measures have not been considered by a Workgroup this cycle. The Workgroup agreed to include CBE #1717 and CBE #3688 on the ballot.

Next, the Workgroup considered CBE #2539: Facility Seven-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy. It is stewarded by CMS/Yale CORE and is currently undergoing Endorsement and Maintenance review. A Workgroup member asked if "all-cause mortality" is an appropriate outcome. The measure developer noted that all-cause status is aligned with CMS requirements and is used for only 7 days post-procedure, and post-procedure hospital visits are usually related to the procedure. The developer clarified that due to limitations on claims data, this measure is for Medicare populations. The Workgroup agreed to include this measure on the ballot.

Ms. Buchanan introduced two social drivers/determinants of health (SDOH) measures: Screen Positive Rate for Social Drivers of Health and Screening for Social Drivers of Health. Because there is not a CQMC cross-cutting Workgroup, the Steering Committee suggested proposing these measures to all the Workgroups for their consideration or addition. These measures are cross-cutting and not specific to gastroenterology but are in frequent use in CMS programs and Screening for Social Drivers of Health is part of the CMS Universal Foundation. Several Workgroup members expressed support for these measures. A couple of members expressed some concern around measurement and tracking. The developer acknowledged awareness of concerns with redundant screenings, and they are considering how improvements can be made here. Both measures will be included on the voting ballot.

Measures for Consideration – Removal

Ms. Buchanan reviewed the process for measure removal consideration and informed the Workgroup that three measures are being considered for removal:

- CBE #0658 Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients
- CBE #0659 Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use
- Age-Appropriate Screening Colonoscopy (MIPS ID 439)

A Workgroup member proposed CBE #0658 Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients for removal. They noted that the measure specifications might incorrectly give the impression that 10 years between colonoscopies is appropriate, despite current evidence to the contrary. A Workgroup member had feasibility concerns related to coding and extracting the recommended information from patients' medical records. A Workgroup member noted that the intent of the measure is to prevent someone from recommending something less than 10 years, which is common but considered inappropriate overuse. A Workgroup member noted that a 10-year interval is reasonable considering current studies showing colonoscopies are good for 15+ years. The developer added that this measure went through the endorsement process in 2022 and, at that time, the gastroenterology quick data were around 80% performance rate, with CMS data showing a higher rate. During the maintenance review, the CMS CBE determined the measure was feasible to implement. The Workgroup agreed to include the measure on the ballot.

A Workgroup member also proposed CBE #0659 Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use for removal. The member noted that current evidence recommends longer surveillance intervals based on polyp characteristics, they did not identify a performance gap for this performance measure based on 2023 MIPS benchmark data, and they expressed concerns around feasibility. The developer clarified that the interval is at least 3 years but there are exceptions. The developer then addressed the concern around the polyp data and noted that current data show there is overuse of surveillance for patients with a history of adenomas. A Workgroup member said that overuse is a huge concern, and this measure aims to reduce overuse. The Workgroup discussed ways to address this procedure and if a patient has a false colonoscopy or if development of symptoms warrants the need for a second or third one. The developer noted that if these situations occurred then those indications would come sooner than the 3-year interval and would not necessarily be considered in this measure. The Workgroup also

recognized there may be difficulties with coding and identifying indications from administrative data. The Workgroup agreed to include the measure on the ballot.

Ms. Buchanan introduced the final measure for discussion, Age-Appropriate Screening Colonoscopy (MIPS ID 439), noting it was proposed by a Workgroup member. The member said that the measure did not identify performance gap data to demonstrate that the measure addresses an opportunity for improvement and expressed confusion around measure specifications because the age range where overuse is more likely is 76 to 85 years of age. The developer replied that this is an inverse measure and the guidelines do not recommend screening for patients 86 years or older due to harm risk and life expectancy. The developer commented on the request for changing the age range from 76-85, noting it could be considered as a separate measure if it did change. A Workgroup member expressed concern over removing this measure, as it aids in collecting data on a population for which it is challenging to capture data. Another Workgroup member suggested that it might not be essential to the core set because the population is so small and the core set is meant to focus on high-impact, high-value measures. The Workgroup agreed to include this measure on the ballot.

Gaps Discussion

Ms. Buchanan provided an overview of measurement gap areas identified in previous Workgroup meetings. Important gaps in the core set include:

- Quality of colonoscopy, including measures for post-colonoscopy complications (e.g., emergency department or hospital visit after a procedure, perforation, hemorrhage)
- Patient safety, including complications after procedures
- Medication management and adherence, especially for patients with IBD and patients on immunosuppressive medications
- Patient continuum of care and vulnerable points of information exchange
- Patient-reported outcome performance measures (PRO-PMs)
- Specific diseases, including gastroesophageal reflux disease (GERD), nonalcoholic fatty liver disease, hypertrophic pyloric stenosis, celiac disease, cirrhosis, infectious hepatitis, chronic pancreatitis, and upper gastrointestinal infections
- Hepatitis A vaccination rates
- Screening for Clostridium difficile colitis
- Correlation between smoking and Barrett's esophagus
- Resource utilization during acute episodes of care
- Capture disparities or measure stratification to identify disparities (e.g., colorectal cancer screening and follow-up rates for groups less likely to receive care)

The co-chairs noted that some of these gap areas were addressed in the measure discussion. A Workgroup member suggested making a distinction between measures that create more administrative burden versus measures that work automatically. The Workgroup also suggested considering measures that will aid in alignment among the health care community in quality measurement.

Next Steps

Kelsey Conner, Battelle, provided an overview of voting procedures and informed the group that voting will open once the meeting summary is available. The voting link will be sent from CQMC@Battelle.org. Ms. Conner reminded the group of supermajority rules around voting and provided an overview of the Full Collaborative Approval process. Ms. Buchanan and the co-chairs gave closing remarks before adjourning the meeting.