

AHIP Comments on Ad Hoc Review of Melanoma and Eye Care Measures

We appreciate the efforts of the NQF to create a broad set of evidence-based, ambulatory care measures to assess physician performance. We are concerned, however, with the reliance of the measurement set on medical record review and medical chart abstraction. Many of the measures included in this set require or are supplemented by data from the medical record. Without widespread adoption of electronic medical records, the burden of data collection for providers may be too great and health plans will unlikely to implement within contracts.

Two measures included in the set (Complications within 30 days following cataract surgery requiring additional surgical procedures & 20/40 or better visual acuity within 90 days following cataract surgery) have 100+ exclusions from the measure denominator. NQF should provide information from the measure developer that demonstrates how numerous exclusions affect the measure's reliability and validity, including administrative burden.

Additionally, AHIP recommends that the measure developer consider developing composite measures for glaucoma, cataracts and AMD out of the component measures below and previously endorsed eye care measures. Composite measures would provide consumers and purchasers with useful and actionable information for decision-making.

Comments on Specific Measures

- Melanoma Coordination of Care
 - This measure represents a standard of care process rather than an assessment of clinical quality that could be used to differentiate providers. AHIP does not support unless utilized as part of a composite measure.
2. Melanoma: Over-utilization of Imaging Studies in Stage 0-1A Melanoma
- The measure title implies that the measure assesses the amount of overutilization of imaging that occurs. However, the measure actually calculates the percentage of patients with *appropriate* utilization (i.e., no imaging studies performed).
 - AHIP suggests changing the name to “Utilization of Imaging Studies in Stage 0-1A Melanoma” or “Non-Utilization of Imaging Studies in Stage 0-1A Melanoma.”
 - AHIP also requests that CPT II codes be created so that the measure could be collected via claims data.

American Optometric Association

Measure NOT Recommended -- AED-09-08 Comprehensive Pre-Operative Assessment for Cataract Surgery with IOL Placement

The American Optometric Association requests that this measure be reconsidered and supports a time-limited endorsement of this measure. Testing of this measure should involve all eye care providers including optometrists. Optometrists perform a significant percentage of the peri-operative care of cataract patients. The AOA Optometric Clinical Practice Guideline on Care of the Adult Patient with Cataract states the following concerning the pre-operative assessment:

Examination of the eye involves identifying the nature and severity of the cataract and assessing any other diseases that might contribute to symptoms or limit the potential for good vision following cataract surgery. Elements of the ocular examination may include, but are not limited to, the following: Measurement of visual acuity under both low and high illumination; Biomicroscopy with pupillary dilation, with special attention to the three clinical zones of the lens and the classification and quantification of the cataract; Stereoscopic fundus examination with pupillary dilation; Assessment of ocular motility and binocularity; Visual fields screening by confrontation, and if a defect is noted, further investigation by formal perimetry; Evaluation of pupillary responses to rule out afferent pupillary defects; Refraction to rule out refractive shift as a cause for the decreased vision; and Measurement of intraocular pressure (IOP).

Additional testing may be necessary to assess and document the extent of the functional disability and to determine whether other diseases (e.g., corneal disease, optic nerve disease, or retinal disease) may limit preoperative vision or may prove to limit postoperative vision. Contrast sensitivity, glare testing, potential acuity testing, threshold visual fields or Amsler grid testing, fluorescein angiography, corneal pachymetry/ endothelial cell count, specialized color vision testing, B-scan ultrasonography, tonography, and electrophysiology testing are not required as a part of the preoperative workup; however, individual circumstances, as documented in the patient record, may justify their use.

National Partnership for Women & Families Comments on *National Voluntary Consensus Standards for Ambulatory Care Additional Eye Care and Melanoma Performance Measures*

General Comments

The National Partnership for Women & Families is pleased to see a set of measures that responds to the needs of consumers by addressing issues of overutilization, complications, and outcomes in the area of eye care and melanoma. And it is gratifying to see a measure set that is meaningful not only to consumers, but to providers as well.

When it comes to outcomes, we are encouraged by the development of measures that measure and report actual outcomes, as opposed to outcomes that are based on numerical goals or baselines, which are often subjective and may change over time due to new evidence. While debate over baselines is necessary, it should occur in the context of specific users and uses of the measures. In addition, we feel that measures related to the three buckets of counseling, plan of care, or patient education require more consistency of specification so that they can be consistently applied. Part of this consistency would require providers to address all three buckets in order to “get credit” for the measure.

Melanoma: Over Utilization of Imaging Studies in State 0-1A

We are excited to see the issue of overuse being addressed in this project through this measure, particularly as it relates to diagnostic imaging studies. Overuse of imaging is a priority issue from both a quality as well as efficiency standpoint.

Primary Open-Angle Glaucoma

The National Partnership supports the idea of having a measure that addresses both outcome and process of care. We believe there should be flexibility afforded to those who implement the measure to report the two rates separately. In addition, we support the technical advisors' assertion that there is an evidence base to support an 18% reduction in IOP, and believe that this should be the minimum reduction rate, as opposed to the 15% as currently specified in the measure.

20/40 or Better Visual Acuity with 90 days

We support having an outcome measure for cataract surgery but believe the evidence clearly supports high level of performance at 20/40 or better visual acuity. We believe a different level of performance is needed to have a more meaningful and actionable measure.

Skin and Eye Care Comments
April 7, 2009
Pacific Business Group on Health

We applaud the measure developer bringing forth a set of measures that address overutilization and outcomes. While we may have issue with how some of the measures are specified, we feel that this is an important step to having meaningful and relevant measures not only for consumers and purchaser, but providers as well.

Below are some overall comments:

For outcomes, we need measures that just measure and report the actual outcomes and do not have embedded in them numerical goals (e.g., 18%, 20/40) that are subject to debate and can change over time based on new evidence. Such debate should occur in the context of specific users and uses of the measures. Also, it is important to capture the specific outcome, rather than a dichotomous response (above / below) so measurement is efficient and flexible. "Locking in" a threshold as a part of the coding makes it impossible to do trending or recalculation if the threshold changes.

For all counseling, plan of care, or patient education measures, issues that are to be addressed as a part of counseling, plan of care, or patient education measures need to be specifically delineated as a part of the measure otherwise the measure can be inconsistently applied. Additionally, all issues need to be addressed for the provider to "get credit" for the education.

We are concerned about the number of exclusions for a couple of measures and wonder if the evidence supports the use of all the exclusions.

Melanoma: Over Utilization of Imaging Studies in State 0-1A – We appreciate seeing a measure addressing overuse, especially related to diagnostic imaging studies. This clearly is an area of importance, both from a quality as well as efficiency standpoint.

Primary Open-Angle Glaucoma: Reduction of IOP – We concur with the technical advisors that evidence supports 18% reduction in IOP and given the lack of data to support using 15%, at a minimum 18% should be used. We support having a measure that addresses both outcome and process of care and depending on how the measure will be used, believe there should be flexibility in reporting the two rates separately.

20/40 or Better Visual Acuity with 90 days – We support having an outcome measure for cataract surgery but believe the evidence clearly supports high level of performance at 20/40 or better visual acuity. We believe a different level of performance is needed to have a more meaningful and actionable measure.