NATIONAL QUALITY FORUM

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"Developing a Viable Physician Payment Policy"

Statement of:

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Thank you Chairman Brady and Ranking Minority Member McDermott for inviting me to participate in today's hearing and provide testimony on behalf of NQF.

My name is Dr. Frank Opelka. I am a member of the NQF-convened Measure Applications Partnership and the Vice Chair of NQF's Consensus Standards Approval Committee (CSAC); I will become Chair of CSAC in July. CSAC oversees measure evaluation and endorsement at NQF. I am a surgeon and in my day job, the Executive Vice President for Health Care and Medical Education Redesign at Louisiana State University as well as the Associate Medical Director for the American College of Surgeons.

Background on NQF

Founded in 1999, NQF is a non-profit, non-partisan organization with over 440 organizational members. NQF members span the health care spectrum, including physicians, hospitals, businesses, consumer and patient representatives, health plans, certifying bodies and other healthcare stakeholders.

NQF has two distinct but complementary roles focused on enhancing the quality and value of the U.S. health care system:

- **NQF reviews and endorses quality performance measures.** These measures are used by public and private payers to assess how well doctors, hospitals and other providers are doing in offering high-quality care, and are also used by providers to benchmark their performance against peers and national standards. About two-thirds of the measures that the federal government uses in its healthcare programs are NQF endorsed. There is also widespread use of NQF-endorsed measures by hospitals and health plans at the state, regional and local levels.
- **In addition to endorsing measures, NQF also convenes diverse, private sector healthcare stakeholders to provide input to the Department of Health and Human Services (HHS) quality improvement efforts.** More specifically, the NQF-convened National Priorities Partnership (NPP) has served as a forum for a diverse group of stakeholders to provide initial and ongoing input to the HHS developed National Quality Strategy (NQS), which is focused on improving care, increasing affordability and building healthier communities. The NQF-convened Measures Application Partnership (MAP) is another diverse stakeholder group that works together to make recommendations on which measures should be used in Federal payment and

public reporting programs, including Hospital Value Based Purchasing and the Physician Quality Reporting System (PQRS), among others.

NQF's Board of Directors is composed of 31 voting members—key public- and private-sector leaders who represent major stakeholders in America's healthcare system (see Appendix A). A distinguishing characteristic of NQF is that our by-laws stipulate that a majority of the Board must be representatives of patients/consumers and purchasers, which assures a strong voice for those who receive care and those who pay for care. By practice, patient representatives are prominent in all NQF committees and workgroups.

NQF is recognized as a voluntary consensus standard-setting organization under the National Technology Transfer and Advancement Act of 1995. Its process for reaching consensus adheres to the Office of Management and Budget's formal definition of consensus.[i] NQF is supported by membership dues, foundation grants, and Federal funding.

Why We Are Here Today

Mr. Chairman, we commend you and your entire committee for undertaking the critical task of reforming physician payment and for placing health care quality at the center of your efforts. Concentrating on health care quality is the right medicine for making our system more patient-focused, along with improving outcomes and reducing costs.

It may sound simple but it is true that focusing on quality will only work if the tools we use to measure are themselves "high quality". For quality measurement to have an impact, the measures must be rigorous and held to high medical and scientific standards. Also, it is critical that a range of stakeholders be involved in choosing which measures will drive the biggest improvements.

At Louisiana State University, I see the power of using standardized measures to compare and contrast different hospitals and provider groups within our system, and to gauge our institution's performance against other hospital systems both regionally and nationally. This kind of feedback and transparency motivates improvement.

It is why I and over 400 other physicians take time away from our practices to serve on NQF committees. Along with experts from other stakeholder groups – totaling about 850 volunteers strong in 2012 and logging about 55,000 hours, translating into approximately a $4 million contribution – we collectively embody NQF's public service mission to improve the health of the nation.

Why High Quality Measures Matter

Mr. Chairman, all of the "measures" work my professional colleagues do is predicated on a precious few goals – to improve care, get optimal use of affordable resources, and to engage patients and make care more patient centered.

There is no one size fits all for measures, rather there are different types of measures for different purposes. There are many measures that physicians use that help them improve the way they practice such as many measures contained in registries or maintenance of certification programs, but which are not necessarily appropriate for public reporting or payment purposes.

NQF's current focus is on measures that are linked to high stakes reporting or payment, which need to be standardized and vetted through a rigorous multi-stakeholder process. Examples of these measures and the difference they make include:

- **NQF-endorsed measures on infections are driving care improvements:** Many have contributed to patient safety gains in hospitals, including a CDC-reported 58 percent reduction in central line associated blood stream infections (CLABSIs) between 2001 and 2009, which is the window of when a new NQF measure in this area came into use. This represents up to 6,000 lives saved and approximately $1.8 billion saved in cumulative excess health-care costs.ii
- **Publicly reported NQF-endorsed measures improved physician group performance:** Physician groups in Wisconsin that publicly reported quality measures between 2004-2009 improved their performance on key indicators, e.g., cholesterol control and breast cancer screening, outperforming peers in the rest of Wisconsin, nearby states of Iowa and South Dakota, and the U.S. as a whole. [iii]
- **Hospitals that use NQF-endorsed measures have better outcomes:** A peer reviewed study of more than 650 hospitals showed a decline in mortality in those hospitals that have fully implemented NQF endorsed Safe Practices.iv
- **NQF's focus on endorsing measures related to prenatal care is making a difference:** The Joint Commission requires hospitals to report on elective delivery prior to 39 weeks. A recent study found that the rate of neonatal intensive care unit (NICU) admissions dropped by 16 percent in 27 hospitals focused on reducing elective deliveries – and that if widely implemented across the country this could result in a dramatic drop off of admissions and hundreds of millions of savings per year.v

Measure Development and Endorsement

Let me now talk about where measures come from and where NQF fits in.

Measures are brought to NQF by over 65 different developers including physician specialty societies, the American Medical Association, The National Committee for Quality Assurance (NCQA), academic and community organizations and others. More than half of NQF's chairs of committees are physicians, and about 30 percent of all measures in NQF's portfolio are developed by medical specialty societies. These measures are largely derived from clinical guidelines. As part of the measure development process, NQF requires developers to test the measures and submit the test results that demonstrate their measures are valid and reliable. NQF does not itself develop measures; we think that would be a conflict of interest. Rather, our job is to assure that measures meet rigorous standards. Let me explain how.

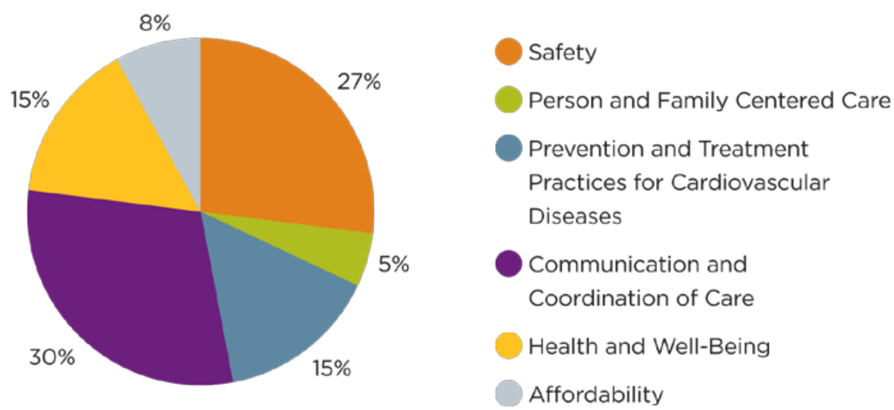
NQF assembles committees with the right specialty expertise on the topic at hand, whether that is related to appropriateness for cardiac imaging or best surgical care. Forty-eight percent of the experts on these committees are physicians who bring their deep clinical expertise to the table; the other half represent patients, payers, hospitals, and others with a stake in healthcare. Overall, these diverse perspectives are helping to move measures from being provider centric to be more patient centered and are reflective of where we collectively want to drive the healthcare system.

When these multi-stakeholder committees are convened, their task is to evaluate sets of measures against agreed upon standards. About 70 percent of measures reviewed are endorsed and receive the NQF good housekeeping seal of approval. In order to receive NQF endorsement, measures must meet key endorsement criteria:

- **Importance to measure and report** – This criteria evaluates whether the measure has potential to drive improvements, including care improvements, and includes a careful evaluation of the clinical evidence
- **Scientific acceptability of measure properties** –This criteria evaluates whether the measure will generate valid conclusions about quality; if measures are not reliable (consistent) and valid (correct), they may be improperly interpreted
- **Usability and use**– This criteria evaluates whether the measure can be appropriately used in accountability and improvement efforts
- **Feasibility** – This criteria requires evaluators to review the administrative burden involved with collecting information on the measure. If a measure is deemed too burdensome, alternative approaches need to be considered
- **Assess related and competing measures** – This criteria requires evaluators to determine whether the measure is duplicative of other measures in the field. NQF endorses best-in-class measures and where appropriate combines (harmonizes) similar measures to reduce burden associated with requests to report near-identical measures.

NQF strategically manages its portfolio of about 700 endorsed measures to simultaneously increase impact and decrease burden on providers, growing the measure portfolio in some areas and shrinking it in others. NQF replaces existing measures with those that are better, reflect new medical evidence, or are more relevant; removes measures that are no longer effective or evidence-based; and expands the portfolio to bring in measures necessary to achieve the National Quality Strategy.

How NQF-Endorsed Measures Stack-Up Against National Quality Strategy Priorities



NQF plays an important role in the harmonization and alignment of performance measures. In the surgical world, NQF served as a key facilitator of a harmonization process between the American College of Surgeons and the CDC to achieve a single national standard for surgical site infections. For something as important as infections after surgery, there needs to be one and only one national standard to drive improvement. NQF has also worked to ensure that measures are aligned across populations and payers. NQF pressed CMS to expand key outcome measures like 30-day mortality beyond the Medicare population so that providers can be judged on their whole patient population. To move performance measurement into the future, NQF can play a critical role in ensuring that the building blocks of measures, like data elements and value sets used to define diabetes or heart failure, are harmonized, reliable and valid.

Rigorous standards are imperative to physician and purchaser confidence in and use of measures. The Committee is right to link rigorous measures to payments, just as you would be right to reject using poor quality measures that will fail to drive the system to be more patient centered and higher performing. Pursuit of the latter will add to cost and burden with no improvement in care.

Retaining a Single Measure Review and Endorsement Process

As policymakers consider payment reforms that focus on quality performance, I strongly believe that ensuring there is one central hub of measure review and endorsement – such as has been created at NQF – allows for the most efficient, rapid, inclusive and effective process for bringing new quality measures into the system.

I know that there are proposals under consideration that would set up an additional process for approving measures. NQF and its wide range of stakeholders – including businesses, consumer groups, health professionals and plans -- are concerned that establishing a separate process will simply result in more cost and redundancy and will do little to move the ball forward in bringing effective, consensus-based quality measures into the health system.

Having an additional process for measure review would likely result in more "look alike" measures and lack of alignment in use of the same measures – both would add to data collection and reporting burden. And when the measure results were publicly reported, it would lead to confusion about whether they were comparable. Having said that, and to be absolutely clear, we welcome and are committed to finding ways to enhance and evolve the measure development, endorsement, and selection process and commend you for opening up the conversation on the critically important issue of getting better measures to market more rapidly.

Our stakeholders also believe it's important that they have a constructive seat at the table. Having HHS review and approve submitted measures instead of the existing consensus-based entity would mean that private sector stakeholders may have less opportunity for ongoing input into the measure review and approval process. Ensuring all stakeholders have a substantive role in this process ensures that the highest quality measures are approved that can drive real change in moving toward a lower cost, patient-centric healthcare system.

Additional Background on NQF's Portfolio of Endorsed Measures: 2012 at a Glance

By way of further background on the role NQF has played in bringing quality metrics to market, let me provide further details on NQF's recent work.

In 2012, NQF completed 16 endorsement projects -- reviewing 430 submitted measures and endorsing 301 measures, or 70 percent. This included 81 new measures and 220 measures that maintained their endorsement after being considered in light of any new evidence and/or against new competing measures submitted to NQF for consideration.

More specifically in 2012, NQF endorsed:

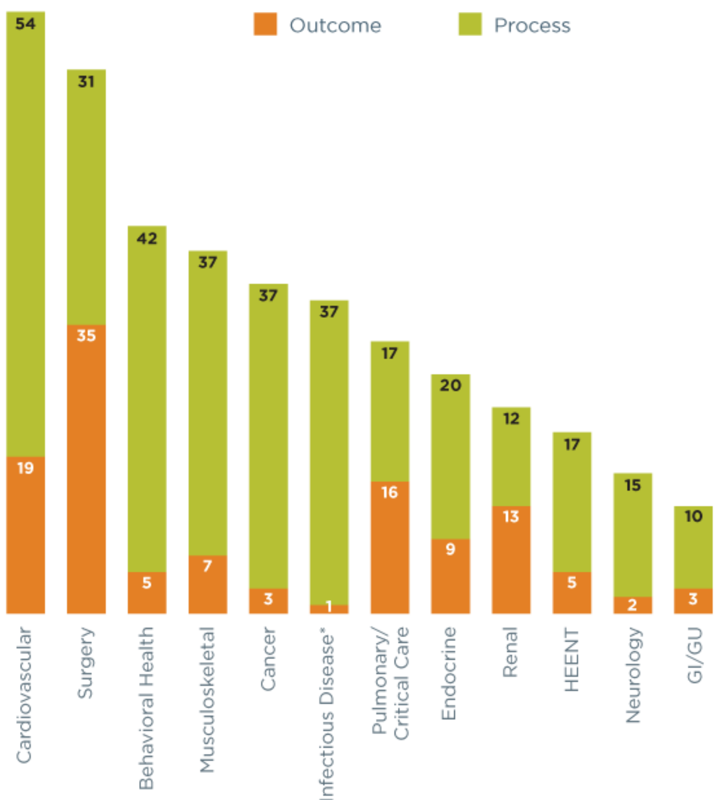
- **Patient safety measures.** Americans are exposed to more preventable medical errors than patients in other industrialized nations, costing the United States close to $29 billion per year in additional healthcare expenses, lost worker productivity, and disability.[vi] NQF endorsed 32 patient safety measures in 2012, focusing on complications such as healthcare-associated infections, falls, medication safety, and pressure ulcers. ,

- **Resource use measures.** The full spectrum of healthcare stakeholders is increasingly attuned to affordability and focused on how we can measure and reduce healthcare expenditures without harming patients and improving care. NQF endorsed its first set of resource use measures—designed to understand how healthcare resources are being used—in January 2012, and it endorsed an additional set in April 2012. These measures are primed to offer a more complete picture of what drives healthcare costs. Used in concert with quality measures, they will enable stakeholders to identify opportunities for creating a higher-value healthcare system.
- **Patient experience measures.** Measures endorsed include a measure evaluating patient satisfaction during hospitalization for surgical procedures; measures focused on effective provider communication with patients regarding disease management, medication adherence, and test results; seven related measures that address health literacy, availability of language services, and patient engagement with providers; and measures that evaluate how bereaved family members perceive care provided to loved ones in long term care facilities and hospitals.
- **Harmonized behavioral health measures.** In 2012, NQF endorsed 10 measures related to mental health and substance abuse, including measures of treatment for individuals experiencing alcohol or drug dependent episodes; diabetes and cardiovascular health screening for people with schizophrenia or bipolar disorder; and post-care follow-up rates for hospitalized individuals with mental illness. As a part of this process, NQF also brought together CMS and the National Committee for Quality Assurance (NCQA) to integrate two related measures into one measure, addressing antipsychotic medication adherence in patients with schizophrenia.
- **A measurement framework for those with multiple chronic conditions.** People with multiple chronic conditions (MCCs) now comprise more than 25 percent of the U.S. population[vii,viii] and are more likely to receive care that is fragmented, incomplete, inefficient, and ineffective.[ix,x,xi,xii,xiii] Yet despite the growing prevalence of people with MCCs, existing quality measures typically do not address issues associated with their care, largely because of data-sharing challenges and because measures are typically limited to addressing a singular disease and/or specific setting. As a response to these challenges, NQF endorsed a measurement framework that establishes a shared vision for effectively measuring the quality of care for individuals with MCCs that developers can use to more expeditiously create measures for this population.
- **Healthcare disparities measures.** Research from the Institute of Medicine shows that racial and ethnic minorities often receive lower quality care than their white counterparts, even after controlling for insurance coverage, socioeconomic status, and comorbidities.[xiv] NQF commissioned a paper outlining methodological issues and an approach to identify measures that are more sensitive to disparities and as such should be stratified. From there, NQF endorsed 12 performance measures, focused on patient-provider communication, cultural competence, language services, and others.

In addition to the endorsement activities highlighted above, NQF is consistently working to ensure resources are devoted to the highest priority work. These initiatives include:

- ***Periodic review of measures to ensure NQF-endorsed measures are up-to-date****:* The size of NQF's portfolio declined in 2012 through retiring competing measures, or removing measures where performance was already topped out at very high levels. Specifically, 93 new measures were added and 103 were removed from the NQF portfolio.
- ***An ever-increasing focus on endorsing outcome measures, which have the greatest promise for improving care and reducing costs****:* At the end of 2012, 27 percent of the measures in NQF's overall portfolio were outcome measures, compared to 24 and 18 percent in 2011 and 2010, respectively. See the chart below for more specificity about NQF-endorsed condition-specific measures, which provide some insight as to the degree a given physician specialty is likely to have outcome measures. Overall the proportion of outcome measures differs across conditions, with proportionally higher percentages of outcome measures for surgery and cardiac care.

Measures Receiving NQF Endorsement in 2012, by Category



*Additional outcome measures captured in safety areas (not shown).

Why Measures Fail Endorsement

While roughly 70 percent of measures submitted to NQF in 2012 received endorsement, other measures did not because they did not adequately meet NQF's rigorous scientific, clinical and other criteria detailed above.

Of the measures that were not endorsed by NQF last year, the vast majority failed to meet the "importance to measure" requirement. The criterion of importance to measure and report is intended to ensure that performance measurement and reporting are focused in areas that have the greatest leverage for driving improvements in quality of healthcare and patient outcomes.

Many things that *can* be measured require additional actions before they can have any meaningful effect for patients. For example, ordering a lab test will not improve care and outcomes unless the results are reviewed in a timely manner, interpreted correctly, and followed with the appropriate treatment. For most measures that failed the importance criterion, there was limited evidence to suggest that a measured "process" had any relation to desired outcomes. Some measures had very high levels of performance with limited opportunity for further improvement. Other measures, especially at the hospital level, did not have fulsome enough risk adjustment to adequately distinguish between quality and unmeasured patient risk (e.g., severity of illness).

Illustrative examples of measures that failed to pass endorsement follow:

- ***No evidence of relation between a measured process and desired patient outcomes***: An NQF expert committee failed to recommend a measure regarding seizures because the measure focused simply on whether the "type of seizure" was documented, rather than how this documentation could be used by clinicians to determine the appropriate care and/or improve outcomes.
- ***Process measure too distal from effect on outcomes***: A measure of whether a physician considered using thrombolytic therapy was rejected in favor of a measure of actually administering life-saving thrombolysis to patients. A measure that included only whether a pain assessment was completed, without assessing whether an intervention reduced pain failed importance.
- ***Lack of a performance gap in care***: Measures that focus on areas where performance is already high are frequently rejected in favor of measures that focus on areas where there are clear deficits in performance. For example, the compliance rate for assessing neonates' initial temperature in the NICU is already at 98 percent. Given this, a recent measure in this area was rejected because the

expert committee determined that such a measure did not meet the "importance" threshold.

- ***Lack of adequate risk adjustment:*** For outcome measures, it is critically important that the measures be risk adjusted to ensure that measurement reflects true outcomes of care, rather than unmeasured severity of illness. In the last year, NQF rejected measures related to stroke mortality and readmissions due to concerns related to adequate risk adjustment. A composite measure of adverse perinatal events was also not approved due to the absence of risk adjustment.

For measures that do not meet rigorous standards, there is an inherent risk in using them. The variation reported may not be true differences in quality across providers but rather measurement "noise." Further, linking payment to poor quality measures will not drive the system to be more patient centered or higher performing and instead will add cost and burden. Linking payment to poor quality measures is not a responsible expenditure of Federal dollars.

Evolving Endorsement as the Science of Measurement Changes

As the healthcare system continues to evolve and demand greater focus on healthcare quality and improvement, I thought I should also spend a minute providing information on how NQF is evolving its processes to meet increasing demand for endorsed measures. For example, over the last year, NQF has solicited feedback on ways to more rapidly bring critical quality measures into the health system. As part of this effort, the organization is moving forward with redesign efforts to reduce the wait for developers to submit measures to NQF and to decrease the amount of time it takes for measures to get through the NQF review process. This plan builds upon the success NQF has already had in reducing the measure review cycle time from 12 to 7 months.

- To provide a few more specifics, some of NQF's re-design efforts include setting up standing committees to expedite the review process, implementing a new approach for technical review of measures, and changing NQF's process for public comment:
    - ***Standing Committees***: NQF will move to Standing Committees, away from committees appointed for each project that receive submissions after a Call for Measures. Standing committees would reduce project start-up time; reduce time between measure submission and measure review; and move to single flow processing of measures, i.e., review measures one at a time. With training and facilitation, standing Committees also will provide greater consistency and a more global view of measures in a topical area.
    - ***Technical Review:*** As a way to provide more consistency and objective input to the Standing Committees, NQF will incorporate peer reviews on the technical aspects of the NQF evaluation, including evidence, reliability and validity. These multiple peer reviews should provide consistent and unbiased input to the Standing Committees.

- ***Open Comment***: NQF will move to a more continuous, open commenting model on all measures, newly submitted and endorsed. This will enhance the information from the field on measures under consideration and provide NQF member and public input prior to committee recommendations.

All of these efforts are helping ensure NQF is ready and capable to meet the growing demand for quality improvement and quality measurement as our healthcare system continues to evolve.

Thank you for this opportunity to provide the Ways and Means Health Subcommittee testimony on behalf of the National Quality Forum. I am happy to answer your questions or elaborate further on any points made in my testimony.

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Appendix A - National Quality Forum Board of Directors

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