NATIONAL QUALITY FORUM

Meeting Summary

Endocrine Standing Committee August 2017 Off-Cycle Webinar

The National Quality Forum (NQF) convened a public webinar for the Endocrine Standing Committee on Wednesday, August 23, 2017. An online archive of the webinar is available for playback. Materials for the call, including the agenda and slide deck, have been posted on NQF's Off-Cycle Activities project page.

Welcome and Member Introductions

Karen Johnson, Senior Director at NQF, opened the meeting by welcoming the committee to the webinar and briefly reviewing the agenda. Dr. Jamie Rosenzweig, co-chair of the Endocrine Standing Committee, welcomed the Committee and provided a brief description of his background and expertise. Committee members, in turn, introduced themselves.

Overview of NQF's Prioritization Criteria and Framework

Ms. Johnson began with a brief description of the National Quality Strategy (NQS), and then described NQF's strategic direction to "*lead, prioritize, and collaborate*" as a way to meet the triple aim of the NQS. Ms. Johnson noted that a key task of NQF's strategic direction is to identify the most important measures to improve U.S. healthcare. She went on to describe the recently developed prioritization criteria and framework that NQF will use to accomplish this task. The four criteria for prioritizing both measures and gaps in measurement are as follows:

- ***Outcome-focused***: Preference for outcome measures and measures with strong link to improved outcomes and costs
- ***Improvable and actionable***: Preference for actionable measures with demonstrated need for improvement and evidence-based strategies for doing so
- ***Meaningful to patients and caregivers***: Preference for person-centered measures with meaningful and understandable results for patients and caregivers
- ***Support systemic and integrated view of care***: Preference for measures that reflect care that spans settings, providers, and time to ensure that care is improving within and across systems of care

The accompanying hierarchical framework distinguishes four distinct levels of measurement, as follows:

- ***High impact outcomes***: *Parsimonious set of high-impact outcomes to assess progress as a nation*. NQF has identified a starter set of seven high-impact outcomes. These include: health outcomes (e.g., function, survival); patient

experience; preventable harm/complications; prevent/healthy behaviors; total cost/low-value care; access to needed care; equity of care. These are, by design, closely aligned with the NQS.

- ***Driver measures***: *Prioritized accountability measures to drive toward higher performance on high-impact outcomes*. These are the relatively few setting-, condition-, and population-agnostic measures that, if improved, would result in (or drive) clear improvement in the high-impact outcomes nationwide.
- ***Priority measures***: *Prioritized measures in specific settings or specific conditions that contribute to high-impact outcomes*. These measures are those that best reflect the above prioritization criteria and have a meaningful association with the driver measures. Because these are setting and/or condition-specific, there likely will be more priority measures than driver measures.
- ***Improvement measures***: *Prioritized measures to drive quality improvement efforts: goal is to standardize and share*. These are measures are used for internal improvement, but may not be standardized or shared in the field. The measure focus of an improvement measures should have a clear causal relationship with the measure focus of a priority measure.

Ms. Johnson walked the committee through this prioritization approach using an example of total/preventable harm (a high-impact outcome). In this example, a driver measure might be a yet-to-be-developed composite measure reflecting healthcare acquired infections, a priority measure could be a measure of central-line associate bloodstream infection in the hospital setting, and an improvement measure could assess hand hygiene. Helen Burstin, Chief Scientific Officer at NQF, provided another example where a driver measure of health outcomes might be days missed from work due to illness. As part of this example, Dr. Burstin noted that the priority measures that would be associated with this driver measure might be quite different from our existing process measures that assess care provided to those with diabetes.

One committee member asked if this prioritization approach might help with the problem of measurement burden. Dr. Burstin agreed and noted that this is one of the goals of NQF's prioritization efforts. Another member suggested that a person-centric high-impact outcome for those with chronic illness might be more about predictability of function rather than functional status overall. Another member observed that measures might "fit" in different categories (e.g., with more than one high-impact outcome). That member also noted that some stakeholders might disagree with the "location" of particular measures (e.g., priority vs. improvement). Dr. Burstin agreed, again noting this might be the case for many of our long-standing endocrine measures. She also stated that NQF is in the process of developing driver diagrams based on the literature to inform identification of driver measures. Overall, committee members reacted positively to the prioritization criteria and framework.

Applying NQF's Prioritization Criteria and Framework to the Endocrine Portfolio of Measures

Ms. Johnson reminded the committee of the current measurement frameworks for diabetes and osteoporosis (the only conditions currently addressed in the portfolio). She also listed the gaps in measurement previously identified by the committee. Ms. Johnson then led the committee through a pilot exercise designed to elicit feedback on which measures in NQF's Endocrine Portfolio could be considered priority or improvement measures and where gaps in these measure categories exist. Throughout the discussion, she referenced those measures from the portfolio that she had identified as either priority or improvement measures (a "straw man" designed to help begin the conversation).

High-Impact Outcome: Health Outcomes (including Function and Survival)

Ms. Johnson began the conversation by suggesting measure #0354 (*Hip Fracture Mortality Rate (IQI 19)*) as a priority measure. The committee disagreed. Instead, members noted that prevention of hip fractures (e.g., through prevention of falls) would have a greater impact than preventing death among patients who already had a fracture. Dr. Burstin agreed and suggested that a measure to assess the frequency of osteoporotic-sensitive fracture could be a priority measure, particularly if measured at a population level, with an improvement measure that would assess the prevention of osteoporosis. Both of these reflect current gaps in measurement.

Ms. Johnson also suggested measure #0059 (*Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*) as a priority measure. The committee again disagreed. One member noted the importance of heart attack and stroke to overall national morbidity, and suggested a priority measure to assess the frequency of these events at the population level. He listed several potential improvement activities that could be measured that would impact the frequency of those events (e.g., use of statins or blood pressure control). There was some discussion of the utility of the poor control measure, particularly around the threshold of >9%. In general, the committee agreed that it might be a reasonable improvement measure, while noting the potential for harm—especially for the elderly—if goals for glucose levels are too low. In fact, a measure of that assesses harm due to too-tight glucose control is a current gap in measurement (one that would fit under the high-impact outcome of preventable harm/complications). Dr. Burstin encouraged the committee to consider other ways in which overuse could cause harm for those with endocrine conditions, a good segue to the next high-impact outcome the committee discussed.

High-Impact Outcome: Preventable Harm/Complications

Ms. Johnson suggested several measures as priority measures for preventable harm/complications, including—for those with diabetes—measures of lower-extremity amputation, admission rates for short and long-term complications and for uncontrolled diabetes, and occurrence of hyperglycemia and hypoglycemia among hospitalized patients. While the committee did not necessarily disagree with these suggestions, they also noted the importance of measuring incidence of retinopathy, nephropathy, and

severe neuropathy, which, coincidentally, may not result in hospitalizations. These represent current gaps in measurement. The committee also suggested the need for a priority measure of emergency department or hospital admission for hypoglycemia.

High-Impact Outcome: Prevention/Health Behaviors

For this outcome, Ms. Johnson suggested priority measures assessing management of diabetes (*#0729: Optimal Diabetes Care*), as well as three medication adherence measures (for statins, ACEIs/ARBs, and oral diabetes agents). She also suggested several improvement measures (weight assessment/counseling; BMI screening and follow-up; eye, foot, neuropathy, nephropathy exams/evaluations, foot care, osteoporosis management and risk assessment/treatment for women with fracture). While the committee agreed with the importance of the adherence measures, members also noted the need for awareness of factors (e.g., mental illness, cultural or economic issues) that make adherence more difficult for some compared to others.

Remaining High Impact Outcomes: Patient Experience, Total Cost/Low-Value Care; Access to Care; Equity of Care

Ms. Johnson did not suggest any measures for these outcomes, thus indicating substantial gaps in measurement. The committee agreed with the need for patient-centered measures. However, one member—a person with Type I diabetes—also noted that while the currently-available measures of patient experience (e.g., timeliness, respect, typically asked after hospitalizations or other interactions with healthcare providers) are probably helpful, she is more interested in staying healthy and actually avoiding doctor visits and hospitalizations. She went on to say that measures that reflect what life is like living with a particular condition, the impact of the conditions, and adequacy of treatment would be more helpful. In terms of low-value care, members noted potential overuse of scans for those with osteoporosis; overly aggressive treatment of diabetes in the elderly, harms associated with polypharmacy; and increased costs to the system due to reliance on lower cost medications that might be harmful to individual patients. Currently, no measures address these issues.

Overview of Changes to NQF's Consensus Development Process

Near the end of the call, Ms. Johnson provided a brief overview of key changes to the endorsement process that are currently underway. As part of this overview, she emphasized offering more frequent endorsement opportunities, condensing the number of topic areas and standing committees, creating the Scientific Methods Panel, simplifying the technical report, and extending the length of the public and member commenting period.

Opportunity for Public Comment

Ms. Johnson then opened the call up to the public for comment. No public comments were offered.

Next Steps

Ms. Johnson closed the meeting by thanking the committee for their participation and describing next steps for the committee, including the probable evaluation of the diabetes and osteoporosis measures in 2018.