Cost and Resource Use Phase II:
Cardiovascular Condition-Specific
Standing Committee Meeting
March 4 – 5, 2014
Evan Williamson
Ashlie Wilbon
Ann Phillips
Taroon Amin
NATIONAL
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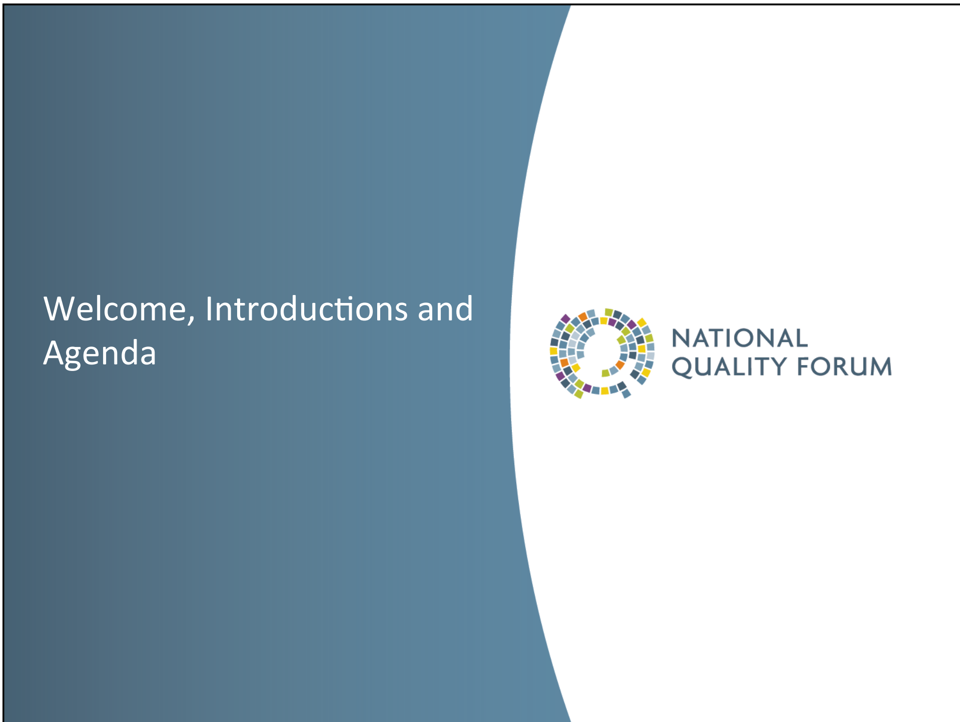
Welcome, Introductions and
Agenda
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Welcome

- Restrooms
  - Exit main conference area, past elevators, on right.
- Breaks
  - 10:45 – 15 Minutes
  - 12:30 – Lunch Provided by NQF
  - 3:15 – 15 Minutes
- Laptops and Cellphones
  - WiFi Network: "NQF-Guests" Password: "NQFguest"
  - Please mute your cellphone during the meeting
- To speak, please raise your placard on end and wait to be called on by the Co-Chairs.

NQF Project Staff

- Evan Williamson
  - Project Manager, Performance Measurement
- Ashlie Wilbon
  - Managing Director, Performance Measurement
- Ann Phillips
  - Project Analyst, Performance Measurement
- Taroon Amin
  - Senior Director, Performance Measurement

Agenda for the Meeting

Day 1

- Breakfast Buffet
- Welcome and Review of the Agenda
- Disclosure of Interest and Committee Introductions
- Standing Committee Role
- NQF Affordability Work
- Review of Cost and Resource Measurement Portfolio /MAP Input
- Overview of Evaluation Process
- Public and Member Comment

Agenda for the Meeting

Day 1 *(continued)*

- Lunch
- Consideration of Candidate Measures
- Public and Member Comment
- Adjourn
- Dinner (Optional)

Disclosure of Interest

- Ann Hammersmith, JD - General Counsel

Standing Committee

- Brent Asplin, MD, MPH (Co-Chair)
- Lisa Latts, MD, MSPH, MBA, FACP (Co-Chair)
- Ariel Bayewitz, MPH*
- Lawrence Becker
- Mary Ann Clark, MHA
- Cheryl Damberg, PhD
- Jennifer Eames-Huff, MPH
- Nancy Garrett, PhD
- Andrea Gelzer, MD, MS, FACP
- Stanley Hochberg, MD
- Matthew McHugh, PhD, JD, MPH, RN
- Martin Marciniak, MPP, PhD
- James Naessens, ScD, MPH
- Eugene Nelson, DSc, MPH
- Jack Needleman, PhD
- Janis Orlowski, MD, MACP*
- Carolyn Pare
- John Ratliff, MD, FACS, FAANS*
- Andrew Ryan, PhD
- Joseph Stephansky, PhD
- Lina Walker, PhD
- William Weintraub, MD, FACC**
- Herbert Wong, PhD
- Dolores Yanagihara, MPH

*New member of the Committee
** Member of the Cardiovascular TEP

The Role of the Standing Committee

CDP Improvement Activities

- Establishment of Standing Committees
- Overseeing of an NQF portfolio of measures in a specific topic area
- Strategic direction for future measure development and addressing gaps
- Increased developer involvement in measure evaluation

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Oversee the Cost and Resource Portfolio

- New function of Standing Committees
- Responsibilities
  - Provide input on the relevant measurement framework(s)
  - Know which measures are included in the portfolio and understand their importance to the portfolio
  - Consider issues of measure standardization and parsimony when assessing the portfolio
  - Identify measurement gaps in the portfolio
  - Become aware of other NQF measurement activities for the topic area(s)
  - Be open to external input on the portfolio
  - Provide feedback about how the portfolio should evolve
  - Consider the portfolio when evaluating individual measures

Role of the Standing Committee

- Act as a proxy for the NQF multi-stakeholder membership
- Serve 2-year or 3-year terms
- Work with NQF staff to achieve the goals of the project
- Review all measures
- Evaluate each measure against each criterion
  - Indicate the extent to which each criterion is met and rationale for the rating
- Make recommendations to the NQF membership for endorsement
- Respond to comments submitted during the review period
- Respond to any directions from the CSAC
- Oversee portfolio of Cost and Resource measures

Role of the Standing Committee, cont.

- All Members review ALL measures
- Evaluate measures against each criterion
  - Indicate the extent to which each criterion is met and rationale for the rating
- Make recommendations to the NQF membership for endorsement

Role of the Standing Committee Co-Chairs

- Facilitate Steering Committee (SC) meetings
- Represent the SC at CSAC meetings
- Keep SC on track to meet goals of the project without hindering critical discussion/input
- Assist NQF in anticipating questions and identifying additional information that may be useful to the SC
- Work with NQF staff to achieve the goals of the project
- Participate as a SC member

Role of the Technical Expert Panel

- Review ALL submitted measures
- Provide input to the committee on the clinical specifications of the measures
- Answer questions from the committee regarding appropriateness of the clinical specifications

A Review of NQF's Current Cost and Resource Measurement Activities

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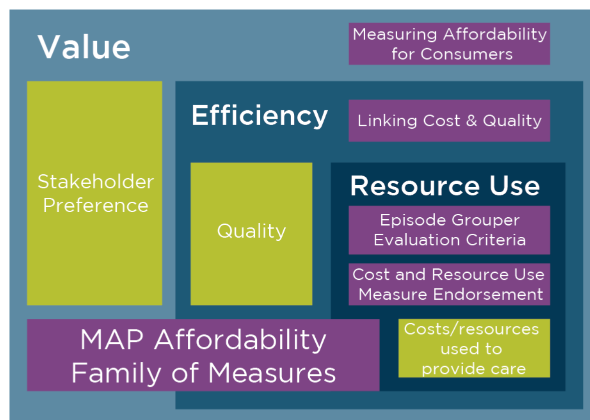
NQF's Current Cost/Resource Use Measurement Work



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Cost and Resource Use CDP Project Scope

- This project is a three-phased effort focused on evaluating and endorsing cost and resource use measures. In the first phase, non-condition specific measures of total cost, using both per-capita or per-hospitalization episode approaches, were evaluated. Phase two will focus on cardiovascular condition specific measures and phase three will focus on pulmonary and other condition-specific measures.
  - Phase 1: Total cost non-condition specific per capita or per hospitalization episodes
  - Phase 2: Cardiovascular condition-specific per capita and condition-specific episodes
  - Phase 3: Pulmonary and other condition-specific per capita and condition-specific episodes

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Scope for Phase 2

Phase 2: Cardiovascular Condition-Specific Measures

- 3 measure submissions
  - 1558: Relative Resource Use for People with Cardiovascular Conditions *(NCQA)**
  - 2431: Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for Acute Myocardial Infarction (AMI) *(CMS/Yale)*
  - 2436: Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for heart failure (HF) *(CMS/Yale)*

*Maintenance Measure

Activities and Timeline: Phase 2

Process Step	Timeline
Measure submission deadline	*12/9/13*
SC member orientation	*1/13/14*
SC and TEP Receive Measures	*1/15/14*
TEP member evaluation and review	*1/15/14 – 1/31/14*
TEP member submit evaluations on SharePoint	*Due by 1/31/14*
SC member preliminary review and evaluation	*1/15/14 – 2/24/14*
SC members submit evaluations online	*Due by 2/24/14*
SC in-person meeting	*3/4/14 – 3/5/14*
Draft report posted for NQF Member and Public Review and Comment	4/21/14 – 5/21/14
SC call to review and respond to comments	6/4/14 from 11am - 1pm ET
Draft report posted for NQF Member vote	6/18/14 – 7/2/14
CSAC review and approval	7/3/14 – 7/23/14
Endorsement by the Board	7/24/14 – 8/4/14
Appeals	8/5/14 – 9/4/14

Overview of Episode Grouper Project

Expert Panel Members: Nancy Garrett and Jim Naessens

Episode groupers are software tools programmed to create condition-specific episodes of care (EOC) from administrative claims data to determine the cost of care associated with those claims. Groupers enable the analysis of services delivered by providers over a defined period of time and for specific clinical conditions, to generate an overall picture of the services used to treat and manage that condition for a given patient.

This project seeks to:

- Define the characteristics of an episode grouper versus other measurement systems, including classification or risk adjustment systems
- Identify the key elements required for the evaluation of an episode grouper
- Review the best practices for the construction of an episode grouper
- Provide guidance and determine the appropriate criteria for the evaluation of an episode grouper

Episode Grouper Evaluation Considerations

- Episode Groupers have a wide range of purposes and functions
  - Intended use of the grouper will influence many of the decisions made during development and must be considered during evaluation
- Given the range of appropriate methodologies in the field, setting a national standard seems unlikely – however, episode groupers should be evaluated to ensure that they meet a minimum set of criteria
- Public and Private Episode Groupers
  - Attempts to align methodologies pose many challenges
  - NQF should consider starting an evaluation of the public sector grouper given the importance of transparency and a justified use case
- It is essential to get multi-stakeholder input during the evaluation

Episode Grouper Timeline

Meeting	Date/Time
Expert Panel member orientation	*1/22/14*
Background Information Review	*1/29/14 – 2/5/14*
Expert Panel In-Person Meeting	*2/5/14 – 2/6/14*
Post-Meeting Conference Calls	3/12/14 12-2pm ET AND 3/19/14 12-2pm ET
Draft report posted for NQF Member and Public Review and Comment	3/24/14 – 4/22/14
SC call to review and respond to comments	5/14/14 from 12-2pm ET
CSAC review and approval	6/3/14 – 6/17/14
Endorsement by the Board	6/18/14 – 6/30/14
Final Report Complete	7/1/14

Measuring Efficiency - Linking Cost and Quality Projects

Expert Panel Members: Jack Needleman & Herbert Wong
White Paper Author: Andrew Ryan

Measuring efficiency presents special challenges as there is currently no standardized and transparent way to assess cost in the context of quality. With funding from the Robert Wood Johnson Foundation (RWJF), and the guidance of an expert panel, the National Quality Forum (NQF) will produce a white paper exploring:

- The current approaches in the field used for measuring and understanding efficiency
- The methodological challenges to linking cost and quality measures for an efficiency signal
- Best practices for combining cost measures with clinical quality measures to assess efficiency of care
- The white paper produced through this work of this project will provide guidance and a pathway toward efficiency measures that matter.

Measuring Efficiency – Linking Cost and Quality Next Steps

Meeting	Date/Time
In-person meeting	May 1, 2014 8:30 AM – 5:00 PM ET May 2, 2014 8:30 AM – 3:00 PM ET
Public comment period	May 23, 2014-June 23, 2014
Call to review comments on draft white paper	July 24, 2014, 2:00 PM – 4:00 PM ET
Consensus Standards Approval Committee (CSAC) Meeting	August 12, 2014, 3:00-5:00 PM ET

Measuring Affordable Care Project

Expert Panel Member: Lina Walker

A first step in addressing cost of care is defining "cost to whom" and how it should be measured. With funding from the Robert Wood Johnson Foundation (RWJF), with the guidance of an expert panel, NQF will examine measurement concepts for affordability from the patient perspective. With the guidance of an expert panel, NQF will produce a white paper to explore more patient-oriented cost measures. Key questions include:

- What types of measures are most important to consumers?
- What types of data will be needed?
- How can we best leverage patient-reported data?
- What factors influence a consumer's perceptions of whether care is affordable?
- How can this information be reported to address consumer needs for discerning affordable and efficient providers?

Measuring Affordable Care Next Steps

Meeting	Date/Time
In-person meeting	March 27, 2014 8:30 AM – 5:00 PM ET March 28, 2014 8:30 AM – 3:00 PM ET
Public Comment Period	May 23, 2014-June 23, 2014
Call to review comments on draft white paper	July 1, 2014, 3:00 PM – 5:00 PM ET

Break

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Review of Cost and Resource Use Measure Portfolio / MAP Input

Previously Endorsed Cost & Resource Use Measures

- Endorsed January 30, 2012:
  - 1598: Total Resource Use Population-based PMPM Index (HealthPartners)
  - 1604: Total Cost of Care Population-Based PMPM Index (HealthPartners)
  - 1558: Relative Resource Use for People with Cardiovascular Conditions (NCQA)*
  - 1557: Relative Resource Use for People with Diabetes (NCQA)
- Endorsed March 30, 2012:
  - 1560: Relative resource use for people with asthma (*NCQA*)**
  - 1561: Relative resource use for people with COPD (*NCQA*)**
  - 1609: ETG-based hip/knee replacement cost-of-care *(Ingenix)*
  - 1611: ETG-based pneumonia cost-of-care (*Ingenix*)**
- Endorsed December 6, 2013:
  - 2158: Medicare Spending per Beneficiary (MSPB) *(CMS)*

  - *Up for Maintenance in Phase 2
  - **Up for Maintenance in Phase 3

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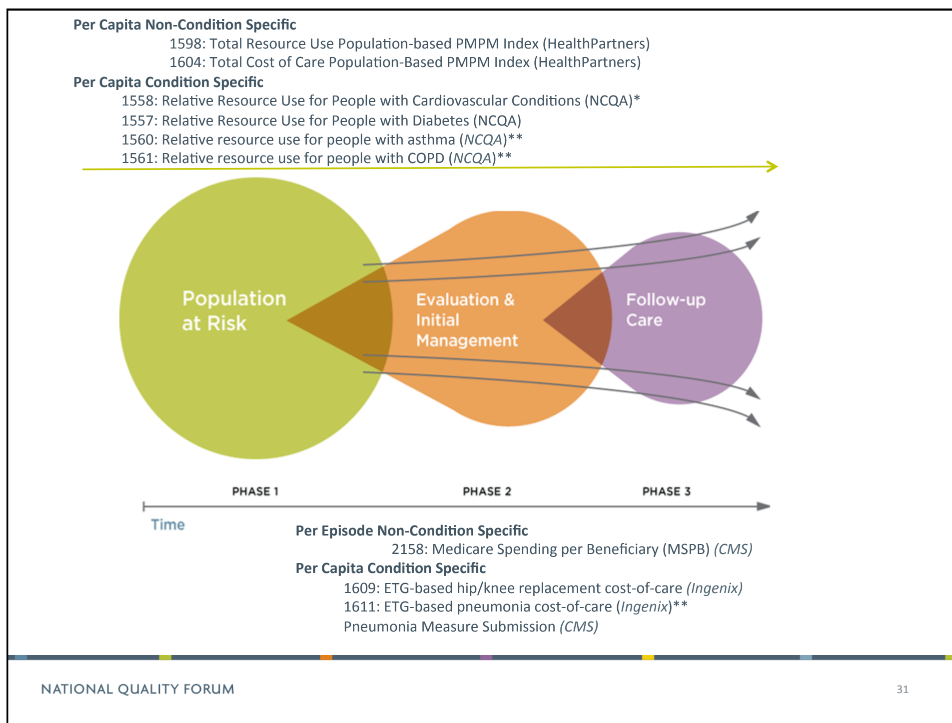

Future Cost and Resource Work - Phase 3:

Phase 3: Pulmonary & Other Condition-Specific Measures

- Measure Submission Deadline – April 18, 2014
  - 1560: Relative resource use for people with asthma (*NCQA*)*
  - 1561: Relative resource use for people with COPD (*NCQA*)*
  - 1611: ETG-based pneumonia cost-of-care (*Ingenix*)*
  - Pneumonia Measure Submission *(CMS)*
  - Dental Cost Measure Submission *(ADA)*

*Maintenance Measures

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MAP Overview

Measure Applications Partnership

Statutory Authority

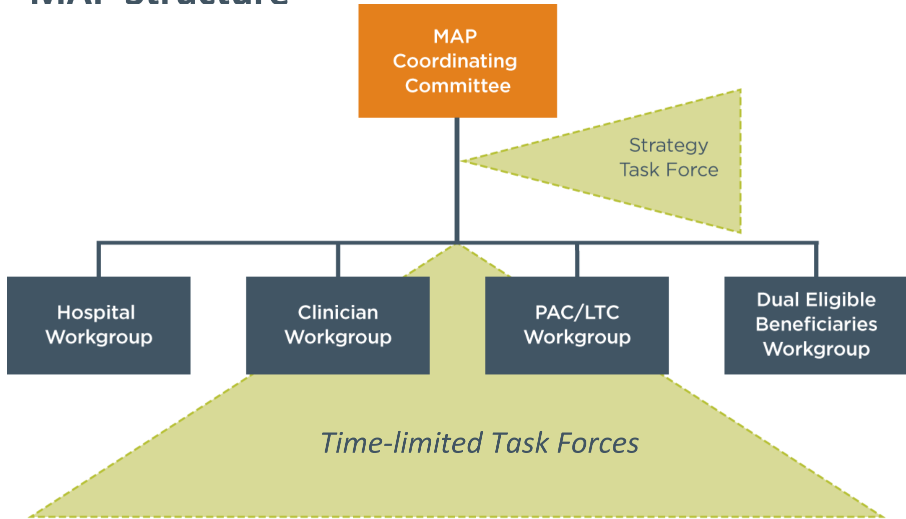
Health reform legislation, the Affordable Care Act (ACA), requires HHS to contract with the consensus-based entity (i.e., NQF) to **"convene multi-stakeholder groups to provide input on the selection of quality measures" for public reporting, payment, and other programs.**

MAP Purpose

In pursuit of the NQS, MAP informs the selection of performance measures to achieve the goal of improvement, transparency, and value for all.

- MAP Objectives:
  1. Improve outcomes in high-leverage areas for patients and their families
  2. Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy on value.
  3. Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden.

MAP Structure



MAP Affordability Task Force Charge

Affordability Task Force Member: Dolores Yanagihara

- Advise the MAP Coordinating Committee on an Affordability Family of Measures, including:
  - Recommendations for measures to include in the family
  - Identification of gaps and recommendations for filling gaps
  - Analysis of barriers to using the measures within the affordability family
- The task force is time-limited and consists of current MAP members from the MAP Coordinating Committee and all MAP workgroups with relevant interests and expertise

Goals for the Affordability Family of Measures

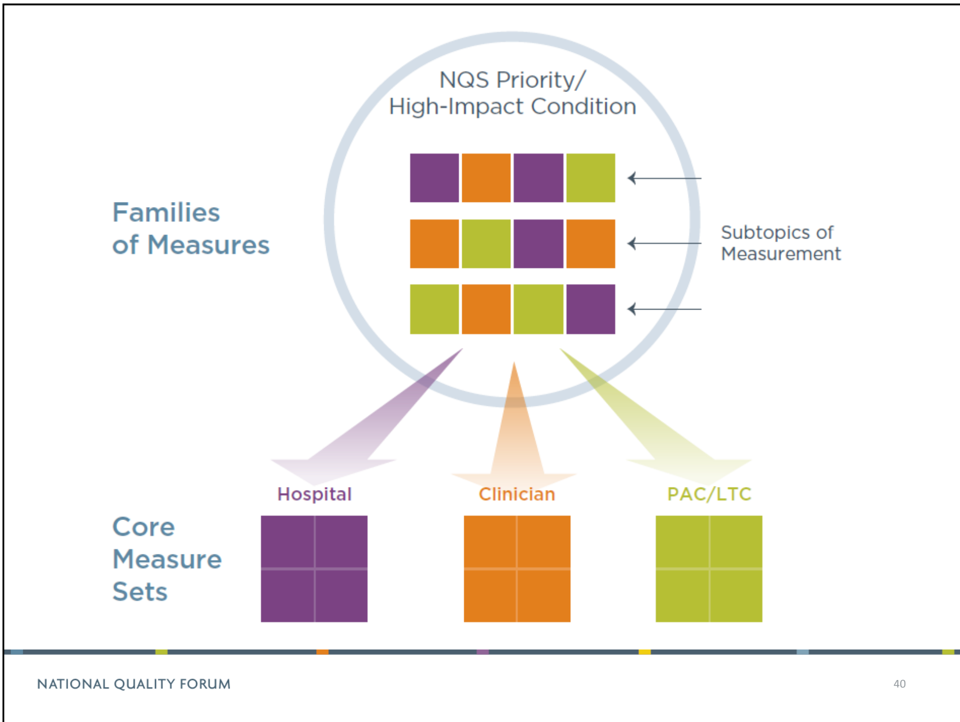
- Promote alignment across settings and sectors
- Create a comprehensive picture of affordability considering all perspectives
- Include measures related to cost drivers and other key components of cost
  - Use to identify high-leverage opportunities and available measures
- Build on existing measures of quality, cost, and efficiency
- Lay out a path forward to build on these initial measures and consider barriers to measurement

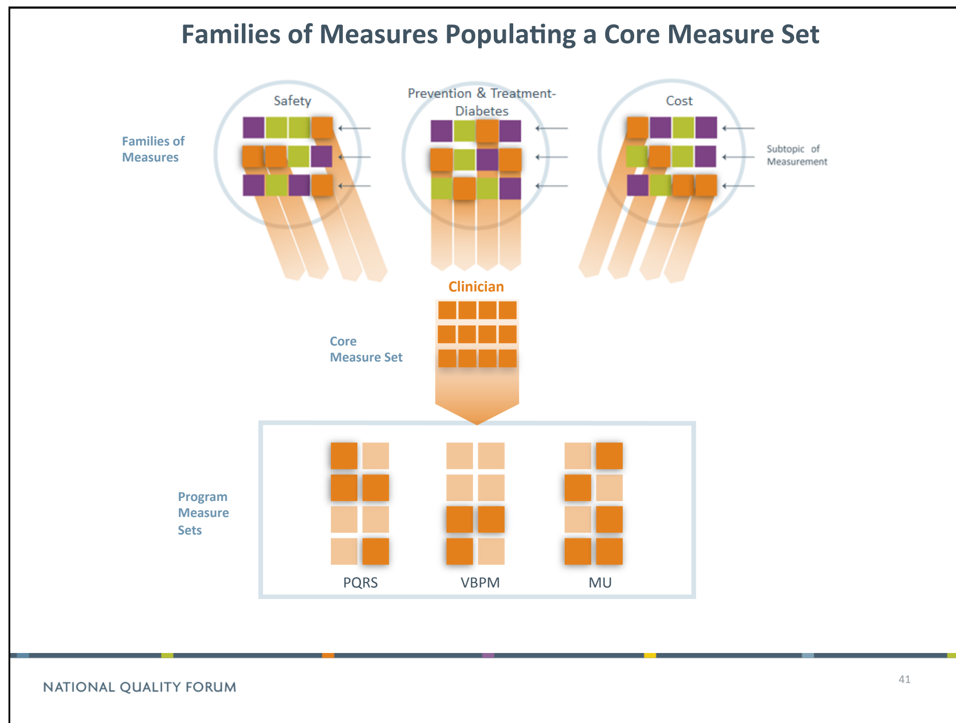
Families of Measures

Families of Measures and Core Measure Sets to Align Performance Measurement Across Federal Programs and Public and Private Payers

Family of measures – "related available measures and measure gaps for specific topic areas that span programs, care settings, levels of analysis, and populations" (e.g., care coordination family of measures, diabetes care family of measures)

Core measure set – "available measures and gaps drawn from families of measures that should be applied to specified programs, care settings, levels of analysis, and populations" (e.g., PQRS core measure set, hospital core measure set, dual eligible beneficiaries core measure set)





Approach to Developing an Affordability Family

1. Develop consensus-based definitions of affordability

- Define the parameters of affordability taking into account multiple stakeholders perspectives
- Conduct stakeholder outreach to understand the range of definitions and perspectives

Approach to Developing an Affordability Family

2. Identify and Prioritize High-Leverage Opportunities for Measurement

- Identification of high-leverage opportunities
  - Major cost drivers across settings and populations(e.g. vulnerable populations, commercially insured, Medicaid, Medicare)
  - National Quality Strategy
  - IOM's Healthcare Imperative: Lowering Costs and Improving Outcomes report
  - Public-sector efforts
  - Private-sector efforts
- Prioritization of high-leverage opportunities
  - Impact, improvability, inclusiveness
  - Areas of waste, inefficiency, overuse
- Consider how high-leverage opportunities span the patient-focused episode of care
  - Do the high-leverage opportunities span settings, levels of analysis?
  - How should measures addressing the high-leverage opportunities vary across settings?

Approach to Developing an Affordability Family

3. Scan of Available and Pipeline Measures that Address the High-Leverage Opportunities

- NQF-endorsed portfolio of measures.
- Measures in federal programs.
- Available private sector efforts.

Approach to Developing an Affordability Family

4. Define the Affordability Family of Measures and Measure Gaps

- Considerations for defining the family
  - Do available measures address the relevant care settings, populations, level of analysis?
  - When appropriate, are measures harmonized across settings, populations, levels of analysis?
  - What are the types of measures available for each setting, population, level of analysis?
- Consider implementation barriers.

Approach to Developing an Affordability Family

5. Consider the application of principles developed through the RWJF work in the context of federal and private programs

- MAP will provide input on the principles developed by the expert panel convened through the RWJF project,
- These principles will explore:
  - Linking cost and quality
  - Attribution
  - Risk adjustment
  - Exclusions
  - Reliability/small numbers
  - Patient perspectives on affordability

High Leverage Opportunities Related to Cost and Resource Use

High Leverage Area	Measurement Areas
Total Costs	Total Cost of Care Disparities between prices charged for the same services Pricing information/price transparency
Costs by Episode	Heart disease Cancer Mental disorders Pulmonary Conditions Orthopedics OB/GYN GI End-organ failure with functional impairment Cognitive impairment with co-existing functional impairment Multi-morbidity with functional/cognitive impairment

High Leverage Opportunities Related to Cost and Resource Use

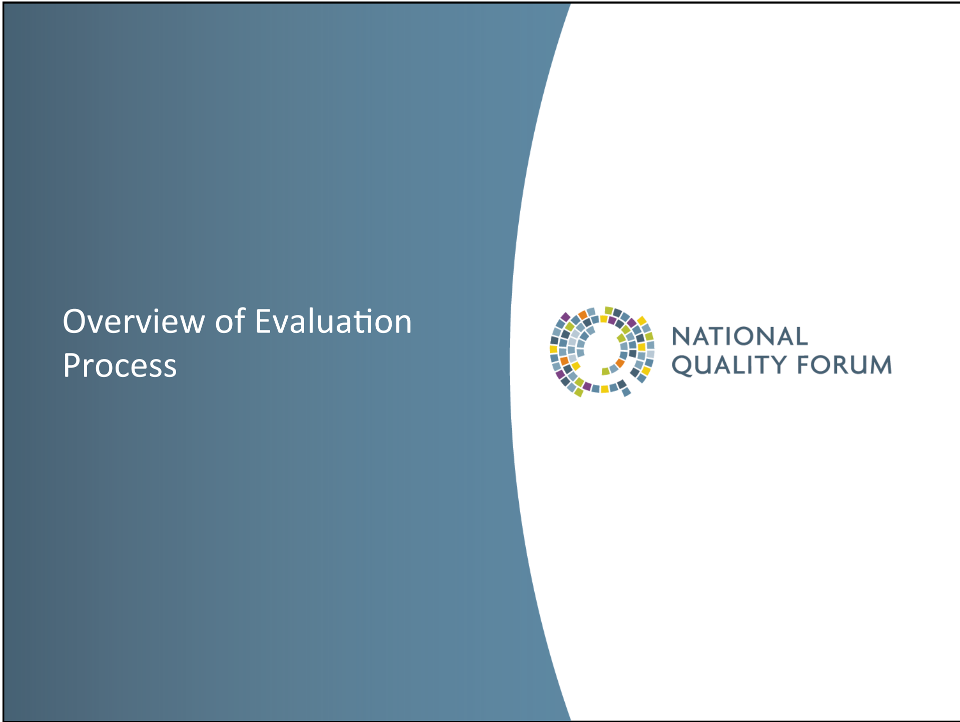
High Leverage Area	Measurement Areas
Utilization	Total Resource use Spending per beneficiary Relative resource use
Costs to the Patient	Premiums Deductibles Out of pocket costs Pricing information/price transparency

Guidance from the Standing Committee

- MAP noted a need for an environment of greater price transparency.
  - Does the Standing Committee agree with this objective?
  - If so, how can measurement support this objective?
- MAP identified a need for additional episode-based measures focusing on high cost, high prevalence conditions.
  - Does the Standing Committee agree with this approach?
  - If so, what are the key gaps in episode-based cost measurement?
- Are there additional cost and resource use gaps that should be addressed in the family of measures?

Key Strategic Opportunities Questions for the Standing Committee to consider

- What are the high-impact measures of cost/resource use that we need in the measure portfolio?
- How should we prioritize the clinical areas for episode-based measures for future work?
- What additional areas should NQF consider in terms of future project work to advance the cost/resource use measurement science?
  - Integration of clinical data and other data sources? Pricing data?
  - What's the impact of the use of the measure on the evaluation and endorsement?
  - Other types of cost measures? Production costs (ABC)?


Overview of Evaluation Process
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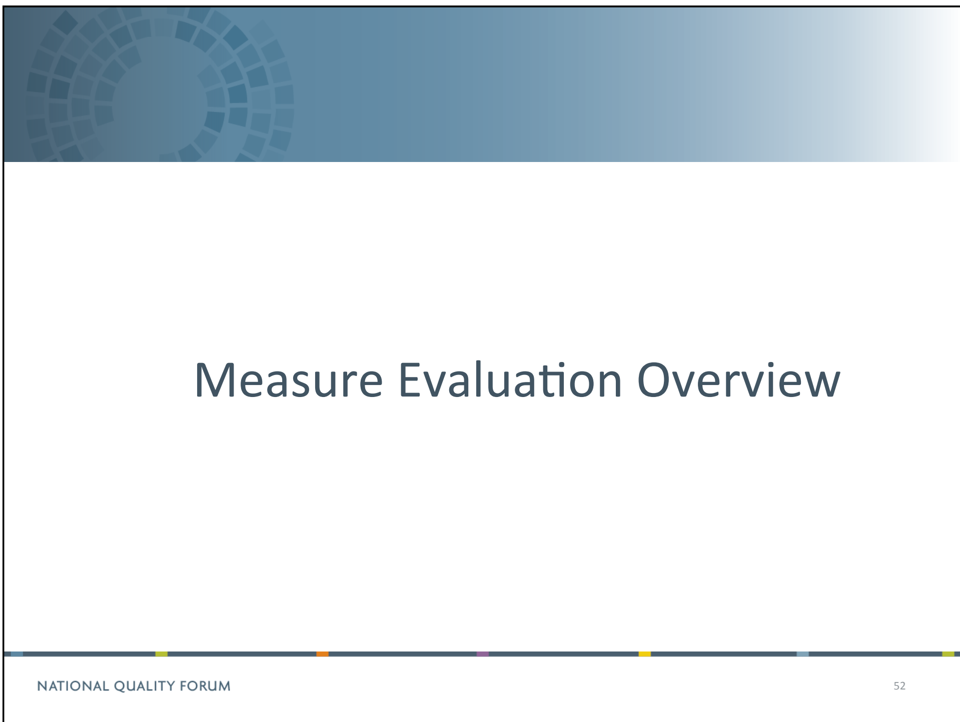
Measure Evaluation Overview
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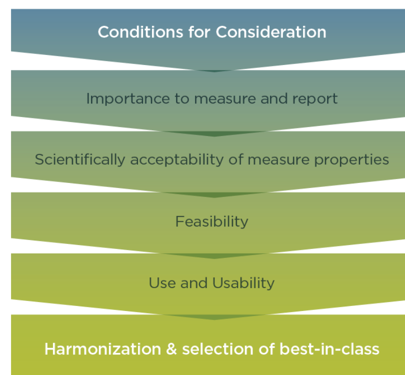
Review of Existing NQF Resource Use Measure Evaluation Criteria



Four Major Endorsement Criteria Hierarchy and Rationale

- Describe desirable characteristics of quality performance measures for endorsement
  - **Importance to measure and report**: Goal is to measure those aspects with greatest potential of driving improvements; if not important, the other criteria are less meaningful (***must-pass***)
  - **Scientific acceptability of measure properties** : Goal is to make valid conclusions about resource use; if not reliable and valid, there is risk of improper interpretation (***must-pass***)
  - **Feasible**: Goal is to, ideally, cause as little burden as possible; if not feasible, consider alternative approaches
  - **Usable**: Goal is to use for decisions related to accountability and improvement; if not useful, probably do not care if feasible
- If suitable for endorsement, evaluate measure harmonization and best-in-class

NQF Measure Criteria
Principles of the Current Measure Criteria

- Some of the key principles that guide the application of these criteria include:
  - There are two must-pass criteria. If a measure does not meet the minimum requirements for *Importance to Measure and Report* or *Scientific Acceptability of Measure Properties*, it cannot be recommended for endorsement and will not be evaluated against the remaining criteria.
  - Subcriteria delineate how to demonstrate that the major criteria are met.
  - The criteria were developed to parallel best practices for measure development.
  - The application of these criteria requires both evidence and expert judgment.
  - The assessment of each criterion is a matter of degree (rather than all or nothing), generally rated on a scale of high, moderate, low, and insufficient.

Importance to Measure and Report

Used to determine:

- If the measure focus (topic) is important to making significant contributions toward understanding healthcare costs for a specific high-impact aspect of healthcare
- There is variation or a demonstrated high-impact aspect of healthcare or overall poor performance.

Subcriteria:

- The measure addresses a specific national health goal/priority or a demonstrated high-impact aspect of healthcare
- There is a demonstrated resource use or cost problem and opportunity for improvement.
- The intent of the measure is clearly described and the types of costs captured (resource service categories) are consistent with the intent.

Scientific Acceptability: Reliability

Used to determine the extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the cost or resources used to deliver care.

- Reliability Subcriteria:
  - Preciseness of the specifications facilitates consistent implementation.
  - Reliability testing results demonstrates the results are repeatable.

Scientific Acceptability: Validity

- Validity:
  - The measure specifications are consistent with the measure intent;
  - Validity testing;
  - Exclusions;
  - Evidence-based risk-adjustment strategy;
  - Adequate discrimination and calibration of the risk model;
  - Statistically significant and practically/clinically meaningful differences in performance;
  - Multiple data sources/methods should produce comparable results;

Feasibility

Used to assess the extent to which the required data are:

- Readily available
- Can be captured without undue burden, and
- can be implemented

Subcriteria:

- The required data elements are routinely generated during care delivery.
- The required data elements are available in electronic sources.
- The data collection strategy can be implemented without undue burden (includes an assessment of financial burden due to the cost of the measures).

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Usability and Use

Used to assess the extent to which potential audiences (e.g., consumers, purchasers, providers, policymakers) are using or could use performance results for both accountability and performance improvement.

Subcriteria:

- Current and planned use of the measure in public reporting and accountability application
- The measure has demonstrated improvement of cost/resource performance
- The benefits of the measure outweigh unintended consequences of the measure
- The measure can be deconstructed to facilitate transparency and understanding

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Related or Competing Measures

If a measure meets the 4 previous criteria and there are related or competing measures, the measures are compared to determine areas of potential harmonization and/or selection of the best measure.

- Related measures may:
  - Share the same measure type (e.g., per episode, per capita), or
  - measure the same costs/resources (e.g., actual prices paid vs. standard prices, resource service categories), or
  - address the same population (e.g., people with diabetes).
- Competing measures would share all of the characteristics previously listed.

Voting Guidance and Process

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Voting Guidance

- A measure is recommended for endorsement by the Standing Committee when the vote on the must-pass criteria (Importance and Scientific Acceptability) and overall vote is greater than 60% of voting members in favor of endorsement.
- A measure is not recommended for endorsement when the vote on any major criteria or overall vote is less than 40% of voting members in favor of endorsement.
- The Standing Committee has not reached consensus if the vote on any must-pass criterion or overall is between 40%-60% in favor of endorsement.

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Lack of Consensus

- When the Standing Committee has not reached consensus, all measures for which consensus was not reached will be put out for NQF Member and public comment.
- The Standing Committee will consider the comments and re-vote on measures where consensus was not reached.
- After the re-vote, all measures that are recommended (>60% in favor of endorsement) by the Standing Committee or where consensus has not been reached (between 40%-60% in favor of endorsement) will be put out for NQF Member vote.

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Voting Process

- Members attending the in-person meeting will use the VoteSnap transmitters to submit their votes
  - The numbers on the VoteSnap device correspond with the numbers on the Voting Slide
  - The VoteSnap software will only record your last input, allowing you to change your vote until the closing of the voting period
- Members participating remotely will submit their votes through the Webinar platform
  - A series of choices will appear on screen when voting is active, select your response before the voting period closes

Public and Member Comment

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Lunch
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Consideration of
Candidate Measures
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Ground Rules for Today's Meeting

During the discussions, Committee members should:

- Be prepared, having reviewed the measures beforehand
- Base evaluation and recommendations on the measure evaluation criteria and guidance
- Remain engaged in the discussion without distractions
- Attend the meeting at all times (except at breaks)
- Keep comments concise and focused
- Avoid dominating a discussion and allow others to contribute
- Indicate agreement without repeating what has already been said

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Measure Review Process

- Developer Introduction
- Assigned Lead Discussant(s)
  - Summarize key issues for Committee discussion
  - Note any areas of disagreement based on preliminary reviews
  - TEP Summary (Bill Wientraub)
- Committee Discussion of each criterion
  - Evaluate the measure "as is" in front of you
- Committee votes on each subcriteria and major criteria
  - Vote on recommendation for endorsement for measures that pass the must-pass criteria

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2431 Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for Acute Myocardial Infarction (AMI)

This measure estimates hospital-level, risk-standardized payment for an AMI episode-of-care starting with inpatient admission to a short term acute-care facility and extending 30 days post-admission for Medicare fee-for-service (FFS) patients who are 65 years of age or older with a principal discharge diagnosis of AMI.

NQF
Measure Evaluation

Voting Slides

Importance to Measure and Report
1a. High Priority

1a. ***High Priority*** *– The measure focus addresses:*

A specific national health Goal/Priority identified by DHHS or the National Priorities Partnership convened by NQF:

OR

A demonstrated high-impact aspect of healthcare (e.g., affects large numbers, leading cause of morbidity/mortality, high resource use [current and/or future], severity of illness, and patient/societal consequences of poor quality).

1. High
2. Moderate
3. Low
4. Insufficient evidence

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Importance to Measure and Report
1a. High Priority

1a. ***High Priority*** *– The measure focus addresses:*

A specific national health Goal/Priority identified by DHHS or the National Priorities Partnership convened by NQF:

OR

A demonstrated high-impact aspect of healthcare (e.g., affects large numbers, leading cause of morbidity/mortality, high resource use [current and/or future], severity of illness, and patient/societal consequences of poor quality).

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Importance to Measure and Report
1b. Opportunity for Improvement

1b. **Opportunity for Improvement** - *Demonstration of resource use or cost problems and opportunity for improvement, i.e., data demonstrating variation in the delivery of care across providers and/or population groups (disparities in care).*

1. 1=High
2. 2=Moderate
3. 3=Low
4. 4=Insufficient evidence

75

Importance to Measure and Report
1b. Opportunity for Improvement

1b. **Opportunity for Improvement** - *Demonstration of resource use or cost problems and opportunity for improvement, i.e., data demonstrating variation in the delivery of care across providers and/or population groups (disparities in care).*

76

Importance to Measure and Report
1c. Measure Intent

1c. ***Measure Intent****- The intent of the resource use measure and the measure construct are clearly described.*

AND

The resource use service categories (i.e., types of resources/costs) that are included in the resource use measure are consistent with and representative of the intent of the measure.

1. 1=High
2. 2=Moderate
3. 3=Low
4. 4=Insufficient evidence

77

Importance to Measure and Report
1c. Measure Intent

1c. ***Measure Intent****- The intent of the resource use measure and the measure construct are clearly described.*

AND

The resource use service categories (i.e., types of resources/costs) that are included in the resource use measure are consistent with and representative of the intent of the measure.

78

Importance to Measure and Report Overall

Based on your rating of the subcriteria, make a summary determination of the extent to which the criterion of ***Importance to Measure and Report*** *has been met.*

1. 1=High
2. 2=Moderate
3. 3=Low
4. 4=Insufficient evidence

79

Importance to Measure and Report Overall

Based on your rating of the subcriteria, make a summary determination of the extent to which the criterion of ***Importance to Measure and Report*** *has been met.*

80

Scientific Acceptability of Measure Properties
2a. Reliability

2a1. *Construction Logic*

2a1. *Clinical Logic*

2a1. *Adjustments for Comparability – Inclusion/Exclusion Criteria*

2a1. *Adjustments for Comparability – Risk Adjustment*

2a1. *Adjustments for Comparability – Costing Method*

2a1. *Adjustments for Comparability – Scoring Method*

2a2. *Reliability Testing*

81

Scientific Acceptability of Measure Properties
2a. Reliability

Based on your evaluation of the criteria, how would you rate the overall reliability of this measure? How well overall has the developer demonstrated the measure results are repeatable and can be implemented consistently?

1. 1=High (*only eligible if adequate testing at both levels*)
2. 2=Moderate
3. 3=Low
4. 4=Insufficient evidence

82

Scientific Acceptability of Measure Properties
2a. Reliability

Based on your evaluation of the criteria, how would you rate the overall reliability of this measure? How well overall has the developer demonstrated the measure results are repeatable and can be implemented consistently?

Scientific Acceptability of Measure Properties
2b. Validity

2b1. *Construction Logic*
2b1. *Clinical Logic*
2b1. *Adjustments for Comparability – Inclusion/Exclusion Criteria*
2b3. *Exclusions*
2b1. *Adjustments for Comparability – Risk Adjustment*
2b4. *Risk Adjustment*
2b1. *Adjustments for Comparability – Costing Method*
2b1. *Adjustments for Comparability – Scoring Method*
2b5. *Significant Differences in Performance*
2b6. *Comparability of Multiple Data Sources*
2b2. *Validity Testing*

Scientific Acceptability of Measure Properties
2b. Validity

Based on your evaluation of the criteria, how would you rate the overall validity of this measure? How well overall has the developer demonstrated this measure is valid?

1. 1=High (*only if adequate testing at both levels & not face validity*)
2. 2=Moderate
3. 3=Low
4. 4=Insufficient evidence

85

Scientific Acceptability of Measure Properties
2b. Validity

Based on your evaluation of the criteria, how would you rate the overall validity of this measure? How well overall has the developer demonstrated this measure is valid?

86

Feasibility

3a. *Byproduct of Care Processes;*
3b. *Electronic sources; and*
3c. *Data Collection Strategy*

Based on your evaluation of the subcriteria, make a summary determination of the extent to which the criterion of ***Feasibility*** *has been met.*

1. 1=High
2. 2=Moderate
3. 3=Low
4. 4=Insufficient information

87

Feasibility

3a. *Byproduct of Care Processes;*
3b. *Electronic sources; and*
3c. *Data Collection Strategy*

Based on your evaluation of the subcriteria, make a summary determination of the extent to which the criterion of ***Feasibility*** *has been met.*

88

Usability and Use

4a. *Accountability/transparency (used in accountability w/in 3 yr, public reporting w/in 6 yr, or if new - credible plan); and*

4b. *Improvement – progress demonstrated (if new - credible rationale);and*

4c. *Unintended Consequences - benefits outweigh evidence of unintended negative consequences (to patients/populations)*

4d. *Measure Deconstruction – can be deconstructed to facilitate transparency and understanding*

Based on your evaluation of the subcriteria, make a summary determination of the extent to which the criterion of ***Usability and Use*** *has been met.*

1. 1=High
2. 2=Moderate
3. 3=Low
4. 4=Insufficient information

89

Usability and Use

4a. *Accountability/transparency (used in accountability w/in 3 yr, public reporting w/in 6 yr, or if new - credible plan); and*

4b. *Improvement – progress demonstrated (if new - credible rationale);and*

4c. *Unintended Consequences - benefits outweigh evidence of unintended negative consequences (to patients/populations)*

4d. *Measure Deconstruction – can be deconstructed to facilitate transparency and understanding*

Based on your evaluation of the subcriteria, make a summary determination of the extent to which the criterion of ***Usability and Use*** *has been met.*

90

Overall Suitability for Endorsement

Does the measure meet NQF criteria for endorsement?

*(**<u>Note</u>**: This may not yet be a recommendation for endorsement. Final recommendation for endorsement may depend on assessment of any related and competing measures.)*

1. 1=Yes
2. 2=No

91

Overall Suitability for Endorsement

Does the measure meet NQF criteria for endorsement?

*(**<u>Note</u>**: This may not yet be a recommendation for endorsement. Final recommendation for endorsement may depend on assessment of any related and competing measures.)*

92

2436 Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for heart failure (HF)

This measure estimates hospital-level, risk-standardized payment for a HF episode of care starting with inpatient admission to a short term acute-care facility and extending 30 days post-admission for Medicare fee-for-service (FFS) patients who are 65 years of age or older with a principal discharge diagnosis of HF.

NQF
Measure Evaluation

Voting Slides

Importance to Measure and Report
1a. High Priority

*1a. **High Priority** – The measure focus addresses:*

A specific national health Goal/Priority identified by DHHS or the National Priorities Partnership convened by NQF:

OR

A demonstrated high-impact aspect of healthcare (e.g., affects large numbers, leading cause of morbidity/mortality, high resource use [current and/or future], severity of illness, and patient/societal consequences of poor quality).

1. High
2. Moderate
3. Low
4. Insufficient evidence

96

Importance to Measure and Report
1a. High Priority

1a. ***High Priority*** *– The measure focus addresses:*

A specific national health Goal/Priority identified by DHHS or the National Priorities Partnership convened by NQF:

OR

A demonstrated high-impact aspect of healthcare (e.g., affects large numbers, leading cause of morbidity/mortality, high resource use [current and/or future], severity of illness, and patient/societal consequences of poor quality).

97

Importance to Measure and Report
1b. Opportunity for Improvement

1b. **Opportunity for Improvement** - *Demonstration of resource use or cost problems and opportunity for improvement, i.e., data demonstrating variation in the delivery of care across providers and/or population groups (disparities in care).*

1. 1=High
2. 2=Moderate
3. 3=Low
4. 4=Insufficient evidence

98

Importance to Measure and Report
1b. Opportunity for Improvement

1b. **Opportunity for Improvement** - *Demonstration of resource use or cost problems and opportunity for improvement, i.e., data demonstrating variation in the delivery of care across providers and/or population groups (disparities in care).*

99

Importance to Measure and Report
1c. Measure Intent

1c. ***Measure Intent**- The intent of the resource use measure and the measure construct are clearly described.*

AND

The resource use service categories (i.e., types of resources/ costs) that are included in the resource use measure are consistent with and representative of the intent of the measure.

1. 1=High
2. 2=Moderate
3. 3=Low
4. 4=Insufficient evidence

100

Importance to Measure and Report
1c. Measure Intent

*1c. **Measure Intent**- The intent of the resource use measure and the measure construct are clearly described.*

AND

The resource use service categories (i.e., types of resources/costs) that are included in the resource use measure are consistent with and representative of the intent of the measure.

101

Importance to Measure and Report
Overall

*Based on your rating of the subcriteria, make a summary determination of the extent to which the criterion of **Importance to Measure and Report** has been met.*

1. 1=High
2. 2=Moderate
3. 3=Low
4. 4=Insufficient evidence

102

Importance to Measure and Report Overall

*Based on your rating of the subcriteria, make a summary determination of the extent to which the criterion of **Importance to Measure and Report** has been met.*

Scientific Acceptability of Measure Properties 2a. Reliability

***2a1.** Construction Logic*

***2a1.** Clinical Logic*

***2a1.** Adjustments for Comparability – Inclusion/Exclusion Criteria*

***2a1.** Adjustments for Comparability – Risk Adjustment*

***2a1.** Adjustments for Comparability – Costing Method*

***2a1.** Adjustments for Comparability – Scoring Method*
***2a2.** Reliability Testing*

Scientific Acceptability of Measure Properties
2a. Reliability

Based on your evaluation of the criteria, how would you rate the overall reliability of this measure? How well overall has the developer demonstrated the measure results are repeatable and can be implemented consistently?

1. 1=High (*only eligible if adequate testing at both levels*)
2. 2=Moderate
3. 3=Low
4. 4=Insufficient evidence

105

Scientific Acceptability of Measure Properties
2a. Reliability

Based on your evaluation of the criteria, how would you rate the overall reliability of this measure? How well overall has the developer demonstrated the measure results are repeatable and can be implemented consistently?

106

Scientific Acceptability of Measure Properties
2b. Validity

2b1. *Construction Logic*

2b1. *Clinical Logic*

2b1. *Adjustments for Comparability – Inclusion/Exclusion Criteria*

2b3. *Exclusions*

2b1. *Adjustments for Comparability – Risk Adjustment*

2b4. *Risk Adjustment*

2b1. *Adjustments for Comparability – Costing Method*

2b1. *Adjustments for Comparability – Scoring Method*

2b5. *Significant Differences in Performance*

2b6. *Comparability of Multiple Data Sources*

2b2. *Validity Testing*

107

Scientific Acceptability of Measure Properties
2b. Validity

Based on your evaluation of the criteria, how would you rate the overall validity of this measure? How well overall has the developer demonstrated this measure is valid?

1. 1=High (*only if adequate testing at both levels & not face validity*)
2. 2=Moderate
3. 3=Low
4. 4=Insufficient evidence

108

Scientific Acceptability of Measure Properties
2b. Validity

Based on your evaluation of the criteria, how would you rate the overall validity of this measure? How well overall has the developer demonstrated this measure is valid?

Feasibility

***3a.** Byproduct of Care Processes;*
***3b.** Electronic sources; and*
***3c.** Data Collection Strategy*

*Based on your evaluation of the subcriteria, make a summary determination of the extent to which the criterion of **Feasibility** has been met.*

1. 1=High
2. 2=Moderate
3. 3=Low
4. 4=Insufficient information

Feasibility

3a. *Byproduct of Care Processes;*
3b. *Electronic sources; and*
3c. *Data Collection Strategy*

Based on your evaluation of the subcriteria, make a summary determination of the extent to which the criterion of ***Feasibility*** *has been met.*

111

Usability and Use

4a. *Accountability/transparency (used in accountability w/in 3 yr, public reporting w/in 6 yr, or if new - credible plan); and*
4b. *Improvement – progress demonstrated (if new - credible rationale);and*
4c. *Unintended Consequences - benefits outweigh evidence of unintended negative consequences (to patients/populations)*
4d. *Measure Deconstruction – can be deconstructed to facilitate transparency and understanding*

Based on your evaluation of the subcriteria, make a summary determination of the extent to which the criterion of ***Usability and Use*** *has been met.*

1. 1=High
2. 2=Moderate
3. 3=Low
4. 4=Insufficient information

112

Usability and Use

4a. *Accountability/transparency (used in accountability w/in 3 yr, public reporting w/in 6 yr, or if new - credible plan); and*

4b. *Improvement – progress demonstrated (if new - credible rationale);and*

4c. *Unintended Consequences - benefits outweigh evidence of unintended negative consequences (to patients/populations)*

4d. *Measure Deconstruction – can be deconstructed to facilitate transparency and understanding*

Based on your evaluation of the subcriteria, make a summary determination of the extent to which the criterion of ***Usability and Use*** *has been met.*

113

Overall Suitability for Endorsement

Does the measure meet NQF criteria for endorsement?

*(**Note**: This may not yet be a recommendation for endorsement. Final recommendation for endorsement may depend on assessment of any related and competing measures.)*

1. 1=Yes
2. 2=No

114

Overall Suitability for Endorsement

Does the measure meet NQF criteria for endorsement?

*(**Note**: This may not yet be a recommendation for endorsement. Final recommendation for endorsement may depend on assessment of any related and competing measures.)*

Public and Member Comment

NATIONAL QUALITY FORUM

Adjourn

Dinner: McCormick & Schmick's
1652 K Street NW
Washington DC, 20006