National Consensus Standards for Cost and Resource Use

New Committee Member Orientation

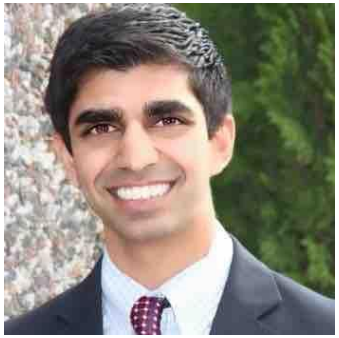
Erin O' Rourke, Senior Director
Taroon Amin, Consultant
Rachel Roiland, Senior Project Manager
Suzanne Theberge, Senior Project Manager
Hiral Dudhwala, Project Manager
Irvin Singh, Project Analyst

February 3, 2017

Welcome

Project Team

Erin O' Rourke
Senior Director



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Consultant

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Senior Project Manager

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Project Analyst

Agenda for the Call

- Standing Committee Introductions
- Overview of NQF, the Consensus Development Process, and Roles of the Standing Committee, co-chairs, NQF staff
- Overview of NQF's Cost & Resource Use measure portfolio
- Review of project activities and timelines
- Overview of NQF's measure evaluation criteria
- SharePoint Tutorial
- Next steps

Cost and Resource Use Standing Committee

- Brent Asplin, MD, MPH
- Larry Becker
- Mary Ann Clark, MHA
- Cheryl Damberg, PhD
- Jennifer Eames Huff, MPH
- Troy Fiesinger, MD, FAAFP
- Nancy Garrett, PhD
- Andrea Gelzer, MD, MS, FACP
- Lisa Latts, MD, MSPH, MBA, FACP *(Inactive 2016-2017)*
- Martin Marciniak, MPP, PhD
- Kristine Martin Anderson, MBA
- James Naessens, ScD, MPH
- Jack Needleman, PhD
- Janis Orlowski, MD, MACP
- Carolyn Pare *(Inactive 2016-2017)*
- Betty Rambur, PhD, RN
- John Ratliff, MD, FACS, FAANS
- Andrew Ryan, PhD *(Inactive 2016-2017)*
- Srinivas Sridhara, PhD, MHS
- Lina Walker, PhD *(Inactive 2016-2017)*
- Bill Weintraub, MD, FACC
- Herbert Wong, PhD
- Dolores Yanagihara, MPH

Overview of NQF, the Consensus Development Process, and Roles

The National Quality Forum: A Unique Role

Established in 1999, NQF is a non-profit, non-partisan, membership-based organization that brings together public and private sector stakeholders to reach consensus on healthcare performance measurement. The goal is to make healthcare in the U.S. better, safer, and more affordable.

Mission:
To lead national collaboration to improve health and healthcare quality through measurement

- An Essential Forum
- Gold Standard for Quality Measurement
- Leadership in Quality

NQF Activities in Multiple Measurement Areas

- **Performance Measure Endorsement**
  - *600+ NQF-endorsed measures across multiple clinical areas*
  - *19 empaneled standing committees*

- **Measure Applications Partnership (MAP)**
  - *Advises HHS on selecting measures for 20+ federal programs, Medicaid, and health exchanges*

- **National Quality Partners**
  - *Convenes stakeholders around critical health and healthcare topics*
  - *Spurs action on patient safety, early elective deliveries, and other issues*

- **Measurement Science**
  - *Convenes private and public sector leaders to reach consensus on complex issues in healthcare performance measurement such as attribution, alignment, sociodemographic status (SDS) adjustment*

NQF Consensus Development Process (CDP)

7 Steps for Measure Endorsement

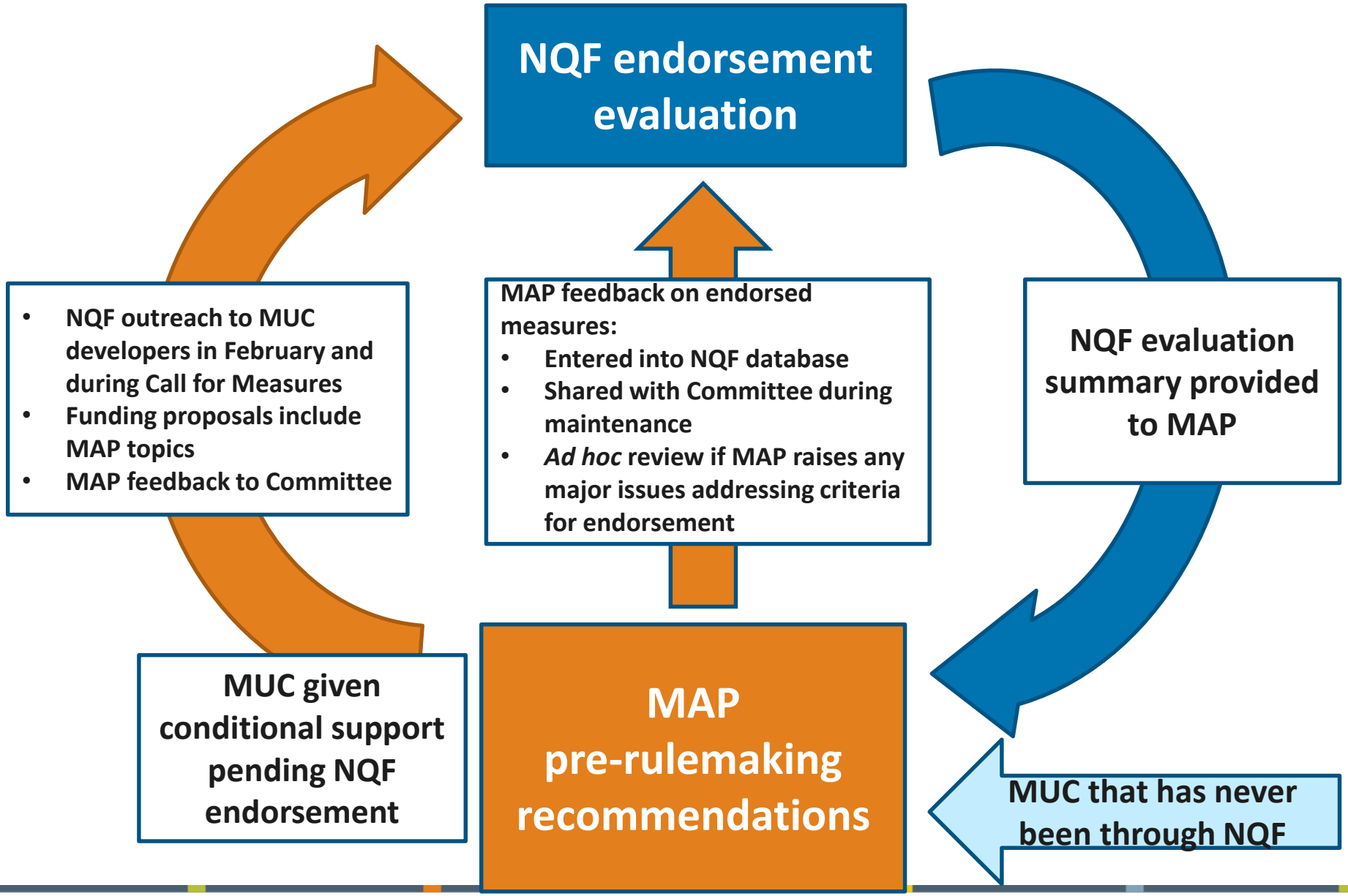
- Call for nominations for Standing Committee
- Call for candidate standards (measures)
- Candidate consensus standards review
- Public and member comment
- NQF member voting
- Consensus Standards Approval Committee (CSAC) ratification and endorsement
- Appeals

Measure Application Partnership (MAP)

In pursuit of the National Quality Strategy, the MAP:

- Informs the selection of performance measures to achieve the goal of improvement, transparency, and value for all
- Provides input to HHS during pre-rulemaking on the selection of performance measures for use in public reporting, performance-based payment, and other federal programs
- Identifies gaps for measure development, testing, and endorsement
- Encourages measurement alignment across public and private programs, settings, levels of analysis, and populations to:
    - *Promote coordination of care delivery*
    - *Reduce data collection burden*

CDP-MAP INTEGRATION – INFORMATION FLOW



Role of the Standing Committee

General Duties

- 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
- Evaluate candidate measures against the measure evaluation criteria
- Respond to comments submitted during the review period
- Respond to any directions from the CSAC

Role of the Standing Committee

Measure Evaluation Duties

- 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
- Oversee Cost and Resource Use portfolio of measures
  - *Promote alignment and harmonization*
  - *Identify gaps*

Role of the Standing Committee Co-Chairs

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

Role of NQF Staff

- NQF project staff works with SC to achieve the goals of the project and ensure adherence to the consensus development process:
  - *Organize and staff SC meetings and conference calls*
  - *Guide the SC through the steps of the CDP and advise on NQF policy and procedures*
  - *Review measure submissions and prepare materials for Committee review*
  - *Draft and edit reports for SC review*
  - *Ensure communication among all project participants (including SC and measure developers)*
  - *Facilitate necessary communication and collaboration between different NQF projects*

Role of NQF Staff
Communication

- Respond to NQF member or public queries about the project
- Maintain documentation of project activities
- Post project information to NQF website
- Work with measure developers to provide necessary information and communication for the SC to fairly and adequately evaluate measures for endorsement
- Publish final project report

Questions?

Overview of NQF's Cost and Resource Use Portfolio

NQF's Prior Cost Work

Episodes of Care Measurement Framework

Efficiency: Resource Use – Phase I Phase II

Cost and Resource Use Phase I

Cost and Resource Use Phase II

Cost and Resource Use Phase III

Developing Episode Grouper Evaluation Criteria

Linking Cost and Quality

Measuring Affordable Care for Consumers

MAP Affordability Family of Measures

Key Definitions (EOC Framework)

This project will build on definitions established by prior consensus-drive work:

- ***Cost of care*** is a measure of total healthcare spending, including total resource use and unit price(s), by payor or consumer, for a healthcare service or group of healthcare services, associated with a specified patient population, time period, and unit(s) of clinical accountability.
- ***Efficiency of care*** is a measure of cost of care associated with a specified level of quality of care.
- ***Value of care*** is a measure of a specified stakeholder's (such as an individual patient's, consumer organization's, payor's, provider's, government's, or society's) preference-weighted assessment of a particular combination of quality and cost of care.

Resource Use: A Building Block

Efficiency Measurement Principles

- *National Voluntary Consensus Standards for Cost and Resource Use* developed principles for efficiency measurement:
  - *Resource use measures must demonstrate they are important to measure, have scientifically acceptable properties, and are usable and feasible.*
  - *Resource use measures that meet these criteria may be used in conjunction with quality measures to assess efficiency.*
  - *Considerations should include the measure type (e.g., outcome, process, patient experience), measurement period (e.g., single point in time, spanning the measurement year), and the number of quality measures that should be paired with a resource use measure.*
  - *Quality measures may be used to monitor for underuse on needed care.*

Cost and Resource Use Portfolio of Measures

- This project will evaluate measures related to cost and resource use that can be used for accountability and public reporting for the specific and tested population.

- The fourth phase of this project will involve the review of three all conditions-focused maintenance measures:
  - *2158 Payment-Standardized Medicare Spending per Beneficiary*
  - *1598 Total Resource Use Population-based PMPM Index*
  - *1604: Total Cost of Care Population-based PMPM Index*

Cost and Resource Use Portfolio of NQF-endorsed measures

- 1598: Total Resource use Population-based PMPM Index
- 1604: Total Cost of Care Population-based PMPM Index
- 2431: Hospital-level, risk-standardized payment associated with a 30-day episode of care for acute myocardial infarction (AMI)
- 2436: Hospital-level, risk-standardized payment associated with a 30-day episode of care for heart failure
- 2579: Hospital-level, risk-standardized payment associated with a 30-day episode of care for pneumonia
- 2158: Medicare Spending Per Beneficiary

Activities and Timeline

Meeting	Date/Time
New Member Orientation Call	February 3, 2017, 2:00 – 4:00 PM EST
Full Committee Orientation/ Measure Evaluation Q & A Call	March 3, 2017, 12:00 – 2:00 PM EST
In-Person Meeting (1 day in Washington, D.C.)	March 15, 2017 8:00 AM – 5:30 PM EST
Post-Meeting Conference Call	March 22, 2017, 2:00 – 4:30 PM EST March 24, 2017, 1:00 – 3:30 PM EST
Post Comment Report Call	June 6, 2017, 2:00 – 4:30 PM EST June 8, 2017, 1:00 – 3:30 PM EST

Questions?

Measure Evaluation Criteria Overview

NQF Measure Evaluation Criteria for Endorsement

NQF endorses measures for accountability applications (public reporting, payment programs, accreditation, etc.) as well as quality improvement.

- Standardized evaluation criteria
- Criteria have evolved over time in response to stakeholder feedback
- The quality measurement enterprise is constantly growing and evolving – greater experience, lessons learned, expanding demands for measures – the criteria evolve to reflect the ongoing needs of stakeholders

Major Endorsement Criteria

Hierarchy and Rationale

- ***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**)*

- ***Reliability and Validity-scientific acceptability of measure properties**: Goal is to make valid conclusions about quality; if not reliable and valid, there is risk of improper interpretation (**must-pass**)*

- ***Feasibility**: Goal is to, ideally, cause as little burden as possible; if not feasible, consider alternative approaches*

- ***Usability and Use**: Goal is to use for decisions related to accountability and improvement; if not useful, probably do not care if feasible*

- ***Comparison to related or competing measures***

Criterion #1: Importance to Measure and Report

1. **Importance to measure and report -** Extent to which the specific measure focus is evidence-based and important to making significant gains in healthcare quality where there is variation in or overall less-than-optimal performance.

   1a. High Priority: *the measure addresses one of the following:*

   - *A specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF.*
   - *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).*

Criterion #1: Importance to Measure and Report

1. **Importance to measure and report -** Extent to which the specific measure focus is evidence-based and important to making significant gains in healthcare quality where there is variation in or overall less-than-optimal performance.

   1b. Opportunity for Improvement: *demonstration of quality problems and opportunity for improvement, i.e., data demonstrating considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or*
   disparities in care across population group

   1c. Measure Intent: *This requirement involves describing the measure intent of the resource use measure and the measure construct.*

Criterion #1: Importance to measure and report

Criteria emphasis is different for new vs. maintenance measures

New measures	Maintenance measures
• Gap – opportunity for improvement, variation, quality of care across providers	**INCREASED EMPHASIS**: data on current performance, gap in care and variation

Criterion #2: Reliability and Validity – Scientific Acceptability of Measure Properties (page 41 -51)

2. **Scientific Acceptability** - Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of health care delivery

*2a. **Reliability (must-pass)***

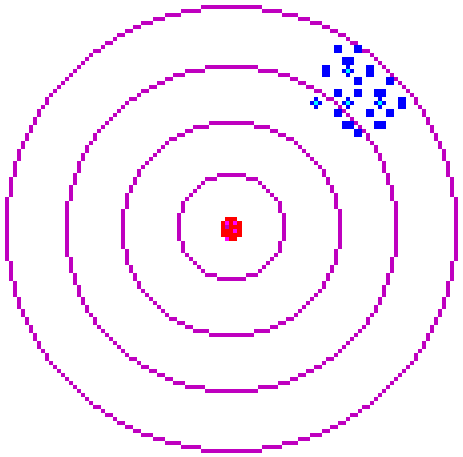
2a1. Precise specifications including exclusions
2a2. Reliability testing—data elements or measure score

*2b. **Validity (must-pass)***

2b1. Specifications consistent with evidence
2b2. Validity testing—data elements or measure score
2b3. Justification of exclusions—relates to evidence
2b4. Risk adjustment—typically for outcome/cost/resource use
2b5. Identification of differences in performance
2b6. Comparability of data sources/methods
2b7. Missing data

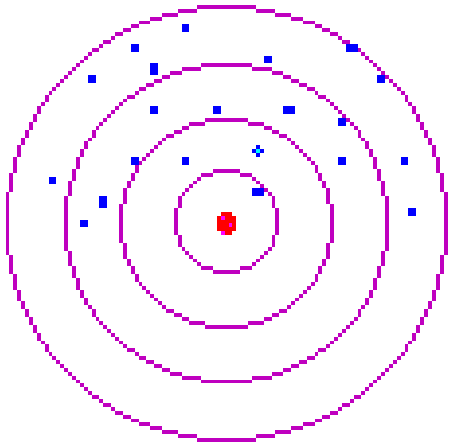
Reliability and Validity (page 42)

Assume the center of the target is the true score…



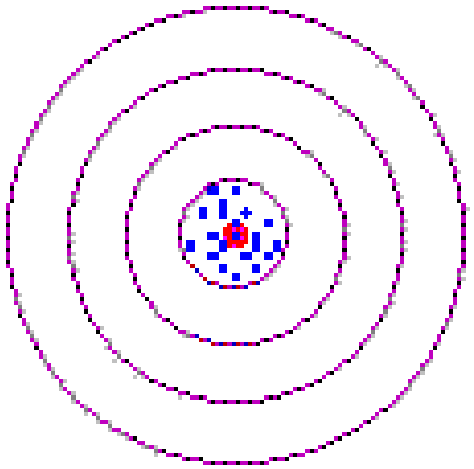
Reliable Not Valid

Consistent, but wrong



Neither Reliable Nor Valid

Inconsistent & wrong



Both Reliable And Valid

Consistent & correct

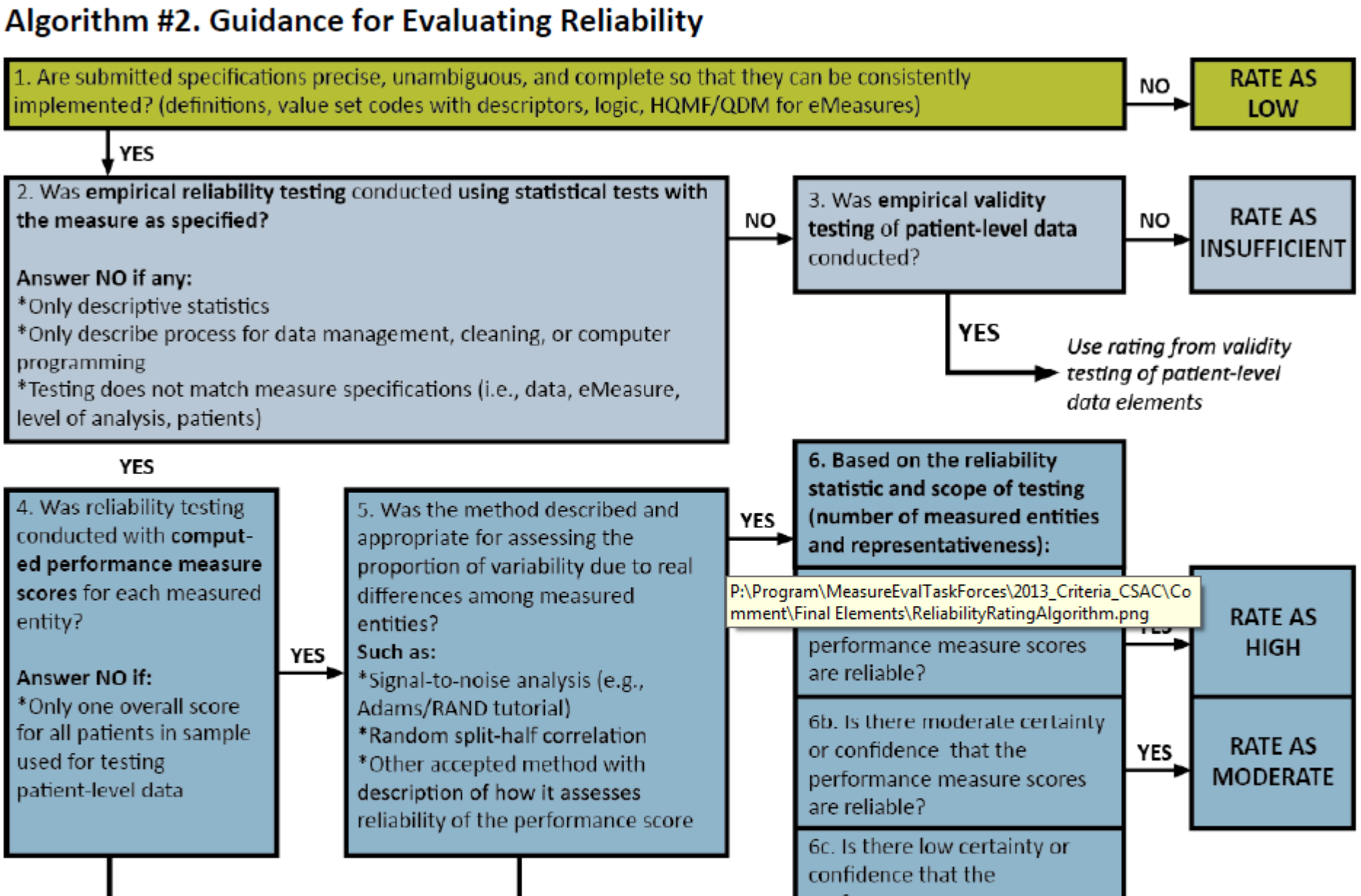
Measure Testing – Key Points (page 43)

Empirical analysis to demonstrate the reliability and validity of the *measure as specified,* including analysis of issues that pose threats to the validity of conclusions about quality of care such as exclusions, risk adjustment/stratification for outcome and resource use measures, methods to identify differences in performance, and comparability of data sources/methods.

Reliability Testing (page 43)
Key points - page 44

- Reliability of the ***measure score*** refers to the proportion of variation in the performance scores due to systematic differences across the measured entities in relation to random variation or noise (i.e., the precision of the measure).
  - *Example - Statistical analysis of sources of variation in performance measure scores (signal-to-noise analysis)*
- Reliability of the ***data elements*** refers to the repeatability/reproducibility of the data and uses patient-level data
  - *Example - inter-rater reliability*
- Consider whether testing used an appropriate method and included adequate representation of providers and patients and whether results are within acceptable norms
- Algorithm #2 – page 48

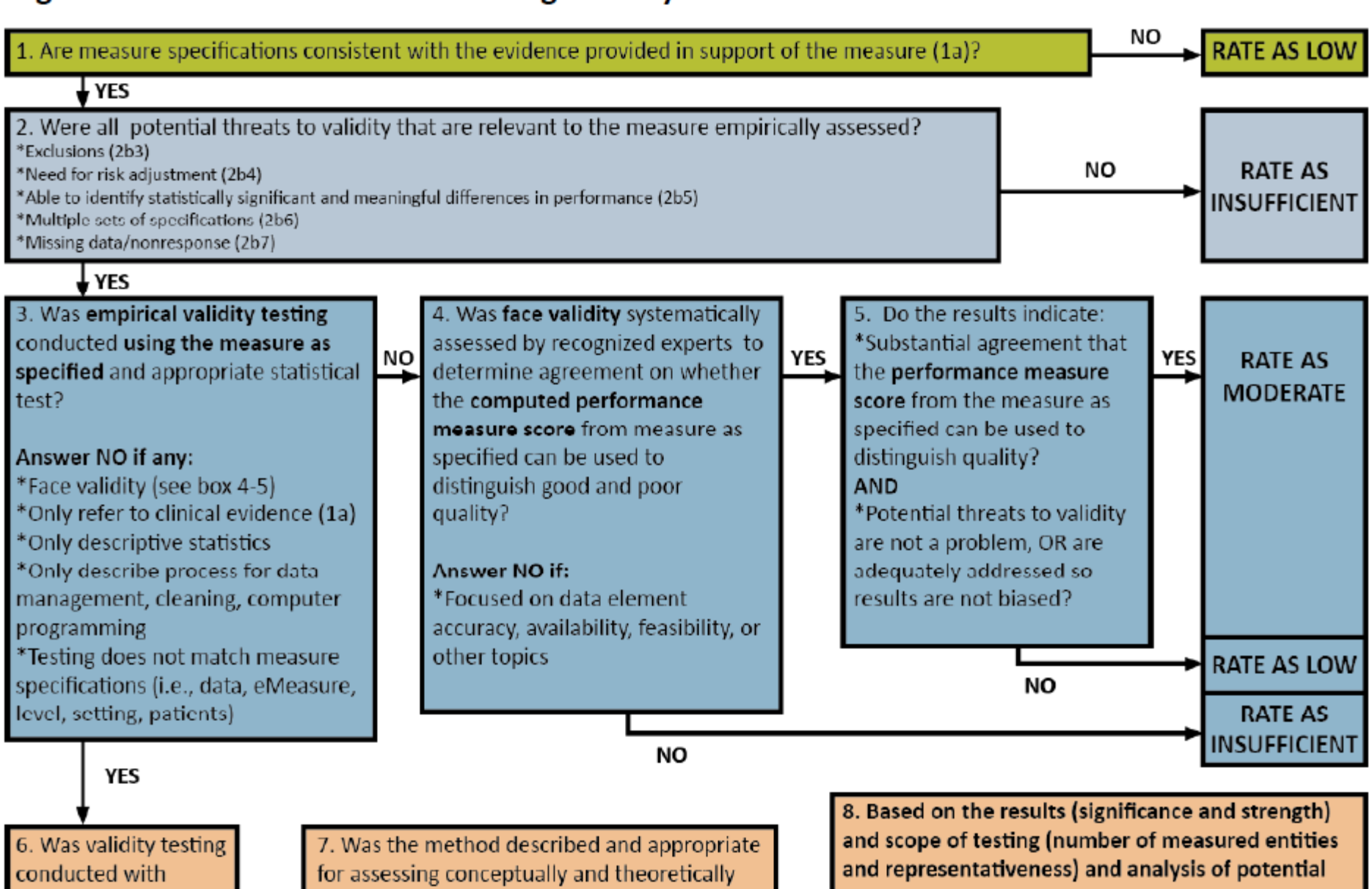
Rating Reliability: Algorithm #2 – page 45



Validity testing (pages 46 - 50) Key points – page 49

- **Empirical testing**
  - *Measure score* – assesses a hypothesized relationship of the measure results to some other concept; assesses the correctness of conclusions about quality
  - *Data element* – assesses the correctness of the data elements compared to a "gold standard"
- **Face validity**
  - Subjective determination by experts that the measure appears to reflect quality of care

Rating Validity: Algorithm #3 – page 50



Threats to Validity

- **Conceptual**
  - *Measure focus is not a relevant outcome of healthcare or not strongly linked to a relevant outcome*
- **Unreliability**
  - *Generally, an unreliable measure cannot be valid*
- Patients **inappropriately excluded** from measurement
- **Differences in patient mix** for outcome and resource use measures
- Measure scores that are generated with **multiple data sources/methods**
- Systematic **missing or "incorrect" data** (unintentional or intentional)

Criterion #2: Scientific Acceptability

New measures	Maintenance measures
• Measure specifications are precise with all information needed to implement the measure	NO DIFFERENCE: Require updated specifications
• Reliability • Validity (including risk-adjustment)	**DECREASED EMPHASIS**: If prior testing adequate, no need for additional testing at maintenance with certain exceptions (e.g., change in data source, level of analysis, or setting) Must address the questions for SDS Trial Period

Criterion #3: Feasibility (page 51)
Key Points – page 52

3. **Feasibility** - Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement.

   *3a**: Clinical data generated during care process***

   *3b**: Electronic sources***

   *3c**: Data collection strategy can be implemented***

Criterion #4: Usability and Use (page 52)
Key Points – page 53

4. Usability and Use - Extent to which potential audiences (e.g., consumers, purchasers, providers, policymakers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. ***Accountability and Transparency:*** Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement.

4b. ***Improvement:*** Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated.

4c. ***Benefits outweigh the harms:*** The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4d. ***Vetting by those being measured and others:*** Those being measured have been given results and assistance in interpreting results; those being measured and others have been given opportunity for feedback; the feedback has been considered by developers.

Criteria #3-4: Feasibility & Usability and Use

New measures	Maintenance measures
Feasibility	
• Measure feasible, including eMeasure feasibility assessment	NO DIFFERENCE: Implementation issues may be more prominent
Usability and Use	
• Use: used in accountability applications and public reporting	**INCREASED EMPHASIS**: Much greater focus on measure use and usefulness, including both impact and unintended consequences
• Usability: impact and unintended consequences	

Criterion #5: Related or Competing Measures (page 53-54)

5. **Related or Competing:** If a measure meets the four criteria and there are endorsed/new related measures (same measure focus or same target population) or competing measures (both the same measure focus and same target population), the measures are compared to address harmonization and/or selection of the best measure**.**

   5a. The measure specifications are harmonized with related measures **OR** the differences in specifications are justified.

   5b. The measure is superior to competing measures (e.g., is a more valid or efficient way to measure) **OR** multiple measures are justified.

Evaluation process

- **Preliminary analysis**: To assist the Committee evaluation of each measure against the criteria, NQF staff will prepare a preliminary analysis of the measure submission and offer preliminary ratings for each of the criteria.
  - *These will be used as a starting point for the Committee discussion and evaluation*
- **Individual evaluation assignments:** Each Committee member will be assigned a subset of measures for in-depth evaluation.
  - *Those who are assigned measures will lead the discussion of their measures with the entire Committee*

Evaluation process (continued)

- **Measure evaluation and recommendations at the in-person meeting:** The entire Committee will discuss and rate each measure against the evaluation criteria and make recommendations for endorsement.

Recommendation for Endorsement and Endorsement +

- The Committee votes on whether to recommend a measure for NQF endorsement.
- Staff will inform the Committee when a measure has met the criteria for possible "Endorsement +" designation:
  - *Meets evidence criteria without exception*
  - *Good results on reliability testing of the measure score*
  - *Good results on empirical validity testing of the measure score (not just face validity)*
  - *Well-vetted in real world settings by those being measured and others*
- Committee votes on recommending the "Endorsement +" designation, indicating that the measure exceeds NQF criteria in key areas.

Questions?

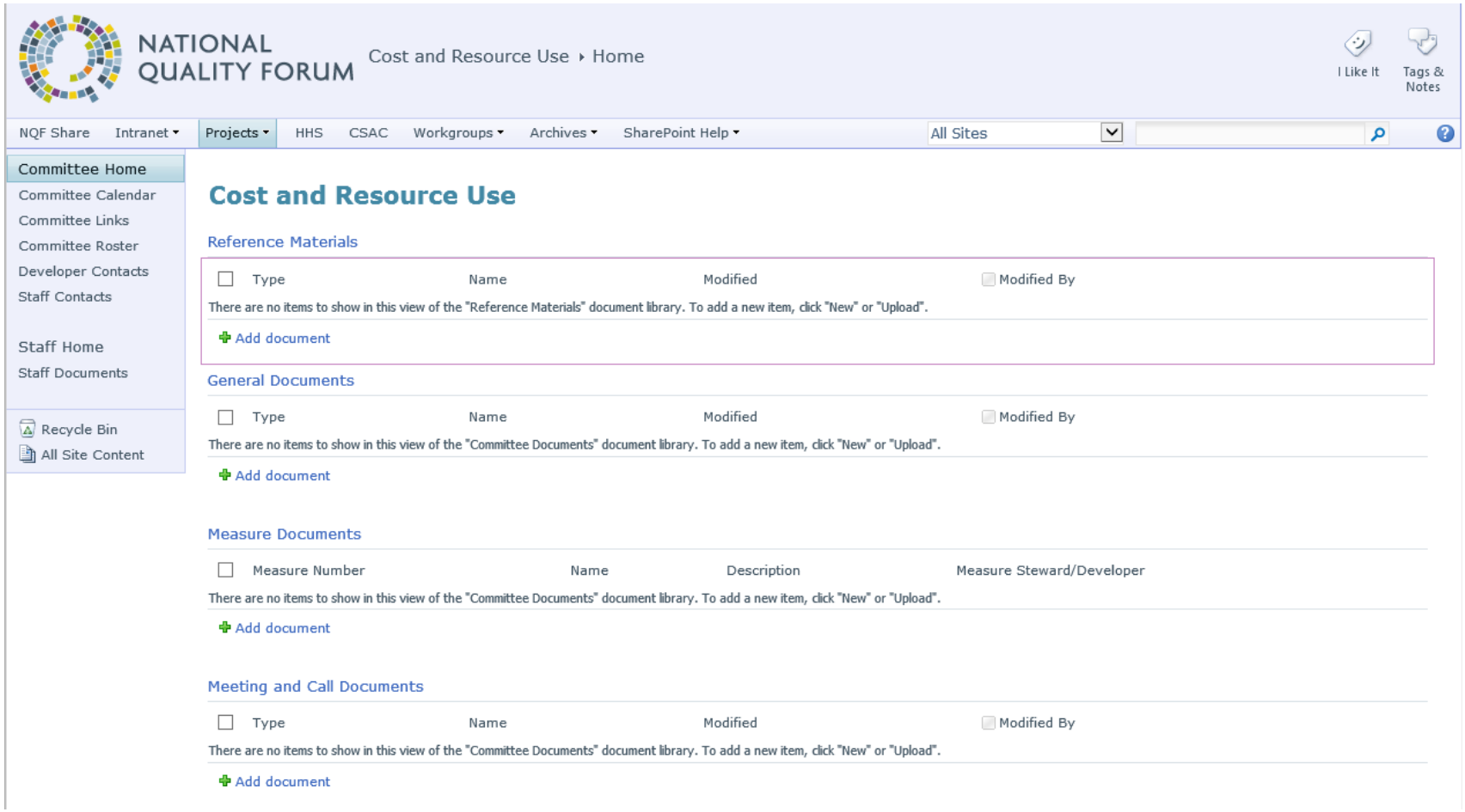
SharePoint Overview

SharePoint Overview

http://share.qualityforum.org/Projects/costRU/SitePages/Home.aspx

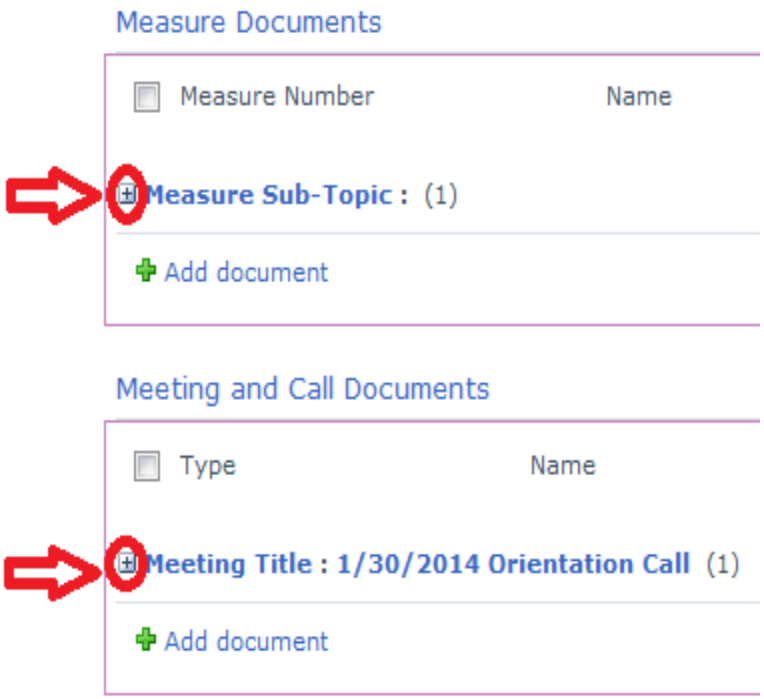
- Accessing SharePoint
- Standing Committee Policy
- Standing Committee Guidebook
- Measure Document Sets
- Meeting and Call Documents
- Committee Roster and Biographies
- Calendar of Meetings

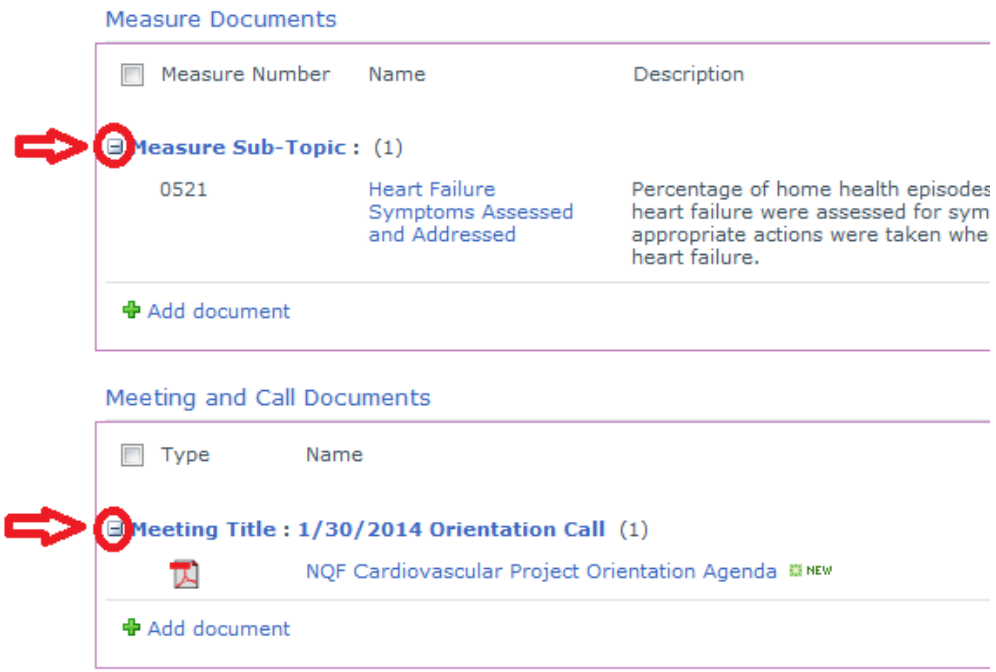
SharePoint Overview



SharePoint Overview

- Please keep in mind:
  - *+ and – signs*





Measure Worksheet and Measure Information

- Measure Worksheet
  - *Preliminary analysis, including eMeasure Technical Review if needed, and preliminary ratings*
  - *Pre-evaluation comments*
  - *Public comments*
  - *Information submitted by the developer*
    - » Evidence and testing attachments
    - » Spreadsheets
    - » Additional documents

Next Steps

- New Committee Member Orientation
  - *February 3, 2017, 2:00 PM – 4:00 PM EST*
- Pre-Meeting Public Comment
  - *February 20, 2017 – March 6, 2017*
- Full Committee Orientation/Measure Evaluation Q&A Call
  - *March 3, 2017, 12:00 PM – 2:00 PM EST*
- In-Person Meeting
  - *March 15, 2017 8:00 AM – 5:30 PM EST*

Project Contact Info

- Email: efficiency@qualityforum.org
- NQF Phone: 202-783-1300
- Project page:

http://www.qualityforum.org/Cost_and_Resource_Use_Project_2016-2017.aspx

- SharePoint site:

http://share.qualityforum.org/Projects/costRU/SitePages/Home.aspx

Questions?