NATIONAL QUALITY FORUM

Conference Call for the National Voluntary Consensus Standards for Resource-Use Measurement: Phase 1 Summary of Measure Specifications and Criteria Work Group
August 5, 2010

Steering Committee members present: Paul Barnett, PhD; Kurt Elward, MD; Lisa Grabert, MPH; Jack Needleman, PhD; David Redfearn, PhD; William L. Rich, MD; Dolores Yanagihara, MPH

NQF Staff present: Sally Turbyville, MA, MS; Ashlie Wilbon, RN, MPH; Sarah Fanta

Audience Members registered: Kay Jewell, Center for Consumers of Health Care; Brennan Niall, CMS Government

INTRODUCTION

A conference call for the National Voluntary Consensus Standards for Resource Use Measurement Project—Phase 1 Work Group was held on Thursday, August 5, 2010. Ms. Wilbon began the meeting with a review of the meeting agenda and roll call. The purpose of the conference call was to discuss the work group's suggestions for components that will be subject to evaluation by the Resource Use Steering Committee and Technical Advisory Panels for endorsement consideration. The work group was provided a draft list of the potential resource-use measure submission items and a side-by-side table of the proposed resource use measure evaluation criteria and corresponding submission requirements based on suggestions from the July 30, 2010 conference call. The results of this work group will be shared with the full Steering Committee once it has been completed.

WORK GROUP DISCUSSION

Section 1: Importance to measure and report – Resource Use Measure Criteria

1b. Demonstration of resource use or cost problems and opportunity for improvement, i.e., data[1] demonstrating considerable variation, or overall ***poor performance*** in the delivery of care across providers and/or population groups (disparities in care).

Workgroup comment: The definition of "poor performance" will be updated based on Steering Committee discussion at the in-person meeting. The Workgroup had concerns based on the populations for which testing will be submitted to NQF, ideally the testing conducted will be done on the same population the measure is intended to capture. This evaluation will be based on the Steering Committee's reaction (Ex. If testing on the Medicare population will be acceptable

for use on a broader population?). The Steering Committee and TAPs will review testing data, which includes information on which population the measure tests. Decisions about the generaliability to populations are part of validity testing (demonstrates external validity).

1c. Measure intent
- intent of the measure and its components
- intended use of the measure

Workgroup comment: There must be a description available for Measure Developers, explaining and possibly giving examples of ways to answer this question. This is a topical question that must be tied back to Scientific Acceptability.

1d. (NEW). Evidence about the measures purpose, justification and why it is important to measure. This evidence or justification should inform why a measure is constructed in a particular way, such that Scientific Acceptability can be evaluated (i.e., is the measure a valid measure for its intended purpose?)
Workgroup comment: This section must be described more clearly in order for Measure Developers to adequately answer the question.

Section 2: Scientific Acceptability of measure properties

2a.Type of resource use measure:
- Per capita (per patient)
- Per episode
- Per hospitalization
- Per procedure
- Other

Workgroup comment: For each location on the form that indicates "other", there should be a text box and a request for measure developers to list what specifically what is meant.

2a.Describe the intent of the measure (Ex. what is it supposed to be measuring and what is the intended use of the measure)
Workgroup comment: This requirement is already requested in sections 1A and 1D, there must be a specified location.

2a.Type of Score
- Proportion (rate)
- Dichotomous
- Ratio
- Frequency distribution
- Count
- Continuous variable
- Composite

Workgroup comment: "Ratio" should include observed vs. expected, and "Continuous variable" should include per capita and PMPM). Examples of each should be provided.

2a. Level of Analysis
- Individual
- Group
- Other
- Facility/Agency
- Health plan
- Integrated delivery system
- Multi-site/corporate chain
- Population
- National
- Regional/Network
- States
- Counties or cities
- Prescription Drug Plan Program
- Disease management
- Quality improvement organization
- Other
- Can be measured at all levels

Workgroup comment: Consider changing "level of analysis" to attribution. Add description to "Level of Analysis" explaining this area focuses on the level of attribution. Add header "Clinician" to individual, group, and other; Add header "Population" to national, regional/network, states, counties or cities. Add "list" and text box after "Other" category. Also, add categories, "Home health", "Hospital home", "Professional services" (specifying outpatient and inpatient), "Imaging facility", "Diagnostic", "Outpatient" and "Inpatient".

2ab (NEW) Measure specifications must detail all data protocol steps measurement functions and rationale including:
- Data cleaning
- Initial inclusion criteria
- Initial exclusion criteria
- Analysis of missing resource use units supports the specifications for scoring/aggregation and handling of missing data for resource use units.

Workgroup comment: Change to "Analysis of *data* supports the specifications for scoring/aggregation and handling of missing data for resource use units."

2ac. (NEW) Measure or episode clinical logic and method
Work Group comment: Expand this header by adding: "…for identifying population to be measured so it is clear what the purpose of this section is.

2ad. (NEW) Measure specifications must detail measure or episode construction logic functions, and rationale including:
- Denominator or episode trigger and end mechanisms
- Redundancy and overlap of episodes
- Linking complementary services

- Unit of resource service – the Steering Committee noted the list was lacking, NQF aggress and stated the list would be updated before giving material to the Steering Committee.
- Care setting
- Individual resource unit analysis demonstrates that the included resource units contribute to the variation in the overall resource use result or score

- Care Setting
  - Ambulatory Care
  - Home
  - Ambulatory surgery center Hospice
  - Office Hospital
  - Clinic Long term acute care hospital
  - Emergency Department Nursing home (NH) /skilled nursing facility (SNF)
  - Hospital Outpatient Rehabilitation facility
  - Assisted living
  - Behavioral health/psychiatric unit All settings
  - Dialysis facility Unspecified or "not applicable"
  - Emergency medical services/ambulance
  - Group homes
  - Other

Workgroup comment: NQF should provide examples of "Unit of resource service" and "Care setting". Depending on the data systems, the resources may not be included in the aggregate data. There should be a preference to measures that that provide care setting and types of resources. There should also be a portion added that has measure developers describe the resources that are left out of the measure. The entire specification "Care setting" should be moved to clinical logic setting, it may also fit under the "measure intent" portion of the form as a sub-category or consider removing it from the submission requirements all together. What is its purpose?

2ae.Adjustments for Comparability

- Describe the risk adjustment model in detail
  - Define risk adjustment variables
  - Rationale for risk adjustment model used

Workgroup comment: The Stratification details should be included in this section as a separate bullet.

2c. Costing Methodology validity testing (which costs or weights being used)

- Data Sample *(Description of data sample and size)*
- Analytic Methods *(Type of reliability and rationale, method for testing)*
- Testing Results *(Reliability statistics, assessment of adequacy in the context of norms for the test conducted)*

Workgroup comment: This section may need to be an entire standalone category. In addition, the "weighting" of the measures must be further explained along with providing an example including how the score is generated.

2d. Clinically ***or resource use or cost*** necessary measure exclusions are identified and must be: supported by evidence[10] of sufficient frequency of occurrence so that results are distorted without the exclusion; AND clinically appropriate exception (e.g., contraindication) to eligibility for the measure focus, AND Precisely defined and specified. If there is substantial variability in exclusions across providers, the measures is specified so that exclusions are computable and the effect on the measure is transparent (i.e., impact clearly delineated, such as the number of cases excluded, exclusion rates by type of exclusion). If patient preference (e.g., informed decision making) or **patient payment amounts (e.g., co-pays)** is a basis for exclusion, there must be evidence that it strongly impacts performance on the measure, and the measure must be specified so that the information about **patient preference or co-pay amount** and the effect on the measures is transparent (e.g., numerator category computed separately, denominator exclusion category computed separately).
Workgroup comment: This section must be broken down and explained and have descriptions of each specification.

PUBLIC COMMENT

There were no public comments made during this conference call.

NEXT STEPS

- The workgroup should submit any further comments or edits to these documents by COB Wednesday, August 11th. At that time NQF staff will determine whether another work group call is needed.
- NQF staff will need to schedule an additional call with the full Steering Committee to discuss work group comments. The call scheduled for October 5th will be strictly for the discussion of comments on the white paper.