NATIONAL QUALITY FORUM

Memo

TO: Endocrine Standing Committee

FR: NQF Staff

RE: Post-Comment Call to Discuss Public and Member Comments

DA: April 10, 2015

Purpose of the Call

The Endocrine Standing Committee will meet via conference call on Thursday, April 16, 2015 from noon-2pm ET. The purpose of this call is to:

- Review and discuss comments received during the post-evaluation public and member comment period
- Provide input on proposed responses to the post-evaluation comments
- Determine whether reconsideration of any measures or other courses of action is warranted
- Solicit Committee feedback on the pilot process of allowing more frequent submission and evaluation of measures

Standing Committee Actions

1. Review this briefing memo, Draft Report, and the recently published National Action Plan for Adverse Event Prevention (see www.health.gov/hai/pdfs/ADE-Action-Plan-508c.pdf, p 117)
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see comment table)
3. Be prepared to provide feedback and input on proposed post-evaluation comment responses

Conference Call Information

Please use the following information to access the conference call line and webinar:
Speaker dial-in #: 1 (877) 564 – 4723 (*NO CONFERENCE CODE REQUIRED)*
Web Link: http://nqf.commpartners.com/se/Rd/Mt.aspx?415330

Registration Link: http://nqf.commpartners.com/se/Rd/Rg.aspx?415330

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments prior to the evaluation of the measures via an online tool located on the project webpage. Third, NQF opens a 30-day comment period to both members and the public after measures have been evaluated by the Committee and once a report of the proceedings has been drafted.

Pre-evaluation comments

The pre-evaluation comment period was open from December 25, 2014 to January 12, 2015. No pre-evaluation comments were received for the measures under review in this cycle of the project.

Post-evaluation comments

The Draft Report was open for Public and Member comment from March 2, 2015 to April 3, 2015. During this commenting period, NQF received six comments from five member organizations:

Consumers – 0	Professional – 0
Purchasers – 0	Health Plans – 2
Providers – 1	QMRI – 0
Supplier and Industry – 1	Public & Community Health - 1

Where possible, NQF staff has proposed draft responses for the Committee to consider. Although all comments and proposed responses are subject to discussion, we will not necessarily discuss each comment and response on the post-comment call. Instead, we will spend the majority of the time considering the major topics and the most significant issues that arose from the comments.

We have included all of the comments that we received in the Comment Table. This comment table contains the commenter's name, comment, associated measure, and draft responses for the Committee's consideration. Please refer to this comment table to view and consider the individual comments received and the proposed responses to each.

Comments and their Disposition

The following comments were received in the post-evaluation comment period:

0061: Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)

NQF received one comment (#4719) in support of the Committee's recommendation for endorsement of this measure.

0729: Optimal Diabetes Care

NQF received five comments regarding this measure, each of which was critical of the measure, for various reasons.

NQF received two comments (#4687 and #4794) ***specifically related to the glucose control component*** of the composite. Commenters referenced the National Action Plan for Adverse Event Prevention (www.health.gov/hai/pdfs/ADE-Action-Plan-508c.pdf, p 117), which was released in August, 2014. This National Action Plan, developed by representatives of 13 Federal agencies as well as non-Federal subject matter expert consultants, states that the blood glucose threshold of <8% for patients <75 years of age does not conform to glycemic control guidelines from the American Diabetes Association, Department of Veterans Affairs, Department of Defense, and American Geriatrics Society (i.e., by excluding certain patients such as those with limited life expectancy or with certain co-morbid conditions, or by stratifying according to medication type).

Developer Response #1: Thank you for your comments. According to the Institute for Clinical Systems Improvement (ICSI) 2014 Guidelines for Diabetes there is high quality evidence and a strong recommendation in support of an A1c target of less than 8.0. Excerpt from the guideline is as follows: Algorithm Annotation #4- Glycemic Control and A1c Goals. Recommendation: A clinician should personalize goals with patients diagnosed with T2DM to achieve glycemic control with a hemoglobin A1c < 7% to < 8% depending on individual patient factors. Benefits: Achieving near-normal glycemic control lowers risk of diabetes microvascular complications such as retinopathy, nephropathy and amputations. Achieving A1c of 6.9 to 7.9% may also significantly reduce macrovascular complications based on Steno-2 and UKPDS data. Quality of Evidence: High Strength of Recommendation: Strong. www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_endocrine_guidelines/diabetes/ Measurement does not and should not preclude good clinical judgement; however the measure development work group believes that a target of < 8.0 is reasonable and supported by guidelines. Our measure does have an upper age limit cut-off of 75 years and we allow exclusions for death, permanent nursing home resident or patients who are receiving hospice or palliative care services.

Proposed Committee Response: Thank you for your comment. During its review of the individual measure assessing HbA1c<8% in the spring of 2014 (#0575), the Committee considered the clinical practice guideline recommendations from American Diabetes Association (2013), American Geriatric Society (2003), VA/DOD (2010), and American Association of Clinical Endocrinologists (AACE) (2011). During their discussion of this measure, members specifically noted that for some patients (e.g., frail elderly patients, those with limited life expectancy,) HbAc1 values slightly above 8% might be reasonable and that target HbA1c values for such patients should be individualized. In their more recent evaluation of the composite measure (#0729) in January 2015, the Committee considered the2014 clinical practice guideline recommendations from the Institute for Clinical Systems Improvement, which suggest a target threshold of <7% - <8%, depending on patient factors. Thus, while they acknowledged that the <8% threshold may not be appropriate for all patients, they agreed that the 8.0% cutoff was a reasonable target for a national healthcare performance measure and that 100% performance on the measure is not expected.

Two of the comments (ID #4717 and #4720) were critical of the composite measure itself, citing concern that use of the composite measure could mask the individual care processes that most need improvement.

Developer Response #1 (ID# 4717): Thank you for your comment. While it is true that the measure is reported at the composite level, the individual components and the associated rates are available to the medical groups for better understanding their rates and for use in quality improvement to know which areas have opportunity for improvement. MNCM and the measure development work group firmly believe that achieving the intermediate physiological outcome targets related to blood pressure and glycemic control in addition being tobacco free and use of daily aspirin and statins where appropriate are the diabetic patient's best mechanisms of avoiding or postponing long term complications associated with this chronic condition which affects millions of Americans. Measuring providers separately on individual targets is not as patient centric as a measure that seeks to reduce multiple risk factors for each patient. Diabetic patients are more likely to reduce their overall risk and maximize health outcomes by achieving several intermediate physiological targets. *(remainder of response refers to other issues)*

Developer Response #2 (ID# 4720): Thank you for your comment and support of the components of this patient level all-or-none composite measure. (*remainder of response same as above and/or refers to other issues)*.

Proposed Committee Response: Thank you for your comment. Use of an all-or-not scoring approach does not hinder providers from tracking performance of the individual components of the composite and instituting appropriate improvement initiatives. Moreover, use of such composite measures is a patient-centric approach that allows providers to assess their success in reducing multiple patient risk factors across a variety of clinical areas.

These same two comments (ID #4717 and #4720) also noted that documenting HbA1c levels >8% but less than 9% cannot be done using CPT-II coding, necessitating need for medical chart review. In a continuation of the developers' responses noted above, developers noted:

Developer Response #1 (ID# 4717): A point of clarification, these measure do not rely on CPTII codes for numerator compliance, nor are they indicated anywhere in our measure specification. Measure specifications focus on the electronic health record as a source of clinical information for calculating numerator compliance; actual A1c values are utilized in the case of the A1c target. Additionally, 80 to 90% of all the clinics in MN are reporting this information from their electronic health records without the need for additional chart abstraction.

Developer Response #2 (ID# 4720): *Almost identical to above.*

One of these two comments (ID#4720) also suggested a need for including sociodemographic factors in the risk-adjustment approach.

Developer Response: Additionally, our risk adjustment model does include insurance product which is a proxy for socioeconomic status.

Finally, one comment (ID #4792 suggested the need for additional detail regarding moderate or high intensity in the description of statin use for the measure. The developer's response is provided below:

Developer Response: Thank you for your comment and suggestion for the inclusion of a dose of statin (moderate or high intensity statin). The measure development work group thoroughly discussed the pros and cons of specifying a certain dose of the statin medication and based on the following factors ultimately decided to not specify a dose of moderate or high intensity for numerator compliance: 1) data burden for practices, 2) controversy and burden surrounding the CV risk calculator, 3) ICSI 2014 Diabetes Guideline recommendations for measurement and 4) cardiology work group member's believe that there is some benefit for some patients who can only tolerate a lower intensity dose.

Committee Action Items:

- After review and discussion of the comments on this measure, does the Committee wish to re-vote on the measure (and therefore potentially change the overall recommendation against endorsement)?
- Review the proposed Committee responses above and provide any additional feedback to incorporate into the responses.

Feedback on Endocrine Pilot

In response to stakeholder desire for a more efficient, consistent, and user-friendly process for measure evaluation, NQF selected the Endocrine project to pilot a process of more frequent submission and evaluation of measures than what is possible in our current 3-year measure maintenance cycle. At the end of the 22-month project, we will have conducted three full endorsement "cycles", allowing for the submission and review of both new and previously-endorsed measures every six months.

Although the desire for more flexible CDP scheduling is long-standing for many of NQF's stakeholders, we are aware that such a change could result in unintended consequences for staff, measure developers, members, volunteers, and other stakeholders. Accordingly, as a part of this pilot effort, we are seeking feedback from our committees, measure developers, and those who provide comments, votes, or attend our meetings and use this information to compile an analysis of "lessons learned" at the conclusion of the project. This analysis will include a formal evaluation of the pilot, as well as recommendations for full-scale implementation of more frequent measure submission and evaluation, as warranted.

Committee Action Items:

- Reflect on your experience with NQF across the 3 measurement cycles and be prepared to offer feedback on some or all of the following:
  - Frequency of evaluations (i.e., roughly every 6 months)
  - Number of measures evaluated per cycle
  - Overlap of cycles
  - In-person meetings versus web meetings
  - Ease of discussion for competing or related measures
  - Project "fatigue"
  - Things we could have done (or do in the future) to improve the process
    - To make the cycles more "cohesive" (e.g., additional tutorials/ Q&A calls, etc.)
    - Scheduling more in advance (e.g., 4 months out/6 months out, etc.)
    - More frequent portfolio review
  - Your ideas of what is next for the Endocrine Committee