THE NATIONAL QUALITY FORUM

MEASURE PRIORITIZATION ADVISORY COMMITTEE
SUMMARY OF MEETING #1: MEASURE DEVELOPMENT & ENDORSEMENT AGENDA

An in-person meeting of the Measure Prioritization Advisory Committee was held on June 14 and June 15, 2010. For those interested in listening to an online audio recording of the meeting please click on the link below:
http://www.qualityforum.org/MeasureDevelopmentandEndorsementAgenda.aspx#t=2&s=&p=2|

The next meeting of the advisory committee will take place on July 22, 2010.

Committee Members in Attendance at the June 14, 2010 Meeting:

George J. Isham (Co-Chair)
Ellen Stovall (Co-Chair)
Bobbie Berkowitz
Christina Bethell
Kent Bottles
Dale W. Bratzler
Carey C. Cotterell
John F. Derr
Lynn Feinberg
Pamela French
Nikki Highsmith
Fred M. Jacobs
Ira Moscovice
William Munier
Gareth Parry
Greg Pawlson
Chesley Richards
Mike Rapp
Kate Goodrich
Frederick L. Grover (via phone)
Ramy A. Mahmoud (via phone)
John Spertus (via phone)

Committee Members in Attendance at the June 15, 2010 Meeting:

George J. Isham (Co-Chair)
Ellen Stovall (Co-Chair)
Kent Bottles
Dale W. Bratzler
Carey C. Cotterell
Lynn Feinberg
Fred M. Jacobs
Gareth Parry
Greg Pawlson
Chesley Richards
Mike Rapp
Frederick L. Grover (via phone)
Christina Bethell (via phone)
Pam French (via phone)
Nikki Highsmith (via phone)
Ramy A. Mahmoud (via phone)
John Spertus (via phone)

This was the first in-person meeting in a series of in-person and web meetings with regard to the Measure Development and Endorsement Agenda Project. The primary objectives of the meeting were to:

- Identify key issues;
- Rank child health conditions;
- Refine top domains and sub-domains for child health and population health and rank the sub-domains;
- Provide an update on Gretzky Group activities; and
- Set up next steps.

DAY ONE: June 14, 2010
Ellen Stovall, Advisory Committee Co-Chair, provided committee members with an overview of the work at hand, the committee charge, and the objectives of the meeting. She indicated the committee will focus on identification and prioritization of identified gaps in performance measures for multiple measurement streams. The committee will focus on the areas of child health, population health, and health information technology (IT) meaningful use measures.

Janet Corrigan, President and Chief Executive Officer of NQF, discussed the importance of the committee's work in the context of the passage of health care reform. She stressed that the building blocks of health care reform rely on having valid, reliable, and important performance measures that address critical areas of performance. These critical areas include transparency, payment alignment, health IT, and quality improvement. She emphasized the importance of this committee's work in providing guidance, through its recommendations, to the Department of Health and Human Services (HHS) to fill the gaps in measurement. She also described the alignment of this effort with other initiatives such as work at the Office of the National Coordinator (ONC), the Gretzky Group, the Agency for Healthcare Research and Quality (AHRQ), and the Child Health Insurance Program Reauthorization Act (CHIPRA).

Nalini Pande, Senior Director, Strategic Partnerships at NQF provided the committee with additional context for, and overview of, this project. She described the key topic areas and work streams feeding Phase I and II of the Measurement Development and Endorsement Agenda project (should Phase II receive HHS funding). Phase I.A. included prioritization of the top 20 Medicare conditions and identification and prioritization of gap domains and sub-domains. This current phase (Phase I.B.) focuses on child health, population health, and HIT meaningful use. The next phase will focus on maternal, neonatal, and adult (non-Medicare). The current project will cross check with other projects and related efforts including: measure developer priorities, an integrated framework for performance measurement, measure gaps identified through the NQF endorsement process and community needs.

PRIORITIZATION OF CHILD HEALTH CONDITIONS AND RISKS

Tom Valuck, Senior Vice President, Strategic Partnerships at NQF described the committee's "homework assignment" which involved the preliminary ranking of 22 child health conditions and risks. The following dimensions were considered in ranking the conditions: prevalence, quality of life and burden, system improvability, infrastructure for measurement success, and motivation for measurement success. While the preliminary rankings revealed a wide dispersion across committee members, overweight/obesity was consistently the highest ranked condition. There was strong agreement around the cluster of top five conditions. The group also agreed the top and bottom ranked conditions were closely linked to prevalence rates. The conditions grouped in the middle of the ranking were characterized by movement of select conditions and risks (e.g. anxiety, depression).

As a result of this exercise and discussions, the committee members recommended tobacco use and oral health for inclusion in the list of conditions. Several themes arose during the discussion, including:

- Level of measurement (lumping vs. splitting);
- Measurement in the context of developmental framework (child vs. adolescent);
- Impact of child health and development on adult health and functioning;

- Socio-cultural considerations (abuse, neglect, poverty);
- Shared decision-making with regard to surgery;
- Developmental learning and achieving milestones vs. overall physical health;
- Addition of oral health, tobacco use; and
- Considerations regarding adding "prevention" block and aggregation concerns.

After committee discussions, committee members voted on the prioritization of the 24 child health conditions and risks. Each committee member was allowed nine votes. The results are presented in TABLE 1.

TABLE 1. CHILD HEALTH CONDITIONS AND RISKS

Condition and Risk	Votes
Tobacco use	29
Overweight/Obese (≥85th percentile BMI for age)	27
Risk of developmental delays or behavioral problems	20
Oral health	19
Diabetes	17
Asthma	14
Depression	13
Behavior or conduct problems	13
Chronic ear infections (3 or more in the past year)	9
Autism, Asperger's, PDD, ASD	8
Developmental delay (diag.)	6
Environmental allergies (hay fever, respiratory or skin allergies)	4
Learning disability	4
Anxiety problems	3
ADD/ADHD	1
Vision problems not corrected by glasses	1
Bone, joint or muscle problems	1
Migraine headaches	0
Food or digestive allergy	0
Hearing problems	0
Stuttering, stammering or other speech problems	0
Brain injury or concussion	0
Epilepsy or seizure disorder	0
Tourette's Syndrome	0

Several themes arose over the course of the discussion of the conditions and risks voting results:

- Measures across conditions should be considered (i.e., measures that cut across multiple conditions);
- Co-morbidity of conditions, such as migraine headaches or mental health, should be considered;
- The conditions and risks ranked included a mix of prevention and conditions;
- Measures are only useful when implemented and parties are held accountable;

- Certain conditions and risks have different implications across age groups (early childhood, elementary school, middle school, later adolescence) such as tobacco use and second-hand smoke exposure;
- The ability of measures to bridge prevention efforts from diagnosis and treatment should be considered; and,
- Alignment with other agency efforts such as the Centers for Disease Control and Prevention or the Children's Health Insurance Program Reauthorization Act.

CHILD HEALTH MEASURE GAP ANALYSIS AND PRIORITIZATION

Christina Bethell, Director of the Child and Adolescent Health Measurement Initiative (CAHMI), provided an overview of the historical context around quality measures relevant to children's health care. She presented draft child health measure domains and sub-domains for the committee to consider. The committee's work was described in relation to CHIPRA core measures and other prominent measure prioritization activities.

Tom Valuck, Senior Vice President, Strategic Partnerships at NQF provided an overview of the child health measure gaps identified through the NQF endorsement process. The source for identification of gaps was a review of over 20 NQF Consensus Development Process (CDP) reports. The research identified measure gaps in child health including: care coordination, cost/efficiency/overuse, patient and family engagement, population health, safety, and palliative care.

Several questions arose during the committee's discussion around the identification of measurement gaps in child health:

- What is the ideal, full set of measurement areas from which the committee is assessing gaps?
- For what application (accountability, quality improvement) and for which units of analysis (national, state, community, health plan, practice, individual) are gaps assessed?
- From whose perspective are gaps assessed?
- For what populations or subgroups should measurement be most focused:
    - Conditions and impact of the common co-morbidity?
    - According to costs (costs to whom-payers, families, society)?
    - According to impact on function and school?
    - According to known quality deficits?
- What information was assessed to determine existing availability of measures? Are measures available but not in use or are measures not available? There are many measures in the NQF set but they are not widely used; why?
- How do measures fit together? Is it possible to obtain multiple measures with one data collection sweep and strategy?
- How are issues of existing capacity for measurement incorporated into what we identify as gaps?

The committee discussed criteria for the ranking of domains and sub-domains to allow a common understanding of what factors committee members should consider when voting on domains and sub-domains. These included:

- Prevalence
- Value/impact/potential impact on
- Impact on disparities
- Burden to families; ability of family to

quality of life across lifespan

- Effectiveness and cost-effectiveness
- Usability; feasibility (including burden of measurement)
- Actionable
- Cost and the cost/quality relationship
- Workforce impact
- Face feasibility of measurement
- Accountability (provider, state, national) with integrated participation in measurement

offer support

- Impact on productive lives for children
- Measurable outcomes which can motivate care innovation
- Degree of improvement in health status
- Ability to influence and prevent disease
- Ability to quantify; evidence base
- Readiness of stakeholders to address
- Ability to manage chronic disease or disability over time

Committee members voted on the prioritization of domains. Committee members were allowed three votes across the domains. The results are presented in TABLE 2.

TABLE 2. CHILD HEALTH GAP DOMAINS

Gap Domains	Votes
Care Coordination, including Transitions	15
Clinical Effectiveness in Acute and Chronic Care Management	14
Patient, Family, & Caregiver Engagement	12
Population Health including Primary and Secondary Prevention & Communities	12
Overuse (includes waste, efficiency, and appropriateness)	10
Safety	3
Palliative Care	0

In addition to voting on the prioritization of domains, the committee voted on the prioritization of sub-domains. Each member was allowed eleven votes. TABLE 3 displays overall results ordered by sub-domain and TABLE 4 displays overall results organized by domain.

TABLE 3. CHILD HEALTH GAPS SUB-DOMAIN, OVERALL

Gap Sub-Domains	Votes
Population health outcomes	15
Appropriate tests and follow-up	15
Having a Medical or “Health Home”	14
Adverse events	13
Early and continuous screening and appropriate, timely follow-up	12
Medications (appropriateness, management, adherence)	12
Self care management and support	12
Shared decision-making	11
Access to referrals and appropriate follow-up	11
Success/failure rates in handoffs	11
Overuse of procedures and surgery	11
Bridge gap between expert and public knowledge	10
Effective care plans	10
Medication overuse	10
Patient/family centered systems of care	8

Community and neighborhood resources, support and safety	8
Communication, respect and cultural sensitivity	7
Avoidable ED and hospital readmission	7
Health literacy	6
Burden of Illness, Symptoms & Functional Status	6
Help coordinating care	4
Population health oriented systems of care (needs assessment, shared accountability, etc)	4
Consumer empowerment, including transparency	3
Patient experience with care	3
Patient/family activation	2
Effective transition to adult services	2
Health Promotion	2
Patient communication and knowledge regarding consent & safety	2
Duplicate testing	2
Caregiver/family burden	2
Medication and sedation safety	1
Advance preparations defined and honored	1
Pain management and symptom relief	0
Access to supportive services	0
Access to spiritual, cultural and psychological needs	0

TABLE 4. CHILD HEALTH GAPS SUB-DOMAIN, by DOMAIN

Gap Sub-Domains	Votes
Domain 1: Patient and Family Engagement	
Shared decision-making	11
Bridge gap between expert and public knowledge	10
Patient/family centered systems of care	8
Communication, respect cultural sensitivity	7
Health literacy	6
Consumer empowerment, including transparency	3
Patient experience with care	3
Patient/family activation	2
Domain 2: Care Coordination including Transitions	
Having a Medical or “Health Home”	14
Access to referrals and appropriate follow-up	11
Success/failure rates in handoffs	11
Help coordinating care	4
Effective transition to adult services	2
Domain 3: Population Health including Primary and Secondary Prevention & Communities	
Population health outcomes	15
Early and continuous screening and appropriate, timely follow-up	12
Community and neighborhood resources, support and safety	8
Population health oriented systems of care (needs assessment, shared accountability, etc)	4
Health Promotion	2
Domain 4: Clinical Effectiveness in Acute and Chronic Care	

Management	
Appropriate tests and follow-up	15
Medications (appropriateness, management, adherence)	12
Self care management and support	12
Effective care plans	10
Burden of Illness, Symptoms & Functional Status	6
Domain 5: Safety	
Adverse events	13
Patient communication and knowledge regarding consent & safety	2
Medication and sedation safety	1
Domain 6: Overuse	
Overuse of procedures and surgery	11
Medication overuse	10
Avoidable ED and hospital readmission	7
Duplicate testing	2
Domain 7: Palliative Care	
Caregiver/family burden	2
Advance preparations defined and honored	1
Pain management and symptom relief	0
Access to supportive services	0
Access to spiritual, cultural and psychological needs	0

Based on the gap domain and sub-domain voting and resultant discussion, the committee identified the following key issues:

- The overuse domain should include waste, efficiency, and appropriateness;
- The dimensions of affordability and cost of care are missing;
- Access vs. coverage and how measures link to reimbursement and payment systems should be considered;
- Measure and measurement barriers (research, burden of measurement, data sources, testing of measures) should be considered;
- Disparities and access: Are inclusion of these as cross-cutting factors sufficient? and,
- Child development over time (0-18) is missing.

HEALTH IT MEANINGFUL USE QUALITY MEASURE GAPS

Karen Adams, Vice President, at NQF provided an overview of the work that NQF is doing with the Gretzky Group. The Gretzky Group's charge is to identify a discrete set of high-leverage measures that might be considered for 2013 meaningful use measures. The primary outcomes from the work includes identifying a parsimonious set of measures that support the National Priorities Partnership (NPP) six priority areas and identifying 3-5 high impact conditions and associated measures that map across the NQF patient-focused episode of care model. The Group has developed a two dimensional measurement framework to use moving forward that is built upon the NPP priorities and the NQF Episode of Care Framework.

Helen Burstin, Senior Vice President, Performance Measures at NQF further described the criteria the Gretzky Group is developing to identify measurement concepts that will be used to identify measures that can be incorporated into the NQF portfolio. The draft criteria include:

- State of readiness (available and ready for use or available but require adaptation);

- Health IT sensitivity (measures built into EHR systems that could result in substantial improvement with minimal re-design);
- Burden of illness (prevalence, impact, mortality, and morbidity); and,
- Strength of evidence for measure focus (quality, quantity, consistency of evidence).

The Group is currently gathering evidence to identify a short list of potential measures for 2013 to be presented to the Office of the National Coordinator in September 2010.

DAY TWO: June 15, 2010

POPULATION HEALTH MEASURE GAPS

George Isham and Ellen Stovall, Advisory Committee Co-Chairs, provided the committee with a review of child health overarching issues discussed during the previous day. These included:

- Building a quality infrastructure that is sophisticated enough to be relevant to multiple conditions, in different markets, across the country;
- Intelligent deployment of measures with varying levels of NQF endorsement;
- Disparities or inequities in child health should be included beyond cross-cutting factors; and,
- Alignment of efforts with public and private partners (e.g. CHIPRA, Beacon Communities, The Robert Wood Johnson Foundation's Aligning Forces for Quality initiative)

Peter Briss, Special Advisor, Centers for Disease Control and Prevention (CDC) provided an overview of the purpose, vision, and goals of the NPP population health subgroup. The purpose is to improve the health of the nation. The NPP envisions communities that foster health and wellness as well as national, state, and local systems of care fully invested in the prevention of disease, injury, and disability; systems that are reliable, effective, and proactive in helping all people reduce the risk and burden of disease. The goals of the Partners are to work together to ensure:

- All Americans will receive the most effective preventive services by the U.S. Preventive Services Task Force (USPSTF);
- All Americans will adopt the most important healthy lifestyle behaviors known to promote health; and,
- The health of American communities will be improved according to a national index of health.

He then presented draft population health measure domains and sub-domains for the committee to consider. During the course of discussion the committee identified the following key issues in relation to population health:

- Wellness should be considered as a global measure—a two-dimensional model of wellbeing and health;
- The purview of NQF as it relates to recommending development or endorsement of factors that are predictors or determinants of health, but not a measure, per se, of the health system (i.e. factors within the healthcare system or within the influence of the healthcare system vs. factors outside the healthcare system);
- The level of community engagement and the role of the community in promoting health and healthcare behaviors;
- Access to services and community resources;

- Influence of the health system on public welfare and the impact of social institutions (e.g. schools, employers, NGOs/CBOs [including faith-based]);
- Accountability (degree and locus) for prevention (which is difficult to measure and pay for); and,
- Discussion of how population, community, and health system are defined?

Committee members voted on the prioritization of the five population health domains. Committee members were allowed two votes across domains. The results are presented in TABLE 5.

TABLE 5. POPULATION HEALTH GAP DOMAINS

Gap Domains	Votes
Clinical Preventive Services	9
Lifestyle Behaviors	9
Health Status (Mortality and Healthy Years)	9
Measures of Health Care and Public Health System Performance	6
Other Factors for a Community Health Index (e.g., social determinants and environmental factors)	4

In addition to voting on the prioritization of domains, the committee voted on prioritization of sub-domains. Each member was allowed five votes. TABLE 6 displays overall sub-domain voting results ordered by the domain ranking noted above.

TABLE 6. POPULATION HEALTH GAP SUB-DOMAINS

Gap Domains	Votes
Domain 1: Clinical Preventive Services	
Cardiovascular disease prevention	4
Child and adolescent health	3
Cancer prevention	1
Injury prevention	0
Vaccine-preventable illness	0
Domain 2: Lifestyle Behaviors	
Physical Activity	8
Diet	5
Smoking	3
Risky alcohol use	3
Domain 3: Health Status (Mortality and Healthy Years)	
Health status (symptoms, function, and QOL)	13
Wellness/well-being	9
Length and quality of life (healthy life years)	5
Mortality	2
Domain 4: Measures of Health Care and Public Health System Performance	
Coordination of care processes across sectors and care coordination across the patient-focused episode to include community context	10
System infrastructure and policies	8

Domain 5: Other Factors for a Community Health Index	
Environmental factors	2
Social determinants	1

Based on the gap domain and sub-domain voting the committee discussed the following key issues:

- There was some discomfort with the sub-domains for clinical preventive services; composite measures for this area should be considered for the block of services that have high priority impact and measure as a system; Important sub-domains, such as vaccinations, are not listed in domain 1;
- Domain 1 could be defined to include: child and adolescent health, injury prevention, immunizations.
- Community resources such as social institutions and employers (schools, CBOs, employer, etc.) should be captured;
- Do the social determinants and environmental factors need to be further specified? Are these terms too broad?
- How do we balance public health and health care system actions and responsibilities, capturing all levels of measurement and accountability?
- There is a clear overlap between domain 2 and domain 4;
- Domain 3 sub-domains should include burden, functional status, and health status
- Satisfaction with quality of health could be a separate domain;
- Should cost be considered as a separate measure stream (though it may be complicated to capture and difficult to report)? and
- Adding wellness as a sixth domain was discussed.

The next web meeting is scheduled for July 22, 2010 (10:00 am – Noon ET).