National Consensus Standards for Musculoskeletal Conditions

Standing Committee Orientation

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NATIONAL QUALITY FORUM

Welcome & Introductions

NQF Project Staff

- Katie Streeter
  - Project Manager, Performance Measures
- Ann Phillips
  - Project Analyst, Performance Measures
- Angela Franklin
  - Senior Director, Performance Measures

Standing Committee

- Thiru Annaswamy, MD
- Carlos A. Bagley, MD, FAANS
- Steven Brotman, MD, JD
- Craig Butler, MD, MBA, CPE
- Roger Chou, MD FACP
- Linda Davis, BSN
- Christian Dodge, ND
- Zoher Ghogawala, MD, FACS
- V Katherine Gray, PhD
- Marcie Harris Hayes, PT, DPT, MSCI, OCS
- Mark Jarrett, MD, MBA
- Puja Khanna, MD MPH
- Wendy Marinkovich, BSN, MPH, RN
- Catherine Roberts, MD
- Arthur Schuna, M.S., BCACP
- Kim Templeton, MD
- John Ventura, DC
- Christopher Visco, MD

Standing Committee

- **Seeking Additional Expertise:**
  - **Primary Care Physicians**
  - **Patient/Consumer Representation**

Agenda for the Call

- Background on NQF and project
- Current project focus
- Overview of NQF criteria
- Role of the Committee
- SharePoint Tutorial
- Measure Evaluation Process

NQF Mission

- Board of Directors
- Steering Committees
- 8 Membership Councils
- Measures Application Partnership (MAP)
- National Priorities Partnership (NPP)
- CSAC, HITACH

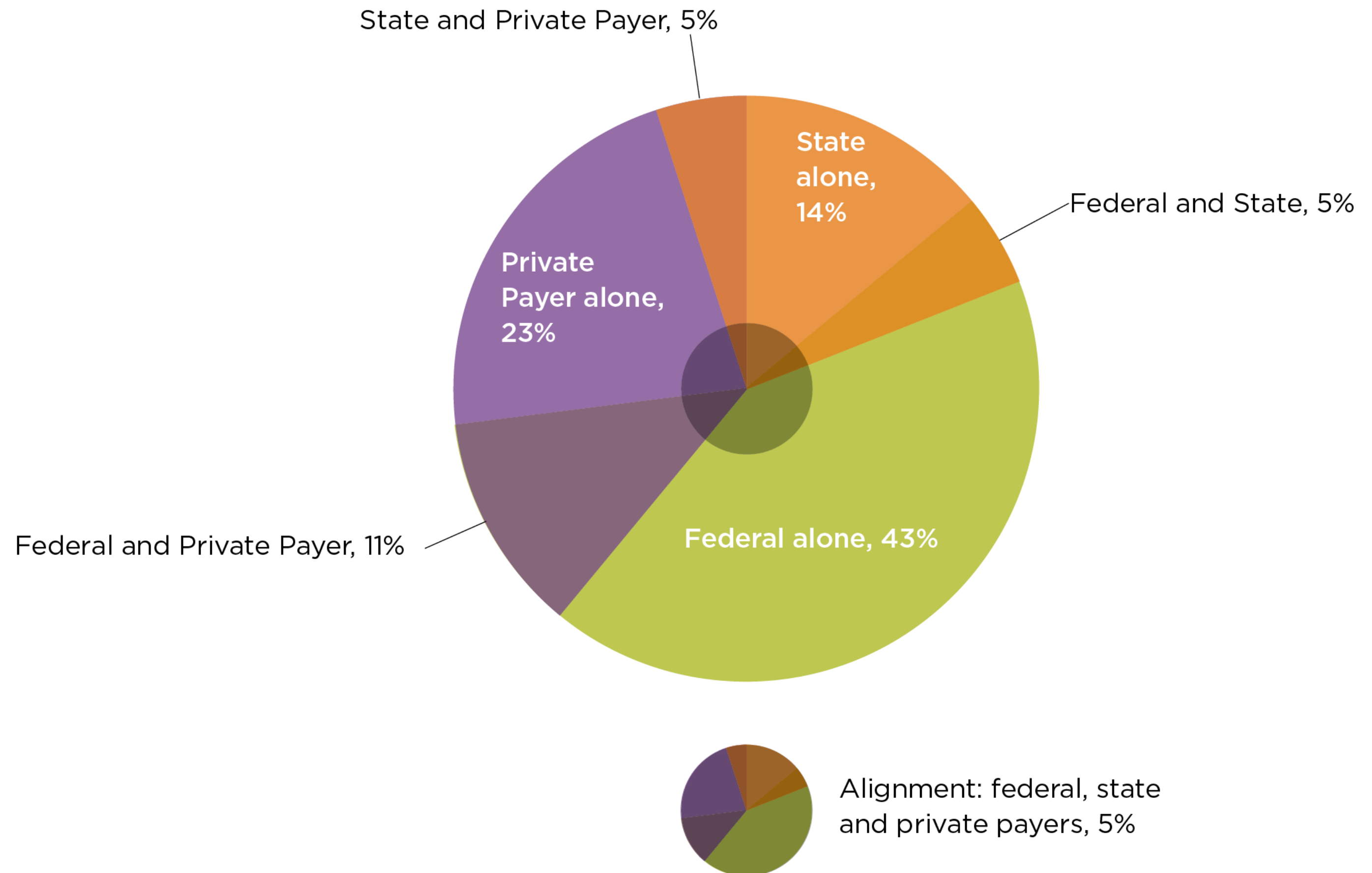
Neutral Convener

Standards Setting Organization

1. Build Consensus
2. Endorse National Consensus Standards
3. Education and Outreach

Who Uses NQF-endorsed Measures?

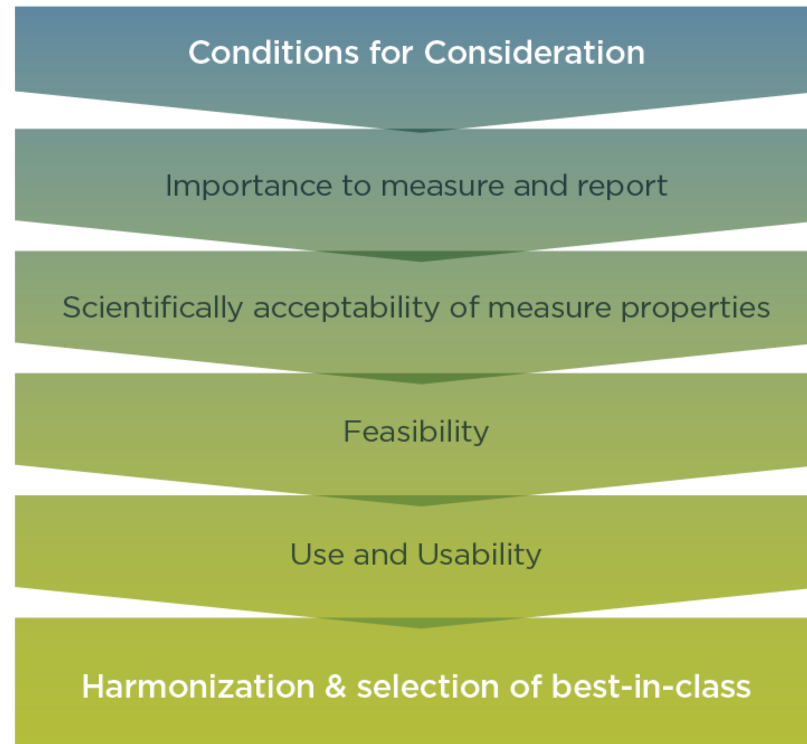
- Approximately 700 endorsed measures
- Various users
  - Federal
  - State
  - Community
  - Facility



NQF Consensus Development Process (CDP)

8 Steps for Measure Endorsement

NQF Measure Evaluation Criteria



Musculoskeletal Portfolio of Measures

- This project will evaluate measures related to musculoskeletal conditions that can be used for accountability and public reporting for all populations and in all settings of care. This project will address topic areas including:
  - Low back pain
  - Osteoarthritis
  - Rheumatoid Arthritis
  - Pain Management
  - Gout

Measures Under Review

0052 : Use of Imaging Studies for Low Back Pain

0514 : MRI Lumbar Spine for Low Back Pain

0662 : Median Time to Pain Management for Long Bone Fracture

2524 : Rheumatoid Arthritis: Functional Status Assessment

2523 : Rheumatoid Arthritis: Assessment of Disease Activity

2522 : Rheumatoid Arthritis: Tuberculosis Screening

0054 : Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

2525 : Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

2550 : Gout: ULT Therapy

2549 : Gout: Serum Urate Target

2526 : Gout: Anti-inflammatory Prophylaxis with ULT Therapy

2521 : Gout: Serum Urate Monitoring

Activities and Timeline: Review Cycle 1

Process Step	Timeline
Measure submission deadline	3/3/2014
SC member orientation	3/14/14
SC member preliminary review and evaluation	3/14/14 – 4/18/14
Measure Evaluation Q&A	4/4/14 and 4/9/14
SC Work group calls	4/14/14, 4/17/17, 4/24/14, 4/25/14
SC in-person meeting	5/7/14 – 5/8/14
Draft report posted for NQF Member and Public Review and Comment	6/13/14 – 7/14/14
SC call to review and respond to comments	7/31/14
Draft report posted for NQF Member vote	8/12/14 – 8/26/14
CSAC review and approval	8/27/14 – 9/17/14
Endorsement by the Board	9/18/14 – 10/8/14
Appeals	10/9/14 – 11/7/14

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
- 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, 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
- Oversee Musculoskeletal portfolio of measures

Role of the Standing Committee Co-Chairs

- Facilitate Standing 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 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, cont.

- 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
- NQF project staff works with communications department to publish final report

SharePoint Overview

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

- Accessing SharePoint
- Standing Committee Guidebook
- Measure Document Sets
- Meeting and Call Documents
- References

Measure Evaluation Overview

Major Endorsement Criteria Hierarchy and Rationale (page 32)

- **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 & Report (page 36-38)

1. **Importance to measure and report -** Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance.

   1a. Evidence – the measure focus is evidence-based.

   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 groups (pages 41-42)

   1c. High Priority – the measure addresses a specific national health goal or priority and/or a high-impact aspect of healthcare. (page 42)

   1d. Quality construct and rationale (composite measures)

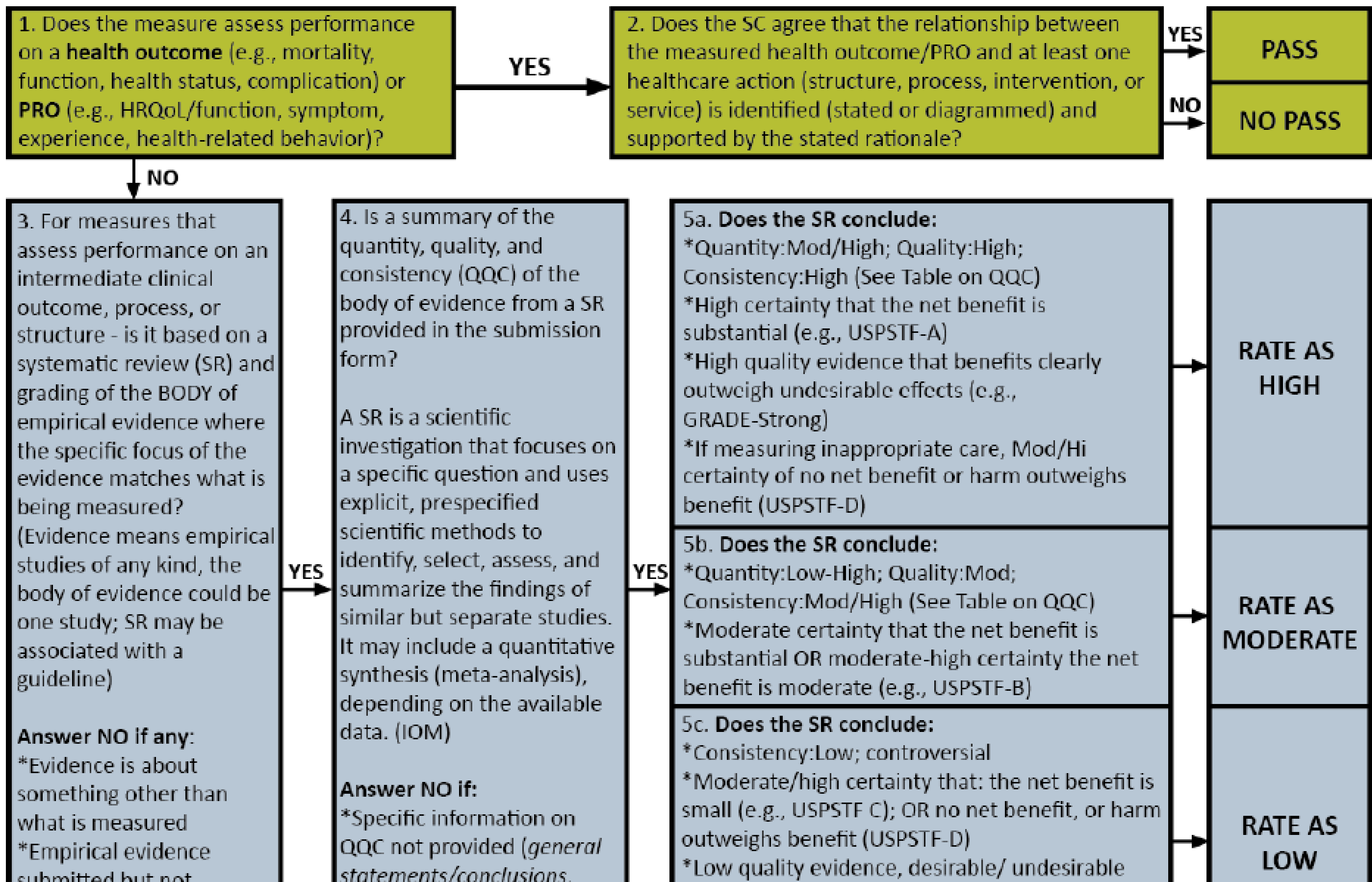
1a Evidence **(page 36-37)**

Requirements for 1a.

- Outcome measures –a rationale (which often includes evidence) for how the outcome is influenced by healthcare processes or structures.
- Process, intermediate outcome measures - the quantity, quality, and consistency of the body of evidence underlying the measure should demonstrate that the measure focuses on those aspects of care known to influence desired patient outcomes
  - Empiric studies (expert opinion is not evidence)
  - Systematic review and grading of evidence
    - Clinical Practice Guidelines – variable in approach to evidence review

Algorithm #1 – page 37

Algorithm #1. Guidance for Evaluating the Clinical Evidence



Criterion # 2: Reliability and Validity – Scientific Acceptability of Measure Properties (page 43 -46)

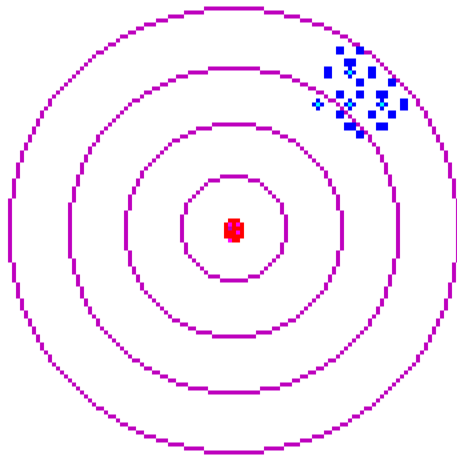
Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of health care delivery

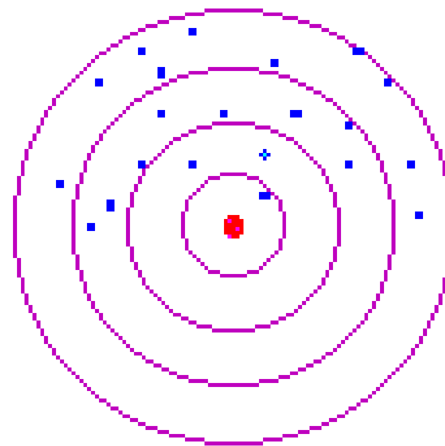
2a. **Reliability (must-pass)**
- 2a1. Precise specifications including exclusions
- 2a2. Reliability testing—data elements or measure score

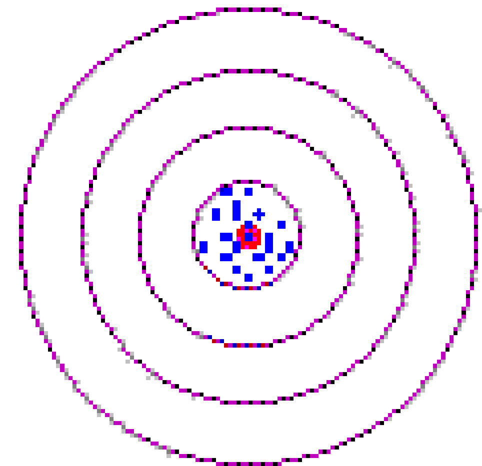
2b. **Validity (must-pass)**
- 2b1. Specifications consistent with evidence
- 2b2. Validity testing—data elements or measure score
- 2b3. Justification of exclusions—relates to evidence
- 2b4. Risk adjustment
- 2b5. Identification of differences in performance
- 2b6. Comparability of data sources/methods

Reliability and Validity

Assume the center of the target is the true score…







Reliable Not Valid	Neither Reliable Nor Valid	Both Reliable And Valid
Consistent, but wrong	Inconsistent & wrong	Consistent & correct

Measure Testing – (Key Points page 46)

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 46)
Key points - page 47

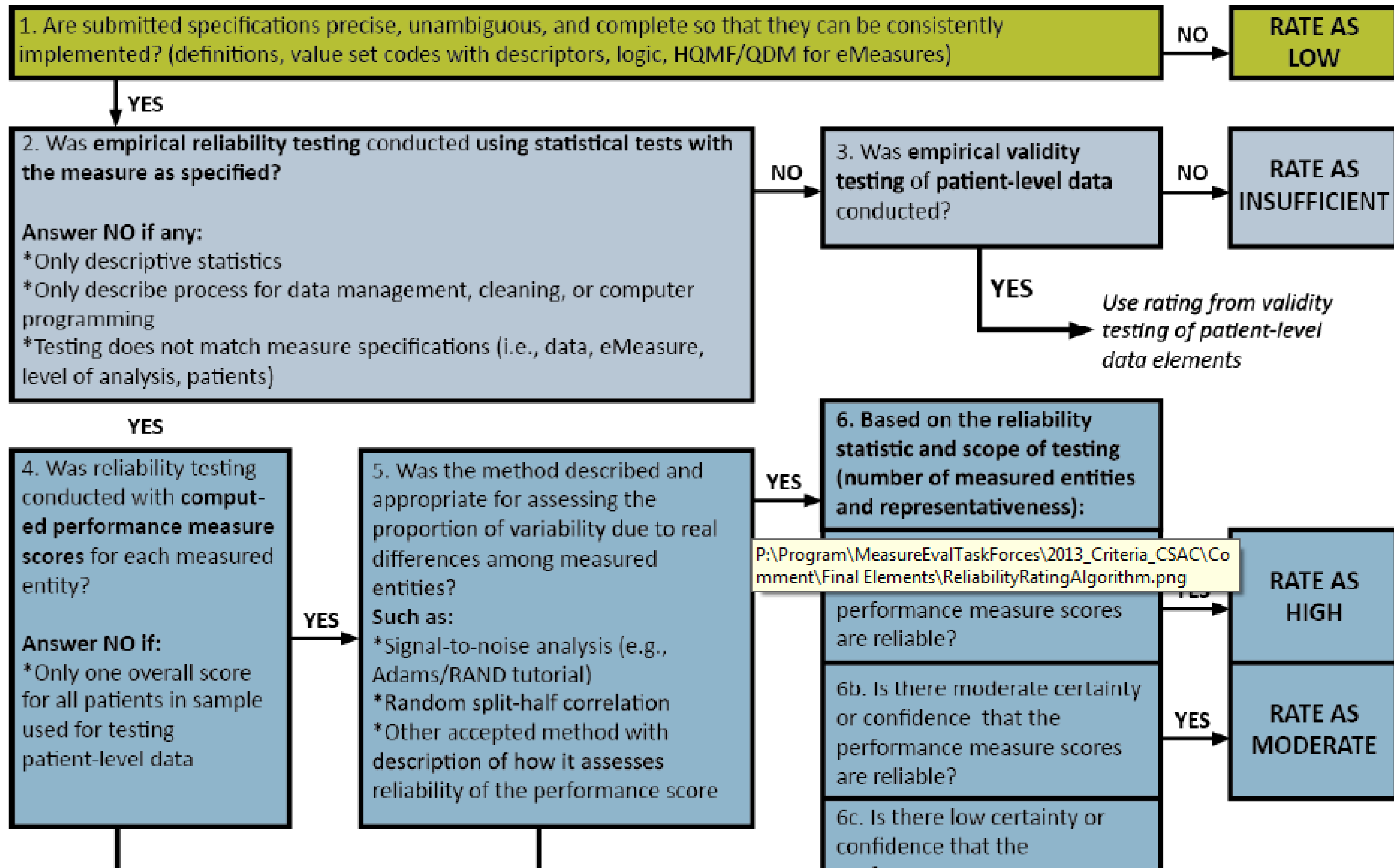
- Reliability of the ***measure score*** refers to the proportion of variation in the performance scores due to systematic differences across the measured entities in relation to random variation or noise (i.e., the precision of the measure).
  - Example - Statistical analysis of sources of variation 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 results are within acceptable norms

- Algorithm #2 – page 48

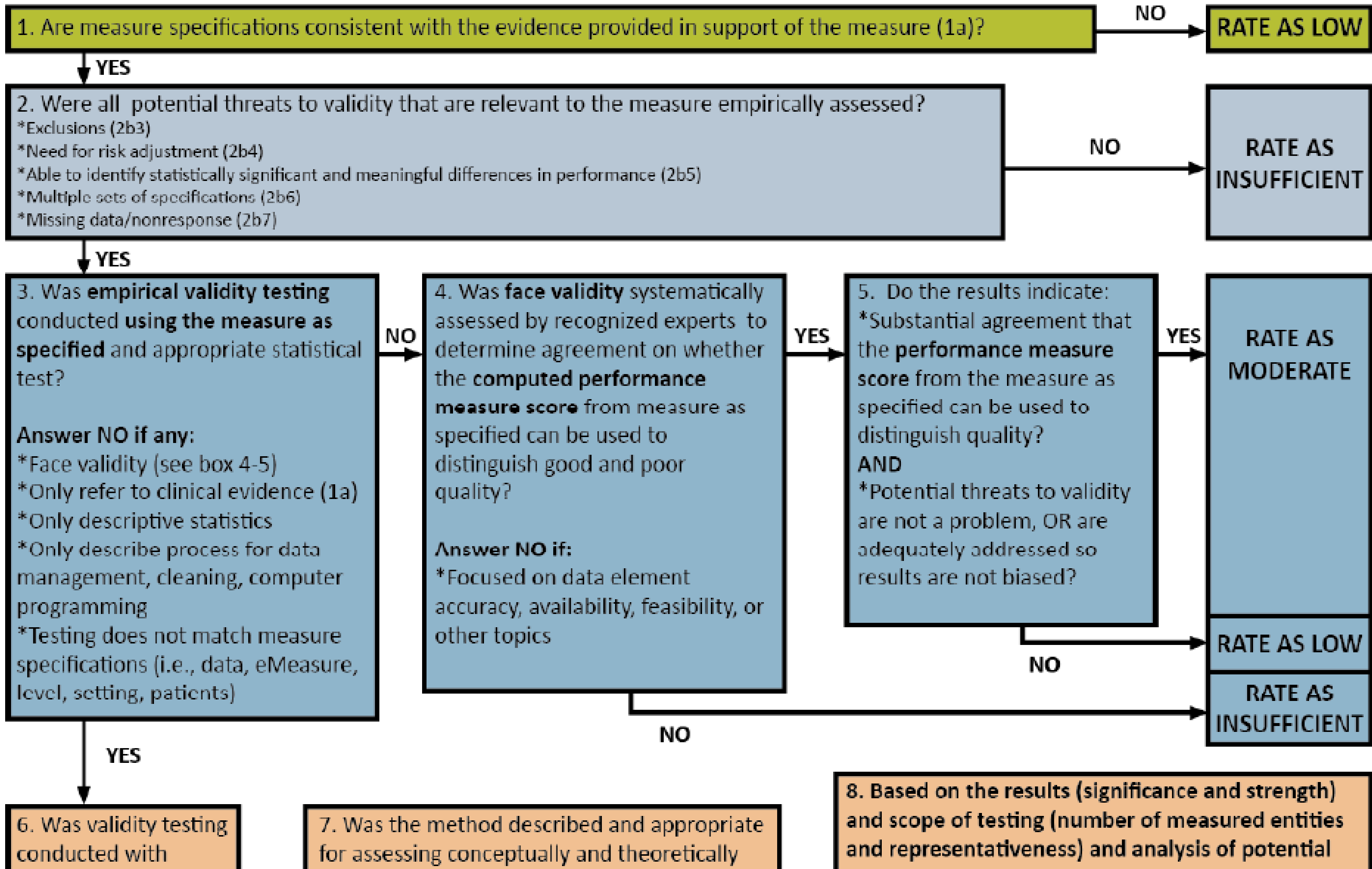
Algorithm #2 – page 48



Validity testing (pages 49- 51)
Key points – page 51

- **Empiric 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

Algorithm #3 – page 52



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 #3: Feasibility (page 53-54) Key Points – page 55

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 54)

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: 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. Transparency: Data and result detail are maintained such that the resource use measure, including the clinical and construction logic for a defined unit of measurement can be deconstructed to facilitate transparency and understanding.

5. Related or Competing Measures (page 55-56)

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.

Questions?

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Next Steps

- Measure Evaluation Q&A Calls: Friday, April 4th 1pm-2pm ET ***OR*** Wednesday, April 9th 1pm-2pm ET
- Complete your preliminary evaluation surveys: See assignments at http://share.qualityforum.org/Projects/musculoskeletal/CommitteeDocuments/Work%20Group%20Assignments.docx
- Travel logistics information sent from NQF Meetings Department in April
- Work Group calls third and fourth week of April
- Full Committee meeting: Wednesday, May 7th and Thursday May 8th in Washington, DC

Project Contact Info

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- SharePoint site:

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

Questions?

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