NATIONAL QUALITY FORUM

National Voluntary Consensus Standards for Patient Outcomes
Summary of the Diabetes/Metabolic Technical Advisory Panel Meeting
March 16, 2010

TAP members present: Sheldon Greenfield, MD (chair); R. Keith Campbell, RPh, FASHP, CDE; Karen Fitzner, PhD; Richard Hellman, MD, FACP, FACE; Stephen Fadem, MD, FACP, FASN ; Carol Motes Headley, DNSc, MSN, RN, CNN ; Erica Swegler, MD; Allen Nissenson, MD, FACP (by phone)

NQF staff present: Reva Winkler, MD, MPH; Heidi Bossley, MSN, MBA; Helen Burstin, MD, MPH; Sarah Fanta; Hawa Camara

Measure Steward Representatives: Ben Hamlin (NCQA); Diane Mayberry (Minnesota Community Measurement)

A meeting of the National Voluntary Consensus Standards for Patient Outcomes Cardiovascular Technical Advisory Panel (TAP) was held on Tuesday, March 16, 2010 in Washington, DC. TAP chair Dr. Sheldon Greenfield opened the meeting and requested introductions, including the disclosure of specific interests pertaining to the measures being evaluated.[1]

Dr. Reva Winkler, NQF project consultant and the outcomes project advisor, briefly reviewed the project goals and measure evaluation criteria that had been discussed on the December 15, 2009 orientation conference call.

Reviewing the Measures

Each Committee member had been asked by NQF staff to review a number of measures in advance of the in-person meeting and lead the TAP discussion of the ratings of the sub-criteria and the strengths and weaknesses of each measure. The measure developer was present during the discussions and responded to queries from TAP members. The ratings and TAP comments are tabulated below.

Submitted Outcome Measures

OT1-028-09: HbAlc control for a selected population (NCQA)

IMPORTANCE TO MEASURE AND REPORT		
1a Impact	Complete	Diabetes is high impact; gap exists in monitoring Hgb A1c values particularly in Medicaid populations; Evidence for Hgb A1c has
1b Gap	Complete	

1c Relation to Outcomes	Complete	changed and there are variations in guidelines recommendations for target values – the evidence isn't there for Hgb A1c < 7 for all patients; Need to look at the potential harm for such tight control; measure developer notes NCQA has been collecting data on this measure for years – just last year added the exclusions to refine the denominator to a more appropriate cohort, but that 100 percent compliance is not expected – the measure is used in NCQA's HEDIS and PRP programs; TAP concern – has the population been narrowed enough so that Hgb A1c < 7 is appropriate?
SCIENTIFIC ACCEPTABILTY		
2a Specs	Complete	Administrative data; concerned some important exclusions missing, (e.g., patients experiencing hypoglycemic episodes); occupational risks such as long-haul truck drivers or pilots; use of multiple medications; Hgb A1c test not performed counts against performance; no risk adjustment beyond exclusions is OK; Stage 4 and 5 CKD is excluded; data is stratified by commercial, Medicare and Medicaid populations
2b Reliability	Complete	
2c Validity	Complete	
2d Exclusions	Partial	
2e Risk Adjustment	Complete	
2f Meaningful Differences	Complete	
2g Comparability	Complete	
2h Disparities	Complete	
USEABILITY		
3a Distinctive	Complete	
3b Harmonization	Complete	
3c Added Value	Complete	
FEASIBILITY		
4a Data a by Product of Care	Complete	Potential harms of overaggressive treatment and hypoglycemia; A TAP member suggests that many in the outpatient community are not aware that 100 percent is not the goal of these measures
4b Electronic	Complete	
4c Exclusions	Complete	
4d Inaccuracies/ Errors	Partial	
4e Implementation	Complete	

OT1-009-09: Optimal diabetes care (Minnesota Community Measurement)

Diane Mayberry introduced the measure, noting that they have been collecting data for eight years for this all or none composite measure. The measure is based on guidelines from Institute for Clinical Systems Improvement (ICSI). They receive data directly from EHRs. Initially the results were 4 percent and now are 19 percent. The measure is used for pay for performance in MN.

IMPORTANCE TO MEASURE AND REPORT		
1a Impact	Complete	Don't agree with the targets – BP<130/880 and aspirin use is not
1b Gap	Partial	

1c Relation to Outcomes	Partial	consistent with guidelines; measure developer response: they are scheduled for a review of the specifications regarding aspirin use in a few weeks and expect some modifications to specifications to conform with revised guidelines; No data on episodes of hypotension or other potential harms; TAP members had some difficulty understanding why the measure results are not 70 to 80 percent. In an all-or-none measure, what is the role of the patient?
SCIENTIFIC ACCEPTABILTY		
2a Specs	Complete	This is a high risk group. Needs more risk adjustment. Developers plan to stratify by coverage.
2b Reliability	Complete	
2c Validity	Complete	
2d Exclusions	Minimal	
2e Risk Adjustment	Minimal	
2f Meaningful Differences	Complete	
2g Comparability	Complete	
2h Disparities	Minimal	
USEABILITY		
3a Distinctive	Complete	Target values are not harmonized with other endorsed measures.
3b Harmonization	Minimal	
3c Added Value	Partial	
FEASIBILITY		
4a Data a by Product of Care	Complete	Low results are discouraging to physicians. Three of five targets are evolving evidence; large patient self-management component; safety concerns
4b Electronic	Complete	
4c Exclusions	Complete	
4d Inaccuracies/ Errors	Partial	
4e Implementation	Complete	

OT1-029-09: Diabetes composite (NCQA)

Helen Burstin, MD, MPH, NQF's senior vice president for performance measures, advised the TAP that NQF's definition of a composite measure requires a single summary score. TAP members agreed that the measure submission information did not have a single score and could not be evaluated as a composite measure. The measure developer was willing to modify their submission for the TAP to review in the near future.

Maintenance Review of NQF-Endorsed Measures for Diabetes

9 NQF-endorsed measures for diabetes were considered by the TAP for their three-year maintenance review.

55 Eye examination

- Results have gotten worse

- Coordination of care problems reflects system performance
- Important area; significant gap
- New technologies not included such as digital retinal exams

TAP vote to maintain endorsement: Yes-8 No-0

63 Lipid profile

- This is really an LCL-C test, not the entire profile.
- Medicaid disparity – 70 percent
- Fasting requirement is a huge patient barrier, as is draw site particularly for Medicaid population
- Specifications don't state fasting
- Is the testing measure needed also with the outcome measure (64)? NCQA reports that only 30 percent have lab value data – the remaining 70 percent can only report the test being done

TAP vote to maintain endorsement: Yes-8 No-0

64 LDL control

- Measure has been revise to include only <100 value
- Recommend excluding patients with ESRD/dialysis – NCQA will take under review
- ADA guidelines provide alternatives to target level <100: maximum tolerated dose of medication or 30 to 40 percent decrease from baseline value – NCQA will be looking at this in the future

TAP vote to maintain endorsement: Yes-8 No-0

56 Foot exam

- Current specifications are visual or sensory or pulse exam; intent is for visual + sensory or pulse exam
- ADA guidelines recommend two modalities
- A documentation issue – how to judge when performed adequately – patient reported data may be important
- This is a measure being re-tooled for EHRs – SNOMED codes
- There are many newer references than those cited – should be updated.
- What is the role of vibratory testing vs monofiliament testing – needs clarity in specifications
- Consider NQF-endorsed measures from American Podiatric Association – harmonization; also APA measure for foot care education
- Wants to include ESRD/dialysis patients and home health patients

TAP vote to maintain endorsement: Yes-8 No-0

57 Hgb A1c test performed
60 Hgb A1c for pediatric patients

- Low performance in some groups
- Only 30 percent can get the lab value for the outcome measure; the testing measures are important for the remainder given the under performance

TAP vote to maintain endorsement: Yes-8 No-0 for both measures

59 Hgb A1c > 9% (poor control)

- Very high numbers in the Medicaid population

TAP vote to maintain endorsement: Yes-8 No-0

61 Blood pressure control: BP< 140/90

- No issues on this target value

TAP vote to maintain endorsement: Yes-8 No-0

Blood pressure control: BP < 130/90

- Still an opinion based target value – no evidence base that this is an appropriate target
- ACCORD trial found no benefit in an aggressive target
- Perhaps lower BP target is appropriate in a younger, healthier population but there is no evidence yet
- Would be useful to collect actual BP values and do sub-analysis for BP < 130/80
- Confusion due to JNC 7 target value of ≤ 120/70

TAP vote Yes -0 No -7 Abstain 1

61 Urine protein screening

- Issues on costs of various tests – A/G, creatinine ratio, though can be managed
- Only one time measure per year – what is reliability?
- Possible harms are unnecessary referrals for false positive values; though identifying true positives likely outweighs potential harms
- Potential new measures : GFR (predictive value) and early referral to nephrologist (found to have positive impact)

  TAP vote to maintain endorsement: Yes-8 No-0

Public comment

- If the Hgb A1c < 7 measure does not apply to Medicare patients – what is the message to patients and geriatricians? There is national data to show that significant numbers of patients over age 65 can safely reach levels < 7.