NATIONAL QUALITY FORUM

National Voluntary Consensus Standards for Patient Outcomes
Summary of the Eye Care Technical Advisory Panel Conference Call
March 25, 2010: 10:00-11:00PM Eastern Standard Time

TAP members participating: David Herman, MD (chair); Priscilla Arnold, MD, FACS; Scott Friedman, MD; Randall Reichle, OD, FAAO.

NQF staff participating: Heidi Bossley, MSN, MBA; Sarah Fanta; Hawa Camara

Audience members registered: Flora Lum, Jodi Mitchell

Introduction

A conference call for the National Voluntary Consensus Standards for Patient Outcomes Eye Care Technical Advisory Panel (TAP) was held on Thursday, March 25, 2010. Heidi Bossley, MSN, MBA, NQF senior director for performance measures and the outcomes project advisor, began the meeting and requested that the TAP members introduce themselves. The purpose of this conference call was to discuss gaps in existing outcome measures for eye care and suggest potential measures or measure concepts that could fill those gaps. Dr. David Herman asked the TAP members to disclose any specific interests pertaining to the measure development.[1]

Orientation to NQF

Ms. Bossley presented a standard slide set used to orient all committees in the project outlines the following topics:

- Description of NQF organization, mission and vision, multi-stakeholder membership, activities and recent accomplishments;
- Encouragement to use NQF's new website;
- The National Priorities Partnership priorities and goals;
- Growth in NQF endorsed measures and evolution of quality measurement; and
- The steps of NQF's formal Consensus Development Process.

Project Goals

Ms. Bossley advised the TAP that the goals of this project, which is funded by the Department of Health and Human Services is to expand NQF's current portfolio of

[1] No relevant conflicts of interest were reported.

outcome measures, specifically focusing on the top 20 Medicare conditions. The two goals of the project are:

- To identify, evaluate, and endorse additional measures suitable for public reporting and quality improvement that specifically address outcomes of healthcare (including cross-cutting [not condition-specific] outcome measures as well as specific outcome measures for 20 common conditions); and
- To identify gaps in existing outcome measures and recommend potential outcome measures to fill those gaps.

Role of the TAP

Ms. Bossley advised the TAP members that their role is to:

- provide technical input to the Steering Committee regarding the sub-criteria in the standard measure evaluation criteria;
- suggest gaps in important outcome measures where additional measures are needed; and
- The TAP chair will be represented as part of the Steering Committee.

NQF Evaluation Criteria

TAP members were advised that new measure evaluation criteria were approved by Board of Directors in August 2008 to clarify, strengthen, and recommend changes to endorsement criteria in order to achieve:

- A stronger link to national priorities and higher-level performance measures;
- Greater measure harmonization;
- Greater emphasis on outcome measures; and
- For process measures, a tighter outcomes-process link.

Project Scope and Timeline

The TAP members were advised that the project defines outcomes after Donabedian:

"outcome refers to changes (desirable or undesirable) in individuals and populations that are attributed to healthcare."

The timeline was presented highlighting the Steering Committee meeting on February 10, 2010 and endorsement in the fall of 2010.

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Currently endorsed outcome measures for cancer:

A list of the three currently endorsed eye care outcome measures within the framework created by the Steering Committee for the identification of key gap areas was presented:

1. Intermediate clinical outcomes (physiological/biochemical)
   NQF #: *0563 Reduction in IOP >15% for glaucoma*
   NQF #: *0565 20/40 or better visual acuity within 90 days after cataract surgery*

2. Healthcare-acquired adverse event or complication (non-mortality)
   NQF#: *0564 Cataract surgery complications within 30 days requiring additional surgery*

TAP discussion

The main reason no additional measures were submitted during the call directly relates to the feasibility of accessing clinical data. Most care is provided within the ambulatory care setting rather than the in-patient setting and the majority of data that would be required for measures would not be captured electronically. For example, frequently complications or clinical morbidity occur in the office setting and are not captured using administrative data. Different avenues—such as clinical data registries must be explored to enable the collection of this data in an effort to minimize burden on the practice. Not only will registries enable data collection on the current set of eye care measures, they will also enable eye care professionals and practices to collect additional data that will lead to data that will advance the clinical evidence base on treatment and desired outcomes but ultimately to a more robust set of measures. Access to a richer set of data will allow researcher and developers to identify appropriate risk adjustment models for outcome measures rather than the current method of identifying exceptions as demonstrated in the cataract outcome measures currently endorsed by NQF.

Professional organizations are aware of the need to identify strategies toward seamless data capture of these data. The American Academy of Ophthalmology (AAO) recently released a data registry that can be used to collect the three outcome measures that are currently NQF-endorsed as well as the process measures. The AAO has been working to identify strategies to facilitate data gathering. Glaucoma treatment is an example of an area where there is variability in care but the data collection burden serves as a challenge to begin to capture and address these variations. Moving toward measures that better assess patient outcomes will require an approach that is not punitive but rather provides feedback to the eye care professional and allows for the sharing of best practices across professionals and practices.

When reviewing the types of outcome measures that the Steering Committee outlined, several are not applicable to eye care (e.g., mortality) while others are directly relevant including patient function, symptoms, health-related quality of life (physical, mental, social), intermediate clinical outcomes (physiologic, biochemical), and non-mortality clinical morbidity related to disease control and treatment. For many of the conditions in eye care, the primary goal is to limit disease progression while assuring that patient function and quality of life is optimal.

In the future, eye care measures should begin to look at appropriate therapies that improve patient's visual function and quality of life while decreasing costs. There are several studies looking at the treatment for age-related macular degeneration (AMD) and glaucoma that will hopefully provide the evidence base needed to further define treatment regimens. Currently, the evidence is weak, in part due to the lack of data on current practice and the impact on patients' outcomes. Until this evidence base is further developed, additional measures on what treatment is most effective on preventing disease progression for AMD, glaucoma diabetic retinopathy, and other eye care conditions cannot be developed.

As more evidence becomes available, measures that address appropriateness of services and treatment and composites that represent comprehensive eye care for given conditions should be prioritized. Composite measures are of particular interest as current evidence indicates that the desired outcomes in eye care are often not well defined. Linking process and outcome measures into one representation of clinical care may provide patients access to better information on the quality of care for an eye care condition. For example, a potential composite for cataract care could include a measure on pre-operative evaluation and the two outcome measures NQF # *0565 20/40 or better visual acuity within 90 days after cataract surgery and* NQF# *0564 Cataract surgery complications within 30 days requiring additional surgery.*

Developing tools and measures on patient functional status and experience with care will remain a challenge in the short term as validating a methodology to assess visual function will be time and resource intensive. These tools would provide valuable information on a patient's satisfaction and quality of life. For example, a measure on whether a patient's visual acuity is 20/40 or better following cataract surgery can serve as a proxy for functional status and quality of life. The ability to capture whether a

patient with a lower visual acuity has a positive outcome based on what could be achieved would provide another component to reflect the quality of care received.

Measures that address counseling for adherence and benefits to treatment should also be explored with the goal that the measures reflect the process most proximal to the outcome or the actual outcome. Future measures should also begin to look at disparities in care and treatment with the goal of identifying best practices – how frequently patients have access to care and treatments.

The proposed NQF endorsement and maintenance cycles that are out for member and public comment will facilitate the integration of these new measures into the NQF portfolio. As measure developers move forward, NQF aims to encourage a continuous review of existing measures to ensure that they remain evidence based and that we move toward more robust sets of measures.

Next steps will be to develop the meeting summary followed by draft text for the Outcomes Project report. This section on eye care in the report will include research recommendations and recommendations on future measure concepts.

Audience comment

Jodi Mitchell asked if the registry would be for ophthalmologists or would it be open to the public. AAO staff responded that it is currently available to members of the Academy of Ophthalmology and American Society for Cataract and Refractive Surgery.