NATIONAL QUALITY FORUM

Patient Safety, Fall 2018 Measure Review Cycle

Standing Committee Orientation Web Meeting

Andrew Lyzenga
Jesse Pines
Nicolette Mehas
Hiral Dudhwala
Desmirra Quinnonez

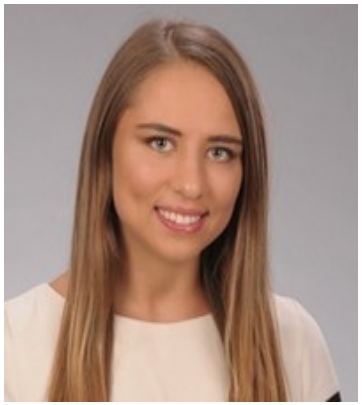
December 3, 2018

Welcome

Patient Safety Project Team

Andrew Lyzenga
Senior Director

Jesse Pines
Consultant



Nicolette Mehas
Senior Director

Hiral Dudhwala
Project Manager

Desmirra Quinnonez
Project Analyst

Agenda

- Welcome
- Fall 2018 Cycle Project Activities and Timeline
- Discussion of Guidance on Harmonization of Medication Reconciliation Measures
- Committee Questions on Consensus Development Process (CDP), Roles of the Standing Committee, and/or Measure Evaluation Criteria
- Public Comment
- Next Steps

Patient Safety Standing Committee

- Ed Septimus, MD (Co-Chair)
- Iona Thraen, PhD, ACSW (Co-Chair)
- Jason Adelman, MD, MS
- Charlotte Alexander, MD
- Laura Ardizzone, BSN, MS, DNP, CRNA
- Curtis Collins, PharMD, MS
- Christopher Cook, PharmD, PhD
- Melissa Danforth, BA
- Theresa Edelstein, MPH, LNHA
- Lillee Gelinas, MSN, RN, FAAN
- John James, PhD
- Stephen Lawless, MD, MBA, FAAP, FCCM
- Lisa McGiffert
- Susan Moffatt-Bruce, MD, PhD
- Patricia Quigley, PhD, MPH, ARNP, CRRN, FAAN, FAANP
- Michelle Schreiber, MD
- Leslie Schultz, PhD, RN, NEA-BC, CPHQ
- Tracy Wang, MPH
- Kendall Webb, MD, FACEP
- Albert Wu, MD, MPH, FACP
- Donald Yealy, MD, FACEP
- Yanling Yu, PhD

Patient Safety Standing Committee Expert Reviewers

- Jamie Roney, DNP, RN-BC, CCRN-K
  - *(Infectious Disease)*
- Pranavi Sreeramoju, MD, MPH, CMQ, FSHEA, FIDSA
  - *(Infectious Disease)*
- Bruno Digiovine, MD
  - *(Pulmonary)*
- Edgar Jimenez, MD, FCCM
  - *(Pulmonary)*
- David Stockwell, MD, MBA
  - *(Pulmonary)*
- Emily Aaronson, MD
  - *(Infectious Disease)*
- Kimberly Applegate, MD, MS, FACR
  - *(Radiology)*
- Richard Brilli, MD, FAAP, FCCM
  - *(Infectious Disease)*

Overview of NQF's Patient Safety Portfolio

Patient Safety Portfolio of Measures

- This project will evaluate measures related to Patient Safety that can be used for accountability and public reporting for all populations and in all settings of care.
- NQF solicits new measures for possible endorsement.
- NQF currently has 64 endorsed measures within this topic area. Endorsed measures undergo periodic evaluation to maintain endorsement “maintenance.”

Patient Safety
Fall 2018 Cycle Activities

Fall 2018 Cycle Measures

Six Maintenance Measures for Committee review

- NQF 0553 Care for Older Adults (COA) – Medication Review
- NQF 0555 INR Monitoring for Individuals on Warfarin
- NQF 0753 American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure*
- NQF 1716 National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure*
- NQF 1717 National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure*
- NQF 3450 Practice Environment Scale - Nursing Work Index (PES-NWI) (composite and five subscales)*

* Reviewed by Scientific Methods Panel for Scientific Acceptability Criterion

Scientific Methods Panel Review

Passed Scientific Acceptability criterion

- NQF 1716 National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure
- NQF 1717 National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure
- NQF 3450 Practice Environment Scale - Nursing Work Index (PES-NWI) (composite and five subscales)

Consensus not reached on Scientific Acceptability criterion

- NQF 0753 American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure

Scientific Methods Panel Review

Did not pass Scientific Acceptability criterion

- NQF 2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient
  - NQF's Scientific Methods Panel agreed that the measure, as submitted, does not meet NQF's requirements for validity due to lack of empirical testing as well as concerns about the generalizability of the measure and the fairness of comparisons of measure results across facilities.

Activities and Timeline – Fall 2018 Cycle
*All times ET

Meeting	Date/Time
Measure Submission Deadline	November 1, 2018
Commenting Period Starts	November 28, 2018
Committee Orientation Web Meeting	December 3, 2018, 1-3 pm
Committee Measure Evaluation Web Meetings	January 29, 2019, 1-3 pm January 31, 2019, 1-3 pm
Committee Post-Measure Evaluation Web Meeting	February 8, 2019, 2-4 pm
Draft Report Comment Period (30 days)	March 11-April 9, 2019 (tentative)
Committee Post-Comment Web Meeting	May 1, 2019, 1-3 pm
CSAC Review	Late May/early June, 2019
Appeals Period (30 days)	June 14-July 15, 2019 (tentative)

Guidance on Harmonization of Medication Reconciliation Measures

Work to Date

- Fall 2017 Behavioral Health Standing Committee (SC) discussion about medication reconciliation
  - *Desire for greater alignment in measure specifications*
- April 2018 CSAC charged the Patient Safety SC to explore issues further
- September 2018 Patient Safety SC started discussion on Medication Reconciliation Measures
  - *Patient Safety SC was interested in a comparison of attributes across measures*
- October 2018 CSAC discussed Medication Reconciliation Harmonization Topic Progress

Medication Reconciliation Measures

- 0097 Medication Reconciliation Post-Discharge
- 2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
- 0419e Documentation of Current Medications in the Medical Record
- 0553 Care for Older Adults (COA)-Medication Review
- 3317 Medication Reconciliation on Admission
- 2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

Areas of Major Differences in Measure Attributes

- Medication Reconciliation/Review Setting
- Defining Medication Reconciliation/Review Requirements
- Documenting the Mediation Reconciliation/Review Process
- Individuals Eligible to Perform the Medication Reconciliation/Review
- Frequency of Medication Reconciliation/Review
- Information Source for Medication Reconciliation/Review
- Populations and Risk Factors

Discussion

- Did any of the summary sections or variations among the measures stand out as priorities?
- Which attributes can and cannot be harmonized?
- How can we involve developers in the next steps towards harmonization/alignment?

Discussion of CDP Process, Roles of Standing Committee, and Measure Evaluation Criteria

Next Steps

Next Steps

- Measure Submission Deadline, Fall 2018 Cycle
  - *November 1, 2018*
  - *Committee members should expect to receive measures for review late December/early January*
- Measure Evaluation Web Meetings
  - *January 29, 2019 1-3 pm EST*
  - *January 31, 2019 1-3 pm EST*
- Post-Measure Evaluation Web Meeting
  - *February 8, 2019 2-4 pm EST*

Project Contact Info

- Email: patientsafety@qualityforum.org
- NQF phone: 202-783-1300
- Project page: http://www.qualityforum.org/Patient_Safety.aspx
- SharePoint site: http://share.qualityforum.org/Projects/patient_safety/SitePages/Home.aspx

Questions?

Adjourn

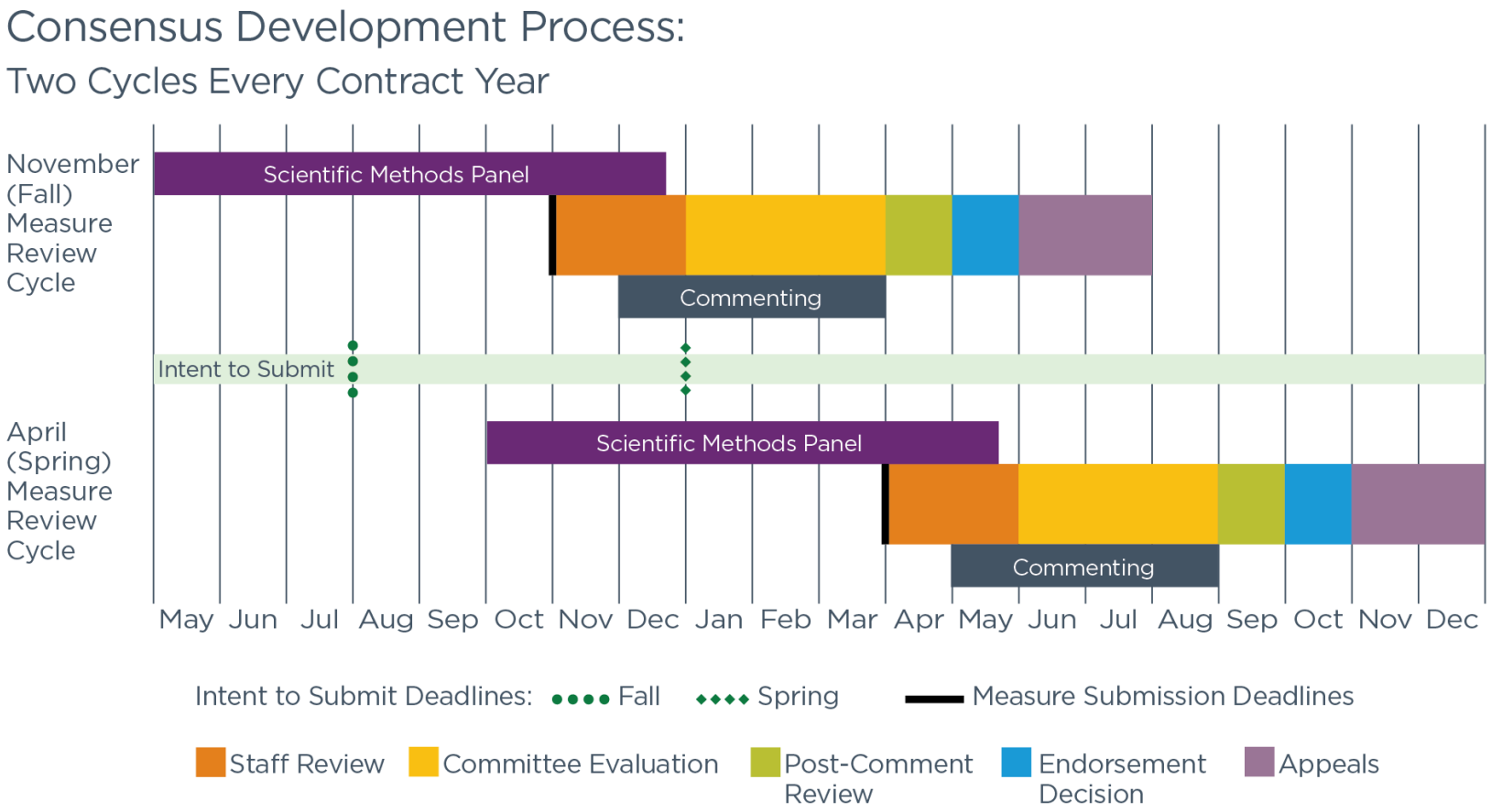
Additional Slides If Needed

Overview of the CDP Process

NQF Consensus Development Process (CDP)
6 Steps for Measure Endorsement

- Intent to Submit
- Call for Nominations
- Measure Evaluation
- Public Commenting Period with Member Support
- Measure Endorsement
- Measure Appeals

Measure Review: Two Cycles Per Year



15 Measure Review Topical Areas

	All Cause Admission/ Readmissions	Behavioral Health	
Cancer	Cardiovascular	Care Coordination	Infectious Disease
Cost and Resource Use	Endocrine	Eyes, Ears, Nose and Throat Conditions	Palliative and End-of Life Care
Gastrointestinal	Genitourinary	Health and Well Being	Musculoskeletal
Neurology	Patient Safety	Pediatrics	Perinatal
Person and Family-Centered Care	Pulmonary and Critical Care	Renal	Surgery

All Cause Admission/ Readmissions	Behavioral Health & Substance Use	Cancer
Cardiovascular	Cost and Efficiency[A]	Geriatric and Palliative Care[B]
Neurology	Patient Experience & Function	Patient Safety[C]
Pediatrics	Perinatal and Women's Health	Prevention and Population Health[D]
Primary Care and Chronic Illness	Renal	Surgery

☐ Denotes expanded topic area

[A] Cost & Efficiency will include efficiency-focused measures from other domains
[B] Geriatric & Palliative Care includes pain-focused measures from other domains
[C] Patient Safety will include acute infectious disease and critical measures
[D] Prevention and Population Health is formerly Health and Well Being

Roles of Standing Committee, Expert Reviewers, and Scientific Methods Panel

Role of the Standing Committee
General Duties

- Act as a proxy for the NQF multistakeholder 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
Measure Evaluation Duties

- All members evaluate ALL measures
- Evaluate measures against each criterion
  - Indicate the extent to which each criterion is met and rationale for the rating
- Make recommendations for endorsement
- Oversee Patient Safety portfolio of measures
  - Promote alignment and harmonization
  - Identify gaps

Role of the Standing Committee Co-Chairs

- Co-facilitate Standing Committee (SC) meetings
- Work with NQF staff to achieve the goals of the project
- Assist NQF in anticipating questions and identifying additional information that may be useful to the SC
- Keep SC on track to meet goals of the project without hindering critical discussion/input
- Represent the SC at CSAC meetings
- 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
Communication

- Respond to NQF member or public queries about the project
- Maintain documentation of project activities
- Post project information to NQF's website
- Work with measure developers to provide necessary information and communication for the SC to fairly and adequately evaluate measures for endorsement
- Post final project report

Role of the Expert Reviewers

- In 2017, NQF executed a CDP redesign that resulted in restructuring and reducing the number of topical areas as well as a bi-annual measure review process

- Given these changes, there is a need to retain a diverse, yet specific, expertise within an “expert reviewer pool” to support longer and continuous engagement from standing committees

Role of the Expert Reviewers

- The expert reviewer pool serves as an adjunct to NQF Standing Committees to ensure broad representation and provide technical expertise when needed
- Expert reviewers will provide expertise as needed to review measures submitted for endorsement consideration
- Expert reviewers may also:
  - *Provide comments and feedback on measures throughout the measure review process;*
  - *Participate in strategic discussions in the event no measures are submitted for endorsement consideration.*

Role of Methods Panel

- Scientific Methods Panel created to ensure higher-level and more consistent reviews of the scientific acceptability of measures
- The Methods Panel is charged with:
  - *Conducting evaluation of complex measures for the Scientific Acceptability criterion, with a focus on reliability and validity analyses and results*
  - *Serve in advisory capacity to NQF on methodologic issues, including those related to measure testing, risk adjustment, and measurement approaches.*
- The Methods Panel review will help inform the standing committee's endorsement decision. The Panel will not render endorsement recommendations.

NQF Consensus Development Process (CDP)
Measure Evaluation

Complex Measures

- **Outcome measures, including intermediate clinical outcomes**
- **Instrument-based measures (e.g., PRO-PMs)**
- **Cost/resource use measures**
- **Efficiency measures (those combining concepts of resource use and quality)**
- **Composite measures**

Noncomplex Measures

- **Process measures**
- **Structural measures**
- **Previously endorsed complex measures with no changes/updates to the specifications or testing**

Questions?

Measure Evaluation Criteria Overview

NQF Measure Evaluation Criteria for Endorsement

NQF endorses measures for accountability applications (public reporting, payment programs, accreditation, etc.) as well as quality improvement.

- Standardized evaluation criteria
- Criteria have evolved over time in response to stakeholder feedback
- The quality measurement enterprise is constantly growing and evolving—greater experience, lessons learned, expanding demands for measures—the criteria evolve to reflect the ongoing needs of stakeholders

Major Endorsement Criteria
(page 28-29 in the SC Guidebook)

- **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 and Report (page 31-39)

1. Importance to measure and report - Extent to which the specific measure focus is evidence-based and important to making significant gains in healthcare quality 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*

1c. Quality construct and rationale *(composite measures only)*

Subcriteron 1a: Evidence (page 32-38)

- Outcome measures
  - *Empirical data demonstrate a relationship between the outcome and at least one healthcare structure, process, intervention, or service. If not available, wide variation in performance can be used as evidence, assuming the data are from a robust number of providers and results are not subject to systematic bias.*
- Structure, 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*
    - » Empirical studies (expert opinion is not evidence)
    - » Systematic review and grading of evidence
      - *Clinical Practice Guidelines – variable in approach to evidence review*
- For measures derived from patient (or family/parent/etc.) report
  - *Evidence should demonstrate that the target population values the measured outcome, process, or structure and finds it meaningful.*
  - *Current requirements for structure and process measures also apply to patient-reported structure/process measures.*

Criterion #1: Importance to measure and report

Criteria emphasis is different for new vs. maintenance measures

New measures	Maintenance measures
• Evidence – Quantity, quality, consistency (QQC) • Established link for process measures with outcomes	**DECREASED EMPHASIS**: Require measure developer to attest evidence is unchanged evidence from last evaluation; Standing Committee to affirm no change in evidence IF changes in evidence, the Committee will evaluate as for new measures
• Gap – opportunity for improvement, variation, quality of care across providers	**INCREASED EMPHASIS**: data on current performance, gap in care and variation

Criterion #2: Reliability and Validity–Scientific Acceptability of Measure Properties (page 40 -50)

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

2a. **Reliability (must-pass)**

2a1. Precise specifications including exclusions

2a2. Reliability testing—data elements or measure score

2b. **Validity (must-pass)**

2b1. Validity testing—data elements or measure score

2b2. Justification of exclusions—relates to evidence

2b3. Risk adjustment—typically for outcome/cost/resource use

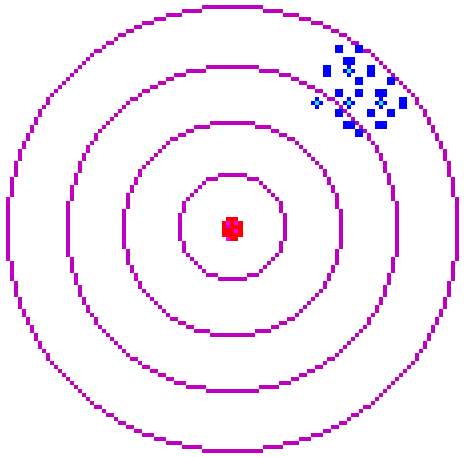
2b4. Identification of differences in performance

2b5. Comparability of data sources/methods

2b6. Missing data

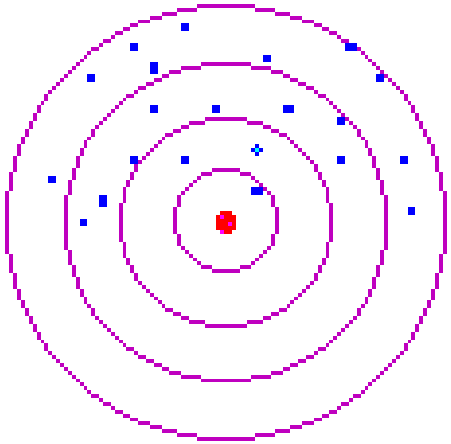
Reliability and Validity (page 41)

Assume the center of the target is the true score…



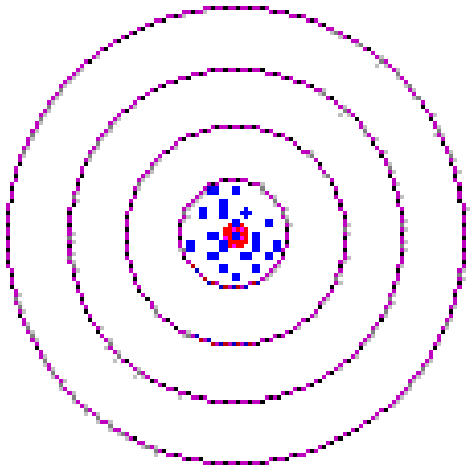
Reliable Not Valid

Consistent, but wrong



Neither Reliable Nor Valid

Inconsistent & wrong



Both Reliable And Valid

Consistent & correct

Evaluating Scientific Acceptability – Key Points (page 42)

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
Key points (page 43)

- 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 whether results are within acceptable norms
- Algorithm #2

Validity Testing (pages 45 - 49)

Empirical 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
  - *Empirical validity testing is expected at time of maintenance review; if not possible, justification is required.*
  - *Requires systematic and transparent process, by identified experts, that explicitly addresses whether performance scores resulting from the measure as specified can be used to distinguish good from poor quality. The degree of consensus and any areas of disagreement must be provided/discussed.*

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 #2: Scientific Acceptability

New measures	Maintenance measures
• Measure specifications are precise with all information needed to implement the measure	NO DIFFERENCE: Require updated specifications
• Reliability • Validity (including risk-adjustment)	**DECREASED EMPHASIS**: If prior testing adequate, no need for additional testing at maintenance with certain exceptions (e.g., change in data source, level of analysis, or setting) Must address the questions regarding use of social risk factors in risk-adjustment approach

Criterion #3: Feasibility
(page 50-51)

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 51-52)

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.

Use (4a) Must-pass for maintenance measures

4a1: Accountability and Transparency: *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.*

4a2: Feedback by those being measured or others: *Those being measured have been given results and assistance in interpreting results; those being measured and others have been given opportunity for feedback; the feedback has been considered by developers.*

Usability (4b)

4b1: Improvement: *Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated.*

4b2: 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).*

Criteria #3-4: Feasibility and Usability and Use

New measures	Maintenance measures
Feasibility	
• Measure feasible, including eMeasure feasibility assessment	NO DIFFERENCE: Implementation issues may be more prominent
Usability and Use	
• Use: used in accountability applications and public reporting	**INCREASED EMPHASIS**: Much greater focus on measure use and usefulness, including both impact and unintended consequences
• Usability: impact and unintended consequences	

Criterion #5: Related or Competing Measures (page 52-53)

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.

Updated guidance for measures that use ICD-10 coding

- For CY2019 and beyond, reliability testing should be based on ICD-10 coded data.
- Validity testing should be based on ICD-10 coded data
- If providing face validity (FV), both FV of the ICD-10 coding scheme and FV of the measure score as an indicator of quality is required update

eMeasures

- "Legacy" eMeasures
  - *Beginning September 30, 2017 all respecified measure submissions for use in federal programs will be required to the same evaluation criteria as respecified measures – the "BONNIE testing only" option will no longer meet endorsement criteria*
- For all eMeasures: Reliance on data from structured data fields is expected; otherwise, unstructured data must be shown to be both reliable and valid

Evaluation Process

- **Preliminary analysis (PA)**: To assist the Committee evaluation of each measure against the criteria, NQF staff and Methods Panel (if applicable) will prepare a PA of the measure submission and offer preliminary ratings for each criterion.
  - *The PA will be used as a starting point for the Committee discussion and evaluation*
  - *Methods Panel will complete review of Scientific Acceptability criterion for complex measures*
- **Individual evaluation**: Each Committee member conduct an in-depth evaluation on all measures
  - *Each Committee member will be assigned a subset of measures for which they will serve as lead discussant in the evaluation meeting.*

Evaluation Process

- **Measure evaluation and recommendations at the in-person/web meeting**: The entire Committee will discuss and rate each measure against the evaluation criteria and make recommendations for endorsement.
- **Staff will prepare a draft report** detailing the Committee's discussion and recommendations
  - *This report will be released for a 30-day public and member comment period*
- **Post-comment call**: The Committee will re-convene for a post-comment call to discuss comments submitted
- **Final endorsement decision by the CSAC**
- **Appeals** (if any)

Questions?

SharePoint Overview

SharePoint Overview

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

- Accessing SharePoint
- Standing Committee Policy
- Standing Committee Guidebook
- Measure Document Sets
- Meeting and Call Documents
- Committee Roster and Biographies
- Calendar of Meetings