NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Primary Care and Chronic Illness Standing Committee – Measure Evaluation In-Person Meeting

The National Quality Forum (NQF) convened the Primary Care and Chronic Illness (PCCI) Standing Committee for an in-person meeting on February 11, 2020 to evaluate six NQF endorsement maintenance measures.

Welcome, Introductions, and Review of Meeting Objectives

NQF welcomed the Standing Committee and participants to the in-person meeting; the Committee co-chairs also provided welcoming remarks. NQF chief of staff Apryl Clark conducted a roll call, during which Committee members each introduced themselves and were asked to disclose any conflicts of interest; no conflicts were disclosed.

Overview of Evaluation Process

NQF staff provided a brief overview of the steps and roles in the Consensus Development Process (CDP), the role of the Scientific Methods Panel (which reviewed the three diabetes measures in this cycle), the measure evaluation criteria, and the voting process. After a brief voting test, the measure evaluation portion of the meeting began.

Measure Evaluation

During the meeting, the Primary Care and Chronic Illness Standing Committee evaluated six measures for maintenance of endorsement. A summary of the Committee deliberations will be compiled and provided in the draft technical report. NQF will post the draft technical report tentatively on March 18, 2020 for public comment on the NQF website. The draft technical report will be posted for 30 calendar days.

Rating Scale: H – High; M – Medium; L – Low; I – Insufficient; NA – Not Applicable

1800 Asthma Medication Ratio (National Committee for Quality Assurance [NCQA])

Measure Steward/Developer Representatives at the Meeting

- Deidra Washington
- Bob Rehm
- Lindsey Roth (via phone)

Standing Committee Votes

- Evidence: H-4; M-17; L-1; I-0
- Performance Gap: H-10; M-12; L-0; I-0
- Reliability: H-2; M-20; L-0; I-0
- Validity: H-1; M-18; L-3; I-0
- Feasibility: H-16; M-6; L-0; I-0
- Use: Pass-18; No Pass-4

- Usability: H-0; M-16; L-6; I-0

Standing Committee Recommendation for Endorsement: Yes-18; No-4

The Standing Committee recommended the measure for continued endorsement. The Committee noted a strong evidence base for the use of both controller and reliever medications with the history of the ratio that serves as the basis for this measure dating back to 2006. The Committee noted that newer approaches using combinations of long acting beta agonists with corticosteroids are serving as both immediate and long term relief and may at one point supersede a need for this measure. It was noted that this measure really determines how much of short acting bronchodilators are being dispensed. The Committee noted a persistent gap in commercial vs Medicare and Medicaid, but also noted that there wasn't a good analysis related to disparities despite this being present in the medical literature. The developer noted that the health plans do not provide race and ethnicity data; while providers may have that information, this does not travel with claims data. The developer further noted that they have stratified some of their measures by some socioeconomic status risk adjusters such as dual eligibility status for research purposes but have not noted strong statistical indicators for a need to risk adjust. The Committee expressed concern that the measure hasn't provided change with only 1-2% improvement over the last three years. The developer noted that they do not have the ability to force plans to prioritize measures, but that the improvement—however modest—does indicate that it is responsive to improvement efforts. The Committee did not express any concerns related to the measure's reliability. The Committee expressed concern in the validity with exclusions of patients 65 and older, as well as concerns for instances when multiple inhalers are dispensed as artificial fills, for example with younger beneficiaries sometimes having multiple rescue inhalers that are not always used but are required for multiple locations such as schools, camps, and split households. Nonetheless, the Committee considered these instances as too few to pose true threats. The Committee noted that the measure is based on data generated during the usual course of asthma management using defined fields. The PCCI Committee noted that this measure is widely used within the Healthcare Effectiveness Data and Information Set (HEDIS) and by the Centers for Medicare and Medicaid Services (CMS), among others. The Committee expressed concern that health plan performance on the measure hasn't improved. There was a concern that the health plans may not be able to make meaningful change in provider behavior and patient behavior. The Committee also noted some clinicians and patients may continue to have fears associated with use of steroids. Nonetheless, the Committee noted improvement especially in the bottom quartiles based on year over year plan performance. The developer noted that adherence to controller medications is generally very poor, with commercial plans generally outperforming Medicaid on most measures. The Committee noted that copay costs for commercial beneficiaries may be quite high resulting in adherence barriers. The Committee noted one measure that was not competing and expressed no concerns related to harmonization.

2856 Pharmacotherapy Management of COPD Exacerbation (NCQA)

Measure Steward/Developer Representatives at the Meeting

- Deidra Washington
- Bob Rehm
- Lindsey Roth (via phone)

Standing Committee Votes

- Evidence: H-2; M-20; L-0; I-0
- Performance Gap: H-5; M-17; L-0; I-0
- Reliability: H-2; M-19; L-1; I-0
- Validity: H-0; M-22; L-0; I-0

- Feasibility: H-6; M-16; L-0; I-0
- Use: Pass-22; No Pass-0
- Usability: H-0; M-19; L-2; I-0

Standing Committee Recommendation for Endorsement: Yes-21; No-0

The Standing Committee recommended the measure for continued endorsement. The Committee noted that there is increasing alignment European practices with using eosinophil counts as therapeutic indicators for systemic corticosteroid treatment for chronic obstructive pulmonary disease (COPD). The 2020 GOLD standards note that systemic corticosteroids *can* be used, but that long acting bronchodilators would be a preferred choice and potentially being dispensed at discharge. This may be the reason that performance data has leveled off starting in 2018. The Committee again noted the disparity gap in the literature and expressed the concern that claims data does not reflect this critical information, but a wide and persistent performance gaps in each plan category. Validity concerns expressed were related to confounding factors from having inhaled corticosteroid medications provided at the hospital bedside but not reflected in the drug claims. The developer noted that their measures are beginning to combine electronic health record (EHR), health insurance exchange (HIE), claims and registry data, but that this measure does not draw on those broader data sources. The Committee did not express any concerns related to feasibility, nor for use. The Committee expressed concern that the measure has not significantly moved in the last several years and questioned whether feedback loops have been appropriately addressed. The Committee noted a few related measures, but none competing and with good harmonization.

0577 Use of Spirometry Testing in the Assessment and Diagnosis of COPD (NCQA)

Measure Steward/Developer Representatives at the Meeting

- Deidra Washington
- Bob Rehm
- Lindsey Roth (via phone)

Standing Committee Votes

- Evidence: H-6; M-14; L-0; I-0
- Performance Gap: H-4; M-16; L-1; I-0
- Reliability: H-2; M-19; L-0; I-0
- Validity: H-1; M-17; L-3; I-0
- Feasibility: H-7; M-13; L-1; I-0
- Use: Pass-21; No Pass-0
- Usability: H-3; M-14; L-4; I-0

Standing Committee Recommendation for Endorsement: Yes-20; No-1

The Standing Committee recommended the measure for continued endorsement. The Committee noted a distinct difference in this measure related to the previous two, which were associated with appropriate treatment. By contrast, the measure focus for NQF 0577 is related to diagnosis and ensuring that beneficiaries are both appropriately diagnosed and assessed for condition severity. The Committee felt that the evidence behind this measure was robust and sufficient. This measure is more complicated as it involves both claims data as well as abstraction from the medical record. It was noted that spirometry is often not submitted for billing. The Committee agreed there is a continuing opportunity for improvement in the performance gap of the measure. One Committee member inquired why providers are not automatically performing spirometry testing, given that desktop spirometry is more

available and inexpensive. The developer speculated it could be due to a gap in care coordination and the providers may not know of the new diagnosis of COPD. One Committee member noted there is also the existing barrier of getting patients to follow up at a provider's office. Another Committee member noted that sometimes spirometry testing and the billing for the test can occur prior to the new diagnosis of COPD. One Committee member expressed a concern related to gap, especially as it relates to data supporting clinical disparities and the issue of using race as a marker within diagnoses. In general for the field of healthcare, the Committee also expressed the importance of having disparities data available based on patient self-identification of race and ethnicity, rather than by the provider. The Committee did not note significant issues related to reliability but expressed some concerns on blood pressure, bone density testing and pharyngitis as comparators for convergent validity. The developer clarified that those measures were based on diagnostic testing and suggested that the tests chosen were as proximate to the measure of interest as the data allowed them to be. The Committee noted that this measure has been in use for several years and expressed no concerns related to its implementation burden. The Committee noted that all six of the measures considered are publicly reported and used in multiple accountability applications with no issues related to implementation. The Committee noted a high degree of churn within the markets between patients use of providers and plans as well as a large amount of consolidation within healthcare that will affect measures of this types and did not express further concerns related to usability. The Committee noted a treatment measure for COPD that was not diagnostic and did not consider this a competing metric.

0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (NCQA)

Measure Steward/Developer Representatives at the Meeting

- Dan Roman
- Mary Barton

Standing Committee Votes

- Evidence: H-11; M-10; L-0; I-0
- Performance Gap: H-13; M-9; L-0; I-0
- Reliability: Does the Committee accept NQF Scientific Methods Panel's rating of Reliability?Yes-22; No-0
    - This measure was evaluated by the NQF Scientific Methods Panel and was rated as moderate in their preliminary analysis (H-2; M-3; L-0; I-0).
- Validity: Does the Committee accept NQF Scientific Methods Panel's rating of Validity? Yes-22; No-0
    - This measure was evaluated by the NQF Scientific Methods Panel and was rated as moderate in their preliminary analysis (H-1; M-3; L-0; I-1).
- Feasibility: H-6; M-16; L-0; I-0
- Use: Pass-22; No Pass-0
- Usability: H-7; M-15; L-0; I-0

Standing Committee Recommendation for Endorsement: Yes-22; No-0

The Standing Committee recommended the measure for continued endorsement. The Committee noted that this measure has undergone some changes in coding and applauded the measure developer for inclusion of telehealth. The Committee noted the measure focus on patients greater than 9.0% HbA1c is a looser goal and perhaps a more appropriate one, but that it may be more challenging for patients to understand. The endocrinologists on the Committee noted that the 9.0 threshold target is a reasonable and actionable therapeutic indicator for poor control. The Committee added that financial and food

insecurity have been shown to be correlated with poor glycemic control. The Committee noted an approximate 4% improvement between 2016-2018 but opportunities to improve for commercial, Medicare and Medicaid plans. The Committee noted new exclusions to exclude populations that would not benefit from intensive glycemic control such as hospice, elderly and frail beneficiaries. The Committee noted that pharmacy claims can be used in the measure to identify patients in the denominator but expressed concerns that several medications could potentially flag patients as having diabetes when they are used for other conditions such as polycystic ovarian syndrome or for weight loss. The Committee also expressed concern that frailty is difficult to define. The developer noted that frailty alone is not sufficient but that it must also include other chronic illnesses and that such patients were excluded from studies that support the recommendations in the guidelines. The Committee did not express concerns related to reliability and validity and voted to uphold the moderate ratings ascribed to the measures by the Scientific Methods Panel. The Committee noted that the data sources for this measure are part of routine care delivery and did not express concerns related to feasibility. The Committee noted that this measure is used in multiple accountability programs and did not express concerns for use or usability. The Committee expressed concern related to usability that this may encourage aggressive glycemic control but noted that the developer had excluded a number of populations that do not carry strong benefits relative to the risks. The Committee noted the next measure NQF 0575 targeting less than 8.0% HbA1c and questioned the need for both measures. The measure developer noted that the population that is not in control is significantly different that the population who is in control or close to it and suggested that the measures are therefore complementary. The developer also noted that the population level measures complement each other by allowing for flexibility in clinical approach for patients without aggressive glycemic targeting. The Committee suggested that continuous glucose monitors may affect the usefulness of NQF 0059 and 0575 in the future.

0575 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) (NCQA)

Measure Steward/Developer Representatives at the Meeting

- Dan Roman
- Mary Barton

Standing Committee Votes

- Evidence: H-5; M-15; L-1; I-0
- Performance Gap: H-14; M-8; L-0; I-0
- Reliability: Does the Committee accept NQF Scientific Methods Panel's rating of Reliability? Yes-22; No-0
    - This measure was evaluated by the NQF Scientific Methods Panel and rated the measure as moderate (H-1; M-4; L-0; I-0).
- Validity: Does the Committee accept NQF Scientific Methods Panel's rating of Validity? Yes-22; No-0
    - This measure was evaluated by the NQF Scientific Methods Panel and rated the measure as moderate (H-2; M-2; L-0; I-1).
- Feasibility: H-11; M-11; L-0; I-0
- Use: Pass-22; No Pass-0
- Usability: H-6; M-14; L-2; I-0

Standing Committee Recommendation for Endorsement: Yes-22; No-0

The Standing Committee recommended the measure for continued endorsement. The Committee noted that this measure is intended to serve as a compliment to NQF 0059. The Committee observed that

there is a substantial population for whom less than 8.0% HbA1c is a reasonable target and that patients with a tighter goal would be a subset of the entire broad population. The Committee added that younger people who don't have complications who have better ability to manage their diabetes are appropriate for a 7.0% target, but complicated patients with concomitant disease have increased risks with tighter controls, such as those with hypertension. The Committee noted that the performance of the measure has improved over time, especially for health plans in the lower quartiles. The issues related to disparities discussed in the previous measure were noted to also carry over to this measure as well. The Committee did not express any concerns related to reliability and validity and elected to accept the NQF Scientific Methods Panel ratings. The Committee did not express concerns related to the feasibility, use or usability of the measure. The relating and competing discussion revisited the theme of the previous measure, but with the same result—the Committee's endocrinologists reassured the other members of the Committee that it was important to keep both measures until entire populations are below 8.0% HbA1c. The developer further clarified that the actions for patients over 9.0% or are unmeasured that require specialized outreach to ensure that they receive care and are different for patients between 8.0-9.0% who typically need refinements to their existing treatment regimen. These populations were characterized by the developer, Committee patients and Committee providers as fundamentally different with significant benefit derived from a quality improvement standpoint.

0061 Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) (NCQA)

Measure Steward/Developer Representatives at the Meeting

- Dan Roman
- Mary Barton

Standing Committee Votes

- Evidence: H-1; M-20; L-0; I-0
- Performance Gap: H-6; M-15; L-0; I-0
- Reliability: Does the Committee accept NQF Scientific Methods Panel's rating of Validity? Yes-21; No-0
    - This measure is deemed as complex and was evaluated by the NQF Scientific Methods Panel and was rated as moderate (H-2, M-3, L-0, I-0).
- Validity: Does the Committee accept NQF Scientific Methods Panel's rating of Validity? Yes-21; No-0
    - This measure is deemed as complex and was evaluated by the NQF Scientific Methods Panel and was rated as high (H-3, M-1, L-0, I-1).
- Feasibility: H-11; M-10; L-0; I-0
- Use: Pass-21; No Pass-0
- Usability: H-6; M-14; L-1; I-0

Standing Committee Recommendation for Endorsement: Yes-20; No-1

The Standing Committee recommended the measure for continued endorsement. The Committee noted that this measure targets the same population as the previous two measures with the same exclusions. The Committee also noted the updated 2017 AHA/AAC blood pressure guideline and the 2019 ADA Standards of Care guideline that have been used to inform the evidence of this measure. The Committee noted that there were no head-to-head studies assessing benefits of blood pressure targets of 140/90 mmHg versus 130/80 mmHg and associated risks. Nonetheless, the 140/90 mmHg goal is one that covers the broadest population and was therefore proffered as the most appropriate goal. The Committee also acknowledged that a 120 mmHg systolic pressure may be the right target for some

patients but keeping the measure focus does not preclude clinicians from setting this target. The Committee noted substantial room for improvement and disparities in performance based on race. The Committee was apprised of the Scientific Methods Panel ratings for moderate and high for reliability and validity respectively and voted to uphold both ratings. The Committee acknowledged the concern that the last blood pressure reading currently called for in the measure specifications may not be the best indicator of control. The developer acknowledged that an average blood pressure reading would be a better indicator of control over time and is something that they are currently assessing. The Committee expressed no concerns for feasibility, nor did they express concerns related to use and usability. The Committee noted the similarity of this measure to several other measures that NCQA stewards that have the same 140/90 targets. The developer noted diagnostic differences for the measures and noted that this is the basis for their separation. The Committee accepted this explanation and voted to recommend the measure for endorsement.

Public Comment

For this evaluation cycle, the commenting period opened on December 5, 2019 and will close on April 16, 2020. As of January 21, 2020, no NQF member comment was received during the pre-commenting period. No public or NQF member comments were provided during the February 11 measure evaluation in-person meeting.

Next Steps

NQF will post the draft technical report tentatively on March 18, 2020 for public comment for 30 calendar days. The continuous public comment with member support will close on April 16, 2020. NQF will re-convene the Standing Committee for the post-comment web meeting on May 11, 2020.