NATIONAL QUALITY FORUM

TO: Pulmonary and Critical Care Steering Committee

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SU: Steering Committee work group preliminary evaluations and conference calls

DA: February 3, 2012

To prepare for the in-person Steering Committee meeting on March 21-22, 2012, four Committee workgroups will perform preliminary evaluations of a group of measures. Individuals in each group are asked to review the ALL the measures for your workgroup and submit your evaluation ratings and comments in the online Survey Monkey tool by the dates indicated.

WORK GROUP ASSIGNMENTS AND PRELIMINARY EVALUATIONS

In order to ensure an in-depth evaluation of all measures by several committee members, we have divided the measures and reviewers into four groups. Committee members are expected to submit ratings for the criteria and sub-criteria for the measures in your group prior to the workgroup conference call. The results of the preliminary reviews will be discussed on the workgroup conference calls.

Committee Member Assignments for In-depth Measure Evaluations

	Measure# and Title	Work Group Members
Group 1 Asthma	Online evaluation due date: Thursday, Feb. 23 Work group call date: Monday, Feb. 27 12pm-2pm ET • 0036 Use of appropriate medications for people with asthma • 0047 Asthma: pharmacologic therapy for persistent asthma • 0143 CAC-1: Relievers for inpatient asthma • 0144 CAC-2 Systematic corticosteroids for inpatient asthma • 0338 CAC-3: Home management plan of care (HMPC) document given to patient/caregiver • 0548 Suboptimal asthma control • 0620 Asthma – short-acting beta agonist inhaler for rescue therapy • 1799 Medication management for people with asthma • 1800 Asthma medication ratio (AMR) • 1876 Optimal asthma care	Burgess Cohen Haeker Glomb Lang Weiss
Group 2	Online evaluation due date: Monday, Feb. 27	Albert

	Measure# and Title	Work Group Members
COPD/ Dyspnea	Work group call date: Wednesday, Feb. 29 11am-1pm ET • 0091 COPD: spirometry evaluation • 0102 COPD: inhaled bronchodilator therapy • 0549 Pharmacotherapy management of COPD exacerbations • 0577 Use of Spirometry testing in the assessment and diagnosis of COPD • 1825 COPD – Management of poorly controlled COPD • 1891 Hospital 30-day, all-cause, risk standardized readmission rate (RSRR) following COPD hospitalization • 1893 Hospital 30-day, All-cause, risk standardized mortality rate (RSMR) following COPD hospitalization • 0179 Improvement in dyspnea	Edelman Grossbart Jewell
Group 3 Pneumonia/ CT Thorax	Online evaluation due date: Friday, Feb. 24 Work group call date: Tuesday, Feb. 28 3pm-5pm ET • 0096 Empiric antibiotic therapy for CAP • 0147 Initial antibiotic selection for community-acquired pneumonia (CAP) • 0148 Blood cultures performed in the emergency department prior to initial antibiotic received in hospital • 0231 Pneumonia mortality rate (IQI #20) • 0233 Emergency medicine: assessment of oxygen saturation for CAP • 0506 Hospital 30-day, all-cause, risk standardized readmission rate (RSRR) following pneumonia hospitalization • 0468 Hospital 30-day, all-cause, risk standardized mortality rate (RSMR) following pneumonia hospitalization • 0513 Thorax CT: use of contrast material • 1895 Mental status evaluation for CAP	Kazarooni Pellicone Rhew Stemple Yealy Whetsell
Group 4 Critical care	Online evaluation due date: Tuesday, Feb. 21 Work group call date: Thursday, Feb. 23 10am-12pm ET • 0356 Blood cultures performed within 24 hours prior to or 24 hours after hospital arrival for patients who were transferred or admitted to the ICU within 24 hours of hospital arrival • 1861 National Healthcare Safety Network (NHSN) ventilator-associated event (VAE) outcome measure • 0334 PICU Severity-adjusted LOS • 0335 Unplanned readmission rate	Almenoff Cantine Larson Levy Stockwell

	Measure# and Title	Work Group Members
	• 0336 Review of unplanned readmissions • 0341 PICU Pain assessment on admission • PICU periodic pain assessment • PCI Standardized mortality ratio	

EVALUATION INSTRUCTIONS

1. The measure information submitted by the developer has been inserted into a measure evaluation form. The forms have been placed in workgroup folders on SharePoint and are also posted on the NQF project web page. After reviewing the measure submission and please rate the measure information on the degree to which the measure meets the NQF criteria. Enter you ratings in the online tool noted above. Please use the Measure Evaluation Guide (January 2011) for reference for the sub-criteria and the rating scales.

2. With the online tool you can evaluate one measure at a time. You can go back and make changes until you exit. When you finish a measure evaluation you will be redirected back to the beginning of the tool to select another measure. ***If after trying the online tool, you find you are not able to use it, please let us know so that we can assist you.***

   It is very important that all workgroup members submit their evaluations for all measures in the group before the workgroup calls.

WORKGROUP CONFERENCE CALLS

NQF staff will compile the evaluations from all workgroup members and provide them to the workgroup members 2-3 days before the workgroup conference call. The preliminary evaluations will form the basis of the workgroup discussion for each measure. NQF staff will assign a lead discussant from the workgroup to lead the discussion of the measure on the workgroup call and at the in-person meeting. The goal is to identify areas of disagreement and areas for which the group feels the measure does not meet the NQF endorsement criteria. A summary of the workgroup preliminary ratings and discussion points will be provided to the entire Committee for the in-person meeting.

EHR SPECIFICATIONS

Several of the measures for maintenance review have been "re-tooled" for electronic health records. The eFormat Review was a DHHS funded project by NQF to create EHR specification for selected paper-based measures. NQF created the Quality Data Model (QDM) as a standardized dataset for EHR measure fields to facilitate the re-tooling work. The QDM is a growing tool that supports the new Measure Authoring Tool (MAT) to simplify the process of creating eMeasures. NQF intends to require EHR specifications for all measures in the near

future; additional details and guidance on those requirements are under consideration by the Consensus Standards Approval Committee (CSAC).

TRANSITION TO ICD-10 codes

To prepare for the implementation of ICD-10 codes by the Department of Health and Human Services in October 2012, NQF is requiring a transition plan for all measures being endorsed going forward. Many developers have submitted both ICD-9 and ICD-10 codes with their submission. An ICD-10 transition plan is needed for all measures before endorsement.

RELATED AND COMPETING MEASURES

In this group of Pulmonary and Critical Care measures, there are many similar and a few competing measures. Stakeholders have repeatedly emphasized that multiple measures, particularly if they are not harmonized, are not desired as they cause confusion with providers and in the marketplace.

Related versus Competing Measures

	Same concepts for measure focus—target process, condition, event, outcome	**Different concepts for measure focus—target process, condition, event, outcome**
Same target patient population	**Competing measures—Select best measure** from competing measures or justify endorsement of additional measure(s).	**Related measures—Harmonize** on target patient population or justify differences.
Different target patient population	**Related measures—Combine** into one measure with expanded target patient population or justify why different harmonized measures are needed.	Neither harmonization nor competing measure issue

NQF staff has identified the following measures as related or competing:

ASTHMA

Competing: 0036, 0047, 0620
Related: 0036, 0047, 0620, 1799, 1800, 1876

COPD:

Competing: 0091 and 0577
Related: 0091, 0102, 1825,

PNEUMONIA

Competing: 0231 and 0468; 0148 and0356;0096 and 0147
Related: 0147, 0148, 0231, 0233, 0468, 0506

There are many harmonization issues including age inclusion; inclusion criteria for the population being measured; and medication lists.

Steering Committee evaluation of Competing and Related measures
Due to the large number of related and competing measures, each workgroup should begin to consider these issues. NQF staff has prepared several side-by-side tables for the related and competing measures to facilitate your review. For competing measures, NQF has developed guidance on related and competing measures to assist the Committee in selecting among competing measures:

First, each measure is assessed on the four measure evaluation criteria. If a measure does not meet the criteria and is not suitable for endorsement, the competing measure issue is resolved. If, however, all competing measures meet all four criteria**,** the assessment of competing measures must include weighing the strengths and weaknesses across ALL the criteria and involves more than just comparing ratings. (For example, a decision is not based on just the differences in scientific acceptability of measure properties without weighing the evaluation of importance to measure and report, usability, and feasibility as well.)

Impact, Opportunity, and Evidence—Importance to Measure and Report:
Competing measures generally will be the same in terms of the measure focus addressing a high-impact aspect of healthcare (1a) and evidence for the focus of measurement (1c). However, due to differences in measure construction, they could differ on alignment with national health goals/priorities or opportunity for improvement.

- Compare measures on alignment with national health goals/priorities (1a)
- Compare measures on opportunity for improvement (1b)

Reliability and Validity—Scientific Acceptability of Measure Properties:

- Compare evidence of reliability (2a1-2a2)
- Compare evidence of validity, including threats to validity (2b1-2b6)

Compare and identify differences in specifications:
All else being equal on the criteria and subcriteria, the preference is for:

- Measures specified for the broadest application (target patient population as indicated by the evidence, settings, level of analysis)
- Measures that address disparities in care when appropriate

Usability:

- Compare evidence of use and usefulness for public reporting, including availability of data for reporting performance results
- Compare evidence of use and usefulness for quality improvement

All else being equal on the criteria and subcriteria, the preference is for:

- Measures that are publicly reported
- Measures with the widest use (e.g., settings, numbers of entities reporting performance results)

- Measures that are in use over those without evidence of use

Feasibility:
- Compare the ease of data collection/availability of required data
- Compare the potential for inaccuracies, errors, and unintended consequences

All else being equal on the criteria and subcriteria, the preference is for:
- Measures based on data from electronic sources
- Clinical data from EHRs
- Measures that are freely available

After weighing the strengths and weaknesses across ALL criteria, identify if one measure is clearly superior and provide the rationale based on the NQF criteria.

HARMONIZATION OF RELATED MEASURES

Measure harmonization refers to the standardization of specifications for related measures with the same measure focus (e.g., *influenza immunization* of patients in hospitals or nursing homes); related measures with the same target population (e.g., eye exam and HbA1c for *patients with diabetes*); or definitions applicable to many measures (e.g., age designation for children) so that they are uniform or compatible, unless differences are justified (e.g., dictated by the evidence). The dimensions of harmonization can include numerator, denominator, exclusions, calculation, and data source and collection instructions. The extent of harmonization depends on the relationship of the measures, the evidence for the specific measure focus, and differences in data sources.

To assist the evaluation of measure harmonization NQF staff has prepared side-by-side tables of the related and competing measures (see SharePoint).

Evaluate for harmonization:
Compare specifications: Are the specifications completely harmonized? Specific areas to compare in clued: inclusion criteria (codes, definitions); age ranges; time windows; numerator inclusions (medications, target values, etc); and exclusions.

Are differences in specifications justified?

Sample Considerations to Justify Lack of Measure Harmonization

Related Measures	Lack of Harmonization	Assess Justification for Conceptual Differences	Assess Justification for Technical Differences
Same measure focus (numerator); different target population (denominator)	Inconsistent measure focus (numerator)	The evidence for the measure focus is different for the different target population so that one measure cannot	• Differences in the available data drive differences in the technical specifications for the measure focus. • Effort has been made to reconcile the differences across

		accommodate both target populations. Evidence should always guide measure specifications.	measures but important differences remain.
Same target population (denominator); different measure focus (numerator)	Inconsistent target population (denominator) and/or exclusions	The evidence for the different measure focus necessitates a change in the target population and/or exclusions. Evidence should always guide measure specifications.	• Differences in the available data drive differences in technical specifications for the target population. • Effort has been made to reconcile the differences across measures but important differences remain.
For any related measures	Inconsistent scoring/ computation	The difference does not affect interpretability or burden of data collection. If it does, it adds value that outweighs any concern regarding interpretability or burden of data collection.	The difference does not affect interpretability or burden of data collection. If it does, it adds value that outweighs any concern regarding interpretability or burden of data collection.