



NQF
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NQF Measure Maintenance Process

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NDNQI Conference
January 21-22, 2010

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Objectives

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Participants will be able to:

- Describe the NQF review process for maintenance of endorsed measures
- Explain the criteria for continued endorsement

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National Quality Forum

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- Private, non-profit voluntary consensus standards-setting organization
- Multi-stakeholder membership organization
- Three-part mission to improve the quality of American healthcare
 - setting national priorities and goals for improvement
 - endorsing national consensus standards for measuring and publicly reporting on performance
 - promoting the attainment of national goals through education and outreach programs

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Consensus Development Process



- Five key attributes of a “voluntary consensus standards body” (openness, balance of interest, due process, consensus, appeals)
- Nine Steps
 1. Call for Intent to Submit Candidate Standards
 2. Call for Nominations
 3. Call for Candidate Standards
 4. Candidate Consensus Standard Review
 5. Public and Member Comment
 6. Member Voting
 7. CSAC Decision
 8. Board Ratification
 9. Appeals

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Measure Maintenance



- Annual updates provided by measure steward
- Ad hoc review for evolving evidence/ identified problems with measure
- Routine full reviews
 - Moving to 3-year cycles by topic area
 - Meet evaluation criteria with focus on data from implementation
 - Harmonization with other NQF-endorsed measures
 - Best-in-class
 - Publicly reported

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Maintenance Process



- Notice of project topic with notice of maintenance review and call for new measures
- Stewards submit information demonstrating criteria are met
- Reviewed by Steering Committee (and possibly TAP)
- Steering Committee draft recommendations
 - If competing measures, recommend best-in-class
- Public Comment
- NQF Member Voting
- CSAC Approval
- Board ratification

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Roles



- Steering Committee/TAP evaluate measures
 - TAP/Workgroup focus on evaluating subcriteria – advise SC
 - SC evaluate criteria & make recommendation
- Staff review the submissions & check if conditions met, prepare SC/TAP members for their role, and guide TAP/SC evaluation discussions to focus on using the criteria

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Background - Quality, Quality Measure, Quality Improvement

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Quality

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- Quality of care is an abstract construct
- The Institute of Medicine's definition for quality of care is: "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (1990, p. 21)

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Quality Measure **NQF**
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- Numeric quantification of healthcare quality
- The purpose of quality measurement is to assess the quality of healthcare and ultimately, to facilitate improvement in the quality of healthcare and health

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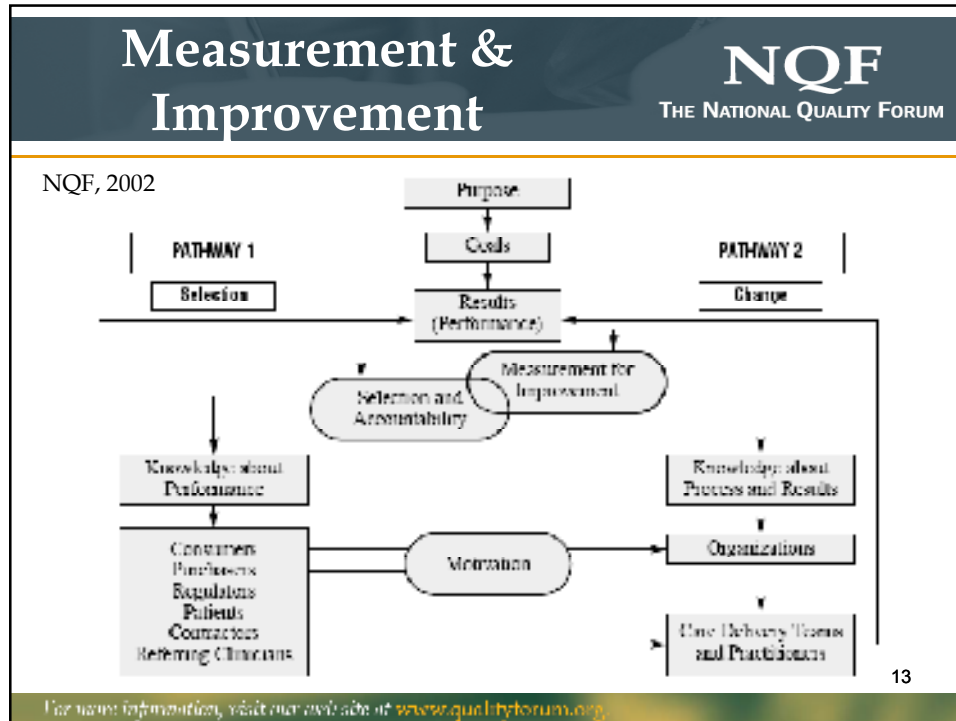
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Measurement Facilitates Improvement **NQF**
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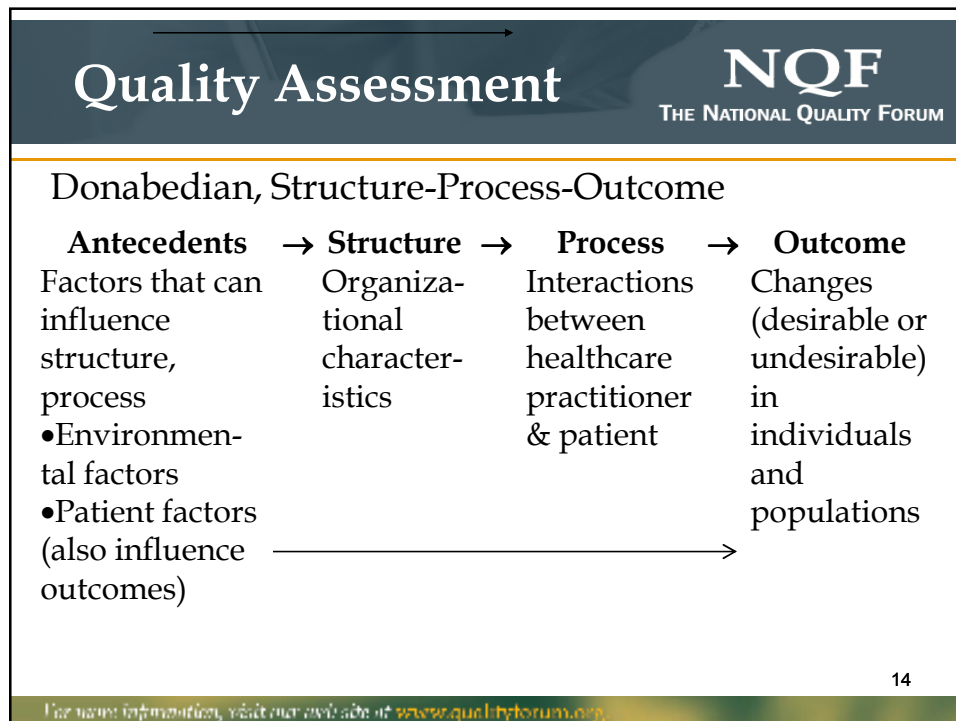
- Measurement is necessary, but insufficient to achieve quality
- Provides information about performance useful for selecting providers with high quality (consumers, purchasers, health plans)
- Provides information about outcomes and processes useful to providers for identifying areas that need improvement and changes in care processes/systems

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Types of Quality Measures

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- Process
- Outcome
- Structure/management
- Access
- Efficiency/cost
- Use of services (used as proxy for outcome, cost)
- Patient experience
- Composite

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Measure Evaluation

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NQF Endorsement Criteria



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- Conditions for consideration
- Importance to measure and report
(must pass criterion)
- Scientific Acceptability of Measure
Properties
- Usability
- Feasibility

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Conditions


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- A. Measure Steward Agreement
 - All non-government organizations
- B. Entity and process to maintain and update the
measure as needed/at least every 3 years
- C. Intended use of the measure includes both
public reporting and quality improvement
- D. Measure submission information complete
 - Generally, measures should be fully developed and
tested so that all the evaluation criteria have been
addressed

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Public Reporting
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Definition: Disclosure of performance results to the public at large

Figure 2. Continuum of Reporting of Performance Results

Internal use of performance information for QI	Reporting of performance information for benchmarking (e.g., registry) & internal QI	Reporting of performance information to private external organizations (e.g., insurers, purchasers)	Reporting of performance information to public agencies acting on behalf of the public (e.g., CMS, states)	Reporting of performance information that is made available to the public at large
Restricted Disclosure		Full disclosure & transparency		

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Evaluation Criteria
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- Four major criteria describe desirable characteristics of measures for endorsement
- Rationale:
 - Important - measure those aspects with greatest potential of driving improvements; if not important, the other criteria don't matter
 - Scientifically acceptable - necessary to make valid conclusions about quality
 - Usable - goal of quality measures is to use for decisions related to selection and QI - need to be valid
 - Feasible - ideally, cause as little burden as possible

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Evaluation Criteria



- Subcriteria delineate how to demonstrate that the criteria are met
 - How do you know a measure is important, scientifically acceptable, etc.?
- Criteria parallel best practices for measure development
 - For example, begin with identifying what is important to measure - before feasibility
- Most criteria/subcriteria involve a matter of degree rather than all-or-nothing determination

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Importance to measure and report



Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance.

- a. High impact
- b. Gap in performance
- c. Evidence supports measure focus

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Evidence



- Strength systematically assessed
- USPSTF grading system
 - [http://www.ahrq.gov/clinic/uspstf07/meth
ods/benefit.htm](http://www.ahrq.gov/clinic/uspstf07/methods/benefit.htm)
 - [http://www.ahrq.gov/clinic/uspstf/grades.
htm](http://www.ahrq.gov/clinic/uspstf/grades.htm)
- Or some other system that is explained

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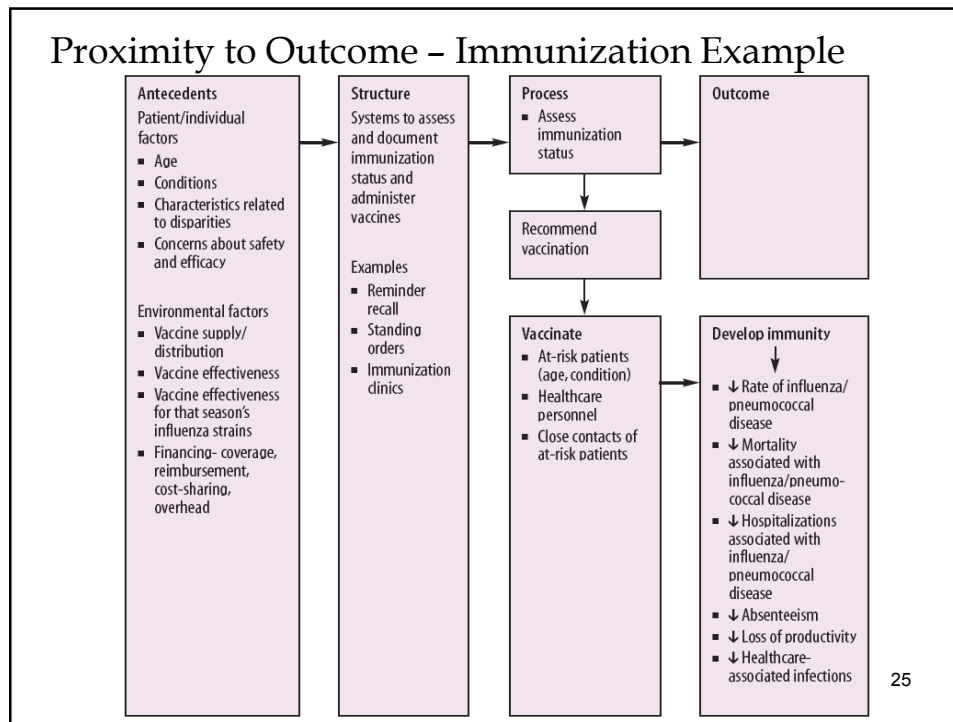
USPSTF Grades for Recommendations



- **A** - The USPSTF recommends the service. High certainty that the net benefit is substantial.
- **B** - The USPSTF recommends the service. High certainty that the net benefit is moderate; or moderate certainty that the net benefit is moderate to substantial.
- **C** - The USPSTF recommends against *routinely* providing the service. At least moderate certainty that the net benefit is small. Offer or provide this service only if other considerations support the offering or providing the service in an individual patient.
- **D** - The USPSTF recommends against the service. Moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.
- **I** - The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

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Scientific acceptability of measure properties

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Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.

- a. Precisely specified
- b. Reliability testing
- c. Validity testing
- d. Exclusions - justified
- e. Risk adjustment - evidence-based, factors at start of care (not related to disparities)
- f. Identification of statistically significant and practically/clinically meaningful differences in performance.
- g. Multiple data sources - comparable results
- h. Disparities - stratification

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Usability

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Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making.

- a. Useful for public reporting and quality improvement
- b. Harmonized
- c. Distinctive or additive value to existing measures

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Feasibility

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Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement.

- a. Clinical data generated during care process
- b. Electronic sources
- c. Exclusions - no additional data source
- d. Susceptibility to inaccuracies/ unintended consequences identified
- e. Data collection strategy can be implemented

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Feasibility

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- Byproduct of care processes during care delivery
 - Generated and used by healthcare personnel in providing care, e.g., blood pressure, lab value, diagnostic test result, medication
 - Not an ICD code generated for billing purposes
- Unintended consequences
 - Outcome measure not risk adjusted so avoid caring for most complex patients
 - Focus on what's being measured to detriment of some other aspect of care
 - Focus on documentation vs. effective interventions

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Best-in-Class

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- Before compare similar measures, must first be determined to sufficiently meet evaluation criteria to be recommended for endorsement
- Goals
 - To endorse the "best" measure for public reporting and quality improvement
 - Patient-focused measures applicable to multiple levels/ settings (3b)
- Potential reasons for similar measures
 - Different settings with different data sources (e.g., hospital-claims, nursing home-MDS) - should be harmonized (3b)
 - Additional measures - distinctive/additive value (3c)

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Common Issues

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Conditions

- D. Measure submission information complete
 - Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed
- Issues
 - Reliance on attachments or URLs
 - Only considered supplemental
 - If used, refer to specific location or page number
 - Use of 'not applicable' (e.g., reliability and validity testing)
 - Only few criteria are not applicable (risk adjustment for process measure)
 - Untested measures (now-only in certain conditions)

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Importance to measure and report



- 1a. High impact
- 1b. Gap in performance
- 1c. Evidence
- Issues
 - Use of general statements or reference to literature without providing specific data (e.g., “the xxx is under-reported”)
 - Confusing evidence of link to desired outcome with scientific acceptability of measure properties

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Scientific acceptability of the measure properties



- 2a. Precisely specified
- Measure Specification Issues
 - Relying on other documents for key definitions – should be in the specification details (e.g., numerator details, denominator details, exclusion details)
 - For outcome measures:
 - the numerator field used for the target outcome and numerator details how that outcome is identified etc.
 - Denominator field used for target population
 - Computation should go under Calculation Algorithm
 - Risk Adjustment Methodology/Variables – specifications here, NOT risk model testing (2e)

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Scientific acceptability of the measure properties



- 2a. Measure Specification Issues
 - Time Window
 - Numerator - period when the numerator event may occur (e.g., up to 30 days form hospital discharge)
 - Denominator - period of time to gather cases (e.g., all admissions in a calendar year)
 - Setting, Level of Analysis, Data Source
 - Checking more options than how the measure is specified and tested (e.g., checking electronic health record, but not specified or tested for electronic health record)

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Scientific acceptability of the measure properties



- 2b. Reliability testing
- 2c. Validity testing
- Issues
 - Thinking these measure properties do not apply to all measures
 - Confusing data analysis and descriptive statistics for reliability or validity testing
 - No systematic assessment of face validity (e.g., "a committee said it was valid")

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Scientific acceptability of the measure properties

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- 2f. Identification of statistically significant and practically/clinically meaningful differences in performance.
 - Methods and scores from testing or current use
- Issues
 - Do not understand that the differences in performance refer to how one identifies that different scores are meaningful
 - Do not provide actual measure scores (if tested or in use, should be able to compute scores)
- 2g. Multiple data sources – comparable results
- Issues
 - Measure specified for multiple data sources but no analysis of whether results are comparable

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Usability & Feasibility


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- 3a. Useful for public reporting and quality improvement
- Issues
 - Even if no formal testing, submitter does not try to address why it would be useful
- 4d. Susceptibility to inaccuracies identified
- 4e. Data collection strategy can be implemented
- Issues
 - Often not addressed

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Questions




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Reference Materials



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- Submitting Standards
 - http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx
- Measure evaluation criteria
 - http://www.qualityforum.org/docs/measure_evaluation_criteria.aspx
- Print view of online submission form
 - <http://www.qualityforum.org/uploadedFiles/Blank%20Measure%20Submission%20Form%20Print%20View.pdf>
- User guide for online submission form
 - http://www.qualityforum.org/Docs/Measure_Submission_Form_User_Guide.aspx

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