What makes a measure meaningful?

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Quality Measurement in Evolution

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- Drive toward higher performance
- Shift toward composite measures
- Measure disparities in all we do
- Harmonize measures across sites and providers
- Promote shared accountability & measurement across patient-focused episodes of care:
  - Outcome measures
  - Appropriateness measures
  - Cost/resource use measures coupled with quality measures

Growth of NQF Endorsed Measures

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- **Expanded set of measures with several drivers:**
  - Measures needed for pay-for-performance programs
  - Measures that address important gaps:
    - Measures at the individual physician level
    - Disparities-sensitive measures
    - Measures of patient experience in multiple settings
    - Cross-cutting areas (e.g., medication management, healthcare associated infections)
- **Key issues for NQF portfolio**:
  - Too many, too few, right measures?
  - Availability of data sources
  - Transition to EHRs

Updated NQF Evaluation Criteria

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- **Importance to measure and report**
  - What is the level of evidence for the measures?
  - Is there an opportunity for improvement?
  - Relation to a priority area or high impact area of care?
- **Scientific acceptability of the measurement properties**
  - What is the reliability and validity of the measure?
- **Usability**
  - Can the intended audiences understand and use the results for decision-making?
- **Feasibility**
  - Can the measure be implemented without undue burden, capture with electronic data/EHRs?

NQF Measure Evaluation Criteria

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Old criteria	Updated criteria
Importance	Importance to measure and report **(must pass criterion)**
Scientific acceptability	Scientific acceptability of measure properties
Feasibility	Feasibility **(greater emphasis on Health IT)**
Usability	Usability

Importance to Measure and Report

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- The specific focus of what is measured should be considered important enough to expend resources for measurement and reporting, not only that it is related to an important broad topic area.
- In the modified criteria, these concepts are addressed in separate sub-criteria for
  - Relation to an NQF priority or high impact aspect of healthcare
  - Evidence to support the measure focus
  - Opportunity for improvement

Bending the Curve Towards Transformed Health

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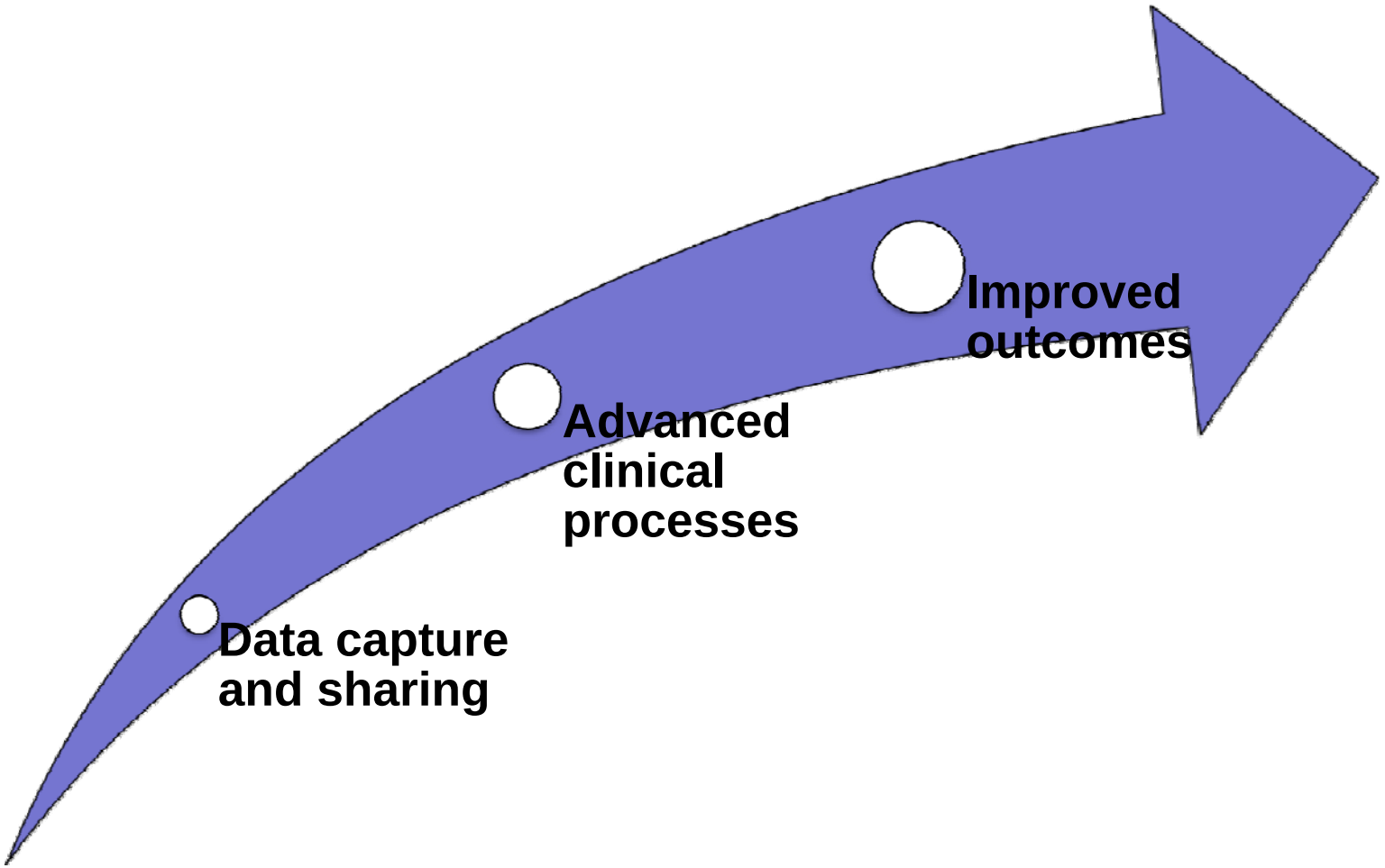

Evidence to support measure focus

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- Intermediate outcome – evidence that the intermediate outcome (e.g., BP) leads to improved health/avoidance of harm, cost/benefit.
- Process – evidence that the clinical or administrative process leads to improved health/avoidance of harm; process step with the greatest effect on improving the desired outcome(s).
- Structure – evidence that the structure supports the consistent delivery of effective processes or access that lead to improved health/avoidance of harm or cost/benefit.
- Efficiency– demonstration of an association between the measured resource use and level of performance with respect to one or more of the other five IOM aims

Role of Clinical Guidelines

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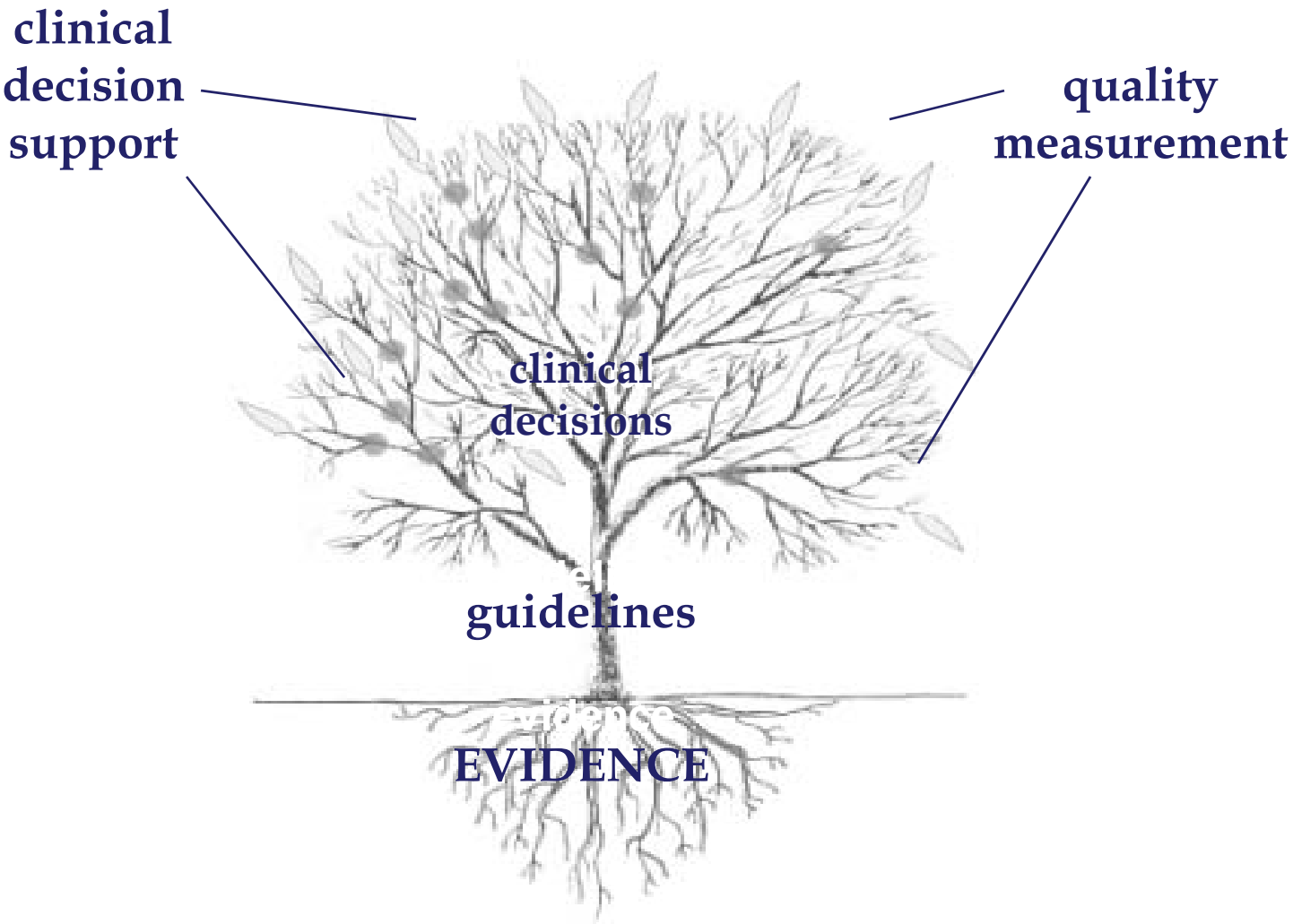
- Clinical guidelines are not developed with quality measurement and clinical decision support in mind:
  - Lack of specificity (e.g., periodicity of testing)
  - Lack of precise definitions (e.g., "high risk")
  - Use of imprecise "action" terms (e.g., "may consider")
- Tendency to focus on the "measurable" branch points from guidelines
- Need to develop standards for computable clinical guidelines

Current State: Shared Evidence



Scientific Acceptability of Measure Properties

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- The label clearly indicates this criterion applies to measure properties:
  - Precise specifications
  - Reliability, validity, and discrimination (testing is expected to demonstrate reliability and validity)
  - Demonstration of comparability if more than one data source/method is allowed
  - Specifications should allow for identification of disparities.
  - Risk-adjustment
  - Exclusions

Exclusions

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- Exclusions increase complexity and measurement burden, limit the use of electronic sources, and often create a barrier to measure harmonization.
  - Evaluation criteria requires that evidence is presented to demonstrate that measure results would be distorted without the specified exclusions.
  - If patient preference is a consideration in numerator or denominator exclusions, the measure should be specified so that the effect of patient preference on the measure is transparent
  - Exclusions should not require additional data sources beyond what is required for scoring the measure (e.g., numerator and denominator) unless justified as supporting measure validity.

Usability

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- Requires evidence that the measure results are meaningful and understandable to intended audiences and useful for both public reporting and informing quality improvement.
  - This is consistent with NQF policy of not endorsing measures solely for quality improvement.
  - New criteria require that measures are harmonized and provide a distinctive or additive value to existing endorsed measures (tough to implement).

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.
  - Required data are routinely generated concurrent with and as a byproduct of care delivery.
  - The required data elements are available in electronic sources OR credible, near-term path to electronic collection by most providers and data elements are specified for transition to EHRs
- Consider cost associated with proprietary systems

Shared Data Elements: "Sweet Spot"

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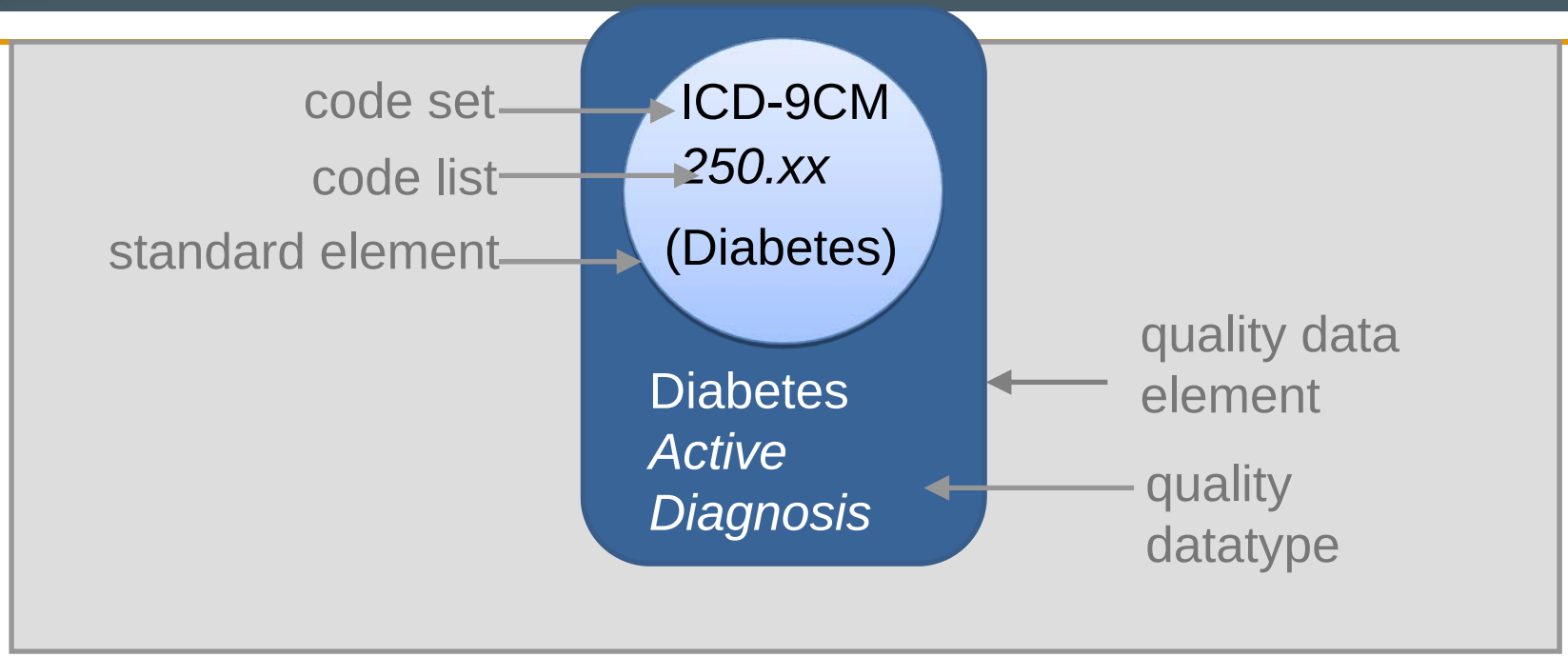
QDS: Framework



Standard element (including code set and code list) as part of the quality data element (rounded rectangle). The standard element (light blue circle) has a *code set* and specific *code list* and is part of the quality data element. The color of the circle indicates the standard category, in this example diagnosis.

Considerations for MU measures

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1. Is the measure related to a national priority or high impact condition?
2. Does the measure reflect leverage of an essential HIT function?
3. Does the measure reflect a more credible representation of quality based on clinical data?
4. Does the measure reflect the use of innovative, patient-centered data sources?
5. Is the measure sensitive to effective coordination of care or data sharing across sites and providers?

Achieving Meaningful Use

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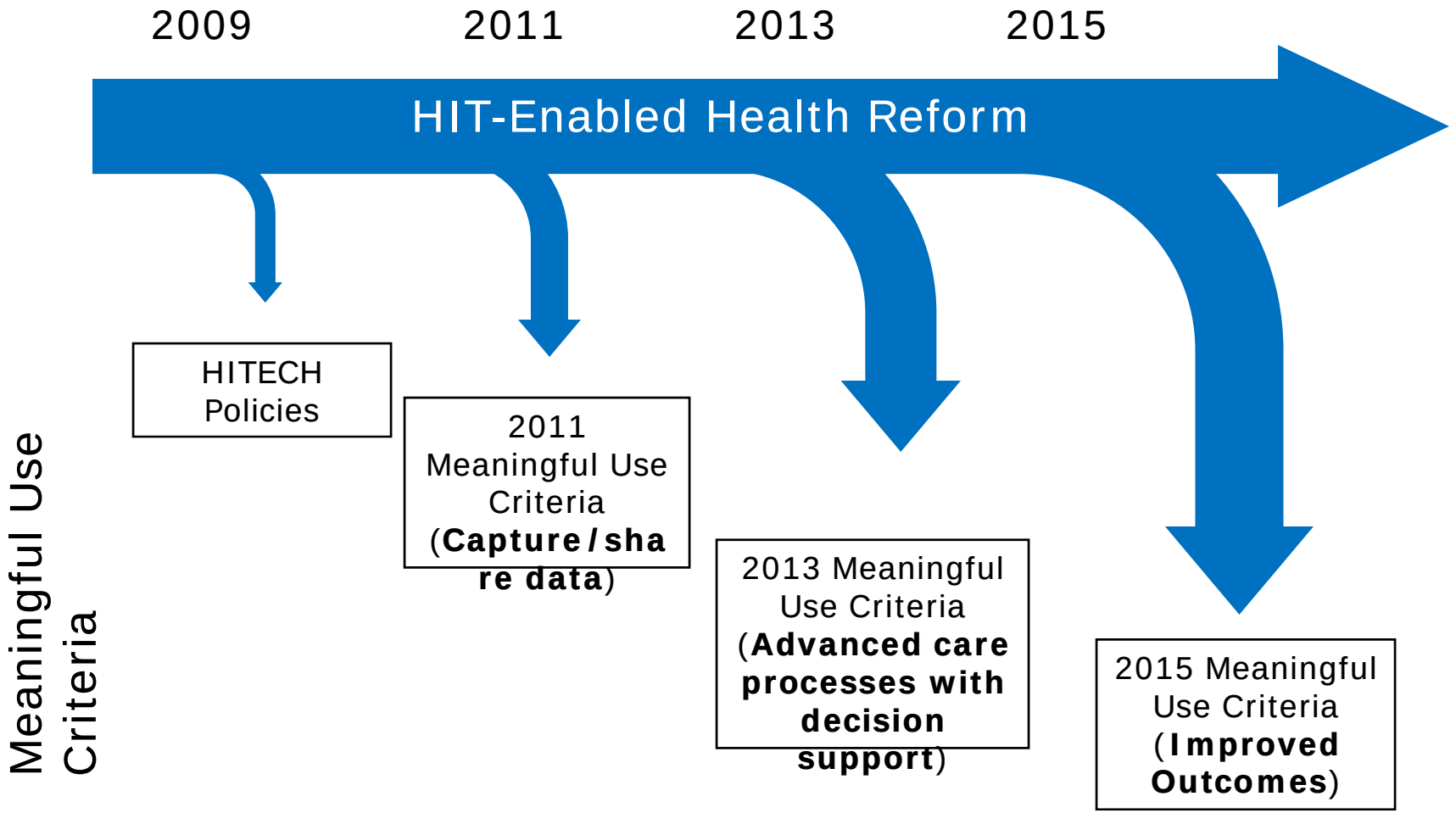

National Priorities & Goals

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- **Ensure patients receive well-coordinated care across all providers, settings, and levels of care**
  - Medication reconciliation
  - Preventable hospital readmissions
  - Preventable ED visits
- **Improve the health of the population**
  - Preventive services
  - Healthy lifestyle behaviors
  - Population health index
- **Improve the safety and reliability of America's health care system**
  - Hospital-level mortality rates
  - Serious adverse events
  - Healthcare associated infections

National Priorities & Goals

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- **Engage patients and families in managing health and making decisions about care**
  - Informed decision-making
  - Patient experience of care
  - Patient self-management
- **Guarantee appropriate and compassionate care for patients with life-limiting illnesses**
  - Relief of physical symptoms; meet psychosocial and spiritual needs
  - Communication regarding treatment options and prognosis
  - Access to palliative care & hospice services
- **Eliminate waste while ensuring the delivery of appropriate care**

Comprehensive Data Needed to Generate Performance Information

Pharmacies

Laboratories

Data Integration

Quality Improvement

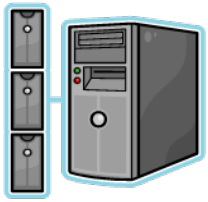
Care Evaluation

Patients

Consumer Activation

Pay for Performance

Data Aggregation



Medical Claims

EHRs

Registries

Hospitals/ Institutions

Comments/Questions

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