NATIONAL
QUALITY FORUM

NQF'S PORTFOLIO OF MEASURES:

WHO IS USING IT, AND HOW IS IT EVOLVING?

JANUARY 2012

SUMMARY

The National Quality Forum's (NQF's) portfolio of measures has grown over the past decade, and particularly in the past couple of years as public and private payers have embraced the notion of using standardized performance measures to drive a value-based agenda. It now addresses many more settings of care, conditions, and types of providers and has expanded beyond clinical measures to include patient experience and cost/resource use measures.

This report provides a high-level overview of what kinds of stakeholders are using the portfolio and for what purposes, based on the best information available to us at this time. It also examines how recent enhancements to the endorsement process that put in place a systematic way for the measures to be culled are resulting in a more targeted portfolio that:

- is outcome focused;
- eliminates duplicative measures and measures that no longer provide meaningful comparisons; and
- focuses on best-in-class metrics.

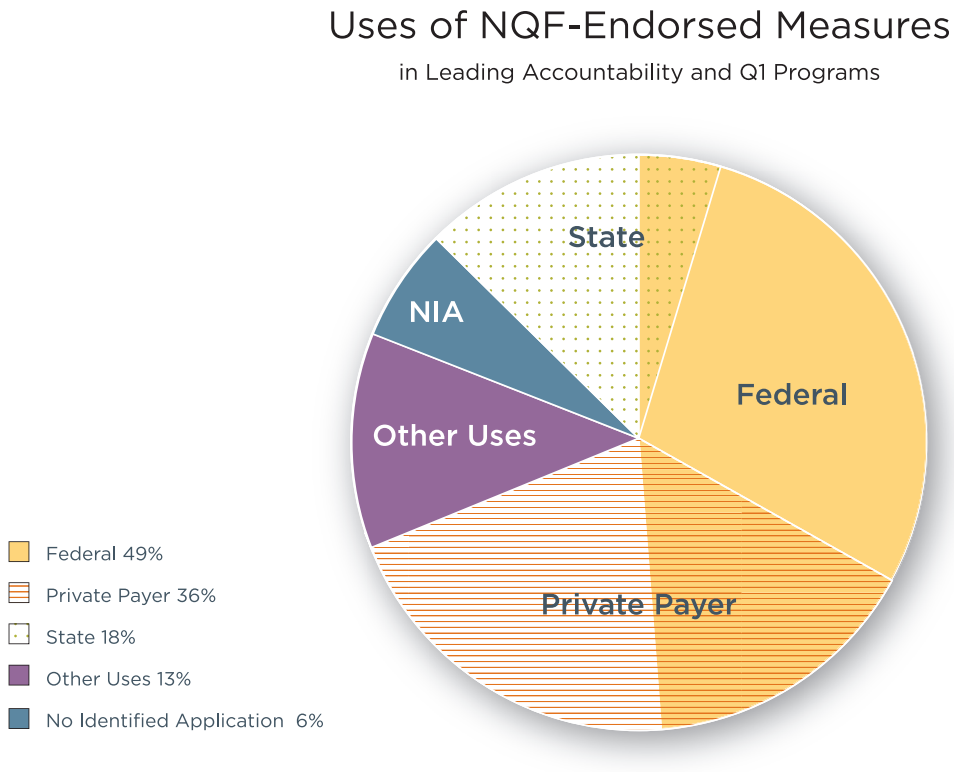
Finally, this report examines how the portfolio is evolving to provide information about our nation's progress against the National Quality Strategy's (NQS's) priorities and anticipating the future by bringing in advanced measures.

While NQF and its Board's efforts to continuously cull the portfolio are commendable, there does need to be an acknowledgement that forces are moving the portfolio toward greater expansion. These include the reality that, in the short term, the portfolio needs to address paper records, administrative data, and electronic health record platforms simultaneously; that with more types of clinicians participating, there is pressure to develop measures for an array of specialties and professions; and finally, that filling measure gaps and bringing advanced measures online, while the right thing to do, adds to the portfolio breadth and depth. Managing these polarities while phasing out measures that are no longer "value add" is a key strategic priority for the organization moving forward.

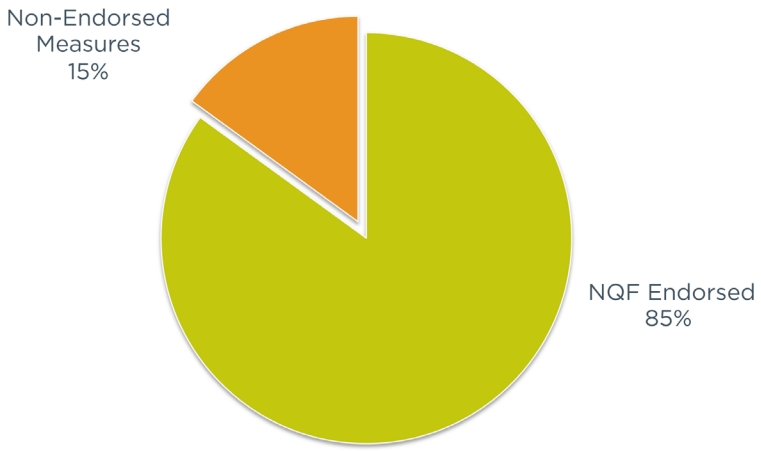
NQF'S PORTFOLIO: ITS USE, EVOLUTION, AND FUTURE

Nearly All of the NQF Portfolio is Being Used, with Some Variation Across Sectors

Both the private and public sectors are heavy users of the more than 700 measures in the NQF portfolio, including the federal government, health plans, hospitals, physicians and other clinicians, state government, and other entities. The following pie chart depicts a rough estimate of the current use of the portfolio based on use by the federal government in its role as a public payer; private payers (health plans and employer-led efforts); and states. Overlap in the use of NQF-endorsed measures—or alignment—is represented by the crosshatched areas. Beyond these stakeholders, measures in the NQF portfolio are used by accrediting and certifying bodies, national registries, health systems, national collaboratives, and others.



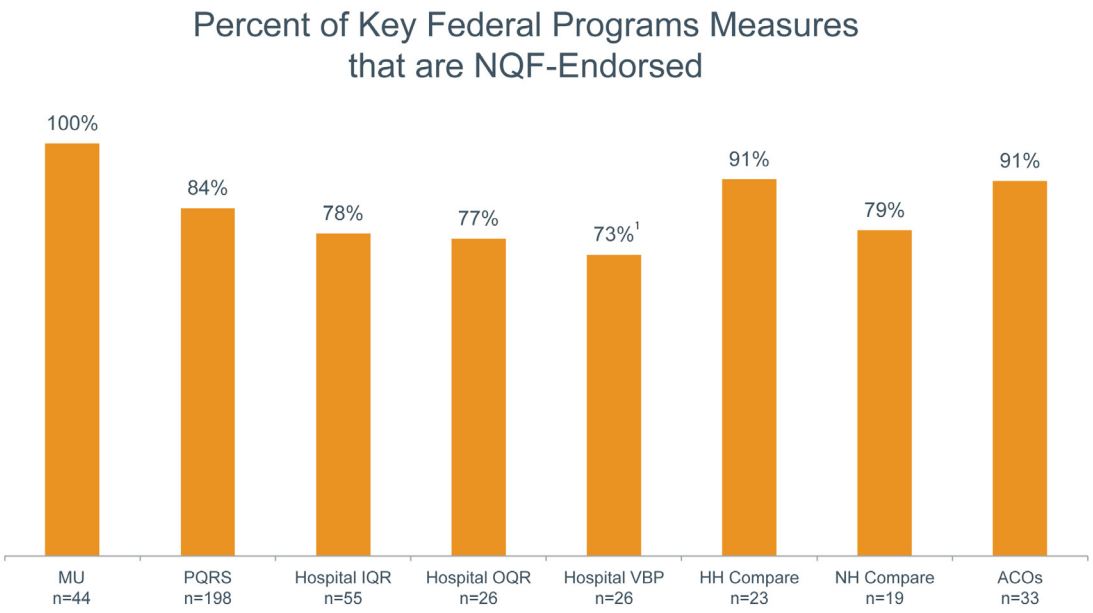
Proportion of Measures Used in Key Federal Programs that are Endorsed as of November 2011



Key federal programs include: Meaningful Use, Physician Quality Reporting System, Hospital Inpatient/Outpatient/Value-Based Purchasing, Home Health Compare, and Nursing Home Compare. Overlapping measures across programs were counted once.

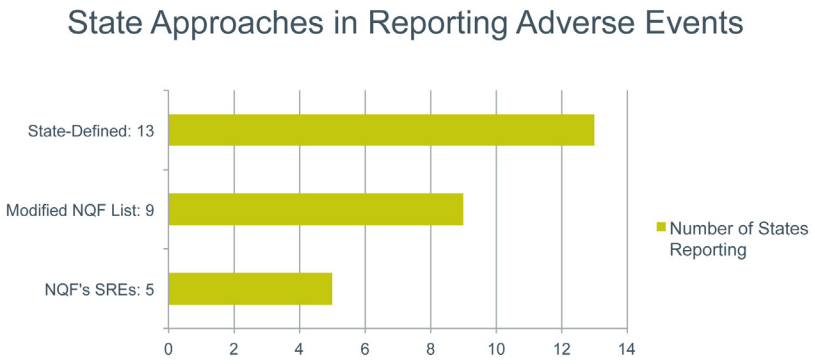
Overall use of NQF-endorsed measures by the Federal government is particularly high—approximately 85% of measures used in key Federal programs are NQF-endorsed. Yet the proportion of NQF-endorsed measures in use by these various programs does differ and sometimes there are shifts in program strategy. For example, the Physician Fee Schedule final rule for 2012, which is not reflected in this analysis, includes a tripling of non endorsed measures—from 24 to 64, in large part because CMS is moving quickly to expand its set of measures to be applicable to a very broad set of specialty and subspecialty areas. Some of these non-endorsed measures have yet to be tested while others are measures that have been used in registries and specialty certifying board programs but never submitted to NQF. NQF will work to quickly bring these measures into existing and expedited projects.

NQF-endorsed measures are used at the state level, in part due to federal programs that encourage standardized reporting, such as the Agency for Healthcare Research and Quality's (AHRQ's) Health Care Utilization Project (HCUP), Centers for Disease Control and Prevention (CDC) measures and surveys, the Children's Health Insurance Program Reauthorization Act (CHIPRA), and the core measures proposed for the adult Medicaid program. For example, 81 percent of the CHIPRA measures are NQF endorsed. There also are additional examples of NQF-endorsed measures being used in individual states.

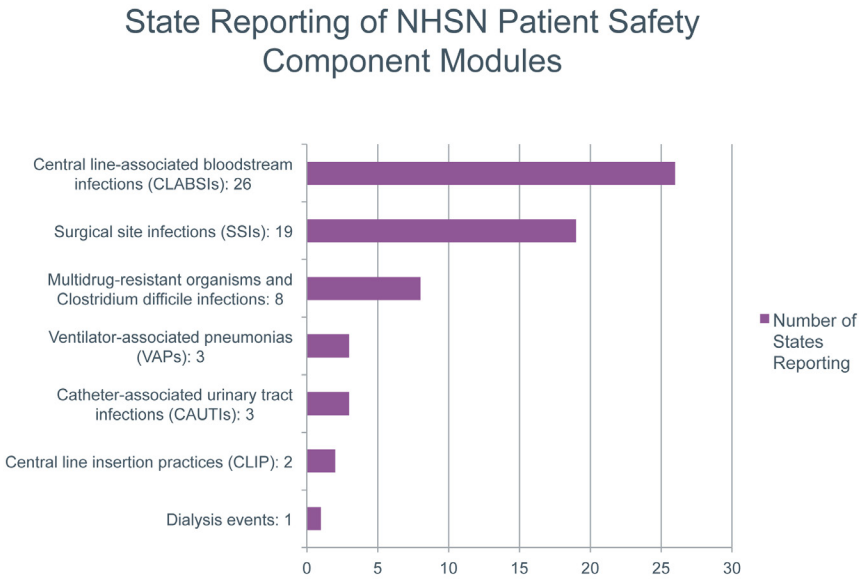


1 The percent of NQF- endorsed measures for hospitals is lower due to the inclusion of seven measures developed by HHS based on healthcare- associated conditions (HACS).

In addition, in the safety realm more than half of states have mandated public reporting of key NQF-endorsed patient safety measures, ranging from 26 reporting central line-associated bloodstream infection measures (CLABSI) to one state reporting a newly endorsed dialysis safety measure. More than half of the states are also publicly reporting Serious Reportable Events (SREs), with about half using NQF or NQF-like definitions.



Almost all of the remaining measures in the NQF portfolio—with the exception of 40 measures—are being used in a variety of national, state, or local initiatives.



This includes use in local or national health systems, national collaboratives (e.g., Institute for Healthcare Improvement, ambulatory surgical care), and national registries (e.g., Society for Thoracic Surgeons, American College of Cardiology, National Surgical Quality Improvement Program). Some recently endorsed measures were developed and are being used by health systems; NQF endorsement offers the potential for them to spread nationally.

With respect to use of NQF-endorsed measures in local communities, a recent survey of 72 public reporting programs conducted by Mathematica Policy Research (MPR) provides some insight about leading-edge communities. Looking in more detail at 14 communities participating in the Robert Wood Johnson Foundation's Aligning Forces for Quality program, it seems that about 25 percent of the measures they are using are NQF endorsed. These measures cross eight key domains, with the largest number of communities using NQF-endorsed care coordination, safety, and patient and family engagement measures. Clearly much work still remains with respect to communities and their embrace of NQF-endorsed measures; NQF's community tool to align measurement is in development; and NQF's Quality Positioning System (QPS) may help to speed such adoption.

How NQF-endorsed measures are used depends on setting and may change over time. To get more systematic information about how NQF-endorsed measures are being used currently, NQF commissioned RAND Health to conduct interviews and

online research across approximately 75 varied stakeholder groups. RAND found that nearly all of these organizations used NQF-endorsed measures, although the extent of use varied dramatically. The most common uses were quality improvement, followed closely by public reporting.

NQF's portfolio also continues to evolve as the organization phases out measures that "top out" with respect to performance, have become outdated because the underlying science has changed, or are no longer considered best in class. That said, NQF also is adding to the portfolio for justifiable reasons: to better address the full range of clinical specialties and respond to acknowledged measurement gaps, such as the meager number of cost/resource use, patient-reported outcomes, and care coordination measures, to name a few gap areas.

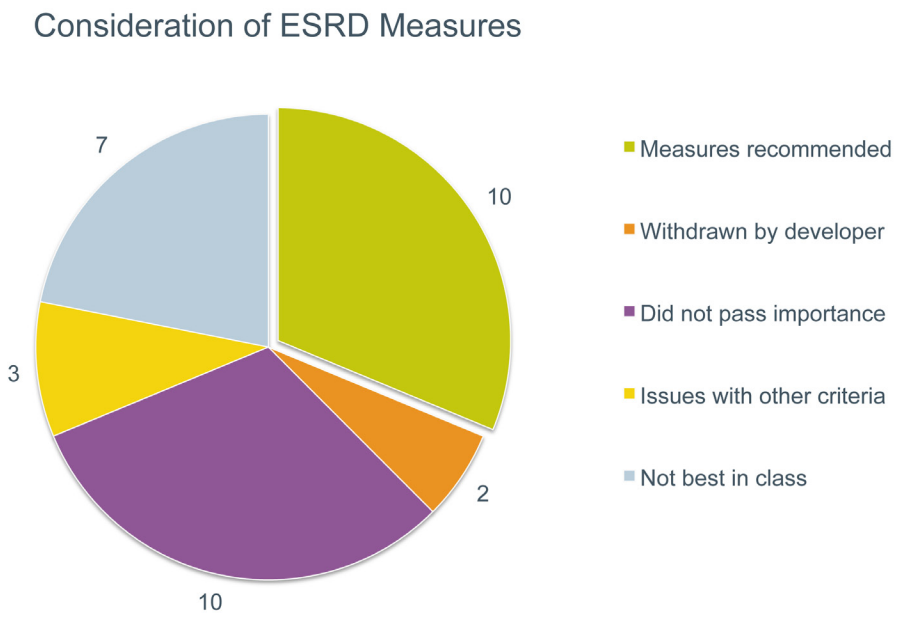
NQF is making progress toward its long-term goal of a targeted and culled portfolio of measures to drive performance improvement

Measure development is increasing exponentially, in response to both the proliferation of public reporting and value-based purchasing programs in the private sector and similar programs coming online in the public sector as a result of the Affordable Care Act. Existing and new approaches that are part and parcel of NQF's endorsement process serve to cull this ever-expanding universe of measures so as to provide public and private purchasers a targeted portfolio of measures to use in public reporting, incentive-based payment programs, and quality improvement.

NQF's approach to producing a targeted portfolio includes three strategies:

- evaluating new measures as part of endorsement and identifying those that are both best in class and respond to identified measure gaps;
- harmonizing and combining similar measures to enhance comparability and reduce redundant data collection; and
- reviewing existing measures in a process known as maintenance, which now is integrated into each project's endorsement process.

The past year has been particularly productive on the measures endorsement front. From October 2010 to September 2011, 495 measures were submitted to NQF for endorsement, and about 51 percent—or 252—were endorsed. The most typical reason for project steering committees to recommend against endorsement is the measures' failure to meet the importance criteria. By way of example, the chart at right illustrates the End Stage Renal Disease (ESRD) measure review process, which concluded in July 2011 and in which 32 measures were submitted but only 10 were endorsed.



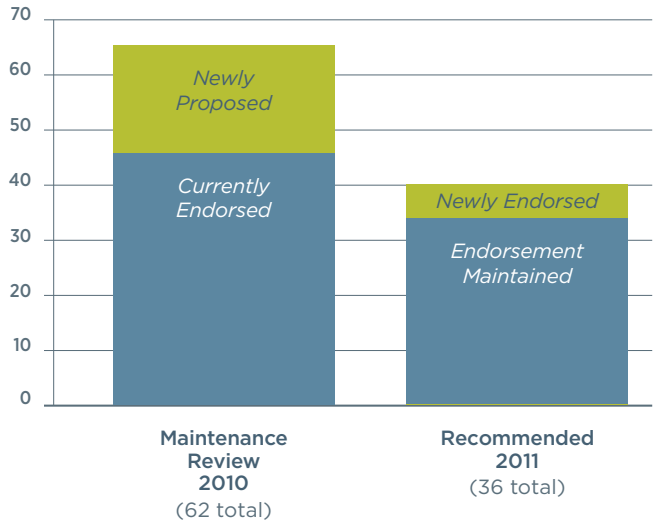
When there are similar measures, NQF pursues "harmonization," which can be time intensive but provides clear benefit for patients, payers, and others. Months may be added to an endorsement project to allow developers the necessary time to harmonize measures, which may be complicated by the fact that their measures have been in use for years. With wider-spread use of the QPS, the hope is that in the future measure developers will know more about the existing NQF portfolio and will not develop similar measures or, alternatively, will bring a measure they think is better forward for review.

The surgical site infection (SSI) measures are a case in point. As part of NQF's Patient Safety project, two similar and competing measures from the CDC and the American College of Surgeons (ACS) were reviewed; the CDC measure has been in use since 2005 and the ACS measure since before 2004. As a result of NQF Member and public comments and requests by the Steering Committee, the developers worked with NQF support to combine two competing measures into one. This measure now is applicable to and comparable across surgeons and hospitals, thereby eliminating the confusion that had existed over reporting of similar but not comparable measures. Stewardship of the SSI measure going forward will be jointly maintained by CDC and ACS—a public-private collaboration to be celebrated.

The third strategy for producing a targeted and culled portfolio is measure maintenance as a part of the endorsement process—a policy that the Board adopted in May 2010. The Cardiovascular project was the first project that incorporated maintenance and review of new measures into a single project.

The chart below illustrates the Committee's recommendations for culling the existing and proposed cardiovascular measures in this project. Using the measure evaluation criteria and guidance on evaluating related and competing measures, the Committee reviewed proposed new measures and those undergoing maintenance with the intent of focusing on measures that address the broadest patient population or settings, while avoiding duplication whenever possible. Based on this rigorous vetting, 36 out of 62 measures (7 new and 29 undergoing maintenance) were recommended by the committee and ratified by the Board. When all is said and done, between 2010 and 2011 this represents approximately 20 percent fewer NQF-endorsed cardiovascular measures in this project.

Consideration of Cardiovascular Measures



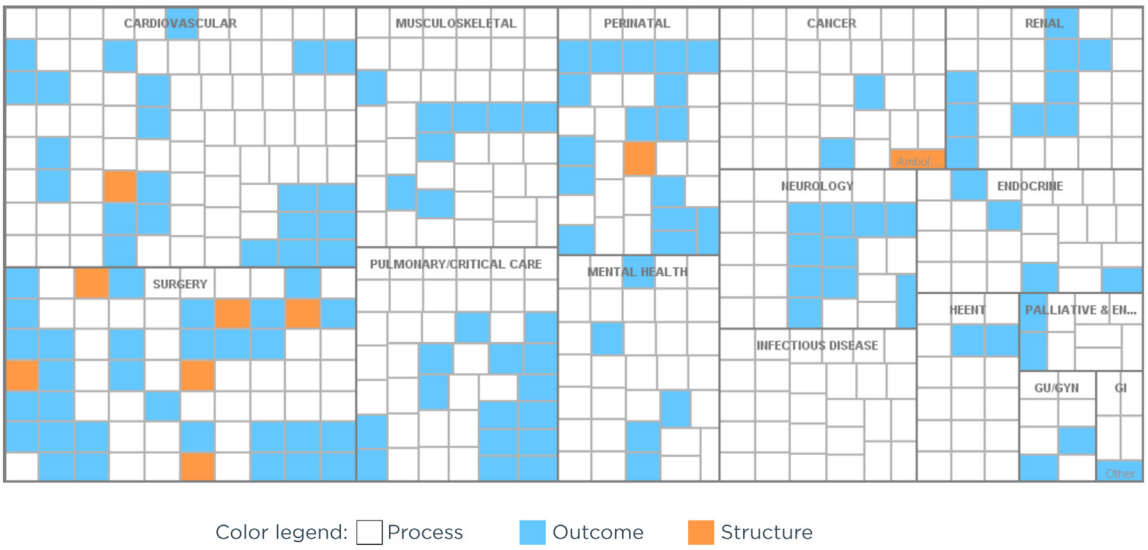
NQF's Measure Portfolio Is Evolving to Better Meet the Needs of End Users

Over the past decade or more, the quality field has focused much attention on clinical process measures. More recently, NQF has been endorsing many more outcome measures, such as those addressing mortality following an acute myocardial infarction or complication rates following elective total hip or knee surgery. Ultimately, these are what matter most to patients and purchasers. That said, process measures closely linked to outcomes provide information clinicians, hospitals, and other providers can use to identify what they need to improve to enhance outcomes.

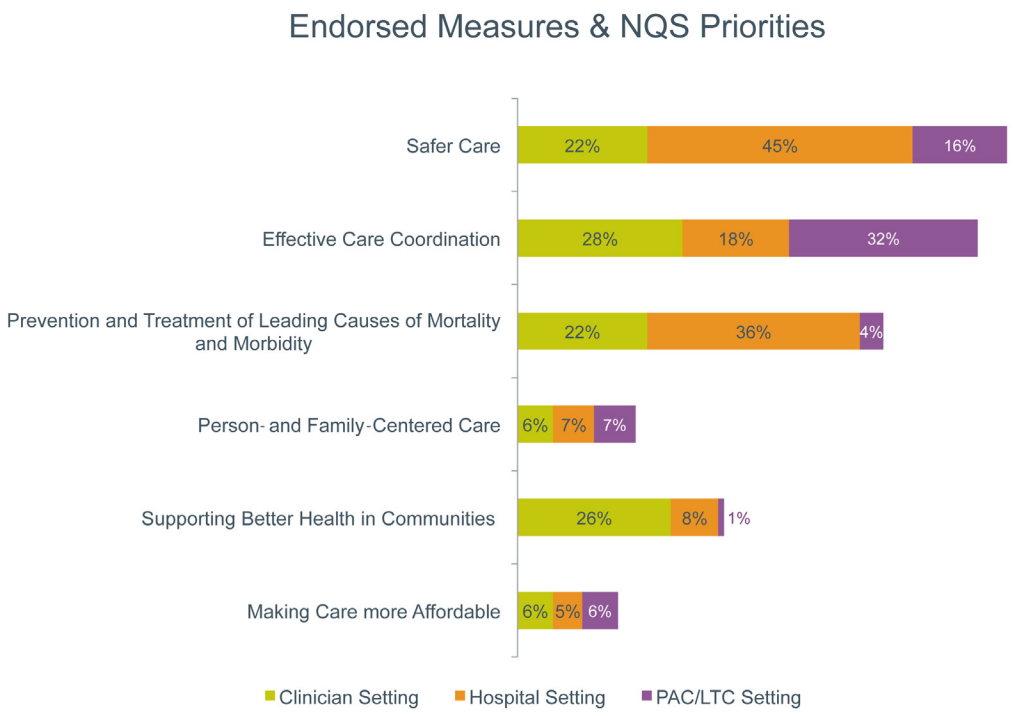
Currently, NQF's portfolio is approximately one-third outcome measures, and the focus is on endorsing more such measures—particularly in clinical areas where process measures remain dominant. There also are a small number of structural measures (e.g., nurse staffing, health IT). Most outcome measures are clinical outcomes (e.g., hemoglobin A1C within normal range), but there also are patient experience of care (e.g., Consumer Assessment of Healthcare Providers and Systems, or CAHPS), and readmission, complication, and mortality measures. There are some patient-reported outcome measures, such as ability to perform activities of daily living; but these are primarily applicable to post-acute care settings. The Department of Health and Human Services (HHS) and other stakeholders are keenly interested in patient-reported outcome measures, especially health functioning, but very few such measures suitable for accountability purposes have been developed and tested. This is an emerging area of measurement where measure development and testing lags behind what end users are seeking.

There also is considerable variation in the proportion of outcome, process, and structural measures across conditions. For example, there are more outcome measures for surgery and perinatal care than there are for mental health and cancer care.

Condition measures by type



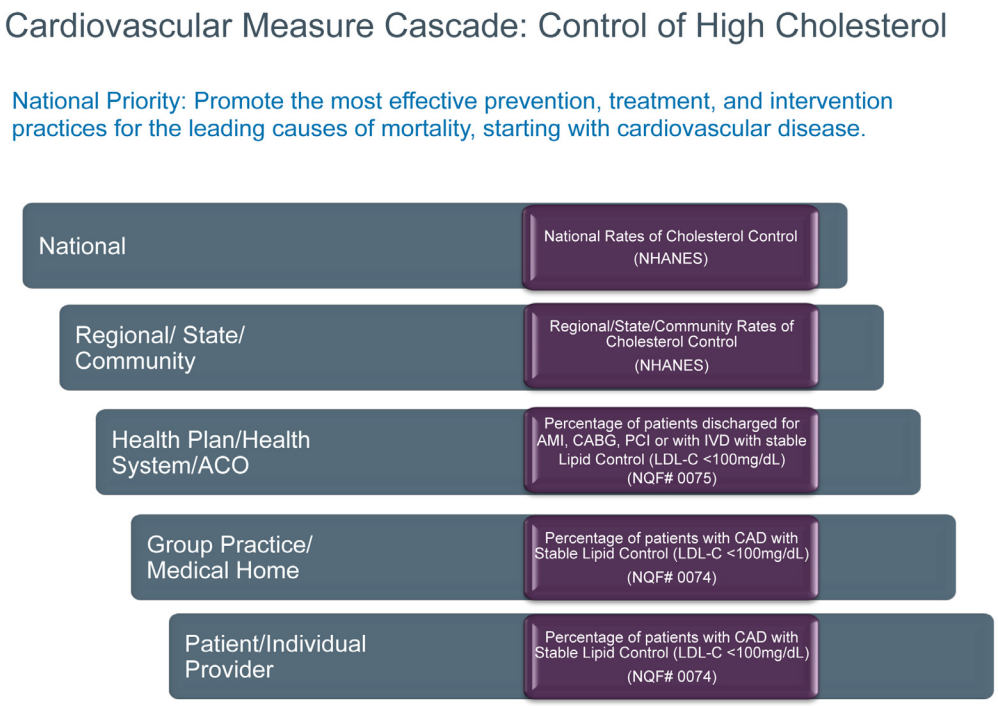
In addition to helping the NQF portfolio evolve to have a larger proportion of outcome measures, there has been a focus at NQF on how well the measures within the portfolio address key priorities such as improving care for the top 20 most prevalent Medicare and children's conditions, or more recently the broader NQS. The chart at right examines three key areas—clinician, hospital, and PAC/LTC—and related federal programs' use of NQF-endorsed measures against the six NQS priorities. The chart provides a very rough gauge of where NQF has measures and where it does not in federal programs—namely person- and family-centered care, population health, and measures related to affordability. The NQF portfolio also is less developed in these areas.



In addition to mapping the NQF portfolio against these priorities, NQF's role as the convener of both the National Priorities Partnership (NPP) and the Measure Applications Partnership (MAP) has provided a systematic way to collect public-private input about where key measure gaps exist and, more importantly, which of those measure developers and NQF's endorsement process should address. A very clear priority is endorsing measures that provide information about cost and resource use so that public payers (federal, state, and local government entities) and private payers have information needed to advance value-based purchasing strategies. Another clear need is for measures that directly address ways to reduce unsafe and costly care, such as unnecessary readmissions, appropriateness of radiologic services, or coordination of care across settings, where many known errors occur. NQF has initiated endorsement projects focused on all of these areas or is poised to start such projects in the next year.

As we look to the future, MAP hopes to encourage cascading sets of harmonized measures on a particular topic (e.g., cardiovascular disease) applicable to all levels of the system, allowing for more efficient measurement and the ability to "roll up"

measures and conversely to cascade into more granular details. Control of high cholesterol is an example of a cascading measure group that could be reported at the national, state/region/community, health plan/health system/ACO, group practice/PCMH, or patient/individual provider level. Using common data elements will help to reduce redundant data collection for providers. In addition, measures that target multiple parts of the system, simultaneously driving improvements in care toward a common goal, hold out the promise of accelerating improvement more quickly than our current approaches, which tend to focus on isolated parts of the system and sometimes result in contradictory efforts.



CONCLUSION

As this report has demonstrated, NQF's growing measures portfolio appears to be in very widespread use, with the federal government a major driver both in its own programs and as a result of its recommended measure sets for use by states. In addition, private payers and other organizations seem to be heavy users of NQF-endorsed measures, and alignment between the public and private sectors is quite strong. NQF also has put in place strategies to continue culling this portfolio, including raising the bar that measures must meet to maintain NQF endorsement and continuing emphasis on measure harmonization. These strategies, which are bearing fruit, do need, however, to be seen in light of justifiable reasons for expanding the portfolio—namely, filling measure gaps (e.g., care coordination), broader coverage of clinical specialty areas, measures applicable to certain types of providers (e.g., dental, physical therapists), and emerging areas of measurement enabled by health IT (e.g., patient-reported outcomes captured through personal health records, kiosks). Finally, the measures portfolio continues to evolve to align better with the National Quality Strategy.

Moving forward, NQF has identified three ways to get a better handle on both use and usefulness of measures to end users, acknowledging that this process is complex and will take time. Specifically, NQF is proposing that measure stewards submit information on measure use at the time of measure maintenance; the QPS enables end users to share information about their use of measures and provide feedback on measures; and NQF anticipates gathering more detailed information on use of measures in accountability programs and the perceptions of users about whether the measures were useful in driving improvement. Measures matter, but only to the extent that they prove to be useful tools to stakeholders engaged in accountability or improvement efforts aimed at driving our system toward better health, better care, and lower costs.

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