Measuring and Assessing the Quality of Health Care

NATIONAL QUALITY FORUM

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NQF: Who We Are

- NQF includes more than 400 members from every part of the healthcare system.
- Our board has a majority of consumer and purchaser representatives.
- NQF Councils:
  - Consumer
  - Health Professionals
  - Health Plans
  - Public/Community Health Agencies
  - Supplier/Industry
  - Purchaser
  - Provider: Hospitals, Long-Term Care and Community Organizations
  - Quality Measurement, Research, and Improvement

NQF: What We Do

- NQF is an essential forum for catalyzing improvement in healthcare:
  - We convene groups that work to foster quality improvement in both public- and private-sectors.
  - We endorse consensus standards for performance measurement.
  - We ensure that consistent, high-quality performance information is publicly available.
  - We seek real time feedback on measure use to ensure that measures are meaningful and accurate.

Why do standardized (endorsed) measures matter?

Standardized measures:

- Help providers know how they are doing because they can benchmark and compare
- Allow payers to purchase on the basis of value, not volume
- Guide patients looking for good medical care and alert them to safety issues
- Reduce the burden associated with use of near identical measures and facilitate alignment

A Look Back:
A young, but rapidly growing movement

EARLY 1990S

Healthcare Effectiveness Data and Information Set (HEDIS)

1998

Report from President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

1999

Institute of Medicine publishes *To Err is Human*

NQF launches in September

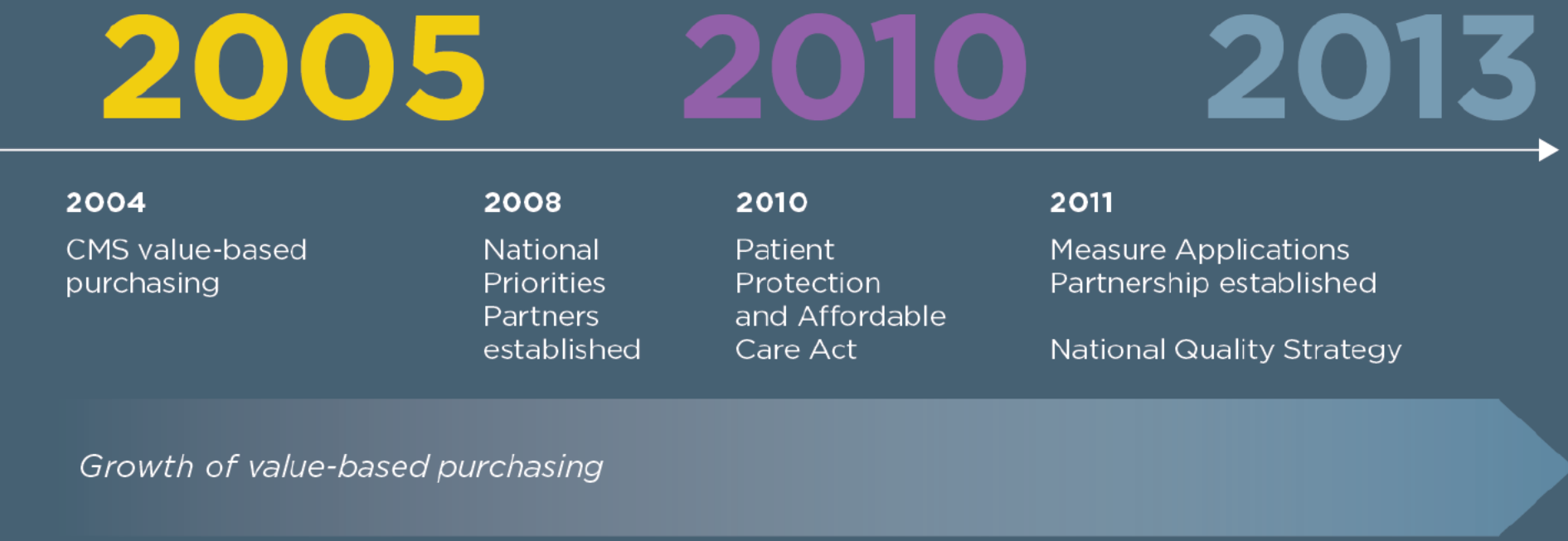
2001

Institute of Medicine publishes *Crossing the Quality Chasm*

2002

A National Framework for Healthcare Quality Measurement and Reporting

A Look Back:
A young, but rapidly growing movement



The National Quality Strategy: Three Aims and Six National Priorities

Quality Measurement in Evolution

- Recognized need to achieve higher performance more quickly
- Critical to align measures across settings and providers to reduce burden and accelerate improvement
- Focus on measures that are more patient centered (e.g., Patient-Reported Outcomes)
- Transition to electronic platforms (eMeasures)
- Recognize broader measure types (e.g., composites) and measurement systems, e.g., registries
- Address disparities in all we do

Preference for Outcomes

- Hierarchical preference for:
  - Outcomes linked to evidence-based processes/structures
  - Outcomes of substantial importance with plausible process/structure relationships
  - Intermediate outcomes
  - Processes/structures (most closely linked to outcomes)

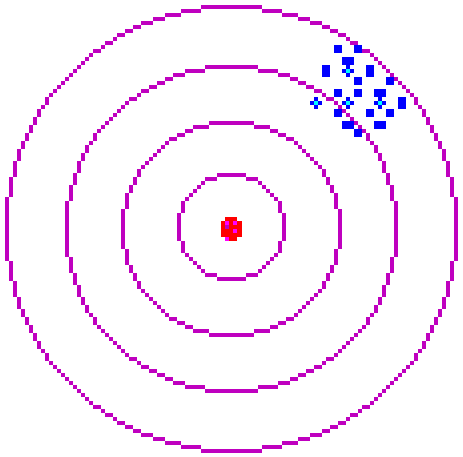
Endorsement Criteria

Major criteria describe desirable characteristics of quality performance measures for endorsement

- Hierarchy and Rationale
  - **Importance to measure and report** – measure those aspects with greatest potential of driving improvements; if not important, the other criteria less meaningful (must-pass)
  - **Scientific acceptability of measure properties** – goal is to make valid conclusions about quality; if not reliable and valid, risk of misclassification and improper interpretation (must-pass)
  - **Feasibility** – ideally, cause as little burden as possible; if not feasible, consider alternative approaches
  - **Usability and Use** – goal is to use endorsed measures for decisions related to accountability and improvement
  - **Harmonization and Selection of Best-in-Class**

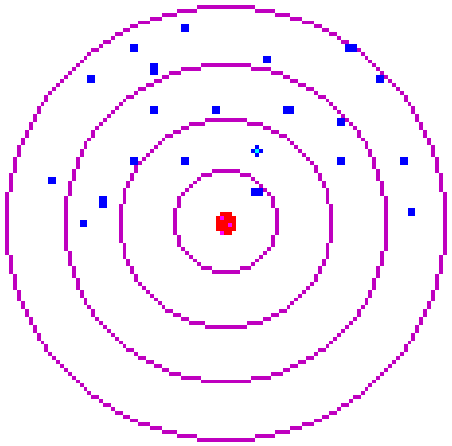
Reliability and Validity

Assume the center of the target is the true score…



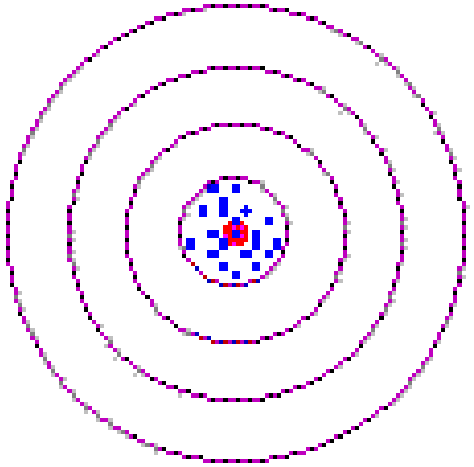
Reliable Not Valid

Consistent, but wrong



Neither Reliable Nor Valid

Inconsistent & wrong



Both Reliable And Valid

Consistent & correct

Threats to Validity

- Measure focus is not a relevant outcome of healthcare or not strongly linked to a relevant outcome
- An unreliable measure cannot be valid
- Patients inappropriately excluded from measurement
- Differences in patient mix for outcome and resource use measures not adjusted
- Measure scores generated with multiple data sources/methods
- Systematic missing or “incorrect” data (unintentional or intentional)

Transition to eMeasures

- Need measure development that takes advantage of clinical data in EHRs, registries, and patient portals.
- Need interoperable systems to track quality and efficiency across settings and populations
- Need better interfaces to other data, including patient demographics and costs (pre-hospital data?)
- Current EHRs present additional challenges
  - Widespread EHR data are not yet available for measure development and testing;
  - Lack of comparability across vendor products;
  - Data elements needed for advanced measures currently may not be feasible to capture in EHRs.

Need for Ongoing Measure Feedback

- IOM report, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, cites feedback loops as essential for continuous learning and system improvement

- Continuously learning system uses information to change and improve its actions and outputs over time

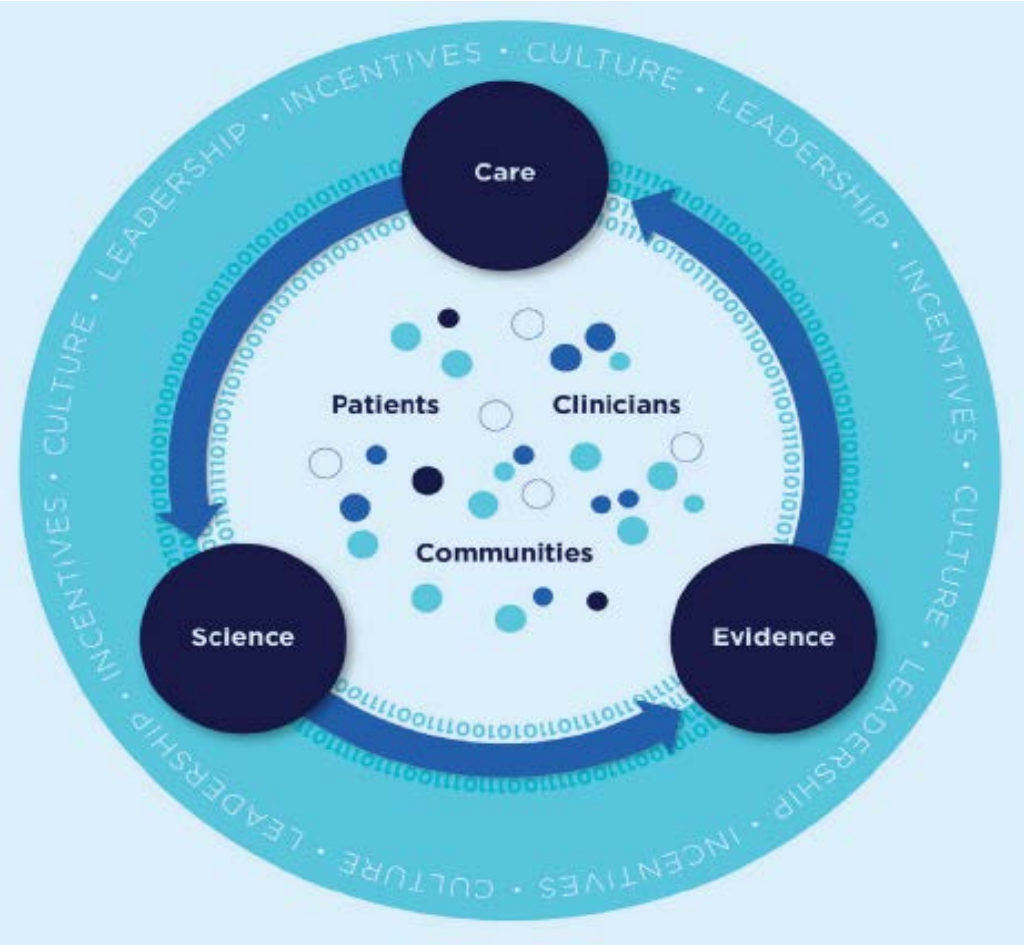
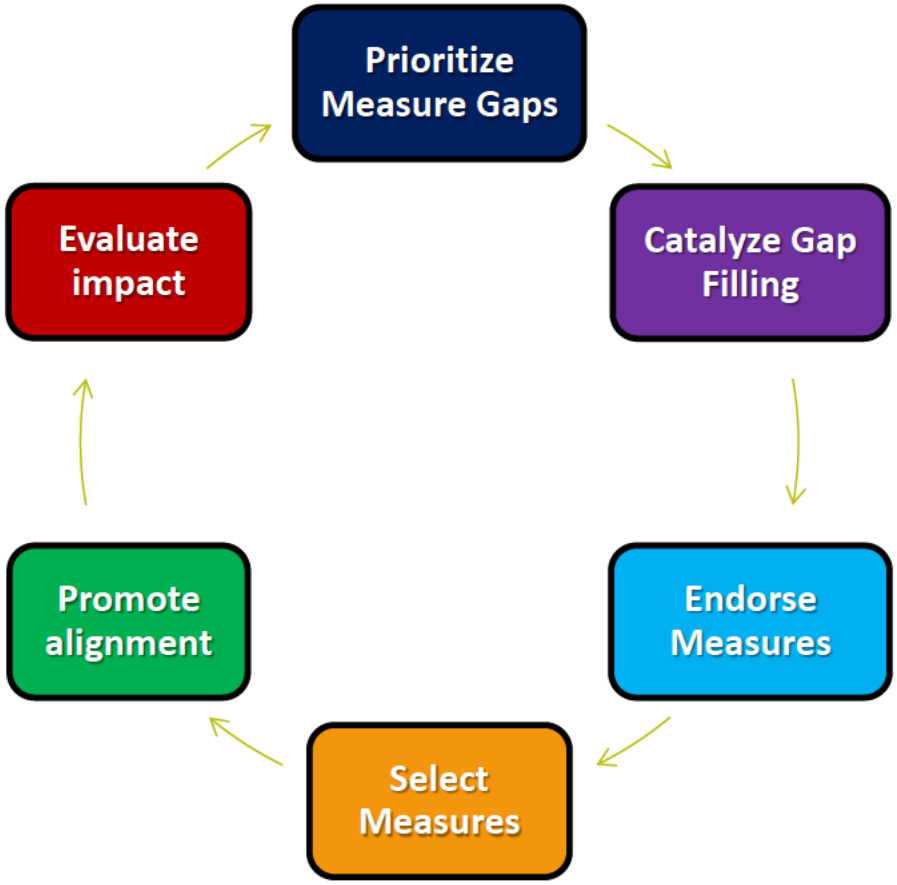


Image Source: http://www.iom.edu/~/media/Files/Report%20Files/2012/Best-Care/BestCareReportBrief.pdf

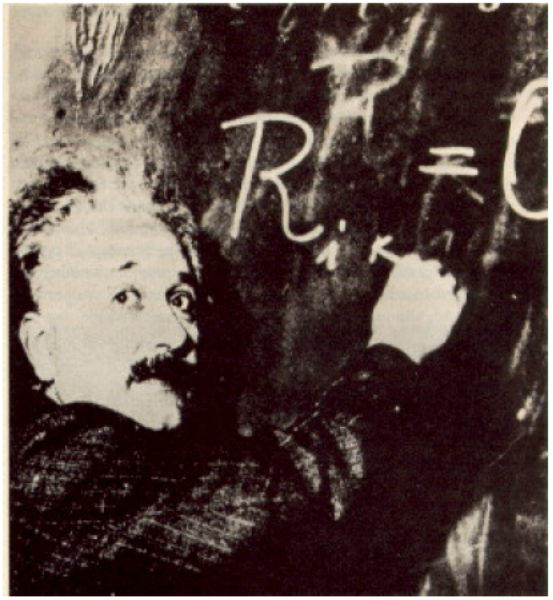
Need for Collaboration in Measurement



The Measurement Imperative

**Not everything that counts can be counted,
and not everything that can be counted counts**

~Albert Einstein



But…..

You can't improve what you don't measure

~ W. Edwards Deming

Discussion

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