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## **Report and Recommendations from the PQA Quality Measure Expert Panel August, 2009**

### **BACKGROUND**

The PQA Quality Metrics Cluster Groups produced 31 measure concepts during the course of their work in 2008, and 28 of these concepts were approved by the general membership at the PQA Members Meeting on November 19-20, 2008.

During the November PQA meeting, a roadmap was presented that delineated how measure concepts will progress toward fully-validated measures. For a measure concept to become a fully-validated measure requires financial resources, an expenditure of time, and the selection of a measure developer to work with to take these measure concepts in order to take them to this next level.

Within the roadmap document, the role of the Quality Measure Expert Panel (QMEP) was defined as including the review and prioritization of these measure concepts. This report includes the QMEP's recommendations regarding which of the 28 measure concepts are best suited for further development and testing by PQA.

### **PQA to Launch On-line Working Library of Measures and Measure Concepts in January 2010**

It is important to understand how measures and measure concepts will be categorized by PQA following the November 2009 meeting, and how they will be made available on our website and to the public, effective January 1, 2010:

#### **1. PQA-Approved Measure Concepts**

These are measure concepts that are developed by the PQA Cluster Groups, and approved by the PQA full membership. These "concepts" will not necessarily have a set of defined technical specifications to accompany these measure concepts. This would depend on whether we took the measure concept to its next level.

These measure concepts can be used by any and all PQA members, and actually we would strongly encourage PQA members and non-members alike to use these measure concepts. In some cases, at the current time, there may not be a data source readily available that can be aggregated to literally "determine the measure score".

Until such data source can be determined, developed or established, it would be otherwise near impossible for a measure developer to validate and test this measure.

## **2. PQA-Approved Measure Concepts that are moving to become fully validated and tested measures**

These are endorsed and approved Measure Concepts, that the PQA Quality Measurement Expert Panel (QMEP) is recommending be MOVED FORWARD to testing and validation by a measure developer.

Please note: this is a process that will take PQA, working with a measure developer, about 12 months to complete, from the point of selecting the measure developer. These measure concepts may or may not all result in a fully-validated measure, as there are instances where a measure concept does not perform well, or cannot be calculated readily, or a variety of other reasons.

## **3. Fully-Validated PQA Measures**

These are measures that have been fully-validated by a measure developer, there are technical specifications in place to accompany each measure, and these measures are available for use in the healthcare marketplace, according to terms for use as defined by PQA and the measure developer (i.e. are the measures being used for commercial use or non-commercial use, and what licensing agreements, if any, need to be in place).

*NOTE: for these measures, PQA can provide detailed measure specifications to the interested company/organization.*

## **4. Fully-Validated PQA Measures that have been endorsed by the National Quality Forum**

These are measures that PQA has developed in conjunction with a measure developer. In addition to having them validated and tested, they have been submitted to the National Quality Forum (NQF) for endorsement. The endorsement process is not something that takes place on a consistent basis. In other words, NQF must issue a “call for medication use measures”, PQA must respond to that call, and submit a rather lengthy document and the clinical evidence demonstrating the need for each measure we submit. PQA has submitted its initial starter set of 15 measures to PQA, and this fourth library will list out all measures that NQF has endorsed.

## **PQA Recognizes the Contribution of its PQA Quality Measurement Expert Panel**

PQA is an organization that relies very heavily on the expertise of our members and is appreciative of the many hours that they devote to the activity and initiatives of PQA. We would like to recognize the efforts of this Panel, and the important steps and deliberations that they underwent in the review of the 31 measure concepts presented to them.

Co-chairs of the QMEP are:

*Dr. Kent Summers, Endo Pharmaceuticals and*

*Julie Kuhle, RPh, Pharmacy Manager, Iowa Foundation for Medical Care*

The PQA members serving on this Committee are:

*Lawrence Brown, University of Tennessee, College of Pharmacy*

*Carey Cotterrell, Kaiser Permanente*

*Eric Culley, Highmark*

*Patrick Gleason, Prime Therapeutics*

*Mary Ann Kliethermes, Midwestern University*

*Lynn Martin, URAC*

*David Nau, Humana*

*Bimal Patel, MedImpact*

*Lynn Pezzulo, Quality Partners*

*Marissa Schlaifer, AMCP*

*Brad Tice, PharmMD*

*Kristina Yu-Isenberg, PhD*

## **MEASURE CONCEPTS CONSIDERED BY THE QMEP**

In November 2008, the PQA membership approved a total of 31 new measure concepts. The breakdown in terms of therapeutic category, or practice area is included below. These measure concepts were then individually reviewed over a period of three months by the Quality Measurement Expert Panel.

<i>Cardiovascular:</i>	<i>3 measure concepts</i>
<i>Diabetes:</i>	<i>3 measure concepts</i>
<i>Medication Therapy Management:</i>	<i>4 measure concepts</i>
<i>Medication Adherence:</i>	<i>2 measure concepts</i>
<i>Mental Health:</i>	<i>3 measure concepts</i>
<i>Patient Safety:</i>	<i>2 measure concepts</i>
<i>Medication Reconciliation:</i>	<i>5 measure concepts</i>
<i>Respiratory Disorders:</i>	<i>4 measure concepts</i>
<i>Prevention and Wellness:</i>	<i>2 measure concepts</i>

## **Quality Measurement Expert Panel's (QMEP) Preparation and Review Process**

A decision tool was created to assist QMEP members as they assessed specific aspects of each measure. The structure of the tool helped reviewers:

- Select the outcome measured (e.g. clinical outcome, process, structure, access)
- Select the care setting measured (e.g. Prescription Drug Plan, Pharmacy, MTM provider)
- Determine if a pharmacist can impact the measure alone or if the prescriber's approval is needed to impact the measure
- Determine what data was needed for the measure and the source of that data and the quality of the data available
- Rate each measure using a scale of 1-5 for
  1. Importance
  2. Scientific acceptability
  3. Usability
  4. Feasibility

Finally, the tool allowed QMEP members to provide narrative comment on the measure and to request additional information from the measure workgroup, if needed.

The QMEP held six conference calls from May through July 2009. Prior to each call, two or three QMEP members were assigned a category of measure concepts (e.g. cardiovascular). These members reviewed and documented their assessment of the measure concepts, forwarded their review to the co-chairs for compilation and distribution prior to the meeting (see Attachment A), and led the discussion of the concepts during the QMEP phone call. All other QMEP members were asked to review and be prepared to discuss the measure concepts prior to the meeting.

The discussions of the QMEP were lively and productive. Panel members were well prepared, insightful, and offered their expertise and knowledge without reservation. Summaries of the conference call sessions for each measure concept follow including the recommendation of the QMEP for future development of the measure concept. Attachment B includes a list of all measure concepts and the recommendations of the QMEP.

### **Cardiovascular:**

#### Rate of use of drugs for dyslipidemia in CAD

QMEP regards this measure as useful to health plans/pharmacists and **recommends further development of this measure concept through measure specification and testing**. The QMEP recommends linking this with the PQA adherence measure for lipid-lowering medications. The Panel questioned whether the Cardiovascular workgroup considered another adherence measure concept that was not moved forward?

#### INR monitoring at least monthly

QMEP raised several significant concerns while noting the importance of monitoring a high-risk drug. Home testing of INR will become more prevalent due to new CMS policy and this testing won't be captured in data for this measure. Days supply is required for the denominator and this isn't a very accurate data field. If this measure is reconsidered, the grace period should add 5 days to the current 30-day interval. **The QMEP does not recommend** advancing this measure concept.

#### Avoidance of chronic NSAID use in heart failure

QMEP had several concerns with the measure concept while noting that pharmacists are in a unique position to decrease use of NSAID (Rx and OTC) in HF patients. Much of NSAID use would not be captured in prescription claims data- rather it would be OTC or a 4-dollar generic. New pain guidelines from American Geriatric Society don't recommend NSAIDs for people 75 y/o and older. There is concern that the prevalence of prescription NSAID use in this population may be small. The Heart Failure diagnosis in the denominator needs to be more clearly defined (Class I) and this is difficult. QMEP questions whether the CV workgroup discussed the opportunity for improvement with this measure. And specifically did the workgroup find the prevalence in medical literature? The workgroup should clarify whether NSAIDs includes the COX II's. **QMEP is reluctant to recommend** this measure concept for further development. If the concerns noted are addressed by the CV workgroup, the measure concept could be reconsidered.

### **Diabetes:**

#### Percent of patients receiving at least 2 HbA1c/year

#### Percent of patients receiving at least one microalbumin urine screen/year

#### Percent of patients receiving at least one LDL-C screening/year

The QMEP concluded that all three screening measures were a low priority for pharmacy measures. Discussion centered on several concerns. Any screening done in the pharmacy would not be available in the medical claims used to calculate the measure.

Whether or not the pharmacist can impact the measure may be questionable (eg: pharmacist promotes screening that would have occurred later in the year). The QMEP **does not recommend** moving these measure concepts forward unless the effort needed to validate them in the pharmacy setting is minimal.

### **MTM:**

#### Patients receiving service

QMEP expressed concerns about the variability of current MTM services - from passive educational information mailings to patient specific comprehensive medication reviews with follow up done via phone or face to face. The measure rate would not meaningfully reflect the quality of the MTM program. This measure is now less relevant since the 2010 Part D MTM programs have a mandatory opt-out provision. The QMEP **does NOT recommend** this measure concept for further development.

#### Declined to enroll

The Panel did not think this measure was very meaningful to pharmacy/pharmacists. And again, since Part D MTM programs will be opt-out, this measure is less important.

The QMEP **does NOT recommend** this concept for further development.

#### Comprehensive Medication Review (CMR)

The Panel had concern about several variables that might impact this measure such as:

- Need for risk adjustment/stratification needed to make it meaningful

- Enrollment issues

- Site of delivery (pharmacy v. call center)

- Personnel providing service (pharmacists v. other health care providers)

The QMEP questioned whether the measure reflects plan-level quality rather than pharmacy quality. However, the group generally believed the concept to be important and **recommends further development of the measure concept through measure specification and testing.**

#### Personal Medication List

The Panel had concern about limited research to support the measure concept's importance and scientific acceptability as well as whether it reflects plan-level quality rather than pharmacy quality. The QMEP felt that measure harmonization is important and the medication reconciliation measure "Patient Personal Medication List Portability" may be a better measure concept. However, the group generally believed the concept important enough to be worthy of continued investment by PQA, with the caveats listed in the recommendation. This measure concept is **NOT** recommended for further development as a separate measure, however the QMEP **recommends further development of this measure concept only if pharmacies or pharmacists are included in the generation or delivery of Personal Medication Lists and if this measure is included as part of CMR.**

### **Medication Adherence:**

#### Proportion of Days Covered: HIV/AIDS Medications

The Panel understands the importance of adherence with HIV/AIDS medications and the need to improve adherence. There was concern that a PDC of >80% will not be optimal for these medications and perhaps this threshold should be increased. Panel was not clear on how the PDC would be calculated given that there would be two or more medications measured. Recommended that PDC for each medication/drug class be calculated and if any fell below threshold, then measure is not met. Panel questioned how drug holidays will be considered.

Additional concern was whether the provider had the ability to impact compliance in a timely manner that would enhance positive outcomes. The QMEP **recommends the measure concept be further developed through measure specification and testing (by a very narrow vote).**

Proportion of Days Covered: Anticonvulsant Medications

Panel verified that this measure needs medical claims data to determine diagnosis. Since a primary diagnosis of epilepsy is needed to be in the denominator, consider revising measure to only one anticonvulsant prescription (see specification in the Eligible population for testing). Consider adding the same measure for those individuals younger than 18 y/o. Delete ICD-9 code for nonfebrile convulsions (780.3) as this is a nonspecific code and not to be used as a primary diagnosis. Expand the list of medications (i.e. could include Klonopin). The QMEP **recommends the measure concept be further developed through measure specification and testing.**

Antidepressant – Gap in Therapy

The Panel understands the Gap in Therapy measures are useful for pharmacists. However, since NQF is reluctant to recommend Gap in Therapy measures, the Panel recommends that PQA focus on PDC when measuring adherence. The QMEP does **NOT recommend this measure concept for further development.**

Proportion of Days Covered: Antidepressants –Continuation Phase

This measure concept is extremely similar to a HEDIS measure except that the PQA measure concept does not require medical claims data and some differences exist in medication list. Panel was concerned that this measure would be seen as duplicating the existing HEDIS measure. Consider a process where PQA can endorse a currently used measure as one that can be impacted by pharmacists. The Panel did **NOT recommend this measure concept for further development.**

Proportion of Days Covered: Antidepressants – Acute Phase

This measure concept is extremely similar to a HEDIS measure except that the PQA measure concept does not require medical claims data and some differences exist in medication list. Panel was concerned that this measure would be seen as duplicating the existing HEDIS measure. Consider a process where PQA can endorse a currently used measure as one that can be impacted by pharmacists. The Panel did **NOT recommend this measure concept for further development.**

**Patient Safety:**

High Alert Drug Review, Indicator 1 and Indicator 2

The Panel had concerns related to the feasibility of getting data for the numerator as the use of codes to document pharmacist services have not been widely accepted. The panel discussed whether each prescription (new and refill) should be included in the denominator and suggested using a time interval such as every 3 months for refilled prescriptions. There was concern that there would be a low volume of patients within a pharmacy for the measures, but it could be a useful measure for a PBM. The measure concepts are based on the list of high alert drugs from ISMP, which is not finalized.

The QMEP **recommended both measure concepts for future development, specification and testing** and suggested that the measure be used for only a couple high alert drugs, new prescriptions and refills included quarterly.

## **Medication Reconciliation:**

Patient Personal Medication List Portability

Evidence of a Patient's Personal Medication List

Patient's Personal Medication List Discrepancies Resolved

Personal Medication List Creation

Patient's Personal Medication List, Comprehensive Review and Reconciliation

Overall, the QMEP thought the measures under review were overly complex and there is not a standard of care yet established for medication reconciliation. The lack of standards hinders their importance in terms of scientific acceptability/evidence of harm or quality concerns. The QMEP had difficulty in defining, understanding the fundamental notion of what is meant by a "patient encounter." Suggestions were made to change the definition of the denominator to limit the measure's complexity (see suggestions below).

The QMEP recognizes that a measure for medication reconciliation is very important and **recommends that these measure concepts be referred back to the workgroup to develop a single measure.** This measure would be reviewed by the QMEP prior to a vote by the general PQA membership at the November 2009 meeting. (Mary Ann agreed to address)

The work group should consider a more defined medication reconciliation measure that addresses such things as:

- Transitions of care
- Targeted patient populations: e.g., elderly, heart failure or other conditions where evidence exists in the literature indicating an important risk of re-hospitalization
- Simple process measures such as counts of events rather than outcome measures of quality or impact from the medication reconciliation process

## **Respiratory Disorders:**

Asthma therapy with LABAs

### **Recommended for further development**

Panel discussed how LABAs are frequently overused in asthma and the measure was based on solid clinical evidence. The Panel recommended that the age limit be expanded to  $\geq 5$  years of age per treatment guidelines and to be consistent with HEDIS measures that look at asthma measures for ages 5-56 years. Panel recognizes that combination products such as fluticasone/salmeterol are not addressed with this measure. Panel suggested that testing be done to determine if measure can include use of combination products without prior use of only a corticosteroid inhaler (which would be considered inappropriate). Reconsider comment section in measure concept "measure is to ensure that Inhaled Corticosteroid (ICS) are used as first line therapy". This measure only ensures that LABA are not used without an ICS. The QMEP **recommends the measure concept be further developed through measure specification and testing.**

Appropriateness of COPD therapy with LABA

Panel was not aware of how problematic is the overuse of Short Acting Beta Agonists (SABA) in COPD patients. The measure does not clearly define overuse of SABA. Treatment guidelines for overuse of SABA in COPD do not define what is considered overuse. The Panel was not convinced the measure could be used to affect clinical outcomes, but would relate more to patient convenience. The Panel did **NOT recommend this measure concept for further development.**

### Suboptimal asthma control

The Panel thought this measure concept is good but needs revision. Consider revising the measure numerator to ER visits that are specifically related to asthma. Would a grace period be included for patients just beginning asthma therapy and who may need steroid bursts before they are controlled? The panel thought there could be debate that poor asthma control was indicated by steroid burst therapy. The QMEP **recommends further consideration of this measure concept** by the respiratory disorders workgroup.

### Duplicate therapy

The Panel discussed how duplication of drug therapy was well identified by software programs. PQA developed asthma measures that have undergone testing have very low incidence and the panel felt this measure would also have small numbers and therefore would be little impact on patient care. The Panel did **NOT recommend this measure** concept for further development.

### **Wellness and Prevention:**

#### Tobacco Cessation Interventions – four sub-measure concepts

1. Number of patients screened
2. Number of patients with positive screen that were offered intervention
3. Number of patients with positive screen offered and accepted intervention
4. Number of patients (users and nonusers) who were provided intervention

The Panel recognizes the importance of measures related to smoking cessation. However, in the interest of harmonizing with existing measures, the Panel recommends that the workgroup harmonize PQA smoking cessation measure concepts with HEDIS tobacco use measures. The Panel **recommends that these measure concepts be referred** back to the Wellness and Prevention workgroup.

### Influenza vaccination – screening

This is a HEDIS measure tweaked to reflect screening in a pharmacy. The Panel thought the current HEDIS measure can be applied within a pharmacy setting. The measure concept was **NOT recommended for further development.**

### Influenza vaccination – received vaccine from pharmacist

Panel members recognized value of documenting pharmacists' ability to improve the rate of vaccination in this population. However, there was considerable discussion about how this measure would be impacted by the patient's pharmacy benefit design rather than by the pharmacy's practice/actions. Additional concerns were voiced that claims data for the numerator would not include cash paying patients. The value of the measure to compare pharmacies is compromised by too many factors unrelated to the professional service of the pharmacy. The Panel did **NOT recommend this measure concept for further development.**

### Influenza vaccination – received vaccine as a result of pharmacist facilitation

Panel was concerned that this measure concept is not feasible. Discussion involved the fact that there are too many complicating factors to accurately determine that a pharmacist was the reason a patient received an influenza vaccine. The QMEP did **NOT recommend the measure concept for further development.**