PQA COPD Treatment Ratio (CTR) Measure Development Technical Expert Panel (TEP) Self-Nomination Information

PQA will convene a measure development TEP to review and provide input on draft specifications for the measure concept, *COPD Treatment Ratio (CTR).* The COPD Treatment Ratio (CTR) Measure Development TEP is a small, technically proficient panel composed of approximately 15 PQA members, selected by PQA staff through a self-nomination process to provide expert input into the refinement and testing of the measure concept *COPD Treatment Ratio (CTR).* The measure concept assesses the percentage of individuals whose COPD Treatment Ratio (CTR) was ≥ 0.7 during the treatment period.

The measure development TEP will be convened as needed via webinar, in a time-limited fashion, with the first meeting in October 2022.

CTR Measure Development TEP Objectives:

- Address key questions identified during feasibility testing and initial measure concept specification;
- Assist the PQA team in refining draft measure concept specifications; and
- Make recommendations on potential advancement of the measure concept for PQA Quality Metrics Expert Panel review prior to testing.

CTR Measure Development TEP Scope of Responsibilities:

- Participate in approximately 4 webinar meetings;
- Review meeting materials in advance;
- Actively participate in discussions; and
- Respond to brief post-meeting surveys as needed.

Information Required for Nomination:

- Name
- Credentials
- Title
- Organization
- Mailing address
- City
- State
- Telephone
- Email
- PQA Measure Development Experience: Please indicate your past PQA and other measure development experience.
- Skills and Experience: Please indicate the skills/experience you have that make you a strong candidate for the COPD Treatment Ratio (CTR) Measure Development TEP.
- Brief Biography: Include relevant information that describes your qualifications for being a member of the COPD Treatment Ratio (CTR) Measure Development TEP (Max 300 words).
- Upload resume or CV

Optional Information for Nomination

As part of PQA's commitment to diversity, equity and inclusion (DE&I), we want to ensure the equitable and meaningful inclusion of individuals, who represent the nation's diverse populations, in PQA's work. We invite you to voluntarily share information about your race, ethnicity and gender, which PQA will use confidentially to evaluate and strengthen our programs and activities. PQA encourages and supports the participation of diverse individuals in its work. If you have any questions about PQA's DE&I work, which is part of our *Blueprint PQA 2025* strategic plan, please contact us at engagement@PQAalliance.org.

1. Race *(multiple choice, allow one answer only, OPTIONAL)*
    1. American Indian or Alaska Native
    2. Asian
    3. Black or African American
    4. Native Hawaiian or Other Pacific Islander
    5. White
    6. Prefer not to answer
    7. Other (please specify) *(text box)*

2. Ethnicity *(multiple choice, allow one answer only, OPTIONAL)*

    a. Hispanic or Latino
    b. Not Hispanic or Latino
    c. Prefer not to answer

3. Do you think of yourself as *(multiple choice, allow one answer only, OPTIONAL)*

    a. Male
    b. Female
    c. Transgender male/trans man/female-to-male
    d. Transgender female/trans woman/male-to-female
    e. Genderqueer, neither exclusively male nor female
    f. Additional gender category or other, please specify *(text box)*
    g. Prefer not to answer

4. Do you consider yourself part of a minority group? If so, please describe? (*text box, OPTIONAL*)

5. What are your preferred gender pronouns? *(multiple choice, allow one answer only, OPTIONAL)*

    a. he/him/his
    b. she/her/hers
    c. they/them/theirs
    d. other (please specify) *(text box)*

Nominations are due by 11:59pm ET on September 9, 2022.

The nomination form must be completed in one continuous session, and you will not be able to save a partially completed form.

Background:

Chronic obstructive pulmonary disease (COPD) is a care-intensive condition that can significantly impair quality of life and lead to excessive healthcare expenditures if not properly treated. Pharmacologic therapies consisting of long-acting controller (maintenance) medications and short-acting rescue medications are used to prevent and control symptoms, improve quality of life, reverse airflow obstruction, and reduce the frequency and severity of COPD exacerbations.

Exacerbations account for the greatest proportion of the total COPD burden on the healthcare system with a direct relationship between severity of COPD and cost of care.[1] Appropriate medication management could potentially prevent a significant proportion of COPD-related costs including those from hospitalizations, emergency room visits, and missed work and school days.[2] Still, controller therapy remains underutilized and adherence to such therapy has been shown to be poor. Additionally, increased use of short acting bronchodilator (rescue medications) has been associated with poor COPD outcomes.[3-6]

To reduce the risk of future COPD exacerbation, especially severe exacerbations, the COPD treatment ratio (CTR) can be used as a surrogate marker of exacerbation risk. CTR is the ratio of controller medications to all COPD medications (controller and rescue medications).[7-9]

Upon suggestion from the PQA Measure Advisement Group (MAG), PQA conducted an independent research study in 2018 to validate the CTR methodology. This study found that the optimal CTR cut point was 0.7, the CTR did not differ by line of business, and that the CTR performed similarly when only prescription claims were used versus medical and prescription claims.

Additionally, in 2021, COPD was identified as a priority area for measure development by PQA and CMS. The Health Plan Measure Concept Advisory Group (MCAG) agreed to move the CTR concept forward for public comment; comments received further supported the recommendation to advance the CTR measure concept for development. PQA has drafted initial specifications and the goal of the CTR TEP will be to fully specify the measure concept to support its advancement for QMEP review prior to testing and subsequent steps in PQA's standard measure development process.

If you have questions, please contact the PQA team at MeasureDev@PQAalliance.org.

References:

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3. Blackstock FC, ZuWallack R, Nici L, Lareau SC. Why don't our patients with chronic obstructive pulmonary disease listen to us? The enigma of nonadherence. *Ann Am Thorac Soc*. 2016; 13(3) 317-23. doi: 10.1513/AnnalsATS.201509-600PS
4. Jenkins CR, Postma DS, Anzueto AR, et al. Reliever salbutamol use as a measure of exacerbation risk in chronic obstructive pulmonary disease. *BMC Pulm Med*. 2015; 15 97. doi: 10.1186/s12890-015-0077-0
5. van Boven JF, Chavannes NH, van der Molen T, Rutten-van Mölken MP, Postma MJ, Vegter S. Clinical and economic impact of non-adherence in COPD: a systematic review. *Respir Med*. 2014; 108(1) 103-13. doi: 10.1016/j.rmed.2013.08.044

6. Mäkelä MJ, Backer V, Hedegaard M, Larsson K. Adherence to inhaled therapies, health outcomes and costs in patients with asthma and COPD. *Respir Med*. 2013; 107(10) 1481-90. doi: 10.1016/j.rmed.2013.04.005
7. Stanford RH, Lau MS, Li Y, Stemkowski S. External validation of a COPD risk measure in a commercial and Medicare population: the COPD treatment ratio. *J Manag Care Spec Pharm*. 2019; 25(1) 58-69. doi: 10.18553/jmcp.2019.25.1.058
8. Stanford RH, Nag A, Mapel DW, et al. Claims-based risk model for first severe COPD exacerbation. *Am J Manag Care*. 2018; 24(2) e45-e53.
9. Stanford RH, Nag A, Mapel DW, et al. Validation of a new risk measure for chronic obstructive pulmonary disease exacerbation using health insurance claims data. *Ann Am Thorac Soc*. 2016; 13(7) 1067-75. doi: 10.1513/AnnalsATS.201508-493OC