

How Physician Quality Measures Are Created

Evidence+Practice Guidelines+Measure Development+Endorsement+Implementation Review+Pilot-testing =
Ready for market

Step One: Development of Evidence - Years

In order for there to be evidence-based medicine, practice guidelines and measures, there has to be evidence. Evidence comes from research. Research requires both time and funding. Not all evidence is created equal and, in fact, evidence is generally broken into three categories: Level I, Level II and Level III. Level I evidence is the “gold standard” and exclusively derived from information collected from randomized, controlled clinical trials. These types of trials costs millions of dollars to operate and are funded primarily by the National Institute of Health or private pharmaceutical companies attempting to gain approval for a new treatment. Because of the time and expense involved, randomized, controlled clinical trials are reserved for those areas with a high prevalence, including heart disease and diabetes. Other levels of evidence are created by the research of individual physician-researchers.

Step Two: Creation of Practice Guidelines – 18-36 months

Practice guidelines attempt to categorize the evidence in a certain area into standards, guidelines and options for treatment. Guideline creation involves months of work compiling all of the research in a certain area, categorizing by level and attempting to draw conclusions from that compilation. Developers must consider alternative treatments and therapies; definitions for patients to be “included” and “excluded” Many individual medical societies have policies in place to ensure that guidelines are developed in a consistent and reliable method. In addition, guidelines must also go through an “approval” process within the organization. To be considered valid, practice guidelines must be published be a peer-review publication.

Step Three: Performance Measurement Creation at the Physician Consortium –9 to 24 months

Once a practice guideline has been approved and published, the topic can be recommended to the Physician Consortium for development of quality measures. The Consortium does not accept all topics for development and has specific criteria for taking on a topic area, including:

First Tier

- Actionable by physician
- Known feasibility (available data sources, physician attribution)
- National, widely accepted guidelines or evidence-base available with the potential to improve health outcomes

Second Tier

- Prevalence of the clinical problem or condition: number of affected persons per 1,000 persons in general U.S. population
- Burden of illness imposed by the problem: individual mortality, morbidity, functional impairment, cost per person and macro-economic burden

- Variability in practice: significant differences in utilization rates for prevention, diagnoses, or treatment options
- Work completed to date in identifying performance measures for a particular condition
- Potential of the guideline or assessment to reduce costs
- Number of specialties treating the condition
- Opportunity for the medical profession to take a leadership role

Once a topic is selected, two chairs are selected for the project. A working group of all affected medical groups is created. The working group then researches and collects all applicable practice guidelines for the area. From this material, draft performance improvement measures are created. Once the working group reaches consensus on the performance improvement measures, they are put out for a public comment period. After all public comments are reviewed and changes are made, the final measures are presented to the full Consortium for a vote.

Step Four: Endorsement by the National Quality Forum – 9 to 24 months

After measures have been created, they must be endorsed by a consensus building organization such as the National Quality Forum. The purpose of the endorsement process is to bring all involved stakeholders together including payers (health plans), purchasers (businesses), other providers (hospitals) and consumer and patient groups. The NQF also has a selection process for determining which measures it will put through the process. Once a measure is taken up by the NQF, a committee is convened to review the measure, its supporting evidence, and its applicability. Measures are also put through a public comment period.

Step Five: Implementation Review by the Ambulatory Care Quality Alliance, or similar organization - 9- 24 months

Once measures have been endorsed by the NQF, they are considered credible and reliable. However, the measure may not be easy to implement in the real world. For example, physicians must be able to simply identify the included patients. Data on these patients must be collected by the health plan using the measure. Data on the physician's actions and inactions and the reasons why must be collected and transmitted to the payer. This information must be analyzed and categorized by the payer. Finally, information on performance must flow back to the physician. In addition, all of this must be done in a consistent manner by all payers across the board and various computer and payment systems. It is not uncommon for performance measures to be developed, but then be declared unusable because of implementation problems.

Step Six: Pilot-testing of data collection methods, reporting

Once implementation methods have been identified, they must be pilot-tested for reliability, administrative burden and usability. This is usually done through demonstration projects involving a variety of practice types and locations.