From the Editor
"TAP Your Feet"

Imagine for a moment how you might react if you were asked to participate in a project to design performance measures to guide the prescribing of various medications in the ambulatory setting for all physicians across the nation. In addition to these measures, you were asked to come up with a system outlining accountability for the use of these measures and, finally, whether these measures were appropriate for a national report card on physician ambulatory prescribing behavior. Who would be brave enough, or as the case might be, "silly enough," to join such an effort and maintain one's sanity!

Having been asked to participate in just such an effort, via the National Quality Forum (NQF), I would like to describe an updated version of the work of the NQF and specifically the Technical Advisory Panels (TAPs) charged with implementing the project known as "Standardizing Ambulatory Care Performance Measures." I will briefly review the work of the NQF and then focus specifically on the activities involved with the various TAP committees. Finally, we will see how this work might be relevant to ongoing activities in measuring ambulatory quality across Jefferson University Physicians (JUP).

Astute readers of our newsletter will remember that the NQF (March 2001) is a quasi-public organization headquartered in Washington, D.C., whose mission is to "improve American health care through the endorsement of consensus-based standards for measurement and public reporting of health care performance data that provides meaningful information about whether care is safe, timely, beneficial, patient centered, equitable, and efficient."[1] Many readers might remember when the immediate past president of the NQF, Dr. Ken Kizer, presented an overview of the organization during his presentation as the 11th Grandon Lecturer on our campus in May of 2002.

A unique feature of the NQF, which many believe represents its strength and weakness, is the open membership representing all healthcare stakeholders. There are member councils that are created with equal voice who help direct a formal consensus development process. Under the Federal OMB circular A-119, this consensus process of the NQF obligates the federal government to adopt voluntary (consensus) standards and encourages the federal government to participate directly in the process itself. In a word, so goes NQF, so possibly goes the Center for Medicare and Medicaid Services (CMS) and how most clinicians might be paid for their work.

The NQF has been hard at work over the past five years with projects that include things like Serious Reportable Events in Health Care, Safe Practices for Better Health Care, National Voluntary Consensus Standards for Hospital Care, and now, Standardizing Ambulatory Care Performance Measures. Space precludes a detailed review of other activities around the nation focused on ambulatory care, but one should recognize that other groups such as the Ambulatory Quality Alliance (AQA), the AMA Physician Performance Improvement Consortium (PPIC) and the National Committee on Quality Assurance (NCQA) are all working hard in the same arena.

In May of 2004, the NQF completed Phase I of the Standardizing Ambulatory Care Performance Measures project and picked 10 priority areas for ambulatory care measurement and evaluation. In 2005, Phase II of this project included the creation of 36 NQF-endorsed and physician-focused consensus standards in seven priority areas. The 36 consensus standards included such things as measures to improve the care of patients with asthma, depression, heart disease, hypertension, and guidelines for prevention, immunization and screening, all in the ambulatory context. Readers can go directly to www.NQF.org to get a more detailed idea of the scope and depth of these ambulatory performance measures.

I think it is appropriate to characterize these measures as evidence-based, detailed, and probably quite challenging for most practices from a compliance perspective. In some respects, this should not come as a surprise to most of our readers as organizations like CMS now pay hospitals like Jefferson a small additional increased percentage on key diagnoses (provided our outcomes meet national threshold standards) in exchange for Jefferson posting its outcomes (on multiple quality indicators) on the CMS website. This is known as the Hospital Quality Alliance project, or HQA. Importantly, there are parallels here. As we create greater systems of accountability on the inpatient side of the ledger, so will NQF lead the struggle to create comparable systems of accountability for what we do in the ambulatory setting. This is, in a word, inevitable.[2]

Back to some of the measures then. Detailed aspects of measures include, for example, (within the label of coronary disease) documentation of a cholesterol screen and lipid profile for every patient, the effectiveness of cholesterol control, and the presence or absence of anti-platelet therapy. Of course, one cannot overlook how important smoking cessation counseling and intervention also is to the measurable quality of ambulatory care. As I noted earlier, how would one operationalize these lofty goals and objectives to improve what we do in the office? To tackle these issues, the NQF has created a series of TAPs all charged with specific project deliverables. I would like to focus on the TAP that I chair, namely, the Medication Management Technical Advisory Panel.

My TAP has been charged with the following deliverables, namely, to review multiple sets of previously endorsed consensus standards and make specific recommendations for implementation and suggest further research issues for each set. We are going to start by reviewing the work of other organizations such as the NCQA and PPIC so as not to reinvent the proverbial wheel every time a group gets together. Our TAP reports up to a Steering Committee charged with oversight of all the TAPs tackling ambulatory care. Here is where it gets dicey. One can just imagine the tough medical politics and horse trading involved in: Where do we go first? Which disease is most important? What measures really work? Who judges the validity of the evidence basis behind every measure, and so on? One has to be part clinician, part medical diplomat, and part process engineer to successfully navigate the charge we have been given by the NQF and the Steering Committee overseeing our work.

Fortunately, we have an outstanding group of staff from the NQF, many with advanced training in public health, medicine, and quality measurement and improvement to help us through the maze of existing standards and to navigate the treacherous policy waters. For now, our committee is focused on key candidate measures that have been assessed against established evaluation criteria including characteristics such as the rationale behind the measure, its clinical importance, its scientific acceptability, and so on. Specifically, we are already knee deep in looking at measures that call for specific drugs to be avoided in the elderly population, a measure we have adopted from the NCQA. We have also already made recommendations up to the Steering Committee to approve another NCQA-like measure concerned with the therapeutic monitoring for patients on persistent medication for certain chronic diseases. We are going to slug our way through at least 10 candidate measures for possible approval knowing that there is a population of over a hundred measures we might eventually be called upon to tackle.

I am aware that while we "TAP" our feet, skeptics out there contend that there are simply too many organizations and too many measures for the average well-meaning clinician to sort through. In part, they might be right! I see my role as chair of this particular TAP to not only accomplish the goals we have been assigned, but also to inject a dose of real-world thinking based, in no small part, on our work with the JUP Clinical Care Committee. Here's what I mean. We have been working as the JUP Clinical Care Committee for nearly two years creating a series of ambulatory measures in both primary care and non-primary care specialties. We recently "Celebrated Our Gains" at an offsite practice-wide meeting with more than a hundred JUP members in attendance including nine chairs of clinical departments. I know from our first-hand, ground-level experience just how tough it is going to be to translate these activities into a national effort that will eventually become a part of a possible pay-for-performance mechanism implemented by Medicare.

So, while it might appear that we are "tapping our feet" in Washington, D.C. and dealing with untold numbers of policy wonk details, the final analysis is this – one way or another, CMS may use aspects of our work to create a pay-for-performance ambulatory care reimbursement mechanism. I am grateful for an opportunity to play a small policy role in this nationally important arena. I am also grateful to the work of our colleagues, most especially on the JUP Clinical Care Committee, who have demonstrated their willingness to lead this effort at the local level. I promise to keep our readers posted on the progress of our TAP and the greater work of the NQF in general. Stay tuned as we learn not only how to "TAP" our feet but also to possibly execute a beautiful ballroom dance with our many partners across the dance floor! As usual, I am interested in your views and you may reach me at my email address, which is david.nash@jefferson.edu.

References

1. www.NQF.org. Accessed on September 21, 2005.
2. Robeznieks A. Going ambulatory: NQF quality standards await implementation. *Modern Hlthcare.* Aug. 8, 2005:8-9.