# Quality Measures Committee process for prioritizing and developing measures from AGA guidelines

***Practice and Quality Department***

***AGA Institute***

## *Purpose and role*

This document was prepared to inform members of the Quality Measures Committee (QMC) of the steps involved in prioritizing development of quality measures from new or existing AGA guidelines. **The role of the QMC is to develop meaningful quality measures for gastroenterology and hepatology to help produce a positive impact on patient outcomes**. The QMC has adopted the following criteria developed for accountability measures by The Joint Commission (TJC):

- Research: Strong scientific evidence exists demonstrating that compliance with a given process of care improves health care outcomes (either directly or by reducing the risk of adverse outcomes).
- Proximity: The process being measured is closely connected to the outcome it impacts; there are relatively few clinical processes that occur after the one that is measured and before the improved outcome occurs.
- Accuracy: The measure accurately assesses whether the evidence-based process has actually been provided. That is, the measure should be capable of judging whether the process has been delivered with sufficient effectiveness to make improved outcomes likely. If it is not, then the measure is a poor measure of quality, likely to be subject to workarounds that induce unproductive work instead of work that directly improves quality of care.
- Adverse effects: The measure construct is designed to minimize or eliminate unintended adverse effects.

There are nine separate and distinct tasks that must be completed in developing and maintaining quality measures for use in internal quality monitoring or in external accountability programs such as the Merit-based Incentive Payment System (MIPS). These tasks include:

**I. Identify content areas through guideline topic alignment**
**II. Assign QMC members to workgroups and assess need for additional content experts**
**III. Review new and recent AGA guidelines and compile potential measure concepts**
**IV. Voting phase I – Workgroup discussion and ranking**
**V. Evidence review/prioritization brief**
**VI. Voting phase II – QMC discussion and ranking**
**VII. AGA member comment**
**VIII. Implementation**
**IX. Existing measure maintenance**

Below are suggested procedures to follow for each step in the measure development process.

I. **Identify content areas through guideline topic alignment**

Each year at Digestive Disease Week® (DDW), the QMC will decide which topics to pursue for the year. This decision will involve a discussion of existing work, AGA guidelines in development, and additional content areas of interest based on a review of existing and forthcoming AGA guidelines. Each content area will be assigned to a complementary workgroup that is responsible for evaluating potential measure concepts and developing new measures as appropriate. These workgroups currently include colorectal cancer (CRC)/general gastroenterology (which includes functional gastrointestinal disorders/irritable bowel syndrome), esophageal and gastric/pancreatic and biliary disorders, hepatitis C/liver disease (HCV/liver disease), and inflammatory bowel disease (IBD). Workgroups may be reorganized, as needed, to align with the strategic goals of AGA.

**The guidelines to measures process approved by the AGA Governing Board is as follows:**

1. Upon the completion of the first draft of an AGA Institute technical review (TR) and the initial drafting of the resulting clinical recommendations, the manuscript of the TR will be sent to the chair of the AGA Institute Quality Measures Committee (QMC). AGA staff will schedule a call between the chair of the QMC (or designee), the Chair of the Clinical Guidelines Committee (CGC), the lead methodologist and at least one content expert author from the technical review. AGA staff liaisons for the QMC and CGC are also expected to participate in the call.
2. During the call, the methodologist and content expert(s) will present to the chairs the findings of the technical review and the most likely clinical recommendations resulting from the findings. Together, the group will determine whether any likely recommendations may lend themselves to one or more useful AGA quality measures.
3. If it appears that one or more likely recommendations from the upcoming guideline would be made into a useful measure, the measure(s) will be developed by a sub-committee of the QMC. The guideline methodologist and content expert(s) will serve as liaisons to this sub-committee and participate on calls and answer questions via email as needed.
4. The measure will be developed in tandem with the development of the clinical guideline document stemming from the TR with the aim of publishing the measure and guideline in immediate succession, if not concurrently.
5. When a past guideline undergoes update by the CGC, the measure data will be used to help inform any revisions to the guideline

To assist in the decision regarding new content areas for quality measure development, the QMC will rely on several factors: First, the QMC will review the list of guideline topics proposed for development by the AGA Guidelines Committee over the coming year. When the draft technical review and guideline are prepared, the appropriate QMC workgroup will review the guideline recommendations and assess whether complementary measures are appropriate for development and publication with the guideline. Second, the QMC will review existing AGA guidelines from the previous five years to determine whether there is potential for measure development from these guidelines. Third, the QMC will review the efficacy of existing workgroups and additional areas of interest on a yearly basis at the annual DDW meeting to determine if the workgroup should continue to exist or if other workgroups will best meet the needs of AGA.

## II. **Assign QMC members to workgroups & assess need for additional content experts**

Based upon the potential content areas anticipated for measure development over the coming year, the chair of the QMC will poll members of the committee following the May meeting to determine their interest in particular content areas. A QMC member will be selected to serve as a workgroup lead for each workgroup. Workgroups may be revised annually depending on the anticipated scope of the work to be completed over the coming year. Members of the QMC may participate on as many workgroups as they wish but must participate on at least one workgroup. Upon selection of the members and lead of a workgroup, the workgroup will be expected to meet via teleconference at least once each month as determined by the scope of the work. The number of meetings may increase or decrease at the discretion of the workgroup lead.

Ideally, each workgroup should have, at a minimum, three content experts in a particular area. The QMC may determine if additional content experts from outside the QMC are required to inform the work of the workgroup. If it is determined that additional experts are needed, the workgroup lead will send a request to the chair of the QMC requesting additional content or methodological experts to supplement the workgroup, as well as recommendations for additional experts. When additional content experts are identified, AGA staff and the QMC chair will coordinate onboarding of the content experts, which may include contacting other medical societies for additional recommendations. Additional content experts will be required to sign a conflict of interest disclosure policy as well as a confidentiality notice prior to beginning work with their workgroup.

All workgroups will have the assistance of AGA staff in the measure development process.

## I. Review of new and recent AGA guidelines for potential measure concepts

Each workgroup will begin their measure prioritization by reviewing new and recent AGA guidelines within their content scope. From these guideline recommendations, a list of potential measure concepts will be compiled based on strong recommendations based on high or moderate quality evidence (similar to the process set forth by the American Thoracic Society in *Ann Am Thorac Soc* 2014;11(4): S186-95). Additional measure concepts not meeting these thresholds may be included at the discretion of the workgroup if specific justification is provided.

## II. Voting phase I – Workgroup discussion and ranking

AGA staff will compile all of the potential measure concepts from each AGA guideline into a survey for each of the workgroup members to rank according to the *importance* of the potential measure in practice. Measures will be ranked, as outlined in section V, using a standard nine-point Likert scale, with "1" being the lowest (strongly disagree with measure concept) and "9" being highest priority (strongly agree with measure concept). Those individual measures that receive a median of "7" or above with minimal variation will then be discussed among the workgroup. The workgroup will then advance the highest priority concepts to the next stage based on a consensus decision.

The purpose of this exercise is to reduce the list of compiled measures into a smaller, more refined list of the highest priority measure concepts based on generalized knowledge about the subject matter. A comprehensive review of literature will not be required at this stage since a rough estimate of the measure priority will suffice to create a list of high priority measures to be ranked.

## III. Evidence review/measure prioritization brief

For each quality measure identified as high priority in voting phase I, the workgroup will develop a (one to two page) measure prioritization brief that describes the following elements of the measure:

- ***Meaningfulness*: Whether the measure is valuable to physicians, patients and/or payors.** **Measures should be meaningful across multiple populations to help facilitate change and quality improvement. If a measure is not meaningful, the measure will not be used by providers to benchmark their practice annually, by patients to inform their selection of providers, or by payers to help determine those providers that are providing high value care to patients, which would result in the purpose of the measure being lost.**
- ***Magnitude of effect*: The reach that a particular measure has across a population.** **If the measure reaches a minor subset of a population, the amount of time to develop a measure and resources expended will outweigh the impact of the measure. If the measure reaches a large population, it could have a significant impact.**
- ***Quality gap*: The gap between the desired performance level and actual performance level.** **Measures should be evaluated for gaps in performance. If providers have a performance rate above 90 percent, building such a measure would create a limited opportunity for improvement. The QMC should look for opportunities to improve upon performance and, therefore, the quality of care.**
- ***Feasibility*: The ease of implementation for a particular measure using data elements available within existing infrastructure.** **The unfortunate reality is that data for some of the best measures cannot be collected because there are no existing data sources to collect that measure. The feasibility of implementation should be considered when developing a measure. A measure for which data cannot be collected is not a feasible measure.**
- ***Applicability*: Whether a measure applies to gastroenterologists and not primary care/other specialties.** **The QMC should consider whether a measure specifically applies to gastroenterologists, or other specialties.**

The measure prioritization brief will be used to inform voting in later stages of prioritization.

## IV. Voting phase II – QMC discussion and ranking

Those measures identified as high priority in voting phase I and recommended for voting phase II will be ranked by the full QMC. Each QMC member will receive and review the list of high priority measures and the measure prioritization brief for each potential measure prepared by the primary workgroup. QMC members will review this information and then independently rate their

agreement with the priority of the measure using the same nine-point Likert scale described above. At a regularly scheduled meeting of the QMC (either by phone or in person), measure rankings will be reviewed and open for discussion. The goal is to come to consensus on an ordered list of measure concepts for further development. If the QMC votes that a measure concept would not support a meaningful quality measure, the measure concept will not be further developed.

## V. Implementation and public comment

Once approved for further development, AGA staff will assist with the initial draft of the new measure and will distribute it to other GI societies for comment. Each workgroup will review, incorporate relevant comments and amend the measure, as needed. Following workgroup revision of the measure(s), the measure will be forwarded to the full QMC for approval.

The revised measure will then be posted on the AGA website for one month for public comment. AGA staff will send invitations to governing board members to participate in the public comment process. This engages the community and allows members to have input into measure prioritization and development.

After the public comment period, the QMC will review any submitted comments, revise the measure as needed and then vote on whether the measure is sufficient to be disseminated in final form. This could include publication in an AGA journal alongside the newly released guideline, publication on the AGA website for further modification and use by practices for local quality improvement efforts, or implementation in the Merit-based Incentive Payment System (MIPS) program after being fully specified and tested per CMS requirements. When a new quality measure is approved by the QMC for formal dissemination, AGA staff will inform the AGA Governing Board via a Memorandum to the Board.

## VI. Measure maintenance

In addition to supporting prioritization and development of new measures, each workgroup is responsible for annual maintenance of existing measures included in MIPS. For MIPS measures, measure maintenance will occur during the measure maintenance cycle, as defined by CMS (typically in May and June of each calendar year). If an existing MIPS measure is determined to no longer be relevant based on new evidence, or additional measures have been developed that obviate the need for an existing measure, the workgroup may recommend to the QMC that a measure be retired from the MIPS program.

Decisions regarding de-implementation of measures will be made by the appropriate workgroup, with final decision approved by the entire QMC. These decisions will be informed by data from AGA programs and publicly available information (MIPS).