MAP 2013 Pre-Rulemaking Recommendations on Measure Gaps

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III. High-Priority Measure Gaps and NQF’s Collaborative Initiative for Gap-Filling

Performance measure gaps are a vital issue for a wide variety of stakeholders, as highlighted in the 2012 MAP Families of Measures report. MAP has played a key role in identifying measure gaps through its various activities. In addition, MAP has taken initial steps to encourage gap-filling by moving toward prioritization of high-leverage opportunities, offering more discrete suggestions for measure development, and involving measure developers in discussions about gaps. However, much work remains to be done by measure developers, NQF, MAP, and many other entities to accelerate closing the gaps.

MAP’s Identification of High-Priority Measure Gaps

The 2012 MAP Families of Measures report described common gap themes and barriers to gap-filling. It detailed how MAP can work to better characterize gaps, provide more granular recommendations, and clarify which gaps are most important. Inherent in this process is the need to consider the anticipated benefit of addressing a specific gap weighed against the costs (financial, time, and potential unintended consequences). In addition, the report pointed to gaps at various stages along the measure lifecycle—from conceptualization, to development and testing, and then on to endorsement, implementation, and monitoring. Key entities that play essential roles in gap-filling may be able to influence some of these steps more readily than others.

In creating the initial Families of Measures, MAP set the stage for building a repository of measures that target the most important opportunities for improvement, in many cases across multiple settings and populations. MAP Families of Measures identify high-priority gaps, in addition to the best available measures for a priority topic or condition. Measure developers attended and participated in the MAP meetings held to create the measure families. During the dialogue between MAP members and measure developers, developers shared plans for new measures in the development pipeline, and MAP members provided developers with a better understanding of the gaps MAP identified as highest priority to address.

During the 2012-2013 MAP pre-rulemaking meetings, a synthesized list of measure gaps was provided to support deliberations (see Appendix F). The MAP list of measure gaps is composed of gaps collated from all previous MAP reports, representing cumulative findings over the past two years. The MAP list cate-
organizes gaps according to the NQS priority areas. Using the list as a guide, MAP members were able to build off their prior efforts by affirming persistent gaps and also identifying additional priority gap areas.

MAP’s Pre-Rulemaking Findings on Gaps

The MAP pre-rulemaking process includes review of currently finalized program measure sets to identify gaps to be filled by available measures (i.e., an implementation gap) or by measures that need to be created (i.e., a development gap). MAP’s iterative review of the program measure sets and its list of previously identified measure gaps facilitate identification of both measure implementation and measure development gaps. In some cases, measures supported by MAP address multiple gap areas.

A current example of MAP recommending a measure under consideration for a program to fill a previously identified gap is NQF #0209 (Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment) for the PQRS program. This measure is included in the MAP Cancer, Duals, Hospice, and Safety Families of Measures; incorporates a patient-reported outcome (PRO); and is currently finalized for the Hospice Quality Reporting Program. Expanding its use to PQRS would help address a previously identified gap in implementation of measures concerning comfort at the end of life. Other measures that utilize a PRO were also supported by MAP. These measures help fill gaps in assessing the patient’s perspective of the care experience in addition to focusing on outcomes. MAP supported NQF #0228 (CTM-3), a PRO measure that addresses a gap in measuring care transitions, for the Hospital Value-Based Purchasing Program. Similarly, NQF #0258 (CAHPS In-Center Hemodialysis Survey) is a PRO measure MAP supported for inclusion in the ESRD Quality Incentive program that assesses person-centered communication, a separate but related gap area. Both the CTM-3 measure and the CAHPS measures are in the MAP Care Coordination and Dual Eligible Beneficiaries Families of Measures.

Despite the relatively large number of measures under consideration by MAP, members indicated that many measure gaps remain. In general, the types of gaps raised were consistent with those that MAP has previously identified and include: a need for more outcome measures; insufficient coverage of certain populations, such as children and the underserved; measures that are not specified at the desired level of analysis and/or setting (e.g., HCAHPS being tested only in the hospital inpatient setting creating a gap in patient experience measurement in the hospital outpatient, ambulatory surgical center, and long-term care hospital settings); measures that go beyond a “checkbox” approach to assess whether high standards of care are being met; a lack of composite measures for multifaceted topics; and a relative dearth of measures addressing certain specialty areas, such as mental and behavioral health. Each of the NQS priority areas remains affected to some degree by persistent measure gaps.

During this year’s pre-rulemaking process, the areas on MAP’s list of previously identified gaps were validated and some nuances were added. For instance, the Clinician Workgroup indicated that measures need to reflect a more diverse set of outpatient conditions, and the group struggled to find available measures that adequately balance issues under the control of individual clinicians versus the larger health system. Public commenters generally agreed with the gap areas identified on the list, and multiple organizations conveyed a need for better measures on diverse topics including care coordination, functional status, medication management, and palliative care. Some public commenters offered specific recommendations for additional priority gap areas, such as prevention and treatment of osteoporosis, and made suggestions for updates to the list of previously identified gaps.
Since implementation gaps also endure, MAP continues to seek opportunities to recommend use of the best available measures where feasible. One member of the Hospital Workgroup advocated that MAP Families of Measures should be used to fill some implementation gaps even when those measures are not on HHS’ list of measures under consideration for certain programs. An example provided for this point was NQF #0646 (Reconciled Medication List Received by Discharged Patients), which is in the MAP Safety Family of Measures and addresses a gap in medication safety, but was not under consideration for any acute care hospital programs. Although this measure assesses a basic process rather than an outcome, MAP in some cases has expressed willingness to support process measures for important issues until outcome measures are available.

**NQF’s Collaborative Initiative for Gap-Filling**

NQF has determined that a coordinated strategy for addressing measure gaps will be an area of focus for the organization in 2013, and has been planning a collaborative initiative for gap-filling. This initiative will build on findings from the 2012 NQF Measure Gap Analysis and Recommendations for Action Report, which includes a summary and analysis of measure gaps identified across the National Priorities Partnership (NPP), MAP, and NQF measure endorsement projects, and lays out a path for NQF’s work on gap-filling for this year and next year.

The Gaps Report’s first major recommendation emphasizes using existing measures wisely. While all stakeholders agree that both measure development and implementation gaps persist and many are crucial, the ultimate goal should be achieving high-value, parsimonious sets of measures. Excessive numbers of measures, measures that overlap, and measures that have low net benefit lead to data collection and reporting burden, as well as confusing signals about healthcare quality. Reducing measure use burden is a priority within NQF 2013 planning efforts. Aligning use of existing measures that meet the most important needs and are effective at driving improvement across settings and populations will help draw attention to the remaining highest priority needs for efficient gap-filling.

The second recommendation from NQF’s Gaps Report and part of NQF 2013 planning is to accelerate progress on the “next generation” of measures. The newer types of measures are often complex but may be able to address multiple priority gap areas. Examples of these measures include composites, PRO measures, resource use measures, and eMeasures. NQF 2013 planning has placed a particular emphasis on the latter, because work on eMeasures has been limited thus far but holds much promise to reduce burden and improve timeliness of quality reporting in the future. All of these measures will still need to meet the NQF endorsement criteria to ensure they are suitable for widespread use. NQF is considering the possibility of graded endorsement—analogous to a bond rating—to provide more granular guidance for the selection of measures for specific types of programs.

The third recommendation in the Gaps Report is that collaboration must be stronger to make optimal progress on closing measure gaps, which is also an integral component of NQF’s 2013 plan for a more coordinated initiative on gap-filling. The resources available to fund measure development, testing, and endorsement are finite, so stakeholders need to establish agreement on the highest priority measurement issues and how to overcome barriers to address them. Duplicative measure development efforts should be discouraged through greater information sharing and harmonization. Emphasis on improved collaboration should include stronger partnerships between stakeholders focused on gaps and those who fund, develop, test, endorse, and implement measures. The work includes proactive outreach to developers and connecting developers to test beds, including electronic health record (EHR) vendors.
Regularly convening measure developers for discussions with those who can elucidate the highest priority gaps can provide real-time feedback as measures are identified, developed, and implemented. NQF is also exploring ways to heighten collaboration through creation of a virtual “measure incubator,” which would allow stakeholders interested in addressing measurement gaps to collaborate with measure funders, developers, EHR vendors, healthcare systems with advanced measures, and local/regional collaboratives.

MAP members expressed strong support for NQF playing a coordination role in gap-filling and working closely with measure developers early in the development process in the role of “coach” to address gaps, rather than only as “referee” during endorsement. One MAP member expressed a collective need to better understand the development pipeline and the cost of stewarding a measure to assess barriers to measure development. Subsequent discussion touched on the need to create a business case for measure development. Another MAP member indicated that the lack of shared knowledge about which measure developers are already working on certain topics can lead to duplicative efforts and inefficient use of resources. The concept of a measure incubator was also met with much enthusiasm by MAP. MAP members pointed out that such a mechanism could focus developers on high-priority gap areas upstream, reduce the cost of and the timeline for development, and would also be an excellent forum for training inexperienced developers.

Public commenters broadly supported NQF’s initiative for making headway on gap-filling. Several of the public commenters mentioned that the measure incubator concept in particular is a promising step to increase collaboration and further progress. Some public commenters offered recommendations for new directions to take in measure development, such as making better use of alternate data sources and increasing research in important areas where evidence is limited. Several organizations stated an explicit desire to assist NQF in its ongoing efforts to address measure gaps.

MAP plays an important role in identifying and filling gaps in measure use. MAP’s work on identifying Families of Measures is already paying dividends by establishing agreement on high-value measures for parsimonious and aligned measure sets. To date, MAP has identified measure families for safety, care coordination, cardiovascular disease, diabetes, cancer, hospice, and dual eligible beneficiaries. In 2013, MAP has proposed identifying additional measure families for affordability, population health, patient and family engagement, and behavioral/mental health. Also during 2013, MAP will engage with stakeholders in new ways. MAP will put feedback loops in place to gather input on measure implementation experience. For example, MAP may learn that measures it has recommended to address gaps may subsequently be found to need modifications to be feasible for particular applications, or to avoid unintended consequences.

Although MAP’s work to date on measure gaps is starting to bear fruit, persistent gaps continue to frustrate measurement efforts. MAP has the capability, in coordination with NQF’s larger initiative, to influence ongoing progress in filling measure gaps through its specific recommendations and by enhanced collaboration with other stakeholders.
MAP Previously Identified Gaps

This section provides a synthesis of previously identified measure gaps compiled from all prior MAP reports. The gaps are grouped by NQS priority.

Safety

- Composite measure of most significant Serious Reportable Events

Healthcare-Associated Infections

- Ventilator-associated events for acute care, post-acute care, long-term care hospitals and home health settings
- Pediatric population: special considerations for ventilator-associated events and C. difficile
- Infection measures reported as rates, rather than ratios (more meaningful to consumers)
- Sepsis (healthcare-acquired and community-acquired) incidence, early detection, monitoring, and failure to rescue related to sepsis
- Post-discharge follow-up on infections in ambulatory settings
- Vancomycin Resistant Enterococci (VRE) measures (e.g., positive blood cultures, appropriate antibiotic use)

Medication and Infusion Safety

- Adverse drug events
  - Injury/mortality related to inappropriate drug management
  - Total number of adverse drug events that occur within all settings (including administration of wrong medication or wrong dosage and drug-allergy or drug-drug interactions)

- Inappropriate medication use
  - Polypharmacy and use of unnecessary medications for all ages, especially high-risk medications
  - Antibiotic use for sinusitis
  - Use of sedatives, hypnotics, atypical-antipsychotics, pain medications (consideration for individuals with dementia, Alzheimer’s, or residing in long-term care settings)

- Medication management
  - Patient-reported measures of understanding medications (purpose, dosage, side effects, etc.)
  - Medication documentation, including appropriate prescribing and comprehensive medication review
  - Persistence of medications (patients taking medications) for secondary prevention of cardiovascular conditions
  - Role of community pharmacist or home health provider in medication reconciliation

- Blood incompatibility

Perioperative/Procedural Safety

- Air embolism
- Anesthesia events (inter-operative myocardial infarction, corneal abrasion, broken tooth, etc.)
- Perioperative respiratory events, blood loss, and unnecessary transfusion
- Altered mental status in perioperative period

Venous Thromboembolism

- VTE outcome measures for ambulatory surgical centers and post-acute care/long-term care settings
- Adherence to VTE medications, monitoring of therapeutic levels, medication side effects, and recurrence
Falls and Immobility
- Standard definition of falls across settings to avoid potential confusion related to two different fall rates
- Structural measures of staff availability to ambulate and reposition patients, including home care providers and home health aides

Obstetrical Adverse Events
- Obstetrical adverse event index
- Measures using National Health Safety Network (NHSN) definitions for infections in newborns

Pain Management
- Effectiveness of pain management paired with patient experience and balanced by overuse/misuse monitoring
- Assessment of depression with pain

Patient & Family Engagement
Person-Centered Communication
- Information provided at appropriate times
- Information is aligned with patient preferences
- Patient understanding of information, not just receiving information (considerations for cultural sensitivity, ethnicity, language, religion, multiple chronic conditions, frailty, disability, medical complexity)
- Outreach to non-compliant patients

Shared Decision-Making and Care Planning
- Person-centered care plan, created early in the care process, with identified goals for all people
- Integration of patient/family values in care planning
- Plan agreed to by the patient and provider and given to patient, including advanced care plan
- Plan shared among all providers seeing the patient (integrated); multidisciplinary
- Identified primary provider responsible for the care plan
- Fidelity to care plan and attainment of goals
  - Treatment consistent with advanced care plan
- Social care planning addressing social, practical, and legal needs of patient and caregivers
- Grief and bereavement care planning

Advanced Illness Care
- Symptom management (nausea, shortness of breath, nutrition)
- Comfort at end of life

Patient-Reported Measures
- Functional status
  Particularly for individuals with multiple chronic conditions
- Optimal functioning (e.g., improving when possible, maintaining, managing decline)
  - Pain and symptom management
  - Health-related quality of life
  - Patient activation/engagement
**Healthy Living**

- Life enjoyment
- Community inclusion/participation for people with long-term services and supports needs
- Sense of control/autonomy/self-determination
- Safety risk assessment

**Care Coordination**

**Communication**

- Sharing information across settings
  - Address both the sending and receiving of adequate information
  - Sharing medical records (including advance directives) across all providers
  - Documented consent for care coordination
  - Coordination between inpatient psychiatric care and alcohol/substance abuse treatment

- Effective and timely communication (e.g., provider-to-patient/family, provider-to-provider)
  - Survey/composite measure of provider perspective of care coordination

- Comprehensive care coordination survey that looks across episode and settings (includes all ages; recognizes accountability of the multidisciplinary team)

**Care Transitions**

- Measures of patient transition to next provider/site of care across all settings, beyond hospital transitions (e.g., primary care to specialty care, clinician to community pharmacist, nursing home to home health) as well as transitions to community services
- Timely communication of discharge information to all parties (e.g., caregiver, primary care physician)

- Transition planning
  - Outcome measures for after care
  - Primary care follow-up after discharge measures (e.g., patients keeping follow-up appointments)
  - Access to needed social supports

**System and Infrastructure Support**

- Interoperability of EHRs to enhance communication
- Measures of “systemness,” including accountable care organizations and patient-centered medical homes
- Structures to connect health systems and benefits (e.g., coordinating Medicare and Medicaid benefits, connecting to long-term supports and services)

**Avoidable Admissions and Readmissions**

- Shared accountability and attribution across the continuum
- Community role; patient’s ability to connect to available resources

**Affordability**

- Ability to obtain follow-up care
- Utilization benchmarking (e.g., outpatient/ED/nursing facility)
- Consideration of total cost of care, including patient out-of-pocket cost
- Appropriateness for admissions, treatment, over-diagnosis, under-diagnosis, misdiagnosis, imaging, procedures
• Chemotherapy appropriateness, including dosing
• Avoiding unnecessary end-of-life care
• Use of radiographic imaging in the pediatric population

Prevention and Treatment for the Leading Causes of Mortality

Primary and Secondary Prevention

• Lipid control
• Outcomes of smoking cessation interventions
• Lifestyle management (e.g., physical activity/exercise, diet/nutrition)
• Cardiometabolic risk
• Modify Prevention Quality Indicators (PQI) measures to assess accountable care organizations; modify population to include all patients with the disease (if applicable)

Cancer

• Cancer- and stage-specific survival as well as patient-reported measures
• Complications such as febrile neutropenia and surgical site infection
• Transplants: bone marrow and peripheral stem cells
• Staging measures for lung, prostate, and gynecological cancers
• Marker/drug combination measures for marker-specific therapies, performance status of patients undergoing oncologic therapy/pre-therapy assessment
• Disparities measures, such as risk-stratified process and outcome measures, as well as access measures
• Pediatric measures, including hematologic cancers and transitions to adult care

Cardiovascular Conditions

• Appropriateness of coronary artery bypass graft and PCI at the provider and system levels of analysis
• Early identification of heart failure decompensation
• ACE/ARB, beta blocker, statin persistence (patients taking medications) for ischemic heart disease

Depression

• Suicide risk assessment for any type of depression diagnosis
• Assessment and referral for substance use
• Medication adherence and persistence for all behavioral health conditions

Diabetes

• Measures addressing glycemic control for complex patients (e.g., geriatric population, multiple chronic conditions) at the clinician, facility, and system levels of analysis
• Pediatric glycemic control
• Sequelae of diabetes

Musculoskeletal

• Evaluating bone density, and prevention and treatment of osteoporosis in ambulatory settings