HHS-Sponsored Measure Registry Needs Assessment

Exploration of Current Systems and Approaches for Measure Information Management

July 26, 2012
Agenda

- Overview of the Measure Registry Needs Assessment Project
- Learn about Several Systems and Approaches for Measure Information Management
- Open Discussion
HHS and other stakeholders have expressed interest in being able to identify and track measures and their versions along the measure development, endorsement, and use pipeline.

NQF is gathering input from stakeholders to understand:
- Measure information needs
- Systems or approaches currently in use
- Potential value in a standardized approach
Project Activities

June/July 2012
- Open call for information about current systems and approaches
- Stakeholder discussions

Sept. 5 2012
- In-person meeting to explore key issues and considerations for a standardized system or approach

Oct./Nov. 2012
- Webinar to present and discuss key findings from project
- Public comment period

End of 2012
- Final report to HHS with findings, related trade-offs, and potential recommendations
Today’s Speakers

- The Joint Commission
- Centers for Medicare & Medicaid Services/Health Services Advisory Group
- Kaiser Permanente
- Agency for Healthcare Research and Quality/ECRI Institute
- U.S. Department of Veterans Affairs
- National Quality Forum
The Joint Commission

Patty Craig
Joint Commission’s Performance Measurement Network Q&A Forum

July 26, 2012
Q&A Forum

Functionality

- Links to the Specification Manual for National Inpatient Quality Measures on the Joint Commission’s website
- Current, Future, and Historical versions of the Specifications Manual for Joint Commission National Quality Core Measures
  - Specification Manual Search
- Frequently Asked Questions
Q&A Forum

Functionality

- Link to the Joint Commission’s Core Measure Solution Exchange for accredited organizations
- Ability to Ask Questions
Q&A Forum

Welcome to the Performance Measurement Network Q&A Forum

Measure Specifications Manuals

<table>
<thead>
<tr>
<th>Joint Commission Only Measures</th>
<th>CMS and Joint Commission Aligned Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Future:</strong> Specifications Manual for Joint Commission National Quality Core Measures (version 2012B) 01 February 2012 (HBIPS and PC Measures: applicable to Discharges 07-01-12 (3Q12) through 12-31-12 (4Q12))</td>
<td><strong>Current Specification Manual for National Hospital Quality Measures</strong></td>
</tr>
<tr>
<td><strong>Current:</strong> Specifications Manual for Joint Commission National Quality Core Measures (version 2012A) 01 September 2011 (HBIPS and PC Measures: applicable to Discharges 01-01-12 (1Q12) through 06-30-12 (2Q12))</td>
<td><strong>Future Specification Manual for National Hospital Quality Measures</strong></td>
</tr>
<tr>
<td><strong>Historical Specification Manuals for National Hospital Quality Measures</strong></td>
<td><strong>Historical Specification Manuals for National Hospital Quality Measures</strong></td>
</tr>
</tbody>
</table>

Archived specification manuals...
Q&A Forum

- Version 2011A
  - Original release - version 2011A (01 December 2010)
- Version 2010B
  - Original release - version 2010B (01 Apr 2010)
  - First update - version 2010B1 (21 Jul 2010)
  - Final version - Version 2010B2 (21 September 2010)
- Version 2010A - HBIPS and PC Measures: applicable to Discharges 04-01-10 (2Q10) through 09-30-10 (3Q10))
  - First Update - version 2010A1 (08 Dec 2009)
  - Final version - version 2010A2 (11 Jan 2010)
# Q&A Forum

## Clinical Specification Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Related to</th>
<th>Answered on</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS Event Dates Prior to Admission</td>
<td>HBIPS,</td>
<td>20 Apr 2009 08:04</td>
</tr>
<tr>
<td>Is the ambulatory patient considered low risk for VTE?</td>
<td>STK,</td>
<td>08 Apr 2010 10:00</td>
</tr>
<tr>
<td>Why aren't there more newborn conditions exclusively feeding breast milk?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reason for Not Prescribing Antithrombotic Discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the Date and Time of Last Well Known</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documented both with a 0-10 scale AND ir</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke VTE Prophylaxis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Question:** HBIPS Event Dates Prior to Admission

Please verify the following is correct in regards to data collection and submission for HBIPs events:

Example: Patient arrived in ED on last day of month one. Patient admitted as inpatient on first day of month two. Event date for restraint event is documented in the ED (month one). There were additional restraint/seclusion events during the inpatient psychiatric stay (month two).

Data Collection: Do not report the month one restraint event, because this occurred prior to admission to the inpatient psychiatric care setting.

Report all of the other events that occurred during inpatient psychiatric stay (month two).

**Answer:**

You are correct. Only the events that occurred as an inpatient in the psychiatric unit would be reported. In this case only the month two events would be reported.

**Question Details**

Focus area(s): Measure Specifications - Clinical, Other

Related documents: HBIPS, Event measures and ED patients
Q&A Forum

Looking for solutions to improve core measure rates? Try the Core Measure Solution Exchange™ (A free application available to all Joint Commission Connect™ users from accredited organizations).

Core Measure Solution Exchange™
-Interactive forum for exchanging quality improvement practices within the diverse community of health care professionals from Joint Commission accredited organizations.

-Users can find (and share) real-world examples of solutions that have been used by organizations to significantly improve their performance on core measures.

Explore Solutions

Search for Solutions

Select Measure: All measures
Advanced search criteria... 
Show solutions
Specifications Manual

Release Notes


Previous Releases:

- Addendum v2011A - August 7, 2011
- Release Notes for Manual v2010B - April 1, 2010
  - Listserv Message - addendum to update for Manual v2010B - sent June 8, 2010

Printable Version

- Download a PDF version of the entire HBIPS Manual
- Download a PDF version of the entire Perinatal Care Manual
Specifications Manual

On this page:
- Set Measures
- General Data Elements
  - Algorithm Output Data Elements
- Measure Set Specific Data Elements
- Related Materials
  - Hospital-Based Inpatient Psychiatric Services (HBIPS) Measure Set
  - Initial Patient Population
- Sample Size Requirements
- Quarterly Sampling
- Monthly Sampling
- Sample Size Examples

Links within webpage and to other webpages

Set Measures

<table>
<thead>
<tr>
<th>Set Measure ID</th>
<th>Measure Short Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-1</td>
<td>Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed</td>
</tr>
<tr>
<td>HBIPS-2</td>
<td>Hours of physical restraint use</td>
</tr>
<tr>
<td>HBIPS-3</td>
<td>Hours of seclusion use</td>
</tr>
<tr>
<td>HBIPS-4</td>
<td>Patients discharged on multiple antipsychotic medications</td>
</tr>
<tr>
<td>HBIPS-5</td>
<td>Patients discharged on multiple antipsychotic medications with appropriate justification</td>
</tr>
<tr>
<td>HBIPS-6</td>
<td>Post discharge continuing care plan created</td>
</tr>
<tr>
<td>HBIPS-7</td>
<td>Post discharge continuing care plan transmitted to next level of care provider upon discharge</td>
</tr>
</tbody>
</table>

General Data Elements

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Collected For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birthdate</td>
<td>All Records,</td>
</tr>
<tr>
<td>CMS Certification Number</td>
<td>Hospital Clinical Data File, Optional for All Records,</td>
</tr>
<tr>
<td>Discharge Date</td>
<td>All Records, Not collected for HBIPS-2 and HBIPS-3</td>
</tr>
</tbody>
</table>

The Joint Commission

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HBIPS-1: Admission Screening For Violence Risk, Substance Use, Psychological Trauma History And Patient Strengths Completed.

Numerator Statement: Psychiatric inpatients with admission screening within the first three days of admission for all of the following: risk of violence to self or others; substance use; history of psychological trauma history, and patient strengths.

Denominator Statement: Psychiatric inpatient discharges.

Start

Run all cases that are included in the Initial Patient Population for HBIPS-1,4,5,6,7 and pass the edits defined in the Transmission Data Processing Flow. Clinical through this measure.

Length of Stay (in days) = Discharge Date – Admission Date

≤ 3 days or ≥ 365 days

> 3 days and < 365 days

HBIPS-1 X

Psychiatric Care Setting

= Missing

= N

HBIPS-1 B

Stratification Table:

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Stratified Measure Name</th>
<th>*Patient Age (Age Ranges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-1a</td>
<td>Overall Rate</td>
<td>1-12 years</td>
</tr>
<tr>
<td>HBIPS-1b</td>
<td>Children</td>
<td>13-17 years</td>
</tr>
<tr>
<td>HBIPS-1c</td>
<td>Adolescent</td>
<td>18-64 years</td>
</tr>
<tr>
<td>HBIPS-1d</td>
<td>Adult</td>
<td>≥ 65 years</td>
</tr>
<tr>
<td>HBIPS-1e</td>
<td>Older Adult</td>
<td></td>
</tr>
</tbody>
</table>

* Each case will be placed in the measure stratum according to the age group within which the case’s age falls in. After the Category Assignments are completed and overall rate is calculated.

** No allowable value for overall rate. Includes all Ages of Psychiatric inpatients
Showing results for **birth weight**
Search instead for **birthweight**

**DataElem0026 - Manual - Performance Measurement Network**
Data Element Name: **Birth Weight**. Collected For: PC-04, ... However, all **birth weights** must be converted to grams prior to indicator calculation. Suggested Data ...
manual.jointcommission.org/releases/TJC2012B/DataElem0026.html

**AppendixATJC - Manual - Performance Measurement Network**
... LOW BIRTHWT 500-999G. Table Number 11.14: **Birth Weight** 1000-1499 Grams ... Table Number 11.17: **Birth Weight** 2500 Grams and over. Code: Shortened ...
manual.jointcommission.org/releases/TJC2012B/AppendixATJC.html

**MIF0169 - Manual - Performance Measurement Network**
This is especially true for very low **birth weight** infants who are at high risk for these infections due to their immature immune systems and need for invasive ...
manual.jointcommission.org/releases/TJC2012B/MIF0169.html

**PerinatalCare - Manual - Performance Measurement Network**
**Birthweight** Missing or Unable To Determine (UTD). NO ICD-9-CM Other Diagnosis Code as defined in Appendix A, Table 11.20 Or **Birth Weight** < 500g. There is ...
manual.jointcommission.org/releases/TJC2012B/PerinatalCare.html
Specifications Manual

- Joint Commission employees with access to maintain the manual:
  - Maintenance is a combination of HTML and Wiki functions

---

This section defines the Introduction text displayed at beginning of topic.
%STARTSECTION{name="intro" type="section"}%

%ENDSECTION{name="intro" type="section"}%

This section defines the other text displayed at end of topic.
%STARTINCLUDE%

Perinatal Care (PC) Initial Patient Population

The PC measure set is unique in that there are two distinct Initial Patient Populations within the measure set, mothers and newborns.

"Mothers"<br>
The population of the PC-Mother measures (PC-01, 02, and 03) are identified using 4 data elements:
* Admission Date
* Birthdate
* Discharge Date
* ICD-9-CM Principal or Other Diagnosis Code</i>
Specifications Manual

- Joint Commission employees with access to maintain the manual:
  - Links the webpage to related sections of the manual.
  - Function is used to add data elements to a specific measure set.
  - Employees also enter release notes for each web page
Ask a New Question

Please [Login](#) or [register](#) on the Performance Measurement Network before posting a question regarding The Joint Commission's ORYX initiative, performance measurement requirements or measure specifications.

---

**Ask Question**

**Step 1: Assign Question Category**

To help us route your question to the appropriate staff, please select appropriate categories in this and the next screen.

**Identify general focus of new question: (select one)**

- **Performance Measurement System Vendor - General Question**
  
  *e.g., General ORYX questions, vendor timelines, vendor conference calls/meetings, communication issues (e.g., list server receipt), vendor infrastructure changes; new vendor evaluation; financial (accounts payable) questions*
  
  **Note:** Vendor specific operational processes, such as contract document review, demographic updates, non-core measure review and legal document exchanges should continue to be submitted to [oryxpms@jointcommission.org](mailto:oryxpms@jointcommission.org).

- **Measure Specifications - Clinical**
  
  *e.g., status of core/test core measure implementation; questions about core measure content, including clinical data elements; specifications manuals for measures; CMS alignment; Hospital Quality Alliance*

- **Health Care Organization - General ORYX Question**
  
  *e.g., What is ORYX?*
  
  **Note:** Questions concerning Joint Commission ORYX performance measure reporting requirements for accredited organizations and those either seeking accreditation or whose accreditation status changes as well as questions concerning measure set/measure selections, the ORYX Performance Measure Report, and core measure data presented on The Joint Commission's Quality Report should be submitted to [oryx@jointcommission.org](mailto:oryx@jointcommission.org).
Q&A Forum

Select Related Measure Sets and Measures: **Required**
- Click on "+" before Measure Set to show related Measures.
- Click on a measure set or measure to select, click again to de-select.

- ACHF - Advanced Certification Heart Failure
- AMI - Acute Myocardial Infarction
  - AMI-1 - Aspirin at Arrival
  - AMI-2 - Aspirin Prescribed at Discharge
  - AMI-3 - ACEI or ARB for LVSD

Select applicable focus area(s): (Check all that apply)
- Typographical error identified
- Other

Select Related Data Elements:
- Start typing name of Data Element. Autofill will list Data Elements starting with those letters.

Enter Data Element:

Select Related Supplemental Materials:
Select...

Select Version of Manual:
Select...
Q&A Forum

Ask a New Question

Step 3: View Related Questions

Focus area(s): Measure Specifications - Clinical

Related documents: AMI - Acute Myocardial Infarction
AMI-1 - Aspirin at Arrival
Transmission

- Effect of NUBC's retirement of Point of Origin for Admission or Visit on Core Measures
- What version of the Joint Commission manual will be used starting with January 1, 2010?

Related questions found: 2

Remember -- if your question is related to Joint Commission/CMS aligned measures, be sure to search the Quality Net system.

Not finding an answer to your question?

Click button below to proceed with posting your new message.
Q&A Forum

Ask a New Question

Step 4: Post Question

Question or short Summary: *(required)* (Please do not use quotes or special characters)

You have 100 characters left

Additional details:

**Question:** test

*If you wish to submit a file related to your question, you'll be able to do so.*

Post follow-up question

Question Details

**Focus area(s):** Measure Specifications - Clinical

**Related documents:** AMI, AMI-1, Transmission

**File:** 📂 Attach File

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Q&A Forum

- Joint Commission employees with access to the forum:
  - Can see all New, Acknowledged, and Answered Questions associated to the categories, measures, and manual sections they are assigned to
  - Employee can transfer the question to a different category, measure, or manual section to “transfer” the question to another employee.
  - Employees can access files attached by the requestor and attach their own files.
  - Answers to questions, including attached files are automatically e-mailed to the requestor.
Q&A Forum and Specification Manual is maintained by multiple Joint Commission employees.

- Q&A Forum is secured by login. Once a user has access they can change the categories they have access too.
- Specification Manual update is secured by login.
Q&A Forum

- Any user can access the manual and download the PDF files.
- Registered users can login to submit and review answers to their questions.
- Q&A Forum and Specification Manual is powered by a Wiki.
Questions or Comments?

Please enter questions into the text/chat box area at the bottom of your screen.
CMS Measures Inventory – Measures Management Tool

Overview
July 26, 2012

Health Services Advisory Group, Inc.
CMS Measures Management Special Study
Measures Management Tool

Overview and History

- **The Past**
  - CMS recognized the need to inventory and track the quality measures used in its programs.
  - Quality Measures Management Information System (QMIS), a Web-based tool, was developed and used (2006–2009).
  - The original QMIS was housed on QualityNet.
  - A second version was created for use on the cms.hhs.gov Web site.

- **The Present**
  - Since 2009, HSAG (the CMS Measures Management contractor) has maintained local databases to meet the needs of CMS.
  - The current CMS Measures Inventory – Measures Management Tool was developed in 2010.
Measures Management Tool

- **Purpose of the System**
  - Centralized storage of all CMS measures
  - Sorting and tracking of measures
  - Management of measures
  - Produce reports

- **Audience**
  - HSAG Measures Management team
  - Reports created for CMS
Measures Management Tool

- Uses
  - Quarterly CMS inventory report
  - CMS program-specific reports
  - ACA Section 3014 pre-rulemaking measures under consideration list
  - Annual update of CMS measures for HHS inventory
  - Ad hoc queries
  - Harmonization/Alignment reports
  - Tracking NQF-endorsement/maintenance
Measures Management Tool

- Platform
  - Microsoft Access user interface (front-end)
    - Allows for deployment to multiple user desktops
    - Allows changes to the user interface to be implemented quickly
  - Data are stored in a SQL database (back-end)
    - Allows for secure storage and back-up in a centralized location
Measures Management Tool

- Tool outline
  - Search functionality
  - Measure information screens
    - Measure details
    - Programs
    - Numerator/denominator
    - NQF endorsement
  - Utility menu
    - Allows team members to manage data in standard look-up tables without technical assistance
      - For example: Measure types, CMS programs
Measures Management Tool

- Main Menu
Measures Management Tool

- Search Page
Measures Management Tool

- Search Page (cont’d)
Measures Management Tool

- Measure Details

**Measure:** Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up

**Measure ID:** 233

**Description:** Percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.

**Setting:** Ambulatory care

**NQF ID:** 0420

**Type:** Process

**NPP Goal:** Patient Safety

**Measure Set:** PQRS; 2010 Individual Report

**Condition:** Pain

**Sub-Condition:**

**URL:**

**Unit of Measure:**

**Data Source:**

- Claims

**National Quality Strategy Priority:**

- Promoting the Most Effective Prevention and Treatment of Pain

---

Information for Health Care Improvement
Measures Management Tool

- Program(s)
# Measures Management Tool

- Numerator/Denominator

<table>
<thead>
<tr>
<th>Measure:</th>
<th>131 Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Patient’s pain assessment prior to initiation of therapy is documented through discussion with the patient including the use of a standardized tool AND a follow-up plan is documented when pain is present; Definitions: Pain Assessment: A clinical assessment of pain through discussions with the patient and use of a standardized tool(s) for the presence and characteristics of pain which may include location, intensity, quality, and onset/duration; Standardized Tool: An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for pain assessment, include, but are not limited to: Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS), and Visual Analog Scale (VAS). Follow-Up</td>
</tr>
<tr>
<td>Denominator:</td>
<td>All patients aged 18 years and older</td>
</tr>
<tr>
<td>Exclusions/Exceptions:</td>
<td>Patient refuses to participate; Severe mental and/or physical Incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools; Situations where the patient’s motivation to improve may impact the accuracy of results of nationally recognized standardized pain assessment tools; Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient’s health status.</td>
</tr>
</tbody>
</table>

Plan for Reporting: 
Level of Reporting: 

Close

Information for Health Care Improvement
Measures Management Tool

- NQF Endorsement
Measures Management Tool

- MMT Notes

![Image of Measures Management Tool interface](image)
Measures Management Tool

- Utility Menu

- Add/Edit Conditions Name
- Sub Conditions
- Link Subconditions to Condition
- Contractors Name
- Data Sources
- Measure Type
- CMS Programs
- Measure Steward
- NPP Goals
- Unit of Measurement
- NQF Status
- Measure Status
- Settings Description
- NQSP Description
- Program Use Description
- Program Status Description
- Return to the Main Menu
- Exit
# Measures Management Tool

- **Report Example**

<table>
<thead>
<tr>
<th>Program Status</th>
<th>CMS Program</th>
<th>Use</th>
<th>Measure</th>
<th>Description</th>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current - Not Implemented</td>
<td>Ambulatory Surgical Center Quality Reporting</td>
<td>ASC Quality Reporting</td>
<td>ASC-4: Hospital Transfer/ Admission</td>
<td>Percentage of ASC admissions (patients) who are transferred or admitted to a hospital upon discharge from the ASC</td>
<td>Ambulatory Surgery Center (ASC) admissions requiring a hospital transfer or hospital admission upon discharge from the ASC</td>
</tr>
<tr>
<td>Current - Not Implemented</td>
<td>Ambulatory Surgical Center Quality Reporting</td>
<td>ASC Quality Reporting</td>
<td>ASC-1: Patient Burn - Percentage of ASC admissions experiencing a burn prior to discharge</td>
<td>The number of admissions (patients) who experience a burn prior to discharge</td>
<td>Ambulatory Surgery Center (ASC) admissions experiencing a burn prior to discharge</td>
</tr>
<tr>
<td>Current - Not Implemented</td>
<td>Ambulatory Surgical Center Quality Reporting</td>
<td>ASC Quality Reporting</td>
<td>ASC-2: Patient Fall</td>
<td>Number of admissions (patients) who experience a fall within the ASC</td>
<td>Ambulatory Surgery Center (ASC) admissions experiencing a fall within the confines of the ASC</td>
</tr>
<tr>
<td>Current - Not Implemented</td>
<td>Ambulatory Surgical Center Quality Reporting</td>
<td>ASC Quality Reporting</td>
<td>ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing</td>
<td>To capture whether antibiotics given for prevention of surgical site infection were administered on time</td>
<td>Number of Ambulatory Surgery Center (ASC) admissions with an order for a prophylactic IV antibiotic for prevention of surgical site infection, who received the prophylactic antibiotic on time</td>
</tr>
<tr>
<td>Current - Not Implemented</td>
<td>Ambulatory Surgical Center Quality Reporting</td>
<td>ASC Quality Reporting</td>
<td>ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant</td>
<td>Percentage of ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant.</td>
<td>All Ambulatory Surgery Center (ASC) admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure or wrong implant.</td>
</tr>
<tr>
<td>Current - Not Implemented</td>
<td>Ambulatory Surgical Center Quality Reporting</td>
<td>ASC Quality Reporting</td>
<td>ASC-6: Ambulatory Surgery Patients with Appropriate Method of Hair Removal</td>
<td>Percentage of ASC admissions with appropriate surgical site hair removal.</td>
<td>ASC admissions with surgical site hair removal with clippers or depilatory cream</td>
</tr>
<tr>
<td>Current - Not Implemented</td>
<td>Ambulatory Surgical Center Quality Reporting</td>
<td>ASC Quality Reporting</td>
<td>ASC-7: Selection of Prophylactic First OR Second Generation Cephalosporin</td>
<td>Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first or second generation cephalosporin prophylactic antibiotic, who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis.</td>
<td>Surgical patients who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis.</td>
</tr>
<tr>
<td>Current - Not Implemented</td>
<td>Ambulatory Surgical Center Quality Reporting</td>
<td>ASC Quality Reporting</td>
<td>ASC-9: Safe Surgery Checklist</td>
<td>This measure assesses the adoption of a Safe Surgery Checklit that assesses whether effective communication and safe practices are performed during three distinct perioperative periods: 1) the period prior to the administration of anesthesia, 2) the period prior to skin incision, 3) the period of the closure of incision and prior to the patient leaving the operating room.</td>
<td>Surgical patients who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis.</td>
</tr>
<tr>
<td>Current - Not Implemented</td>
<td>Ambulatory Surgical Center Quality Reporting</td>
<td>ASC Quality Reporting</td>
<td>ASC-10: ASC Facility Volume Data on Selected ASC Surgical Procedures</td>
<td>Isolated CABG and Valve Surgeries (NGF# 0124), Percutaneous Coronary Intervention (PCI) (NGF# 0165), Pediatric Heart Surgery (NGF# 0340), Abdominal Aortic Aneurysm Repair (NGF# 357), Esophageal Resection (NGF# 3801), and Pancreatic Resection (NGF# 3950)</td>
<td>Surgical patients who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis.</td>
</tr>
</tbody>
</table>
**Measures Management Tool**

- **Most useful components**
  - **Flexibility**
    - Deleting/adding data fields
    - Meeting the complexity of CMS programs
    - Changes can be made quickly and relatively easily
  - **Query capabilities**
    - Overall list of measures
    - Used to find similar measures for alignment/harmonization purposes
    - Ad hoc query requests for special projects
Measures Management Tool

- Challenges—managing content
  - Frequency
    - Updates ongoing
  - Burden of maintaining accuracy
    - CMS program lead and/or contractor review
    - CMS program specifications manuals
    - NQF database
  - Alignment of fields and definitions to other measures database
  - Data entry—inconsistent format of information
Measures Management Tool

- Challenges
  - Frequently changing environment
    *Example:* IOM domains, National Priority Partnership Priorities, National Quality Strategy Priorities
  - The need to keep the system simple for users, yet flexible to meet needs
    *Example:* Finding a balance between ease of use and full search capabilities
  - Sharing information
  - Tool is only available to HSAG users
Measures Management Tool

- **Future enhancements desired**
  - Composite measures
  - Measures with multiple specifications
    - PQRS measures that may have two or three different data sources with accompanying specifications
    - Capturing current and future measure specifications concurrently
  - Identification of “same measures”
    - NQF ID is used to identify the same measure that may be used in a different program; however, no unique identifier exists for non-endorsed measures.
Measures Management Tool

- Lessons learned
  - High need for flexibility to meet evolving needs
  - Standardized reports needed, as well as flexibility for ad hoc reports and queries
  - Don’t expect too much too fast. Start simple before adding complex business requirements.
  - Web sites may have security restrictions that impede development of some functions.
Measures Management Tool

Summary

– Current CMS Measures Inventory Management Tool
  • Collaborative effort with internal team consisting of technical and subject-matter experts
  • Continuously evolves to meet business requirements
We convene providers, practitioners, and patients to build and share knowledge, spread best practices, and achieve rapid, wide-scale improvements in patient care; increases in population health; and decreases in health care costs for all Americans.

www.hsag.com

This material was prepared by Health Services Advisory Group, Inc., the Measures Management Innovation Project Contractor for the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

Publication No. AZ-10SOW-MM-072312-01
Questions or Comments?

Please enter questions into the text/chat box area at the bottom of your screen.
Kaiser Permanente

Joe Jentzsch
Quality Measure Clearinghouse

System Overview

Presented by
Joseph Jentzsch
July 24, 2012
Overview

The KP Quality Measure Clearinghouse (KPQMC) is an on-line repository of important quality measures collected and reported by KP nationally. Measures included in the Clearinghouse may be reported internally, externally, or both.

- KPQMC was created to provide the KP user community a solution with distinct advantages over alternative solutions*
  - KPQMC has a direct link to KP’s actual performance results for those measures that are in the Big Q Dashboard
  - KPQMC provides a search functionality that is proprietary and therefore can be fine-tuned to the needs of KP users
  - KPQMC is built on the Big Q Dashboard “look and feel”, providing familiar and comfortable navigation
  - KPQMC combined some potentially useful information available in either the AHRQ database or the NQF database, but not both

*NQF’s Quality Positioning System (QPS), or AHRQ’s National Quality Measures Clearinghouse (NQMC)
Overview (cont.)

Purpose

- Storage of metadata underlying important quality measures to assure reasonableness of inferences about improvements over time
- Tool to help inform senior leaders about the "balance" of quality measures across important domains and to guide decisions about resource allocation for quality measurement
- Repository to assist in responding to RFP's and for value demonstration purposes
- Provide advanced search functionality
  - Help demonstrate depth and breadth of quality measures for RFP's and other purposes
  - Provide retrievability of metadata
  - Provide linkage to KP performance results
Overview (cont.)

Audience

- Senior leaders
- Research
- Analytical
- Reporting groups
- Several others

KPQMC Maintenance

- Many different groups within KP maintain measures that are displayed
  - Each group has one or more designated “Contacts” that update measures their group maintains
    - Contacts responsible for all information about measures
  - Measures are grouped into Portfolios for ease of recognition within the tool
  - As new measures are identified, existing measures are retired or measure specifications change, the “Contact” updates the Quality Measure Clearinghouse
Overview (cont.)

Technical Platform

- Current (see Status slides below)
  - Hosted on Interwoven Teamsite Content Management System (HP Autonomy)
  - Web based tool set
    - DHTML
    - VBScript
    - XML
  - Data repository
    - MS Access
Quality Measure Clearinghouse

Status

KPQMC is currently a fully functional prototype populated with HEDIS® and TJC measures

- Description
- Definitions
- Eligible Population
- Denominator
- Exclusions
- Numerator
- Steward Linkage (as applicable)
  - Unique Code
  - Collection
  - Set and Subset
  - Link to PDF version of Technical Specification
Status (cont.)

KPQMC Under Construction Activities

- Linkage to AHRQ
- Linkage to NQF
- Display of eMeasure Specification (where applicable)
- Linkage to BigQ
- Where measure is used
  - ACO, CMS Part C / D Stars, Meaningful Use, etc.
- Key categorization / classification
  - Domain, IOM Domain, Setting, Condition, Data Source, Current Use
- Versioning functionality
  - Changes in specification
  - Trigger process change designation in Big Q
Status (cont.)

KPQMC Under Construction Activities (cont.)

- Migration to Production System
  - Hosted on Virtual Windows 2008 R2 server
  - Web based tool set
    - ASP.NET (Razor)
  - Data Repository
    - SQL Server
    - MS Access for front end data entry
  - Adding relevance ranking to search engine
# KPQMC Measure Maintenance

## Required Information

<table>
<thead>
<tr>
<th>Measure Maintenance Grid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portfolio: TJC</td>
</tr>
<tr>
<td>Measure Contact Name:</td>
</tr>
<tr>
<td>Filter by Contact:</td>
</tr>
<tr>
<td>Sequence (PK): 100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name (Short):</th>
<th>Aspirin at Arrival</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (Long Version):</td>
<td>Aspirin at Arrival (AMI-1)</td>
</tr>
<tr>
<td>Measure Type:</td>
<td>Computed Measure</td>
</tr>
<tr>
<td>Numerator Count:</td>
<td>1</td>
</tr>
<tr>
<td>Category:</td>
<td>Inpatient Effectiveness</td>
</tr>
<tr>
<td>Steward Name:</td>
<td>TJC</td>
</tr>
<tr>
<td>Steward's Code:</td>
<td>AMI-1</td>
</tr>
<tr>
<td>Steward Collection:</td>
<td>TJC</td>
</tr>
<tr>
<td>Steward Set:</td>
<td>Acute Myocardial Infarction (AMI)</td>
</tr>
<tr>
<td>Steward Subset:</td>
<td></td>
</tr>
<tr>
<td>Product Lines:</td>
<td>Commercial, Medicaid, Medicare, Medicare SNP</td>
</tr>
<tr>
<td>Description:</td>
<td>Acute myocardial infarction (AMI) patients who received aspirin within 24 hours before or after hospital arrival. The early use of aspirin in patients with acute myocardial infarction results in a significant reduction in adverse events and subsequent mortality. The benefits of aspirin therapy on mortality are comparable to fibrinolytic therapy. The combination of aspirin and fibrinolysis provides additive benefits for patients with ST-elevation myocardial infarction (STEMI-2, 1988). Aspirin is also effective in patients with non-ST-elevation myocardial infarction (Theroux, 1988 and RISE Group, 1990).</td>
</tr>
<tr>
<td>Definitions:</td>
<td></td>
</tr>
<tr>
<td>Contact Name:</td>
<td>Patrick Smith</td>
</tr>
<tr>
<td>Tech Spec Link:</td>
<td>tjc/2b_ami1.pdf</td>
</tr>
<tr>
<td>Status:</td>
<td>Active</td>
</tr>
</tbody>
</table>

**Eligible Populations:**

AMI patients included: Populations: Discharges with an ICD-9-CM Principal Diagnosis Code for AMI as defined in Appendix A, Table 1.1

**Denominator:**

AMI patients included: Populations: Discharges with an ICD-9-CM Principal Diagnosis Code for AMI as defined in Appendix A, Table 1.1

**Numerator:**

AMI patients who received aspirin within 24 hours before or after hospital arrival

**Excluded Populations:**

- Patients less than 18 years of age
- Patients who have a Length of Stay greater than 120 days
- Patients with Comfort Measures Only documented on day of or day after arrival
- Patients enrolled in clinical trials
- Patients discharged on day of arrival
- Patients discharged to another hospital on day of or day after arrival
- Patients who left against medical advice on day of or day after arrival
- Patients who expired on day of or day after arrival
- Patients with a documented Reason for No Aspirin on Arrival

*Privileged and Confidential*
Quality Measure Clearinghouse

KPQMC Measure Maintenance

Required information (cont.)

![Screenshot of Measure Maintenance](image-url)

**NOF-ENDORSED VOLUNTARY CONSSENSUS STANDARDS FOR HOSPITAL CARE**

**Measure Information Form**

**Collected For:** The Joint Commission Only

CMS Voluntary Only

**Measure Set:** Acute Myocardial Infarction (AMI)

**Set Measure ID #:** AMI-1

**Performance Measure Name:** Aspirin at Arrival

**Description:** Acute myocardial infarction (AMI) patients who received aspirin within 24 hours before or after hospital arrival

**Rationale:** The early use of aspirin in patients with acute myocardial infarction results in a significant reduction in adverse events and subsequent mortality. The benefits of aspirin therapy on mortality are comparable to fibrinolytic therapy. The combination of...
KPQMC Measure Maintenance

Linkage
KPQMC Measure Maintenance

Categorization / Classification
User Experience

Initial Screen

- User is presented with a list of all measures in KPQMC.
User Experience (cont.)

Filter Results

- Enter Search Term (mimic “Google”)

![Quality Measure Clearinghouse](image-url)
User Experience (cont.)

Filter Results (cont.)

- List is limited to measures that contain the exact phrase as well as those that contain one or more of the search terms entered.
Quality Measure Clearinghouse

User Experience (cont.)

Filter Results (cont.)

• Further restrict list
  o Quick Filters
  o Additional Criteria
    – Only fully populated fields are presented as options
User Experience (cont.)

View Measure

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Name (Long)</th>
<th>Measure Type</th>
<th>Numerator Count</th>
<th>Category</th>
<th>Steward</th>
<th>Steward Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>TJC5102</td>
<td>Median Time from ED Arrival to ED Departure for Admitted ED Patients - Reporting Measure (ED-1a)</td>
<td>Computed Measure</td>
<td>1</td>
<td>Inpatient: Effectiveness</td>
<td>TJC</td>
<td>ED-1a</td>
</tr>
</tbody>
</table>

**Description:**
Median Time from ED Arrival to ED Departure

**Denominator:**
Any ED Patient from the facility's emergency department

**Eligible Populations:**
Any ED Patient from the facility's emergency department

**Numerator:**
ED-1a: Median Time from ED Arrival to ED Departure for Admitted ED Patients

**Steward:**
TJC

**Steward Code:**
ED-1a

**Steward Collection:**
TJC

**Steward Set:**
Emergency Department Measures

**Technical Spec Links:**
Steward Technical Spec Links

**Frequency:**
Quarterly

**Risk Adjusted:**
No

**Product Lines:**
Medicare, Medicaid, Commercial

**IOM Domain:**
Effectiveness

**Reports:**
Promoting a Quality Culture

---

**Note:**
Rationale: Reducing the time patients remain in the emergency department (ED) can improve access to treatment and improve the quality of care. Reducing this time is potential to improve access care specific to the patient condition and increases the capability to provide additional treatment. In recent times, EDs have experienced significant overcrowding. Although not only a problem in large, urban, teaching hospitals, the phenomenon has spread to other urban and rural healthcare organizations. According to a 2002 national U.S. survey, more than 50% of large hospitals report Ed operating "at or over" capacity. Additionally, one third of hospitals in the US report increases in ambulance diversion in a given year, which is up to half report crowded conditions in the ED. In a recent national survey, 39% of hospital leaders viewed ED overcrowding as a symptom of workforce shortages. ED overcrowding may result in delays in the administration of medication such as anticoagulants, and has been associated with perceptions of compromised emergency care. For patients with non-ST-segment-elevation myocardial infarction, long ED stays were associated with decreased use of guideline-recommended therapies and a higher risk of recurrent myocardial infarction. Overcrowding and heavy emergency resource demand have led to a number of problems, including ambulace refusals, prolonged patient waiting times, increased suffering for those who wait, and increased demands on treatment environments and potentially poor patient outcomes. When EDs are overcrowded, their ability to respond to community emergencies and disasters may be compromised.
User Experience (cont.)

View Measure (cont.)

- If technical specification is available online, a link is provided
- If measure is in AHRQ's National Quality Measures Clearinghouse (NQMC), a link is provided
- If measure is in NQF's Quality Positioning System (QPS), a link is provided
  - If a eMeasure specification is available, both the human readable and value sets links are provided
User Experience (cont.)

View Measure (cont.)

- If the measure is on the Big Q Dashboard, a link is provided
Questions or Comments?

Please enter questions into the text/chat box area at the bottom of your screen.
NQF Measure Registry Needs Assessment Webinar

The National Quality Measures Clearinghouse (NQMC)
July 26, 2012

Mary P. Nix, MS, MT(ASCP)SBB, PMP (AHRQ)
Vivian H. Coates, MBA (ECRI Institute)
Melanie M. Swan, MPH, PMP (ECRI Institute)
NQMC Purpose

- Promote widespread access to evidence-based quality measures
  - Provide accessible mechanism for obtaining detailed information on quality measures
  - Further their dissemination, implementation, and use to inform health care decisions

- Database & Web Site
  - Information on specific evidence-based health care quality measures and measure sets
  - [www.qualitymeasures.ahrq.gov](http://www.qualitymeasures.ahrq.gov)
Audience

- Physicians
- Physician Assistants or Nurse Practitioners/Nurses
- Quality Managers
- Measure Developers
- Health Services/Clinical Researchers
- Students (Medical, Nursing or Pharmacy)
- Administrators/Managers of Hospital, Health Plan or Medical Group
- Educators/Teachers/Instructors
- Pharmacists or Other Clinical Specialists
Inputting/Managing Information Over Time

1. Measures submitted to NQMC and copyright received (if applicable)

2. NQMC reviews against inclusion criteria and developer is notified of submission status (2 to 3 weeks)

3. Measures enter NQMC work queue (summaries prepared and reviewed) (approximately 8 to 10 weeks) (Naming Measures, Template of Measure Attributes, Classification Scheme)

4. Developer verification (3 to 4 weeks)

5. Post to NQMC Web site (2 to 3 weeks)

6. Annual verification – reassess currency of measures annually
Major Features – Domain Framework

NQMC Domain Framework

- Health Care Delivery Measures
  - Measures applied to clinicians, clinical delivery teams, delivery organizations, or health insurance plans

- Clinical Quality Measures
  - Process
  - Access
  - Outcome
  - Structure
  - Patient Experience

- Clinical Efficiency Measures
  - User-Enrollee Health State
    - Management
    - Use of Services
    - Cost
    - Efficiency

- Population Health Measures
  - Measures applied to public health agencies, organizations that are not primarily deliverers of care, or geographic regions

- Population Health Quality Measures
  - Population Process
  - Population Access
  - Population Outcome
  - Population Structure
  - Population Experience

- Related Population Health Measures
  - Population Health State
  - Population Management
  - Population Use of Services
  - Population Cost
  - Population Health Knowledge
  - Social Determinants of Health
  - Environment
  - Population Efficiency

- Related Population Efficiency Measures
  - Population Efficiency
NQMC Challenges – Maintaining System & Information

- **Work involved in**
  - Measure lead development
  - Getting copyright permission to include specific measures
  - Getting clean data: NQMC staff input all data

- **Versioning**
  - NQF endorsed versions vs versions in current use
  - NHQR/NHDR
  - Measure developers may not realize when they create new versions

- **Developer burden – dual submission**
  - NQF and NQMC
Keeping on top of measure endorsement, measure initiatives

Frequency of measure updating/lack thereof

Keeping pace with rapidly evolving quality measures field

Transition to eMeasures

Multi-domain composites

Care coordination/transition measures
Most Useful NQMC Components

- Domain framework
- Measure naming convention
- Inclusion criteria
- Template of measure attributes
- Extensive meta-tagging, including UMLS indexing of all content (summaries, commentaries)
  - Display UMLS concepts
- Citation management system
- Annual verification
Lessons Learned/Incentives

- Robust measure lead development critical
- Facilitated processing of content
  - Post-publication verification
  - “Blanket” copyright permission
- Need for extensive workflow tracking
- Help users understand why different # of NQF-endorsed measures in NQMC vs NQF
- Users want to see measure results (user inquiries, user needs assessment)
HHS Measure Inventory

- **Purpose:** Provide public an inventory of the measures that are currently being used by HHS agencies for quality measurement, improvement, and reporting

- **Goal:** Advance collaboration among members of the quality community and to advance the effective use and harmonization of quality of care measures

- **Audience:** public, quality community
HHS Measure Inventory

- **Platform:** NQMC (relational database backend, integrated web front end)

- **Process:** HHS leads annual call for & collection of measures and updates, NQMC assists

- **Content:**
  - One inclusion criterion
  - 16 attributes
<table>
<thead>
<tr>
<th></th>
<th>NQMC</th>
<th>HHS Measures Inventory</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>Wide dissemination evidence-based measures, sets</td>
<td>Public transparency of measures in use by HHS</td>
</tr>
<tr>
<td><strong>Inclusion Criteria</strong></td>
<td>4 criteria</td>
<td>1 criterion</td>
</tr>
<tr>
<td><strong>Audience</strong></td>
<td>Same</td>
<td>Same</td>
</tr>
<tr>
<td><strong>Platform</strong></td>
<td>Same</td>
<td>Same</td>
</tr>
<tr>
<td><strong>Content inputs</strong></td>
<td>NQMC team</td>
<td>HHS agencies</td>
</tr>
<tr>
<td><strong>Naming Convention</strong></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Measure Attributes</strong></td>
<td>&gt;60</td>
<td>16</td>
</tr>
<tr>
<td><strong>Taxonomy</strong></td>
<td>UMLS-driven, plus additional controlled vocabularies developed by NQMC team</td>
<td>HHS-driven at start; continue to refine &amp; align with NQMC</td>
</tr>
<tr>
<td><strong>Indexing</strong></td>
<td>Professional indexers</td>
<td>No</td>
</tr>
<tr>
<td><strong>Download measure attribute content</strong></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Cross-linking</strong></td>
<td>Will be</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Compare side-by-side</strong></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
Thank you!

Questions?

Mary Nix, mary.nix@ahrq.hhs.gov
Vivian Coates, vcoates@ecri.org
info@qualitymeasures.ahrq.gov
Questions or Comments?

Please enter questions into the text/chat box area at the bottom of your screen.
U.S. Department of Veterans Affairs

Steven M. Wright
Kristin Janssen
Measure Management System within the Department of Veterans Affairs Healthcare System

Office of Analytics and Business Intelligence
Steven M. Wright & Kristin Janssen
26 July 2012
Background: Veterans Health Administration

• 153 Hospitals, 800+ Community Based Outpatient Clinics, comprehensive delivery of health care to veterans.

• Key Attributes of the Performance Measurement System
  – Driver of VHA quality improvement
  – Transparency (no black box business rules or methodologies)
  – Network and facility managers performance plan
  – Management of large inventory of measures (>400)
Types of Measures in VA System

- Accountability - Managers’ Performance Appraisal Plan
- Quality Indicators (with and without goals) – monitoring and tracking
- Operational – internal operational metrics
- External stakeholders (e.g., Congress)
Metric Development

Identify Priorities

- Imposed Priorities:
  - OIG
  - OMB
  - GAO

- VHA Programs and Offices:
  - Special Populations
  - Administrative Services
  - National Prevention Center
  - Special Studies

- VHA Strategic Initiatives:
  - Strategic Planning
  - Secretary Priorities

- Evidence Based Practice:
  - Clinical Guideline Recommendations
  - Emerging Evidence
  - Research

Develop Measures

- Priorities assigned for Development and Piloting

- Development of a Performance Metric with Clinical Sponsors

- Final review and approval

- Defined for Accountability vs. Quality Improvement

- Targets sets for Accountability Metrics

Measurement Oversight

Imposed Priorities:

- OIG
- OMB
- GAO

External Comparators:

- Joint Commission
- NCQA
- CMS
- NQF
- AHRQ

VHA Programs and Offices:

- Special Populations
- Administrative Services
- National Prevention Center
- Special Studies

VHA Strategic Initiatives:

- Strategic Planning
- Secretary Priorities

Evidence Based Practice:

- Clinical Guideline Recommendations
- Emerging Evidence
- Research

Implementation
PITA - Performance Integrated Tracking Application
Core of VA Measure Management System

- Metadata library of information about performance measures that contains the technical specifications and administrative attributes about measures.
- PITA is a tool used for:
  - Internal management of measures
  - Drive specifications for reporting
  - Populate technical manual for measure users
- PITA users:
  - Facility Quality Managers and front line staff
  - Facility Directors
  - Network Directors
  - Program Office Administration
  - Leadership
Integrated Measure Management System
Integrated Measure Management System
Electronic Technical Manual (eTM)
Measure Measurement System - Useful Components

- Centralization of measure management and reporting
- Central repository for measure specifications and results
- Standardized definition of measures and key attributes for collection and scoring
- Standardized assignment of unique mnemonic for tracking and continuity
- Integrity of data, metadata and reporting
- Recognition of leaders and field that PITA is gold standard source for data
PITA Tool

Welcome: Kristin Janssen
You permission set is:
  Measure Helper  No
  Measure Owner  Yes
  Is Administrator  Yes

View Measure Summary
Create NEW Measure

Administrator Only Options
Manage Issues
Manage People
Manage Organizations

Common Links
  Electronic Technical Manual
  Contact Summary (for SHRED)
  Change History

Owner Links
  EPRP Measure Run Chart

Admin Links
  Issue Management
  GC: What Measures are in Which Years?
  Check Condition of Measures

Change Management
  Change Management Summary
  Create NEW Change Record

VETERANS HEALTH ADMINISTRATION
PITA: Specifications and Administrative Attributes

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Domain</td>
<td>Clinical</td>
</tr>
<tr>
<td>Tech Manual Contact</td>
<td>Kristin Janssen</td>
</tr>
<tr>
<td>Tech Manual Contact Office</td>
<td>OQP / OQP</td>
</tr>
<tr>
<td>Clinical Measure Type</td>
<td>Process</td>
</tr>
<tr>
<td>Cohort</td>
<td>DM Outpatients</td>
</tr>
<tr>
<td><strong>Cohort Inclusions</strong></td>
<td>Evidence in the medical record that within the past two years, the patient refused VHA Primary Care and is receiving ONLY his/her primary care in a non-VHA setting.</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>DM outpatients in sample</td>
</tr>
<tr>
<td><strong>Denominator Inclusions</strong></td>
<td>Bilateral lower extremity amputation</td>
</tr>
<tr>
<td><strong>Denominator Exclusion</strong></td>
<td>Documentation in record that within the past year the pulses were checked in the patient’s feet</td>
</tr>
<tr>
<td>Previous Results</td>
<td></td>
</tr>
<tr>
<td>Business Rules for setting goals</td>
<td></td>
</tr>
</tbody>
</table>
## 2012 Performance Measure Report For National

<table>
<thead>
<tr>
<th>Measure Type</th>
<th>Measure Name</th>
<th>Mnemonic</th>
<th>Most Recent Data Data Provided</th>
<th>Target</th>
<th>YTD</th>
<th>Qtr1</th>
<th>Qtr2</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCPP</td>
<td>PACT Implementation</td>
<td>pact1</td>
<td>7/9/2012</td>
<td>3/5</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>PACT: Completed PC Appts w/in 7d of Desired Data</td>
<td>pact6</td>
<td>7/9/2012</td>
<td>50%</td>
<td>88.83%</td>
<td>89.79%</td>
<td>89.52%</td>
</tr>
<tr>
<td></td>
<td>PACT: Same-Day Appts w/PCP</td>
<td>pact7</td>
<td>7/9/2012</td>
<td>66%</td>
<td>56.03%</td>
<td>55.43%</td>
<td>55.82%</td>
</tr>
<tr>
<td></td>
<td>PACT: Primary Care Provider Continuity</td>
<td>pact8</td>
<td>7/9/2012</td>
<td>75%</td>
<td>75.05%</td>
<td>74.80%</td>
<td>75.70%</td>
</tr>
<tr>
<td></td>
<td>PACT: Telephone Utilization</td>
<td>pact9</td>
<td>7/9/2012</td>
<td>20%</td>
<td>27.09%</td>
<td>22.69%</td>
<td>28.82%</td>
</tr>
<tr>
<td></td>
<td>PACT: Post-Discharge Contact</td>
<td>pact11</td>
<td>7/9/2012</td>
<td>50%</td>
<td>44.85%</td>
<td>32.92%</td>
<td>48.85%</td>
</tr>
<tr>
<td></td>
<td>HUD-VASH Vouchers - Percentage of Veterans Housed</td>
<td>huds3</td>
<td>7/10/2012</td>
<td>88%</td>
<td>88.12%</td>
<td>76.40%</td>
<td>83.08%</td>
</tr>
</tbody>
</table>
PITA: Change Management of Meta Data

- Internal
  - Log of all changes made to record during development, piloting and implementation
  - Two tiered approval process for changes
  - Issue tracking to monitor pending change, items for clarification
- External
  - Transparent log of all changes (doesn’t post spelling corrections, etc.)
  - Ability to link a retired measure to the next iteration and vice versa
Challenges

• Complex organization with complex process for measurement development and reporting
• Initial development of a one stop shopping reporting platform
• Introduction of eTM to user community
• Capturing variety of measures being used
• Standardization of measure name (mnemonic) - Facilities that have modified national measures but not the name/mnemonic
Lessons Learned

• Measurement, database and reporting expertise required – need all the players to succeed
• Transparency in change management - PITA tool in use while undergoing refinements
• Leadership Support to champion development and use of tool
• Need mechanism to identify/accommodate pilots and developing measures
Questions or Comments?

Please enter questions into the text/chat box area at the bottom of your screen
National Quality Forum

Jason Johnson
Anisha Dharshi
NQF’s Measure Information Management

- Track measure information for NQF’s measure endorsement and maintenance processes.
- Provide access to support measure development and use of endorsed measures.
- Rely on a back-end database to house full measure specifications and related information (from measure developers and staff).
Naming Conventions & Versioning

- Measures are assigned a number and retain that number throughout their lifecycle, regardless of endorsement status.

- Measure versions are documented using a numbering system. The convention reflects ‘major’, ‘minor’, and ‘patch’ updates to a measure.
Through the Quality Positioning System (QPS), anyone can access information about endorsed measures.

Only major updates to endorsed measures are displayed publicly.
Open Discussion

Please enter questions into the text/chat box area at the bottom of your screen.
Next Steps

- Webinar recording and summary posted next week
- Stakeholder Discussion Summary on NQF website
- In-person meeting: September 5, 2012
- Final report to HHS: End of 2012

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