## Measure Applications Partnership Hospital Workgroup Discussion Guide

*Notes for Measure Deliberations*

*Version Number*: 3.1  
*Meeting Date:* December 16-17, 2015

## Full Agenda

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| **Day 1** |  |
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| 8:30 am | Breakfast |
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| 9:00 am | Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives |
|  | Cristie Upshaw Travis, MAP Hospital Workgroup Co-Chair; Ronald Walters, MAP Hospital Workgroup Co-Chair; Christine Cassel, President and CEO, NQF; Ann Hammersmith, General Counsel, NQF |
| 9:15 am | CMS Opening Remarks |
|  | Pierre Yong, CMS |
| 9:30 am | Overview of Pre-Rulemaking Approach |
|  | Erin O’Rourke, Senior Project Manager, NQF; Zehra Shahab, Project Manager, NQF |
| 9:45 am | Overview of the Hospital Inpatient Quality Reporting (IQR) |
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| 9:50 am | Opportunity for Public Comment on Measures Under Consideration for IQR |
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| 10:00 am | Pre-Rulemaking Input on Hospital Inpatient Quality Reporting (IQR) Measure Set - Consent Calendar 1 |
|  |  |
|  | Programs under consideration: Hospital Inpatient Quality Reporting and EHR Incentive Program |
|  | 1. **Adult Local Current Smoking Prevalence** (MUC ID: MUC15-1013)    * *Description:* Percentage of adult (age 18 and older) U.S. population that currently smoke, defined as adults who reported having smoked at least 100 cigarettes in their lifetime and currently smoke. (*The endorsed specifications of the measure are: Percentage of adult (age 18 and older) U.S. population that currently smoke.*)    * *Preliminary analysis summary*      + *Contribution to program measure set:*This structure measure addresses the high-priority domain “Best Practices of Healthy Living” but it does not fill any of the high-priority gap areas previously identified by CMS. CMS has indicated strong interest in exploring this measure with MAP. The measure is under development for the city and county level of analysis. The applicability of this population measure to the role of hospitals needs further exploration. Furthermore, this measure is focused on smoking and does not align with the tobacco use screening and treatment provided measures currently in the IPFQR program or other tobacco use measures in other programs.      + *Impact on quality of care for patients:*This measure is an indicator of population health at the city or county level rather than the quality of care received in the acute inpatient setting. The updated tobacco use and dependence guideline recommends coordinated interventions between the clinician, health care administrator, insurer, and purchaser therefore quality measurement should focus on all entities to ensure tobacco users receive consistent and effective interventions.    * *Preliminary analysis result:* Encourage further development    * *Notes:* 2. **American College of Surgeons-Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure** (MUC ID: MUC15-534)    * *Description:* Organ/space Surgical Site Infections (SSI) at the primary incision site among adult patients at least 18 years of age undergoing inpatient colon procedures and/or abdominal hysterectomies as reported through the ACS-NSQIP or CDC NHSN. The measure yields separate SIRs for each procedure. (*The endorsed specifications of the measure are: Prototype measure for the facility adjusted Standardized Infection Ratio (SIR) of deep incisional and organ/space Surgical Site Infections (SSI) at the primary incision site among adult patients aged >= 18 years as reported through the ACS National Surgical Quality Improvement Program (ACS-NSQIP) or CDC National Health and Safety Network (NHSN). Prototype also includes a systematic, retrospective sampling of operative procedures in healthcare facilities. This prototype measure is intended for time-limited use and is proposed as a first step toward a more comprehensive SSI measure or set of SSI measures that include additional surgical procedure categories and expanded SSI risk-adjustment by procedure type. This single prototype measure is applied to two operative procedures, colon surgeries and abdominal hysterectomies, and the measure yields separate SIRs for each procedure.*)    * *Preliminary analysis summary*      + *Contribution to program measure set:*This is an update to the name of the measure from “reliability adjusted SIR” to “Adjusted Ranking Metric (ARM).”      + *Impact on quality of care for patients:*The continued use of this measure will promote SSI prevention activities, which will lead to an improvement in patient outcomes, reducing avoidable medical costs, patient morbidity and mortality. Guidelines to prevent SSIs are available here (<http://www.cdc.gov/hicpac/SSI/001_SSI.html>).    * *Preliminary analysis result:* Conditional support, pending NQF annual update    * *Notes:* 3. **INR Monitoring for Individuals on Warfarin after Hospital Discharge** (MUC ID: MUC15-1015)    * *Description:* Percentage of adult inpatient hospital discharges to home for which the individual was on warfarin and discharged with a non-therapeutic International Normalized Ratio (INR) who had an INR test within 14 days of hospital discharge    * *Preliminary analysis summary*      + *Contribution to program measure set:*This facility level measure has been submitted to NQF for endorsement and has been reviewed and recommended by the Patient Safety Standing Committee and is currently in the voting phase. This measure addresses two gap areas identified by CMS as high-priority, adverse drug events and care transitions. This measure also compliments the VTE (NQF #0373) and stroke (NQF #0436) measures currently in the IQR program which do not assess INR after discharge. The burden of implementing this hybrid measure should be minimal because the data sources include administrative claims and EHR.      + *Impact on quality of care for patients:*Implementing this measure can help to ensure a timely INR after hospital discharge and help prevent readmissions and reduce mortality associated with warfarin-related bleeding and thromboembolic events.    * *Preliminary analysis result:* Support    * *Notes:* 4. **IQI-22: Vaginal Birth After Cesarean (VBAC) Delivery Rate, Uncomplicated** (MUC ID: MUC15-1083)    * *Description:* Vaginal births per 1,000 deliveries by patients with previous Cesarean deliveries. Excludes deliveries with complications (abnormal presentation, preterm delivery, fetal death, multiple gestation diagnoses, or breech procedure).    * *Preliminary analysis summary*      + *Contribution to program measure set:*This facility level measure is currently one of AHRQ’s IQIs and reported by multiple states. If implemented this measure will complement the elective delivery measure (NQF #0469) currently in the program.      + *Impact on quality of care for patients:*Cesarean deliveries are a common surgical procedure in the United States, accounting for 1 in 3 US births. A planned labor after cesarean/vaginal birth after cesarean (LAC/VBAC) is an appropriate option for most women with a history of prior cesarean birth. Increased access to providers and facilities capable of managing LAC/VBAC are required to reduce the US cesarean rate and associated maternal morbidity while increasing choice for childbearing women and their families (<http://www.annfammed.org/content/13/1/80.full>).    * *Preliminary analysis result:* Conditional support, pending NQF review and endorsement    * *Notes:* 5. **National Healthcare Safety Network (NHSN) Antimicrobial Use Measure** (MUC ID: MUC15-531)    * *Description:* Assesses antimicrobial use (AU) in hospitals based on medication administration data hospitals collect electronically at the point of care and report via electronic file submissions to NHSN. AU data included in the measure are antibacterial agents administered to adult and pediatric patients in a specified set of hospital ward and intensive care unit locations.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This measure has been submitted to NQF for endorsement. The Patient Safety Standing Committee and comments received during the public comment period expressed concerns about the reliability and validity of the measure due to the small sample size used to conduct the initial analysis. In the submission, the measure developer stated that the measure is intended for use in the National Healthcare Safety Network (NHSN) and wishes to gain greater experience and gather more information before using it for reporting or payment. MAP recognizes the high importance of antimicrobial stewardship and would conditionally support the inclusion of this measure in the IQR program to allow for the opportunity for additional testing to address feasibility issues. However, MAP notes these issues should be addressed before the measure is reported on Hospital Compare.      + *Impact on quality of care for patients:*The measure provides summary results that hospital and health system antimicrobial stewardship programs (ASPs) can use as quantitative aids in their efforts to evaluate and improve antibiotic prescribing.    * *Preliminary analysis result:* Conditional support, pending additional use    * *Notes:* |
|  | Pre-Rulemaking Input on Hospital Inpatient Quality Reporting (IQR) Measure Set - Consent Calendar 2 |
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|  | Programs under consideration: Hospital Inpatient Quality Reporting and EHR Incentive Program |
|  | 1. **Aortic Aneurysm Procedure Clinical Episode-Based Payment Measure** (MUC ID: MUC15-835)    * *Description:* The measure constructs a clinically coherent group of services to inform providers about resource use and effectiveness. It sums Parts A and B payments related to an aortic aneurysm procedure inpatient (IP) stay and attributes them to the hospital where the index IP stay occurred. It includes abdominal aortic aneurysm and thoracic aortic aneurysm subtypes.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This measure does not address any of the high-priority domains identified by CMS for future measure consideration. Analytic evidence demonstrating that a performance gap exists or that there is a variation in performance among providers for aortic aneurysm procedures was not provided as required for measures that may be considered for potential adoption in the IQR program. Furthermore, a similar measure, NQF #2151 Medicare Spending Per Beneficiary (MSPB), is already in the program and captures a broader population than the MUC, which is procedure specific.      + *Impact on quality of care for patients:*Episode-based performance measurement allows meaningful comparisons between providers based on resource use for certain clinical conditions or procedures, as noted in the NQF report for the “Episode Grouper Evaluation Criteria” project (available at <http://www.qualityforum.org/Publications/2014/09/Evaluating_Episode_Groupers__A_Report_from_the_National_Quality_Forum.aspx>) and in various peer-reviewed articles (e.g., Hussey, P. S., Sorbero, M. E., Mehrotra, A., Liu, H., & Damberg, S. L. (2009). Episode-Based Performance Measurement and Payment: Making It a Reality. Health Affairs, 28(5), 1406-1417. doi:10.1377/hlthaff.28.5.1406).    * *Preliminary analysis result:* Do not support    * *Notes:* 2. **Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure** (MUC ID: MUC15-836)    * *Description:* The measure constructs a clinically coherent group of services to inform providers about resource use and effectiveness. It sums Parts A and B payments related to a Cholecystectomy and Common Duct Exploration IP stay and attributes them to the hospital where the index IP stay occurred.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This measure does not address any of the high-priority domains identified by CMS for future measure consideration. Analytic evidence demonstrating that a performance gap exists or that there is a variation in performance among providers for cholecystectomy and common duct exploration procedures was not provided as required for measures that may be considered for potential adoption in the IQR program. Furthermore, a similar measure, NQF #2151 Medicare Spending Per Beneficiary (MSPB), is already in the program and captures a broader population than the MUC, which is procedure specific.      + *Impact on quality of care for patients:*Episode-based performance measurement allows meaningful comparisons between providers based on resource use for certain clinical conditions or procedures, as noted in the NQF report for the “Episode Grouper Evaluation Criteria” project (available at <http://www.qualityforum.org/Publications/2014/09/Evaluating_Episode_Groupers__A_Report_from_the_National_Quality_Forum.aspx>) and in various peer-reviewed articles (e.g., Hussey, P. S., Sorbero, M. E., Mehrotra, A., Liu, H., & Damberg, S. L. (2009). Episode-Based Performance Measurement and Payment: Making It a Reality. Health Affairs, 28(5), 1406-1417. doi:10.1377/hlthaff.28.5.1406).    * *Preliminary analysis result:* Do not support    * *Notes:* 3. **Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia** (MUC ID: MUC15-378)    * *Description:* This measure estimates hospital-level, risk-standardized payment for a pneumonia episode of care starting with inpatient admission to a short term acute-care facility and extending 30 days post-admission for Medicare fee-for-service (FFS) patients who are 65 years of age or older with a principal discharge diagnosis of pneumonia, aspiration pneumonia, and sepsis in cases where sepsis is accompanied by secondary diagnosis of pneumonia present on admission. (*The endorsed specifications of the measure are: This measure estimates hospital-level, risk-standardized payment for a pneumonia episode of care starting with inpatient admission to a short term acute-care facility and extending 30 days post-admission for Medicare fee-for-service (FFS) patients who are 65 years of age or older with a principal discharge diagnosis of pneumonia.*)    * *Preliminary analysis summary*      + *Contribution to program measure set:*This NQF-endorsed cost and resource measure is already in the IQR program and addresses the previously identified gap of affordability/cost measures. CMS is expanding the cohort to match the pneumonia mortality measure which includes patients with a principle diagnosis of aspiration pneumonia and sepsis in cases where sepsis is accompanied by secondary diagnosis of pneumonia present on admission. CMS is encouraged to submit the updated specifications to NQF when revisions to the measure are complete.      + *Impact on quality of care for patients:*A measure of payments for Medicare patients to hospitals that is aligned with current quality of care measures will facilitate profiling hospital value (payments and quality). This measure will reflect differences in the management of care for patients with pneumonia both during hospitalization and immediately post-discharge. Pneumonia is a condition with substantial range in costs of care and for which there are well-established publicly reported quality measures and is therefore an ideal condition for assessing relative value for an episode-of-care that begins with an acute hospitalization. By focusing on one specific condition, value assessments may provide actionable feedback to hospitals and incentivize targeted improvements in care.    * *Preliminary analysis result:* Conditional support, pending NQF review and endorsement of revised specifications    * *Notes:* 4. **Spinal Fusion Clinical Episode-Based Payment Measure** (MUC ID: MUC15-837)    * *Description:* The measure constructs a clinically coherent group of services to inform providers about resource use and effectiveness. It sums Parts A and B payments related to a Spinal Fusion IP stay and attributes them to the hospital where the index IP stay occurred.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This measure does not address any of the high-priority domains identified by CMS for future measure consideration. Analytic evidence demonstrating that a performance gap exists or that there is a variation in performance among providers for spinal fusion procedures was not provided as required for measures that may be considered for potential adoption in the IQR program. Furthermore, a similar measure, NQF #2151 Medicare Spending Per Beneficiary (MSPB), is already in the program and captures a broader population than the MUC, which is procedure specific. \*The stage of development for this MUC was updated to "Fully Developed" on December 2, 2015, after the MUC was publicly released.      + *Impact on quality of care for patients:*Episode-based performance measurement allows meaningful comparisons between providers based on resource use for certain clinical conditions or procedures, as noted in the NQF report for the “Episode Grouper Evaluation Criteria” project (available at <http://www.qualityforum.org/Publications/2014/09/Evaluating_Episode_Groupers__A_Report_from_the_National_Quality_Forum.aspx>) and in various peer-reviewed articles (e.g., Hussey, P. S., Sorbero, M. E., Mehrotra, A., Liu, H., & Damberg, S. L. (2009). Episode-Based Performance Measurement and Payment: Making It a Reality. Health Affairs, 28(5), 1406-1417. doi:10.1377/hlthaff.28.5.1406).    * *Preliminary analysis result:* Do not support    * *Notes:* 5. **Transurethral Resection of the Prostate (TURP) for Benign Prostatic Hyperplasia Clinical Episode-Based Payment Measure** (MUC ID: MUC15-838)    * *Description:* The measure constructs a clinically coherent group of services to inform providers about resource use and effectiveness. It sums Parts A and B payments related to a TURP IP stay and attributes them to the hospital where the index IP stay occurred.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This measure does not address any of the high-priority domains identified by CMS for future measure consideration. Analytic evidence demonstrating that a performance gap exists or that there is a variation in performance among providers for transurethral resection of the prostate (TURP) for benign prostatic hyperplasia procedures was not provided as required for measures that may be considered for potential adoption in the IQR program. Furthermore, a similar measure, NQF #2151 Medicare Spending Per Beneficiary (MSPB), is already in the program and captures a broader population than the MUC, which is procedure specific.      + *Impact on quality of care for patients:*Episode-based performance measurement allows meaningful comparisons between providers based on resource use for certain clinical conditions or procedures, as noted in the NQF report for the “Episode Grouper Evaluation Criteria” project (available at <http://www.qualityforum.org/Publications/2014/09/Evaluating_Episode_Groupers__A_Report_from_the_National_Quality_Forum.aspx>) and in various peer-reviewed articles (e.g., Hussey, P. S., Sorbero, M. E., Mehrotra, A., Liu, H., & Damberg, S. L. (2009). Episode-Based Performance Measurement and Payment: Making It a Reality. Health Affairs, 28(5), 1406-1417. doi:10.1377/hlthaff.28.5.1406).    * *Preliminary analysis result:* Do not support    * *Notes:* |
|  | Pre-Rulemaking Input on Hospital Inpatient Quality Reporting (IQR) Measure Set - Consent Calendar 3 |
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|  | Programs under consideration: Hospital Inpatient Quality Reporting and EHR Incentive Program |
|  | 1. **Excess Days in Acute Care after Hospitalization for Pneumonia** (MUC ID: MUC15-391)    * *Description:* This measure assesses the difference (“excess”) between the average number of risk-adjusted days a hospital’s patients spend in an ED, observation, or readmission in the 30 days following a hospitalization for pneumonia (“predicted”) and the number of days in acute care that they would have been expected to spend if discharged from an average hospital.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This is an update to a measure previously supported by the MAP with the condition that NQF review and endorse the measure. The cohort has been expanded to include patients with principle discharge diagnosis of aspiration pneumonia and sepsis with an accompanying secondary diagnosis of pneumonia that is present on admission and aligns with NQF #0468 - Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following pneumonia hospitalization and NQF #0506 - Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following pneumonia hospitalization.      + *Impact on quality of care for patients:*Existing measures publicly report readmission rates and mortality rates following hospitalization for pneumonia. These measures do not include all post-discharge outcomes that matter to patients, such as having to return to the ED or spend time under observation. Moreover, the increasing use of observation care may be replacing some readmissions. Hospitals with high rates of observation stays in the post-discharge period may therefore have low readmission rates that do not fully reflect the quality of care. This measure adds to the existing measurement landscape by including other outcomes (i.e., ED visits, observation stays), by capturing the total amount of time patients spend in acute care, and by accounting for time at risk of an event (i.e. survival time).    * *Preliminary analysis result:* Conditional support, pending NQF review and endorsement    * *Notes:* 2. **Hospital 30-Day Mortality Following Acute Ischemic Stroke Hospitalization Measure** (MUC ID: MUC15-294)    * *Description:* This stroke mortality measure will estimate the hospital-level, risk-standardized mortality rate (RSMR) for patients discharged from the hospital with a principal discharge diagnosis of acute ischemic stroke. The outcome is all-cause 30-day mortality, defined as death from any cause within 30 days of the index admission date, including in-hospital death, for stroke patients. The measure uses Medicare fee-for-service (FFS) administrative claims to derive the cohort and outcome, and for risk adjustment. The major revision is to include NIH Stroke Scale as a measure of stroke severity in the risk-adjustment.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This outcome mortality measure adjusts for stroke severity using the NIHSS as recommended by the [clinical practice guidelines](http://stroke.ahajournals.org/content/34/4/1056.full). The current publicly reported stroke mortality measure does not include stroke severity in the risk adjustment model.      + *Impact on quality of care for patients:*There is a need to define the relevant stroke outcomes to measure and the factors that should be accounted for to make comparisons across different facilities valid so that the quality of stroke care can be evaluated and optimized. Stroke severity is the most important prognostic factor for individual patients and appears to be a significant predictor in hospital-level performance therefore inclusion in the risk model is recommended in a [Statement for Healthcare Professional from the American Heart Association/American Stroke Association](http://stroke.ahajournals.org/content/45/3/918.full)    * *Preliminary analysis result:* Conditional support, pending NQF endorsement    * *Notes:* 3. **Hybrid 30-Day Risk-Standardized Acute Ischemic Stroke Mortality Measure with Claims and Clinical Electronic Health Record (EHR) Risk Adjustment Variables** (MUC ID: MUC15-1135)    * *Description:* This hybrid stroke mortality measure will estimate the hospital-level, risk-standardized mortality rate (RSMR) for patients discharged from the hospital with a principal discharge diagnosis of acute ischemic stroke. The outcome is all-cause 30-day mortality, defined as death from any cause within 30 days of the index admission date, including in-hospital death, for stroke patients. The measure is referred to as a hybrid because it will use Medicare fee-for-service (FFS) administrative claims to derive the cohort and outcome, and claims and clinical EHR data for risk adjustment.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This outcome mortality measure adjusts for stroke severity using the NIHSS as recommended by the [clinical practice guidelines](http://stroke.ahajournals.org/content/34/4/1056.full). The currently publicly reported stroke mortality measure uses administrative claims data only for risk adjustment, and does not include an assessment of stroke severity. \*The stage of development for this MUC was updated to "Fully Developed" on December 3, 2015, after the MUC was publicly released.      + *Impact on quality of care for patients:*There is a need to define the relevant stroke outcomes to measure and the factors that should be accounted for to make comparisons across different facilities valid so that the quality of stroke care can be evaluated and optimized. Stroke severity is the most important prognostic factor for individual patients and appears to be a significant predictor in hospital-level performance therefore inclusion in the risk model is recommended in a [Statement for Healthcare Professional from the American Heart Association/American Stroke Association](http://stroke.ahajournals.org/content/45/3/918.full)    * *Preliminary analysis result:* Conditional support, pending NQF review and endorsement    * *Notes:* 4. **Hybrid 30-Day Risk-Standardized Acute Ischemic Stroke Mortality Measure with Electronic Health Record (EHR)-Extracted Risk Adjustment Variables** (MUC ID: MUC15-1033)    * *Description:* This hybrid stroke mortality measure will estimate the hospital-level, risk-standardized mortality rate (RSMR) for patients discharged from the hospital with a principal discharge diagnosis of acute ischemic stroke. The outcome is all-cause 30-day mortality, defined as death from any cause within 30 days of the index admission date, including in-hospital death, for stroke patients. The measure is referred to as a hybrid because it will use Medicare fee-for-service (FFS) administrative claims to derive the cohort and outcome, and clinical data (EHR extracted) for risk adjustment.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This outcome mortality measure adjusts for stroke severity using the NIHSS as recommended by the [clinical practice guidelines](http://stroke.ahajournals.org/content/34/4/1056.full). The currently publicly reported stroke mortality measure uses administrative claims data only for risk adjustment, and does not include an assessment of stroke severity. \*The stage of development for this MUC was updated to "Fully Developed" on December 3, 2015, after the MUC was publicly released.      + *Impact on quality of care for patients:*There is a need to define the relevant stroke outcomes to measure and the factors that should be accounted for to make comparisons across different facilities valid so that the quality of stroke care can be evaluated and optimized. Stroke severity is the most important prognostic factor for individual patients and appears to be a significant predictor in hospital-level performance therefore inclusion in the risk model is recommended in a [Statement for Healthcare Professional from the American Heart Association/American Stroke Association](http://stroke.ahajournals.org/content/45/3/918.full).    * *Preliminary analysis result:* Conditional support, pending NQF review and endorsement    * *Notes:* 5. **Patient Safety and Adverse Events Composite** (MUC ID: MUC15-604)    * *Description:* Patient Safety and Adverse Events Composite (Patient Safety Indicator, or PSI90) is a composite measure of 10 individual PSIs, each measuring a different aspect of harm associated with patient safety. Each PSI is reliability-adjusted (smoothed) and indirectly standardized (risk adjusted). The composite is the weighted average of the reliability-adjusted, indirectly standardized, observed-to-expected ratios for component indicators. The final weight for each component is the product of harm weights and volume weights (numerator weights). Harm weights are calculated by multiplying empirical estimates of excess harms associated with the patient safety event by utility weights linked to each of the harms. Excess harms are estimated using statistical models comparing patients with a safety-related event to those without that safety-related event in a CMS Medicare fee-for-service sample that allowed up to one year of follow-up from the discharge date of the hospital stay associated with the index event. Volume weights, the second part of the final weight, are calculated on the basis of the number of safety-related events for the component indicators in the all-payer reference population. The observed to expected ratios (indirect standardization) of the reliability adjusted (smoothed) rates are multiplied by a component weight and the weighted scores are summed to determine the final PSI 90 score. A score of 1 means that the hospital performs as expected, scores greater than one indicate worse performance than expected.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This updated version of PSI 90 addresses a number of concerns raised by the NQF Safety Standing Committee. Three additional PSIs have been added to the measure. Two of the component PSIs were redesigned; specifically PSI 12 with the removal of isolated calf deep vein thromboses (DVT) which have limited clinical relevance and PSI 15 with a greater focus on accidental punctures and lacerations that occur during abdominal/pelvic surgery and those that result in re-operation within one day which reflect events that are more likely preventable. PSIs were better linked to important changes in clinical status with “harm weights” that are based on diagnoses that were assigned after the complication. This is intended to allow the measure to more accurately reflect the impact of the events.      + *Impact on quality of care for patients:*The PSI measures were developed to identify harmful healthcare related events that are potentially preventable. Patients that experience a PSI event are hospitalized for two to three times longer, have twp to twenty times higher rates of inpatient mortality and two to eight times higher total hospital charges. The composite measure was constructed to increase the statistical precision by increasing the sample size and to assist consumers, providers, and payers with their decision-making. This updated version would three additional PSIs: PSI09 Postoperative Hemorrhage or Hematoma, PSI10 Physiologic and Metabolic Derangement, and PSI11 Postoperative Respiratory Failure.    * *Preliminary analysis result:* Support    * *Notes:* |
| 11:30 am | Break |
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| 11:40am | CMS Measure Concepts Presentation |
|  | Tara Lemons, CMS |
| 11:50 am | Overview of the Hospital Value-Based Purchasing Program (HVBP) |
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| 11:55 am | Opportunity for Public Comment on Measures Under Consideration for HVBP |
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| 12:05 pm | Pre-Rulemaking Input on Hospital Value-Based Purchasing Program Measure Set - Consent Calendar 1 |
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|  | Programs under consideration: Hospital Value-Based Purchasing Program |
|  | 1. **Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia** (MUC ID: MUC15-378)    * *Description:* This measure estimates hospital-level, risk-standardized payment for a pneumonia episode of care starting with inpatient admission to a short term acute-care facility and extending 30 days post-admission for Medicare fee-for-service (FFS) patients who are 65 years of age or older with a principal discharge diagnosis of pneumonia, aspiration pneumonia, and sepsis in cases where sepsis is accompanied by secondary diagnosis of pneumonia present on admission. (*The endorsed specifications of the measure are: This measure estimates hospital-level, risk-standardized payment for a pneumonia episode of care starting with inpatient admission to a short term acute-care facility and extending 30 days post-admission for Medicare fee-for-service (FFS) patients who are 65 years of age or older with a principal discharge diagnosis of pneumonia.*)    * *Preliminary analysis summary*      + *Contribution to program measure set:*This measure would add another measure to the Efficiency domain of the program. The measure addresses a common condition in the Medicare FFS population that is associated with significant variation in costs and an opportunity for improvement. However, this measure would overlap with the current Medicare Spending Per Beneficiary Measure and MAP has previously advocated keeping a parsimonious set of measures for the VBP program to avoid rewarding or penalizing a provider mulitple times for the same case.      + *Impact on quality of care for patients:*Pneumonia is the second leading cause of hospitalization for Americans over 65 years old resulting in 1.2 million hospital admissions with annual expenditures of over $10 billion.Costs of care for an pneumonia episode vary significantly. Implementing this measure could help lower costs related to variations in quality.    * *Preliminary analysis result:* Do not support    * *Notes:* 2. **Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for Acute Myocardial Infarction (AMI)** (MUC ID: MUC15-369)    * *Description:* This measure estimates hospital-level, risk-standardized payment for an AMI episode-of-care starting with inpatient admission to a short term acute-care facility and extending 30 days post-admission for Medicare fee-for-service (FFS) patients who are 65 years of age or older with a principal discharge diagnosis of AMI.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This measure would add another measure to the Efficiency domain of the program. The measure addresses a common condition in the Medicare FFS population that is associated with significant variation in costs and an opportunity for improvement. However, this measure would overlap with the current Medicare Spending Per Beneficiary Measure and MAP has previously advocated keeping a parsimonious set of measures for the VBP program to avoid rewarding or penalizing a provider mulitple times for the same case.      + *Impact on quality of care for patients:*AMI is a leading cause of hospitalizations for Americans over 65 years old and costs approximately $18 billion annually. Costs of care for an AMI episode vary significantly. Implementing this measure could help lower costs related to variations in quality.    * *Preliminary analysis result:* Do not support    * *Notes:* 3. **Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for heart failure (HF)** (MUC ID: MUC15-322)    * *Description:* This measure estimates a hospital-level, risk-standardized payment for a heart failure episode-of-care starting with inpatient admission to a short term acute-care facility and extending 30 days post-admission for Medicare fee-for-service (FFS) patients who are 65 years of age or older with a principal discharge diagnosis of heart failure.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This measure would add another measure to the Efficiency domain of the program. The measure addresses a common condition in the Medicare FFS population that is associated with significant variation in costs and an opportunity for improvement. However, this measure would overlap with the current Medicare Spending Per Beneficiary Measure and MAP has previously advocated keeping a parsimonious set of measures for the VBP program to avoid rewarding or penalizing a provider mulitple times for the same case.      + *Impact on quality of care for patients:*This measure addresses the cost of care for a common condition. Heart failure is a common condition and one of the leading causes of hospitalization for Americans over 65 years old. Costs related to heart failure total approximately $34 billion annually. Unadjusted 30 day episode of care payments for heart failure have been found to range significantly. Payments range from $6,865 to $26,696 with a mean of $13,081. Use of this measure could drive improvement in variation in costs related to quality of care.    * *Preliminary analysis result:* Do not support    * *Notes:* 4. **Hospital-level, risk-standardized payment associated with an episode of care for primary elective total hip and/or total knee arthroplasty (THA/TKA)** (MUC ID: MUC15-295)    * *Description:* This measure estimates hospital-level, risk-standardized payments for a primary elective total THA/TKA episode of care starting with inpatient admission to a short term acute-care facility for Medicare fee-for-service (FFS) patients who are 65 years of age or older.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This measure would add another measure to the Efficiency domain of the program. The measure addresses a common condition in the Medicare FFS population that is associated with significant variation in costs and an opportunity for improvement. However, this measure would overlap with the current Medicare Spending Per Beneficiary Measure and MAP has previously advocated keeping a parsimonious set of measures for the VBP program to avoid rewarding or penalizing a provider mulitple times for the same case.      + *Impact on quality of care for patients:*This measure addresses the cost of care for a common condition. Over 33% of Americans 65 and older suffer from osteoarthritis. Joint replacement surgeries are becoming more commonly utilized as Medicare covered 337,419 THA procedures and 750,569 TKA procedures between 2009 and 2012 and annual Medicare payments for THA and TKA exceed $15 billion annually. There is significant variation in costs for these procedures that are often related to quality of care as complications and readmissions increase the total payment for post-surgical care. The mean 90-day risk-standardized payment among Medicare FFS patients with a qualifying THA/TKA procedure in 2010–2012 was$23,248, and ranged from $16,421 to$35,12. Use of this measure could drive improvement in variation in costs related to quality of care.    * *Preliminary analysis result:* Do not support    * *Notes:* |
|  | Pre-Rulemaking Input on Hospital Value-Based Purchasing Program Measure Set - Consent Calendar 2 |
|  |  |
|  | Programs under consideration: Hospital Value-Based Purchasing Program |
|  | 1. **Cellulitis Clinical Episode-Based Payment Measure** (MUC ID: MUC15-1143)    * *Description:* The measure constructs a clinically coherent group of services to inform providers about resource use and effectiveness. It sums Parts A and B payments related to a cellulitis IP stay and attributes them to the hospital where the index IP stay occurred. It includes subtypes for diabetics, decubitus pressure ulcers, and other cellulitis patients.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This measure would add another measure to the Efficiency domain of the program. The measure addresses a common condition in the Medicare FFS population that is associated with significant variation in costs and an opportunity for improvement. However, this measure would overlap with the current Medicare Spending Per Beneficiary Measure and MAP has previously advocated keeping a parsimonious set of measures for the VBP program to avoid rewarding or penalizing a provider mulitple times for the same case.      + *Impact on quality of care for patients:*While the costs can be high, only a small subset of patients with cellulitis require hospitalization. (Acumen. Methodology for Developing the Six Hospital-based Episode Measures: Supplemental Documentation for the Fiscal Year 2015 Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System Proposed Rule. Available at: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/hospital-value-based-purchasing>) CMS has noted that the variations in cost associated with treating cellulitis are the result of post discharge costs that reflect variations in quality. An episode-based approach could help drive improvement in both cost and quality. (http://content.healthaffairs.org/content/28/5/1406.full.pdf)    * *Preliminary analysis result:* Do not support    * *Notes:* 2. **Gastrointestinal Intestinal (GI) Hemorrhage Clinical Episode-Based Payment Measure** (MUC ID: MUC15-1144)    * *Description:* The measure constructs a clinically coherent group of services to inform providers about resource use and effectiveness. It sums Parts A and B payments related to a GI hemorrhage IP stay and attributes them to the hospital where the index IP stay occurred. It includes subtypes for 1) upper, 2) lower, 3) upper and lower, and 4) undefined bleeds.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This measure would add another measure to the Efficiency domain of the program. The measure addresses a common condition in the Medicare FFS population that is associated with significant variation in costs and an opportunity for improvement. However, this measure would overlap with the current Medicare Spending Per Beneficiary Measure and MAP has previously advocated keeping a parsimonious set of measures for the VBP program to avoid rewarding or penalizing a provider mulitple times for the same case.      + *Impact on quality of care for patients:*CMS has noted that the variations in cost associated with treating GI hemorrhages are the result of post discharge costs that reflect variations in quality. An episode-based approach could help drive improvement in both cost and quality. (http://content.healthaffairs.org/content/28/5/1406.full.pdf)    * *Preliminary analysis result:* Do not support    * *Notes:* 3. **Kidney/Urinary Tract Infection Clinical Episode-Based Payment Measure** (MUC ID: MUC15-1145)    * *Description:* The measure constructs a clinically coherent group of services to inform providers about resource use and effectiveness. It sums Parts A and B payments related to a kidney/urinary tract infection IP stay and attributes them to the hospital where the index IP stay occurred.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This measure would add another measure to the Efficiency domain of the program. The measure addresses a common condition in the Medicare FFS population that is associated with significant variation in costs and an opportunity for improvement. However, this measure would overlap with the current Medicare Spending Per Beneficiary Measure and MAP has previously advocated keeping a parsimonious set of measures for the VBP program to avoid rewarding or penalizing a provider mulitple times for the same case.      + *Impact on quality of care for patients:*CMS has noted that the variations in cost associated with treating kidney/urinary tract infections are the result of post discharge costs that reflect variations in quality. An episode-based approach could help drive improvement in both cost and quality. (http://content.healthaffairs.org/content/28/5/1406.full.pdf)    * *Preliminary analysis result:* Do not support    * *Notes:* |
|  | Pre-Rulemaking Input on Hospital Value-Based Purchasing Program Measure Set - Consent Calendar 3 |
|  |  |
|  | Programs under consideration: Hospital Value-Based Purchasing Program |
|  | 1. **American College of Surgeons-Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure** (MUC ID: MUC15-534)    * *Description:* Organ/space Surgical Site Infections (SSI) at the primary incision site among adult patients at least 18 years of age undergoing inpatient colon procedures and/or abdominal hysterectomies as reported through the ACS-NSQIP or CDC NHSN. The measure yields separate SIRs for each procedure. (*The endorsed specifications of the measure are: Prototype measure for the facility adjusted Standardized Infection Ratio (SIR) of deep incisional and organ/space Surgical Site Infections (SSI) at the primary incision site among adult patients aged >= 18 years as reported through the ACS National Surgical Quality Improvement Program (ACS-NSQIP) or CDC National Health and Safety Network (NHSN). Prototype also includes a systematic, retrospective sampling of operative procedures in healthcare facilities. This prototype measure is intended for time-limited use and is proposed as a first step toward a more comprehensive SSI measure or set of SSI measures that include additional surgical procedure categories and expanded SSI risk-adjustment by procedure type. This single prototype measure is applied to two operative procedures, colon surgeries and abdominal hysterectomies, and the measure yields separate SIRs for each procedure.*)    * *Preliminary analysis summary*      + *Contribution to program measure set:*This is an update to the name of the measure from “reliability adjusted SIR” to “Adjusted Ranking Metric (ARM).”      + *Impact on quality of care for patients:*The continued use of this measure will promote SSI prevention activities, which will lead to an improvement in patient outcomes, reducing avoidable medical costs, patient morbidity and mortality. Guidelines to prevent SSIs are available here (<http://www.cdc.gov/hicpac/SSI/001_SSI.html>).    * *Preliminary analysis result:* Conditional support, pending NQF annual update    * *Notes:* 2. **Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery** (MUC ID: MUC15-395)    * *Description:* This measure estimates hospital-level, risk-standardized mortality rates for Medicare fee-for-service (FFS) patients who are 65 years of age or older and discharged from the hospital following a qualifying isolated CABG surgery. (*The endorsed specifications of the measure are: The measure estimates a hospital-level, risk-standardized mortality rate (RSMR) for patients 18 years and older discharged from the hospital following a qualifying isolated CABG procedure. Mortality is defined as death from any cause within 30 days of the procedure date of an index CABG admission. The measure was developed using Medicare Fee-for-Service (FFS) patients 65 years and older and was tested in all-payer patients 18 years and older. An index admission is the hospitalization for a qualifying isolated CABG procedure considered for the mortality outcome.*)    * *Preliminary analysis summary*      + *Contribution to program measure set:*CABG is a common surgery with notable variation in mortality. Adding this measure to the VBP measure set could provide an incentive to improve patient safety in this area.      + *Impact on quality of care for patients:*Coronary Artery Bypass Graft (CABG) Surgery is one of the most commonly performed surgeries in the United States. However, mortality for CABG surgery varies significantly. The measure developer found a mean rate of 3.2% with a range from 1.5%-7.9%. The developer found a median rate of 3.0% (25th and 75th percentiles are 2.6% and 3.6%, respectively). Adding this measure to the VBP program could help to reduce this variation and drive improvement.    * *Preliminary analysis result:* Support    * *Notes:* 3. **Patient Safety and Adverse Events Composite** (MUC ID: MUC15-604)    * *Description:* Patient Safety and Adverse Events Composite (Patient Safety Indicator, or PSI90) is a composite measure of 10 individual PSIs, each measuring a different aspect of harm associated with patient safety. Each PSI is reliability-adjusted (smoothed) and indirectly standardized (risk adjusted). The composite is the weighted average of the reliability-adjusted, indirectly standardized, observed-to-expected ratios for component indicators. The final weight for each component is the product of harm weights and volume weights (numerator weights). Harm weights are calculated by multiplying empirical estimates of excess harms associated with the patient safety event by utility weights linked to each of the harms. Excess harms are estimated using statistical models comparing patients with a safety-related event to those without that safety-related event in a CMS Medicare fee-for-service sample that allowed up to one year of follow-up from the discharge date of the hospital stay associated with the index event. Volume weights, the second part of the final weight, are calculated on the basis of the number of safety-related events for the component indicators in the all-payer reference population. The observed to expected ratios (indirect standardization) of the reliability adjusted (smoothed) rates are multiplied by a component weight and the weighted scores are summed to determine the final PSI 90 score. A score of 1 means that the hospital performs as expected, scores greater than one indicate worse performance than expected.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This updated version of PSI 90 addresses a number of concerns raised by the NQF Safety Standing Committee. Three additional PSIs have been added to the measure. Two of the component PSIs were redesigned; specifically PSI 12 with the removal of isolated calf deep vein thromboses (DVT) which have limited clinical relevance and PSI 15 with a greater focus on accidental punctures and lacerations that occur during abdominal/pelvic surgery and those that result in re-operation within one day which reflect events that are more likely preventable. PSIs were better linked to important changes in clinical status with “harm weights” that are based on diagnoses that were assigned after the complication. This is intended to allow the measure to more accurately reflect the impact of the events.      + *Impact on quality of care for patients:*The PSI measures were developed to identify harmful healthcare related events that are potentially preventable. Patients that experience a PSI event are hospitalized for two to three times longer, have twp to twenty times higher rates of inpatient mortality and two to eight times higher total hospital charges. The composite measure was constructed to increase the statistical precision by increasing the sample size and to assist consumers, providers, and payers with their decision-making. This updated version would three additional PSIs: PSI09 Postoperative Hemorrhage orHematoma, PSI10 Physiologic and Metabolic Derangement, and PSI11 Postoperative Respiratory Failure .    * *Preliminary analysis result:* Support    * *Notes:* |
| 1:00 pm | Lunch |
|  |  |
| 2:00 pm | Overview of the Hospital Acquired Condition Reduction Program (HACRP) |
|  |  |
| 2:05 pm | Opportunity for Public Comment on Measures Under Consideration for HACRP |
|  |  |
| 2:15 pm | Pre-Rulemaking Input on Hospital Acquired Condition Reduction Program Measure Set |
|  |  |
|  | Programs under consideration: Hospital Acquired Condition Reduction Program |
|  | 1. **American College of Surgeons-Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure** (MUC ID: MUC15-534)    * *Description:* Organ/space Surgical Site Infections (SSI) at the primary incision site among adult patients at least 18 years of age undergoing inpatient colon procedures and/or abdominal hysterectomies as reported through the ACS-NSQIP or CDC NHSN. The measure yields separate SIRs for each procedure. (*The endorsed specifications of the measure are: Prototype measure for the facility adjusted Standardized Infection Ratio (SIR) of deep incisional and organ/space Surgical Site Infections (SSI) at the primary incision site among adult patients aged >= 18 years as reported through the ACS National Surgical Quality Improvement Program (ACS-NSQIP) or CDC National Health and Safety Network (NHSN). Prototype also includes a systematic, retrospective sampling of operative procedures in healthcare facilities. This prototype measure is intended for time-limited use and is proposed as a first step toward a more comprehensive SSI measure or set of SSI measures that include additional surgical procedure categories and expanded SSI risk-adjustment by procedure type. This single prototype measure is applied to two operative procedures, colon surgeries and abdominal hysterectomies, and the measure yields separate SIRs for each procedure.*)    * *Preliminary analysis summary*      + *Contribution to program measure set:*This is an update to the name of the measure from “reliability adjusted SIR” to “Adjusted Ranking Metric (ARM)”, which provides a better estimate of the hospital’s true SIR relative to other facilities.      + *Impact on quality of care for patients:*The continued use of this measure will promote SSI prevention activities, which will lead to an improvement in patient outcomes, reducing avoidable medical costs, patient morbidity and mortality. Guidelines to prevent SSIs are available here (<http://www.cdc.gov/hicpac/SSI/001_SSI.html>).    * *Preliminary analysis result:* Conditional support, pending NQF annual update    * *Notes:* 2. **Patient Safety and Adverse Events Composite** (MUC ID: MUC15-604)    * *Description:* Patient Safety and Adverse Events Composite (Patient Safety Indicator, or PSI90) is a composite measure of 10 individual PSIs, each measuring a different aspect of harm associated with patient safety. Each PSI is reliability-adjusted (smoothed) and indirectly standardized (risk adjusted). The composite is the weighted average of the reliability-adjusted, indirectly standardized, observed-to-expected ratios for component indicators. The final weight for each component is the product of harm weights and volume weights (numerator weights). Harm weights are calculated by multiplying empirical estimates of excess harms associated with the patient safety event by utility weights linked to each of the harms. Excess harms are estimated using statistical models comparing patients with a safety-related event to those without that safety-related event in a CMS Medicare fee-for-service sample that allowed up to one year of follow-up from the discharge date of the hospital stay associated with the index event. Volume weights, the second part of the final weight, are calculated on the basis of the number of safety-related events for the component indicators in the all-payer reference population. The observed to expected ratios (indirect standardization) of the reliability adjusted (smoothed) rates are multiplied by a component weight and the weighted scores are summed to determine the final PSI 90 score. A score of 1 means that the hospital performs as expected, scores greater than one indicate worse performance than expected.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This updated version of PSI 90 addresses a number of concerns raised by the NQF Safety Standing Committee. Three additional PSIs have been added to the measure. Two of the component PSIs were redesigned; specifically PSI 12 with the removal of isolated calf deep vein thromboses (DVT) which have limited clinical relevance and PSI 15 with a greater focus on accidental punctures and lacerations that occur during abdominal/pelvic surgery and those that result in re-operation within one day which reflect events that are more likely preventable. PSIs were better linked to important changes in clinical status with “harm weights” that are based on diagnoses that were assigned after the complication. This is intended to allow the measure to more accurately reflect the impact of the events.      + *Impact on quality of care for patients:*The PSI measures were developed to identify harmful healthcare related events that are potentially preventable. Patients that experience a PSI event are hospitalized for two to three times longer, have twp to twenty times higher rates of inpatient mortality and two to eight times higher total hospital charges. The composite measure was constructed to increase the statistical precision by increasing the sample size and to assist consumers, providers, and payers with their decision-making. This updated version would three additional PSIs: PSI09 Postoperative Hemorrhage or Hematoma, PSI10 Physiologic and Metabolic Derangement, and PSI11 Postoperative Respiratory Failure.    * *Preliminary analysis result:* Support    * *Notes:* |
| 3:15 pm | Overview of the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program |
|  |  |
| 3:20 pm | Opportunity for Public Comment on Measures Under Consideration for PCHQR |
|  |  |
| 3:35 pm | Pre-Rulemaking Input on PPS-Exempt Cancer Hospital Quality Reporting Program Measure Set |
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|  | Programs under consideration: Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program |
|  | 1. **Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy** (MUC ID: MUC15-951)    * *Description:* Measure estimates risk-adjusted rates of inpatient admissions or emergency department (ED) visits for cancer patients >18 years of age with at least one of the following diagnoses—anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, or sepsis—within 30 days of hospital outpatient chemotherapy treatment. Two rates are reported.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This measure fits in a high-priority domain and would align PCHQR with other measure sets that include admissions and readmissions measures, including ASCQR and HRRP.The measure has not been submitted for endorsement to NQF. This measure was conditionally supported by the MAP in 2013 for use in the PCHQR program, pending NQF endorsement.      + *Impact on quality of care for patients:*According to research by the measure developer, nearly 20% of chemotherapy patients are affected by potentially preventable adverse events that are so severe they require a hospital admission of ED visit. Incentivizing HODs to better manage chemotherapy complications should reduce burden on patients and lower cost for payers.    * *Preliminary analysis result:* Conditional support, pending NQF endorsement    * *Notes:* 2. **American College of Surgeons-Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure** (MUC ID: MUC15-534)    * *Description:* Organ/space Surgical Site Infections (SSI) at the primary incision site among adult patients at least 18 years of age undergoing inpatient colon procedures and/or abdominal hysterectomies as reported through the ACS-NSQIP or CDC NHSN. The measure yields separate SIRs for each procedure. (*The endorsed specifications of the measure are: Prototype measure for the facility adjusted Standardized Infection Ratio (SIR) of deep incisional and organ/space Surgical Site Infections (SSI) at the primary incision site among adult patients aged >= 18 years as reported through the ACS National Surgical Quality Improvement Program (ACS-NSQIP) or CDC National Health and Safety Network (NHSN). Prototype also includes a systematic, retrospective sampling of operative procedures in healthcare facilities. This prototype measure is intended for time-limited use and is proposed as a first step toward a more comprehensive SSI measure or set of SSI measures that include additional surgical procedure categories and expanded SSI risk-adjustment by procedure type. This single prototype measure is applied to two operative procedures, colon surgeries and abdominal hysterectomies, and the measure yields separate SIRs for each procedure.*)    * *Preliminary analysis summary*      + *Contribution to program measure set:*This is an update to the name of the measure from “reliability adjusted SIR” to “Adjusted Ranking Metric (ARM).”      + *Impact on quality of care for patients:*The continued use of this measure will promote SSI prevention activities, which will lead to an improvement in patient outcomes, reducing avoidable medical costs, patient morbidity and mortality. Guidelines to prevent SSIs are available here (<http://www.cdc.gov/hicpac/SSI/001_SSI.html>).    * *Preliminary analysis result:* Conditional support, pending NQF annual update    * *Notes:* 3. **National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure** (MUC ID: MUC15-533)    * *Description:* Standardized infection ratio (SIR) of hospital-onset CDI Laboratory-identified events (LabID events) among all inpatients in the facility, excluding well-baby nurseries and neonatal intensive care units (NICUs). Additional metric added- Adjusted Ranking Metric also known as the “reliability-adjusted SIR.” (*The endorsed specifications of the measure are: Standardized infection ratio (SIR) of hospital-onset CDI Laboratory-identified events (LabID events) among all inpatients in the facility, excluding well-baby nurseries and neonatal intensive care units (NICUs)*)    * *Preliminary analysis summary*      + *Contribution to program measure set:*This measure would promote alignment between programs assessing general acute care and cancer hospitals (IQR and PCHQR). This measure is included in the MAP Safety Family of Measures. This measure addresses a condition that is a significant cause of morbidity and mortality among hospital patients and is associated with increased healthcare costs. The measure addresses a common condition in the Medicare FFS population that is associated with significant variation in costs and an opportunity for improvement. This measure is fully-specified and tested, but the update has not been reviewed by NQF.      + *Impact on quality of care for patients:*The measure is already in the program and will continue to promote multi-drug resistant organism prevention activities, such as CDI. CDC estimated that 107,700 infections occurred in United States acute care hospitals in 2011 (<http://www.cdc.gov/hicpac/pubs.html>). Adherence to clinical guidelines has resulted in decreased rates of infection.    * *Preliminary analysis result:* Conditional support, pending NQF annual update    * *Notes:* 4. **National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure** (MUC ID: MUC15-532)    * *Description:* Standardized infection ratio (SIR) of hospital-onset unique blood source MRSA Laboratory identified events (LabID events) among all inpatients in the facility    * *Preliminary analysis summary*      + *Contribution to program measure set:*The measure promotes alignment between programs, since it is currently in use in the PPS-Exempt Cancer Hospital Quality Reporting Program, Hospital Inpatient Quality Reporting, Hospital Value-Based Purchasing, Inpatient Rehabilitation Facility Quality Reporting, and Long-Term Care Hospital Quality Reporting. This measure is fully-specified and tested, but the update has not been reviewed by NQF.      + *Impact on quality of care for patients:*The measure is already in the program and will continue to promote multi-drug resistant organism prevention activities, (<http://www.cdc.gov/hicpac/pubs.html>) including MRSA, which will help improve patient outcomes including reduction of avoidable costs, morbidity, and mortality.    * *Preliminary analysis result:* Conditional support, pending NQF review and endorsement of revised specifications    * *Notes:* 5. **Oncology: Radiation Dose Limits to Normal Tissues** (MUC ID: MUC15-946)    * *Description:* Percentage of patients, regardless of age, with a diagnosis of breast, rectal, pancreatic or lung cancer receiving 3D conformal radiation therapy who had documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues    * *Preliminary analysis summary*      + *Contribution to program measure set:*This measure is currently in the program and is undergoing a substantial change. The update is to expand the denominator to include breast and rectal cancers.      + *Impact on quality of care for patients:*The continued use of this measure will promote effective coordination of care for oncology patients by identifying normal tissue dose constraints for those who receive radiation therapy treatments. Even though there is no specific data available, the American College of Radiation Oncology has found that normal dose constraints are not frequently included in the patient chart.    * *Preliminary analysis result:* Conditional support, pending NQF endorsement    * *Notes:* |
| 4:40 pm | Opportunity for Public Comment |
|  |  |
| 4:55 pm | Summary of Day |
|  | Erin O'Rourke, Senior Project Manager |
| 5:00 pm | Adjourn |
|  |  |
| **Day 2** |  |
|  |  |
| 8:30 am | Breakfast |
|  |  |
| 9:00 am | Welcome and Review of Day 1 |
|  | Cristie Upshaw Travis, MAP Hospital Workgroup Co-Chair; Ronald Walters, MAP Hospital Workgroup Co-Chair; Melissa Mariñelarena, Senior Director, NQF |
| 9:15 am | Overview of the End-Stage Renal Disease Quality Improvement Program (ESRD-QIP) |
|  |  |
| 9:20 am | Opportunity for Public Comment on Measures Under Consideration for ESRD-QIP |
|  |  |
| 9:30 am | Pre-Rulemaking Input on End-Stage Renal Disease Quality Improvement Program Measure Set |
|  |  |
|  | Programs under consideration: End-Stage Renal Disease Quality Incentive Program |
|  | 1. **Avoidance of Utilization of High Ultrafiltration Rate (= 13 ml/kg/hour)** (MUC ID: MUC15-758)    * *Description:* Percentage of adult in-center hemodialysis patients in the facility whose average ultrafiltration rate (UFR) is = 13 ml/kg/hour.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This NQF-endorsed measure fills a priority gap in the ESRD-QI program, measuring an intermediate outcome closely associated in the literature with severe adverse events, including elevated mortality. The measure has been tested at the appropriate level, and found to be valid and reliable. The measure is not expected to be burdensome to implement, as the necessary data elements exist already as part of the CROWNWeb repository.      + *Impact on quality of care for patients:*Implementation of this measure could encourage providers to slow down and extend dialysis sessions, reducing mortality and other adverse events for patients. A wide variation in facility-level performance suggests potential for improved outcomes for many patients.    * *Preliminary analysis result:* Support    * *Notes:* 2. **ESRD Vaccination: Full-Season Influenza Vaccination** (MUC ID: MUC15-761)    * *Description:* Percentage of ESRD patients = 6 months of age on October 1 and on chronic dialysis = 30 days in a facility at any point between October 1 and March 31 who either received an influenza vaccination, were offered and declined the vaccination, or were determined to have a medical contraindication.    * *Preliminary analysis summary*      + *Contribution to program measure set:*MUC-761 is a process measure consistent with CDC clinical guidelines and a necessary precursor to mitigate severe negative outcomes, including hospitalization and death. Influenza is particularly deadly and debilitating in the often immune-compromised ESRD population. While the measure has not been submitted for NQF endorsement, it has been fully tested at the appropriate level and setting, and is closely aligned with similar measures used in other CMS hospital quality programs.      + *Impact on quality of care for patients:*CDC estimates indicate influenza is associated with approximately 36,000 deaths and 226,000 every year, and particularly affects immune-compromised individuals, including many ESRD patients. The literature suggests 20% or more of ESRD patients are unvaccinated, and the vaccination is associated with improved mortality.This measure is particularly sensitive to the dual-eligible population, who has higher than average rates of ESRD. This measure addresses a gap in care coordination and preventative services.    * *Preliminary analysis result:* Conditional Support, pending NQF endorsement    * *Notes:* 3. **Measurement of Phosphorus Concentration** (MUC ID: MUC15-1136)    * *Description:* Percentage of all peritoneal dialysis and hemodialysis patient months with serum or plasma phosphorus measured at least once within the month.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This measure, NQF#0255, tracks performance of a precursor process that is consistent with clinical guidelines to mitigate patient morbidity and mortality. The measure has been found to be reliable, valid, and not burdensome to calculate. This updated measure has been broadened to include pediatric patients and permit an alternative measurement mechanism, plasma phosphorous.      + *Impact on quality of care for patients:*While the performance gap is small (mean performance is at 87%), the minimum performance is 0%, suggesting some facilities are not following this process at all. Moreover, over 500,000 patients were included in the developer’s analysis – even a difference of just a few percent means higher quality of care for tens of thousands of patients.    * *Preliminary analysis result:* Support    * *Notes:* 4. **Proportion of Patients with Hypercalcemia (NQF #1454)** (MUC ID: MUC15-1165)    * *Description:* Percentage of adult dialysis patients with a 3-month rolling average of total uncorrected calcium (serum or plasma) greater than 10.2 mg/dL (hypercalcemia)    * *Preliminary analysis summary*      + *Contribution to program measure set:*MUC 1165 is an update to a measure previously in the ESRD QIP, is NQF-endorsed, and measures an outcome that is established in the literature as a correlate of cardiovascular disease and death. The measure has been appropriately tested. The update to the measure removed an incentive to non-measurement, and expanded the possible measurement to either serum or plasma, consistent with scientific consensus.      + *Impact on quality of care for patients:*Validity testing showed a correlation between outcomes on this measure and worse mortality outcomes; an analysis of testing data estimated 15% of facilities are performing worse than expected, suggesting a performance gap. Implementing this updated measure is likely to encourage facilities performing below expectations to improve their standard of care, potentially improving patient safety for hundreds of thousands of dialysis patients nationwide.    * *Preliminary analysis result:* Support    * *Notes:* 5. **Standardized Hospitalization Ratio - Modified** (MUC ID: MUC15-693)    * *Description:* Standardized hospitalization ratio for admissions among ESRD dialysis patients.    * *Preliminary analysis summary*      + *Contribution to program measure set:*MUC-693 measures a critical outcome in a high-priority domain for the ESRD QIP program. ESRD patients average nearly two hospitalizations per year that burden patients and health systems alike. Hospitalizations are measured in other federal programs under consideration by the MAP Hospital Workgroup, including the OQR and ASCQR programs. MUC-693 is aligned with MUC-1167, a measure of readmissions.      + *Impact on quality of care for patients:*There are over 600,000 ESRD cases in the U.S. currently, most of whom are receiving treatment at a dialysis facility. These patients average nearly two hospitalizations per year that burden patients and health systems alike. Reducing those hospitalizations would doubtless improve the general health and well-being of the ESRD population, as well as reduce costs for Medicare, which spends roughly 37% of its total outlay for ESRD patients on hospitalizations.    * *Preliminary analysis result:* Conditional Support, pending NQF endorsement    * *Notes:* 6. **Standardized Mortality Ratio - Modified** (MUC ID: MUC15-575)    * *Description:* Standardized ratio for death among ESRD dialysis patients. (*The endorsed specifications of the measure are: Risk-adjusted standardized hospitalization ratio for admissions for dialysis facility patients.*)    * *Preliminary analysis summary*      + *Contribution to program measure set:*MUC 575 would bolster the ESRD QIP measure set by addressing the high-priority need of Patient Safety with a high-value outcome measure of patient mortality. The measure is an updated version of a previously endorsed measure (NQF #0369), and has been submitted for endorsement maintenance with a decision pending in 2016. Adding a mortality measure would align the ESRD QIP program with IQR without adding a measurement burden, as the measure is calculated using CROWNWeb data and claims data, and has been reported on Dialysis Facility Compare since 2001.      + *Impact on quality of care for patients:*MUC 575 measures patient mortality, ultimately the highest-value quality measure. A performance gap is clearly established through testing, where 15% of facilities were shown to perform 30% worse than the national average. As the ESRD QIP program measures performance across nearly 6,000 facilities treating nearly a half-million patients, this measure would drive better care for a large group of particularly vulnerable patients.    * *Preliminary analysis result:* Conditional Support, pending NQF endorsement    * *Notes:* 7. **Standardized Readmission Ratio (SRR) for dialysis facilities** (MUC ID: MUC15-1167)    * *Description:* The Standardized Readmission Ratio is the ratio of a dialysis facility’s (DF) total Medicare-paid index discharges for its dialysis patients from acute care hospitals (ACHs) that result in an unplanned Medicare-paid ACH readmission within 30 days to the total readmissions expected for the DF, given the discharging ACH, the DF, patient/index hospitalization characteristics, and the US median for DFs. (*The endorsed specifications of the measure are: The Standardized Readmission Ratio (SRR) is defined to be the ratio of the number of index discharges from acute care hospitals that resulted in an unplanned readmission to an acute care hospital within 30 days of discharge for Medicare-covered dialysis patients treated at a particular dialysis facility to the number of readmissions that would be expected given the discharging hospitals and the characteristics of the patients as well as the national norm for dialysis facilities. Note that in this document, “hospital” always refers to acute care hospital.*)    * *Preliminary analysis summary*      + *Contribution to program measure set:*MUC 1167 is a measure that was previously in the ESRD QIP program, and has been re-submitted to reflect changes to the measure calculation. The updated measure is tested at the ESRD facility level, and testing shows the measure is both valid and reliable. A significant performance gap was established in both measure testing and in national statistics of ESRD patient outcomes.      + *Impact on quality of care for patients:*Readmission is a costly adverse event that negatively affects patient quality of life. Over a third of discharges for ESRD patients lead to a readmission, presenting a significant opportunity for improvement. Performance scores are normally distributed with a standard deviation approximately one-third the mean, suggesting many facilities could improve their performance significantly to attain the high standard set by top performing facilities.    * *Preliminary analysis result:* Support    * *Notes:* |
| 10:45 am | Break |
|  |  |
| 11:00 am | Overview of the Hospital Outpatient Quality Reporting Program (HOQR) |
|  |  |
| 11:05 am | Opportunity for Public Comment on Measures Under Consideration for HOQR |
|  |  |
| 11:15 am | Pre-Rulemaking Input on Hospital Outpatient Quality Reporting Program Measure Set |
|  |  |
|  | Programs under consideration: Hospital Outpatient Quality Reporting Program |
|  | 1. **Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy** (MUC ID: MUC15-951)    * *Description:* Measure estimates risk-adjusted rates of inpatient admissions or emergency department (ED) visits for cancer patients >18 years of age with at least one of the following diagnoses—anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, or sepsis—within 30 days of hospital outpatient chemotherapy treatment. Two rates are reported.    * *Preliminary analysis summary*      + *Contribution to program measure set:*This measure fits in a high-priority domain and would be the first hospital admissions measure in the OQR set, which would align OQR with other measure sets that include admissions and readmissions measures, including ASCQR and HRRP. This measure would also help expand cancer quality measurement to the Hospital Outpatient setting. The measure has not been submitted for endorsement to NQF. This measure was conditionally supported by the MAP in 2014 for use in the PCHQR program, pending NQF endorsement.      + *Impact on quality of care for patients:*According to research by the measure developer, nearly 20% of chemotherapy patients are affected by potentially preventable adverse events that are so severe they require a hospital admission of ED visit. Incentivizing HODs to better manage chemotherapy complications should reduce burden on patients and lower cost for payers.    * *Preliminary analysis result:* Conditional Support, pending NQF endorsement.    * *Notes:* 2. **Risk-standardized hospital visits within 7 days after hospital outpatient surgery** (MUC ID: MUC15-982)    * *Description:* The measure score is a hospital-level, post-surgical risk-standardized hospital visit (RSHV) ratio, which is a ratio of the predicted to expected number of all-cause, unplanned hospital visits within 7 days of a same-day surgery at a hospital outpatient department (HOPD) among Medicare fee-for-service (FFS) patients aged 65 years and older. (*The endorsed specifications of the measure are: Facility-level, post-surgical risk-standardized hospital visit ratio (RSHVR) of the predicted to expected number of all-cause, unplanned hospital visits within 7 days of a same-day surgery at a hospital outpatient department (HOPD) among Medicare fee-for-service (FFS) patients aged 65 years and older.*)    * *Preliminary analysis summary*      + *Contribution to program measure set:*This measure addresses a OQR priority domain by adding the first measure of hospital admissions to the OQR measure set. Adding this measure would align OQR with other CMS programs addressing similar settings including ASCQR. This measure has been fully specified and tested, and is endorsed by the National Quality Forum.      + *Impact on quality of care for patients:*This measure directly assesses variations in patient outcomes following surgery at a HOPD. Hospital admissions are costly for payers and burdensome to patients, and there is a broad effort across federal programs to reduce excess admissions. The literature finds significant room for improvement in HOPDs: up to 40% of direct admissions after outpatient surgery are preventable.    * *Preliminary analysis result:* Support    * *Notes:* |
| 12:00 pm | Lunch |
|  |  |
| 1:00 pm | Overview of the Ambulatory Surgical Center Quality Reporting (ASCQR) Program |
|  |  |
| 1:05 pm | Opportunity for Public Comment on Measures Under Consideration for ASCQR |
|  |  |
| 1:15 pm | Pre-Rulemaking Input on Ambulatory Surgical Center Quality Reporting Program Measure Set |
|  |  |
|  | Programs under consideration: Ambulatory Surgical Center Quality Reporting Program |
|  | 1. **Toxic Anterior Segment Syndrome (TASS) Outcome** (MUC ID: MUC15-1047)    * *Description:* This measure is used to assess the number of ophthalmic anterior segment surgery patients diagnosed with TASS within 2 days of surgery.    * *Preliminary analysis summary*      + *Contribution to program measure set:*The measure does not necessarily fill a gap in the program measure set. Moreover, performance on the measure cannot be definitively attributed to the ambulatory surgical center; FDA investigations suggest device manufacturers are responsible for endotoxin contamination that leads to TASS.      + *Impact on quality of care for patients:*The measure would add the first outcome measure to Effective Prevention and Treatment, and could improve on the existing cataract surgery measure by basing the results on medical records and physician diagnoses rather than patient self-report.    * *Preliminary analysis result:* Do not support    * *Notes:* |
| 1:50 pm | Overview of the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program |
|  |  |
| 1:55 pm | Opportunity for Public Comment on Measures Under Consideration for IPFQR |
|  |  |
| 2:05 pm | Pre-Rulemaking Input on Inpatient Psychiatric Facilities Quality Reporting Program Measure Set |
|  |  |
|  | Programs under consideration: Inpatient Psychiatric Facility Quality Reporting Program |
|  | 1. **Substance Use Core Measure Set (SUB)-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge** (MUC ID: MUC15-1065)    * *Description:* Overall rate which includes all hospitalized patients 18 years of age and older to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received alcohol or drug use disorder treatment at discharge. (*The endorsed specifications of the measure are: The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received alcohol or drug use disorder treatment at discharge. The Provided or Offered rate (SUB-3) describes patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. The Alcohol and Other Drug Disorder Treatment at Discharge (SUB-3a) rate describes only those who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment. Those who refused are not included.These measures are intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).*)    * *Preliminary analysis summary*      + *Contribution to program measure set:*Adding this measure set would enhance the substance abuse measures currently in the set by helping to ensure patients are offered treatment. Studies have shown that less than one in 20 patients with a substance abuse disorder are offered treatment.      + *Impact on quality of care for patients:*Individuals with serious mental illnesses have high rates of substance abuse disorders which frequently go untreated and can result in poorer outcomes. 40 to 60% of psychiatric inpatients have been found to have substance abuse disorders. Improving care of these disorders could lead to better outcomes and fewer co-morbidities. Additionally, alcohol, drug, and tobacco use are the cause of more than one out of every four deaths in the United States annually. Substance abuse also has severe economic impacts. Annual health care spending on alcohol and drug abuse is approximately $19 billion and $14 billion respectively.    * *Preliminary analysis result:* Support    * *Notes:* 2. **Thirty-day all-cause unplanned readmission following psychiatric hospitalization in an Inpatient Psychiatric Facility (IPF)** (MUC ID: MUC15-1082)    * *Description:* The measure estimates a facility-level risk-standardized readmission rate for unplanned, all-cause readmission within 30 days of discharge from an Inpatient Psychiatric Facility of adult Medicare fee-for-service (FFS) patients with a principal diagnosis of a psychiatric disorder. The performance period for the measure is 24 months.    * *Preliminary analysis summary*      + *Contribution to program measure set:*Readmissions to IPFs are a common occurrence that negatively impacts patients and drives up the cost of care. An analysis of 2012-2013 claims data shows an opportunity for improvement. The mean observed readmission rate was 20.7% with a range of 16.6%-24.4%. The crude risk-adjusted mean rate was 22.6% with a range of 19.7%-25%. \*The stage of development for this MUC was updated to "Fully Developed" on December 3, 2015, after the MUC was publicly released.      + *Impact on quality of care for patients:*Implementing this measure could increase the urgency to implement strategies to reduce readmissions such as improved care transitions and ensuring the patient is stabilized before discharge.    * *Preliminary analysis result:* Conditional support, pending NQF endorsement    * *Notes:* |
| 2:40 pm | Opportunity for Public Comment |
|  |  |
| 2:55 pm | Wrap Up |
|  | Zehra Shahab, Project Manager |
| 3:00 pm | Adjourn |
|  |  | |