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Call for Nominations

Attribution for Critical Illness and Injury Committee

Background

Measurement approaches that attribute care in new ways are becoming increasingly important as the healthcare system moves towards models of value-based care and payment. Attribution is defined as the methodology used to assign patients, and their quality outcomes, to providers or clinicians.[1] To date, attribution models have focused on chronic conditions and care coordinated through a central unit. Different factors, however, must be considered when considering attribution for patient outcomes during emergencies. High-acuity Emergency Care Sensitive Conditions (ECSCs), such as critical illness or injury, infectious diseases, radiation or chemical exposure, and other public health emergencies require prompt, team-based care. Current measurement attribution approaches do not account for shared accountability across multiple entities involved in preparing, responding, and providing care, which limits their direct applicability to ECSCs.

Where patients seek care for emergency conditions is frequently driven by system design, availability, and proximity, rather than payer or health system affiliations. The COVID-19 pandemic underscores the complexities associated with determining appropriate attribution for patient outcomes during emergencies. Factors such as resource availability, different entities providing care, communication of test results and patient needs between providers, and orders that aim to minimize infection spread must be considered to understand and assign responsibility for health outcomes during emergencies.

Evidence to support the best way to attribute patients for emergency conditions and events is limited. Therefore consensus-based recommendations that define the elements of such models and considerations for their development are needed. Such models should incentivize multiple stakeholders involved in care delivery to work collaboratively in an integrated, population health-focused manner to improve patient outcomes.

This project builds upon previously CMS funded work, NQF's 2016 Attribution: Principles and Approaches[1] and 2018 Improving Attribution Models[2], as well as the Health Care Payment Learning & Action Network (HCP-LAN)'s 2016 Report on Patient Attribution[3]. It will consider foundational work on population-based care measurement, NQF's 2019 Healthcare System Readiness Measurement Framework[4] that considers approaches to care delivery and the organization of resources prior to, during, and after emergencies or disasters. NQF will use a multistakeholder approach to make

[1] National Quality Forum. Attribution: Principles and Approaches. Washington, DC: December 2016.
[2] National Quality Forum. Improving Attribution Models. Washington, DC: August 2018.
[3] Health Care Payment Learning & Action Network. Accelerating and Aligning Population-Based Payment Models: Patient Attribution. June 2016.
[4] National Quality Forum. Healthcare System Readiness Measurement Framework. Washington, DC: June 2019.

recommendations on different population-based attribution models applicable to high-acuity ECSCs. This work will help advance the development of attribution approaches that encourage care coordination and can be used to gauge provider performance and strengthen accountability at the system level and across payers to improve outcomes for patients with ECSCs.

Committee Charge and Project Structure

For this CMS-funded work, NQF will convene a multistakeholder Committee to develop recommendations to guide the development of a geographical/population-based attribution model applicable to a community-based system response for unplanned high acuity ECSCs. The Committee will consist of no more than 25 individuals. Additionally, NQF will also seek to identify Federal Liaisons with expertise in high-acuity ECSCs and/or attribution.

NQF will convene the Committee for six (6) 2-hour web meetings over a 12-month period. During these web meetings the Committee will 1) review the environmental scan and themes from key informant interviews 2) identify the necessary elements of population/geographic-based attribution models focused on high acuity ECSCs; and 3) leverage the NQF 2016 and 2018 reports on attribution to develop attribution approaches for high-acuity ECSCs. The Committee will aim to reach consensus surrounding the feasibility of different attribution approaches for high-acuity ECSCs, a geographic unit that accurately captures health care use for unplanned high-acuity ECSCs, and how the attribution approaches will be patient-centered, and will encourage care coordination. The report will include five (5) use cases of high-acuity ECSCs in situations of pandemics, natural disasters, mass violence, or other national emergencies to illustrate what to consider in developing an attribution approach for measuring quality of care related to health outcomes.

The Committee will be responsible for steering the development of major project components, including:

- An environmental scan of current population/geographic-based attribution approaches for high-acuity ECSCs supplemented by key informant interviews with experts in the field
- Use cases to exemplify considerations for the development of team-based attribution approaches for several emergency scenarios
- A final report that documents the Committee's recommendations on the necessary elements of population/geographic-based attribution models, theoretical and empirical approaches to attribution, and guidance for the future development of population/geographic-based quality measurement attribution approaches for emergency conditions

Terms

Committee members will serve for a term of 12 months.

Participation on the Committee requires a significant time commitment.

Committee members are expected to participate in all scheduled meetings. Over the course of the Committee member's term, additional meetings may be scheduled, or meetings may be rescheduled; new dates are set based on the availability of the co-chairs.

Committee participation includes:

- Participating in six, 2-hour web meetings over a 12-month period
- Guiding the development and implementation of an environmental scan assessing the current landscape of attribution models for emergency care
- Providing input on key informants and interview guide content to better understand the current themes, gaps, and approaches to attribution for emergency conditions to supplement the environmental scan
- Creating use cases as concrete examples of how outcomes may be attributed to multiple entities during emergencies
- Developing actionable recommendations for population-/geographic-based measurement attribution approaches that incentivize coordinated care to improve outcomes during emergencies
- Reviewing and providing feedback on written deliverables
- Providing additional feedback and input as needed

Tentative Meeting Dates

Meeting	Date/Time
Web Meeting #1 – Orientation	January 2021
Web Meeting #2 – Environmental Scan, Key Informant Interview (KII) Guides	January 2021
Web Meeting #3 – Environmental Scan and KII Findings, Elements of Population/Geographical Attribution Models	March 2021
Web Meeting #4 – Environmental Scan Public Comments, Use Case Activities	April 2021
Web Meeting #5 – Draft Report Feedback, Finalize Committee Recommendations	May 2021
Web Meeting #6 – Final Report Public Comments, Final Comments	July 2021

Preferred Expertise and Composition

Committee members are selected to ensure representation from a variety of stakeholders, including consumers, purchasers, providers, payers, measure developers, suppliers, community and public health leaders, patients, caregivers, and healthcare quality experts. Because NQF attempts to represent a diversity of stakeholder perspectives on committees, a limited number of individuals from each of these

stakeholder groups can be seated onto a committee.

NQF seeks the following representation for the 25-person Committee:

- National experts in attribution approaches for quality measurement
- National experts in high-acuity ECSCs, including providers and/or researchers in emergency care, trauma, burn, infectious disease, radiation treatment, etc.
- Patients/consumers/caregivers, including patients or patient representatives with lived experience in high-acuity ECSCs
- Practicing clinicians specializing in high-acuity ECSCs, including clinicians who had provided care during the COVID-19 pandemic, previous public health emergencies, natural disasters, mass violence, etc.
- First responders, such as emergency medical technicians (EMTs), paramedics, law enforcement officers, firefighters or other trained personnel who provide rescue or assistance during emergency situations like pandemics, terrorism, natural disasters, and mass violence
- State/local agencies staff (e.g., state health departments) with experience in the design, implementation, and/or evaluation of disaster preparedness/readiness programs
- Representatives of health plans, preferably plans serving New York City, New Jersey, Boston, Chicago, Seattle, the Gulf Coast region, California, and the Washington, DC capital area.
- Representatives of healthcare facilities, preferably individuals with work experience in emergency departments, intensive care units, trauma centers, nursing homes, etc.
- Representatives of specialty societies focused on emergency care

Please review the NQF conflict of interest policy to learn about how NQF identifies potential conflicts of interest. All potential Committee members must disclose any current and past activities prior to and during the nomination process in order to be considered.

Consideration and Substitution

Priority will be given to nominations from NQF members when nominee expertise is comparable. Please note that nominations are to an individual, not an organization, so "substitutions" of other individuals are *not permitted.* Committee members are encouraged to engage colleagues and solicit input from them throughout the process.

Application Requirements

Nominations are sought for individuals and individual subject matter experts. Self-nominations are welcome. Third-party nominations must indicate that the individual has been contacted and is willing to serve.

To nominate an individual to the Attribution for Critical Illness and Injury Committee please **submit** the following information:

- A completed online nomination form, including:
    - A brief statement of interest

  - A brief description of nominee expertise highlighting experience relevant to the committee
  - A short biography (maximum 100 words), highlighting experience/knowledge relevant to the expertise described above
  - Curriculum vitae or list of relevant experience (e.g., publications) *up to 20 pages*
- A completed disclosure of interest form. This will be requested upon submission of the nominations form.
- Confirmation of availability to participate in currently scheduled calls and meeting dates.

Deadline for Submission

All nominations *MUST* be submitted by **6:00 pm ET on November 30, 2020.** The proposed Committee roster will be posted for public comment from December 18, 2020 – December 31, 2020. The final Committee roster will be posted on January 7, 2021.

Questions

If you have any questions, please contact Udara Perera or Wei Chang at 202-783-1300 or Attribution@qualityforum.org. Thank you for your interest.