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Driving measurable health improvements together

Attribution for Critical Illness and Injury

Web Meeting #4

April 20, 2021

This project is funded by the Centers for Medicare & Medicaid Services (CMS) under Task Order 75FCMC20F0005 – Attribution for Critical Illness and Injury.

Welcoming Remarks

Welcome!

Housekeeping reminders:

- Please mute your computer or line when you are not speaking
- Please ensure your name is displayed correctly (right click on your picture and select "Rename" to edit)
- We encourage you to turn on your video, especially during the discussions and when speaking
- To switch your display, click in the upper-right hand corner and toggle between "Speaker View" or "Gallery View" to choose your preferred view
- Please use the 'hand raised' feature if you wish to provide a point or raise a question.
  - *To raise your hand, click on the "participants" icon on the bottom of your screen. At the bottom of the list of participants you will see a button that says, 'Raise Hand'*

- Feel free to use the chat feature to communicate with the National Quality Forum (NQF) Host
- For this meeting, we will be using RingCentral for presentations and discussions. Please ensure you have access to this platform.

If you are experiencing technical issues, please contact us at attribution@qualityforum.org

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Agenda

- Roll Call and Meeting Objectives
- Web Meeting #3 Recap
- Review Environmental Scan Public Comments
- Key Informant Interview (KII) Themes
- Public Comment
- Next Steps

Roll Call and Meeting Objectives

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NQF Project Staff

Project Staff
Nicolette Mehas, PharmD, Senior Director, Quality Measurement
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Committee Members

Committee Members	
Brendan Carr, MD, MA, MS (co-chair)	Gerald Maloney, Jr., DO, CHCQM, CPPS, CPHQ, FACEP, FACMT
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Michael Barr, MD, MBA, MACP, FRCP	Fred Neis, MS, RN, FACHE, FAEN
Sue Anne Bell, PhD, FNP-BC, NHDP-BC	Brian Park, RN, BSN
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Federal Liaisons

Federal Liaison	Affiliation
Craig Goolsby, MD, MEd, FACEP	Department of Defense (DoD)
Richard C. Hunt, MD	Office of the Assistant Secretary for Preparedness & Response (ASPR)
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Meeting Objectives

- Recap Web Meeting #3
- Review public comments received on the Draft Environmental Scan Report to determine Committee responses and Report updates
- Review Key Informant Interview (KII) progress and discuss thematic results

Recap of Web Meeting #3

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Web Meeting #3 Recap and Progress Update

- Reviewed the updated KII progress and questions
- Reviewed and discussed attribution considerations for three use cases
  - Trauma (Motor Vehicle Accident)
  - Trauma (Bombing)
  - High-Consequence Infectious Disease

Public Comments on Draft Environmental Scan Report

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Public Comments Received

- Public Commenting Period open from February 24 through March 29
- Received 10 comments from 2 organizations
- Themes include:
  - Defining the Scope
  - Attribution Model Design and Approaches
  - Editorial and Organizational

Comments Received with Proposed Responses

[screenshare comments with proposed responses]

Key Informant Interview Themes Discussion

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Review: Key Informant Interviews – Purpose and Methods

- Purpose: to identify major schools of thoughts, additional existing knowledge and literature gaps, and issues of debate central to the development of population/geographic-based attribution approaches for measuring health outcomes resulting from emergency care sensitive conditions (ECSCs)/national emergencies

- Seven 60-minute interviews held between 3/15 and 4/5
- Two remaining interviews
- Interviews were audio recorded and transcribed verbatim
- All interviewees gave consent to participate, be recorded and acknowledged for their contributions

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Review: Key Informant Interview Recruitment

- Breakdown of interview stakeholder groups:
  - Patient/consumer group (1)
  - Experts on developing measurement attribution models (2)
  - Experts in high-acuity ECSCs, including providers, researchers, and/or representatives from healthcare facilities (1)
  - Front-line clinicians to COVID-19 or other public health crises (2)
  - Transport medicine/Emergency response providers (1)
  - Health insurance providers (1)
  - Federal, State/local agencies staff that design, implement, or evaluate emergency preparedness programs (1)

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Overview: Key Informant Interview Themes

- Goal of the attribution methodology
- Health system readiness
- Defining the population/geographic regions
- Timing of attribution
- Data challenges
- Patient role in decision-making during emergencies
- Team-based attribution
- Aspirational approaches
- Unintended consequences

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Goal of the Attribution Methodology

- Save as many lives as possible
- Support longitudinal measurement of quality care outcomes for patients over providers, settings, and time
- Ensure proactive coordination and communication across multiple health care entities and non-healthcare entities
- Incentivize readiness rather than penalize health care entities operating in emergency situations
- Implement technology without creating a burden for data collection and reporting measures

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Health System Readiness

- Encourage proactive coordination, communication
- Ensure appropriate stock of personal protective equipment (PPE), resources and equipment to respond to various types of mass casualty incidents (MCIs) since you cannot treat all mass casualty situations the same
  - If some one was acting in good faith that should be the standard
- Regional coordination of health care entities (regional task forces that can organize local response) – also known as "healthcare coalitions" funded through the Hospital Preparedness Program (HPP) at the Assistant Secretary for Preparedness and Response (ASPR)
  - This regional coordination should be building community resilience with special attention to equity
  - Consider what is the funding for these regional coordination efforts, what is the authority that they can exercise, what real-time data do they have access to, and the clinical leadership for the coordination

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Health System Readiness cont.

- Support telehealth infrastructure
  - Telemedicine options for calling specialists to help assist community facilities. This must be technology independent - usable by any provider in any emergency department, and we want to be able to utilize specialists that are not directly involved to be able to be called in from a different state (with Federal assistance in credentialing)
- Interoperability to share patient information in a MCI
- Consider structure and safety measures rather than outcome measures
- Consider the Joint Commission/CMS regulatory requirements for MCI readiness; those requirements should be reviewed. Requirements for MCI readiness should not just be for trauma centers
- Rural readiness is even more challenging given the limited staff resources that are often available
- Proactive coordination for the portions of care required for the patient in MCI events

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Defining the Population/Geographic Regions

- Varies by region and dependent on MCI
- Overall, should be as granular as possible, as is it easier to aggregate up
- Consider all patients or populations that are at risk of exposure to MCI (dependent upon type of MCI and time of attribution/endpoint)
- Draw a realistic radius based on the probability of an event, considering the most likely way that patients will be distributed
- Should be prospectively defined to ensure coordination

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Timing of Attribution

- Prospective is preferable but is challenging given the payment system
  - Choice of attribution approach is contingent on the type of MCI and trajectory of an injury/condition
- Also, consider a hybrid model (of prospective and retrospective approaches) to encourage proactive coordination and communication but also retrospective to evaluate the effectiveness of care response plans

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Data Challenges

- One of the major challenges is that health systems and other non-claims-based service providers cannot, or are not willing to share data in real time
  - Interoperability challenge makes it difficult to be able to understand the patient's journey
- Mass notification systems that truly reach all of the impacted entities in real time, and do a better job standardizing what gets communicated and how it gets communicated, with hazards in particular, and looking at receiving capability (not just open beds) of hospitals
- Most incident data systems aren't clinical at all - will talk about risks and what's happening but not clinical load.
  - Need to account for both emergency medical services (EMS) and spontaneous patient load
- Infrastructure is not there for most of the country. Needs to be an incentive to create a better data sharing system because of the cost and need for resources and encouragement

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Patient Role in Decision-Making During Emergencies

- MCIs require urgent clinical attention and saving lives is the top priority
- Patients should always have a role in decision-making but also consider the urgency of the care needed and decision-making ability of the patient at the time
  - Protocols that provide guidance on conditions under which seeking patient input is appropriate should be developed and used to inform attribution approaches
- Systems should be organized proactively to ensure the best possible outcomes for patients if patient decision making is impaired due to the MCI

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Team-Based Attribution

- All providers that are expected to deliver care in an MCI should be part of measurement
- Consider capability-based planning; while we cannot plan for every event what are the capabilities that we would expect to see from each member of the team

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Aspirational Approaches

- Ability to recognize who provided care to understand the patient's journey throughout the system, and to provide the full picture and reimburse for providers' efforts
- Reinforce telehealth through strengthening access to technology and increasing capabilities
- Penalize vs incentivize: The goal should not be to penalize poor performance, but rather to work with the organizations that are not meeting the standards
- Only when the entities are operating broadly outside the standard of care and are not meeting safety standards should a penalty be used, but even then, that scenario should be used to provide technical assistance as opposed to adjusting payment

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Aspirational Approaches cont.

- We need to figure out how to get healthcare entities to plan more, do more in the planning phase. And then, when an event happens, need to give them better information to respond.
- For coalitions, we need to set standards for more clinical expertise, more proper emergency management expertise in real time, and give them authority to actually act
- Prioritize time-sensitive metrics; actions should be taken quickly to save lives in an MCI
- Combination of technology, communication and stakeholder engagement: get to the point where we can minimize data collection burden, get buy-in on data sources and their accuracy, and agree on the universal payers and entities involved

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Unintended Consequences

- Do not penalize, be cautious of disincentives for coordination and communication for outcomes that may not be immediately apparent.

NQF Member and Public Comment

Next Steps

Next Steps (cont.)

- Web Meeting #5: May 11, 2021, 2:30 pm – 4:30 pm ET
  - » Continue Use Case Discussion
  - » Discuss incorporation of Use Case findings and KII results within the Final Report

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Project page: http://www.qualityforum.org/Attribution_for_Critical_Illness_and_Injury.aspx

SharePoint site: https://share.qualityforum.org/portfolio/AttributionCriticalIllnessInjury/SitePages/Home.aspx

THANK YOU.

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