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Driving measurable health improvements together

Attribution for Critical Illness and Injury

Web Meeting #5

May 11, 2021

This project is funded by the Centers for Medicare & Medicaid Services 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 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 #4 Recap
- Review and Incorporate Use Case Findings and KII Themes within Final Report
- Continue Use Case Discussion
- Public Comment
- Next Steps

Roll Call and Meeting Objectives

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NQF Project Staff

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Committee Members

Committee Members	
Brendan Carr, MD, MA, MS (co-chair)	Gerald Maloney, Jr., DO, CHCQM, CPPS, CPHQ, FACEP, FACMT
Carol Raphael, MPA, Ed (co-chair)	William Miles, MD, FACS, FCCM, FAPWCA
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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Marsha Smith, MD, MPH, Medical Officer, DPMS/QMVIG/CSSQ

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Meeting Objectives

- Recap Web Meeting #4
- Review and Incorporate Use Case Findings and KII Themes within Final Report
- Continue Use Case Discussion

Recap of Web Meeting #4

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Web Meeting #4 Recap

- Reviewed public comments received on the draft environmental scan report to determine Committee responses and report updates
- Reviewed Key Informant Interview (KII) progress and discussed thematic results

Use Case Findings and Key Informant Interview Themes

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Attribution Overview

- Methodology to assign patients and their quality and cost outcomes to providers or entities
- Simple attribution approaches are less applicable to mass casualty incidents (MCIs)
- Challenge to attribute a single outcome (e.g., mortality) to a team or multiple entities with different involvement or abilities to impact a particular outcome

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Final Report Themes

- The final report will incorporate key themes from the KIIs and web meeting discussion. Including:
  - Goal of the Attribution Methodology
  - Defining the Population/ Geographic Regions
  - Team-Based Attribution
  - Timing of Attribution
  - Data Availability and Capture
  - Patient Role in Decision-Making During Emergencies
  - Aspirational Approaches
  - Unintended Consequences
  - Health System Readiness
  - Quality Measures, Concepts, and Gaps

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Goal of the Attribution Methodology

- Foster and promote shared accountability and best possible outcomes
- Determining measurement attribution purpose
  - Encourage proactive coordination and communication between healthcare providers, public health entities, and EMS
  - Determine which population-level outcomes are desired based on previous gaps
- Determining entities and responsibilities
  - Account for roles of all entities involved
- Limitation of undue burden

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Defining the Population/Geographic Regions

- Population-based approaches
  - Granularity of geographic boundaries
  - Realistic radius developed by the probability of an emergency event
  - Use data on existing patterns of healthcare receipt (e.g., Dartmouth Atlas' hospital service areas or hospital referral regions, Assistant Secretary for Preparedness and Response's (ASPR's) Hospital Preparedness Program (HPP) Health Care Coalitions (HCCs), Federal Emergency Management Agency's (FEMA's) flood maps)
- Patient inclusion considerations
  - All patients in a region, patients at risk of exposure to an MCI, or limit to only those that interact with the healthcare system

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Team-Based Attribution

- Attribution to multiple entities
  - Expected providers during an MCI would be part of quality measurement or accountability
  - Proactive awareness of accountability
  - Determination of timing (e.g., EMS would only take part in the early part of an event)
- Weighting approaches
  - Determination of each entities' level of influence

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Timing of Attribution

- Prospective, Hybrid, and Retrospective Methods
  - Prospective or hybrid model is recommended to incentivize a multidisciplinary, coordinated response to emergencies
  - Retrospective models have the benefit of tracking patients and outcomes, can be best utilized for reviews of gaps and opportunities for improvement
- Measurement Duration
  - Varies depending on type of MCI
  - Additional layers of accountability may develop over time

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Data Availability and Capture

- Major challenges include interoperability, data sharing, and ability to notify all impacted entities in real-time
- Most incident data systems do not include clinical data, but rather focus on risks and events
  - Need to account for emergency medical services (EMS) and spontaneous patient load
- Need to standardize what gets communicated and how
- Receiving capability, not just open hospital beds, is a critical data point
- Data infrastructure is mainly non-existent
  - 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 need to consider the urgency of the care and decision-making capacity 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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Aspirational Approaches

- Ability to recognize who provided care to have a full picture of the patient's journey and reimburse for providers' efforts
- Reinforce telehealth use
- Work with organizations that are not meeting the standards rather than penalize poor performance
  - Technical assistance instead of payment reduction
- Encourage planning and provide better information for entity response
- Provide coalitions authority to act; set standards for clinical expertise and emergency management expertise within coalitions
- Prioritize time-sensitive metrics (e.g., promoting actions that should be taken quickly to save lives in an MCI)
- Minimize data collection burden, get buy-in on data sources and their accuracy and real-time availability, and agree on the entities involved

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Unintended Consequences

- Penalties may disincentivize coordination and communication for outcomes that may not be immediately apparent (e.g., acute or chronic conditions that arise long after the MCI)
- Be careful about creating a system that is complicated and burdensome, especially on constrained organizations like safety net organizations
- Uncertainty and hesitation around applying attribution for accountability purposes when responding to emergencies, and concerns about adding burden during these types of events

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Measurement of Healthcare System Readiness and ECSCs

- Creation of important, valid, feasible, and useable measures for readiness (structure and process measures)
- Encourage proactive coordination, communication
- Measurement of specific preparedness actions or resources (e.g., simulations, exercises, sufficient PPE)
  - Principles and protocols: Staff, Resources (both medical and nonmedical), Structure
- Currently, quality of readiness is assessed retrospectively after an MCI
  - Considering attribution could enable prospective and population/geographic-based attribution
- Enforced only through accreditation or regulatory requirements
- ECSC measurement is more advanced, still gaps
  - Chief complaint measures

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Quality Measures, Concepts, and Gaps

- Limited quality measures for PHEs and MCIs
- Traditional measures for ECSCs
- Types of measures
  - Population- and team-based measures
  - Structure and process measures and measure concepts
  - Facility-level operational activities and metric concepts
- Established preparedness and EMS measures and measure concepts
  - HPP measures
  - EMS measure concepts
  - National EMS Quality Alliance (NEMSQA) measures

Use Case Discussion Breakout Rooms

Use Case Discussion Breakout Room Instructions

- NQF will divide participants into three assigned breakout rooms to discuss each of the remaining Use Cases
  - Burns (independent of trauma)
  - Chemical
  - Nuclear
- Each room will have 25 minutes to discuss key themes as discussed in previous use cases, and report to the full group after the breakout room to answer the following questions:
  - What quality measures should be used in this scenario (current or concepts)?
  - How should attribution models promote shared accountability for this scenario?
- A volunteer from each group will report out key findings from discussion

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Use Case Discussion Report Out

- Use Case 4 – Burns (independent of trauma)
- Use Case 5 – Chemical
- Use Case 6 – Nuclear

NQF Member and Public Comment

Next Steps

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Next Steps

- Final Environmental Scan will be posted publicly May 17
- Final Report draft will be shared with the Committee for feedback **today**, due back to NQF May 18, COB
- Final Report draft will be posted for public comment from June 2 through July 1
- Web Meeting #6: July 28, 2021, 1:00 pm – 3:00 pm ET
  - Discuss and adjudicate public comments on the Final Report
  - Gather any final comments to refine the Final Report

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Project Contact Information

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Project page: Attribution for Critical Illness and Injury

THANK YOU.

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http://www.qualityforum.org