NATIONAL QUALITY FORUM

Memo

TO: Consensus Standards Approval Committee (CSAC)

FR: Angela Franklin, Wunmi Isijola and Zehra Shahab

RE: Care Coordination Phase 3 Member Voting Results

DA: July 2, 2014

The CSAC will review recommendations from the *Care Coordination* project at its July 9-10 in-person meeting.

This memo includes a summary of the project, recommended measures, and themes identified from and responses to the public and member comments.

This project followed the National Quality Forum's (NQF) version 1.9 of the Consensus Development Process (CDP). Member voting on these recommended measures ends on July 7th.

Accompanying this memo are the following documents:

1. **Care Coordination Draft Report.** The draft report has been updated to reflect the changes made following Standing Committee discussion of public and member comments. The complete draft report and supplemental materials are available on the project page.
2. **Comment table**. Staff has identified themes within the comments received. This table lists 75 comments received and the NQF/Standing Committee responses.

CSAC ACTION REQUIRED
Pursuant to the CDP, the CSAC may consider approval of 11 candidate consensus standards.

Care Coordination Measures Recommended for Endorsement:

- 0291: Administrative Communication
- 0292: Vital Signs
- 0293: Medication Information
- 0294: Patient Information
- 0295: Physician Information
- 0296: Nursing Information
- 0297: Procedures and Tests
- 0495: Median Time from ED Arrival to ED Departure for Admitted ED Patients
- 0496: Median Time from ED Arrival to ED Departure for Discharged ED Patients
- 0497: Admit Decision Time to ED Departure Time for Admitted Patients
- 2456: Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

Care Coordination Measures Not Recommended

- 0487: EHR with EDI prescribing used in encounters where a prescribing event occurred

BACKGROUND

Care Coordination is increasingly recognized as fundamental to the success of healthcare systems and improved patient outcomes. Poorly coordinated care regularly leads to unnecessary suffering for patients, as well as avoidable readmissions and emergency department visits, increased medical errors, and higher costs. The Institute of Medicine (IOM) estimates that a potential opportunity of $240 billion in savings would result from care coordination initiatives such as patient education and the development of new provider payment models.[1]

NQF has undertaken several projects to provide guidance and measurement of care coordination, including a 2006 project that yielded an endorsed definition and framework for care coordination, a 2010 project through which 25 Preferred Practices and ten performance measures were endorsed, and a project completed in 2012 through which twelve performance measures were endorsed.

Most recently, the newly-convened 25 Standing Committee members recommended 11 out of 12 measures initially submitted for endorsement against NQF's standard measure evaluation criteria.

DRAFT REPORT

The Care Coordination Draft Report presents a discussion of the overall portfolio of Care Coordination measures and the results of the evaluation of the 12 measures considered under the CDP in the current phase of the project. Currently, NQF's portfolio of care coordination measures include measures for emergency department transfers, plan of care, e-prescribing, timely transitions, medication management, transition records, and medical home. This portfolio contains 20 measures: eight process measures, three outcome and resource use measures, eight structural measures, and one composite measure. Eleven measures, ten existing measures and one new measure are recommended for endorsement as voluntary consensus standards suitable for accountability and quality improvement. An existing measure was not recommended for consideration. The measures were evaluated against the 2013 version of the measure evaluation criteria.

	MAINTENANCE	NEW	TOTAL
Measures considered	11	1	12
Withdrawn from consideration	5	0	5
Recommended	10	1	11
Not recommended	1	0	1
Reasons not Recommended	Importance- 1		

[1] IOM, *Roundtable on Value & Science-Driven health Care: The Healthcare Imperative: Lowering Costs and Improving Outcomes:* Workshop Serious Summary, Washington, DC: National Academies Press, 2010.

COMMENTS AND THEIR DISPOSITION

NQF received a total of 75 comments from six member organizations and individuals about the general draft report and the measures under consideration.

A complete table of comments submitted during the comment period, along with the responses to each comment and the actions taken by the Standing Committee and measure developers, is posted to the Care Coordination project page.

Comment Themes and Committee Responses

Themes were identified in the post-evaluation comments regarding use of the evidence exception, feasibility of the measures, construction of several recommended measures as composites, and gaps in the portfolio. Several of the comments provided recommendations and/or expressed concerns regarding the specifications of the measures evaluated for endorsement. Additionally, several comments received were supportive of the Committee's decisions.

While there were several comments that were not supportive of the Committee's recommendations, most expressed their position on the measures without offering additional information that would promote further discussion of the measure.

The Committee member focused its discussion on the comment themes and measures with the most significant issues.

Theme 1 – Evidence Base

Commenters expressed concern regarding the Committee's decision to exercise the exception to the evidence criterion for the seven ED patient transfer measures #0291-0297.

Committee response: The Committee recognizes that the state of the evidence within these measures is not ideal and notes that the literature presented does not provide a direct linkage to patient outcomes; however, these measures have the potential to improve care coordination by addressing communication, a critical aspect of patient safety. Additionally the measures address an important gap area, the communication of comprehensive information in the transfer of ED patients from rural facilities to other facilities. These issueswere weighed heavily by the Committee, and the Committee agreed to move the measures forward by exercising the exception to the evidence criterion.

Theme 2 – Feasibility of Recommended Measures

Commenters expressed concern about the administrative burden associated with data abstraction from paper medical records for measure #2456: Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient.

Committee response: The Committee discussed the feasibility concerns raised for measure #2456, but emphasized that feasibility concerns should be balanced by the need for more meaningful metrics which will begin to reflect the actual processes of care coordination.

Commenters were concerned about the ability of a patient or a caregiver to accurately communicate the necessary information needed for measure #2456.

Committee response: The Committee agreed that collecting accurate information from patients/caregivers may pose a challenge but stated that utilizing medically trained professionals (i.e. pharmacists) to provide patient education may help alleviate these inaccuracies over time. Committee members also noted that the inaccuracy of patient recall may be overstated, citing a recent study indicating that nearly two-thirds of patients accurately recall newly prescribed medications, and that if appropriate patient education is provided this concern should not deter providers.

Theme 3 – Future Recommendations

Composite measures. Several commenters recommended that measures #0291-0297 be constructed as a composite.

Committee response: **T**he Committee discussed the issue of combining these measures into a composite measure at length during it deliberations, noting that these seven measures (#0291, 0292, 0293, 0294, 0295, 0296, and 0297) regarding the transfer of patients from rural emergency departments to other facilities are intended to be reported together to communicate a comprehensive set of patient information. The Committee strongly recommended that in future, the developer construct these measures as a composite.

Commenters recommended measures #0495, 0496 and 0497 be constructed as a composite or otherwise captured in fewer measures.

Committee response: Although the Committee acknowledged that these measures should remain as stand-alone measures it was recommended that the developer consider further harmonizing these measures in the future.

Portfolio gaps. Commenters noted gaps in the Care Coordination portfolio in the areas of bi-directional communication, patient reported outcomes and health IT.

Several commenters stressed the importance of bi-directional communication in assessing the quality of care coordination provided, specifically with respect to measures #0291-0297.

Committee response: In reviewing measures 0291-0297 the Committee noted that although communication has occurred, it does not mean that care coordination has occurred. However, the Committee agreed that the measures are important to address a gap area, the communication of comprehensive information in the transfer of ED patients from rural facilities to other facilities. The Committee stressed the need for measures that are bi-directional in nature and that address other aspects of care related to communication.

Another commenter expressed noted the scarcity of measures that address patient and family engagement. The commenter also recommended that measures of patient reported outcomes be included in the portfolio.

Committee response: The Committee discussed at length gaps in the Care Coordination portfolio of measures and the critical need for measures to be brought forward that assess bi-directional communication across settings, positive health outcomes, and patient and family engagement. The Committee identified numerous areas where additional measure development is needed, and where persistent gaps across settings have been identified by NQF staff and the Measures Application Partnership (MAP), specifically:

- Measures of patient-caregiver engagement;

- Measures that evaluate "system-ness" rather than measures that address care within silos; and
- Outcome and composite measures, which are prioritized by both the Committee and the MAP over individual process and structural measures, but with the recognition that some of these latter measures are valuable.

The Committee agreed with the need for patient reported outcomes and acknowledged that these are being evaluated by NQF through the Person and Family Centered Care portfolio.

While these priorities have been emphasized in previous phases of this project, only one new measure (an outcome measure) was submitted during this phase of the project. The Committee and NQF strongly encourage the development and submission of measures addressing these identified gaps.

One commenter noted that with the withdrawal of several measures in the area of Health IT, and the Committee's decision not recommend measure #0487: "EHR with EDI prescribing used in encounters were a prescribing event occurred" there is a significant gap in the portfolio in this important area.

Committee response: The Committee agreed that there is a critical need for the next generation of health IT focused measures that will reflect processes of true care coordination. Measure development in this area is strongly encouraged as this topic area evolves.

One commenter noted that medication-related problems are a major cause for serious adverse events and preventable hospitalizations and readmissions, and recommended that the Comprehensive Medication Management (CMM) process be recognized as a key component of care coordination. CMM is "a continuous systematic process used by providers to ensure patients' medications are coordinated, appropriate, understood by the patient and move patients toward clinical goals."

Committee response: The Committee agreed with the commenter and believes CMM to be a systematic approach to addressing gaps in the area of medication management within the care coordination portfolio. The development and submission of measures in this area is strongly encouraged.

REMOVE ENDORSEMENT OF MEASURES

Five measures previously endorsed by NQF have not been re-submitted, withdrawn from maintenance of endorsement, or not recommended for continued endorsement:

Measure	Description	Reason for removal of endorsement
0486: Adoption of Medication e-Prescribing	Documents whether provider has adopted a qualified e-Prescribing system and the extent of use in the ambulatory setting.	Provider adopted a qualified e-Prescribing system and extent of use in the ambulatory setting was retired from the PQRS program at the end of 2008 and was absorbed by the Electronic Prescribing (e-RX) incentive program.
0488: Adoption of Health Information Technology	Documents whether provider has adopted and is using health information technology. To qualify, the provider must have adopted and be using a certified/qualified electronic health record (EHR).	Retired from PQRS program at the end of 2012 and absorbed into the Meaningful Use Program.
0489: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data Elements	Documents the extent to which a provider uses certified/qualified electronic health record (EHR) system that incorporates an electronic data interchange with one or more laboratories allowing for direct electronic transmission of laboratory data into the EHR as discrete searchable data elements.	CMS was not able to provide the reliability and validity data required for re-endorsement.
0491: Tracking of Clinical Results Between Visits	Documentation of the extent to which a provider uses a certified/qualified electronic health record (EHR) system to track pending laboratory tests, diagnostic studies (including common preventive screenings) or patient referrals. The Electronic Health Record includes provider reminders when clinical results are not received within a predefined timeframe.	CMS was not able to provide the reliability and validity data required for re-endorsement.
0493: Participation by a physician or other clinician in systematic clinical database registry that	Participation in a systematic qualified clinical database registry involves: a. Physician or other clinician submits standardized data elements to registry	CMS was not able to provide the reliability and validity data required for re-endorsement.

Measure	Description	Reason for removal of endorsement
includes consensus endorsed quality measures	b. Data elements are applicable to consensus endorsed quality measures c. Registry measures shall include at least two (2) representative NQF consensus endorsed measures for registry's clinical topic(s) and report on all patients eligible for the selected measures. d. Registry provides calculated measures results, benchmarking, and quality improvement information to individual physicians and clinicians. e. Registry must receive data from more than 5 separate practices and may not be located (warehoused) at an individual group's practice. Participation in a national or state-wide registry is encouraged for this measure. f. Registry may provide feedback directly to the provider's local registry if one exists.	

Measure Evaluation Summary Tables

LEGEND: Y = Yes; N = No; H = High; M = Moderate; L = Low; I = Insufficient

0291 Administrative Communication

Submission | Specifications

Description: Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that administrative information was communicated to the receiving facility within prior to departure

Numerator Statement: Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that administrative information was communicated to the receiving facility prior to departure

- Nurse communication with receiving hospitals
- Practitioner communication with receiving practitioner or transfer coordinator

Denominator Statement: All emergency department patients who are transferred to another healthcare facility

Exclusions: All emergency department patients not discharged to another healthcare facility.

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry

Measure Steward: University of Minnesota Rural Health Research Center

STANDING COMMITTEE MEETING [03/18/2014- 03/19/2014]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence: 1b. Performance Gap, 1c. High Priority)

1a. Evidence: **H-0**; **M-0**; **L-1; IE-17; I-0** 1b. Performance Gap: **H-2**; **M-15**; **L-0**; **I-5** 1c. High Priority: **H-8**; **M-11**; **L-4**; **I-0**

Rationale:

- The Committee noted that the evidence presented to support the measure is based several articles and input from an expert panel. They expressed that expert opinion is not considered empirical evidence, and noted the lack of a systematic literature review, including a review of the quality, quantity and consistency of the evidence. Committee members also acknowledged the lack of evidence could be due to few of studies including rural health departments. The Committee agreed the evidence presented to support the measure is insufficient, however, elected to exercise the exception to the evidence criterion, as the measure addresses a gap area, will have a high impact and the benefits of the measure outweighs potential harms.
- The Committee discussed that in terms of performance gap, the measure is intended to fill a gap in performance measurement for emergency departments in rural hospitals transferring patients to other settings.

0291 Administrative Communication

- Committee members agreed the measures will have a high impact due to the fact that transfer of comprehensive information is critical, especially for rural hospitals that do not have other healthcare facilities nearby. However, they expressed the need for measures to go further than assessing the transfer of patient information.
- Committee members noted this measure and the other six related measures from University of Minnesota are not stratified by race, gender or ethnicity. One Committee member articulated a desire to see disparities information. The developer explained that the measures are already disparity-sensitive as rural hospitals have a higher percentage of low-income and a higher percentage of elderly patients.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0**; **M-12**; **L-7**; **I-4** 2b. Validity: **H-0**; **M-16**; **L-4**; **I-2**

Rationale:

- For all the measures, the Committee agreed that reliability and validity testing were sufficient to meet the criteria. The developer performed in two field test with data from 2006, 2008, 2010 and data from 2012-2013 abstracted from paper records and EHRs. Approximately 75 rural hospitals are included in the initial rounds of testing and an additional 73 were included in the second rounds. Approximately 1500 patients were included in the first round of testing and details are not yet available for the second round of testing.
    - For field test one, for 68% of transfer records, the hospital abstractors' findings agreed 100% with the QIO staff abstraction. And in a second test, 82.4% of transfer records, the hospitals' abstraction findings agreed 100% with the QIO staff abstraction. The developer explains the number of inconsistencies in abstraction decreased by more than 50% from the first quarter to the second quarter.
    - For field test two, on-site inter-rater reliability was conducted shortly after the training. Sixty transfer records were abstracted and nearly all elements of all records matched the trainer's abstractions (statistics are not provided). The developer notes that clarification on admission dates and times was required.
    - The developer interprets these testing results to mean that initial understanding of elements was high, with little review, reinforcement or revision or clarification of the material indicated.
    - The measure's validity was determined through face validity and an expert panel used to demonstrate accord with professional standards.

3. Feasibility: H-10; M-10; L-2; I-0

(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)

Rationale:

- The Committee discussed the potential administrative burden of the measures due to the need to use of multiple data sources (EHR, lab and paper) to report the measure. The developer

0291 Administrative Communication

explained that the records being transferred are relatively short and there have been no complaints from implementers about burden in the implementation of this measure.

4. Use and Usability: H-7; M-12; L-0; I-3

(4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)

Rationale:

- A member of the Committee questioned how the measure has been used since prior endorsement. The developer explained that as of January 2012, the state of Minnesota requires the submission of this data from all of its critical access hospitals. However, the developer does not have access to data due to privacy regulations.
- The Committee suggested that in future, the focus of this suite of measures could be expanded to include patients transferred to additional settings, such as home health.

5. Related and Competing Measures

- The measure is related to other measures in the suite: 0292, 0293, 0294, 0295, 0296, and 0297.

Standing Committee Recommendation for Endorsement: Y-16; N-6

- The Steering Committee recommended this measure for endorsement acknowledging that while communication may have occurred, it does not necessarily mean care coordination has occurred. However, the committee stated that these are small steps towards care coordination, since there are not many measures that encompass every aspect of care coordination.

6. Public and Member Comment:

Comments received:

- Several comments were posed recommending a bi-directional approach as it is difficult to confirm receipt of communication from a transferring facility prior to a patient's departure. The data element description is not clear and seems implied. Additionally, many of the methods of communication (i.e. facsimile or eDelivery) are viewed as problematic and do not warrant proof that the intended recipient has the appropriate information.

Developer response:

- This measure looks for documentation that the communication occurred. This should not be a "judgment call," either the communication is documented or it is not. This step of communication, prior to transfer is EMTALA based to ensure that the services needed are available.

Committee response:

EMTALA is evolving and determining how it is being used is relative. The Committee continues to emphasize that bi-directional communication that closes the loop is critical in ensuring that care is coordinated.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

0292 Vital Signs

Submission | Specifications

0292 Vital Signs

Description: Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that the entire vital signs record was communicated to the receiving FACILITY within 60 minutes of departure

Numerator Statement: Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that the entire vital signs record was communicated to the receiving facility within 60 minutes of departure

- Pulse
- Respiratory rate
- Blood pressure
- Oxygen saturation
- Temperature
- Glasgow score (where appropriate)

Denominator Statement: All emergency department patients who are transferred to another healthcare facility

Exclusions: All emergency department patients not discharged to another healthcare facility.

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy

Measure Steward: University of Minnesota Rural Health Research Center

STANDING COMMITTEE MEETING [03/18/2014- 03/19/2014]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. Evidence: 1b. Performance Gap, 1c. High Priority)

1a. Evidence: **H-0**; **M-0**; **L-1; IE-19; I-3** 1b. Performance Gap: **H-0**; **M-13**; **L-5**; **I-4** 1c. High Priority: **H-6**; **M-11**; **L-4**; **I-1**

<u>Rationale</u>:

- Similar to 0291, the Committee agreed the evidence presented to support the measure is insufficient, however, elected to exercise the exception to the evidence criterion, as the measure addresses a gap area, will have a high impact and the benefits of the measure outweighs potential harms.

0292 Vital Signs

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0**; **M-15**; **L-4**; **I-3** 2b. Validity: **H-0**; **M-13**; **L-7**; **I-2**

<u>Rationale</u>:

- The Committee discussed that the difference between this measure and 0291 was the content of the data being transferred with the patient.
- For all the measures, the Committee agreed that reliability and validity testing were sufficient to meet the criteria.

3. Feasibility: H-12; M-9; L-1; I-0

(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)

<u>Rationale</u>:

- The Committee discussed that data the measure would be easy to collect, and agreed feasibility for the measure is high. However, the Committee discussed that this is is measure assessing transfers of data, instead of quality of care.

4. Use and Usability: H-4; M-12; L-3; I-2

(4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)

<u>Rationale</u>:

- The Committee agreed the measure will enhance quality and is being used in a variety of other projects. The developer explained that additional data is beginning to come in for this measure.

5. Related and Competing Measures

- The measure is related to other measures in the suite: 0291, 0293, 0294, 0295, 0296, and 0297.

Standing Committee Recommendation for Endorsement: Y-16; **N-5**

- Standing Committee members noted that just because communication has occurred, it does not mean that care coordination has occurred. However, they did acknowledge there is no one measure that includes every aspect of care coordination.

0292 Vital Signs

6. Public and Member Comment:

Comments received:

- Although in support of this measure, there was consensus that more vital signs need to be communicated. Suggestions from commenters included **EKG findings, if applicable such as rhythm, ST changes, heart block, bundle branch blocks etc. Additionally, not only should pulsoximetry readings be noted but also any periods of desaturation, severity and length. Also if there were any large shifts in vitals, this should be identified as well (e.g. change in GCS from 12 to 3T or equivalent or HR shift from 60 to 125 bpm).**

Developer response:

- The EKG suggestion is a good one. We will forward with the next review. The developer was in agreement that changes in vital signs should be noted in MD and nurse notes.

Committee response:

- The Committee agreed that although condition-specific vital signs are beneficial, more generally-based vital signs are crucial. The Committee encourages the gradual inclusion of these more specific vital signs in future measures.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

0293 Medication Information

Submission | Specifications

Description: Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that medication information was communicated to the receiving FACILITY within 60 minutes of departure

Numerator Statement: Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that medication information was communicated to the receiving FACILITY within 60 minutes of departure

- Documentation regarding medication history
- Allergies
- Medications given (MAR)

Denominator Statement: All emergency department patients who are transferred to another healthcare facility

Exclusions: All emergency department patients not discharged to another healthcare facility.

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy

Measure Steward: University of Minnesota Rural Health Research Center

STANDING COMMITTEE MEETING [03/18/2014- 03/19/2014]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. Evidence: 1b. Performance Gap, 1c. High Priority)

1a. Evidence: **H-0**; **M-0**; **L-1; IE-14; I-8** 1b. Performance Gap: **H-0**; **M-14**; **L-5**; **I-4** 1c. High Priority: **H-2**; **M-17**; **L-1**; **I-2**

<u>Rationale</u>:

- Similar to 0291 and 0292, the Committee agreed the evidence presented to support the measure is insufficient, however, the Committee elected to exercise the exception to the evidence criterion, as the measure addresses a gap area, will have a high impact and the benefits of the measure outweighs potential harms.
- Committee members discussed the importance of receiving a comprehensive medication list with a full history, and agreed the measure will have a high impact in terms of improving the coordination of care.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0**; **M-14**; **L-3**; **I-5** 2b. Validity: **H-0**; **M-12**; **L-8**; **I-2**

<u>Rationale</u>:

- For all the measures, the Committee agreed that reliability and validity testing were sufficient to meet the criteria.
- Committee members discussed that while this measure is specified for rural hospitals, it can be used for any facility even though it was originally developed to assess rural hospitals. The developer acknowledged that the measure can be used at other hospitals, but it would not apply to larger, tertiary university hospitals.

3. Feasibility: H-10; M-11; L-0; I-1

(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)

<u>Rationale</u>:

- Committee members agreed this measure is highly feasible since data is capture during routine aspects of care coordination.

4. Use and Usability: H-1; M-16; L-4; I-0

(4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)

<u>Rationale</u>:

- A member of the Committee questioned how the measure has been used since its prior endorsement. The developer explained that as of January 2012, the state of Minnesota requires the submission of this data from all of its critical access hospitals, though the developer itself has not been given access to the data due to privacy regulations. Additionally, the QIO in Minnesota, Stratus Health, is now on contract to lead 8 more states in the requirement of submission of data on these measures.

5. Related and Competing Measures

- The measure is related to other measures in the suite: 0291, 0292, 0294, 0295, 0296, and 0297.

Standing Committee Recommendation for Endorsement: Y-14; **N-8**

6. Public and Member Comment:

Comments received:

- Commenters were in support of this measure viewing this as a critical aspect of communication in care coordination. Although in support, there was emphasis to include further details of the medications administered (during transfer or at ED arrival), including time, method, and patient response.

Developer response:

- The method, time, dose, etc. should be in the MAR. The responses to medications should be in the MD and nurses notes.

Committee response:

- The Committee agrees with the developer's response.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

0294 Patient Information

Submission | Specifications

Description: Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that patient information was communicated to the receiving FACILITY within 60 minutes of departure

Numerator Statement: Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that patient information was communicated to the receiving FACILITY within 60 minutes of departure

- Patient name
- Address
- Date of birth
- Gender
- Significant other contact information
- Health insurance information

Denominator Statement: All emergency department patients who are transferred to another healthcare facility

Exclusions: All emergency department patients not discharged to another healthcare facility

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy

Measure Steward: University of Minnesota Rural Health Research Center

0294 Patient Information

STANDING COMMITTEE MEETING [03/18/2014-03/19/2014]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. Evidence, 1b. Performance Gap, 1c. High Impact)

1a. Evidence: **H-0**; **M-2**; **L-0**; **I-5; IE-14**; 1b. Performance Gap: **H-0**; **M-14**; **L-7**; **I-1;** 1c. Impact: **H-0**; **M-18**; **L-4**; **I-1**

<u>Rationale</u>:

- Similar to 0291, 0292 and 0293, the Committee agreed the evidence presented to support the measure is insufficient, however, the Committee elected to exercise the exception to the evidence criterion, as the measure addresses a gap area, will have a high impact and the benefits of the measure outweighs potential harms.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0**; **M-16**; **L-4**; **I-3** 2b. Validity: **H-0**; **M-13**; **L-7**; **I-3**

<u>Rationale</u>:

- For all the measures, the Committee agreed that reliability and validity testing were sufficient to meet the criteria.
  Committee members expressed concerns that the 60 minutes time frame may lead to variation, due to differences is distance traveled, but concluded reliability testing for the measures was sufficient.

3. Feasibility: H-8; M-13; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Committee discussed the potential administrative burden of the measure, due to the multiple data sources (EHR, lab and paper) required to report the measures. The developer explained that the records being transferred are relatively short and there have been no complaints about the burden in the implementation of this measure.
- The Committee accepted this explanation and agreed the measure is feasible.

4. Use and Usability: H-1; M-16; L-4; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

<u>Rationale</u>:

- The measure is not currently publicly reported or used in other accountability applications.

5. Related and Competing Measures

- The measure is related to other measures in the suite: 0291, 0292, 0293, 0295, 0296, 0297.

Standing Committee Recommendation for Endorsement: **Y-15**; **N-7**

6. Public and Member Comment:

Comments received:

- Commenters generally expressed support for the measure and the Committee's recommendation for endorsement.

0294 Patient Information

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

0295 Physician Information

Submission | Specifications

Description: Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that physician information was communicated to the receiving FACILITY within 60 minutes of departure

Numerator Statement: Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that physician information was communicated to the receiving FACILITY within 60 minutes of departure

- Physician or practitioner history and physical
- Physician or practitioner orders and plan

Denominator Statement: All emergency department patients who are transferred to another healthcare facility

Exclusions: All emergency department patients not transferred to another healthcare facility

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy

Measure Steward: University of Minnesota Rural Health Research Center

STANDING COMMITTEE MEETING [03/18/2014-03/19/2014]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap, 1c. High Impact)

1a. Evidence: **H-0**; **M-5**; **L-0**; **I-6; IE-11**; 1b. Performance Gap: **H-0**; **M-16**; **L-2**; **I-4;** 1c. Impact: **H-4**; **M-13**; **L-4**; **I-1**

Rationale:

- Similar to 0291, 0292, 293 and 0294, the Committee agreed the evidence presented to support the measure is insufficient, however, the Committee elected to exercise the exception to the evidence criterion, as the measure addresses a gap area, will have a high impact and the benefits of the measure outweighs potential harms.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0**; **M-15**; **L-5**; **I-2** 2b. Validity: **H-0**; **M-12**; **L-7**; **I-3**

Rationale:

0295 Physician Information

- For all the measures, the Committee agreed that reliability and validity testing were sufficient to meet the criteria.
- Committee members expressed concerns that a lack of resources in rural hospitals compared to urban hospitals may lead to variation on this measure, but concluded the measure is reliable. A Committee member also noted that the expert panel used for the testing was relatively small and lacked consumer representation. The Committee agreed the measure is valid, but only by a slim margin, indicating true consensus was not reached.

3. Feasibility: H-4; M-13; L-3; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The Committee agreed this measure is feasible and data abstraction does not appear to place undue burden on the facility, although it may be somewhat difficult to collect without discrete data fields being used.

4. Use and Usability: H-1; M-17; L-3; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- The measure is not currently publicly reported or used in other accountability applications.

5. Related and Competing Measures

- The measure is related to other measures in the suite: 0291,0292, 0293, 0294, 0296, 0297.

Standing Committee Recommendation for Endorsement: Y-15; N-6

6. Public and Member Comment:

Comments received:

- Although comments supported this measure, there were concerns that although assessing compliance with the provision of this type of information is important, this should minimize the burden of data collection for any new measures introduced into the healthcare system, thus questioning its feasibility.

Committee response:

- The Committee discussed the feasibility of this measure and agrees that the data abstraction does not appear to present an undue burden. It is expected that the adoption and use of electronic health records will help to reduce burden over time.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

0296 Nursing Information

Submission | Specifications

0296 Nursing Information

Description: Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that nursing information was communicated to the receiving FACILITY within 60 minutes of departure

Numerator Statement: Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that nursing information was communicated to the receiving facility within 60 minutes of departure

- Assessments/intervention/response
- Impairments
- Catheters
- Immobilizations
- Respiratory support
- Oral limitations

Denominator Statement: All emergency department patients who are transferred to another healthcare facility

Exclusions: All emergency department patients not discharged to another healthcare facility

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy

Measure Steward: University of Minnesota Rural Health Research Center

STANDING COMMITTEE MEETING [03/18/2014-03/19/2014]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. Evidence, 1b. Performance Gap, 1c. High Impact)

1a. Evidence: **H-0**; **M-2**; **L-0**; **I-5; IE-14**; 1b. Performance Gap: **H-0**; **M-14**; **L-4**; **I-2;** 1c. Impact: **H-5**; **M-13**; **L-1**; **I-2**

<u>Rationale</u>:

- Similar to 0291, 0292, 293 , 0294 and 0295, the Committee agreed the evidence presented to support the measure is insufficient, however, the Committee elected to exercise the exception to the evidence criterion, as the measure addresses a gap area, will have a high impact and the benefits of the measure outweighs potential harms.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0**; **M-15**; **L-3**; **I-3** 2b. Validity: **H-0**; **M-14**; **L-2**; **I-5**

<u>Rationale</u>:

- For all the measures, the Committee agreed that reliability and validity testing were sufficient to meet the criteria.

3. Feasibility: H-3; M-15; L-0; I-1

0296 Nursing Information

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The Committee determined this measure was feasible and data abstraction does not appear to place an undue burden on the facility, although data collection may be somewhat difficult without designated discrete data fields.

4. Use and Usability: H-2; M-13; L-2; I-3

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- The measure is not currently publicly reported or used in other accountability applications.

5. Related and Competing Measures

- The measure is related to other measures in the suite: 0291, 0292, 0293, 0294, 0295, 0297.

Standing Committee Recommendation for Endorsement: **Y-15**; **N-5**

6. Public and Member Comment:

Comments received:

- Commenters generally expressed support for the measure and the Committee's recommendation for endorsement.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

0297 Procedures and Tests

Submission | Specifications

Description: Performance Measure Name: Procedures and Tests

Description: Patients who are transferred from an ED to another healthcare facility have communicated with the receiving facility within 60 minutes of discharge a list of tests done and results sent.

Numerator Statement: Percentage of patients transferred to another Healthcare Facility whose medical record documentation indicated that procedure and test information was communicated to the receiving FACILITY within 60 minutes of departure

- Tests & procedures done
- Tests & procedure results sent

Denominator Statement: All emergency department patients who are transferred to another Healthcare Facility

Exclusions: ED admissions not transferred to another Healthcare facility.

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility

0297 Procedures and Tests

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy

Measure Steward: University of Minnesota Rural Health Research Center

STANDING COMMITTEE MEETING [03/18/2014-03/19/2014]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap, 1c. High Impact)

1a. Evidence: **H-0**; **M-1**; **L-0**; **I-3; IE-15** 1b. Performance Gap: **H-0**; **M-12**; **L-5**; **I-2** 1c. Impact: **H-7**; **M-10**; **L-0**; **I-2**

Rationale:

- Similar to 0291, 0292, 293 , 0294 and 0295, the Committee agreed the evidence presented to support the measure is insufficient, however, the Committee elected to exercise the exception to the evidence criterion, as the measure addresses a gap area, will have a high impact and the benefits of the measure outweighs potential harms.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0**; **M-12**; **L-3**; **I-3** 2b. Validity: **H-0**; **M-13**; **L-1**; **I-4**

Rationale:

- For all the measures, the Committee agreed that reliability and validity testing were sufficient to meet the criteria.

3. Feasibility: H-5; M-12; L-0; I-1

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The Committee determined this measure was feasible and data abstraction does not appear to place undue burden on the facility, although may be somewhat difficult to collect without discrete data fields being used.

4. Use and Usability: H-2; M-13; L-2; I-1

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- The measure is not currently publicly reported or used in other accountability applications.

5. Related and Competing Measures

- The measure is related to other measures in the suite: 0291,0292, 0293, 0294, 0295, 0296.

Standing Committee Recommendation for Endorsement: **Y-14**; **N-5**

6. Public and Member Comment:

0297 Procedures and Tests

Comments received:

- Commenters generally expressed support for the measure and the Committee's recommendation for endorsement.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

Submission | Specifications

Description: This measure assesses the median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department

Numerator Statement: Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.

Denominator Statement: Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.

Exclusions: Patients who are not an ED Patient

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Outcome

Data Source: Electronic Clinical Data, Electronic Health Record

Measure Steward: Centers for Medicare and Medicaid Services

STANDING COMMITTEE MEETING [03/18/2014-03/19/2014]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap, 1c. High Impact)

1a. Evidence: **H-0**; **M-10**; **L-4**; **I-3; IE-2**; 1b. Performance Gap: **H-1**; **M-14**; **L-4**; **I-0;** 1c. Impact: **H-4**; **M-11**; **L-4**; **I-0**

Rationale:

- Committee members expressed concerns regarding the strength of the evidence presented linking Emergency Department (ED) stays and patient outcomes.
    - The developer explained that most EDs are experiencing overcrowding and that this can lead to ambulance refusals, prolonged waiting times and delays in care for patients. Reducing the time spent in the Emergency Department for admitted patients may also mean that patients receive the specific care that they need that cannot or should not be provided in the ED sooner.
    - According to studies cited by the developer, there is an overall link of ED stays with the

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

outcomes of care. In particular, studies cited a link between longer ED stays and poor patient outcomes for specific conditions.

- Some Committee members noted that although this evidence significant, it could tend to reflect research interests. However, the Committee ultimately agreed the evidence presented is sufficient to support the measure.
- Committee members noted the trend data provided did not show improvement in performance on this measure since previous endorsement. According to the data provided, there was a difference of roughly 70 to 80 minutes in median time from ED arrival to ED departure for admitted patients, when comparing the top 10 percent with the national median. Additionally, there is no evidence of disparities in ED crowding.
    - The developer noted that the evidence clearly shows wide variation in ED wait times with room for improvement. While the data provided does not show improvement over time, that data was collected over a relatively short time window (15 months). It was suggested that examining trends over a longer period of time would show more variability in ED length of stay, although not necessarily improvement.
- Committee members agreed that this measure may help motivate improvements and potentially avoid long-term declines in performance. It addresses a high priority area and could also be an important tool for evaluating changes associated with implementation of the Affordable Care Act (ACA). As more and more patients are admitted through the ED, timeliness of care within the ED will take on greater importance in determining overall timeliness of care for admitted patients.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **N/A** 2b. Validity: **H-3**; **M-11**; **L-5**; **I-0**

<u>Rationale</u>:

- Committee members agreed that the specifications provided were clear and precise, making the measure adequate for consistent implementation.
- The Committee discussed that reliability testing was not needed because validity testing had been done at the critical data element level with good results, indicating the validity of the measure.
    - The developer explained that there were two data elements, "decision to admit time" and "ED departure time" with slightly lower agreement rates (63.29 and 76.79% respectively), due to the nature of testing time related elements, which are more prone to mismatch. The ICC statistics for these elements were very high when those time values were grouped in intervals rather than as single discreet points.
- Some Committee members conveyed uncertainity about the low kappa statistic for the data element "observation services" but noted there was a high agreement rate.
    - The developer explained that the definition of the element had been recently updated to ease abstraction from medical charts. However the impact of that change has been investigated empirically.

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

- Committee members noted that the strong kappa statistics for the arrival and departure time elements suggests that this is not a substantial concern, but only if the time stamps used as the gold standard comparison were a reflection of real care processes and not just an artifact of administrative processes.

- Committee members noted that the measure is not risk adjusted to account for severity of illness, and that more acute patients may require specialized care, which may not be readily available for ED admitted patients. However, the Committee ultimately agreed the validity of the measure is demonstrated.

3. Feasibility: H-12; M-7; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- Committee members agreed the measure is feasible.

4. Use and Usability: H-7; M-8; L-4; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- Committee members agreed there is sufficient evidence to support public reporting (currently used in public reporting by the CMS HIQR payment program). Additionally, this measure has a strong record of widespread use, supporting its usability (currently used by the Joint Commission Accreditation program).
- Committee members agreed that this measure would be an important tool in monitoring impacts of changes in health care coverage and insurance policies.
- Committee members suggested that it is unclear how the performance results can be used to further the goal of high-quality, efficient healthcare. The data provided displayed no improvement and the developer notes that this trend may continue due to other factors (such as the expansion of state Medicaid programs). However, there do not appear to be any unintended consequences associated with the measure.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **Y-13**; **N-6**

6. Public and Member Comment:

Comments received:

- Recommendations were provided concerning the populations assessed within this measure, particularly patient diagnosis. In this instance, mental health as there is research that indicates treatment delays.

Developer response:

- We appreciate your support of these measures. These measures do provide the ability to drill down by mental health diagnosis, as the non-reporting strata contain cases with a mental health diagnosis (Table 7.01 in Appendix A of the Specifications Manual). For the inpatient setting,

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

facilities are provided with an overall rate, a reporting rate, and a rate for cases with a psychiatric diagnosis. The reporting rate excludes cases with a psychiatric diagnosis. For the outpatient setting, there is an overall rate, a reporting rate, a rate for cases with a psychiatric diagnosis, and a rate for cases that are transferred. The reporting rate excludes the cases that are transferred and those with a psychiatric diagnosis. Facilities are able to determine treatment delays for other diagnoses by calculating throughout time according to diagnoses.

Committee response:

- For quality purposes, the Committee agrees there is value in being able to access more details relative to treatment delays, by drilling down to the facility level, so that institutes may use this information and make improvements.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients

Submission | Specifications

Description: This measure assesses the median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department

Numerator Statement: Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.

Denominator Statement: Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.

Exclusions: Patients who expired in the emergency department

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Outcome

Data Source: Administrative claims

Measure Steward: Centers for Medicare and Medicaid Services

STANDING COMMITTEE MEETING [03/18/2014-03/19/2014]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap, 1c. High Impact)

1a. Evidence: **H-2**; **M-10**; **L-2**; **I-3; IE-2**; 1b. Performance Gap: **H-4**; **M-11**; **L-3**; **I-1;** 1c. Impact: **H-8**; **M-7**; **L-4**; **I-0**

Rationale:

- While Committee members agreed this measure is important, they were concerned that improvement was not shown for the data presented over 5 quarter in 2012 to 2013.
- Committee members found the evidence presented to support the measure compelling, and noted

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients

that there is room for improvement on the measure. Committee members reasoned that if performance is stagnating or declining, that argues for the continued importance of this measure to monitor trends and motivate further change.

- The developer explained that although there have not been significant improvements within the metrics; there are areas of within coordination of services on the inpatient side that show improvement. The developer is working closely with the Emergency Department Benchmarking Alliance to standardize these metrics across all settings and include electronic medical records. They do also recognize this measure is somewhat dependent on Emergency Department volume. CMS, as the steward, has made the decision at least for the public display of the data, to start stratifying this performance measure by total Emergency Department annual volume, which will eventually capture a better picture of how hospitals are moving performance over time.

- This measure was identified as targeting the issue of the need to better examine/move populations through the emergency room. Committee members noted that this measure is and especially a high priority during the ACA implementation, and these are all key priority areas as we move into the new redesigned healthcare system.
    - The developer noted that the ED volume has increased between 2011 and 2012 by 3 percent to 5 percent and the acuity has increased with over 68 percent of the hospital admissions being processed through the ED. This further supports the importance of this group of patients in terms of whether there is a potential health problem.
- While the Committee agreed the measure will have a high impact, Committee members noted that additional comments were made during the workgroup call as to whether this should be a process measure focused on efficiency rather than an outcome measure.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **N/A** 2b. Validity: **H-6**; **M-10**; **L-1**; **I-2**

<u>Rationale</u>:

- Committee members agreed that the specifications provided were clear and precise, making the measure adequate for consistent implementation.
- Reliability testing was not needed because validity testing had been done at the critical data element level with good results, indicating the validity of the measure.
- Some Committee members were concerned about the low kappa statistic for the data element "observation services" but noted there was a high agreement rate.
    - The developer explained that the definition of the element had been recently updated to ease abstraction from medical charts. However the impact of that change has been not been investigated empirically.
- Committee members noted that during the workgroup calls, there was some sensitivity around

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients

exclusions surrounding the denominator. It was unclear as to who was identified in the denominator as well as those who were not in the site populations.

3. Feasibility: H-11; M-6; L-2; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- Committee members agreed the measure is feasible.

4. Use and Usability: H-6; M-9; L-3; I-1

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- Committee members agreed there is sufficient evidence to support public reporting (the measure is currently used in public reporting by the CMS HIQR payment program). Additionally, this measure has a strong record of widespread use, supporting its usability (currently used by the Joint Commission Accreditation program).

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Y-14; N-5

6. Public and Member Comment:

Comments received:

- Commenters recommended combining measures #0495, #0496, and #0497 to create a single composite to assess the efficiency and effectiveness of emergency room processes and medical decision-making.

Developer response:

- While we understand the concerns of the Committee about the potential for unintended consequences of performance measures, we do not think it is feasible to create a "composite" measure of the three ED throughput measures. This is due to the fact that #0495 and #0496 are measures from two separating reporting programs for hospitals and also because we are not aware of any methodology for creating composites for median times.

Committee response:

- The Committee agrees with the developer's response.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

0497 Admit Decision Time to ED Departure Time for Admitted Patients

Submission | Specifications

Description: This measure assesses the median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status

0497 Admit Decision Time to ED Departure Time for Admitted Patients

Numerator Statement: Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients.

Denominator Statement: Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients.

Exclusions: Any ED Patient from the facility's emergency department.
Adjustment/Stratification:
Level of Analysis: Individual, Group/Practice, Facility, Health Plan
Setting of Care: Hospital/Acute Care Facility
Type of Measure: Process
Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Electronic Clinical Data : Pharmacy

Measure Steward: Centers for Medicare and Medicaid Services

STANDING COMMITTEE MEETING [03/18-19/2014]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. Evidence, 1b. Performance Gap, 1c. High Impact)

1a. Evidence: **H-1**; **M-10**; **L-1**; **I-4; IE-1**; 1b. Performance Gap: **H-2**; **M-15**; **L-1**; **I-0;** 1c. Impact: **H-8**; **M-8**; **L-2**; **I-0**

<u>Rationale</u>:

- Committee members agreed that this measure speaks more directly to care coordination than 0495 and 0496, as it focuses on the time from decision to admit to actual patient discharge from the ED. The Committee noted the measure emphasizes the logistical aspects of care that occur after initial evaluation. Although Committee members noted the literature cited in support of the measure does not appear to specifically address this narrow window from decision to departure, the Committee agreed the evidence presented supports the importance of timely care and poor outcomes associated with delays in care.
- Committee members noted the lack of significant improvement in performance on the measure since prior endorsement.
    - The developer explained that although there have not been significant improvements within the metrics; there are areas of coordination of services on the inpatient side that show improvement. The developer is however, working closely with the Emergency Department Benchmarking Alliance to standardize these metrics across all settings, and include electronic medical records. The developer stated they do also recognize this measure is somewhat dependent on Emergency Department volume. CMS, as the steward, has made the decision at least for the public display of the data, to start stratifying this performance measure by total Emergency Department annual volume, which will eventually capture a better picture of how hospitals are moving performance over time.
- The Committee accepted this explanation and agreed there is an opportunity for improvement

0497 Admit Decision Time to ED Departure Time for Admitted Patients

and the measure will have a high impact.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **N/A** 2b. Validity: **H-4**; **M-12**; **L-2**; **I-0**

<u>Rationale</u>:

- Committee members agreed that the specifications provided were clear and precise, making the measure adequate for consistent implementation.
- Reliability testing was not needed because validity testing had been done at the critical data element level with good results, indicating the validity of the measure
- Some Committee members conveyed uncertainity about the low kappa statistic for the datt aelement "observation services" but noted there was a high agreement rate
    - The developer explained that the definition of the element had been recently updated to ease abstraction from medical charts. However the impact of that change has been investigated empirically.
- Committee members discussed growth of observation units and its impact on this measure (given it was last updated in 2008).
    - The developer stated that the metrics were changed significantly recently and that there have not been any significant performance changes within this measure. However, it is difficult to predict how increased bed units would impact this measure.

3. Feasibility: H-10; M-7; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- Committee members agreed the measure is feasible.

4. Use and Usability: H-7; M-11; L-0; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

<u>Rationale</u>:

- Committee members agreed there is sufficient evidence to support public reporting (the measure is currently used in public reporting by the CMS HIQR payment program). Additionally, this measure has a strong record of widespread use, supporting its usability (currently used by the Joint Commission Accreditation program).

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **Y-15**; **N-3**

6. Public and Member Comment:

<u>Comments received:</u>

- <u>Commenters recommended combining measures #0495, #0496, and #0497 to create a single</u>

0497 Admit Decision Time to ED Departure Time for Admitted Patients

composite to assess the efficiency and effectiveness of emergency room processes and medical decision-making.

Developer response:

- While we understand the concerns of the Committee about the potential for unintended consequences of performance measures, we do not think it is feasible to create a "composite" measure of the three ED throughput measures. This is due to the fact that #0495 and #0496 are measures from two separating reporting programs for hospitals and also because we are not aware of any methodology for creating composites for median times.

Committee response:

- The Committee agrees with the developer's response.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

Submission | Specifications

Description: This measure assesses the actual quality of the medication reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. The target population is any hospitalized adul

Numerator Statement: For each sampled inpatient in the denominator, the total number of unintentional medication discrepancies in admission orders plus the total number of unintentional medication discrepancies in discharge orders.

Denominator Statement: The patient denominator includes a random sample of all potential adults admitted to the hospital. Our recommendation is that 25 patients are sampled per month, or approximately 1 patient per weekday.

So, for example, if among those 25 patients, 75 unin

Exclusions: Patients that are discharged or expire before a gold standard medication list can be obtained.

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Outcome

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Healthcare Provider Survey, Other, Paper Medical Records, Patient Reported Data/Survey, Electronic Clinical Data : Pharmacy

Measure Steward: Brigham and Women's Hospital

STANDING COMMITTEE MEETING [03/18/2014-03/19/2014]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap, 1c. High Impact)

1a. Evidence: **H-1**; **M-14**; **L-0**; **I-2; IE-0**; 1b. Performance Gap: **H-8**; **M-9**; **L-0**; **I-0;** 1c. Impact: **H-12**; **M-5**; **L-0**; **I-0**

Rationale:

- The Committee agreed the evidence presented provided moderate support for the measure

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

focus. The evidence included a systematic review consisting of 26 studies consistently demonstrating that medication reconciliation interventions result in a reduction in medication discrepancies (17/17 studies), potential adverse drug events (5/6), adverse drug events (2/2), and reduction in health care utilization (2/8 studies), however the studies were of fair quality, as graded by the United States Preventive Services Task Force (USPSTF). While the Committee viewed this measure as a proxy outcome for a short-term outcome of good care coordination around medication, they did not find a strong connection between the measure and long-term error reduction and overall better patient outcomes. The Committee recommended further study to determine the long-term benefits of medication reconciliation interventions.

- The Committee concluded there is a gap in performance as the rate of unintentional medication discrepancies per patient is high and there is variation by site, with 2.78 to 4.57 discrepancies per patient (average of 3.44 per patient), making medication reconciliation errors the single biggest source of medication errors in the hospital (i.e., as opposed to errors in prescribing, transcribing, or administration).
- The Committee agreed the measure will have a high impact, as nationwide 10 percent to 67 percent of inpatients have at least one unexplained discrepancy in their prescription medication history at the time of admission; 25 percent to 71 percent have at least one medication error at discharge. Reasons for medication discrepancies among hospitalized patients are primarily: 1) "history errors," errors in taking or documenting the patient's preadmission medication history, and 2) "reconciliation errors," errors of reconciling the medication history with medication orders. In addition, approximately 70 percent of potentially harmful discrepancies are due to history errors, usually errors of omission resulting from not documenting that a patient was taking a medication prior to admission.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-2**; **M-14**; **L-1**; **I-0** 2b. Validity: **H-2**; **M-14**; **L-1**; **I-0**

<u>Rationale</u>:

- The Committee determined that the measure specifications were reliable and valid, noting that all codes necessary to calculate the measure were present and the specifications were consistent with the evidence presented, however, suggested for future development the developer move past just listing medications and focus on appropriate usage.
- The Committee expressed concerns regarding the small sample size used in the testing and lack of risk adjustment done in the reliability testing. The developer explained they did take these factors into consideration but ultimately favored feasibility over reliability. Requiring extra data collection and adding to the regular work flow may cause too high of a burden on providers. The developer further explained that many training precautions were taken to assure that pharmacists at different hospitals were implementing the same process. The Committee accepted the developer's explanation and agreed that while the sample size was small, the reliability testing results are acceptable.

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

- Committee members agreed the measure is valid, noting validity testing was performed at the performance measure score with a systematic assessment of face validity indicated: literature is cited to support that the process of pharmacists taking pre-administration medication histories is a proxy for a gold-standard medication history.

3. Feasibility: H-1; M-10; L-5; I-1

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- While the Committee agreed the measure is feasible by a slim margin, members were unable to come to true consensus. Many members voiced concerns about the amount of extra resources required to gather the gold standard data. Several Committee members stated that the measurement burden is considerable, requiring a pharmacist trained in the measure protocol to spend time (1) creating a gold standard medication list (2) comparing the list to admission orders and (3) comparing the gold standard to discharge orders. That means actions on at least 2 different days (admission day and discharge day). In addition, creating the gold standard list will require going to several sources, including speaking with the patient or family, and potentially reaching out to providers outside the hospital. Committee memners noted that this level of pharmacist involvement is not routine at most hospitals. Even at facilities where a pharmacist-generated gold standard list is a part of routine care, taking the time to compare that list to the admission and discharge orders and use the measure protocol to calculate a score is still a considerable measurement burden.
- The Committee did, however, consider whether the benefits of a substantive medication reconciliation measure outweigh this considerable measurement burden and agreed with the measure steward that this measure is a tremendous step forward in assessing the true quality of medication reconciliation, rather than relying on a "check-the-box" measure.

4. Use and Usability: H-1; M-11; L-1; I-1

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- This is a new measure and is not currently being publicly reported but a 5-year plan for use in accountability applications was presented by the developer, although a specific program was not identified. The Committee agreed with the developer that improvements in the number of patients measured and gap in care with use of the measured intervention after 18 months were seen and the presented data was statistically significant.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **Y-17**; **N-X**

6. Public and Member Comment:

Comments received:

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

- Although supportive of this measure, there were comments that addressed the dependency on the quality of communication particularly the patient and/or caregivers' comprehensive disclosure and recall aspect as it related to existing and/or new medications, which may have implications on this measure.
- One commenter questioned the specifications within this measure stating that the population should be exclusively high-risk patients, categorized by number of medications, and severity of illness or co-morbidities.

Developer response:

- We acknowledge that patient/caregiver disclosure and recall of new and existing medications is an important data source in assembling an accurate medication history. However, because there may be limitations in the accuracy of this information (and indeed, in the accuracy of information from any source), our methods never rely on this information exclusively. As part of our methodology for completing a "gold standard" medication history with which to measure discrepancies, we require at least two independent sources of information, at least one of which must come from an entity other than a patient or caregiver. These include (but are not limited to) outpatient electronic medical record (EMR) medication lists, pharmacy prescription refill information, discharge medication lists, and non-electronic sources of information from primary care physicians and other outpatient offices and nursing facilities. These sources must be compared with each other and reviewed with patients, caregivers, and providers. We can never guarantee that the "gold standard" list is perfect, but it is as accurate as humanly possible. This methodology is highly reliable and has been performed in thousands of patients.

Committee response:

- The Committee agrees with the developer's response, and further emphasizes the importance of the patient/ caregiver voice.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

Measures Not Recommended

0487 EHR with EDI prescribing used in encounters where a prescribing event occurred

Submission | Specifications

Description: Of all patient encounters within the past month that used an electronic health record (EHR) with electronic data interchange (EDI) where a prescribing event occurred, how many used EDI for the prescribing event.

Numerator Statement: Number of encounters using an electronic health record (EHR) with EDI, where EDI was used for a prescribing event.

Denominator Statement: All patient encounters where medication prescribing occurred

Exclusions: 1. controlled substance(s) requiring non-EDI prescription are printed, or

2. prescriptions are printed due to patient preference for non-EDI prescription and indicated in a structured and auditable format, or

3. no prescriptions are generated during the encounter, or

4. the receiving-end of EDI transmission is inoperable and unable to receive EDI transmission at the time of prescribing

Adjustment/Stratification:

Level of Analysis: Clinician : Individual

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: Structure

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Pharmacy

Measure Steward: City of New York Department of Health and Mental Hygiene

STANDING COMMITTEE MEETING [03/18-19/2014]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. Evidence: 1b. Performance Gap, 1c. High Priority)

1a. Evidence: **H-X**; **M-X**; **L-X; IE-X; I-X**; 1b. Performance Gap: **H-X**; **M-X**; **L-X**; **I-X** 1c. High Priority: **H-X**; **M-X**; **L-X**; **I-X**

<u>Rationale</u>:

- While the Committee noted that electronic prescribing is becoming more common, potentially leading to fewer errors in dispensing than handwritten prescriptions, they agreed it is not clear that measuring the number of electronic prescriptions alone will lead to any meaningful conclusions about or improvements in quality of care. Although the developer cited several studies displaying a high prevalence of medication errors, the Committee pointed out that they do not show a clear link between the measure of the number of electronic prescription and health outcomes. Committee members encouraged the developer to provide more recent data and evidence to support measure focus given the rapid changes in the use of electronic health records in the United States.
- The Committee agreed the evidence presented was insufficient to support the measure and that there is low confidence that the measure addresses a significant health problem.
- The Committee also agreed that while there do not appear to be any potential harms associated with this measure, the potential benefits of this measure in improving the quality of care or patient outcomes are not clear, and did not recommend the measure.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-X**; **M-X**; **L-X**; **I-X** 2b. Validity: **H-X**; **M-X**; **L-X**; **I-X**

<u>Rationale</u>:

- N/A

3. Feasibility: H-X; M-X; L-X; I-X

(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)

<u>Rationale</u>:

- N/A

4. Use and Usability: H-X; M-X; L-X; I-X

(4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)

<u>Rationale</u>:

- N/A

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Y-X; N-X

Rationale

- The Committee did not recommend this measure for endorsement since it did not pass importance, which is a must pass criteria.

6. Public and Member Comment:

Comments received:

- Commenters generally did not express support for the measure and supported the Committee's recommendation to not endorse the measure.