NATIONAL QUALITY FORUM

Memo

TO: Care Coordination: Phase 3 Standing Committee

FR: NQF Staff

RE: Voting Draft Report: *NQF-Endorsed Measures for Care Coordination*

DA: June 6, 2014

Purpose of the Call

The Care Coordination Standing Committee will meet via conference call on Thursday, June 12, 2014 from 2-4 pm ET. The purpose of this call is to:

- Review and discuss comments received during the post-evaluation public and member comment period.
- Provide input on proposed responses to the post-evaluation comments.
- Determine whether reconsideration of any measures or other courses of action is warranted.

Due to time constraints on the call, we would like for the Committee member who served as the lead discussant for each measure to be prepared to summarize the rationale for the Committee's decision on the measure and to summarize any new information that was included in the comments.

Due to time constraints, during this call we will review comments by exception, in the case the Committee disagrees with the proposed responses.

Standing Committee Actions

1. Review this briefing memo and Draft Report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see Comment Table).
3. Be prepared to provide feedback and input on proposed post-evaluation comment responses.

Conference Call Information

Please use the following information to access the conference call line and webinar:

Speaker dial-in #: (877) 457-4684 *(NO CONFERENCE CODE REQUIRED)*
Web Link: http://nqf.commpartners.com/se/Rd/Mt.aspx?689705
Registration Link: http://nqf.commpartners.com/se/Rd/Rg.aspx?689705

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and

public comments prior to the evaluation of the measures via an online tool located on the project webpage. Third, NQF opens a 30-day comment period to both members and the public after measures have been evaluated by the full committee and once a report of the proceedings has been drafted.

Pre-evaluation comments

The pre-evaluation comment period was open from February 6, 2014 to February 20, 2014 for all of the measures under review; however no pre-evaluation comments were received.

Post-evaluation comments

The Draft Report went out for Public and Member comment from April 29, 2014 to May 28, 2014. During this commenting period, NQF received 75 comments from 6 member organizations:

Consumers – 0	Professional – 0
Purchasers – 0	Health Plans – 2
Providers – 0	QMRI – 1
Supplier and Industry – 1	Public & Community Health - 2

In order to facilitate discussion, the majority of the post-evaluation comments have been categorized into major topic areas or themes. Where possible, NQF staff has proposed draft responses for the Committee to consider. Although all comments and proposed responses are subject to discussion, we will not necessarily discuss each comment and response on the post-comment call. Instead, we will spend the majority of the time considering the major topics and/or those measures with the most significant issues that arose from the comments. Note that the organization of the comments into major topic areas is not an attempt to limit Committee discussion.

We have included all of the comments that we received in the Comment Table. This comment table contains the commenter's name, comment, associated measure, topic (if applicable), and—for the post-evaluation comments—draft responses for the Committee's consideration. Please refer to this comment table to view and consider the individual comments received and the proposed responses to each.

Comments and their Disposition

Overall themes were identified in the post-evaluation comments regarding construction of several recommended measure as composites, use of the evidence exception, and gaps in the portfolio. Several of the comments received expressed recommendations and concerns regarding the specifications of the measures evaluated for endorsement. Several additional comments also expressed support of the Committee's decisions, but also requested clarification regarding measure specifications.

While there were several comments that were not supportive of the Committee's recommendations, most expressed their position on the measures but did not offer additional information that would promote additional discussion of the measure.

Major themes were identified in the post-evaluation comments as follows:

1. Exercise of the exception to evidence for the ED patient transfer measures 0291-0297
2. Concern regarding the feasibility of the measures recommended for endorsement
3. Future recommendations regarding structuring the set of measures 0291-0297, and the set of measures 0495-0497 as composites, and gaps in the Care Coordination portfolio.

Theme 1 – Evidence Base

A commenter expressed concern regarding the Committee's decision to exercise the exception to the evidence criterion for the seven ED patient transfer measures 0291-0297, even though they fill a gap area.

> **Proposed Committee response:** Pending discussion during post-comment call.

Theme 2 – Feasibility of Recommended Measures

Commenters expressed concern regarding the administrative burden associated with the need to collect data via data abstraction and from paper medical records for the recommended measures.

> **Developer response:** As for the burden of data collection, we consider this analogous to the effort required for the National Surgical Quality Improvement Program (NSQIP), which has been adopted by almost all U.S. hospitals and requires medical record review, often performed by trained nurses. The effort required for the proposed measures would be much less than that required for NSQIP (1-2 hours per day total) and would be fairly distributed to all hospitals.
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> **Proposed Committee response:** The Committee discussed the feasibility of measures and determined that the data abstraction does not appear to place undue burden on facilities collecting the measures.

Commenters were concerned about the ability of a patient or a caregiver to accurately communicate the necessary information needed for measures #0294 and #2456.

> **Developer response, #2456:** 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.
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> This measure will drive hospitals to implement interventions to improve their medication reconciliation processes. These processes include gathering medication

information from several sources, not just patients and caregivers, knowing when to stop gathering additional data, consolidating data from discrepant sources into one coherent list (i.e., compiling a "best possible medication history"), and using the final list to order medications at admission and discharge. Our measure accurately describes errors and omissions in any and all of these processes. Even hospitals with patient populations that have challenges to the comprehensive disclosure and recall of medications can score well in this measure if these steps are followed.

This new measure directly detects error rates in medication orders, enabling hospitals to better understand where their errors are occurring and the types of errors that exist. This will enable them to implement targeted interventions that reduce error rates. The result will be true improvements in medication safety during transitions in care.

Committee response: Pending discussion during post-comment call.

Theme 3 – Future Recommendations

Composite measures. Commenters recommended that measures #0291-0297 be constructed as a composite. In its discussions the Committee noted that seven measures (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 as part of such transfers. The Committee strongly recommended that in future, the developer construct these measures as a composite. This sentiment was expressed in many of the comments.

Proposed Committee response: The Committee strongly recommends 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.

Developer response: While we understand the concerns of the committee about the potential for unintended consequences of performance measures that evaluate the number of minutes a patient may reside in an emergency department prior to disposition, we do not think it is feasible to create a "composite" measure of the three ED throughput measures (NQF #s: 0495, 0496, and 0497). When these measures were first developed, the Emergency Department Technical Expert Panel (largely made up of representatives of the American College of Emergency Physicians as well as hospital representatives) discussed potential unintended consequences extensively. Here are the reasons we believe it is not feasible to create a composite measure:

NQF #0495 and NQF #0496 (median times from arrival to departure for patients seen in the ED and admitted to the hospital – 0495 and discharged from the ED – 0496) are measures from two separate reporting programs for hospitals. NQF 0495 is a part of the Hospital Inpatient Quality Reporting (HIQR) program and cases are sampled from hospital administrative claims for inpatients. NQF 0496 is a part of the Hospital Outpatient Quality Reporting (HOQR) program and cases are sampled based on E/M codes for ambulatory ED visits. These two programs (HIQR and HOQR) are separate programs specified in different federal laws and with different rule making processes. Most acute care hospitals participate in the HIQR program but many do not currently participate in the HOQR program. Because participation is voluntary and because the

sampling methodology for these two measures is so different, a composite measure is not feasible.

All three of these measures are reported as median times. The technical expert panel made the explicit decision to use median times to reduce the impact of outlier cases where a longer stay in the ED may reduce the need for hospitalization.

When the technical expert panel originally developed the measures, we considered setting some arbitrary time frame for ED throughput (the one discussed the most was a 4 hour window of time) and reporting these measures as proportions – e.g., the proportion of patients seen in the ED who were subsequently admitted and the time from arrival to ED departure was 4 hours or less. However, we felt that the risk of unintended consequences for a measure based on a proportion of patients whose departure was within an arbitrary time frame was much greater than using median times which addressed outlier cases. Median time measures allow a clinician to hold on to a patient longer when necessary whereas an arbitrary time frame may have pushed ED physicians to make rapid decisions to admit or discharge without appropriate evaluation or stabilization.

We are not aware of any methodology for creating composites for median times.

NQF #0497 (admit decision time to ED departure) is a component time of NQF #0495. It is not independent of 0495. NQF #0497 is the ED "boarding time" measure which was strongly supported by the ED Technical expert panel and the Emergency Department Benchmarking Alliance.

With respect to patients with psychiatric diagnoses, they are included in the measure information that is provided back to the hospital for quality improvement purposes, but are not included in the median times that are publicly reported. This decision was made to include them in a feedback measure to hospitals (we felt it was important to provide information to the hospital on throughput times for their entire ED population) but because of the variability in the availability of resources for follow-up or inpatient care for patients with psychiatric diagnoses, we did not include them in the public reported median times.

Committee response: Pending discussion during post-comment call.

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 the assessing the quality of care coordination provided, specifically discussing measures #0291-0297. The Committee discussed this issue at length and noted that although communication may have occurred, this does not necessarily mean that care coordination occurred.

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

Another commenter expressed concerns about the lack of measures in the portfolio that capture bi-directional communication in care coordination and 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; however these measures are being captured in in the Person and Family Centered Care portfolio.

> **Proposed 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. During its discussions 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:
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> - 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.
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> 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 submission of measures addressing these identified gaps.

A commenter noted that with the withdrawal of several measures in the area of Health IT, and as measure #0487: "EHR with EDI prescribing used in encounters were a prescribing event occurred" is not recommended for endorsement, there is a significant gap in the portfolio in this important area.

> **Proposed Committee response:** Pending discussion during post-comment call.

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."

> **Proposed Committee response:** Pending discussion during post-comment call.

Measure Specific Comments

Measure 0291: Administrative Communication

Several comments were posed recommending a more 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 more 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.

This measure has been tested in 16 states in more than 250 Critical Access Hospitals. Some data is available at http://www.flexmonitoring.org/publications/ds8/ at the Flex Monitoring Team website Rural Hospital Emergency Department Quality Measures: Aggregate Data Report (Data Summary Report #8)

Proposed Committee response: Pending discussion during post-comment call.

Measure 0292: Vital Signs

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. Changes in VS should be noted in MD and nurse notes.

Proposed Committee response: Response pending discussion during post-comment call, related to recommendations for this measure in the future.

Measure 0293: Medication Information

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.

Proposed Committee response: Pending discussion during post-comment call.

Measure 0295: Physician Information

Although comments supported this measure, there were concerns I 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.

Proposed Committee response: The Committee discussed the feasibility of this measure and determined that the data abstraction does not appear to place undue burden on facilities collecting the measure.

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

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, 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 throughput time according to diagnoses.

Proposed Committee response: Pending discussion during post-comment call.

Measure 2456: Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

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: Medication reconciliation is a process of identifying the most accurate list of all medications a patient is taking and should be taking —including name, dosage, frequency, route, purpose and duration — and using this list to provide correct medications for patients anywhere within the healthcare system. We advocate for facilitating this process for all patients to enhance patient safety and to reduce the incidence of adverse events. While we acknowledge the importance of caring for all patients, we realize that throughout hospitalization, high-risk patients often receive low-intensity efforts despite complex medication reconciliation needs. We consider this as a potential failure mode in medication reconciliation. Therefore, one of the most important interventions to implement is a risk-stratification process with the provision to offer the intensive bundle to high-risk patients. The Intensive bundle has the same core elements of the standard bundle but addresses higher-risk patients who likely require additional dedicated time and expertise to manage the patient interview, reconciliation at discharge, and education for the patient. The MARQUIS toolkit includes a risk stratification tool with guidelines for operationalizing use of the tool by various providers and detailed descriptions of an intensive bundle that could be provided to high-risk patients.

If the concern is that certain hospitals will be unfairly penalized for caring for a high-risk patient population, we do have plans in place to adjust for number of medications and patient age during the 4-year roll-out period of this measure if warranted and approved by NQF and stakeholders. But we want to reiterate that medication reconciliation needs to be done correctly in all patients and that focusing solely on high-risk patients could lead to ignoring the process for many patients who would benefit from relatively simple interventions. Quality improvement efforts should improve the medication reconciliation process for all patients while recognizing the need to focus additional efforts on high-risk patients. Our measure as designed can accommodate both those realities.

Proposed Committee response: Pending discussion during post-comment call.

Measure 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 relates to existing and/or new medications which may have implications on this measure.

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.

Secondly, MARQUIS strongly fosters the concept of patient-owned medication lists. If all patients admitted to the hospital came with a completely accurate and up-to-date medication list in their possession, then many of the hazards of poorly-done medication reconciliation would be avoided. The toolkit describes an intervention component which facilitates patient ownership of the list and provides a template to assist patients with this process. If implemented, then over time patient and caregiver recall of medications would indeed become increasingly accurate.

Proposed Committee response: Pending discussion during post-comment call.