NATIONAL QUALITY FORUM

Measure Applications Partnership

Hospital Workgroup In-Person Meeting
Day 1

December 8-9, 2016

Welcome, Introductions, Disclosures of Interest and Review of Meeting Objectives

MAP Hospital Workgroup Members

Workgroup Chairs (voting)	
Cristie Upshaw Travis, MSHHA	
Ronald S. Walters, MD, MBA, MHA, MS	
Organizational Members (voting)	**Organizational Representative**
American Hospital Association	Nancy Foster
America's Essential Hospitals	David Engler, PhD
Baylor Scott & White Health*	Marisa Valdes, RN, MSN
Blue Cross Blue Shield of Massachusetts	Wei Ying, MD, MS, MBA
Children's Hospital Association	Andrea Benin. MD
Geisinger Health System	Heather Lewis, MS, MBA
Kidney Care Partners	Allen Nissenson, MD
Medtronic-Minimally Invasive Therapy Group*	Karen Shehade, MBA

MAP Hospital Workgroup Members

Organizational Members (con't)	Organizational Representative
Mothers Against Medical Error	Jennifer Eames Huff
National Association of Psychiatric Health Systems*	Frank Ghinassi, PhD, ABPP
National Rural Health Association	Brock Slabach, MPH, FACHE
Nursing Alliance for Quality Care*	Kimberly Glassman, PhD, RN, NEA-BC, FAAN
Pharmacy Quality Alliance*	Woody Eisenberg, MD
Premier, Inc.	Mimi Huizinga, MD
Project Patient Care	Martin Hatlie, JD
Service Employees International Union	Sarah Nolan
The Society of Thoracic Surgeons	Jeff Jacobs, MD
University of Michigan*	Marsha Manning

MAP Hospital Workgroup Members

Individual Subject Matter Experts (voting)	
Nursing	Gregory Alexander, PhD, RN, FAAN
Renal	Elizabeth Evans, DNP
Measure Methodology	Lee Fleisher, MD*
Patient Safety	Jack Jordon*
Palliative Care	R. Sean Morrison, MD
Mental Health	Ann Marie Sullivan, MD
Health Informatics	Lindsey Wisham, BA, MPA*
MAP Duals Workgroup Liaison (non-voting)	
New Jersey Hospital Association	Aline Holmes
Federal Government Liaisons (non-voting)	
Agency for Healthcare Research and Quality (AHRQ)	Pam Owens, PhD
Centers for Disease Control and Prevention (CDC)	Dan Pollock, MD
Centers for Medicare & Medicaid Services (CMS)	Pierre Yong, MD, MPH

MAP Hospital Workgroup Staff Support Team

- Melissa Mariñelarena: Senior Director
- Kate McQueston: Project Manager
- Desmirra Quinnonez: Project Analyst

- **Project Email: MAPHospital@qualityforum.org**

Agenda: Day 1

- Welcome, Introductions, and Review of Meeting Objectives
- Pre-Rulemaking Input:
  - *End-Stage Renal Disease (ESRD) QIP*
  - *PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)*
  - *Ambulatory Surgical Center Quality Reporting (ASCQR)*
  - *Inpatient Psychiatric Facility Quality Reporting (IPFQR)*
  - *Hospital Outpatient Quality Reporting (HOQR)*
- Feedback on Current Measure Sets for ESRD QIP, PCHQR, ASCQR, IPFQR, and OQR
- Opportunity for Public Comment
- Adjourn Day 1

Agenda: Day 2

- Review Day 1
- PROMIS Discussion
- Pre-Rulemaking Input:
  - *Hospital Inpatient Quality Reporting (IQR) Program and Medicare and Medicaid EHR Incentive Program for Eligible Hospitals and Critical Access Hospitals (CAHs)*
- Feedback on Current Measure Sets for IQR and VBP
- Opportunity for Public Comment
- Adjourn Day 2

Meeting Objectives

Review and provide input on measures under consideration for use in federal programs

Finalize input to the MAP Coordinating Committee on measures for use in federal programs; and

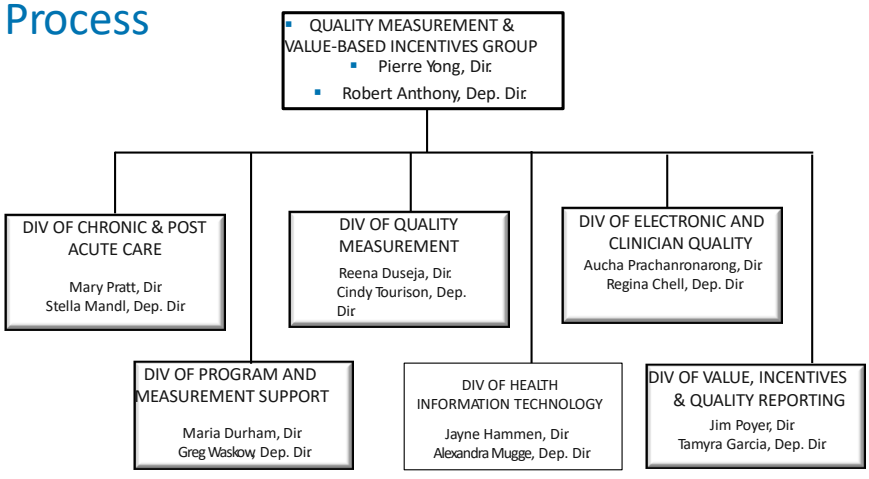
Identify gaps in measures for federal hospital quality programs.

CMS Opening Remarks

Pierre Yong, Director, Quality Measurement and Value-Based Incentives Group, CMS

Creation of the MUC List

CMS' Center for Clinical Standards & Quality: Home to the Pre-Rulemaking Process



Statutory Authority: Pre-Rulemaking Process

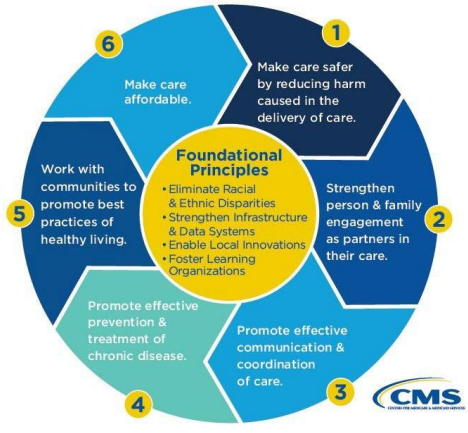
- ***Under section 1890A of the Act and ACA 3014, DHHS is required to establish a pre-rulemaking process under which a consensus-based entity (currently NQF) would convene multi-stakeholder groups to provide input to the Secretary on the selection of quality and efficiency measures for use in certain federal programs. The list of quality and efficiency measures DHHS is considering for selection is to be publicly published no later than December 1 of each year. No later than February 1 of each year, NQF is to report the input of the multi-stakeholder groups, which will be considered by DHHS in the selection of quality and efficiency measures.***

Pre-rulemaking Process: Measure Selection

- Pre-rulemaking Process – provides for more formalized and thoughtful process for considering measure adoption:
  - Early public preview of potential measures
  - Multi-stakeholder groups feedback sought and considered prior to rulemaking (MAP feedback considered for rulemaking)
  - Review of measures for alignment and to fill measurement gaps prior to rulemaking
  - Endorsement status considered favorable; lack of endorsement must be justified for adoption.
  - Potential impact of new measures and actual impact of implemented measures considered in selection determination

CMS Quality Strategy Aims and Goals

CMS Quality Strategy Goals and Foundational Principles



Measure Inclusion Requirements

- Respond to specific program goals and statutory requirements.
- Address an important topic, including those identified by the MAP, with a performance gap and is evidence based.
- Focus on one or more of the National Quality Strategy priorities.
- Identify opportunities for improvement.
- Avoid duplication with other measures currently implemented in programs.
- Include a title, numerator, denominator, exclusions, measure steward, data collection mechanism.
- Alignment of measures across public and private programs.

Caveats

- Measures in current use do not need to go on the Measures under Consideration List again
  - *The exception is if you are proposing to expand the measure into other CMS programs, proceed with the measure submission but only for the newly proposed program*
- Submissions will be accepted if the measure was previously proposed to be on a prior year's published MUC List, but was not accepted by any CMS program(s).
- Measure specifications may change over time, if a measure has significantly changed, proceed with the measure submission for each applicable program

Medicare Programs

Ambulatory Surgical Center Quality Reporting Program
End-Stage Renal Disease Quality Incentive Program
Home Health Quality Reporting Program
Hospice Quality Reporting Program
Hospital-Acquired Condition Reduction Program
Hospital Inpatient Quality Reporting Program
Hospital Outpatient Quality Reporting Program
Hospital Readmissions Reduction Program
Hospital Value-Based Purchasing Program
Inpatient Psychiatric Facility Quality Reporting Program
Inpatient Rehabilitation Facility Quality Reporting Program
Long-Term Care Hospital Quality Reporting Program
Medicaid and Medicare EHR Incentive Program for Eligible Hospitals and Critical Access Hospitals
Medicare Shared Savings Program
Merit-based Incentive Payment System
Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program
Skilled Nursing Facility Quality Reporting Program
Skilled Nursing Facility Value-Based Purchasing Program

Measures Under Consideration List Publishing

MAP Meeting Results

Early MAP Input from Hospital Workgroup

- PROMIS: Patient Reported Outcomes Measurement Information System
  - Seek MAP input on concept of using PROMIS tools as basis for future PRO-Performance Measures for potential inclusion in future programs

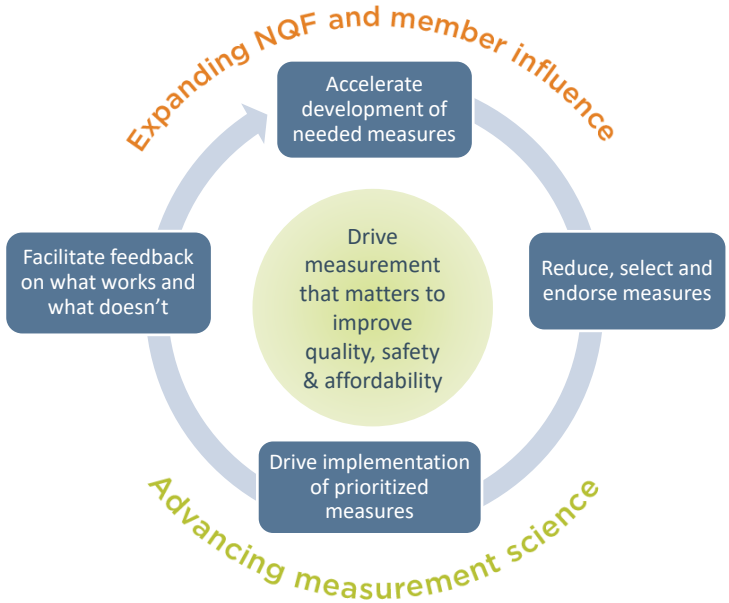
CMS "Feedback Loop"

- Trial period – October 2016 PAC-LTC Workgroup meeting
- Based on discussions with Workgroup at December 2015 Meeting
- Review previously presented measures to the Workgroup
- Additional work done in measure development, including work generated from Workgroup feedback
- Additional Workgroup discussion

NQF Strategic Plan

Helen Burstin, Chief Scientific Officer, NQF

NQF: Lead. Prioritize. Collaborate.



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NQF 3-year strategic plan and metrics

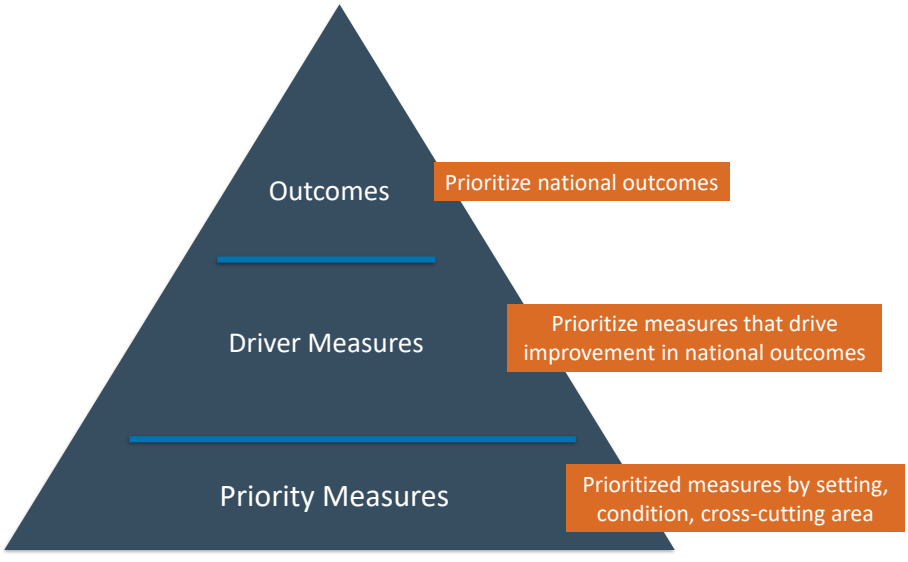
NQF THREE-YEAR STRATEGIC PLAN AND METRICS

Accelerate Development of Needed Measures	Objective #1: Identify and prioritize gaps	Objective #2: Fill prioritized measure gaps through the NQF Measure Incubator	Objective #3: Develop NQF Measure Incubator Learning Collaborative.	Outcomes: • Prioritized list of gaps developed and disseminated nationally • Prioritized measure gaps filled • Improved measure development process through sharing what works and what does not • Collaborative space for networking and problem solving in measure development established	Metrics: • Prioritized measure gaps targeted for measure development • Prioritized measure gaps filled, including through measure incubation • Prioritized measurement issues addressed through Learning Collaborative
Prioritize Measures that Matter: reduce, select, and endorse	Objective #1: Establish criteria to prioritize measures and gaps	Objective #2: Identify priority outcomes that will improve the health of the nation Identify priority accountability measures that can drive high quality and value	Objective #3: Use measure endorsement and selection processes to reduce number of measures where burden outweighs benefit	Outcomes: • NQF criteria for measure and gap prioritization disseminated nationally • NQF prioritization criteria inform efforts by others to select and prioritize measures for implementation • Identified prioritized sets of outcomes and accountability measures that will drive improvement for the nation • Reduction of unnecessary measures through endorsement and selection	Metrics: • Use of NQF prioritization criteria for public and private sector measure selection • Prioritized measures identified to address needs of healthcare system • Reduction in unnecessary measure burden
Drive Implementation of Prioritized Measures	Objective #1 Identify levers to drive implementation of prioritized measures	Objective #2 Identify strategies to take advantage of identified levers	Objective #3 National Quality Partners will focus efforts that will drive improvement in national outcomes	Outcomes • Prioritized measures used by public and private sector to drive improvement in national outcomes • Prioritized measures used in NQF efforts to drive improvement activities with NQF members	Metrics: • Prioritized measures selected for use in private and public sector programs
Facilitate Feedback on What Works and What Doesn't	Objective #1: Assess measure impact through multiple feedback loops	Objective #2: Inform measure endorsement, selection and prioritization with information gathered through feedback	Objective #3: Fully integrate information flow between measure endorsement and measure selection processes	Outcomes • Improved information available for endorsement and selection of measures • Prioritization informed by measure feedback	Metrics: • Private and public sector partners working with NQF on measure feedback • Measures for which feedback information is available • Bidirectional flow of information between endorsement and selection processes
Foster Quality Leadership and Awareness	Objective #1 Educate and engage NQF members about Federal quality legislation via a Quality Policy Member Network	Objective #2 Influence NQF's legislative and funding strategies through a Quality Policy Advisory Group	Objective #3 Foster key stakeholder leadership support for continued NQF funding	Outcomes • NQF members more knowledgeable about federal quality legislation • NQF members inform NQF technical assistance on the Hill • Quality-related legislation reflects NQF input where appropriate • Key stakeholders demonstrate support for NQF's reauthorization • NQF funding reauthorized	Metrics: • NQF members actively participating in Quality Policy Member Network • Requests for NQF technical input into quality-related bills • Quality Policy Advisors outreach to solicit Congressional support for NQF

7/2016

Prioritization of Measures and Gaps

Prioritize Measures that Matter



Environmental Scan: Prioritization Criteria

- National Quality Strategy
- IOM Vital Signs
- NQF Prioritization Advisory Committees
- Healthy People 2020 Indicators
- Kaiser Family Foundation Health Tracker
- Consumer priorities for Hospital QI and Implications for Public Reporting, 2011
- IOM: Future Directions for National Healthcare Quality and Disparities Report, 2010
- IHI Whole System Measures
- Commonwealth Fund International Profiles of Healthcare Systems, 2015
- OECD Healthcare Quality Project
- OECD Improving Value in Healthcare: Measuring Quality
- Conceptual Model for National Healthcare Quality Indicator System in Norway
- Denmark Quality Indicators
- UK NICE standards – Selecting and Prioritizing Quality Standard Topics
- Australia's – Indicators used Nationally to Report on Healthcare, 2013
- European Commission Healthcare Quality Indicators
- Consumer-Purchaser Disclosure Project – Ten criteria for usable meaningful and usable measures of performance

Potential Prioritization Criteria

- Actionable & improvable (amenable to interventions, potential to transform care)
- Reduces disparities
- High impact area
- Integrated care (measurement across providers and settings, including transitions)
- Easy to understand and interpret
- Lack of adverse consequences
- Meaningful to patient and/or caregiver
- Outcome-focused
- Patient-centered
- Burden of measurement
- Drives system-level improvement

Word Cloud: Prioritization Criteria

Gap Construct

- An accountability measure gap should provide the following:
  - *Topic area that needs to be addressed (condition specific, cross-cutting)*
  - *The type of measure (e.g., process, outcome, PRO)*
  - *The target population of the measure (denominator)*
  - *Aspect of care being measured within this quality problem (numerator)*
  - *Specific attribution of the healthcare entity being measured*
  - *Description of how the measure would fill the gap in NQF's measure portfolio*

Reduce Measures

Prioritize Measures that Matter: Reduce, Select & Endorse

Reduce measures where benefits outweighs burden

- *Consider MAP and CDP opportunities to drive measure reduction*

MAP: Recommendations for Measure Removal

- MAP has expressed a need to better understand the program measure sets, including how new measures under consideration interact with current measures.
- For the 2016-2017 pre-rulemaking cycle, MAP will offer guidance on measures finalized for use:
  - **MAP will offer input on ways to strengthen the current measure set including recommendations for future removal of measures**.
  - This guidance will be built into the final MAP report but will not be reflected in the "Spreadsheet of MAP Final Recommendations."

MAP Pre-Rulemaking Approach

Kate McQueston, Project Manager, NQF

Approach

The approach to the analysis and selection of measures is a four-step process:

- Provide program overview
- Review current measures
- Evaluate MUCs for what they would add to the program measure set
- Provide feedback on current program measure sets

Evaluate Measures Under Consideration

- MAP Workgroups must reach a decision about every measure under consideration
  - *Decision categories are standardized for consistency*
  - *Each decision should be accompanied by one or more statements of rationale that explains why each decision was reached*
- The decision categories have been updated for the 2016-2017 pre-rulemaking process
  - *MAP will no longer evaluate measures under development using different decision categories*

Preliminary Analysis of Measures Under Consideration

To facilitate MAP's consent calendar voting process, NQF staff will conduct a preliminary analysis of each measure under consideration.

The preliminary analysis is an algorithm that asks a series of questions about each measure under consideration. This algorithm was:

- Developed from the MAP Measure Selection Criteria, and approved by the MAP Coordinating Committee, to evaluate each measure
- Intended to provide MAP members with a succinct profile of each measure and to serve as a starting point for MAP discussions

MAP Decision Categories

Decision Category	Evaluation Criteria
Support for Rulemaking	The measure is fully developed and tested in the setting where it will be applied and meets assessments 1-6. If the measure is in current use, it also meets assessment 7.
Conditional Support for Rulemaking	The measure is fully developed and tested and meets assessments 1-6. However, the measure should meet a condition (e.g., NQF endorsement) specified by MAP before it can be supported for implementation. MAP will provide a rationale that outlines the condition that must be met. Measures that are conditionally supported are not expected to be resubmitted to MAP.
Refine and Resubmit Prior to Rulemaking	The measure addresses a critical program objective but needs modifications before implementation. The measure meets assessments 1-3; however, it is not fully developed and tested OR there are opportunities for improvement under evaluation. MAP will provide a rationale to explain the suggested modifications.
Do Not Support for Rulemaking	The measure under consideration does not meet one or more of the assessments.

MAP Measure Selection Criteria

1	NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective
2	Program measure set adequately addresses each of the National Quality Strategy's three aims
3	Program measure set is responsive to specific program goals and requirements
4	Program measure set includes an appropriate mix of measure types
5	Program measure set enables measurement of person- and family-centered care and services
6	Program measure set includes considerations for healthcare disparities and cultural competency
7	Program measure set promotes parsimony and alignment

MAP Voting Instructions

MAP Voting Instructions: Key Voting Principles

- The Chair and NQF staff will give introductory presentations to provide context to each programmatic discussion; discussion and voting begin using the electronic Discussion Guide
- The Discussion Guide is organized as follows:
  - *The measures under consideration are divided into a series of related groups (consent calendars) for the purposes of discussion and voting*
  - *Each measure under consideration has a preliminary staff analysis*
  - *The discussion guide notes the result of the preliminary analysis and provides the rationale to explain how the conclusion was reached*
- Lead discussants have been assigned to each group of measures

Voting Procedure

Step 1. Staff will review a Preliminary Analysis Consent Calendar

- Staff present each group of measures as a consent calendar reflecting the result of the preliminary analysis using MAP selection criteria and programmatic objectives

Voting Procedure

Step 2. MUCs can be pulled from the Consent Calendar and become regular agenda items

- The co-chairs will ask the Workgroup members to identify any MUCs they would like to pull off the consent calendar. Any Workgroup member can ask that one or more MUCs on the consent calendar be removed for individual discussion
- Once the identified measures are removed from the consent calendar, the co-chair will ask if there is any objection to accepting the preliminary analysis and recommendation of the MUCs remaining on the consent calendar
- If no objections are made for the remaining measures, the consent calendar and the associated recommendations will be accepted (no formal vote will be taken)

Voting Procedure

Step 3. Voting on Individual Measures

- Workgroup member(s) who identify measures for discussion will describe their perspective on the measure and how it differs from the preliminary analysis and recommendation in the Discussion Guide.
- Workgroup member(s) assigned as lead discussant(s) for the group of measures will respond to the individual(s) who requested discussion. Lead discussant(s) should state their own point of view, whether or not it is in agreement with the preliminary recommendation or the divergent opinion.
- Other Workgroup members should participate in the discussion to make their opinions known. However, in the interest of time, one should refrain from repeating points already presented by others.
- After discussion of each MUC, the Workgroup will vote on the measure with four options:
  - *Support for Rulemaking*
  - *Conditional Support for Rulemaking*
  - *Refine and Resubmit Prior to Rulemaking*
  - *Do Not Support for Rulemaking*

Voting Procedure
Step 4: Tallying the Votes

	DO NOT SUPPORT	REFINE AND RESUBMIT	CONDITIONAL SUPPORT	SUPPORT
If the MUC receives >60% of the votes in one category	> 60% consensus of do not support	≥ 60% consensus of refine and resubmit	≥ 60% consensus of conditional support	≥60% consensus of support
If the MUC does NOT receive >60% of the votes in one category	< 60% consensus for the combined total of refine and resubmit, conditional support and support	≥ 60% consensus of refine and resubmit, conditional support and support	≥ 60% consensus of both conditional support and support	N/A

*Abstentions are discouraged but will not count in the denominator

Voting Procedure
Step 4: Tallying the Votes

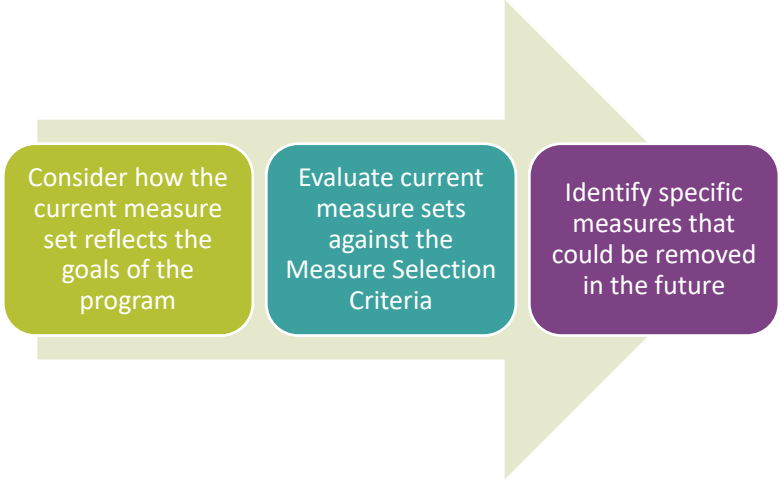
25 Committee Members
2 members abstain from voting

Voting Results	
Support	10
Conditional Support	4
Refine and Resubmit	2
Do Not Support	7
Total:	23

10+4 = 14/23 = 61%
The measure passes with Conditional Support

Current Measure Sets

Provide Feedback on Current Measure Sets



Potential Criteria for Removal

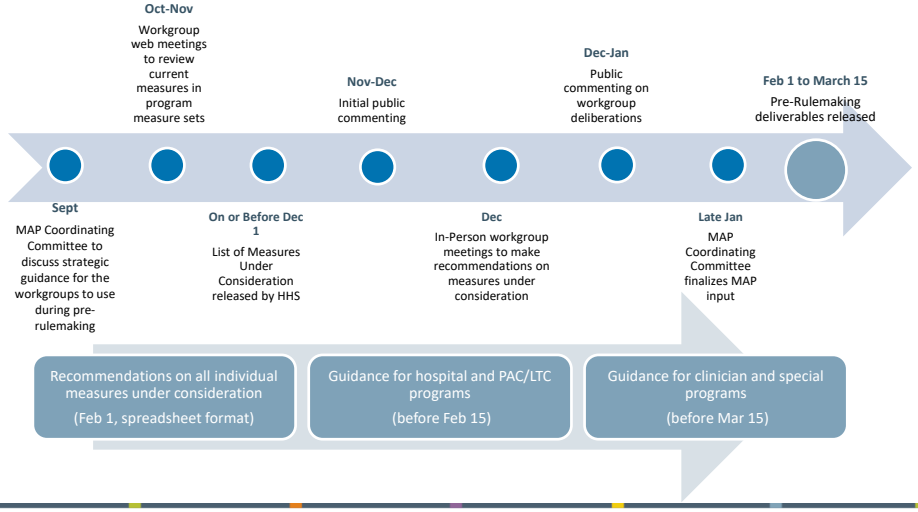
1	The measure is not evidence-based and is not linked strongly to outcomes
2	The measure does not address a quality challenge (i.e. measure is topped out)
3	The measure does not utilize measurement resources efficiently or contributes to misalignment
4	The measure cannot be feasibly reported
5	The measure is not NQF-endorsed or is being used in a manner that is inconsistent with endorsement
6	The measure has lost NQF-endorsement
7	Unreasonable implementation issues that outweigh the benefits of the measure have been identified
8	The measure may cause negative unintended consequences
9	The measure does not demonstrate progress toward achieving the goal of high-quality, efficient healthcare

Commenting Guidelines

Commenting Guidelines

- Comments from the early public comment period have been incorporated into the discussion guide
- There will be an opportunity for public comment before the discussion on each program.
  - *Commenters are asked to limit their comments to that program and limit comments to **two minutes.***
  - *Commenters are asked to make any comments on MUCs or opportunities to improve the current measure set at this time*
- There will be a global public comment period at the end of each day.
- Public comment on the Workgroup recommendations will run from December 21st 2016—January 12th, 2017.
  - *These comments will be considered by the MAP Coordinating Committee and submitted to CMS.*

MAP Approach to Pre-Rulemaking
A look at what to expect



Timeline of Upcoming Activities

In-Person Meetings

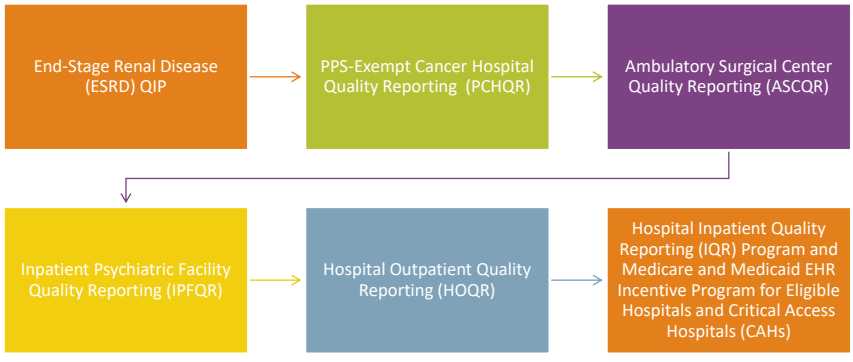
- Hospital Workgroup – **December 8-9**
- Clinician Workgroup – **December 12-13**
- PAC/LTC Workgroup – **December 14-15**
- Coordinating Committee – **January 24-25**

Web Meetings

- Dual Eligible Beneficiaries Workgroup – January 10, 2017, 12-2pm ET
  - *Reviews recommendations from other groups and provide cross-cutting input during the second round of public comment*

Public Comment Period #2: December 21st 2016—January 12th, 2017

MAP Hospital Workgroup Charge



End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

- **Program Type:**
  - Pay for performance and public reporting
- **Incentive Structure:**
  - As of 2012, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score. Payment reductions will be on a sliding scale, which could amount to a maximum of two percent per year.
- **Program Goals:**
  - Improve the quality of dialysis care and produce better outcomes for beneficiaries.

End-Stage Renal Disease Quality Incentive Program

NQS Priority	Number of Measures in ESRD Quality Incentive Program		
	Implemented/ Finalized*	Proposed for Rule**	2016 MUC List
Effective Prevention and Treatment	12	3	3
Making Care Safer	2	1	0
Communication/Care Coordination	1	0	0
Best Practice of Healthy Living	0	0	0
Making Care Affordable	0	0	0
Patient and Family Engagement	1	0	0

Implemented: Quality measures implemented for data collection. **Proposed: Quality measures proposed for data collection. * The Dialysis Adequacy Composite Measure is a combination of 4 existing measures Kt /V measures*

Measure Need reconciliation, anemia management reflecting FDA labeling, coordination of dialysis-related services, over-utilization of oral medications, medication side effects including immunocompromise, quality of life.

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ESRD QIP: Current Program Measure Information

Type	NQF #	Measure Title	NQF Status	National Rates
Outcome	1460	National Healthcare Safety Network (NHSN) Bloodstream Infection in Hemodialysis Patients	Endorsed	
	2979	Anemia of chronic kidney disease: Dialysis facility standardized transfusion ratio (STrR)	Currently under review	
	0257	Vascular Access Type: AV Fistula	Endorsed	66%
	0256	Vascular Access Type – Catheter >= 90 Days	Endorsed	11%
	1454	Proportion of Patients with Hypercalcemia	Endorsed	1%
	2496	Standardized Readmission Ratio (SRR) for dialysis facilities	Endorsed	
	N/A	Standardized Hospitalization Ratio for Dialysis Facilities	Not Endorsed	
	N/A	Standardized Mortality Ratio for Dialysis Facilities	Not Endorsed	
	Kt/V Dialysis Adequacy Comprehensive Clinical Measure			
	0249	Adult Hemodialysis Adequacy	Endorsed	93%
	0318	Adult Peritoneal Dialysis Adequacy	Endorsed	84%
	1423	Pediatric Hemodialysis Adequacy	Endorsed	89%
	N/A	Pediatric Peritoneal Dialysis Adequacy	Not Endorsed	56%
	0258	CAHPS In-Center Hemodialysis Survey	Endorsed	
Process	N/A	Mineral Metabolism Reporting Measure	Not Endorsed	
	N/A	Anemia Management Reporting Measure	Not Endorsed	
	0431	NHSN Healthcare Personnel Influenza Vaccination Reporting Measure	Endorsed	
	0418	Clinical Depression Screening and Follow-Up Reporting Measure	Endorsed	
	0420	Pain Assessment and Follow-up Reporting Measure	Endorsed	

Public Comment

End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

Allen Nissenson, Kidney Care Partners
Elizabeth Evans, Individual Subject Matter Expert (on the phone)

- **Consent Calendar 1:**
  - 1. Standardized Transfusion Ratio for Dialysis Facilities (MUC16-305)—Pulled for discussion by Allen Nissenson
  - 2. Hemodialysis Vascular Access: Standardized Fistula Rate (MUC16-308)
  - 3. Hemodialysis Vascular Access: Long-term Catheter Rate (MUC16-309)

PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)

PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)

- **Program Type:**
  - Quality reporting program
- **Incentive Structure:**
  - PCHQR is a voluntary quality reporting program. Data are published on Hospital Compare
- **Program Goals:**
  - Provide information about the quality of care in cancer hospitals, in particular the 11 cancer hospitals that are exempt from the inpatient prospective payment system and the Inpatient Quality Reporting Program
  - Encourage hospitals and clinicians to improve the quality of their care, to share information, and to learn from each other's experiences and best practices

PPS-Exempt Cancer Hospital Quality Reporting Program

NQS Priority	Number of Measures in PPS-Exempt Cancer Hospital QRP		
	Implemented/ Finalized*	Proposed for Rule**	2016 MUC List
Effective Prevention and Treatment	6	1	0
Making Care Safer	5	0	0
Communication/Care Coordination	2	0	4
Best Practice of Healthy Living	1	0	0
Making Care Affordable	1	0	0
Patient and Family Engagement	1	0	1

**Implemented/Finalized: Quality measures implemented/finalized for data collection.* ***Proposed: Quality measures proposed for data collection.*

Measure Needs: Care coordination with other facilities and outpatient settings, patients' functional status and quality of life, efficiency and appropriateness of treatment modalities, patient-centered care planning and shared decision-making.

PCHQR : Current Program Measure Information

Type	NQF #	Measure Title	NQF Status	National Rates
Outcome	0166	HCAHPS - Hospital Consumer Assessment of Healthcare Providers and Systems Survey	Endorsed	
	0138	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection(CAUTI) Outcome Measure	Endorsed	
	0139	National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	Endorsed	
	0753	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	Endorsed	
	1717	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Endorsed	
	1716	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	Endorsed	
	2936	Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy[1]	Failed Initial Endorsement	
Process	0384	Oncology: Medical and Radiation - Pain Intensity Quantified	Endorsed	
	0383	Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology	Endorsed	
	0382	Oncology: Radiation Dose Limits to Normal Tissues[2]	Endorsed	
	0559	Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0M0, or Stage IB - III hormone receptor negative breast cancer	Endorsed	94%
	0220	Adjuvant Hormonal Therapy	Endorsed	97%
	0390	Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients	Endorsed	
	0389	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Endorsed	
	0223	Adjuvant Chemotherapy is Considered or Administered Within 4 Months (120 days) of Diagnosis to Patients Under the Age of 80 with AJCC III (lymph node positive) Colon Cancer	Endorsed	94%
	1822	External Beam Radiotherapy for Bone Metastases	Endorsed	
	0431	Influenza Vaccination Coverage among Healthcare Personnel	Endorsed	

Public Comment

PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)

R. Sean Morrison, Individual Subject Matter Expert
Sarah Nolan, Service Employees International Union
Heather Lewis, Geisinger Health System

- **Consent Calendar 2:**
  - Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life (MUC16-271)
  - Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life (MUC16-273)
  - Proportion of patients who died from cancer admitted to hospice for less than 3 days (MUC16-274)
  - Proportion of patients who died from cancer not admitted to hospice (MUC16-275)
  - PRO utilization in non-metastatic prostate cancer patients (MUC16-393)

Ambulatory Surgical Center Quality Reporting Program (ASCQR)

Ambulatory Surgical Center Quality Reporting Program (ASCQR)

- **Program Type:**
  - Pay for reporting and public reporting
- **Incentive Structure:**
  - Ambulatory surgical centers (ACSs) that do not participate or fail to meet program requirements receive 2.0 % reduction in annual payment update
- **Program Goals:**
  - Promote higher quality, more efficient health care for Medicare beneficiaries through measurement
  - Allow consumers to find and compare the quality of care given at ASCs to inform decisions on where to get care

Ambulatory Surgical Center Quality Reporting Program

NQS Priority	Number of Measures in Ambulatory Surgical Center QRP		
	Implemented/ Finalized*	Proposed for Rule**	2016 MUC List
Effective Prevention and Treatment	2	1	0
Making Care Safer	6	1	3
Communication/Care Coordination	1	0	0
Best Practice of Healthy Living	0	0	0
Making Care Affordable	2	0	0
Patient and Family Engagement	0	1	0
Not Assignable	1	0	0

**Implemented/Finalized: Quality measures implemented/finalized for data collection.* ***Proposed: Quality measures proposed for data collection.*

Measure Needs: Infection rates, experience of care for patients and families, patient self-management, quality of life for patients with multiple chronic conditions, surgical outcomes, improved communication for transitions across practice settings and health systems, and the reduction of unexpected hospitalizations or ED visits.

ASCQR :Current Measure Set

Type	NQF #	Measure Title	NQF Status	National Rate 2014	National Rate 2013
Outcome	0263	Patient Burn	Endorsement Removed	0.364	0.247
	0267	Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	Endorsement Removed	0.028	0.039
	0266	Patient Fall	Endorsed	0.095	0.156
Process	0264	Prophylactic Intravenous (IV) Antibiotic Timing	Failed Maintenance Endorsement	960.04	962.43
Process	N/A	Normothermia Outcome: Percentage of patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration who are normothermic within 15 minutes of arrival in the post-anesthesia care unit (PACU)[1]	Never Submitted		
Structural	9999	Safe Surgery Checklist Use	Not Endorsed	99.75	
	9999	ASC Facility Volume Data on Selected ASC Surgical Procedures	Not Endorsed	3978	
Outcome	0265	All-Cause Hospital Transfer/ Admission	Endorsed	0.475	0.537
	1536	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	Endorsed		
Process	0431	Influenza Vaccination Coverage Among Healthcare Personnel	Endorsed	74.62	
	0658	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Endorsed	78.38	
	0659	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	Endorsed	80.38	
Outcome	2539	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	Endorsed		
	N/A	Unplanned Anterior Vitrectomy[1]	Never Submitted		
	N/A	OAS CAHPS (five measures)[1]	Never Submitted		

Public Comment

Ambulatory Surgical Center Quality Reporting Program (ASCQR)

Jeff Jacobs, The Society of Thoracic Surgeons
Marisa Valdes, Baylor Scott & White Health

- **Consent Calendar 3:**
  - Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures (MUC16-152)
  - Hospital Visits after Urology Ambulatory Surgical Center Procedures (MUC16-153)
  - Ambulatory Breast Procedure Surgical Site Infection (SSI) Outcome Measure (MUC16-155)

Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)

Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)

- **Program Type:**
  - Pay for reporting and public reporting
- **Incentive Structure:**
  - Inpatient psychiatric facilities (IPFs) that do not submit data on all required measures receive a 2.0% reduction in annual payment update
- **Program Goals:**
  - Provide consumers with quality of care information to make more informed decisions about heath care options
  - Encourage hospitals and clinicians to improve the quality of inpatient psychiatric care by ensuring that providers are aware of and reporting on best practices

Inpatient Psychiatric Facility Quality Reporting Program

NQS Priority	Number of Measures in Inpatient Psychiatric Facility QRP		
	Implemented/ Finalized*	Proposed for Rule**	2016 MUC List
Effective Prevention and Treatment	4	1	0
Making Care Safer	2	0	0
Communication/Care Coordination	3	1	3
Best Practice of Healthy Living	2	0	0
Making Care Affordable	0	0	0
Patient and Family Engagement	1	0	0
Not Assignable	1	0	0

**Implemented/Finalized: Quality measures implemented/finalized for data collection.* ***Proposed: Quality measures proposed for data collection.*

Measure Needs: (1) medication prescribing/adherence/reconciliation, (2) transitions and follow-up, (3) family and caregiver involvement and education, (4) follow-up after positive metabolic screening, and (5) evidence-based inpatient treatment for schizophrenia and mood disorders. CMS is interested in increasing the use of outcomes measures where appropriate.

IPFQR: Current Measure Set

NQF #	Measure Title	NQF Status	National Rate
1661	SUB-1 Alcohol Use Screening	Endorsed	71.01
1651	TOB-1 Tobacco Use Screening	Endorsed	
N/A	Screening for Metabolic Disorders	Endorsed	
0640	Hours of Physical Restraint	Endorsed	0.41
0641	Hours of Seclusion Use	Endorsed	0.21
1654	TOB-2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment	Endorsed	
1663	SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention	Endorsed	
1659	Influenza Immunization	Endorsed	
1656	TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge	Endorsed	
1664	SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge	Endorsed	
0560	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	Endorsed	36.62
0647	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	Endorsed	
0648	Timely Transmission of Transition Record	Endorsed	
0576	Follow-Up After Hospitalization for Mental Illness (FUH)	Endorsed	Not Available
0431	Influenza Vaccination Coverage Among Healthcare Personnel	Endorsed	
N/A	Use of Electronic Health Record	Never Submitted	
N/A	Assessment of Patient Experience of Care	Never Submitted	
2860	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF	Currently under review	
Removed from IPFQR Program for FY 2018 Payment Determination & Subsequent Years			
0557	Post Discharge Continuing Care Plan Created	Endorsement Removed	
0558	Post Discharge Continuing Care Plan Transmitted to Next Level of Care at Discharge	Endorsement Removed	

Public Comment

Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)

Frank Ghinassi, National Association of Psychiatric Health Systems (NAPHS)
Ann Marie Sullivan, Individual Subject Matter Expert
Woody Eisenberg, Pharmacy Quality Alliance

- **Consent Calendar 4:**
  - Continuation of Medications Within 30 Days of Inpatient Psychiatric Discharge (MUC16-48)
  - Medication Reconciliation at Admission (MUC16-49)
  - Identification of Opioid Use Disorder among Patients Admitted to Inpatient Psychiatric Facilities (MUC16-428)

Hospital Outpatient Quality Reporting Program (HOQR)

Hospital Outpatient Quality Reporting Program (HOQR)

- **Program Type:**
  - Pay for reporting and public reporting
- **Incentive Structure:**
  - Hospitals that do not report data on required measures receive a 2.0% reduction in annual payment update
- **Program Goals:**
  - Provide consumers with quality of care information to make more informed decisions about heath care options
  - Establish a system for collecting and providing quality data to hospitals providing outpatient services such as emergency department visits, outpatient surgery and radiology services

Hospital Outpatient Quality Reporting Program

NQS Priority	Number of Measures in Hospital Outpatient QRP		
	Implemented/ Finalized*	Proposed for Rule**	2016 MUC List
Effective Prevention and Treatment	10	1	2
Making Care Safer	2	0	1
Communication/Care Coordination	3	1	0
Best Practice of Healthy Living	0	0	0
Making Care Affordable	8	0	0
Patient and Family Engagement	1	1	0
Not Assignable	1	0	0

**Implemented/Finalized: Quality measures implemented/finalized for data collection.* ***Proposed: Quality measures proposed for data collection.*

Measure Needs: Reduction of risk in the delivery of health care, patient and family engagement in care, transition of care and more effective health system navigation, and reduction of unexpected/emergency visits or admissions.

55

HOQR: Current Program Measure Set

Type	NQF #	Measure Title	NQF Status	National Rate
Process	0498	Door to Diagnostic Evaluation by a Qualified Medical Professional	Failed Maintenance Endorsement	25 Minutes
	0662	Median Time to Pain Management for Long Bone Fracture	Failed Maintenance Endorsement	52 Minutes
	0496	Median time from ED Arrival t o ED Departure for Discharged ED Patients	Endorsed	148 Minutes
Structural	0499	Left Without Being Seen	Failed Maintenance Endorsement	2%
Efficiency	0289	Median Time to ECG	Failed Maintenance Endorsement	7 Minutes
Process	0287	Median Time to Fibrinolysis	Failed Maintenance Endorsement	56%
	0288	Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	Failed Maintenance Endorsement	58%
	0290	Median Time to Transfer to Another Facility for Acute Coronary Intervention	Endorsed	57 Minutes
	0286	Aspirin at Arrival	Failed Maintenance Endorsement	0.96
	0661	ED- Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 Minutes of Arrival	Endorsed	0.68
Efficiency	9999	Mammography Follow-Up Rates	Failed Initial Endorsement	8.9%
	0513	Thorax CT- Use of Contrast Material	Endorsed	2.1%
	9999	Abdomen CT - Use of Contrast Material	Failed Initial Endorsement	8.4%
	9999	Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)	Failed Initial Endorsement	2.9%
	0669	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	Endorsed	4.8%
Outcome	0514	MRI Lumbar Spine for Low Back Pain	Endorsed	39.5%
Process	1822	External Beam Radiotherapy for Bone Metastases	Endorsed	
Process	0658	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Endorsed	74%
	0659	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	Endorsed	80%
Outcome	2539	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	Endorsed	
Structural	9999	Safe Surgery Checklist Use	Not Endorsed	
	9999	Hospital Outpatient Department Volume on Selected Outpatient Surgical Procedures	Not Endorsed	
Outcome	1536	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	Endorsed	
Structural	0489	The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data Elements	Failed Maintenance Endorsement	
	9999	Tracking Clinical Results between Visits	Not Endorsed	
Process	0431	Influenza Vaccination Coverage among Healthcare Personnel	Endorsed	
Outcome	2936	Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	Failed Initial Endorsement	
	2687	Hospital Visits after Hospital Outpatient Surgery	Endorsed	
	N/A	OAS CAHPS (five measures)	Never Submitted	

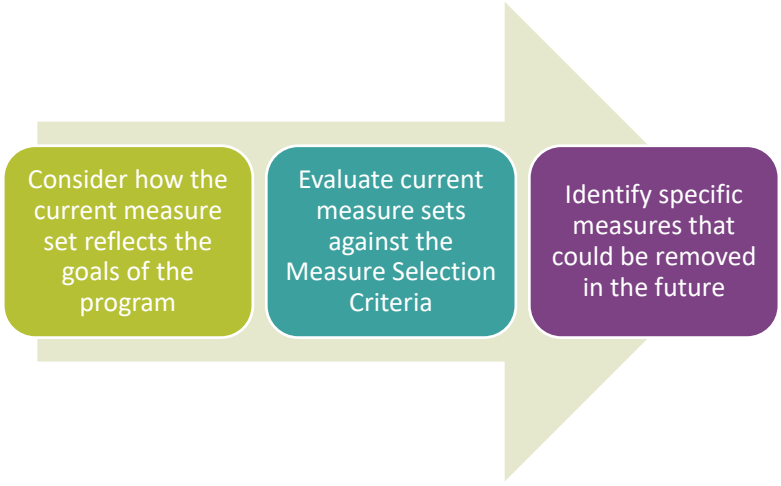
Hospital Outpatient Quality Reporting Program (HOQR)

Lee Fleisher, Individual Subject Matter Expert
Jack Jordan, Individual Subject Matter Expert

- **Consent Calendar 5:**
  - *Median Time from ED Arrival to ED Departure for Discharged ED Patients (MUC16-55)*
  - *Median Time to Pain Management for Long Bone Fracture (MUC16-56)*
  - *Safe Use of Opioids – Concurrent Prescribing (MUC16-167) —Pulled for discussion by R. Sean Morrison*

Feedback on Current Measure Sets for ESRD QIP, PCHQR, ASCQR, IPFQR, and OQR

Provide Feedback on Current Measure Sets



Potential Criteria for Removal

1	The measure is not evidence-based and is not linked strongly to outcomes
2	The measure does not address a quality challenge (i.e. measure is topped out)
3	The measure does not utilize measurement resources efficiently or contributes to misalignment
4	The measure cannot be feasibly reported
5	The measure is not NQF-endorsed or is being used in a manner that is inconsistent with endorsement
6	The measure has lost NQF-endorsement
7	Unreasonable implementation issues that outweigh the benefits of the measure have been identified
8	The measure may cause negative unintended consequences
9	The measure does not demonstrate progress toward achieving the goal of high-quality, efficient healthcare

Public Comment

Wrap Up and Next Steps

Kate McQueston, Project Manager

Agenda – Day 2

- Review Day 1
- PROMIS Discussion
- Pre-Rulemaking Input:
  - *Hospital Inpatient Quality Reporting (IQR) Program and Medicare and Medicaid EHR Incentive Program for Eligible Hospitals and Critical Access Hospitals (CAHs)*
  - *Hospital Value-Based Purchasing (VBP)*
- Measure Gaps and Feedback on Current Measure Sets for IQR & VBP
- Opportunity for Public Comment
- Adjourn Day 2

NATIONAL QUALITY FORUM

Measure Applications Partnership

Hospital Workgroup In-Person Meeting
Day 2

December 8-9, 2016

Agenda – Day 2

- Review Day 1
- PROMIS Discussion
- Pre-Rulemaking Input:
  - *Hospital Inpatient Quality Reporting (IQR) Program and Medicare and Medicaid EHR Incentive Program for Eligible Hospitals and Critical Access Hospitals (CAHs)*
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- Adjourn Day 2

PROMIS Discussion

Ashley Wilder Smith, PhD, MPH, National Cancer Institute

PROMIS®: Applying State-of-the-Science PROs to Quality Measurement

Ashley Wilder Smith, PhD, MPH & Roxanne Jensen, PhD
Outcomes Research Branch
National Cancer Institute / National Institutes of Health

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December, 2016

Patient Reported Outcomes Measurement Information System®

PRO system: brief, precise, valid, reliable fixed or tailored tools for patient-reported health status in physical, mental, and social well-being for adult & pediatric populations

Advantages: Disease-agnostic, Flexible, Adaptable, Low burden, Comparable, Accessible

Development: Item Response Theory (IRT) for construction

Standardized: One metric (T-score, Mean=50, SD=10; reference=US population)

PROMIS is Domain specific, not Disease or Setting specific

A **domain** is the specific feeling, function or perception you want to measure.

Cuts across different diseases and facilities

Examples

- **Fatigue**
- **Pain**
- **Anxiety**
- **Physical Function**
- **Sleep Disturbance**
- **Global Health**
- **Participation in Social Role**

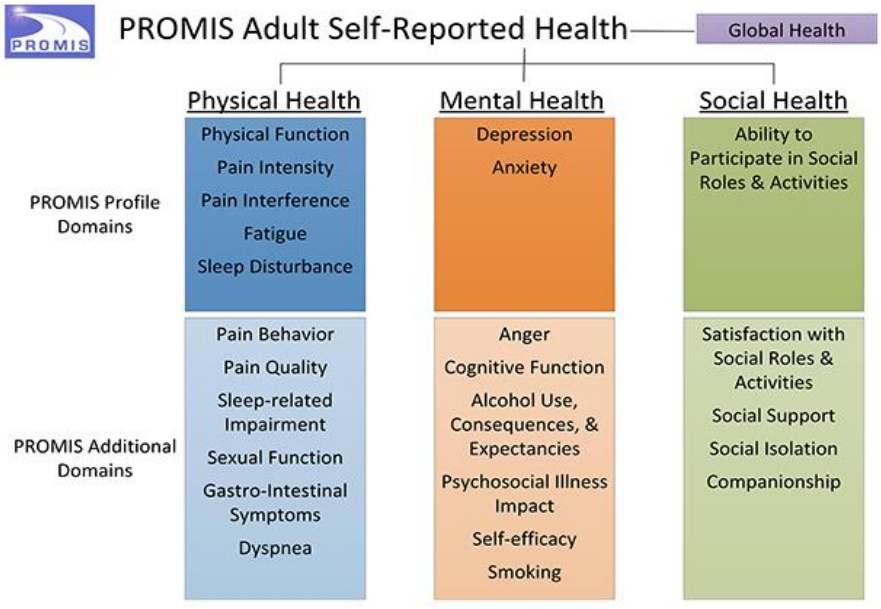
Constructed using Item Response Theory

IRT Methodology Used To:

- Develop and evaluate groups of questions called "item banks"
- Evaluate properties and refine items
- Score individuals
- Link multiple measures onto a common scale

An **item bank** is a large collection of items (questions) measuring a single domain.

Any and all items can be used to provide a score for that domain.



www.healthmeasures.net/explore-measurement-systems/promis/intro-to-promis/list-of-adult-measures

HealthMeasures: What is Available?

- Fixed Questionnaires: Short Forms (download pdfs)
  - "Ready made" or "Make your own"
- Individually "tailored" electronic questionnaires (Computerized Adaptive Tests, CAT)
  - Next item administered depends on previous answer
- Computer platforms (e.g., REDCap)
- Application Programing Interface (API)
- Tablet Distribution (currently iPad)
- http://www.healthmeasures.net/explore-measurement-systems/promis/obtain-administer-measures

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COMPREHENSIVE CANCER CENTER

Part II: PROMIS in the Real World

PATIENT CARE
RESEARCH
EDUCATION
COMMUNITY

NCI CCC A Comprehensive Cancer Center Designated by the National Cancer Institute

http://lombardi.georgetown.edu
Lombardi CancerLine: 202.444.4000

Before PROMIS: Selecting a PRO Tool

…So you want to Measure Physical Function

1. How detailed?
2. How many items?
3. Who do you want to compare to:
   - General Population?
     HAQ (34), SF-12
   - Cancer Patients?
     FACT-G (27) ,EORTC QLQ-C-30

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Before PROMIS: Potential Issues

- Response Burden
- Comparability Beyond Study Sample
- PRO Tool Sensitivity

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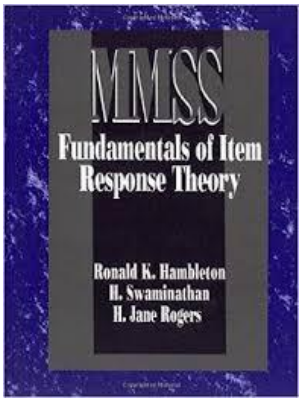
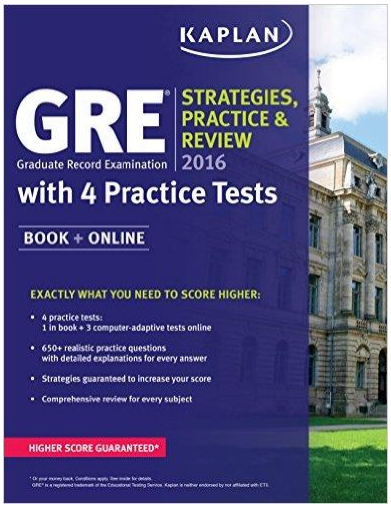
New Methods in Measurement Theory





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After PROMIS: Selecting a PRO Tool

- Administration Format? Computer or Paper
- Administration Method? Fixed or Adaptive
- Established PROMIS Short Form? 4, 6, 8,10, 20
- Create your own? 124 questions available
- Number of Items on Tool? 3 -124

Then: Create and Administer

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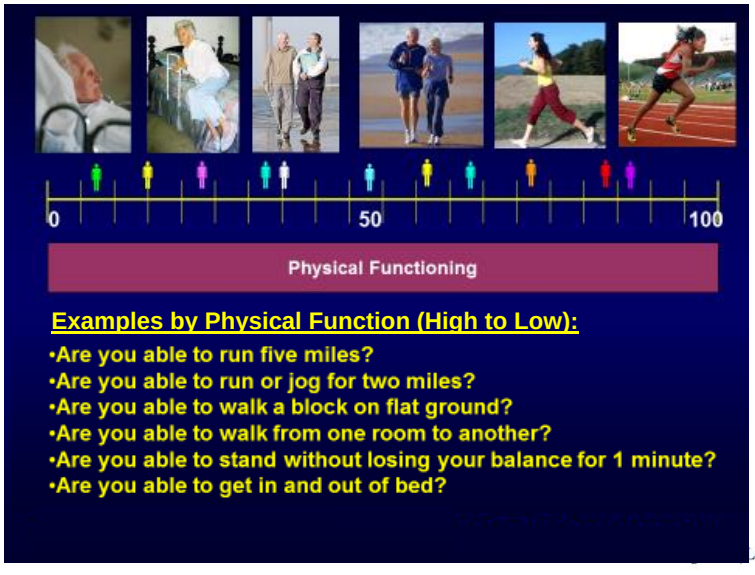
Flexibility: Lots of Options Available



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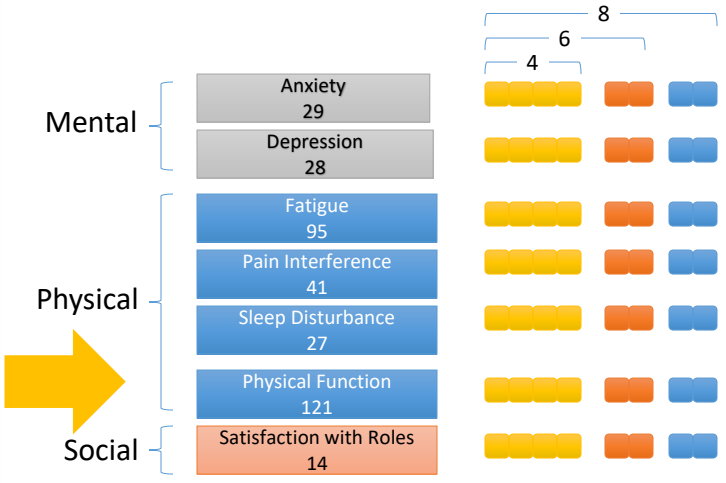
Flexibility: PROMIS Short Forms



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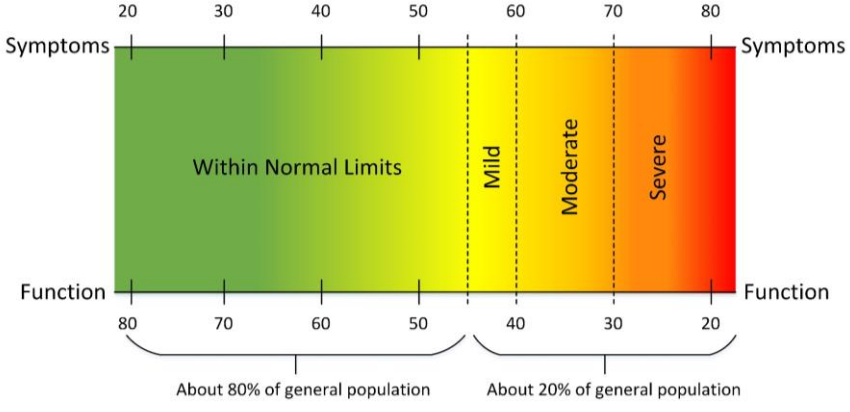
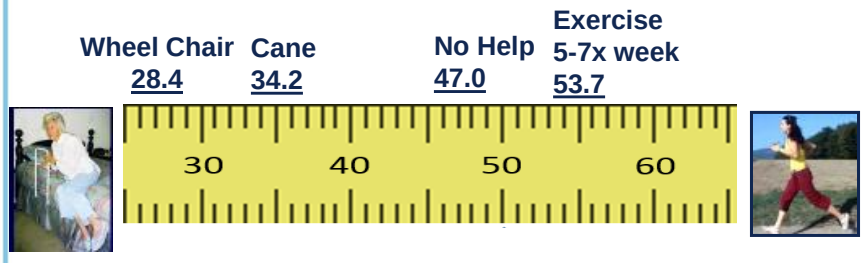
Interpretability: All PF Scores, One Scale



*These are general guidelines to aid in interpreting PROMIS T-scores.
Within a given condition or PROMIS domain, thresholds may differ.

Interpretability: All PF Scores, One Scale

- T-Score (Reference = U.S. General Population)
  - 50 = U.S. General Population Average
  - 10 = 1 Standard Deviation (for the U.S. Population)



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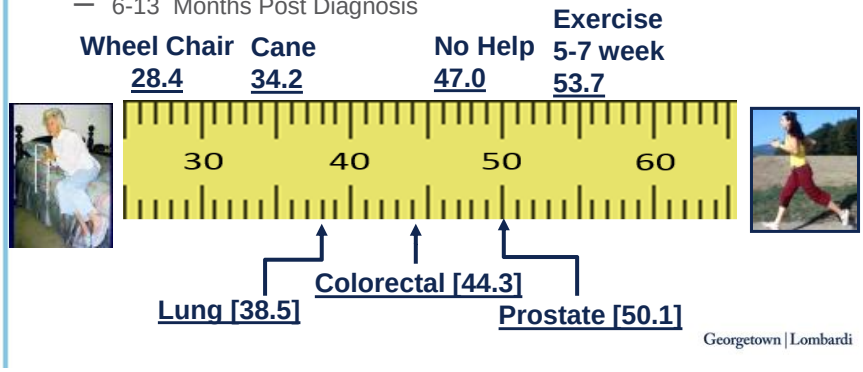
Interpretability: All PF Scores, One Scale

- T-Score (Reference = U.S. General Population)
  - 50 = U.S. General Population Average
  - 10 = 1 Standard Deviation (for the U.S. Population)
- Cancer-Specific U.S. PROMIS PF Reference Values
  - Adjusted to reflect U.S. cancer incidence rates
  - 6-13 Months Post Diagnosis



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Interpretability: All PF Scores, One Scale

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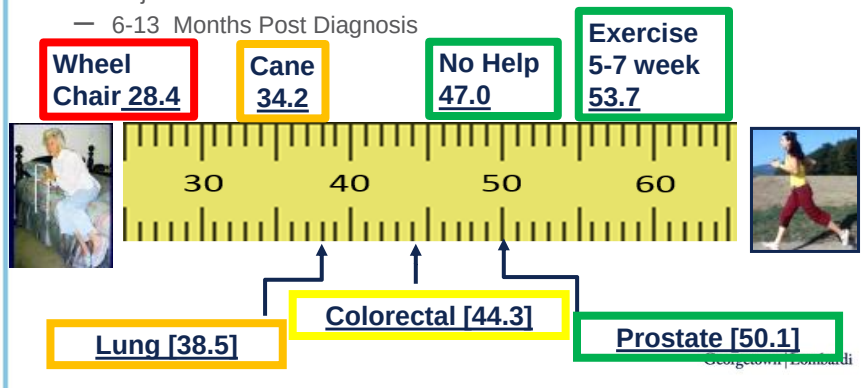
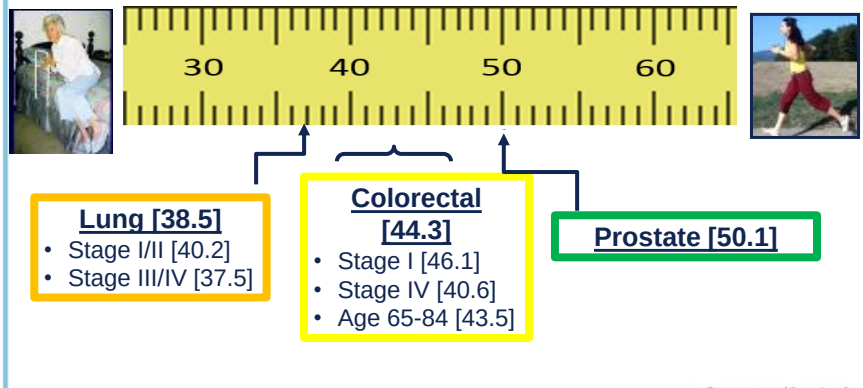


Comparability: All Scores, One Scale

- T-Score (Reference = U.S. General Population)
  - 50 = U.S. General Population Average
  - 10 = 1 Standard Deviation



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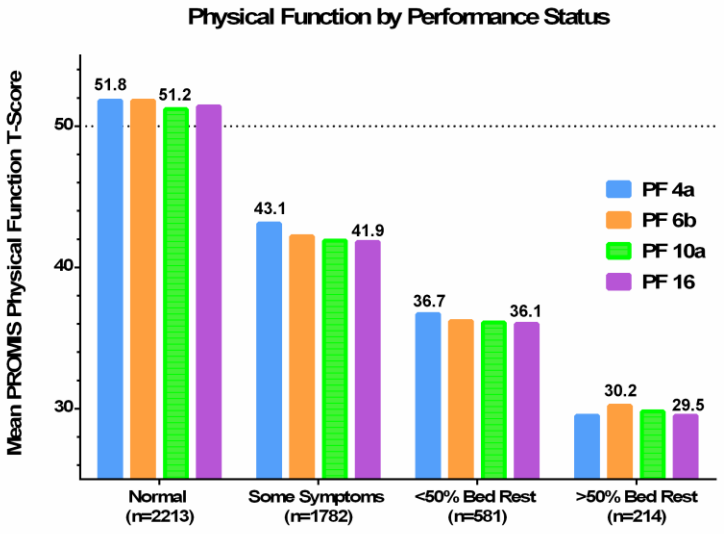
Known Groups: By Short Form



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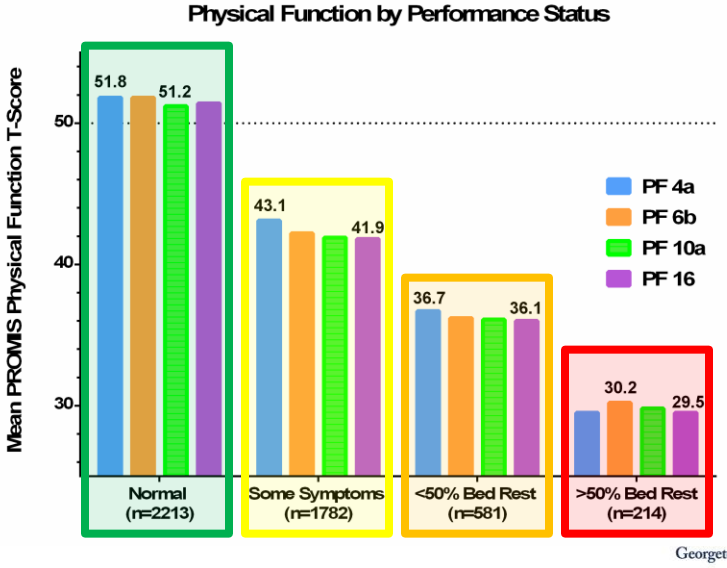
Known Groups: By Short Form



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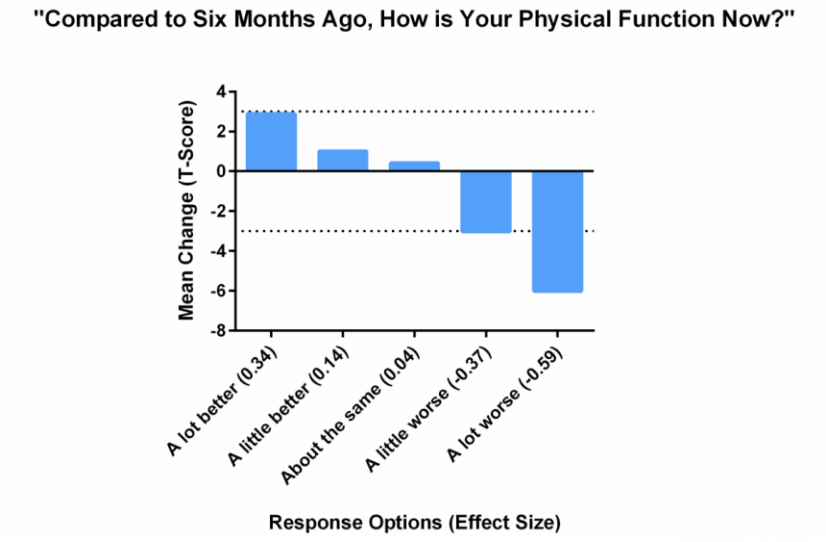
Responsiveness: Retrospective Anchor



Use in Clinical Settings

- Increasing adoption for Clinical Care and Treatment decision-making
- Earliest Adopters: Orthopedics and Oncology settings (out-patient, also in-patient)
- Availability via EHR Vendors:
  - Availability in Epic (Spring 2017 release of …)
  - Availability in Cerner (Coming… 2017)

Example: Potential Use in PAC Settings

Possible response to the IMPACT Act

Approach could consider PROMIS items from domains including

- Cognitive Function
- Anxiety
- Physical Function, Mobility
- Fatigue
- Sleep Disturbance
- Social Role Functioning
- Depression
- Pain

Enable calculation of domain-level self-assessment score

Contribute to calculation of self-report Profile score

Enable crosswalking of CMS items to PROMIS scales

For more info

Ashley.Smith@nih.gov

www.healthmeasures.net
www.nihpromis.org

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Hospital Inpatient Quality Reporting Program (IQR) and Medicare and Medicaid EHR Incentive Program for Eligible Hospitals and Critical Access Hospitals (CAHs)

Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:**
  - Pay for reporting and public reporting
- **Incentive Structure:**
  - Hospitals that do not participate or meet program requirements receive a ¼ reduction of the annual payment update
- **Program Goals:**
  - Progress towards paying providers based on the quality, rather than the quantity of care they give patients
  - Interoperability between EHRs and CMS data collection
  - To provide consumers information about hospital quality so they can make informed choices about their care

Medicare and Medicaid EHR Incentive Program for Eligible Hospitals and Critical Access Hospitals (CAHs)

- **Program Type & Incentive Structure:**
  - Medicare EHR Incentive Program:
    - » Eligible hospitals & CAHs that do not successfully demonstrate meaningful use = reduced Medicare payments
  - Medicaid EHR Incentive Program:
    - » Eligible hospitals & CAHs that *only* participate in the Medicaid EHR Incentive Program and do *not* bill Medicare are *not* subject to Medicare payment adjustments
  - Medicare and Medicaid EHR Incentive Programs:
    - » Eligible hospitals & CAHs that participate in *both* the Medicare and Medicaid EHR Incentive Programs will be subject to the payment adjustments *unless* they successfully demonstrate meaningful use under one of these programs
- **Program Goals:**
  - Promote the adoption and meaningful use of interoperable health information technology (HIT) and qualified health records (EHRs)
  - Accelerate the adoption of HIT and utilization of qualified EHRs

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Hospital Inpatient Quality Reporting & Medicaid and Medicare EHR Incentive Program for Eligible Hospitals/Critical Access Hospitals

NQS Priority	Number of Measures in Hospital Inpatient QRP & Medicare and Medicaid EHR Incentive Program EH/CAH		
	Implemented/ Finalized*	Proposed for Rule**	2016 MUC List
Effective Prevention and Treatment	21 (14)	-1 (-6)	8 (3)
Making Care Safer	19 (6)	0 (-4)	7 (2)
Communication/Care Coordination	13 (2^)	1 (0)	10 (1)
Best Practice of Healthy Living	1 (0)	0 (0)	3 (1)
Making Care Affordable	8 (2)	3 (-2)	0 (0)
Patient and Family Engagement	4 (5)	-1 (-1)	4 (0)
Not Assignable	2 (0)	-2 (0)	0 (0)

**Implemented/Finalized: Quality measures implemented/finalized for data collection. **Proposed: Quality measures proposed and proposed for removal in FY 2017 IPPS Proposed Rule. ^ All EHR Incentive Program eCQMs, represented in parenthesis, are reportable in both the EHR incentive and IQR program except ED-3—Median time from ED arrival to ED discharge for discharged patients which may be submitted to EHR Incentive Program.*

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Measure Needs: Adverse drug events, cancer, behavioral health, care transitions, palliative and end of life care, and medication reconciliation.

IQR –EHR Incentive Program Current Measure Set

Type	NQF #	Measure Title	NQF Status	National Rate
		NHSN		
Outcome	0138	NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Endorsed	N/A
	1717	NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Endorsed	N/A
	0139	NHSN Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	Endorsed	N/A
	0753	ACS-CDC Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	Endorsed	N/A
	1716	NHSN Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	Endorsed	N/A
Process	0431	Influenza Vaccination Coverage Among Healthcare Personnnel	Endorsed	86%
		Claims-based Payment		
Cost/Resource Use	2431	Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI)	Endorsed	$ 22,760
	2436	Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure (HF)	Endorsed	$ 15,959
	2579	Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode -of Care for Pneumonia	Endorsed	$ 14,817
	2158	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	Endorsed	
	N/A	Hospital-Level, Risk-Standardized Payment Associated with a 90-Day Episode -of Care for Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)	Never Submitted	
	N/A	Cellulitis Clinical Episode-Based Payment Measure	Never Submitted	
	N/A	Gastrointestinal (GI) Hemorrhage Clinical Episode-Based Payment Measure	Never Submitted	
	N/A	Kidney/Urinary Tract Infection Clinical Episode-Based Payment Measure	Never Submitted	
	N/A	Aortic Aneurysm Procedure clinical episode-based payment (AA Payment) Measure*	Never Submitted	
	N/A	Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure*	Never Submitted	
	N/A	Spinal Fusion Clinical Episode-Based Payment Measure*	Never Submitted	

IQR –EHR Incentive Program Current Measure Set

Type	NQF #	Measure Title	NQF Status	National Rate
		Claims-based Outcome		
Outcome	0230	Hospital 30-day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization	Endorsed	14.1%
	2558	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) surgery	Endorsed	3.2%
	1839	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	Endorsed	8.0%
	0229	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) hospitalization.	Endorsed	12.1%
	0468	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization	Endorsed	16.3%
	0505	Hospital 30-Day All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization	Endorsed	16.8%
	2515	Hospital 30-Day, All-Cause, Unplanned, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery	Endorsed	14.4%
	1891	Hospital-Level, 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	Endorsed	20.0%
	0330	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization.	Endorsed	21.9%
	1789	Hospital-Wide All-Cause, Unplanned Readmission Measure (HWR)	Endorsed	15.6%
	0506	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization.	Endorsed	17.1%
	N/A	30-Day Risk-Standardized Readmission Rate Following Stroke Hospitalization	Withdrawn	12.5%
	1551	Hospital-level 30 day, all-cause, risk-standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)	Endorsed	4.6%
	2881	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	Currently under review	
	2880	Excess Days in Acute Care after Hospitalization for Heart Failure	Currently under review	
	2882	Excess Days in Acute Care after Hospitalization for Pneumonia*	Currently under review	
	1550	Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA).	Endorsed	3.0%
	0351	Death among Surgical Inpatients with Serious, Treatable Complications	Endorsed	136.48 per 1,000 patient discharges
	0531	Patient Safety for Selected Indicators, PSI 90 (Iatrogenic pneumothorax, perioperative PE or DVT, post-op wound dehiscence, accidental puncture or laceration, pressure ulcers, central venous catheter-related blood stream infection, post-op hip fracture, post-op sepsis)	See updated specifications below	0.90[1]
	0531	Patient Safety for Selected Indicators Composite Measure (pressure ulcers, iatrogenic pneumothorax rate, post-op hip fracture rate, post-op hemorrhage or hematoma, physiologic and metabolic derangement, post-op respiratory failure, post-op PE or DVT, post-op sepsis, post-op wound dehiscence, and accidental puncture or laceration rate), Modified PSI 90 (Updated Title: Patient Safety and Adverse Events Composite) - *Finalized for FY 2019 Payment Determination and Subsequent Years*	Endorsed	N/A

IQR –EHR Incentive Program Current Measure Set

Type	NQF #	Measure Title	NQF Status	National Rate
		Electronic Clinical Quality Measures (eCQMs)		
Outcome	N/A	Median Time from ED Arrival to ED Departure for Admitted ED Patients*	Never Submitted	
Process	N/A	Admit Decision Time to ED Departure Time for Admitted Patients*	Never Submitted	
	N/A	Primary PCI Received within 90 minutes of hospital arrival	Never Submitted	
	N/A	Home Management Plan of Care Document Given to Patient/Caregiver	Never Submitted	
	3058	Hearing screening before hospital discharge	Endorsed	
	2829	Elective Delivery*	Endorsed	
	2830	Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother's Choice	Endorsed	
	3042	Discharged on Antithrombotic Therapy	Failed Initial Endorsement	
	3043	Anticoagulation Therapy for Atrial Fibrillation/Flutter	Failed Initial Endorsement	
	3045	Antithrombotic Therapy by the End of Hospital Day Two	Failed Initial Endorsement	
	3046	Discharged on Statin Medication	Failed Initial Endorsement	
	N/A	Stroke Education	Never Submitted	
	3047	Assessed for Rehabilitation	Failed Initial Endorsement	
	N/A	Venous Thromboembolism Prophylaxis	Never Submitted	
	N/A	Intensive Care Unit Venous Thromboembolism Prophylaxis	Never Submitted	
Finalized for removal FY 2019		Aspirin Prescribed at Discharge for AMI		
		Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival		
		Statin Prescribed at Discharge		
		Healthy Term newborn		
		Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients		
		Prophylactic Antibiotic Received within 1 Hour Prior to Surgical Incision		
		Prophylactic Antibiotic Selection for Surgical Patients		
		Urinary Catheter Removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with Day of Surgery Being Day Zero.		
		Thrombolytic Therapy		
		Venous Thromboembolism Patients with Anticoagulation Overlap Therapy		
		Venous Thromboembolism Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol (or Nomogram).		
		Venous Thromboembolism Discharge Instructions.		
		Incidence of Potentially Preventable VTE		

IQR –EHR Incentive Program Current Measure Set

Type	NQF #	Measure	NQF Status	National Rate
		Chart-abstracted		
Outcome	0495	Median Time from ED Arrival to ED Departure for Admitted ED Patients*	Endorsed	
Process	0497	Admit Decision Time to ED Departure Time for Admitted Patients*	Endorsed	280 Minutes
	1659	Influenza immunization	Currently under review	94%
	0469	Elective Delivery*	Endorsed	3%
Composite	0500	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	Endorsed	
Outcome	0376	Incidence of Potentially Preventable Venous Thromboembolism	Failed Maintenance Endorsement	
Finalized for removal FY 2019		Thrombolytic Therapy		
		VTE Discharge Instructions		
		Patient Survey		
Survey	0166	HCAHPS - Hospital Consumer Assessment of Healthcare Providers and Systems Survey	Endorsed	
	0228	3-Item Care Transitions Measure (CTM-3)	Endorsed	
		Structural Measures		
Structural	N/A	Hospital Survey on Patient Safety Culture	Never Submitted	
	N/A	Safe Surgery Checklist Use	Never Submitted	
Finalized for removal FY 2019		Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care		
		Participation in a Systematic Clinical Database Registry for General Surgery		

Public Comment

IQR - EHR Incentive Program

Marsha Manning, University of Michigan
David Engler, America's Essential Hospitals
Jennifer Eames Huff, Mothers Against Medical Error

- **Consent Calendar 6:**
  - Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention (MUC16-178)
  - Alcohol Use Screening (MUC16-179)
  - Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and Alcohol & Other Drug Use Disorder Treatment at Discharge (MUC16-180)
  - Patient Panel Smoking Prevalence IQR (MUC16-68)

IQR - EHR Incentive Program

Martin Hatlie, Project Patient Care
Mimi Huizinga, Premier, Inc.
Kimberly Glassman, Nursing Alliance for Quality Care
Nancy Foster, American Hospital Association

- **Consent Calendar 7:**
  - Follow-Up After Hospitalization for Mental Illness (MUC16-165)
  - Measure of Quality of Informed Consent Documents for Hospital-Performed, Elective Procedures (MUC16-262)
  - Communication about Pain During the Hospital Stay (MUC16-263) *[Questions HP-1, HP-2, and HP-3]*

IQR - EHR Incentive Program

Brock Slabach, National Rural Health Association
Andrea Benin, Children's Hospital Association
Wei Ying, Blue Cross Blue Shield of Massachusetts
Karen Shehade, Medtronic-Minimally Invasive Therapy Group

- **Consent Calendar 8:**
  - Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment (MUC16-372)
  - Completion of a Malnutrition Screening within 24 Hours of Admission (MUC16-294)
  - Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 Hours of a Malnutrition Screening (MUC16-296)
  - Appropriate Documentation of a Malnutrition Diagnosis (MUC16-344)

IQR - EHR Incentive Program

Gregory Alexander, Individual Subject Matter Expert
Lindsey Wisham, Individual Subject Matter Expert
Lee Fleisher, Individual Subject Matter Expert
Jack Jordan, Individual Subject Matter Expert

- **Consent Calendar 9:**
  - Tobacco Use Screening (TOB-1) (MUC16-50)
  - Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting (MUC16-41)
  - Influenza Immunization (IMM-2) (MUC16- 53)
  - Safe Use of Opioids – Concurrent Prescribing (MUC16-167)

Hospital Value-Based Purchasing Program (VBP)

Hospital Value-Based Purchasing Program (HVBP)

- Program Type:
  - Pay for performance
- Incentive Structure:
  - The amount withheld from reimbursements increases over time:
    - » FY 2016: 1.75%
    - » FY 2017 and future fiscal years: 2.0%
- Program Goals:
  - Improve healthcare quality by realigning hospitals' financial incentives
  - Provide incentive payments to hospitals that meet or exceed performance standards

Hospital Value-Based Purchasing Program

NQS Priority	Number of Measures in Hospital Value-Based Purchasing Program		
	Implemented / Finalized*	Proposed for Rule**	2016 MUC List
Effective Prevention and Treatment	5	1	0
Making Care Safer	7	0	0
Communication/Care Coordination	1	0	1
Best Practice of Healthy Living	0	0	0
Making Care Affordable	1	2	0
Patient and Family Engagement	1	0	0

**Implemented/Finalized: Quality measures implemented/finalized for data collection.* ***Proposed: Quality measures proposed and proposed for removal in FY 2017 IPPS Proposed Rule.*

Measure Needs: Adverse drug events, cancer, behavioral health, care transitions, palliative and end of life care, and medication reconciliation.

VBP: Current Measure Set

NQF #	Measure Title	NQF Status
	Safety Measures	
0138	NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Endorsed
1717	NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Endorsed
0139	NHSN Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	Endorsed
0753	ACS-CDC Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	Endorsed
1716	NHSN Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	Endorsed
0531	Patient Safety for Selected Indicators (PSI 90)	Endorsed
0469	Elective Delivery	Endorsed
	Clinical Care Measures	
0505	Hospital 30-Day All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization	Endorsed
0330	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization.	Endorsed
0506	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization.	Endorsed
1551	Hospital-level 30 day, all-cause, risk-standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)	Endorsed
	Efficiency and Cost Reduction Measure	
2158	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	Endorsed
	Person and Community Engagement Domain	
0166	HCAHPS - Hospital Consumer Assessment of Healthcare Providers and Systems Survey	Endorsed

VBP: Current Measure Set

NQF #	Measure Title	NQF Status
	Clinical Care Domain	
0230	Hospital 30-day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization	Endorsed
0229	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) hospitalization.	Endorsed
0468	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization	Endorsed
1839	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	Endorsed
1550	Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA).	Endorsed
	Efficiency and Cost Reduction Measures	
2431	Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI)	Endorsed
2436	Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure (HF)	Endorsed
	Clinical Care Domain	
2558	Hospital 30-Day All-Cause Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery (CABG)	Endorsed

Hospital Value-Based Purchasing Program (HVBP)

Kimberly Glassman, Nursing Alliance for Quality Care
Nancy Foster, American Hospital Association

- **Consent Calendar 11:**
  - Communication about Pain During the Hospital Stay (MUC16-263) *[Questions HP-1, HP-2, and HP-3]*

Feedback on Current Measure Sets for IQR, HACs, Readmissions, and VBP

Previously Identified Crosscutting Gaps

Previously Identified Gaps

Hospital Inpatient Reporting Program

- Obstetrics
- Pediatrics
- Measures addressing the cost of drugs, particularly specialty drugs
- All-harm or global-harm eMeasure

Previously Identified Gaps

Hospital Acquired Conditions

- Adverse drug events
- Ventilator associated events
- Additional surgical site infection locations
- Outcome risk-adjusted measures
- Diagnostic Errors
- All-cause harm

Hospital-Acquired Condition Reduction Program (HACRP)

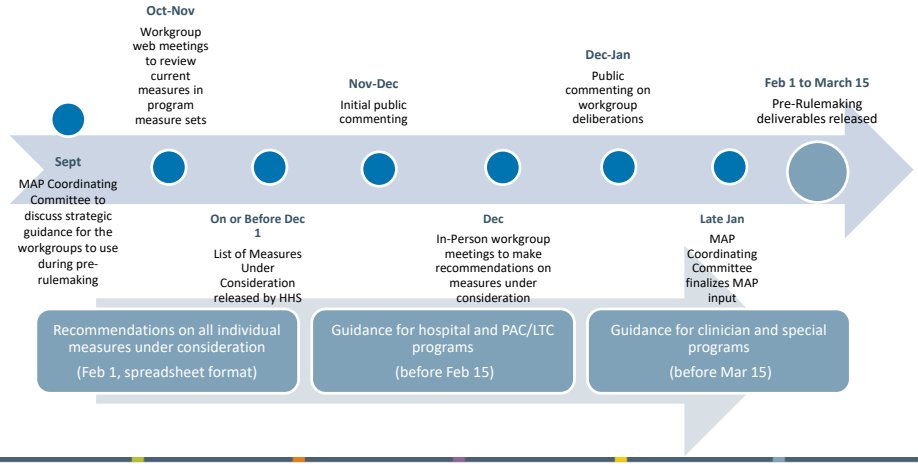
Type	NQF #	Measure Title	NQF Status	National Rate
Composite	0531	Patient Safety for Selected Indicators (PSI90 - Composite) (Iatrogenic pneumothorax, perioperative PE or DVT, post-op wound dehiscence, accidental puncture or laceration, pressure ulcers, central venous catheter-related blood stream infection, post-op hip fracture, post-op sepsis)	See updated specifications below	0.90[1]
Composite	0531	Patient Safety for Selected Indicators Composite Measure (pressure ulcers, iatrogenic pneumothorax rate, post-op hip fracture rate, post-op hemorrhage or hematoma, physiologic and metabolic derangement, post-op respiratory failure, post-op PE or DVT, post-op sepsis, post-op wound dehiscence, and accidental puncture or laceration rate), Modified PSI 90 (Updated Title: Patient Safety and Adverse Events Composite) - Finalized for FY 2017	Endorsed	
Outcome	0138	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Endorsed	
Outcome	0139	National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	Endorsed	
Outcome	0753	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	Endorsed	
Outcome	1717	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Endorsed	
Outcome	1716	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	Endorsed	

Hospital Readmissions Reduction Program (HRRP)

Type	NQF #	Measure Title	NQF Status	National Rate
Outcome	0330	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization	Endorsed	21.9%
	0505	Hospital 30-Day All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization	Endorsed	16.8%
	0506	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization	Endorsed	17.1%
	1551	Hospital-level 30 day, all-cause, risk-standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)	Endorsed	4.6%
	1891	Hospital-Level, 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	Endorsed	20.0%
	2515	Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary Artery Bypass Graft (CABG) Surgery	Endorsed	14.4%

Public Comment

MAP Approach to Pre-Rulemaking
A look at what to expect



Next Steps: Upcoming Activities

In-Person Meetings

- Hospital Workgroup – **December 8-9**
- Clinician Workgroup – **December 12-13**
- PAC/LTC Workgroup – **December 14-15**
- Coordinating Committee – **January 24-25**

Web Meetings

- Dual Eligible Beneficiaries Workgroup – January 10, 2017, 12-2pm ET
  - *Reviews recommendations from other groups and provide cross-cutting input during the second round of public comment*

Public Comment Period #2: December 21st 2016—January 12th, 2017

Adjourn