

Measure Development & Endorsement Agenda Project

September 23, 2010

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Meeting Objectives

- Provide overview of committee charge
- Set context for, and explain committee's work
- Prepare public audience for public comment
- Set up next steps

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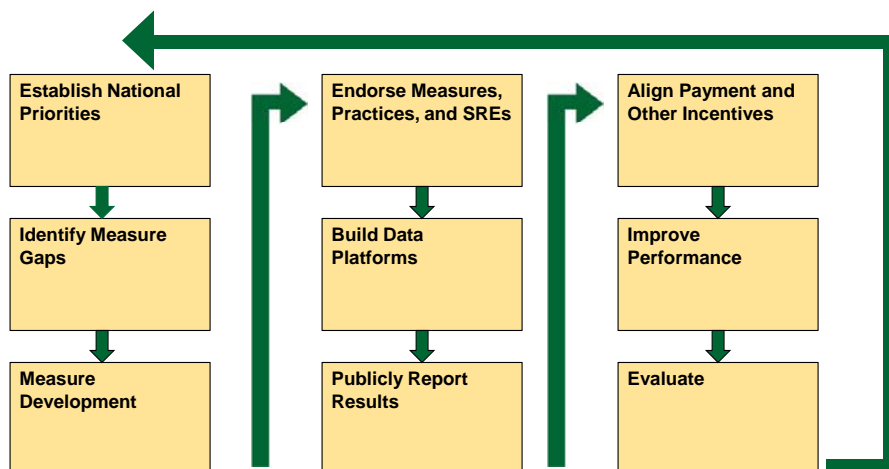
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Meeting Overview

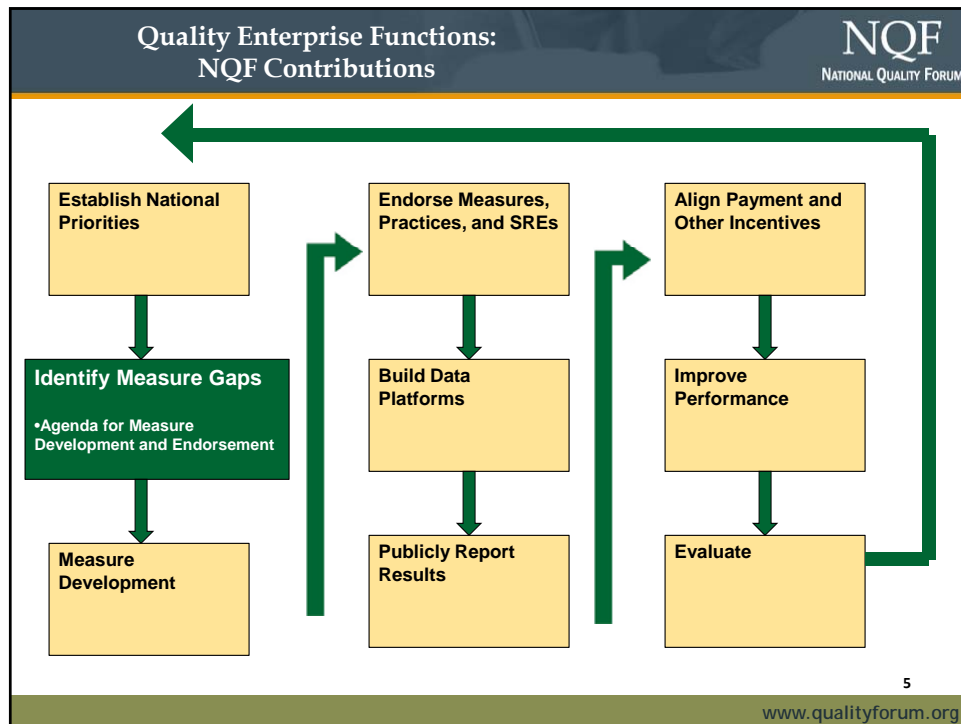
- Overview: Measure Development and Endorsement Agenda Project
- Measure Gap Streams
- Cross-Check Streams
- Identification and Prioritization of Consolidated List of Measure Gaps
- Open Q&A Session
- Next Steps

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Quality Enterprise Functions: NQF Contributions



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**Building an Agenda for
Measure Development and Endorsement**

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Measure Prioritization Advisory Committee

- Charge
 - Determine priorities for a measure development agenda to address identified gaps in endorsed measures
 - Consider priority conditions
 - Consider cross-cutting national priorities
- Co-Chairs
 - George Isham, HealthPartners
 - Ellen Stovall, National Coalition for Cancer Survivorship

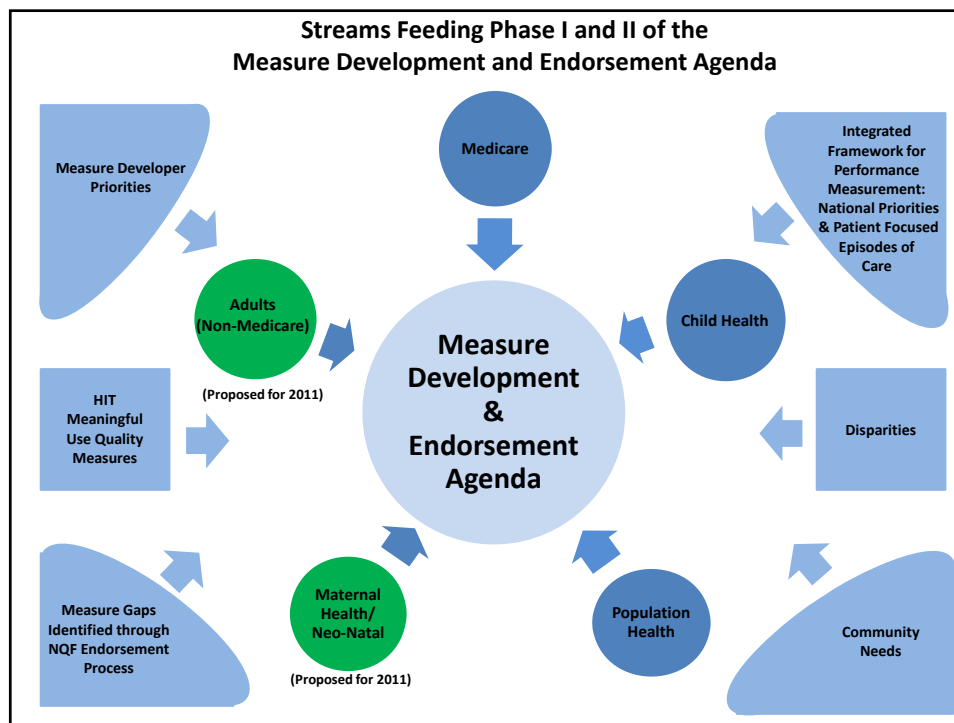
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Background & Context-Setting

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Purpose

- Alignment with the development of a national strategy for health care performance measurement
- Development of a clear agenda to ensure that resources are directed to high leverage areas
- Continuous scan of the environment to identify and make mid-course corrections, as necessary
- Alignment of this work with payment reform and meaningful use in the context of the American Recovery and Reinvestment Act (ARRA) and the Affordable Care Act (ACA) legislation
 - Both of these laws require a robust set of performance measures to serve a variety of needs: meaningful use measures, various new and emerging payment systems, and expanded public reporting.

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Booz Allen Hamilton Environmental Scan of Pipeline Measures

- Booz is currently conducting an Environmental Scan of pipeline performance measures relating to the National Priorities Partnership (NPP) Priorities, including Child Health and Population Health
- The Environmental Scan focuses on two core sources:
 - Interviews with measure developers
 - Website searches of key words based on a taxonomy of defined search terms

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Committee Progress to Date

Feb.
2010

- Convene Measure Prioritization Advisory Committee to prioritize high-impact conditions and identified measure gaps (HHS-specified conditions and dimensions/criteria).

March
2010

- Convene Measure Prioritization Advisory Committee to consider additional measure streams to inform measure development and endorsement agenda.

May
2010

- Convene Measure Prioritization Advisory Committee to explain new streams and proposed process and review child health conditions and risks ranking exercise.

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Committee Progress to Date

June
2010

- Convene Measure Prioritization Advisory Committee to prioritize child health conditions, risks and measure gap areas for child health and population health.

July
2010

- Convene Measure Prioritization Advisory Committee to set context for the HIT Meaningful Use Quality Measure gap stream, review disparities issues as well as discuss measure developer priorities.

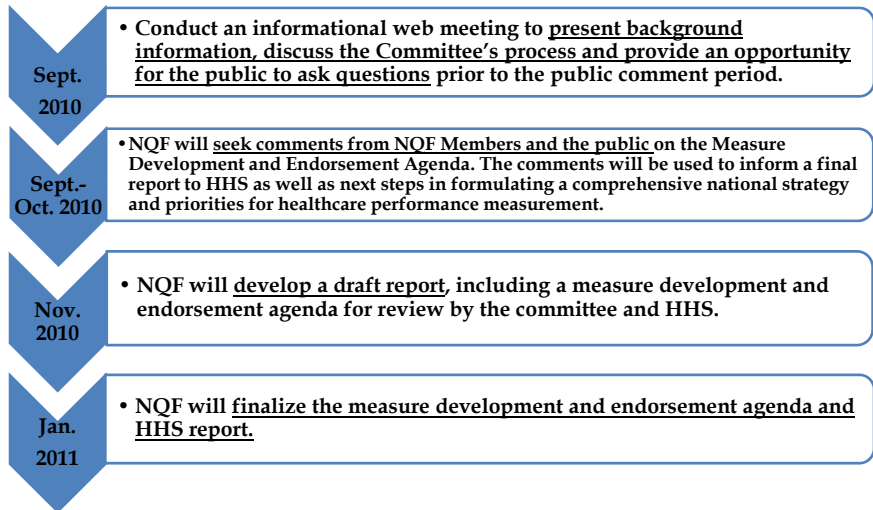
August
2010

- Convene Measure Prioritization Advisory Committee to prioritize a consolidated list of gap areas and finalize a measure development and endorsement agenda.

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Committee Scope of Work & Timeline



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Public Comment: 4 Key Areas

- General Comments on the Measure Development and Endorsement Agenda project
- Comments on the Prioritized, Consolidated List of Measure Gap Areas and Key Issues
- Comments on the Prioritization of Child Health Conditions, Child Health Measure Gap Areas, and Key Issues
- Comments on the Prioritization of Population Health Measure Gap Areas and Key Issues

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Questions?

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Measure Gaps Streams

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Medicare

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Medicare Conditions and Gap Domains and Sub-Domains

Medicare Conditions

Condition	Votes
1. Major Depression	30
2. Congestive Heart Failure	25
3. Ischemic Heart Disease	24
4. Diabetes	24
5. Stroke/Transient Ischemic Attack	24
6. Alzheimer's Disease	22
7. Breast Cancer	20
8. Chronic Obstructive Pulmonary Disease	15
9. Acute Myocardial Infarction	14
10. Colorectal Cancer	14
11. Hip/Pelvic Fracture	8
12. Chronic Renal Disease	7
13. Prostate Cancer	6
14. Rheumatoid Arthritis/Osteoarthritis	6
15. Atrial Fibrillation	5
16. Lung Cancer	2
17. Cataract	1
18. Osteoporosis	1
19. Glaucoma	0
20. Endometrial Cancer	0

Gap Domains

Health Status
Functional Status
Burden on Patients and Families
Productivity
Care Coordination
Communication
Patient Follow-up
Medication Management
Accountability for Care Coordination
Use of Care Plans
Cost/Efficiency
Appropriateness/Efficiency
Direct Costs
Indirect Costs
Patient & Family Engagement
Patient Engagement
Patient Experience and Satisfaction
Shared Decisionmaking
Patient Self-Management
Patient Activation
Population Health
Effective Preventive Services
Healthy Lifestyle Behaviors
Safety
Ambulatory Safety
Medication Adherence/Use
Prevention of Serious Events
Standardized HAI Rates

Gap Sub-Domains

Gap Area	Votes
Appropriateness/Efficiency	23
Communication	13
Patient Follow-up	11
Direct Costs	11
Effective Preventive Services	11
Functional Status	9
Medication Management	8
Accountability for Care Coordination	8
Use of Care Plans	7
Patient Engagement	7
Healthy Lifestyle Behaviors	7
Burden on Patients and Families	6
Patient Experience and Satisfaction	6
Ambulatory Safety	6
Medication Adherence/Use	6
Shared Decisionmaking	5
Patient Self-Management	5
Prevention of Serious Events	5
Indirect Costs	4
Standardized HAI Rates	3
Productivity	2
Patient Activation	2

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- Limitations of a condition-by-condition approach
- Inclusion of upstream risk-factors
- Burden as a criterion for prioritization
- Population-based measurement
- Implementation gaps

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Child Health

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Child Health Conditions and Risks and Gap Domains and Sub-Domains

Child Health Conditions and Risks

Condition and Risk	Votes
Tobacco Use	29
Overweight/Obese (≥85 th percentile BMI for age)	27
Risk of developmental delays or behavioral problems	20
Oral Health	19
Diabetes	17
Asthma	14
Depression	13
Behavior or conduct problems	13
Chronic Ear Infections (3 or more in the past year)	9
Autism, Asperger's, PDD, ASD	8
Developmental delay (diag.)	6
Environmental allergies (hay fever, respiratory or skin allergies)	4
Learning Disability	4
Anxiety problems	3
ADD/ADHD	1
Vision problems not corrected by glasses	1
Bone, joint or muscle problems	1
Migraine headaches	0
Food or digestive allergy	0
Hearing problems	0
Stuttering, stammering or other speech problems	0
Brain injury or concussion	0
Epilepsy or seizure disorder	0
Tourette Syndrome	0

Gap Domains

Gap Domains	Votes
Care Coordination, including Transitions	15
Clinical Effectiveness in Acute and Chronic Care Management	14
Patient, Family, & Caregiver Engagement	12
Population Health including Primary and Secondary Prevention & Communities	12
Overuse (includes waste, efficiency, and appropriateness)	10
Safety	3
Palliative Care	0

Gap Sub-Domains

Gap Sub-Domains	Votes
Domain 1: Patient and Family Engagement	
Shared decision-making	11
Bridge gap between expert and public knowledge	10
Patient/family centered systems of care	8
Communication, respect cultural sensitivity	7
Health literacy	6
Consumer empowerment, including transparency	3
Patient experience with care	3
Patient/family activation	2

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Child Health Gap Sub-Domains (Continued)

Gap Sub-Domains

Domain 2: Care Coordination including Transitions		Domain 4: Clinical Effectiveness in Acute and Chronic Care Management		Domain 6: Overuse	
Having a Medical or "Health Home"	14	Appropriate tests and follow-up	15	Overuse of procedures and surgery	11
Access to referrals and appropriate follow-up	11	Medications (appropriateness, management, adherence)	12	Medication overuse	10
Success/failure rates in handoffs	11	Self care management and support	12	Avoidable ED and hospital readmission	7
Help coordinating care	4	Effective care plans	10	Duplicate testing	2
Effective transition to adult services	2	Burden of Illness, Symptoms & Functional Status	6	Domain 7: Palliative Care	
Domain 3: Population Health including Primary and Secondary Prevention & Communities		Domain 5: Safety		Caregiver/family burden	2
Population health outcomes	15	Adverse events	13	Advance preparations defined and honored	1
Early and continuous screening and appropriate, timely follow-up	12	Patient communication and knowledge regarding consent & safety	2	Pain management and symptom relief	0
Community and neighborhood resources, support and safety	8	Medication and sedation safety	1	Access to supportive services	0
Population health oriented systems of care (needs assessment, shared accountability, etc)	4			Access to spiritual, cultural and psychological needs	0
Health Promotion	2				

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- Considerations for Prioritizing Child Health Conditions, Risks, and Gaps
 - Defining the Child Health Population
 - Approach to Defining Conditions and Risks
- Additional Conditions and Risks
- Lifelong Impact of Child Health and Development
- Factors Affecting Children's Health
 - Caregiver/Parent Engagement
 - Access
 - Family Factors
 - Social and Environmental Factors
- Alignment with CHIPRA

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Population Health

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Population Health Gap Domains and Sub-Domains

Gap Domains	
Gap Domains	Votes
Clinical Preventive Services	9
Lifestyle Behaviors	9
Health Status (Mortality and Healthy Years)	9
Measures of Health Care and Public Health System Performance	6
Other Factors for a Community Health Index (e.g., social determinants and environmental factors)	4

Gap Sub-Domains	
Gap Domains	Votes
Domain 1: Clinical Preventive Services	
Cardiovascular disease prevention	4
Child and adolescent health	3
Cancer prevention	1
Injury prevention	0
Vaccine-preventable illness	0
Domain 2: Lifestyle Behaviors	
Physical Activity	8
Diet	5
Smoking	3
Risky alcohol use	3
Domain 3: Health Status (Mortality and Healthy Years)	
Health status (symptoms, function, and QOL)	13
Wellness/well-being	9
Length and quality of life (healthy life years)	5
Mortality	2
Domain 4: Measures of Health Care and Public Health System Performance	
Coordination of care processes across sectors and care coordination across the patient-focused episode to include community context	10
System infrastructure and policies	8
Domain 5: Other Factors for a Community Health Index	
Environmental factors	2
Social determinants	1

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Population Health: Assumptions and Key Issues

- Defining Communities and Populations
 - Definitions and Scope
 - Accountability and Level of Analysis
- Health Care Delivery and Public Health Integration
- Mental Health
- Clinical Preventive Services
- Healthy Lifestyle Behaviors

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Questions?

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Cross-Check Streams

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Integrated Framework for Performance Measurement

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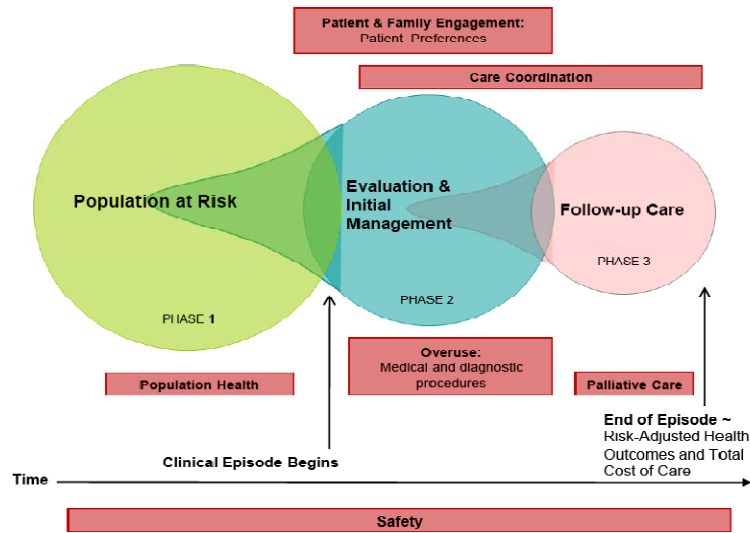
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Cross-Check Stream: Integrated Framework for Performance Measurement

- National Priorities Partnership:
 - Patient and Family Engagement
 - Population Health
 - Safety
 - Care Coordination
 - Palliative and End-of-life Care
 - Overuse
- Patient-focused episodes of care

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HIT Meaningful Use Gaps

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- Develop list of potential measures for each prioritized measure concept:
 - NQF-endorsed measures
 - Measures in the NQF endorsement pipeline
 - Measures in current use by leading health systems
- Identification of measurement gaps

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- Synthesize input from the following sources on measures that may be appropriate for 2013 MU:
 - Input from federal agencies
 - Input from Gretzky group
 - Environmental scan of available EHR-based measures from leading public and private health systems

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MU 2013 Criteria (1)

- **State of readiness:** state of measure development and endorsement as consensus standards by NQF.
- **HIT-sensitive:** evidence that measures built into EHR-systems with implementation of relevant HIT functions (e.g., clinical decision support) result in improved outcomes and/or clinical performance.
- **Promotes parsimony:** measures applicable across multiple types of providers, care settings and conditions.
- **Preventable burden:** evidence that measurement could support potential improvements in population health and reduce burden of illness.

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MU 2013 Criteria (2)

- **Supports health risk status and outcomes assessment** – supports assessment of patient health risks that can be used for risk adjusting other measures and assessing change in outcomes, including general cross-cutting measures of risk status and functional status and condition-specific measures.
- **Enables longitudinal measurement** –enables assessment of a longitudinal condition-specific patient-focused episode of care.

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Tracer Conditions

- Identified a set of “tracer conditions” among the leading conditions. The tracer conditions were selected based on the following factors:
 - applicability to a broad patient population (e.g., children and adults);
 - mix of both medical and surgical conditions, including preference-sensitive procedures;
 - conditions for which a longitudinal focus would be important;
 - conditions that align with the selected conditions for complementary efforts, such as ACO pilots and the Beacon community project.

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Sample Measurement Gaps

- Population health – community measures
- Medication safety - exchanging and incorporating information from adverse events (e.g., EDs)
- Adherence to medications (patient self-report)
- Use of generic medications
- Reduce cost of redundant testing
- General health status (and delta measures)

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Disparities-Sensitive Domains and Sub-Domains

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Primary Criteria: Disparity-Sensitive Criteria

- **Prevalence**
 - Is this disease or condition among the most prevalent in the disparity population?
- **Impact of the condition**
 - Does the condition have a relatively high impact on the health of disparity population—e.g., mortality, QOL, stigma?
- **Impact of the quality process**
 - What proportion of the target population are likely to benefit from broader implementation of the targeted quality process?
- **Quality gap**
 - How large is the gap in quality between the disparity population and the benchmark populations?

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Secondary Criteria: Disparity-Sensitive Measures

- **Ease and feasibility of improving the quality process**
 - Any evidence that care can be improved for healthcare disparity populations, whether an intervention exists to reduce the disparity, and that gaps between different groups can be closed.
- **Low health literacy**
 - Any evidence that low literacy negatively affects health outcomes for that specific measure's leverage point.
- **Unintended or Adverse Consequences**
 - Example: measures that might penalize safety net providers based on factors that are beyond their control

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Disparities-Sensitive Domains

- Care Coordination and Managementⁱ
- Health Statusⁱⁱ
- Palliative Careⁱⁱⁱ
- Patient and Family Engagement
- Population Health^{iv}
- Safety Outcomes

ⁱ National Quality Forum (NQF). A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report. Washington, DC: NQF; 2009.

ⁱⁱ Mead H., Cartwright-Smith L., Jones K., Ramos C., Siegel B., Woods K., (2008). "Racial and Ethnic Disparities in U.S. Healthcare: A Chartbook." The Commonwealth Fund.

ⁱⁱⁱ Agency for Healthcare Research and Quality, National Healthcare Disparities Report, 2008.

^{iv} Agency for Healthcare Research and Quality, National Healthcare Disparities Report, 2008.

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Disparities-Sensitive Sub-Domains

Care Coordination & Management

- Communication
- Medication Management (Appropriateness, Adherence)
- Transitions
- Having a Medical or Health Home
- Help Coordinating Care

Health Status

- Function, Symptoms, & Quality of Life
- Burden of Illness
- Well Being
- Mortality / Length of Life

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Disparities-Sensitive Sub-Domains

Palliative Care

- Access to Supportive Services
- Access to Spiritual, Cultural, and Psychological Needsⁱ

Patient & Family Engagement

- Shared Decision Making
- Experience

Population Health

- Effective Preventive Services
- Healthy Lifestyle Behaviors
- Environmental Factors
- Social Determinants
- Community Index
- Population Health Outcomes

ⁱ National Quality Forum (NQF). A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report. Washington, DC: NQF; 2009.

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Resource Use / Overuse

- Appropriateness / Efficiency

Safety Processes & Outcomes

- Prevention of Adverse Events
- Medication Safety

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Gaps Identified by the NQF Endorsement Process

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Child Health Measure Gaps Identified by NQF Endorsement Process

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Measure Gaps Identified Through the NQF Endorsement Process

- Collected Over 20 NQF Consensus Development Process (CDP) Reports (2007-Present)
- Focused on Research Recommendations Section of Reports
- Identified Report Recommendations on Measure Gaps Related to Child Health, Population Health, and/or Disparities

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Child Health

- Care Coordination
- Cost/Efficiency/Overuse
- Patient and Family Engagement
- Population Health
- Safety
- Palliative Care

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Care Coordination

- Management Care Plan Effectiveness
- Prescription Fill Rate
- Patient Management Across Care Settings

Cost/Efficiency/Overuse

- Appropriate Selection and Use of Medications

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Patient and Family Engagement

- Parental Education
- Effective Communication Between Healthcare Professionals and Patient and/or Family
- Patient and Family Experiences of Care

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Population Health

- Environmental Factors/Determinants
- Screening & Surveillance
- Well-Child
 - Screenings and Developmental Milestones
- Mental Health
 - Depression
 - Substance Use Illness

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Child Health: Measure Gaps Identified Through the NQF Endorsement Process



Safety

- Healthcare Associated Infections
- Antimicrobial Therapies' Monitoring
- Serious Treatable Complications

Palliative Care

- Roles and Responsibilities of Healthcare Professionals
- Patient and Family Experiences of Care

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Measure Gaps Identified Through the NQF Endorsement Process



Disparities

- Racial, Ethnic and Culturally Appropriate Delivery of End-of Life Services
- Assessment of Quality and Disparities for At-Risk Pops
- Access to Care

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Population Health Measure Gaps Identified by NQF Endorsement Process

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Measure Gaps Identified Through the NQF Endorsement Process

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- Identified Report Recommendations on Measure Gaps Related to Child Health, Population Health, and/or Disparities

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Population Health

- Clinical Preventive Services
- Lifestyle Behaviors
- Community Level Measurement

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Clinical Preventive Services

- Screening & Surveillance/Monitoring
- Mental Health
 - Depression
 - Substance Use Illness

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Lifestyle Behaviors

- Composite Measurement of Lifestyle Behaviors (e.g., physical activity, nutrition)
- Children & Maternal Drivers of Lifestyle Behaviors (e.g., prenatal counseling)
- Assessment of Understanding and Ability to Execute Care Plan
- Environmental/Regulatory Influences

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Community Level Measurement

- Environmental Factors/Determinants
- Faith-Based Interventions
- Public Health Interventions at the Community Level

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Disparities

- Racial, Ethnic and Culturally Appropriate Delivery of End-of Life Services
- Assessment of Quality and Disparities for At-Risk Pops
- Access to Care

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Measure Developer Priorities

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Priorities from Select Measure Developers

- AHRQ
- CMS
- Joint Commission
- NCQA
- PCPI as convened by AMA

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Summary of Measure Developers' Priorities

Priorities:

- Care Coordination
 - In the Context of Emerging Care Models (e.g., ACOs, Medical Home, etc)
- Efficiency/Overuse
 - Appropriateness
 - Resource Use
 - Avoidable Admissions/Readmissions/ED Visits
- Child Health
 - Prevention Broadly
 - Racial, Ethnic, and SES Disparities
- Safety
 - HACs/HAIs
 - Medication Reconciliation

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Issues:

- Comprehensive Measure “Dashboards”
- Composite Measures Addressing Quality & Cost
- E-Measure Specifications for EHRs/Meaningful Use
- Measures Addressing Multiple Chronic Conditions

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Questions?

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Identification and Prioritization of Consolidated List of Measure Gaps

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Committee Resources & Background Materials

- **NPP Priorities and patient-focused episode of care framework**
 - NPP Executive Summary
http://www.nationalprioritiespartnership.org/uploadedFiles/NPP/About_NPP/Exec_Sum_no_ticks.pdf
 - Patient-Focused Episodes of Care Report – Executive Summary
http://www.qualityforum.org/Publications/2010/01/Measurement_Framework_Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx
- **Measure Developer priorities**
- **Gaps identified from the NQF endorsement process**
- **Disparities-sensitive domains and sub-domains**
- **HIT-sensitive domains and sub-domains and state of readiness**

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Preliminary voting of gap domains and sub-domains was based on the following dimensions:

- Impact/burden (including prevalence, cost)
- Improvability/variability (including actionability, effectiveness)
- Feasibility (including data source, burden of measurement)

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- Reviewed the Medicare, Child Health, and Population Health Measure Gap Domains & Sub-Domains
- Focused on Convergence of Domains and Sub-Domains Across Measurement Streams
- Consolidated to a list of Domains and Sub-Domains Based Upon Identified Areas of Convergence

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Domain Voting Results

Domains	Votes
Resource Use/Overuse	16
Care Coordination & Management	15
Health Status	8
Safety Processes & Outcomes	8
Patient and Family Engagement	7
System Infrastructure Supports	5
Population Health	4
Palliative Care	0

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Sub-Domain Voting Results

Sub-Domains	Votes
Domain 1: Care Coordination & Management	
Communication	11
Medication Management (Appropriateness, Adherence)	9
Transitions*	9
Having a Medical or Health Home	4
Appropriate and Timely Follow-up	3
Effective Care Plans	2
Help Coordinating Care	1
Domain 2: Systems Infrastructure Supports	
System Capacity & HIT	8
Patient/Family Centered Systems of Care	7
Research, Quality Improvement, and Knowledge Dissemination	7
Workforce Development	4
Performance Measurement	3

*Accountability, Success/Failure Rates

**Bridge Gap Between Expert and Public Knowledge, Patient Communication and Knowledge Regarding Consent & Safety

***Activation, Consumer Empowerment

^Satisfaction, Health Literacy, Communication, Respect and Cultural Sensitivity

^^Cardiovascular Disease Prevention, Early and Continuous Screening, Child and Adolescent Health, Cancer Prevention, Injury Prevention, Vaccine Preventable Illness

^^^Physical Activity, Diet, Smoking, Risky Alcohol Use, Health Promotion

†Overuse of Procedures and Surgery, Medication Overuse, Avoidable ED and Hospital Readmission, Duplicate Testing

Domain 3: Health Status	
Function, Symptoms, and Quality of Life	16
Productivity	2
Well Being	2
Burden of Illness	0
Mortality/Length of Life	0
Domain 4: Palliative Care	
Advance Preparations Defined and Honored	2
Pain Management and Symptom Relief	2
Access to Supportive Services	1
Access to Spiritual, Cultural, and Psychological Needs	0
Caregiver/Family Burden	0
Domain 5: Patient & Family Engagement	
Shared Decision Making **	19
Self-Management***	6
Experience ^	0
Domain 6: Population Health	
Effective Preventive Services^^	10
Healthy Lifestyle Behaviors^^^	7
Population Health Outcomes	4
Community Index	2
Environmental Factors	1
Social Determinants	1
Domain 7: Resource Use/Overuse	
Appropriateness/Efficiency	23
Direct Cost†	2
Indirect Cost	0
Domain 8: Safety Processes & Outcomes	
Prevention of Adverse Events	13
Medication Safety	9
Ambulatory Setting	2
Standardized HAI	2

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Sub-Domain Voting Results

Appropriateness/Efficiency	23
Shared Decision Making *	19
Function, Symptoms, and Quality of Life	16
Prevention of Adverse Events	13
Communication	11
Effective Preventive Services**	10
Medication Management (Appropriateness, Adherence)	9
Medication Safety	9
Transitions**	9
System Capacity & HIT	8
Healthy Lifestyle Behaviors†	7
Patient/Family Centered Systems of Care	7
Research, Quality Improvement, and Knowledge Dissemination	7
Self-Management^	6
Having a Medical or Health Home	4

*Bridge Gap Between Expert and Public Knowledge, Patient Communication and Knowledge Regarding Consent & Safety
 **Cardiovascular Disease Prevention, Early and Continuous Screening, Child and Adolescent Health, Cancer Prevention, Injury Prevention, Vaccine Preventable Illness
 ***Accountability, Success/Failure Rates
 †Physical Activity, Diet, Smoking, Risky Alcohol Use, Health Promotion
 Hospital Readmission, Duplicate Testing
 ^Activation, Consumer Empowerment
 ^^Overuse of Procedures and Surgery, Medication Overuse, Avoidable ED and
 ^^^Satisfaction, Health Literacy, Communication, Respect and Cultural Sensitivity

Population Health Outcomes	4
Workforce Development	4
Appropriate and Timely Follow-up	3
Performance Measurement	3
Advance Preparations Defined and Honored	2
Ambulatory Setting	2
Community Index	2
Direct Cost^^	2
Effective Care Plans	2
Pain Management and Symptom Relief	2
Productivity	2
Standardized HAI	2
Well Being	2
Access to Supportive Services	1
Environmental Factors	1
Help Coordinating Care	1
Social Determinants	1
Access to Spiritual, Cultural, and Psychological Needs	0
Burden of Illness	0
Caregiver/Family Burden	0
Experience^^^	0
Indirect Cost	0
Mortality/Length of Life	0

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Key Issues from the Committee

- Scope
- Domains and Sub-Domains
 - Definitions
 - Overlapping Concepts
 - Relationship between the Two Levels
- Clustering/Tiering of Results
- Ambulatory Care
- Disparities/ Access
- Resource Use/Overuse
- Palliative Care
- System Infrastructure Supports

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Questions?

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Next Steps

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Immediate Next Steps

- September 20-October 19, 2010:
 - Public Comment Period
- November 2010:
 - NQF will develop a draft report, including a measure development and endorsement agenda for review by the committee and HHS.
- January 2011:
 - NQF will finalize the measure development and endorsement agenda and HHS report.

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Committee Scope of Work & Timeline

Sept.-Oct.
2010

- NQF will seek comments from NQF Members and the public on the Measure Development and Endorsement Agenda. The comments will be used to inform a final report to HHS as well as next steps in formulating a comprehensive national strategy and priorities for healthcare performance measurement.

Nov. 2010

- NQF will develop a draft report, including a measure development and endorsement agenda for review by the committee and HHS.

Jan. 2011

- NQF will finalize the measure development and endorsement agenda and HHS report.

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General Questions?

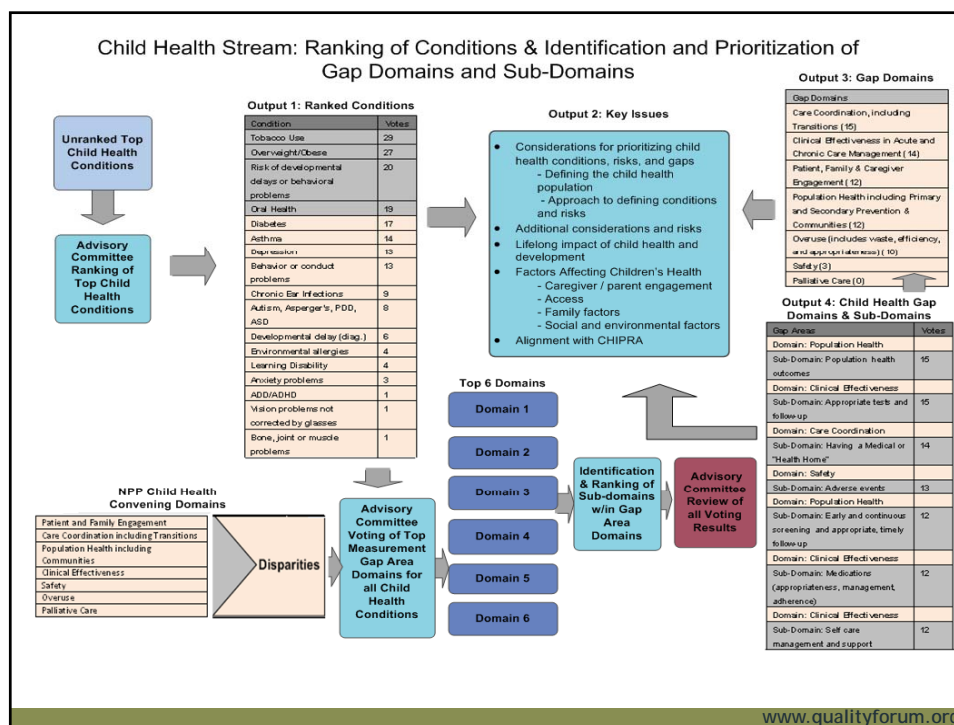
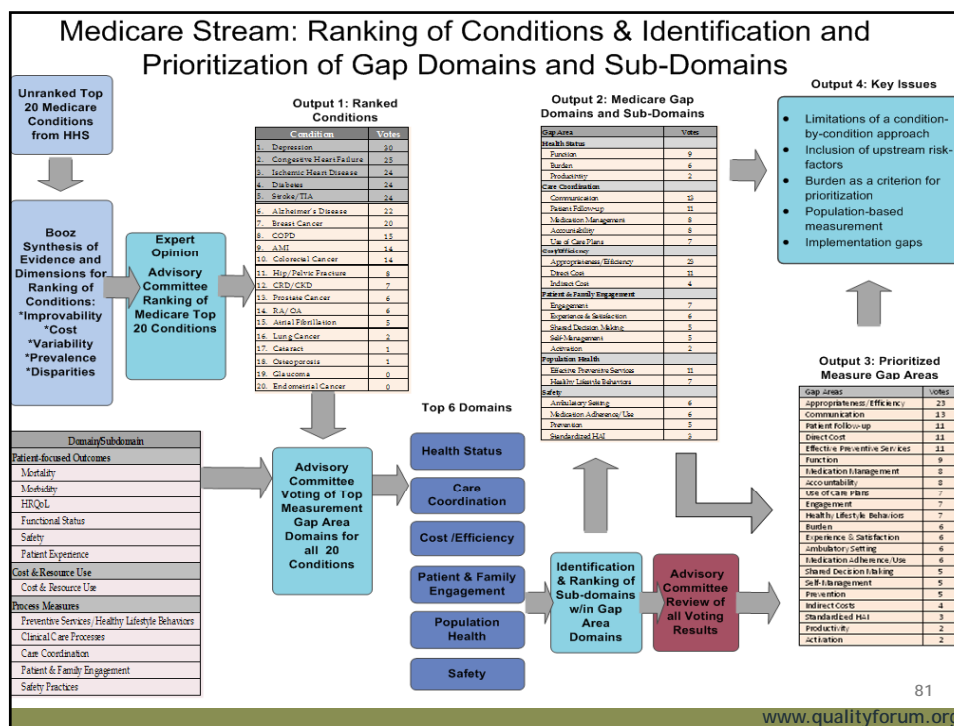
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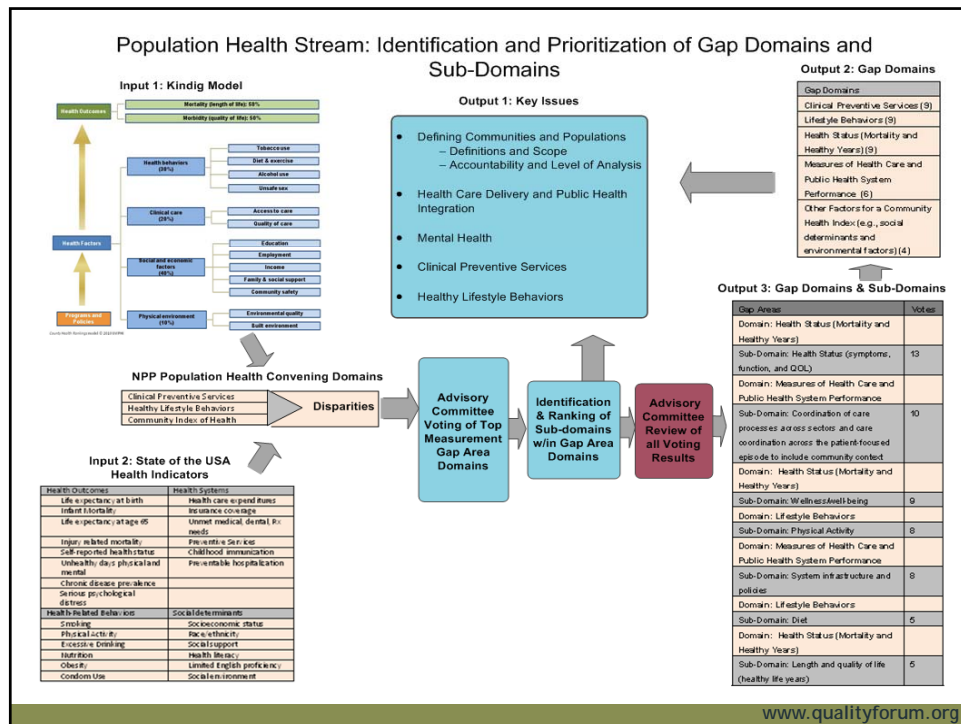
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Appendix

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National Priorities Partnership

NQF
NATIONAL QUALITY FORUM

32 stakeholder organizations

- Consumers
- Purchasers/Employers
- Health professionals/providers
- Health Plans
- Accreditation/certification groups
- Quality alliances
- Suppliers/Industry
- Community/Regional Collaboratives
- Public sector: CMS, AHRQ, CDC, NIH, NGA

Co-Chairs:



— Donald Berwick
Institute for Healthcare Improvement



— Margaret O'Kane
National Committee for Quality Assurance

- Engage patients and their families in managing their health and making decisions about their care
- Areas of focus:
 - Patient experience of care
 - Patient self-management
 - Informed decision-making



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www.qualityforum.orgNATIONAL PRIORITY
Population Health

- Improve the health of the population
- Areas of focus:
 - Preventive services
 - Healthy lifestyle behaviors
 - National index to assess health status



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- Improve the safety and reliability of America's healthcare system
- Areas of focus:
 - Healthcare-associated infections
 - Serious adverse events
 - Mortality



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- Ensure patients receive well-coordinated care within and across all healthcare organizations, settings, and levels of care
- Areas of focus:
 - Medication reconciliation
 - Preventable hospital readmissions
 - Preventable emergency department visits



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NATIONAL PRIORITY Palliative and End-of-Life Care

NQF
NATIONAL QUALITY FORUM

- Guarantee appropriate and compassionate care for patients with life-limiting illnesses
- Areas of focus:
 - Relief of physical symptoms
 - Help with psychological, social and spiritual needs
 - Effective communication regarding treatment options, prognosis
 - Access to high-quality palliative care and hospice services



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NATIONAL PRIORITY Overuse

NQF
NATIONAL QUALITY FORUM

- Eliminate overuse while ensuring the delivery of appropriate care
- Areas of focus:
 - Inappropriate medication use
 - Unnecessary lab tests
 - Unwarranted maternity care interventions
 - Unwarranted diagnostic procedures
 - Unwarranted procedures
 - Unnecessary consultations
 - Preventable emergency department visits and hospitalizations
 - Inappropriate nonpalliative services at end of life
 - Potentially harmful preventive services with no benefit



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Patient-Focused Episodes of Care Project

- Co-chaired by Elliott Fisher & Kevin Weiss
- Developed a comprehensive measurement framework to evaluate efficiency across extended episodes of care including:
 - Clear definitions
 - A discrete set of domains
 - Guiding principles for implementation
- Selected two priority conditions - AMI & LBP - to serve as operational examples to measure, report and improve efficiency across episodes

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Patient-Focused Episodes of Care

- Patient-focused orientation
 - Follows the natural trajectory of care over time
- Directed at value
 - Quality, costs, and patient preferences
- Emphasizes care coordination
 - Care transitions and hand-offs
- Promotes shared accountability
 - Individual, team, system
- Addresses shared decision making
 - Attention to patient preferences
- Needed to support fundamental payment reform

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- Patient-level outcomes (better health)
 - Morbidity and mortality
 - Functional status
 - Health-related quality of life
 - Patient experience of care
- Processes of care (better care)
 - Technical
 - Care coordination/transitions /care planning
 - Decision quality – care aligned with patients' preferences
- Cost and resource use (less overuse, waste, misuse)
 - Total cost of care across the episode
 - Patient opportunity costs

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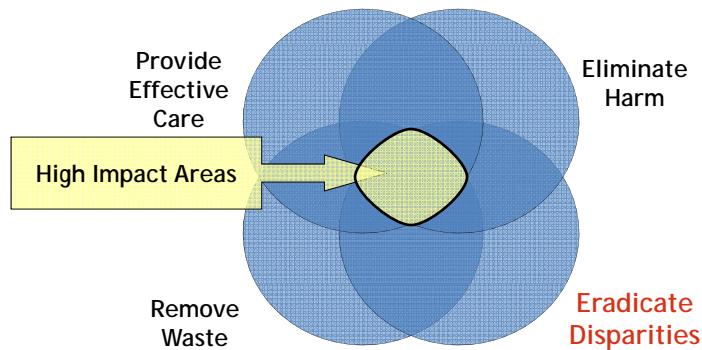
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Disparities

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Selecting the National Priorities



Quality and Disparities Measurement

- Assessment of quality by race, ethnicity, primary language and socioeconomic status should be a routine and expected part of performance measurement
 - **Inclusion in the Quality Data Set (QDS)**
- Need to collect race, ethnicity, primary language, and socioeconomic status data in an efficient, effective, patient-centered manner or consider indirect methods
 - **Endorsed HRET toolkit (cultural competency project)**
- Identify measures that are “disparity-sensitive” and routinely stratify quality data
 - **Identified disparity-sensitive criteria**

Disparity-Sensitive Measures

- Ambulatory care project:
 - Identified 35 “disparity-sensitive” measures at the clinician level (hypertension, diabetes, mental health, asthma, heart disease, immunization, screening/prevention, patient experience)
 - Includes 14 AHRQ Prevention Quality Indicators – capture potentially avoidable hospitalizations for ambulatory care-sensitive conditions
- Plan to review all measures in the NQF portfolio across sites and providers to identify disparity-sensitive measures

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CDP Projects: Examples of Disparity-Related Gaps

- Outcome measures that address the reduction of healthcare disparities.
- Assess availability of appropriate interpreter services
- Examine disparities related to socioeconomic status and 30-day readmission rates
- Creation of measures that assess quality and disparities specifically for at-risk populations.
- Best practices for pay-for-performance and measurement efforts that are most likely to reduce disparities.

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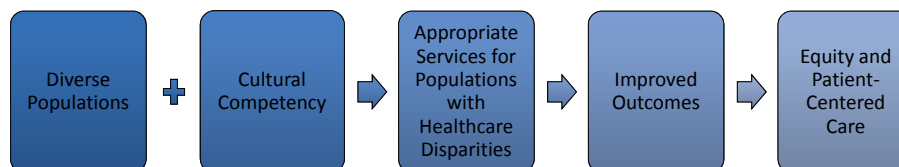
Approaches to Disparities Measurement

- **Disparity-sensitive measures:**
 - For disparity sensitive measures, quality measures should be routinely stratified by race, ethnicity, language, and SES.
- **Cross-cutting measures:**
 - Cultural competency measures (e.g., access to interpreter services)
 - Disparities measures (e.g., routine collection of race, ethnicity)
- **Population-specific measures:**
 - Focus on targeted population-specific measurement concerns (e.g., screening foreign-born adults for chronic hepatitis B)

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Reducing Disparities Through Culturally Competent Care



Adapted from Brach C, Fraser I, Can cultural competency reduce racial and ethnic health disparities? a review and conceptual model, *Med Care Res Rev*, 2000; 57: 187 – 217.

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Measuring Cultural Competency

- In 2009, NQF endorsed a framework and preferred practices
- NQF identified high-priority research and measure development to advance evaluation of cultural competency
- Built consensus around major questions:
 - ✓ What constitutes culturally competent care?
 - ✓ Who is accountable to ensure it is delivered?
 - ✓ How do health systems and providers measure cultural competency?
 - ✓ Can we attribute culturally competent healthcare to improved health outcomes?

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Defining Cultural Competency

Cultural competency is the ongoing capacity of healthcare systems, organizations and professionals to provide for diverse patient populations high quality care that is safe, family and patient- centered, evidence-based, and equitable.

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Cultural Competency Framework - Domains

1. Leadership
2. Integration into management systems and operations
3. Patient-Provider Communication
4. Care Delivery and Supporting Mechanisms
5. Workforce Diversity and Training
6. Community Engagement
7. Data Collection, Public Accountability, and Quality Improvement

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Policy Recommendations → Preferred Practices → Measures

IOM Policy Recommendation:

An entity collecting data from individuals for purposes related to health and healthcare should collect data on granular ethnicity using categories that are applicable to the population it serves.

NQF-Endorsed Preferred Practice:

- Ensure that, at minimum, data on an individual patient's race and ethnicity and primary written and spoken language are collected in health records and integrated into the organization's management information systems. Periodically update the language information.

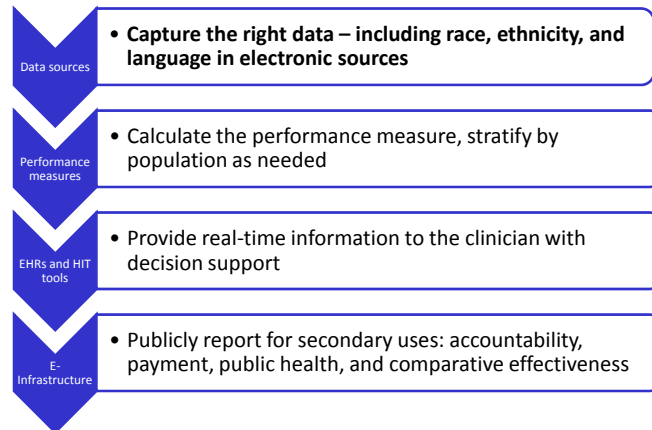
Opportunities for Measurement:

- Number of patients who have appropriate data collected on race, ethnicity, and primary written and spoken language

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Disparities Measurement: Link to Health IT:



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Priorities from Select Measure Developers

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AHRQ

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AHRQ's Measurement Activities

- National Healthcare Quality Reports
- Consumer experience surveys (CAHPS)
- Culture surveys (SOPS)
- PSOs (including Common Formats)
- Consumer reporting (in development)
- Medicare Patient Safety Monitoring System (MPSMS)
- Quality Indicators - QIs & PSIs
- Medical Expenditure Patient Surveys (MEPS)

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AHRQ's Common Formats

- Standardize the patient safety event information collected
 - Common language & definitions
 - Standardized rules for data collection
- Allow aggregation of comparable data at local, PSO, regional, & national levels
- Facilitate exchange of information, learning



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Conceptual Framework

- Limit initial focus to safety: preventing harm to patients from the delivery of health care
- Develop for specific delivery settings:
 - Hospitals first
 - Designed as QI tool for use by hospitals
- Start with first phase of improvement cycle – the initial report
- Construct in modules

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Scope

- Common Formats apply to *all* patient safety concerns, not a limited set of conditions/events
 - Incidents – patient safety events that reached the patient, whether or not there was harm
 - Near misses (or close calls) – patient safety events that did not reach the patient
 - Unsafe conditions – any circumstance that increases the probability of a patient safety event

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Technical Specifications v1.1

- Implementation Guide – CDA – for data submission to national level
- Common Formats flow charts
- Validation rules & errors document
- Data Dictionary
- Local specifications

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CMS

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Centers for Medicare and Medicaid Services (CMS)

Vision for 2010-2011:

- To produce robust measure sets across settings and by measure types utilizing the episodes of care model
 - Focusing on four priority clinical conditions - hypertension, musculoskeletal diseases, diabetes, and sepsis.
 - Particular focus on outcome measures, including functional status and quality of life measures.
 - Continued development of electronic specifications of measures to use in the ARRA HITECH and PQRI pay for reporting programs.

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Development Priorities:

- **Care Coordination**
 - Measures of care coordination in the context of emerging care models (e.g., ACOs, Medical Home Model, etc.)
 - A standardized set of questions relating to patients' feedback regarding care coordination should be included in patient survey instruments for all health care settings.
 - A set of harmonized measures on medication reconciliation across setting and across all conditions is needed. Emphasis of these measures should be on achieving medication reconciliation in a timely manner to assure quality care.
 - More measures relating to preventable ED visits are needed in settings other than home health, e.g., ambulatory care, nursing home, health plans.
 - A comprehensive, robust set of measures that addresses all aspects of care coordination, applicable to all population and all health care settings is needed.

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- **Meaningful Use of EHRs Measures**
 - Development of EHR-based measures that utilize a greater amount of direct clinical data as compared to claims-based measures.
 - Development of outcomes measures that are directly paired with process measures (that include a scientific/medical evidence base). Consequently, we will be able to better gauge quality performance and establish a baseline evaluation for possible future agency plans for pay for reporting
 - Identification and implementation of a methodology for assessing outcomes for EPs that include small samples of patients in the numerator.
 - Broadening measures for all Eligible Professional (EP) specialties for HITECH.

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- **Palliative Care**

- The CMS hospice and palliative care measures developed under contract with CCME need further development.
- Measures are needed for fatigue and delirium since these are common symptoms suffered by patients at the end of life. Delirium measures currently exist in the nursing home and home health settings; if measures for these conditions are developed for end of life patients, the measures should be harmonized as much as possible.
- The CARE Instrument includes items that address physical and mental symptoms often experienced by patients at the end of life. It is a potential data source for hospice measures. If hospice measures will be developed using CARE Instrument items, these measures should be harmonized with the other CMS hospice/palliative care, nursing home, and home health measures.
- Only one process measure was planned for development for social, spiritual, or psychological needs in 2009/2010. A potential source for measures relating to this goal is a patient or caregiver survey similar to CAHPS.

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- **Resource Use/Efficiency**

- Measures to assess and reduce duplicated services due to test results not being available.
- Measures to assess appropriateness and overuse of consultations and preventive screening, i.e., Pap smears.
- Measures to assess appropriate use of procedures such as cardiac catheterization, echocardiography, colonoscopy, joint replacements, and upper GI endoscopy.
- Consider efficiency measures developed from QASC/Brookings across episodes of care when available.
- Measures to assess system level efficiencies (e.g. preventable hospital or ED use)

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- **Patient and Family Engagement**

- Additional measures in all setting should be developed in prospective harmonization across settings that assess patient experience of care.
- Additional measures in all setting should be developed that assess a patient's experience with the coordination of their care.
- Measures to assess patient experience with culturally competent care must be developed
- Measures should be developed within the following NPP sub-domains:
 - *Patient Experience of Care*
 - *Tools and Support Systems for Self Management*
 - *Treatment Options*
 - *End of Life Care*

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- **Patient Safety**

- Development of Sepsis prevention measures across the spectrum of care settings and attribution-levels (facility, providers, and systems).
- Development of outcome and process measures related to the hospital acquired conditions (HACs) and other healthcare acquired infections (HAIs) and serious reportable events (SREs). Harmonized measures for all other appropriate settings should be developed concurrently.
- Development of harmonized patient safety measures, such as pressure ulcers, falls, and urinary catheter related UTIs and medication errors for all settings. In addition to outcome measures, the sets should include process measures which examine key prevention areas for each topic.
- Development of medication safety measures for the nursing home setting. This includes both process and outcome measures.
- Harmonize existing measures of patient safety across all settings.

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- **Multiple Chronic Conditions**
 - Measures of quality that are predictive of disability
 - Specific measures for pairings of conditions
 - Avoidance of poly-pharmacy and drug-drug interactions
 - Preventing acceleration of chronic diseases – particularly impact of obesity on chronic conditions.

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- **Additional CHIPRA-specific Priorities:**
 - Availability of care in a range of ambulatory and inpatient settings
 - Racial, ethnic, and SES disparities
 - Duration of coverage
 - Prevention broadly
 - Acute conditions for children including healthy birth, premature birth, risk of physical and mental conditions

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Joint Commission



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The Joint Commission

Vision for 2010-2011:

Available to meet Accreditation Requirements

- VTE measures NEW (publicly report 1st time 9/10)
- Stroke NEW (publicly report 1st time 9/10)
- Perinatal care measures NEW (data collection with 4/10 discharges)
- Global immunization measures (date TBD)
- Alcohol/tobacco measures (date TBD)

Under development for other uses

- Blood management measures
- Sudden cardiac arrest measures

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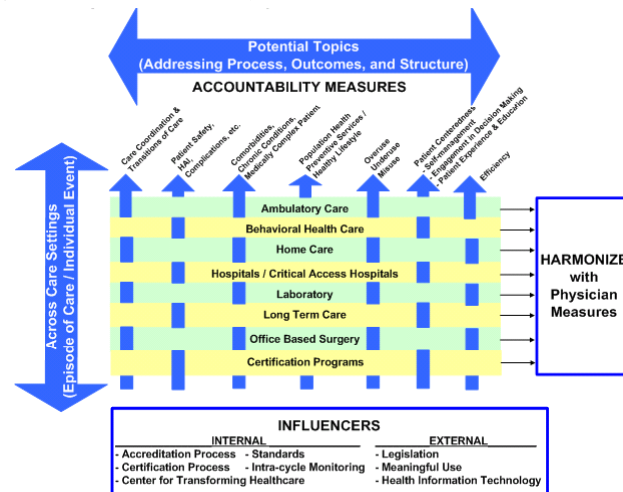
New Joint Commission Framework for Future Development of Quality Measures

Accountability Measures

Measures with highest validity that meet specific criteria (QI, P4P, Public Reporting)

- Strong evidence base demonstrating that given care processes leads to improved outcomes
- Measure accurately captures whether the evidence-based care process has been provided
- Measure addresses a process that has very few intervening care processes that must occur before the improved outcome is realized
- Implementing the measure has little or no opportunity of inducing unintended adverse consequences

Quality Measurement & Improvement Across the Continuum of Care



NCQA

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Vision for 2010-2011:

- Adapt and tailor measures for optimal use in electronic data environments
- Begin creating new measures uniquely adapted to EHRs environments
- Create new composites related to both quality and resource use-cost (efficiency)

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*Priorities: In general follow National
Priorities Partnership*

- Cost related (resource use, utilization, ambulatory sensitive admission, readmission, appropriateness)
- Total cardiovascular risk measures linkage to CDS
- Care Coordination
- Child health –Medicaid and CHIPRA
- Addressing measurement in small populations

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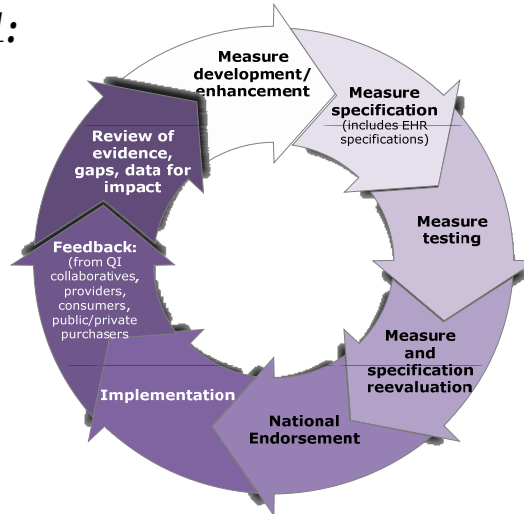
*PCPI as Convened
by AMA*

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Vision for 2010-2011:

- Comprehensive approach to measure development (including timely data to inform measurement, testing, implementation vehicles identified, foster QI)
- Comprehensive measure sets or “dashboards” (multiple measure types, for multiple settings & levels of analysis)
- Leveraging data from electronic health records and clinically-enhanced data sets



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Priorities:

- Measure “dashboards”: portfolio of measures applicable across inpatient & outpatient settings; outcome/process/structure; individual clinicians/care teams/facilities
- Composite measures where useful
- Specifying measures for EHRs/meaningful use
- Expanded measure testing (eg, Care Transitions)
- Overuse/inappropriate use
- Care coordination, safety, other NPP priorities

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Specific measure topics prioritized:

- Overuse/inappropriate use¹
 - Percutaneous Coronary Intervention
 - Maternity Care
 - Sinusitis
 - Cardiac Diagnostic Imaging
 - Diagnostic Imaging
 - Back Pain Management
- Other new measure development
 - Dementia
 - Atopic Dermatitis²
 - Radiation Dose Optimization²

1 Collaborative work with NCQA and relevant medical specialty societies

2 Collaborative work with relevant ABMS member boards

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