Healthcare Performance Measurement for Rural Providers

NATIONAL QUALITY FORUM

Rural Health Committee

February 5-6, 2015

Welcome

Committee Charge

- To make recommendations to CMS for mitigating challenges in performance measurement for rural providers
  - Consider issues through the lens of engaging rural providers in CMS pay-for-performance programs
  - One key issue to be addressed is the low case-volume problem

Meeting Objectives

- Finalize a consensus set of measurement challenges for Committee discussion
- Make recommendations regarding measures appropriate for use in CMS pay-for-performance programs for rural hospitals and clinicians
- Make recommendations to help mitigate measurement challenges, including low-case volume
- Identify measurement gaps for rural hospitals and clinicians

Day 1: Thursday, February 5, 2015 (Morning Session)

9:15: Introductions and Disclosures of Interest

9:30: Setting the Stage

10:30: Morning Break

10:40: Discussion of Overarching Measurement Challenges

11:30: Discussion of Potential Solutions: Low Case-Volume

12:50: Opportunity for Public Comment

1:00: Lunch

Day 1: Thursday, February 5, 2015 (Afternoon Session)

1:30: Discussion of Potential Solutions: Other Overarching Challenges

3:00: Afternoon Break

3:15: Break-out groups: Discussion of potential hospital- and clinician-specific solutions

4:15: Report Out from Break-out Groups

5:15: Opportunity for Public Comment

5:30: Summarize Themes and Adjourn for the Day

Introductions and Disclosures of Interest

Rural Health Committee Members

Kelly Court, Wisconsin Hospital Association	**Bruce Landon,** Harvard Medical School
Ira Moscovice, University of Minnesota School of Public Health	**Jonathan Merrell**, OCHIN, Inc.
Ann Abdella, Chautauqua County Health Network	**Guy Nuki**, BlueWater Emergency Partners
Michael Baer, AmeriHealth Caritas Pennsylvania	**Kimberly Rask**, Alliant Health Solutions
Tonya Bartholomew, Platte Valley Medical Clinic	**Robert Rauner**, SERPA-ACO
John Gale, University of Southern Maine	**Sheila Roman**, Independent consultant
Aaron Garman, Coal Country Community Health Center	**Susan Saunders**, American College of Nurse-Midwives
Gregory Irvine, St. Luke's McCall Orthopedics Clinic	**Stephen Schmaltz**, The Joint Commission
Jason Kessler, Iowa Medicaid Enterprise	**Tim Size**, Rural Wisconsin Health Cooperative
Jason Landers, Highmark West Virginia	**Brock Slabach**, National Rural Health Association

Project Overview

Project Description

To provide multistakeholder information and guidance on performance measurement issues for rural providers, including:

- Facilities
  - Critical Access Hospitals (CAHs)
  - Rural Health Clinics (RHCs)
  - Community Health Centers (CHCs)
  - Small hospitals
  - Small-practice offices
- Clinicians who serve in these settings

Project Description

- Project will entail:
  - Environmental scan of measures and measurement programs
  - Multistakeholder input on measurement efforts and challenges for rural providers
  - Written report of Committee recommendations regarding performance measurement for rural providers in the context of Federal payment incentive programs
    - » Measures that are most appropriate for these programs
    - » Resources to address identified measurement gap areas
    - » Mitigation of measurement challenges

General Project Timeline

Sept 2014	• Call for Committee nominations • Begin environmental scan
Jan 2015	• Hold orientation web meeting for the Rural Health Committee • Deliverable #1: Environmental scan and analysis report
Feb 2015	• Hold Rural Health committee in-person meeting
Apr 2015	• Deliverable #2: **Draft report** containing committee recommendations on priorities for rural health measurement
June-July 2015	• Hold public comment period to obtain additional multistakeholder input on draft committee recommendations
Sep 2015	• Deliverable #3: **Final report** on highest-leverage opportunities for measure development and use

Insights From Environmental Scan and Committee Pre-Work

Rural Issues

- Limited availability of healthcare providers, including specialists and post-acute care providers
- Limited emergency response options
- Geographic isolation, resulting in transportation issues that affect patient care and lack of involvement in quality improvement efforts (which can foster a sense of neglect)
- Limited hours of operation for many providers, including emergency physicians and pharmacists
- Patient characteristics, including sociodemographic factors, health status, and health behaviors

Rural Issues

- Limited workforce capacity, particularly of those with specialized technological skills or quality improvement expertise
- Less predictable, and often low, patient volume
- Lack of financial resources to invest in HIT and quality improvement initiatives
- Heterogeneity of rural areas, resulting in heterogeneity between rural healthcare providers

Many Public and Private QI Programs

- CMS measurement programs for Medicare
- CMS QIO programs
- CMS Medicaid programs (e.g., PCMH iniatives)
- HRSA MBQIP
- HRSA Telehealth programs
- Private-sector P4P programs
- Regional QI collaboratives

Specific Feedback

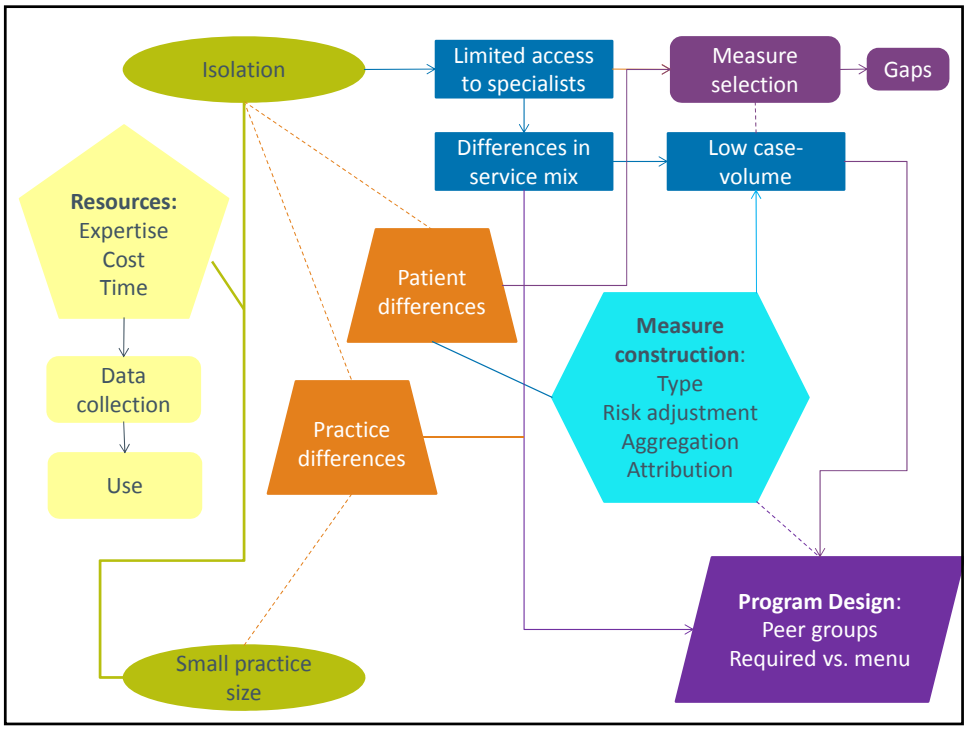
- State regulations can impact which measures are used in programs
- Low case-volume problem is known
  - Variety of measures used, including structural measures
  - Doesn't impact ability to provide clinician-specific feedback
- Employers in rural areas may not be as focused on quality measurement as other purchasers

Measure Availability

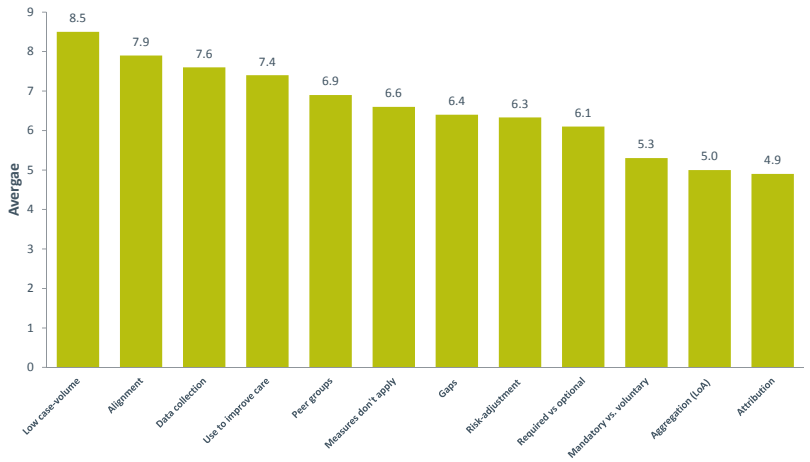
- Many available (~1,265…although probably many duplicates)
  - Hospital-specific (n=221)
  - Clinician-specific (n=418)
- Rural relevancy
  - Small hospitals (2004)
  - CAHs (2010)
  - RHCs (on-going)

Gaps in Measurement

- Medication safety/reconciliation
- Surgical checklist
- Advance care planning
- PROs: Shared decisionmaking
- Telehealth/telemedicine



Pre-Meeting Exercises

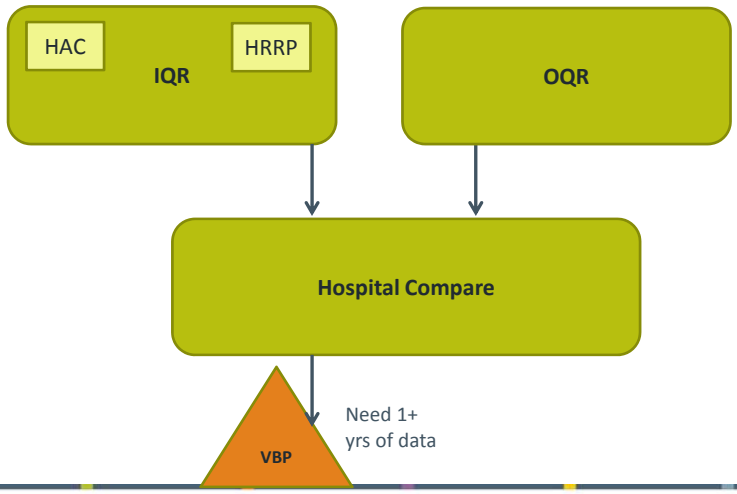


Overview of CMS Quality Improvement Programs

Overview of CMS Hospital Programs

- Pay for Reporting Programs
  - Hospital Inpatient Quality Reporting (IQR) Program
  - Hospital Outpatient Quality Reporting (OQR) Program
  - Ambulatory Surgical Center Quality Reporting (ASCQR) Program
  - Medicare and Medicaid EHR Incentive Program for Eligible Hospitals, and Critical Access Hospitals (CAHs)
- Public Reporting Program
  - Hospital Compare
- Pay-for-Performance Programs
  - Hospital Value-Based Purchasing (VBP) Program
  - Hospital-Acquired Condition (HAC) Reduction Program
  - Hospital Readmissions Reduction Program

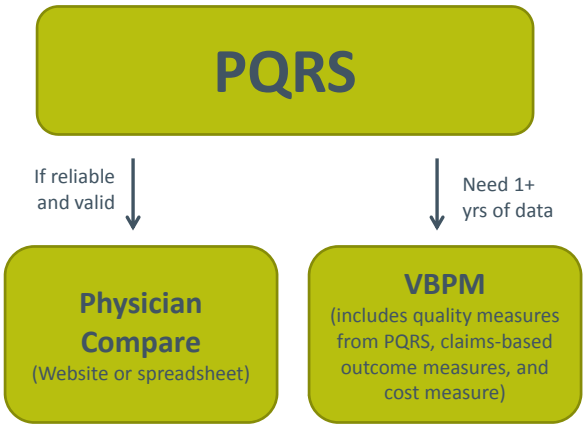
Relationships between CMS Hospital Programs



Overview of CMS Clinician Programs

- Pay for Reporting Programs
  - Physician Quality Reporting System (PQRS)
  - Medicare and Medicaid EHR Incentive Program for Eligible Professionals (EPs)
- Public Reporting Program
  - Physician Compare
- Pay-for-Performance Program
  - Physician Value-Based Payment Modifier
- Federal ACO Program
  - Shared Savings Program

Relationship Between CMS Clinician Programs



Where Do Rural Providers Fit In?

- CMS hospital programs discussed above limited to those paid under the Prospective Payment System
  - CAHs excluded, but can report on voluntary basis
- CMS clinician programs discussed above limited to those clinicians paid under the Medicare Physician Fee Schedule
  - Excludes those working in RHCs and CHCs
  - Have requirements for minimum number of practitioners, patients, or reliability/validity
    - » May exclude small-practice providers

Setting "primers"

- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Community Health Centers (CHCs)
- Small hospitals
- Small-practice offices

Break

Discussion of Overarching Measurement Challenges

Potential Solutions: Low Case-Volume

What is known…

- This isn't a new problem
- Programs often exclude providers/measures when case volume is lower than some minimum threshold (e.g., <30)
- Low case-volume impacts reliability of measures

Variety of Potential Solutions Identified

- Measure selection
  - Use of broadly applicable measures (e.g., screening)
  - Using indicators that do not have a "typical" denominator (e.g., time since last adverse event)
- Measure construction
  - Pooling data (e.g., across years, providers, settings)
  - Composite measures
  - Statistical approaches (e.g., shrinkage estimates)
- Measure reporting
  - Including CIs, numerator counts, denominator counts
  - Stratification: comparing like-to-like

Opportunity for Public Comment

Lunch

Potential Solutions: Other Challenges

Break

Potential Solutions: Break-out Groups

Potential Solutions: Break-out Groups Report-Out

Opportunity for Public Comment

Summary of Day

Day 2: Friday, February 6

8:15: Recap

10:00: Morning Break

10:15: SDS discussion

11:30: MAP discussion

12:00: Lunch

12:30: Round-Robin: Reflections on Recommendations and Future Work

1:30: Final Opportunity for Public Comment

1:45: Wrap Up and Next Steps

2:00: Adjourn

Review of Day 1 Recommendations

Consensus Set of Challenges

- Low case-volume
- Need for meaningful measures for rural providers
  - Relevancy
  - Gaps in measurement
- Alignment
- Voluntary vs. mandatory participation

Low case-volume

- "Broad" measures
  - Broadly-applicable
    - » Preferably not condition-specific
    - » Include key issues (e.g., hand washing, vaccinations, blood pressure control, diabetes control, medication reconciliation)
  - Must be relevant to rural environment
  - Consider measures that reflect the "community good"
  - Focus on outcomes, but consider other types of measures
    - » Patient centered medical home
    - » Perhaps some structural measures
      - *Example might be something based on AHRQ culture of safety survey*

Low case-volume

- Measure construction
  - Re-consider certain exclusions (e.g., CAHPS)
  - More measures that are continuous
    - » HOWEVER, timing measures may not be optimal
    - » Not always easy to do
  - Consider social determinants of health
    - » Risk-adjustment implications
    - » Other??

Low-case volume

- Level of analysis
  - Need reporting/feedback at clinician level, but payment could be at higher levels
  - Perhaps allow informal grouping of providers for payment
    - » Must be voluntary
    - » Encourage synergy/mutual learning between providers
    - » Small hospitals/practices should be allowed to opt in (i.e., not just CAHs, RHCs, CHCs)

Measure Selection Principles

- Criteria underlying meaningful and relevant measure development and use include:
  - Evidence-based
  - Support the triple aim
  - Address low-volume problem
  - Data availability (exists, feasible to collect)
  - Relevant internally for providers
  - Relevant externally for public reporting
  - Focus on outcomes??
  - Comparability across relevant peer groups
  - Actionable
  - Addresses areas of risk and opportunity
  - Supports local access to care

Program design

- Participation in programs should be mandatory
  - TA must be "built in"
- Need for phased approach
  - For CAHs, RHC, CHCs, begin with pay-for-reporting
  - Too soon to go into P4P
- Allow menu of measures to choose from (e.g., by service line)
  - Set up weighting scheme so that not score not dependent on very few measures
- Facilitate faster cycle time between performance and use in programs
- Include component for improvement, not just threshold

Program design

- Peer groups
  - For QI/benchmarking, use like-to-like comparisons
    - » Service lines
    - » Capabilities (e.g., surgical, ICU, etc.)
    - » Type (CAHs to CAHs)
  - For payment, unclear if peer groups needed
    - » Can use statistical adjustment for patient factors (SDS)
      - *Need to consider other actors (e.g., capabilities) that might also be appropriate*
    - » Peer groups might be needed for some composite measures
  - Needs more study!

Alignment

- Need a uniform measurement set across HHS, payers, accrediting bodies, etc.
- Develop a standardized process so that data are collected/reported once
- Need alignment of measures across sectors (e.g., ambulatory and hospital)
- Improvement resources (e.g., TA) should be aligned across HHS

Gaps

- More measures about hand-offs
- Transitions (including timeliness)
- Alcohol/drug screening
- Telehealth
- Accessibility/timeliness measures
  - Are you serving your community?
  - Can community get care in a timely manner?
- Access to care measures
- Cost measures
- Population health at the geographic level
- For hospitals: procedures (e.g., OT/PT/imaging)
- Advance directives/end-of-life measures
- Appropriateness measures (alignment with Choosing Wisely??)
- More specialty measures

Measurement Gaps Identified by MAP

- Measures for patients with multiple chronic conditions
- End-of-life care including inappropriate non-palliative services at EoL
- Appropriateness of diagnostic and therapeutic services
- Measures of diagnostic accuracy
- Measures of lost productivity (e.g., days missed from work due to illness)
- Patient out-of-pocket costs
- Outcome measures for Alzheimer's, including quality of life and experience with care
- Outcome measures for cancer patients, including cancer- and stage-specific survival and patient-reported measures
- Measures of adverse drug events
- Patient-reported measures of pain and symptom management
- Patient-centered care planning

Additional recommendations

- Create a MAP workgroup for rural providers
- Relax requirements for use of vendors for CAHPS surveys and/or offer alternative data collection mechanism (e.g., similar to CART tool for hospitals)
- Allow access to Medicare claims data???

Further discussion

- Our committee needs further discussion on aggregation issues at the provider level, measure level, time frame level etc.
- Constant measure retirement and introduction of new measures creates instability for relevant longitudinal measurement
- Relationship of quality to access and cost dimensions needs to be examined
- Part A/B difficulties??
- TA across entities—concrete suggestions??
- Gaps

NQF Expert Panel Report

Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors

TECHNICAL REPORT

August 15, 2014

NATIONAL QUALITY FORUM

Background

- Patient sociodemographic factors influence outcomes through a variety of pathways
- Sociodemographic factors may also be related to disparities in health and healthcare
- NQF policy to date has prohibited consideration of sociodemographic factors in risk adjustment
  - Sociodemographic factors =
    - » Socioeconomic (e.g., income, education, occupation)
    - » Demographic factors (e.g., age, race, ethnicity, primary language)*

*Race/ethnicity should not be used as a proxy for SES.

NQF Risk Adjustment and SES Expert Panel: Key Points

- Each measure must be assessed individually to determine if SDS adjustment appropriate.
- Not all outcomes should be adjusted for SDS factors (e.g., central line infection would not be adjusted)
  - Need conceptual basis (logical rationale, theory) and empirical evidence
- The recommendations apply to any level of analysis including health plans, facilities, and individual clinicians.

Final NQF Recommendations (1)

- NQF has launched a two-year trial period comparing SDS-adjusted and non-SDS adjusted (clinically adjusted only).
- During the trial period if SDS adjustment is determined to be appropriate for a given measure, NQF will endorse one measure with specifications to compute:
  - SDS-adjusted measure
  - Non-SDS version of the measure (clinically adjusted only)
  - Stratification of the non-SDS-adjusted version

Final NQF Recommendations (2)

- NQF will convene a new NQF Standing Disparities Committee to monitor implementation of the revised policy as well as ensure continuing attention to disparities
- NQF and others such as CMS, ONC, and AHRQ should develop strategies to identify a standard set of sociodemographic variables (patient and community-level) to be collected and made available for performance measurement and identifying disparities.
  - Community-level variables for rural status?

MAP Pre-Rulemaking

- The NQF-convened Measure Applications Partnership, or MAP, provides multi-stakeholder input to HHS
- MAP provides recommendations on which measures to use in over 20 Federal programs in advance of proposed rules
- The MAP includes:
  - approximately 150 healthcare leaders and experts
  - A total of nearly 90 private-sector organizations
  - federal liaisons from seven different agencies

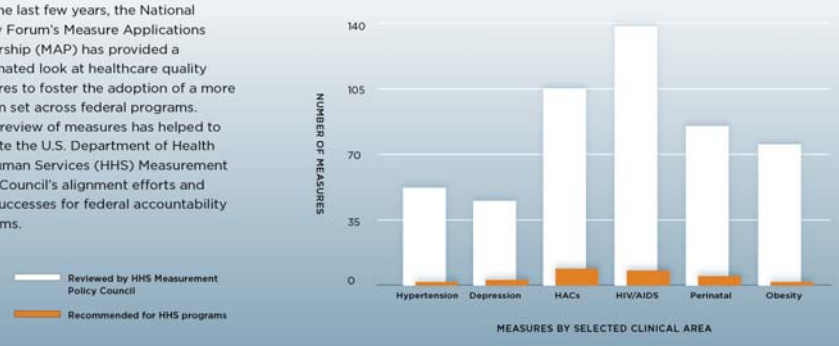
20 Medicare Programs: MAP Pre-Rulemaking

Federal Program	
Ambulatory Surgical Center Quality Reporting	Long-Term Care Hospital Quality Reporting
End Stage Renal Disease Quality Improvement Program	Medicare and Medicaid EHR Incentive Program (Meaningful Use) for Eligible Professionals
Home Health Quality Reporting	Medicare and Medicaid EHR Incentive Program (Meaningful Use) for Hospitals and CAHs
Hospital-Acquired Condition Reduction Program	Medicare Physician Quality Reporting System
Hospital Inpatient Quality Reporting	Medicare Shared Savings Program
Hospital Outpatient Quality Reporting	Physician Feedback/Quality and Resource Utilization Reports
Hospital Readmission Reduction Program	Physician Value-Based Modifier Program
Hospital Value-Based Purchasing	Physician Compare
Inpatient Psychiatric Facility Quality Reporting	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting
Inpatient Rehabilitation Facility Quality Reporting	Hospice Quality Reporting

MAP Facilitates Alignment Across HHS Programs

ALIGNING MEASURES ACROSS FEDERAL PROGRAMS: EARLY SUCCESSES
March 2012-November 2014

Over the last few years, the National Quality Forum's Measure Applications Partnership (MAP) has provided a coordinated look at healthcare quality measures to foster the adoption of a more uniform set across federal programs. MAP's review of measures has helped to facilitate the U.S. Department of Health and Human Services (HHS) Measurement Policy Council's alignment efforts and early successes for federal accountability programs.



Potential Solutions: Additional Challenges

Break

Additional Recommendations

Lunch

Reflections

Opportunity for Public Comment

Wrap Up/Next Steps

Upcoming Events

- **March 19, 2015:** Rural Health Committee web meeting to review draft report
- **April 15, 2015:** Draft Report of Committee recommendations due to HHS
- **June/July 2015**: Draft report will be available for public comment
- **September 14, 2015:** Final report due to HHS