Measure Applications Partnership Coordinating Committee

Web Meeting #2

Background Materials

October 19, 2011
2:00 pm – 4:00 pm ET

Webinar access: http://www.MyEventPartner.com/nqfmeetings11

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MAP Coordinating Committee August 17-18 Meeting Summary

Tab 1

MEASURE APPLICATIONS PARTNERSHIP
COORDINATING COMMITTEE
Convened by the National Quality Forum

Summary of In-Person Meeting #3

An in-person meeting of the Measure Applications Partnership (MAP) Coordinating Committee was held on Wednesday, August 17 and Thursday, August 18, 2011. For those interested in reviewing an online archive of the meeting please click on the link below:

http://www.qualityforum.org/Setting_Priorities/Partnership/MAP_Coordinating_Committee.aspx

The next meeting of the MAP Coordinating Committee will be a web meeting on October 19, 2011, from 2:00 pm – 4:00 pm EST.

Committee Members in Attendance at the August 17-18, 2011 Meeting:

George Isham (Co-Chair)	Elizabeth Mitchell, Maine Health Management Coalition (phone)
Elizabeth McGlynn (Co-Chair)	Ira Moscovice [subject matter expert: rural health]
Rhonda Anderson, American Hospital Association	Steven Brotman, AdvaMed (substitute for Michael Mussalem)
Richard Antonelli [subject matter expert: child health]	Frank Opelka, American College of Surgeons
Christine Bechtel, National Partnership for Women and Families	Cheryl Phillips, LeadingAge
Joseph Betancourt (phone) [subject matter expert: disparities]	Harold Pincus [subject matter expert: mental health
Marissa Schlaifer, Academy of Managed Care Pharmacy (substitute for Judith Cahill)	Carol Raphael [subject matter expert: health IT]
Mark Chassin, The Joint Commission	Peggy O'Kane, National Committee for Quality Assurance
Suzanne Delbanco, Catalyst for Payment Reform (phone)	Chesley Richards, Centers for Disease Control and Prevention (phone)
Joyce Dubow, AARP	Gerald Shea, AFL-CIO
Victor Freeman, Health Resources and Services Administration	Carl Sirio, American Medical Association
Aparna Higgins, America's Health Insurance Plans	Thomas Tsang, Office of the National Coordinator for HIT
Christine Cassel, American Board of Medical Specialties	Margaret VanAmringe, The Joint Commission (substitute for Mark Chassin Day 2)
Samantha Burch, Federation of American Hospitals (substitute for Chip Kahn)	Marla Weston, American Nurses Association
William Kramer, Pacific Business Group on Health	Nancy Wilson, Agency for Healthcare Research and Quality
Sam Lin, American Medical Group Association	

This was the third in-person meeting of the MAP Coordinating Committee. The primary objectives of the meeting were to:

- Refine draft measure selection criteria;
- Consider report drafts for Coordinating Committee reaction from Dual Eligible Beneficiaries, Clinician, and Ad Hoc Safety Workgroups;
- Review interim findings from PAC/LTC workgroup.

In the first session, Beth McGlynn, Coordinating Committee Co-Chair, began the section on the MAP measure selection criteria. Beth stated that the Coordinating Committee would not be adopting criteria at this meeting but would identify key aspects of criteria for further enhancement. Connie Hwang, Vice President, Measure Applications Partnership, NQF, provided an update on the developmental timeline of the measure selection criteria and the latest version of the criteria. Connie discussed how the development of the measure selection criteria is a critical component of the pre-rulemaking task, and the intent to finalize the criteria via a web meeting on October 19, 2011. This is in advance of the next in-person meeting on November 1-2, 2011, where the Coordinating Committee will prepare for the pre-rulemaking process to culminate in a report due to HHS on February 1, 2012. Connie highlighted two key updates to the criteria including merging the individual measure criteria and measure set criteria and creating binary response options. These changes were made to avoid redundancies between individual and measure set criteria in addition to more clearly discriminating ratings of criteria.

Following the presentation, Coordinating Committee members suggested the addition of definitions and interpretive guidance to all criteria. These suggestions came after several members discussed the need for greater clarity as well as hierarchy for certain types of measures (e.g., outcome, process linked to outcomes, structure). Furthermore, there was dialogue around how the criteria should consider data collection burden/effort versus the benefits of measurement. Committee members suggested moving from binary response options to a greater range of responses where precision allows. Finally, committee members suggested that the criteria should consider disparities more broadly than just social economic status and ethnicity (e.g., equitable access and treatment).

In the next session, Tom Valuck, Senior Vice-President, Strategic Partnerships, NQF, provided an overview of the themes across the MAP draft reports. Tom briefly touched on measure and measurement issues; priority measure gap areas; data sources and HIT implications; alignment; special considerations for dual eligible beneficiaries; and the path forward for improving measure applications. Discussion focused on gap areas in quality measures and identifying priorities for measure development.

Following Tom's presentation, Alice Lind, Chair of the MAP Dual Eligible Beneficiaries Workgroup, presented the contents of the workgroup's draft interim report. Alice stated that the workgroup's discussions emphasized that "Dual Eligible" is not an identity that patients or providers identify with. The dual eligible population is diverse and has distinct needs based on demographics. With this in mind, the workgroup developed a strategic approach to quality measurement for the population comprised of:

- A vision for high-quality care for dual eligible beneficiaries;
- Guiding principles to assist in developing a measurement framework;
- High-need subgroups; and
- High-leverage opportunities for improvement through measurement.

Coordinating Committee members' discussion focused on identifying the right class of measures as well as measurement approaches for cost and levels of accountability/attribution. Members cited the fragmentation and misalignment between the Medicare and Medicaid benefit structures as a factor.

The Coordinating Committee provided the following guidance and input to the dual eligible beneficiaries report:

- Use NQS definition for "health";
- Although cost is an important consideration, affordability is different for duals so need to be careful to avoid creating access issues;
- Mechanism needed for stratifying sub-populations;
- Structural measures may be particularly important for this population to assess Medicare/Medicaid disconnects;
- Connection "breakpoints" should be measured: relationships, information, care plans;
- Medication therapy management is a broader need and therefore beyond just measurement of medication adherence; and
- Need for tracking duals across settings and time—transitions often excluded in measure denominators.

The Committee then heard a presentation by Mark McClellan, Chair of the MAP Clinician Workgroup, regarding the contents of the workgroup's draft report. Mark stated that the report will assist the MAP in providing a coordination strategy on alignment across clinician performance measurement programs. To accomplish this, Mark highlighted the content of the report, which included:

- Alignment considerations for measures and data sources to reduce duplication and burden;
- Characteristics of an ideal measure set to promote common goals across programs and catalyze improvement;
- An evaluation by the workgroup of the proposed Physician Value-Modifier measure set using the MAP measure selection criteria;
- Data source principles that promote standardized data sources and health information technology to ease data collection burden and leverage use of data during the course of care; and
- A pathway for improving measure applications to meet the needs of all relevant programs.

Discussion focused on identifying as well as prioritizing measurement gaps, and attribution/accountability for medically complex patients in an integrated health care delivery environment. There was also conversation on the need to transition from an autonomous clinician culture to one that fosters team-based, patient-centered care.

Following their discussion, the Coordinating Committee provided the following guidance and input to the clinician report:

- Define "clinician" broadly to include the care team;
- Context needed that captures the importance and elements of "teamness";
- A need for enhanced data liquidity—data elements during the course of care should be applied for multiple uses;

- Clarification needed on patient-centric vs. clinician-centric data collection and measurement;
- Additional measure gaps should include appropriateness and diagnostic inaccuracies; and
- Coordinated strategy and funding necessary for the development of new measures, using both “engineering” approach within systems and “scientific research” approach.

The first day concluded with George Isham providing a summary of the day’s themes and an overview of the second day’s activities and points of discussion.

The second day of the meeting began with Beth McGlynn providing a recap of day 1, touching on the overarching themes that emerged in day 1 discussions.

In the morning session, Frank Opelka, Chair of the Ad Hoc Safety Workgroup, reviewed the contents of the workgroup’s draft report. The report concentrated on developing a coordination strategy for addressing readmissions and healthcare-acquired conditions across public and private payers. Frank stated that the workgroup utilized a conceptual model depicting the dimensions of alignment, and although the model evolved over the course of the work, the workgroup was able to identify three focus areas: measures, data, and specific coordination strategies. Using these areas, the workgroup developed the following recommendations for alignment:

- A national core set of safety measures that are applicable to all patients should be created and maintained;
- Data elements needed to calculate the measures in the safety core set should be collected on all patients; and
- Public and private sector entities should coordinate their efforts to make care safer, beginning with incentive structures.

The Coordinating Committee discussed the tension among standardization, harmonization, and innovation of measures. Committee members felt that there is an opportunity for all three, and further work is needed to get there. There was also discussion on what information needs to be down at the patient/provider level and what needs to be at the system level and its utility.

The Coordinating Committee provided the following guidance and input to the safety report:

- Harmonized set of safety measures needed especially for private sector, with proactive plans for continued innovation;
- Offer more opportunities for consumers and purchasers to engage in safety, with greater emphasis on better transparency;
- Underreporting or gaps in reporting safety issues (especially HAC) needs to be addressed—can be related to credibility of data and lack of incentives;
- Consideration of causes, prevention strategies, and interventions for undesirable readmissions is needed;
- Extremely important to consider the unintended consequences of monitoring and reporting safety issues;
- Accreditation and certification organizations are particularly important in safety arena;
- Sense of urgency needed around developing a coordination strategy or accountability structure; and
- Data aggregation for multiple sources is a problem that needs to be solved.

Following the discussion, Carol Raphael, Chair of the MAP Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup, presented the interim findings of the workgroup. Carol discussed the guiding principles for the coordination strategy, which included performance measures and measurement issues, data source and HIT implications, special considerations for dual eligible beneficiaries, and alignment across settings. Through discussions, the workgroup identified key considerations and priority areas for measurement across the PAC/LTC settings, which included:

- Priority measurement areas of function, goal attainment, care coordination, and cost/access and
- Key considerations of balancing standardization and customization, multi-level measurement, and reducing data collection burden.

The Coordinating Committee provided the following guidance:

- Balancing of standardized vs. customized care and measurement;
- Appropriateness related to end of life care particularly important;
- Safety is an important PAC/LTC issue for consideration;
- Accountability and attribution important for consideration by the workgroup, with team based care and medical home/ACO concepts at the forefront;
- Advanced care plans with person and family centered goals of great importance for this population;
- Staffing stability and caregiver preparedness need to be contemplated;
- Variety of settings contributes to complexity of measurement in this arena;
- Patient desires and payer priorities often at odds for those under age 65 in PAC/LTC care;
- Cognitive impairment as a topic of interest for this population; and
- This setting offers an opportunity to discuss the distinction between family, caregiver, and social networks.

To close the meeting, George Isham and Connie Hwang proposed the following synthesis of the emerging themes from the draft report discussions and the areas where the themes converged and diverged:

- NQS approach provides guidance to improving both outcomes and determinants of health;
- Transactional versus population approach;
- Harmonized measures, with proactive plans for continued innovation;
- Care coordination not an add-on, served better by looking at underlying flow;
- Types of measures determined by program goals;
- Patient-centric vs. clinician/provider-centric data collection and measurement;
- Data considerations of ability to compare across settings and standardized methodology for data collection;
- Parsimony—burden as effort;
- Clear and meaningful reporting;
- Need to clarify how to measure and apply total cost of care;
- Appropriateness as a priority measure gap;
- Unintended/undesirable consequences—zero readmissions may not be ideal; and
- Patient reported outcomes (e.g., functional status, quality of life).

The meeting concluded with a summary of day 2 and discussion of next steps. The next meeting of the Coordinating Committee will be a web meeting on October 19, 2011.

Schedule of Deliverables

Tab 2

Measure Applications Partnership - Schedule of Deliverables

Task	Task Description	Deliverable	Timeline
15.1: Measures to be implemented through the Federal rulemaking process	Provide input to HHS on measures to be implemented through the Federal rulemaking process, based on an overview of the quality issues in hospital, clinician office, and post-acute/long-term care settings; the manner in which those problems could be improved; and the measures for encouraging improvement.	Final report containing the Coordinating Committee framework for decision making and proposed measures for specific programs	Draft Report: January 2012 Final Report: February 1, 2012
15.2a: Measures for use in the improvement of clinician performance	Provide input to HHS on a coordination strategy for clinician performance measurement across public programs.	Final report containing Coordinating Committee input	Draft Report: September 2011 Final Report: October 1, 2011
15.2b: Measures for use in quality reporting for post-acute and long term care programs	Provide input to HHS on a coordination strategy for performance measurement across post-acute care and long-term care programs.	Final report containing Coordinating Committee input	Draft Report: January 2012 Final Report: February 1, 2012
15.2c: Measures for use in quality reporting for PPS-exempt Cancer Hospitals	Provide input to HHS on the identification of measures for use in performance measurement for PPS-exempt cancer hospitals.	Final report containing Coordinating Committee input	Draft Report: May 2012 Final Report: June 1, 2012
15.2d: Measures for use in quality reporting for hospice care	Provide input to HHS on the identification of measures for use in performance measurement for hospice programs and facilities.	Final report containing Coordinating Committee input	Draft Report: May 2012 Final Report: June 1, 2012
15.3: Measures that address the quality issues identified for dual eligible beneficiaries	Provide input to HHS on identification of measures that address the quality issues for care provided to Medicare-Medicaid dual eligible beneficiaries.	Interim report from the Coordinating Committee containing a performance measurement framework for dual eligible beneficiaries	Draft Interim Report: September 2011 Final Interim Report: October 1, 2011
		Final report from the Coordinating Committee containing potential new performance measures to fill gaps in measurement for dual eligible beneficiaries	Draft Report: May 2012 Final Report: June 1, 2012
15.4: Measures to be used by public and private payers to reduce readmissions and healthcare-acquired conditions	Provide input to HHS on a coordination strategy for readmission and HAC measurement across public and private payers.	Final report containing Coordinating Committee input regarding a strategy for coordinating readmission and HAC measurement across payers	Draft Report: September 2011 Final Report: October 1, 2011