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Measure Applications Partnership
Clinician Workgroup
In-Person Meeting #1
June 7-8, 2011

Supplemental Presentation Slides

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Measure Selection Principles

June 7th 11:45am

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Measure Selection Criteria Project

Ted von Glahn

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Principal Investigator

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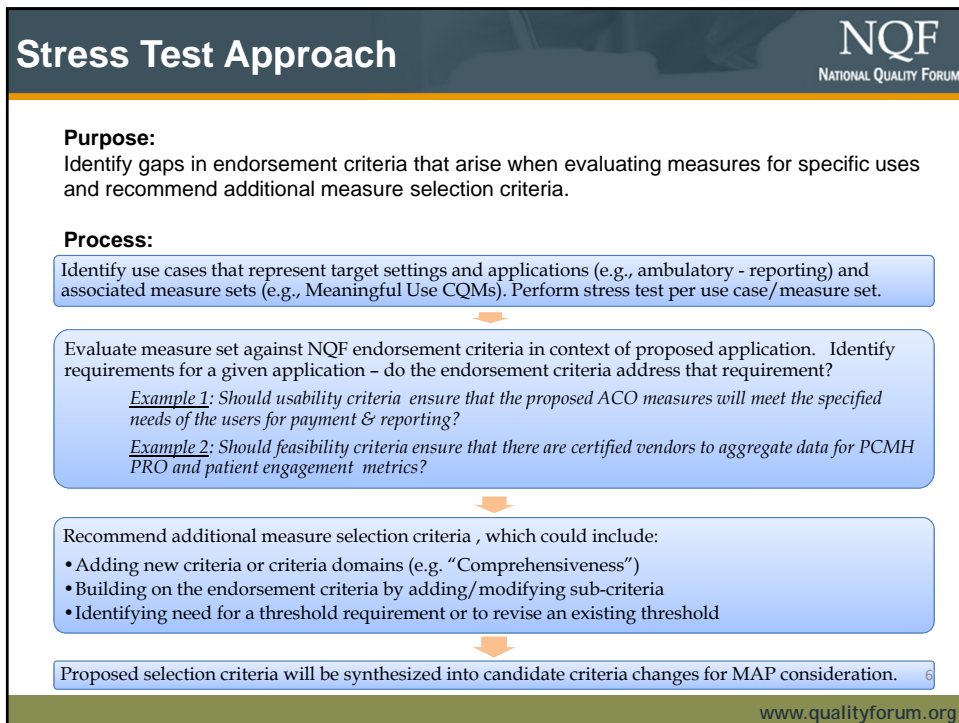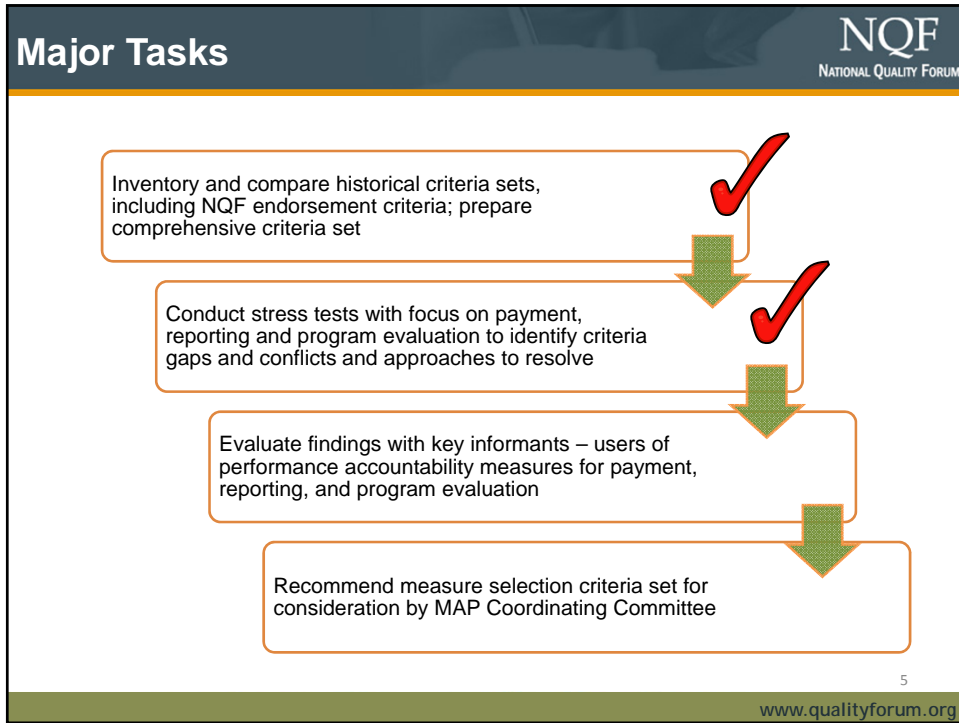

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Purpose

Provide input to the MAP Coordinating Committee and workgroups on measure selection <u>criteria</u> to equip MAP with an evidence base to select measures for:

- public reporting
- payment programs
- program monitoring and evaluation

The MAP measure selection criteria will build on, not duplicate, the NQF measure endorsement criteria.

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Major Tasks

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Inventory and compare historical criteria sets, including NQF endorsement criteria; prepare comprehensive criteria set

Conduct stress tests with focus on payment, reporting and program evaluation to identify criteria gaps and conflicts and approaches to resolve

Evaluate findings with key informants – users of performance accountability measures for payment, reporting, and program evaluation

Recommend measure selection criteria set for consideration by MAP Coordinating Committee

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Stress Test Approach

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Purpose:
Identify gaps in endorsement criteria that arise when evaluating measures for specific uses and recommend additional measure selection criteria.

Process:

Identify use cases that represent target settings and applications (e.g., ambulatory - reporting) and associated measure sets (e.g., Meaningful Use CQMs). Perform stress test per use case/measure set.

Evaluate measure set against NQF endorsement criteria in context of proposed application. Identify requirements for a given application – do the endorsement criteria address that requirement?

Example 1: Should usability criteria ensure that the proposed ACO measures will meet the specified needs of the users for payment & reporting?

Example 2: Should feasibility criteria ensure that there are certified vendors to aggregate data for PCMH PRO and patient engagement metrics?

Recommend additional measure selection criteria , which could include:
• Adding new criteria or criteria domains (e.g. "Comprehensiveness")
• Building on the endorsement criteria by adding/modifying sub-criteria
• Identifying need for a threshold requirement or to revise an existing threshold

Proposed selection criteria will be synthesized into candidate criteria changes for MAP consideration. 6

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Deliverables

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- Industry-wide scan of historical measures criteria, including NQF measure endorsement criteria

- Synthesis of scanned criteria and identification of criteria gaps and conflicts that arise when moving from endorsement to application for payment, reporting, and program evaluation

- Recommendations to resolve gaps, conflicts, and/or lack of criteria harmonization across the three applications

- Proposed measure selection criteria set for payment, reporting, and program evaluation

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Intersection with Workgroups

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- MAP Coordinating Committee adopts or revises proposed criteria set for measure selection

- Each MAP workgroup will employ criteria to advise Coordinating Committee on measures for inclusion in input to HHS

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Project Team

Stanford University (Principal Investigator)
- Arnold Milstein, MD, MPH

UC Davis
- Patrick Romano, MD, MPH

UC San Francisco
- Andrew Bindman, MD
- Edgar Pierluissi, MD

Pacific Business Group on Health
- David Lansky, PhD
- Ted von Glahn, MSPH
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Steps to Identify Candidate Criteria

Step 1: Scan existing criteria for new application-relevant concepts

- Research team scanned 35+ existing historical criteria sets to identify new concepts for application-specific measure selection criteria that are not addressed in the NQF endorsement criteria

Step 2: Perform use cases through population lens (ambulatory, inpatient, LTC, duals)

- Research team identified measures selection requirements for each setting by considering the following questions:
- a) Importance : What is the performance accountability framework for the application? Should the criteria domains be prioritized based on the needs of the users of the application?
- b) Scientific Acceptability: What methods issues are attendant to sets of measures that are aggregated for an application?
- c) Usability: Who are the audiences that will use this information? How does the information need to be organized, compiled, and reported to meet the users needs?
- d) Feasibility: What measurement systems are required to handle the data?
- e) Harmonization: Are there unique requirements for the target population, the data sources, or measure types?
- e) Comprehensiveness: What is the scope/depth of the proposed measures set?

Step 3: Perform use cases through application lens (payment, reporting, monitoring)

- Key informants identify additional measures criteria for each of the 3 target applications
- Reconcile conflicts by adopting a "primary user" for each application and prioritizing their requirements

Step 4: Synthesize and reconcile proposed criteria for selection to recommend to MAP

- Research team synthesizes proposed measures selection criteria into a candidate measure selection criteria set for applications

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Ambulatory Use Cases

The following slides highlight *selected preliminary findings* from the Ambulatory Care Setting Use Cases.

The following use cases and measure sets were evaluated.

Use Cases	Associated Measure Sets
Chronically Ill Patients	ACO Proposed Quality Measures
Patients in Ambulatory Setting with EHR	Meaningful Use Clinical Quality Measures
Primary Care Patients -- Patient-Centered Medical Home	•PCMH Patient Experience Survey • Beacon PRO Pilot Measures • Patient Centered Primary Care Collaborative Center (PCPCC) Recommended Measures

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Finding: Importance

Issue: There is potential for cost of care and quality conflicts. To ensure that accountability programs are sustainable, measure sets should balance incentives to reduce overuse in certain areas while encouraging better care and support in other areas.

Potential measure selection criterion: Measure sets should foster alignment between cost of care and quality performance.

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Finding: Scientific Acceptability

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Issue: Performance accountability programs should include a critical mass of providers for meaningful payment and public reporting uses. But, a number of providers could be excluded given uneven information capabilities/resources.

Potential measure selection criterion: Methods should be incorporated into the measure set to enable provider participation if the provider is unable to supply data for all measures.

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Finding: Usability

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Issue: Sets of measures increase the complexity for the intended users.

Potential measure selection criterion: Measure aggregation methods should accompany proposed measure sets to ensure performance information can be summarized at a level that is meaningful and useful for the intended audiences.

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Finding: Feasibility

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Issue: Across accountability programs, the proliferation of similar but distinct measure sets/composites will lead to burden and complexity.

Potential measure selection criterion: Proposed condition-specific or other sub-domain composites should include a standard set of measures.

Accompanying methods should offer flexibility – do not require that all providers report all measures in set.

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Finding: Comprehensiveness

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New domain proposed based on scan of existing criteria sets

Issue: The 3 applications—public reporting, payment, and program monitoring and evaluation—have important consequences for the accountable entities and the information users. Given these consequences, sets of measures are needed to capture multiple dimensions of the accountability program's quality and cost domains.

Potential measure selection criterion: Use groups of measures that address the same construct, condition, procedure, or setting.

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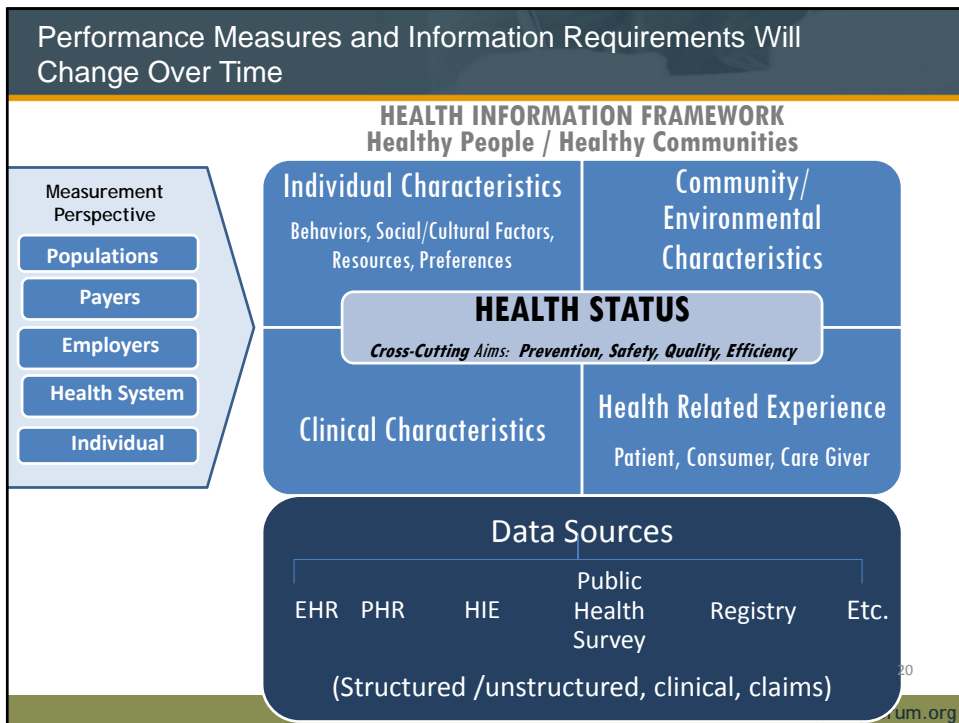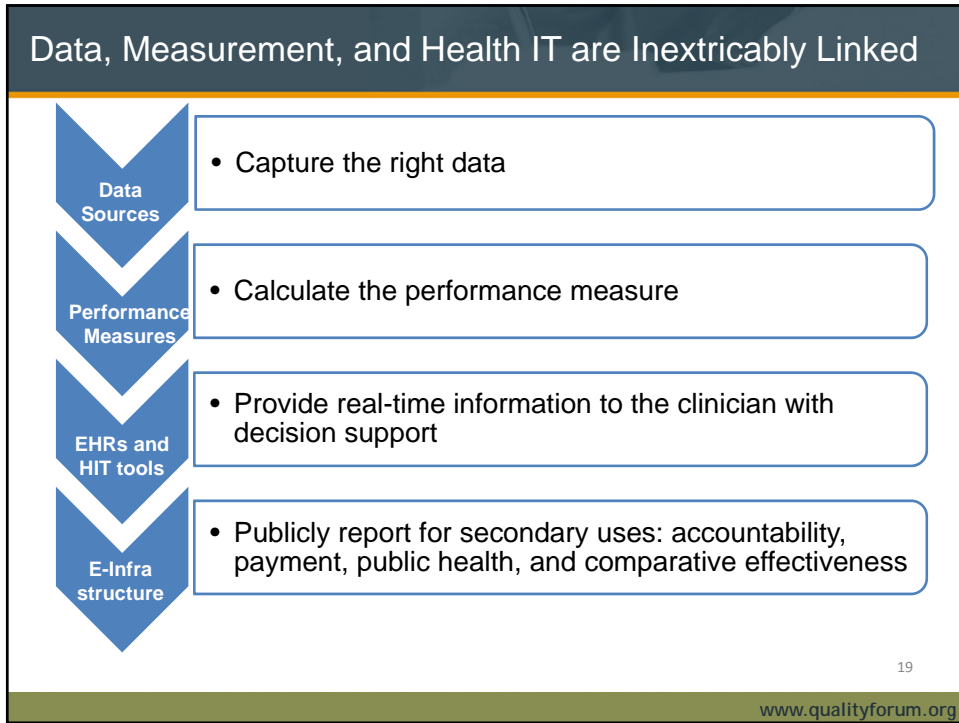# Data Sources and HIT Implications

June 8th 9:30am

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Data, Measurement, and Health IT

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Data, Measurement, and Health IT are Inextricably Linked

Data Sources
- Capture the right data

Performance Measures
- Calculate the performance measure

EHRs and HIT tools
- Provide real-time information to the clinician with decision support

E-Infra structure
- Publicly report for secondary uses: accountability, payment, public health, and comparative effectiveness

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Performance Measures and Information Requirements Will Change Over Time

HEALTH INFORMATION FRAMEWORK
Healthy People / Healthy Communities

Measurement Perspective
- Populations
- Payers
- Employers
- Health System
- Individual

Individual Characteristics
Behaviors, Social/Cultural Factors, Resources, Preferences

Community/ Environmental Characteristics

HEALTH STATUS
Cross-Cutting Aims: **Prevention, Safety, Quality, Efficiency**

Clinical Characteristics

Health Related Experience
Patient, Consumer, Care Giver

Data Sources

EHR   PHR   HIE   Public Health Survey   Registry   Etc.

(Structured /unstructured, clinical, claims)

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Quality Data Model is Working to Define the Data

Quality Data Model (QDM) element

Electronic Quality Measures using the QDM

Individual Family Social Context

PHR

Clinicians Healthcare Organizations

EHR

Communities Public Health

registry

Universal Interoperable Health IT Standards using the QDM

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NQF is Helping Build the Necessary Electronic Infrastructure

Capture Data → Calculate Performance Measures → Real-Time Info to Clinician → Publicly Report

What (data/information) is available in an EHR that I can use to create my measure?

Quality **D**ata **M**odel

How can I say what I want/need to say so that all readers will interpret it the same way?
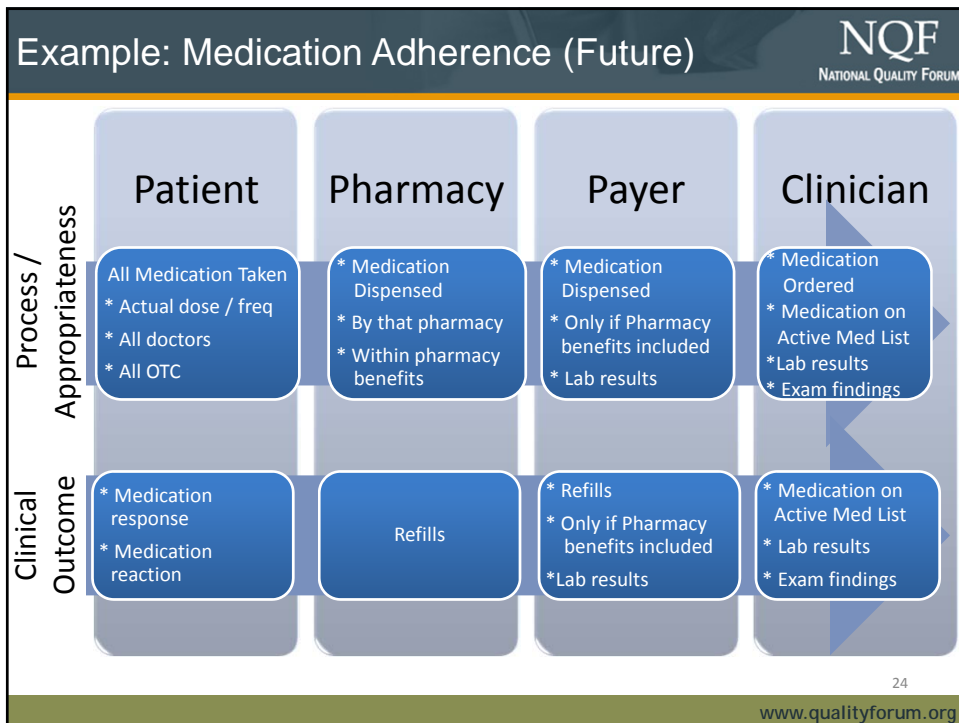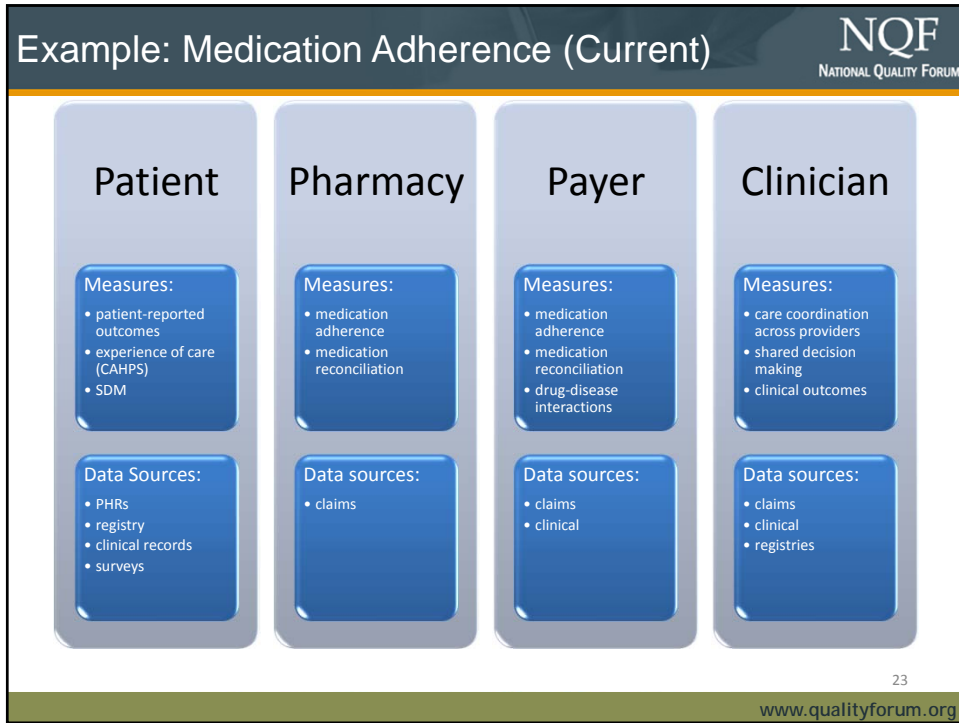
Logic

Standards

How can I create my measure so that an EHR and the average clinician can each understand it?

Measure Authoring Tool

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Example: Medication Adherence (Current)

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Patient	Pharmacy	Payer	Clinician
Measures: • patient-reported outcomes • experience of care (CAHPS) • SDM	**Measures:** • medication adherence • medication reconciliation	**Measures:** • medication adherence • medication reconciliation • drug-disease interactions	**Measures:** • care coordination across providers • shared decision making • clinical outcomes
Data Sources: • PHRs • registry • clinical records • surveys	**Data sources:** • claims	**Data sources:** • claims • clinical	**Data sources:** • claims • clinical • registries

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Example: Medication Adherence (Future)

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	Patient	Pharmacy	Payer	Clinician
Process / Appropriateness	All Medication Taken * Actual dose / freq * All doctors * All OTC	* Medication Dispensed * By that pharmacy * Within pharmacy benefits	* Medication Dispensed * Only if Pharmacy benefits included * Lab results	* Medication Ordered * Medication on Active Med List *Lab results * Exam findings
Clinical Outcome	* Medication response * Medication reaction	Refills	* Refills * Only if Pharmacy benefits included *Lab results	* Medication on Active Med List * Lab results * Exam findings

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Key Questions: eMeasures, Data Sources and Platforms, and Stakeholders

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Issue	Potential Policy Solutions	HIT Role

How can a coordinated strategy move the system toward electronic measures and interoperable data platforms?	• Certification and Meaningful Use Criteria using the same standards for primary data capture and interoperability as for secondary uses
	  • Templates
	  • Vocabulary
		• Parsimoniously harmonize overlapping standards
		• Fill gaps where standards are lacking

How should the data platform (e.g., EHR) be constructed to support various levels of analysis Group practice vs. individual	• Consensus for attribution at individual, group, and higher levels. • Criteria to differentiate patient outcomes Vs. provider effectiveness (not always a direct relationship)	• Standards for rolling up individual providers to groups
How can approaches to data collection best be coordinated to the minimize burden on providers, stakeholders?	• Certification and Meaningful Use Criteria that require data driven approach to information	• Standard model in information (QDM)

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Key Issues: Federal Programs, Measure Reporting Requirements, Data Sources, and Standards

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Issue	Potential Policy Solutions	HIT Role
Separate reporting processes for the same measures under different Federal programs	• Harmonization of Federal programs • Alignment and use of same criteria and formats for requesting and reporting information for measurement	• Parsimoniously harmonize overlapping standards for measure specification and reporting
Submission of data to CMS vs. measure calculations with certified EHR technology	• Harmonization of Federal programs • Certification of EHR modular capabilities • Policy decision	• Standards to enable workflow for data submission or summary reporting (QRDA)
Lack of standardized set of data elements for EHRs	• Certification and Meaningful Use requirements for standard vocabularies and templates	• Standard value sets for incorporation within EHRs (QDM)
Clarification of best use of claims, registries, and EHRs	• Consensus for appropriate workflows as guidance to enable local implementation decisions • Standardization of information submission to registries identical to interoperability models	• Consistent, standard model for expressing information (QDM)

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