

Measure Applications Partnership

Coordinating Committee Meeting

January 8-9, 2013



NATIONAL
QUALITY FORUM

Welcome and Review of Meeting Objectives

Meeting Objectives

- Review **progress on measure alignment** through the lenses of the National Quality Strategy, MAP Families of Measures, MAP Dual Eligible Beneficiaries Workgroup recommendations, Buying Value initiative, and IOM Core Metrics workshop.
- Consider **high-priority measure gaps** and **NQF's collaborative initiative for gap-filling**.
- Finalize **recommendations to HHS on measures for use in federal programs** for the hospital, clinician, and post-acute care/long-term care settings.
- Discuss **feedback loops** about measure use, impact, and implementation experience.

MAP Purpose

In pursuit of the NQS, MAP informs the selection of performance measures to achieve the goal of **improvement, transparency, and value for all**

- MAP Objectives:
 1. Improve outcomes in high-leverage areas for patients and their families
 2. Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy on value
 3. Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden

NQF 2013 Planning

Priority Issues

In its 2013 work of reviewing, recommending and relating measures to The National Quality Strategy, NQF will focus on six pressing problems:

- The lack of a parsimonious set of high-impact measures for assessing value in health care
- The need for more clinical measures for specialties and subspecialties
- The burden of measure use
- The lack of overall coordination of the measures pipeline
- The slow pace of transition to electronic measurement methods, “eMeasures”
- The lack of an effective measurement framework to improve affordability and value in healthcare

Priority Solutions

To address these problems, NQF's 2013 priorities are to:

- Move from identifying measure gaps to helping to fill them by stimulating the creation of the highest priority measures
- Replace ad hoc review panels for measures with 19 standing ones
- Host a process among, and provide technical assistance to, purchasers and payers trying to agree on a common set of measures of value
- Build a network of feedback loops to gather reliable and real-time data on measure use and usefulness
- Expand the "eMeasures Collaborative", a problem solving forum for developers, vendors, and users of electronic measurement
- Continue support for the Stand for Quality effort for Congressional funding for measure development
- Create a comprehensive measurement framework for tackling affordability and a set of metrics of success.

2013 NQF Work Characteristics

In 2013, NQF will focus on improving its operations both externally and internally:

- **Externally** – Broaden and deepen collaboration with all healthcare stakeholders. We seek more collegial relationships across-the-board.
- **Internally** – Fully integrate core operations and programs to achieve greater efficiency and impact.

Progress on Measure Alignment

National Quality Strategy and MAP Families of Measures

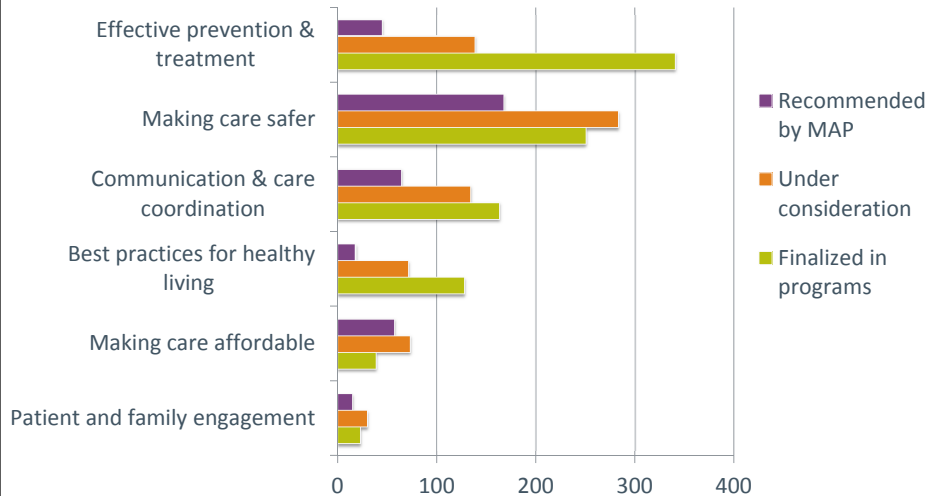
MAP Foundation for Aligned Performance Measurement: National Quality Strategy



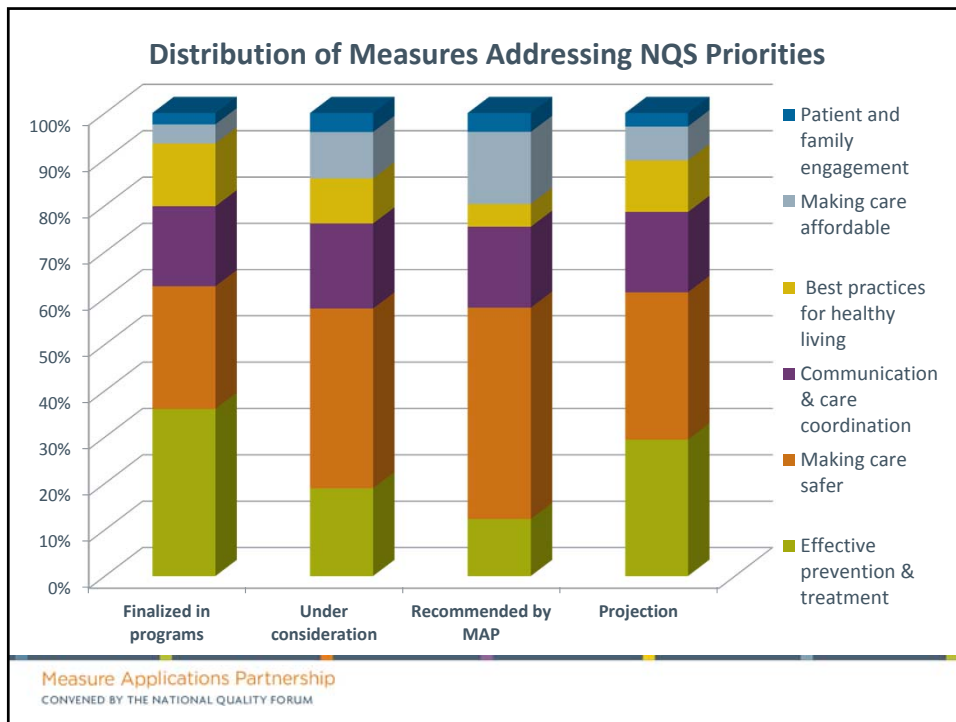
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Use of Measures Addressing NQS Priorities



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Families of Measures and Core Measure Sets

Families of Measures

“Related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS ” (e.g., care coordination family of measures, diabetes care family of measures)

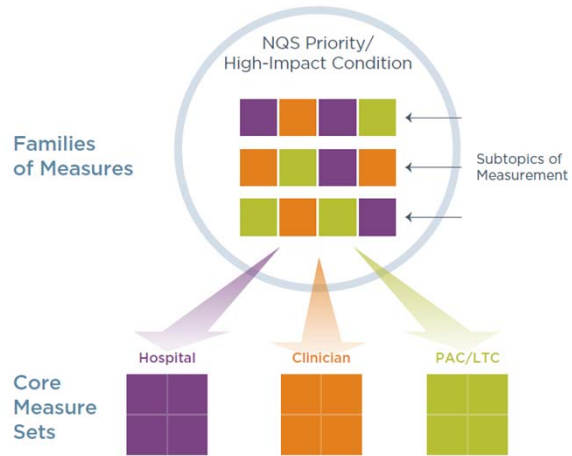
Core Measure Sets

“Available measures and gaps drawn from families of measures that should be applied to specified programs, care settings, levels of analysis, and populations” (e.g., ambulatory clinician measure set, hospital core measure set, dual eligible beneficiaries core measure set)

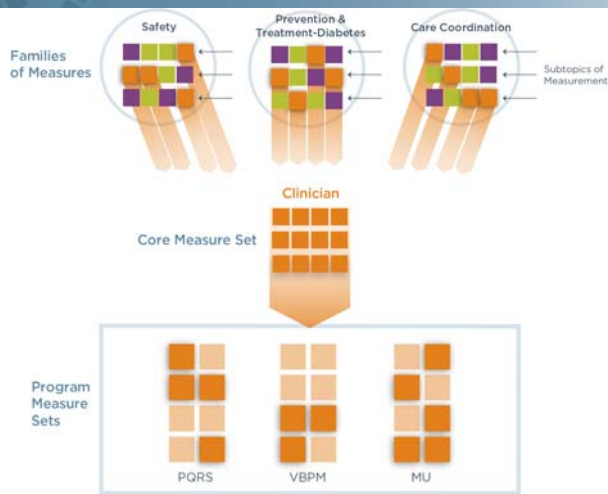
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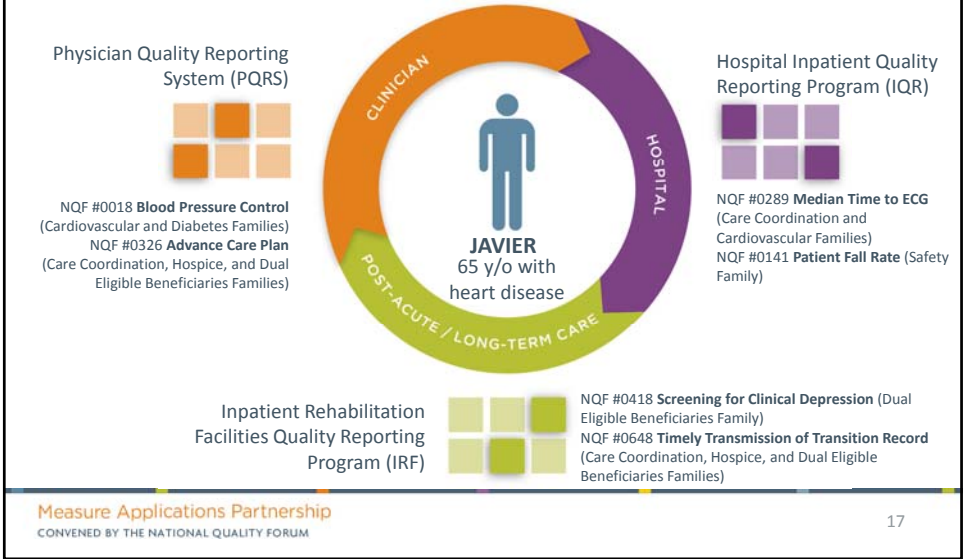
Families of Measures



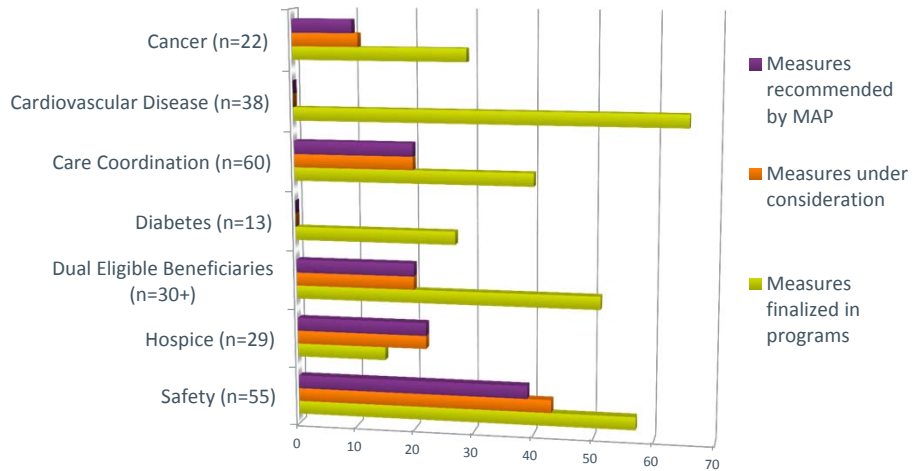
Families of Measures Populating Core Sets and Program Sets



A Patient-Centered Approach to Core Measure Sets

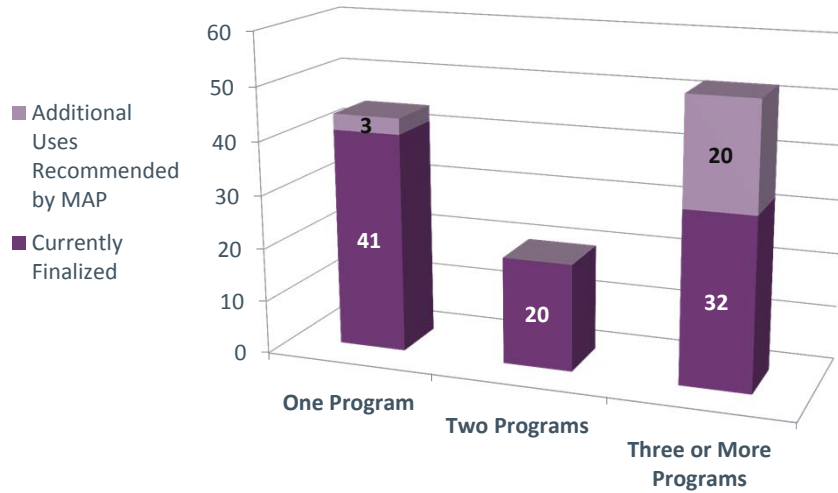


Use of Measures from MAP Families in Pursuit of Alignment

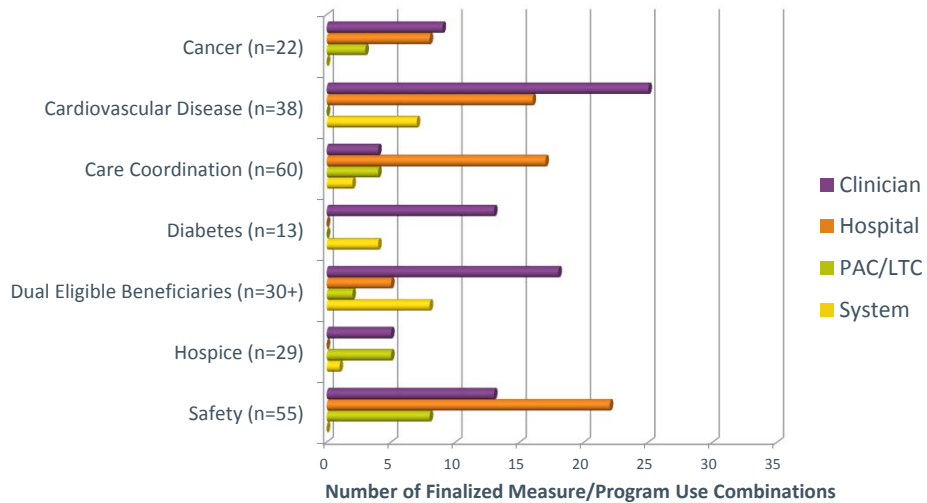


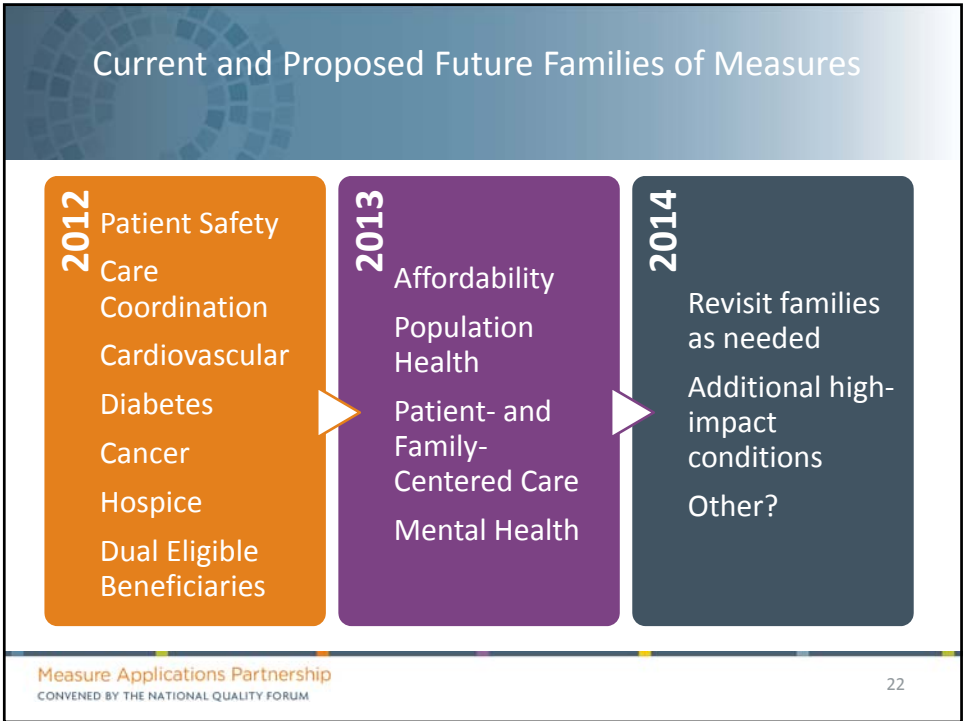
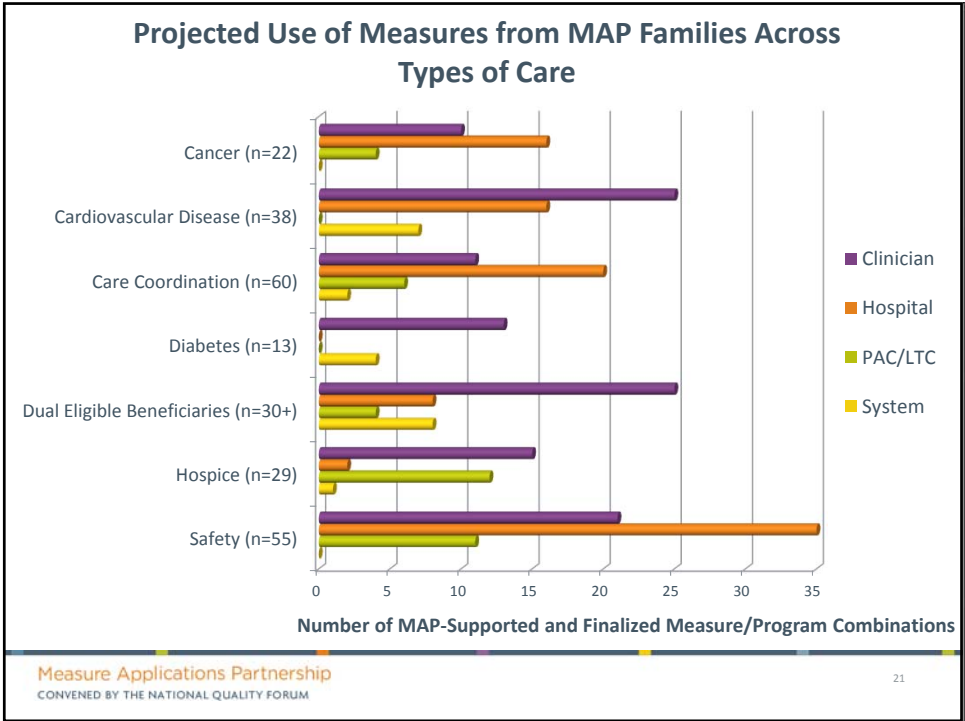
When a measure from a family was under consideration for use in a program, MAP recommended it 96% of the time.

Current and Projected Use of Measures from MAP Families Across Multiple Programs



Finalized Measures from MAP Families Across Types of Care





Discussion

MAP Dual Eligible Beneficiaries Workgroup Recommendations

Year 1 MAP Pre-Rulemaking Uptake of Dual Eligible Beneficiaries Workgroup Recommendations

- During MAP's 2011/2012 pre-rulemaking cycle, the Dual Eligible Beneficiaries Workgroup encouraged other MAP workgroups to recommend measures relevant to dual eligible beneficiaries
- MAP Coordinating Committee and the MAP Clinician, Hospital, and PAC/LTC Workgroups responded by supporting several measures across a range of programs
 - 12 measures from the Dual Eligible Beneficiaries Core Measure Set are now finalized in two or more HHS programs
 - An additional 6 measures from the set are finalized in one HHS program

Evolving Core Measure Set for Dual Eligible Beneficiaries

NQF Measure Number/Status	Measure Name
<i>NQF 0004 Endorsed</i>	<i>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</i>
NQF 0022 Endorsed	Use of High-Risk Medications in the Elderly
<i>NQF 0028 Endorsed</i>	<i>Tobacco Use Assessment and Tobacco Cessation Intervention</i>
<i>NQF 0097 Endorsed</i>	<i>Medication Reconciliation</i>
<i>NQF 0101 Time-Limited Endorsement</i>	<i>Screening for Fall Risk</i>
<i>NQF 0209 Endorsed</i>	<i>Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment</i>
<i>NQF 0228 Endorsed</i>	<i>3-Item Care Transition Measure</i>
NQF 0260 Endorsed	Assessment of Health-related Quality of Life [Physical and Mental Functioning]
<i>NQF 0326 Endorsed</i>	<i>Advance Care Plan</i>
<i>NQF 0418 Endorsed</i>	<i>Screening for Clinical Depression</i>
NQF 0420 Endorsed	Pain Assessment Prior to Initiation of Patient Therapy
<i>NQF 0421 Endorsed</i>	<i>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up</i>
NQF 0430 Endorsed	Change in Daily Activity Function as Measured by the AM-PAC
NQF 0557 Endorsed	HBIPS-6 Post Discharge Continuing Care Plan Created
NQF 0558 Endorsed	HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next level of Care Provider Upon Discharge

Evolving Core Measure Set for Dual Eligible Beneficiaries	
NQF Measure Number/Status	Measure Name
NQF 0576 Endorsed	Follow-up after Hospitalization for Mental Illness
NQF 0647 Endorsed	Transition Record with Specified Elements Received by Discharged Patients
NQF 0648 Endorsed	Timely Transmission of Transition Record
NQF 0729 Endorsed	Optimal Diabetes Care
NQF 1632 Endorsed	CARE – Consumer Assessments and Reports of End of Life
NQF 1626 Endorsed	Patients Admitted to ICU who Have Care Preferences Documented
NQF 1641 Endorsed	Hospice and Palliative Care – Treatment Preferences
NQF 1768 Endorsed	Plan All-Cause Readmissions
NQF 1789 Endorsed	Hospital-Wide All-Cause Unplanned Readmissions
NQF 1825 Endorsed	COPD – Management of Poorly Controlled COPD
NQF 1909 Endorsed	Medical Home System Survey
NQF 1919 Endorsed	Cultural Competency Implementation Measure
Multiple Surveys Endorsed	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys
Not Endorsed; to be added pending endorsement	Unhealthy Alcohol Use: Screening and Brief Counseling
Not Endorsed	SNP 6: Coordination of Medicare and Medicaid Coverage

Year 2 Approach to Sharing Dual Eligible Beneficiaries Workgroup Perspective for Pre-Rulemaking

- Continued Year 1 efforts to expand the use of measures that are relevant to the dual eligible population’s unique needs by recommending they be added to existing programs.
- Shared update at the December All MAP Web Meeting
- Liaisons from MAP Dual Eligible Beneficiaries Workgroup helped to carry communications between the groups, accompanied by written guidance.
- Workgroup convened via web meeting on December 19 to review and discuss the results of other groups’ deliberations.
- Now have cross-cutting input for Coordinating Committee regarding the applicability and appropriateness of measures supported across MAP.

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Input from Dual Eligible Beneficiaries Workgroup to Hospital Workgroup

- Hospitals can deliver high-quality care to dual eligible beneficiaries by ensuring that care is safe and appropriate.
- Improvement can be achieved by developing relationships between health systems and community services to reduce readmissions from both community and long-term care settings.
- A mix of creativity and compassion may be needed to deal with challenges posed by emergency department crowding and “frequent users.”
- Considering the heterogeneity of the population, the Dual Eligible Beneficiaries Workgroup encourages broad thinking about measures of care coordination, patient experience, and outcomes.

Outcome of Discussion Related to Duals Core Measures

- HCAHPS (NQF #0166)
 - Current finalized measure in IQR and Hospital VBP, supported the direction of this measure for PPS-exempt Cancer Hospital Quality Reporting
- 3-Item Care Transition Measure (NQF #0228)
 - Current finalized measure in IQR, supported for Hospital VBP
- Follow-up After Hospitalization For Mental Illness (NQF #0576)
 - Supported for Inpatient Psychiatric Facility Quality Reporting
- Hospital-wide All Cause Unplanned Readmission (NQF #1789)
 - Supported for IQR, pending NQF-endorsement of the updated version

Input from Dual Eligible Beneficiaries Workgroup to Clinician Workgroup

- Clinicians can deliver high-quality care to dual eligible beneficiaries by focusing on the management of chronic conditions, including mental illness.
- Clinicians and the care teams within which they operate have a major role in facilitating successful care coordination and transitions.
- Clinicians are also expected to focus on the “Screening and Assessment” high-leverage opportunity area, working with an individual to understand their goals for care and taking appropriate steps to manage symptoms, medications, and risks.
- The Dual Eligible Beneficiaries Workgroup urged the Clinician Workgroup to focus on alignment opportunities presented by measures in the Evolving Core Measure Set for Dual Eligible Beneficiaries and their use across clinician measurement programs.

Outcome of Discussion Related to Duals Core Measures

Four measures from the Evolving Core Set specified for the clinician level of analysis were under consideration for PQRS:

- Patients Admitted to ICU Who Have Care Preferences Documented
- Hospice and Palliative Care – Treatment Preferences
- CAHPS® Surgical Care Survey
- CAHPS Adult Primary Care Survey: Shared Decision-Making
- *Based on the principles developed by the Clinician Workgroup, all should be supported for inclusion because they are endorsed.*
- *Many measures in the Evolving Core Measure Set for Dual Eligible Beneficiaries are currently finalized for use in clinician programs.*
- *Other clinician-level measures from the Evolving Core Set might be under consideration in future years.*

Input from Dual Eligible Beneficiaries Workgroup to Post-Acute Care/Long-Term Care Workgroup

- Post-Acute Care and Long-Term Care providers can deliver high-quality care to dual eligible beneficiaries by emphasizing person-centeredness and responsiveness to an individual's goals for care.
- Attention should be paid to delivering services in the least intense setting that is realistic for the beneficiary.
- Common themes and points of discussion include functional status and quality of life.
- Dual Eligible Beneficiaries Workgroup advocated for background research on the ESRD population to explore the possibility of measure stratification by dual eligible beneficiary status.

Outcome of Discussion Related to Duals Core Measures

Measure Name	Program in Which Measure Is Under Consideration	MAP Decision
Medication Reconciliation (#0097)	Long-Term Care Hospital Quality Reporting (LTCH)	Support Direction
HCAHPS (#0166)	LTCH	Support Direction
3-Item Care Transition Measure (#0228)	LTCH	Support Direction
CAHPS In-Center Hemodialysis Survey (#0258)	End-Stage Renal Disease Quality Reporting	Support
Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (#0647)	LTCH	Support Direction
Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (#0648)	LTCH	Support Direction
Hospice and Palliative Care – Treatment Preferences (#1641)	Hospice Quality Reporting	Support

Measure Topics Requiring Further Emphasis

Coordinating Committee should consider:

- Accounting for different types of diversity and disparities in care
- Creative approaches to patient and family engagement
- Presence of risk adjustment to appropriately protect providers and health plans treating more vulnerable beneficiaries
- Targeting measures that drive improved outcomes, removing low-value measures as needed
- Measure gaps in:
 - Shared accountability for care coordination through transitions
 - Advanced care planning
 - Mental and behavioral health
 - Structural measures as they apply to providers and health plans integrating with community organizations or other providers of LTSS

Important Dates

- Wrapping up current work on high-need subgroups
 - December 21: Interim Duals Report Submitted to HHS
 - December 27 - January 30: Public Comment on Interim Duals Report
- Continuing work with focus on high-need behavioral health subgroups
 - February 2013: Web Meeting of Dual Eligible Beneficiaries Workgroup (*tentative*)
 - March 2013: In-Person Meeting of Dual Eligible Beneficiaries Workgroup (*tentative*)



Discussion

Buying Value Initiative

Discussion

IOM Core Metrics Workshop

Measuring the Triple Aim: Observations and Reflections*

George Isham, M.D., M.S.

*Isham's observations and reflections on attending the workshop on *Core Metrics for Better Care, Lower Costs, and Better Health*, Sponsored by the Institute of Medicine, Roundtable on Value and Science Driven Health Care, Irvine California, December 5th and 6th, 2012



Core Metrics for Better Care, Lower Costs and Better Health (IOM Workshop)

Meeting goals

1. Discuss the vision for the nature, use, and impact of core health metrics.
2. Identify the important principles, targets, infrastructure, processes, strategies, and policies.
3. Describe lessons from efforts at national, state, community, and organization levels.
4. Specify core needs and requirements, and propose priority metric categories that will most reliably measure care outcomes, care costs, and health improvement.
5. Consider specific examples of metric options within categories.
6. Describe the implementation strategies—national, state, community, organizational.

Planning Committee

Craig Jones (Chair)	Vermont Blueprint for Health
David Atkins	Veterans Health Administration
Maureen Bisognano	Institute for Healthcare Improvement
Michael E. Chernew	Harvard Medical School
Diana S. Dooley	California Health and Human Services
Julie Gerberding	Merck and Co, Inc.
Marjorie Ginsburg	Center for Healthcare Decisions
Kate Goodrich	Centers for Medicare & Medicaid Services
George J. Isham	HealthPartners, Inc
Peter Margolis	Cincinnati Children's Hospital Medical Center
Leo S. Morales	University of California, Los Angeles
Judy Murphy	Office of the National Coordinator for HIT
Samuel R. Nussbaum	WellPoint, Inc.
Patrick Remington	U. Wisconsin School of Medicine & Public Health
Edward J. Sondik	National Center for Health Statistics
David M. Stevens	National Association of Community Health Centers
Thomas B. Valuck	National Quality Forum
Anne F. Weiss	Robert Wood Johnson Foundation
Nancy Wilson	Agency for Healthcare Research and Quality

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Nature of the System

- Complex Adaptive System (Isham looking at Plsek)
- Multilevel System (see the planning committee background paper for the meeting, Isham, Burstin, Steifel) with a system and subsystem structure important for getting whole or total population impact. (look at the excellent NQF working paper by Jacobson and Teutsch, not on the IOM website)
- Need for *Harmony*, *Parsimony* and *Alignment* (nearly everyone including State of Oregon, State of Minnesota and NQF) Could this be a country song? (a lament?) Could this be a folk song? (a Kumbaya?)
- Many as yet undiscovered insights from modeling approaches (Bobby Milstein and David Eddy) may take these conversations to new and important levels that affect priorities and choices. (Steifel)
- Imbalance between Federal and State quality ecosystems (Queram)
- With respect to health or the triple aim, the role of public health and other actors is not at all clear. Accountabilities and accountability models are not clear at any level in the system (non-system?).



Nature of the Triple Aim or the 3 aims

- Federal vs. Private Versions (Alignment?)
- Where do the social and environmental determinants of health fit in? (Isham - Kindig Blog)
- Differences between the explicit nature of cost goals and objectives at the state (very explicit) vs the federal levels (soft and vague) of the triple aim or 3 aims.
- At the community level – preliminary lessons from IHI and others.
- At the organizational level- an operational, improvement focus and the issue of determining the relationship of the organization to population and subpopulation community cost and health goals and objectives.
- Is there an opportunity for a triple aim atlas? (Dartmouth Atlas like at the National, state, county and community level?)

Lessons From the Early Days

- Critical role of an integrator
- A need to identify “a population”
- Definition of measures, a portfolio of projects, a tempo, and constraints

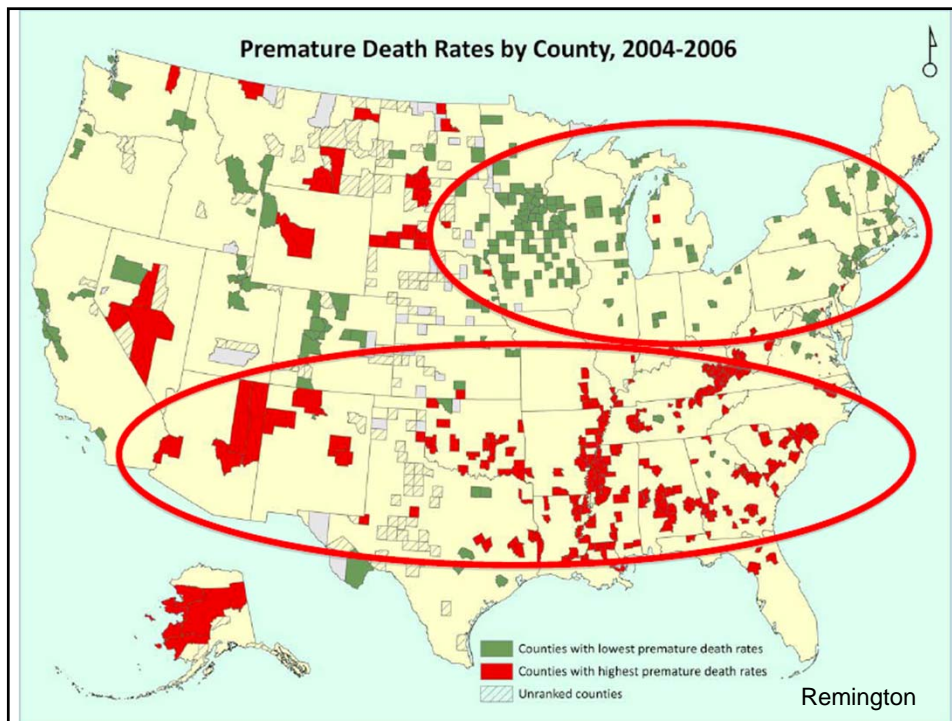
Maureen Bisognano



Collaborative Lessons

- Need measures for comparison and for learning (data over time)
- Need a learning system and a broader coalition to move the numbers
- Clarity on measuring progress in outcomes, processes, and at the population level
- Governance – a key role of the integrator – is harder than management

Maureen Bisognano



☀ Some Challenges

- Data and data collection structures – Single data sources and unitary data collection infrastructures such as in Vermont (Jones) vs distributed data collection infrastructures used by Brookings built on common standards (Gage).
- Harmony, Parsimony and Alignment
- E-measures (Burstin) and meaningful use (Larsen).
- Definition of the notion of “Core Measurement Set” (Isham – NQF MAP)
- Balancing the Triple aim – Costs (Isham and many others)

4. Challenges and learnings

- Aligning with other purchasers’ metrics, e.g., Oregon’s exchange, public employee benefits, Oregon’s high risk pool, commercial employers
- Setting attainable and meaningful performance goals
- Narrowing the list to a reasonable set that covers critical aspects of the Triple Aim

Romm

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Challenges (cont.)

- Collecting data at a reasonable cost
- Establishing a baseline for new metrics
- Avoiding unintended consequences in selection of metrics
- Getting to outcomes measures

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Learnings: Beyond Metrics

- Metrics cannot stand alone: multiple levers are critical
- Stakeholder involvement is critical
- Align around a model (Coordinated Care model)

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Challenges & Lessons

- Establishing clarity about purpose in developing measures
- Customizing measure set(s) customized for a given purpose
- Aligning measures within states and across payers (including federal)
- Speeding up measure development cycle
- Growing evidence about effectiveness of initiatives in public health and prevention
- Tracking & communicating measurement results in a more organized fashion (and not by data set)
- Developing composites or indexes that help policy makers assess progress
- And...



Gildemeister

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Ongoing Challenges

- Uniformity in data measuring
 - Initiatives aligned with NQS, such as Million Hearts campaign, may collect data differently than state or community-level initiatives
- Lags in timely trend data
 - Data reporting can be spotty or slow and may not capture progress/issues in a timely manner
- Are we collecting the kind of data that organizations need to make rapid, real-time improvements?

Carolyn Clancy

☼ General Observations - Isham

- It's a complex, multilevel, adaptive system
- Many public and private proposed frameworks.
- Definitions not consistent or clear, example "Population Health" "Core Measurement Set" etc.
- Population Health and Cost often seen through the lens of care delivery
- Not enough emphasis on disparity reduction
- The nature of national, state and community organization for improving the triple aim at the community level is not at all clear (governance, funding, infrastructure)
- Explicit goals for quality, health and cost are being set by some states and private organizations
- Public Transparency is important

☼ Breakout Session Day 1 Drafts

Metric Domain	Metric Categories	Example Metrics	Implementation
Population Health	Current Health	<ul style="list-style-type: none"> - Length of life: Mortality, life expectancy - Quality of life: Morbidity, functional status, indicator diseases - Composite: QALY, HALY 	<ul style="list-style-type: none"> - Defining the population - Communication/education of measures - Data collection - Transparent methods for composites/indices - Tension in targeting innovators or all actors - Actionability of measures
	Future Health	<ul style="list-style-type: none"> - Health Determinants: Health risks, health behaviors, healthy communities and extrinsic determinants 	

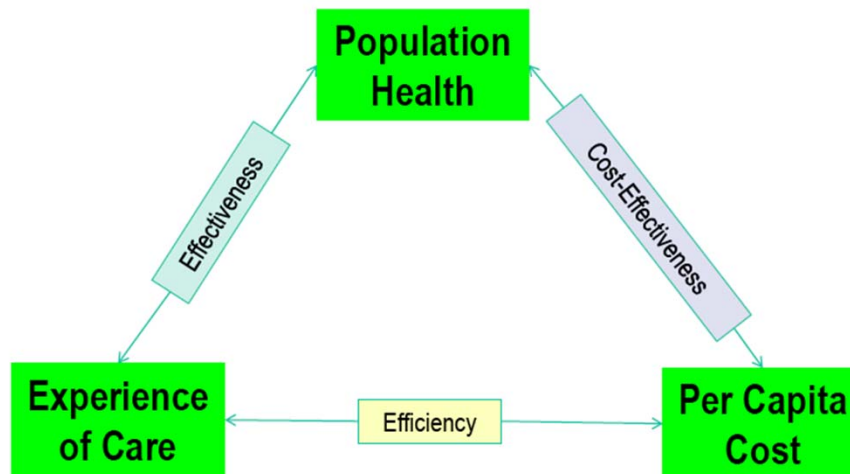
Breakout Session Day 1 Drafts

Metric Domain	Metric Categories	Example Metrics	Implementation
Health Care	Patient centered	<ul style="list-style-type: none"> - Patient experience: HCAHPS metric - Equitable - Timeliness 	<ul style="list-style-type: none"> - Risk adjustment critical - Appropriateness of care - Timeliness of care under all metrics (both in initial access and time to return to function)
	Effective	<ul style="list-style-type: none"> - Mortality amenable to health care - Functional status - Equitable 	
	Safe	<ul style="list-style-type: none"> - Composite medical harm measure (including medical errors and health associated infections) - Equitable 	
	Efficiency	<ul style="list-style-type: none"> - Utilization: Ambulatory care sensitive admissions and readmissions - Equitable 	
	Coordination and communication	<ul style="list-style-type: none"> - Timeliness 	

Breakout Session Day 1 Drafts

Metric Domain	Metric Categories	Example Metrics	Implementation
Cost	Total cost of care (actual costs)	<ul style="list-style-type: none"> - Total Cost of Care Metric, actual cost and risk adjusted. Population-based per member per month (all conditions). 	<ul style="list-style-type: none"> - Antitrust - HIPAA - Proprietary Interests - Standardization - Governance - Attribution - Legal - Costs
	Total cost of care (standardized costs)	<ul style="list-style-type: none"> - Total Cost of Care Metric, standardized costs and risk adjusted. Population-based per member per month (all conditions) 	
	Affordability	<ul style="list-style-type: none"> - Percent of household spending on health - Percent of national GDP and/or federal government health care spend as percent of total federal government spend - Percent individual, employer, Medicare spending - Premiums 	

Value Measurement



stiefel



McGinnis Summary – Important Buckets of Issues (Isham's Notes)

- Purpose - Capture what's been suggested for the alternatives for the purposes involved. Why core metrics?
 - Are they to be aligned to identify the major factors for improving better care, better health and lower cost?
 - Are they for structuring Rankings?
 - Are they to provide management tools?
 - Are they for structuring payment?
- Players – who needs to be consulted around each of those purposes? the metrics?

☼ McGinnis Summary (Continued)

- Portrayal – (models or frameworks) different models or framework by purpose? Need frameworks that are easily to engage by the public.
- Points- Data points. What are the critical data points and metrics that have been offered for consideration in the core set of metrics?
- Poignancy- For targeting different populations (disparities), which data points are particularly poignant to capture this? Or which sentinel indicators can trigger local initiatives? Or which are especially robust to trigger initiative and focus on important issues

☼ McGinnis Summary (Continued)

- Process – how are these data points to be reported? Whose collecting them? What data is available to develop a truly functional set for the nation?
- Priorities – once there are data sets, what are the priorities that are most important?
- Prospection- (Future) Need to build a dynamic system so we have a continuous learning system, not a static one.

☼ McGinnis: Next Steps

- Create a summary
- Should a deeper dive should be considered by the IOM? Around which purpose should we anchor? Can't do them all.

☼ Resources

- Agenda, copies of presentations, briefing book, environmental scan of integrated approaches and video of the conference available at:
- <http://www.iom.edu/Activities/Quality/VSRT/2012-DEC-05.aspx>

Discussion

Opportunity for Public Comment

High-Priority Measure Gaps and NQF's Collaborative Initiative for Gap-Filling

MAP's Previous Work on Measure Gaps

- Through pre-rulemaking activities, MAP has identified many measure gaps for different programs, settings, and populations
- MAP's work on Families of Measures began a process of narrowing the focus to the highest-priority gaps
- Measure developers participated in MAP meetings to gain perspective and provide feedback
- Common gap themes and barriers to gap-filling at the various stages along the measure lifecycle are apparent

Major Gap Themes and Barriers

Major Measure Gap Themes

Person-Centered Measurement
Bi-Directional Communication
Outcome Measures
Affordability
Measures in Need of Modifications

Barriers to Gap-Filling

Funding Streams
Lack of Evidence
Data Limitations
Attribution

Assessing Progress on Gap-Filling

- During the December workgroup meetings, a list of measure gaps was synthesized from prior MAP reports
- Workgroup supported selecting measures that could fill high-priority gaps, such as:
 - Measures incorporating Patient Reported Outcomes
 - Care Coordination measures
 - Measures that focus on important safety issues (e.g., obstetrical adverse events)
- However, persistent gaps remain a critical problem

Collaborative Approach to Gap Filling

Develop stronger partnerships between those who seek, fund, develop, test, endorse, and implement measures.

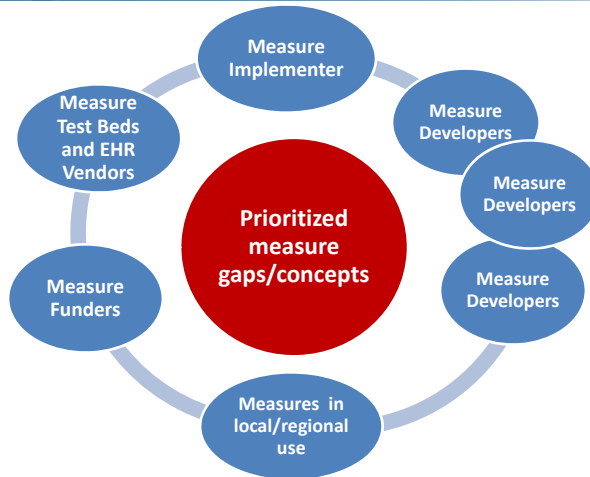
- Share prioritized measure gaps with measure developers
- Encourage collaborative development and early harmonization across developers
- Regularly convene measure developers to focus on prioritized gaps and encourage collaboration
- Explore opportunity to create a virtual “measure incubator” that would encourage collaboration and sharing among stakeholders interested in addressing measure gaps

Measure Incubator

Intended use of collaborative measurement space:

- Facilitate discussion of prioritized measure gaps
- Track current and planned measure development
- Share funding opportunities for measure development
- Facilitate testing opportunities and collaboration with EHR vendors
- Connect measure developers to those who seek measures in order to allow real-time feedback as measures are identified, developed and implemented

Measure Incubator Concept




MAP Pre-Rulemaking Approach

Federal Program for MAP Pre-Rulemaking Input	MAP Workgroup
Physician Feedback/Value-Based Payment Modifier	Clinician Workgroup
Physician Quality Reporting System	
Medicare and Medicaid EHR Incentive Program for Eligible Professionals	
Medicare Shared Savings Program	
Physician Compare	
Hospital Inpatient Quality Reporting	Hospital Workgroup
Hospital Value-Based Purchasing	
Hospital Outpatient Quality Reporting	
Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	
Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	
Inpatient Psychiatric Facility Quality Reporting	
Hospital Readmission Reduction Program	
Hospital-Acquired Conditions Payment Reduction	
Medicare Shared Savings Program	
Ambulatory Surgical Center Quality Reporting	
Home Health Quality Reporting	PAC/LTC Workgroup
Nursing Home Quality Initiative and Nursing Home Compare Measures	
Inpatient Rehabilitation Facility Quality Reporting	
Long-Term Care Hospital Quality Reporting	
Hospice Quality Reporting	
End Stage Renal Disease Quality Management	

Pre-Rulemaking Approach

1. Build on MAP's prior recommendations
2. Evaluate each finalized program measure set using MAP Measure Selection Criteria
3. Evaluate measures under consideration for what they would add to the program measure sets
4. Identify high-priority measure gaps for programs and settings


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1. Build on MAP's Prior Recommendations

MAP's Prior Efforts	Pre-Rulemaking Use
Coordination Strategies (i.e., Safety, Clinician, PAC-LTC, Dual Eligible Beneficiaries Cross-Cutting Input)	<ul style="list-style-type: none"> Provides setting-specific considerations that will serve as background information for MAP's pre-rulemaking deliberations. Key recommendations from each coordination strategy will be compiled in background materials.
Gaps Identified Across All MAP Efforts	<ul style="list-style-type: none"> Provides historical context of MAP gap identification activities. Will serve as a foundation for measure gap prioritization. A universal list of MAP's previously identified gaps will be compiled and provided in background materials.

***While MAP's prior efforts serve as guidance for this work, pre-rulemaking decisions are not restricted to measures identified within these efforts.**

1. Build on MAP's Prior Recommendations

MAP's Prior Efforts	Pre-Rulemaking Use
2012 Pre-Rulemaking Decisions	<ul style="list-style-type: none"> Provides historical context and represents a starting place for pre-rulemaking discussions. Prior MAP decisions will be noted in the individual measure information.
Families of Measures NQS priorities (safety, care coordination) Vulnerable populations (dual eligible beneficiaries, hospice) High-impact conditions (cardiovascular, diabetes, cancer)	<ul style="list-style-type: none"> Represents a starting place for identifying the highest-leverage opportunities for addressing performance gaps within a particular content area. Setting- and level-of-analysis-specific core sets will be compiled, drawing from the families and population cores. Core measures will be flagged in the individual measure information. MAP will compare the setting and level-of-analysis cores against the program measure sets.

2. Evaluate Finalized Program Measure Set Using MAP Measure Selection Criteria

MAP will identify:

- Potential measures for inclusion (e.g., from core sets, newly endorsed measures)
- Potential measures for removal
- Gaps—implementation gaps (core measures not in the set) and other gaps (e.g., development, endorsement) along the measure lifecycle
- Additional programmatic considerations (e.g., guidance on implementing MAP recommendations, data collection and transmission, attribution methods)

3. Evaluate Measures Under Consideration

MAP will indicate a decision and rationale for each measure under consideration:

MAP Decision Category	Rationale (Examples)
Support	<ul style="list-style-type: none"> • Addresses a previously identified measure gap • Core measure not currently included in the program measure set • Promotes alignment across programs and settings
Support Direction	<ul style="list-style-type: none"> • Addresses a gap, but not tested for the setting • Promotes parsimony, but data sources do not align with programs data sources
Phased Removal	<ul style="list-style-type: none"> • Measure previously finalized in the program, but a better measure is now available • NQF endorsement removed or retired
Do Not Support	<ul style="list-style-type: none"> • Overlaps with a previously finalized measure
Insufficient Information	<ul style="list-style-type: none"> • Measure numerator/denominator not provided

4. Identify High-Priority Measure Gaps for Programs and Settings

MAP's Previously Identified Gaps

- Compiled from all of MAP's prior reports
- Categorized by NQS priority and high-impact conditions
- Compared with gaps identified in other NQF efforts (e.g., NPP, endorsement reports)

MAP will:

- Identify priorities for filling gaps across settings and programs
- Present measure ideas to spur development
- Capture barriers to gap filling and potential solutions

Finalize Pre-Rulemaking Recommendations for Hospital Programs

***1:45 pm – 4:00 pm
Discussion Guide Items # 13-24***

Hospital Programs and Measures Under Consideration

Programs	Number of Measures Under Consideration
Hospital Inpatient Quality Reporting (IQR)	20
Hospital Value-Based Purchasing (VBP)	17
Hospital Outpatient Quality Reporting (OQR)	7
Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs (Meaningful Use)	1
Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	19
Inpatient Psychiatric Facility Quality Reporting	5
Hospital Readmission Reduction Program	6
Hospital-Acquired Conditions (HAC) Payment Reduction	18
Medicare Shared Savings Program (MSSP)	0
Ambulatory Surgical Center (ASC) Quality Reporting	5

Opportunity for Public Comment

Welcome and Review of Day 1

Finalize Pre-Rulemaking Recommendations for Clinician Programs, including Medicare Shared Savings Program and Cost Measures

***8:45 am – 11:00 am
Discussion Guide Items # 29-38***

Clinician Programs with Measures Under Consideration

Programs

Physician Quality Reporting System (PQRS)

Physician Compare

Physician Feedback/Value-Based Payment Modifier (VBPM)

Medicare and Medicaid EHR Incentive Program for Eligible Professionals (MU-EP)

Medicare Shared Savings Program (MSSP)

Opportunity for Public Comment

Finalize Pre-Rulemaking Recommendations for Post- Acute/Long-Term Care Programs

11:15 am – 12:00 pm

12:30 pm – 1:15 pm

Discussion Guide Items #40-49

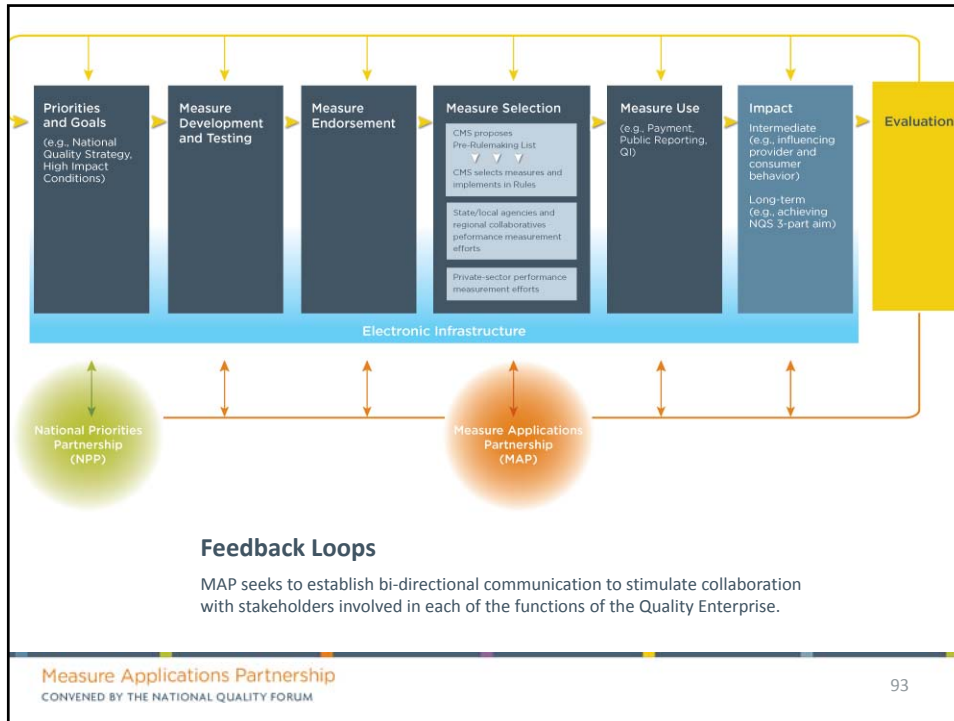
PAC/LTC Programs and Measures Under Consideration

Programs	Number of Measures Under Consideration
Long-Term Care Hospital Quality Reporting (LTCH)	29
Inpatient Rehabilitation Facility Quality Reporting (IRF)	10
End Stage Renal Disease Quality Management (ESRD)	21
Hospice Quality Reporting	7
Nursing Home Quality Initiative and Nursing Home Compare Measures	5
Home Health Quality Reporting	2

Feedback Loops about Measure Use, Impact, and Implementation Experience

Feedback Loops

- MAP Strategic Plan 2012-2015 emphasizes the need to engage stakeholders more deeply in MAP's work
- In 2013, NQF will establish feedback loops to garner information about measure implementation, use, and impact



What are feedback loops and why are they important?

- IOM report, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, cites feedback loops as essential for continuous learning and system improvement
- Continuously learning system uses information to change and improve its actions and outputs over time

Measure Applications Partnership
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Image Source: <http://www.iom.edu/~media/Files/Report%20Files/2012/Best-Care/BestCareReportBrief.pdf>

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Illustrative Purposes for Feedback Loops

- MAP seeks information about measure use to ensure alignment across programs and sectors
- NQF endorsement maintenance process collects information about experience with specific measures every three years
- Measure developers want to understand unintended consequences to inform future measure modifications
- HHS and other program implementers need information about measure impact to evaluate their programs
- Measure end users are interested in feasibility and data collection burden and in sharing their implementation experience

Ideal Characteristics of Feedback Loops

- Systematic
- Standardized
- Real-time
- Two-way
- Among all levels of the system
- Take best advantage of information technology
- Other?

Potential Information Sources for Feedback Loops

Information Type	Sources	Information Available
Measurement Priorities and Opportunities	National Quality Strategy/NPP	2012 National Quality Strategy and NPP reports provide consensus priorities
	HHS websites	AHRQ, CDC, CMS, VHA, Partnership for Patients, and others provide statistics and research findings
Measure Use	NQF reports/tools/activities	NQF reports describe recommendations and actual use in multiple settings; Alignment Tool describes community use; NQF endorsement processes and measure database contains developer information on use
	Private organization websites	Multiple private program sites list measures in use (e.g., Alternative Quality Contract, eValue8, Joint Commission, Leapfrog)
	AHIP and QASC surveys	Identifies measures used by health plans and health systems
Measure Results	CMS Impact Assessment	Medicare measure trends over 2+ years
	HHS Compare sites	National, state, and local results for select measures in various programs
	AHRQ NHQRDRnet	National and state results for select measures, with demographic stratification
	Private organization websites and reports	Some private organizations provide limited performance data (e.g., ASC Quality Collaboration, clinical registries, Medical Specialty Societies, Joint Commission Annual Report, NCQA State of Health Care Quality Report)
	Medical Specialty Boards	Diagnostic acumen and maintenance of certification (MOC)

Potential Information Sources for Feedback Loops

Information Type	Sources	Information Available
Measure Implementation Experience	CMS 2010 Reporting Experience (PQRS & eRx)	Participation rates, including measures reported by the largest number of Eligible Professionals in PQRS
	Alignment Tool	Details on measure use experiences of AF4Q communities
	NQF structured feedback	Comments submitted through QPS; endorsement implementation feedback and developer responses; barriers to the use of measures through NQF councils
Measure Impact	2015 CMS Impact Assessment	In planning stages; MAP will focus on aligning with RE-AIM framework
	Various from above	Many of the other sources for measure use, performance, and implementation experience information can inform impact assessment

Potential Channels for Feedback Loops

- Pushed into a repository through routine submissions
- Pulled into a repository through targeted outreach
- Gathered through the use of surveys
- Obtained via active information exchanges, such as:
 - Focus groups
 - Listening sessions
 - Online discussion forums
 - Learning networks
- Other?

Feedback Loops Discussion Questions

- What are the most important purposes for measure feedback loops to meet? The most important information for MAP to obtain or share?
- What are the essential characteristics for measure feedback loops?
- What existing or new information sources about measures should measure feedback loops be built on? Who holds that information?
- What channels for obtaining and sharing information about measures would be the most useful? The most practical mechanisms for exchange?
- What resources are available to support the implementation of measure feedback loops?
- What feedback mechanisms or information sources about measures do MAP members already have in place?
- What structured questions should NQF ask (e.g., through QPS, endorsement maintenance, NPP, MAP) about measure implementation experience, use, and impact?

MAP Approach and Progress to Date: Round Robin Discussion

Committee Questions

- As we near the end of the second year of MAP's work, what feedback do you have about the structure, processes, and deliverables?
- What guidance do you have for enhancing MAP's function?

Opportunity for Public Comment

Next Steps

Next Steps

- **MAP Pre-Rulemaking Report**
 - **January 14-28:** 2-week public comment period on draft MAP Pre-Rulemaking Report
 - **February 1:** MAP Pre-Rulemaking Report due to HHS
- **MAP Dual Eligible Beneficiaries Report**
 - **December 27-January 30:** Public comment on Interim Duals Report
 - **February 2013:** Web Meeting of Dual Eligible Beneficiaries Workgroup (*tentative*)
 - **March 2013:** In-Person Meeting of Dual Eligible Beneficiaries Workgroup (*tentative*)