Measure Applications Partnership Coordinating Committee

In-Person Meeting #1

May 3-4, 2011
9:00 am – 5:00 pm EST

Welcome and Review of Meeting Objectives

Presenters

Beth McGlynn, Committee Co-Chair
Director, Kaiser Permanente Center for Effectiveness and Safety Research

George Isham, Committee Co-Chair
Medical Director and Chief Health Officer, HealthPartners

Arnold Milstein
Director, Stanford Clinical Excellence Research Center

Janet Corrigan
President and Chief Executive Officer, NQF

Ann Hammersmith
General Counsel, NQF

Tom Valuck
Senior Vice President, Strategic Partnerships, NQF

Lindsey Spindle
Senior Vice-President, Communications, NQF

Nalini Pande
Senior Director, Strategic Partnerships, NQF

Meeting Objectives

- Establish decision making framework for the MAP,
- Consider measure selection criteria,
- Finalize workgroup charges,
- Review the Ad Hoc Safety Workgroup roster, and
- Direct workgroups to consider measurement strategies for HACs and readmissions.

Meeting Agenda: Day 1

- Welcome and Review of Meeting Objectives
- Introductions and Disclosures of Interests
- MAP Member Responsibilities and Communications Policies and Support
- Establishment of the MAP Decision-Making Framework
- MAP Coordinating Committee Member Terms
- Consideration of MAP Measure Selection Criteria
- MAP Workgroup Charges and Tasks
- Summary of Day 1 and Look Forward to Day 2
- Adjourn for the day

MAP Coordinating Committee Membership

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Co-chairs	
	George Isham, MD, MS
	Elizabeth McGlynn, PhD, MPP

Organizational Members	Organization Representative
AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Judith A. Cahill
AdvaMed	Michael A. Mussallem
AFL-CIO	Gerald Shea
America's Health Insurance Plans	Aparna Higgins, MA
American College of Physicians	David Baker, MD, MPH, FACP
American College of Surgeons	Frank G. Opelka, MD, FACS
American Hospital Association	Gary L. Gottlieb, MD, MBA
American Medical Association	Carl A. Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA, MPA, MS
American Nurses Association	Marla J. Weston, PhD, RN
Catalyst for Payment Reform	Suzanne F. Delbanco, PhD
Consumers Union	Steven Findlay, MPH
Federation of American Hospitals	Charles N. Kahn III
LeadingAge	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Association of Medicaid Directors	Foster Gesten, MD
National Partnership for Women and Families	Christine A. Bechtel, MA
Pacific Business Group on Health	William E. Kramer, MBA

MAP Coordinating Committee Membership

Subject Matter Experts	Richard Antonelli, MD, MS
	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
	Joseph Betancourt, MD, MPH
	Ira Moscovice, PhD
	Harold Pincus, MD
	Carol Raphael, MPA

Federal Government Members	Agency for Healthcare Research and Quality	Federal Government Representative	Nancy J. Wilson, MD, MPH
	Centers for Disease Control and Prevention		Chesley Richards, MD, MPH
	Centers for Medicare & Medicaid Services		Karen Milgate, MPP
	Health Resources and Services Administration		Victor Freeman, MD, MPP
	Office of Personnel Management/FEHBP		John O'Brien
	Office of the National Coordinator for HIT		Thomas Tsang, MD, MPH
Accreditation / Certification Liaisons	American Board of Medical Specialties	Accreditation / Certification Liaison Representative	Christine Cassel, MD
	National Committee for Quality Assurance		Margaret E. O'Kane, MPH
	The Joint Commission		Mark R. Chassin, MD, FACP, MPP, MPH

Introductions and Disclosures of Interests

MAP Member Responsibilities and Communications Policies and Support

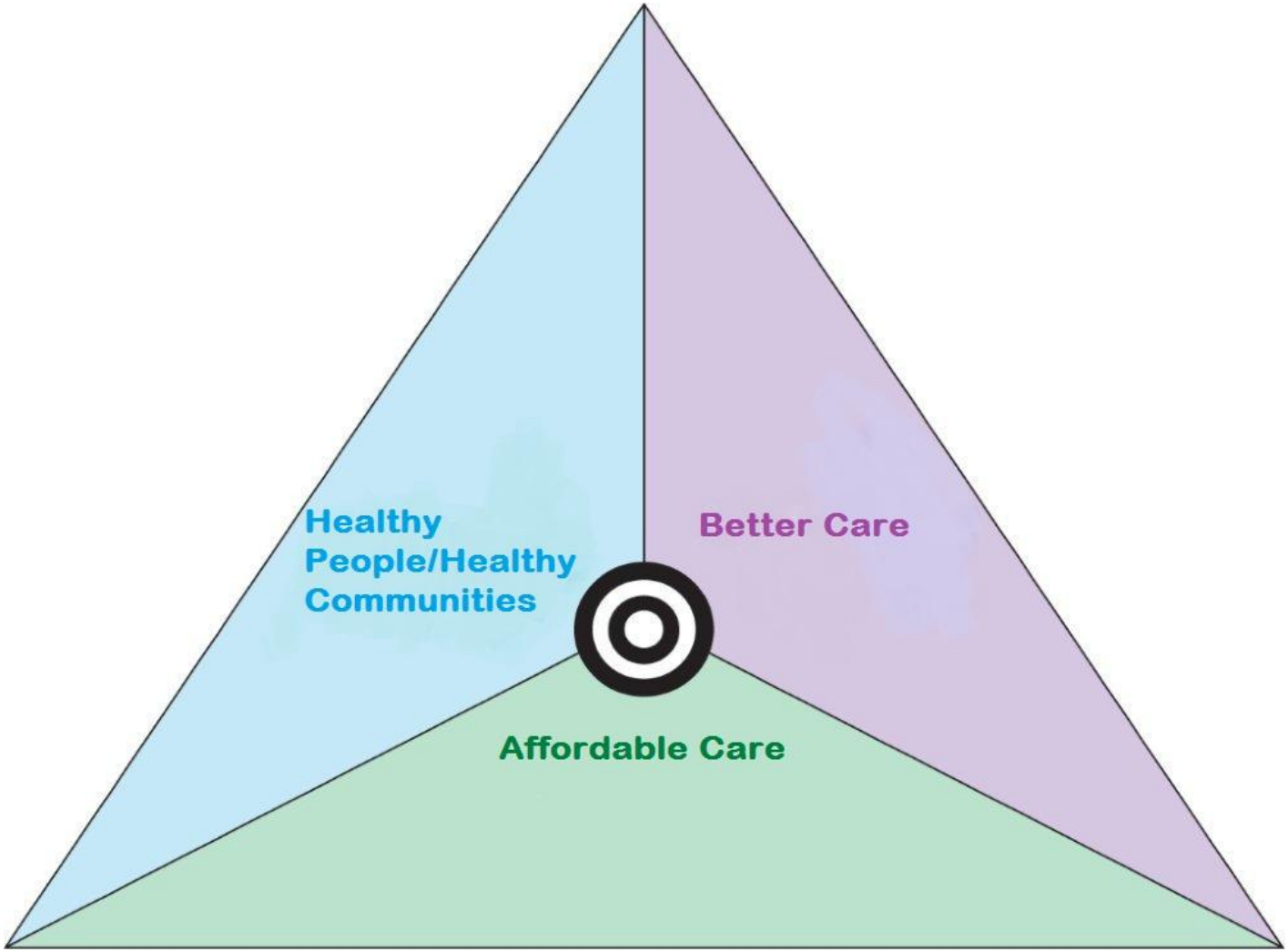
Establishment of the MAP Decision Making Framework

MAP Coordinating Committee Charge

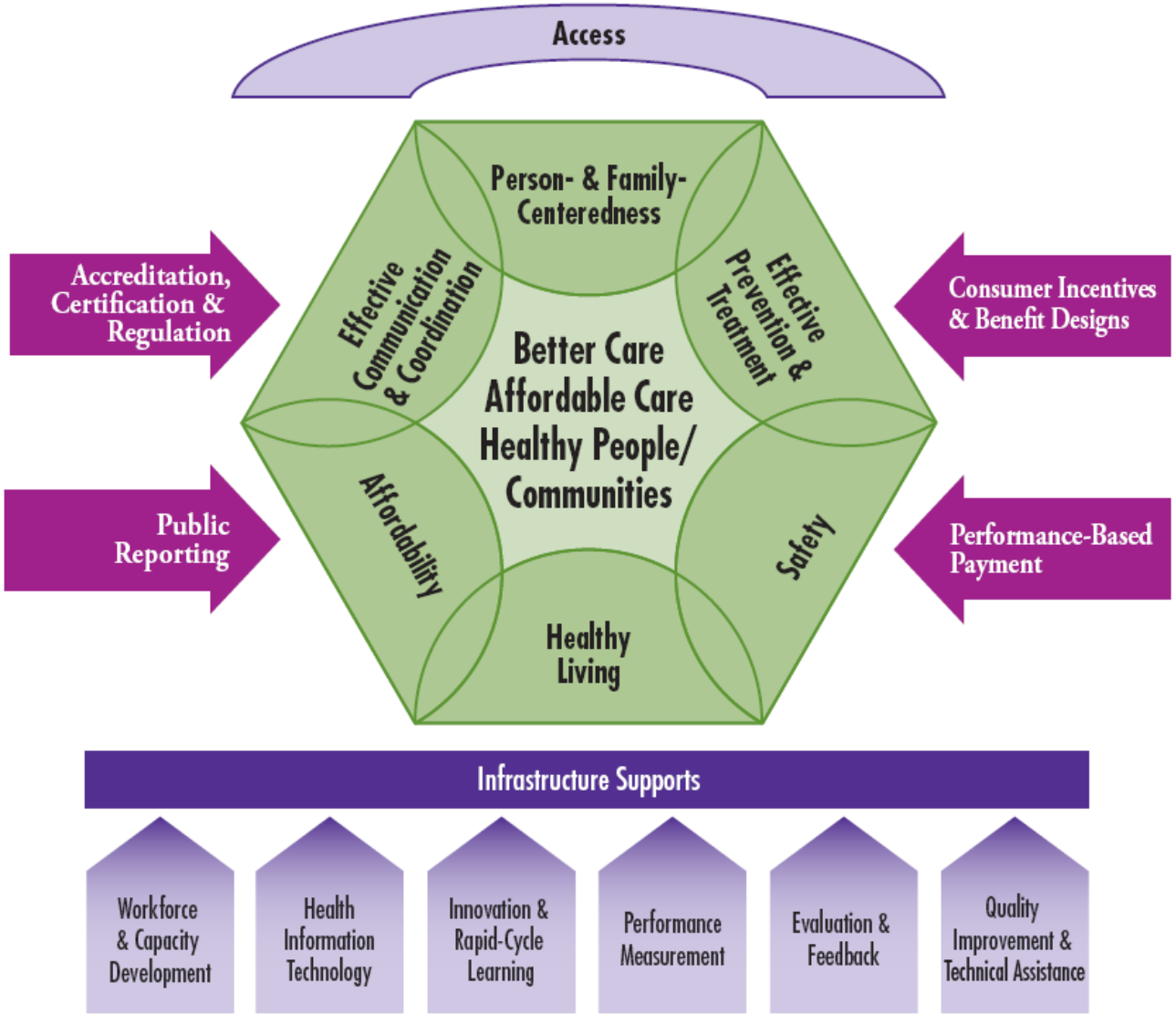
The charge of the Measure Applications Partnership Coordinating Committee is to:

- Provide input to HHS on the selection of performance measures for use in public reporting, performance-based payment, and other programs;
- Advise HHS on the coordination of performance measurement strategies across public sector programs, across settings of care, and across public and private payers;
- Set the strategy for the two-tiered Partnership; and
- Give direction to and ensure alignment among the MAP advisory workgroups.

HHS Aims for the National Quality Strategy



HHS National Quality Strategy



High Impact Conditions

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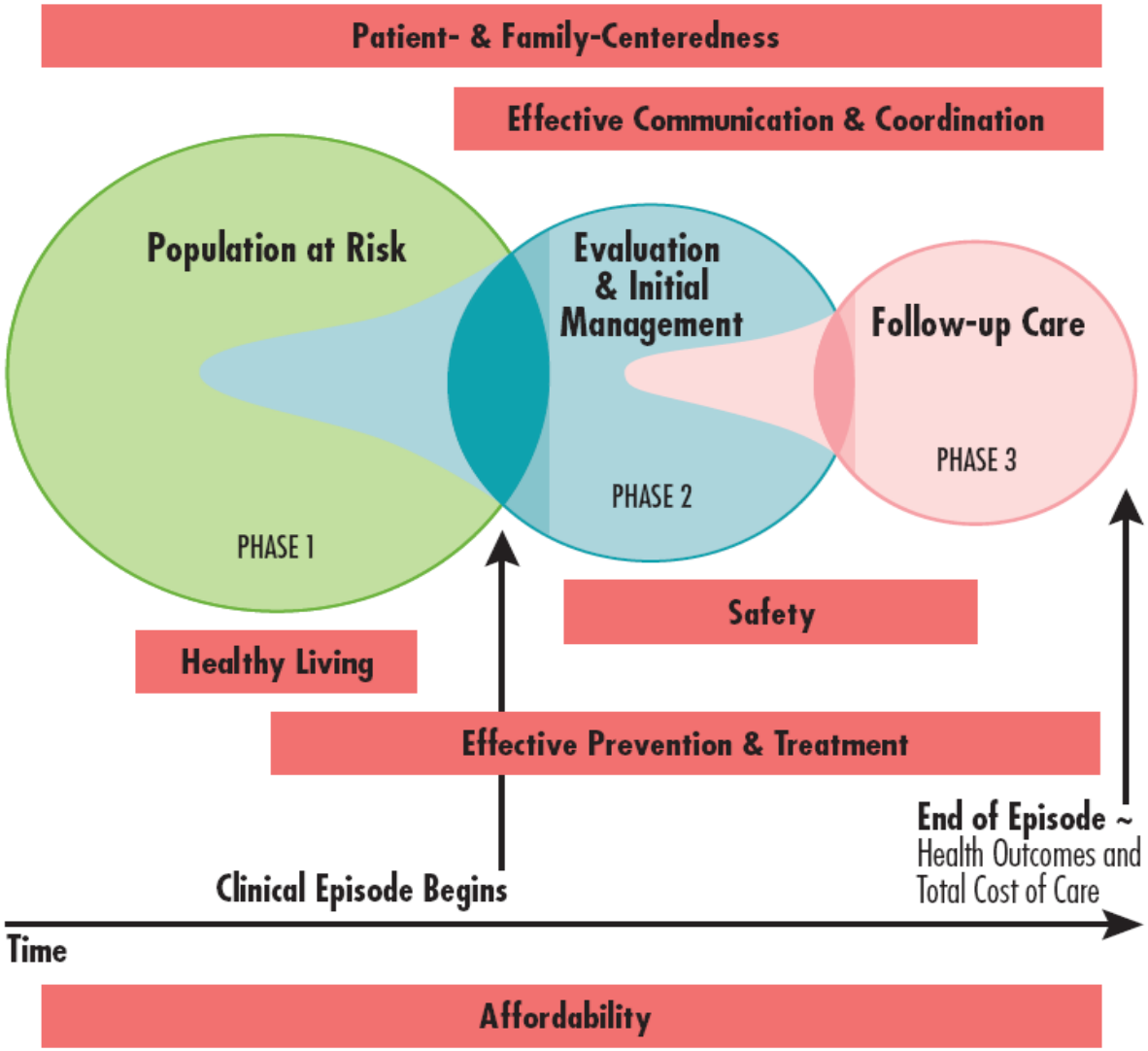
Medicare Conditions

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

Child Health Conditions and Risks

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

Patient-Focused Episodes of Care Model



MAP Decision Making Framework

- Overarching Principle:
  - The priorities and goals of the National Quality Strategy (NQS) will provide the foundation for MAP decision making.

- Additional factors for consideration:
  - The two dimensional framework for performance measurement—NQS priorities and high impact conditions—will provide focus.
  - The patient-focused episodes of care model will reinforce patient-centered measurement across settings and time.
  - Other?

Discussion and Questions

Opportunity for Public Comment

MAP Coordinating Committee Member Terms

Committee Member Terms

- The terms for MAP members are for three years.

- The initial members will serve staggered 1-, 2-, and 3-year terms, determined by random draw at the first in-person meeting.

Consideration of MAP Measure Selection Criteria

Measure Selection Criteria Project

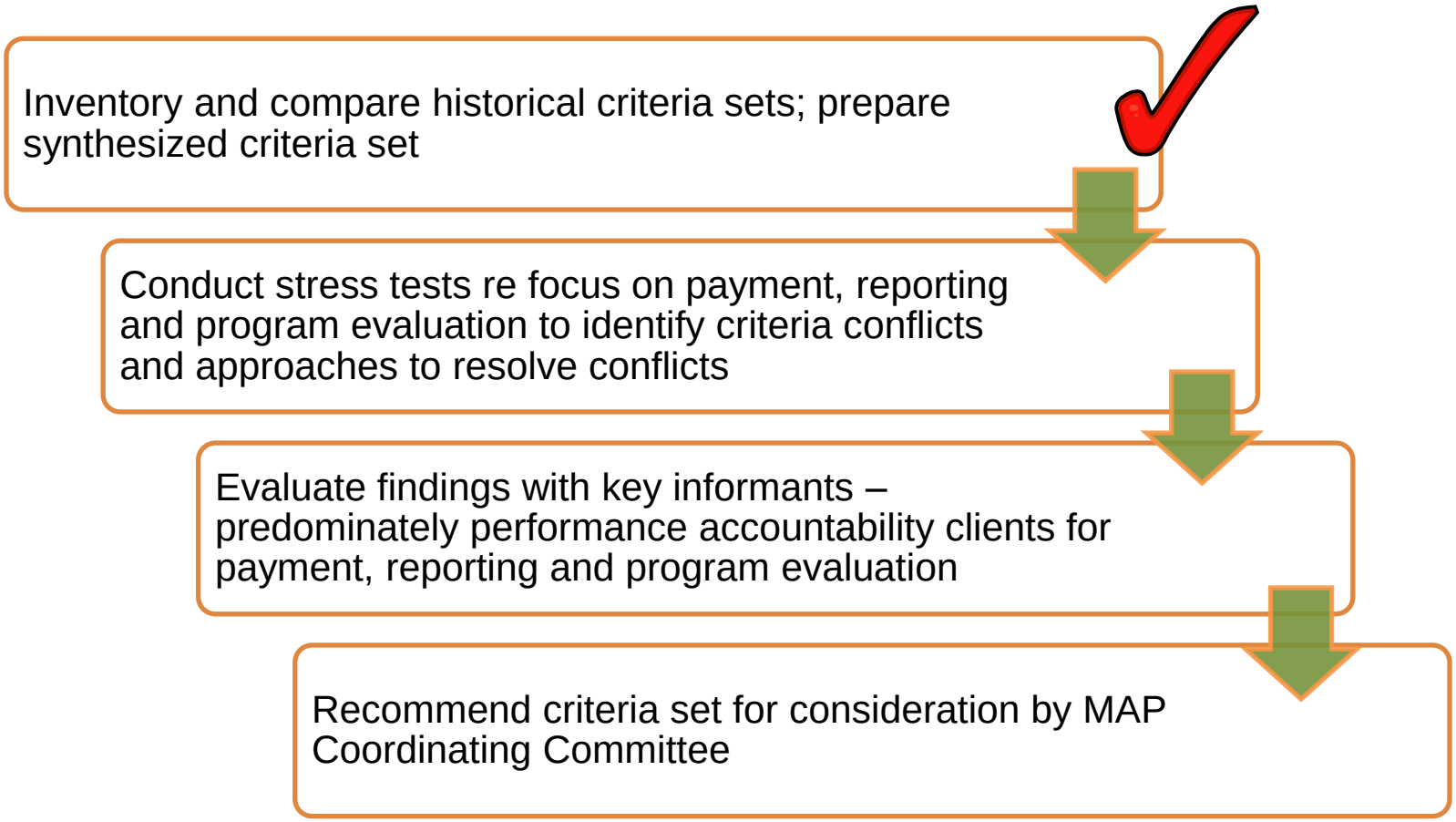
Arnold Milstein, MD, MPH
Principal Investigator
May 3, 2011

Purpose

Provide input to the MAP Coordinating Committee on measure selection criteria to equip MAP with an evidence base to select measures for:

- Public reporting
- Payment programs
- Program monitoring and evaluation

Major Tasks


Inventory and compare historical criteria sets; prepare synthesized criteria set
Conduct stress tests re focus on payment, reporting and program evaluation to identify criteria conflicts and approaches to resolve conflicts
Evaluate findings with key informants – predominately performance accountability clients for payment, reporting and program evaluation
Recommend criteria set for consideration by MAP Coordinating Committee

Criteria Inventory Methods

Through a literature search and targeted interviews, gathered both general and setting-specific measures criteria from:

- Consumer organizations
- Government agencies
- Quality organizations
- Provider organizations
- Quality researchers
- Purchasers
- Health plans
- International measurement organizations

Assembled 30+ sets of measures criteria/principles

Criteria Inventory Methods

Analyzed where the criteria sets converged and diverged.

Domains	Major categories, e.g. “technical characteristics”
Elements	Specific components, e.g. “construct validity”
Application	The intended use (e.g. public reporting) and/or care setting within which the criteria are to be applied

Criteria Synthesis

Domains	Element Topics (Draft)
Importance	•Impact on health •Health/care improvement opportunity •Relevant to stakeholder needs
Technical characteristics	•Fully specified and tested •Strong measurement properties •Fair & sensitive to factors not modifiable by accountable entities
Usability	•Meets objectives re transparency, improvement etc. •Strength of scoring & performance classification method •Actionable uses of the results •Spans care settings
Feasibility	•Measurement system availability •Minimize burden of data collection •Integrity of data that underlies measure •Availability – in public domain, entity to maintain

Criteria Synthesis (cont.)

Domains	Element Topics (Draft)
Measure characteristics	•Evidence-based •Types of measures (patient-experience, clinical, access etc.) •Aggregated and multi-component measures
Reporting	•Meets objectives of users •Reporting methods properties •Spans care settings •Inclusive report development process •Data/results corrections mechanism
Comprehensiveness	•Addresses spectrum of care for a condition/topic •Multi-component measures that address construct
Standards Alignment	•Measures are endorsed •Aligned with IOM/other standard setters

Criteria Current State

Evidence for the success of the historical criteria to drive broad implementation and health improvement is lacking

- Much of the existing criteria is purposed for endorsement rather than tailored for application.
- A number of criteria are general statements, open to different interpretations by various stakeholders.
- Certain criteria conflict when considering different stakeholder values – a barrier to measure adoption for payment, reporting and program evaluation.

Gaps in Criteria Specifics

Domain	Element Standard	Gaps/Interpretation Uncertain
Reporting	Fair and equitable method to display performance differences	Whose values and what standards determine appropriate methods?
Feasibility	Data readily available or captured without undue burden	What constitutes undue burden? Many measures, important to patients, not available without new systems investment.
Comprehensive	Complete assessment of care for the condition	Does complete assessment mean the National Quality Strategy 6 priority areas?
Usability	Actionable by clinicians; for system change/QI	"Actionable" is missing reference to patient, purchaser, regulator etc.

Criteria: Potential Conflicts

Conflicts in values inherent in the criteria can thwart implementation. For example:

Domain	Potential Stakeholder Value Conflicts
Usability	Patients value certain measures that are discounted by providers due to diffuse accountability or difficulty to influence performance.
Feasibility	Patients value patient-reported outcomes and experience but there is no/limited measurement systems.
Importance	Patients ascribe less importance to events in which they exert more control (e.g., preventive screenings, patient adherence) yet these are highly important from a public health and clinical effectiveness perspective.

Approaches to Resolve Conflicts

Candidate approaches to resolve conflicts among criteria and to further specify criteria for the 3 applications include:

- Stating values or assigning weights to anchor the criteria – per the interests of the users of measures for payment, reporting & program evaluation
- Linking the criteria with relevant measurement system(s) for a given application
- Equipping the MAP with proposed measures criteria and related criteria conflicts that are relevant to payment, reporting and program evaluation for ambulatory, hospital, LTC and dual-eligibles.

Next Step: Stress Test

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Goal: Determine whether the candidate criteria set yields well-suited measures for the three applications (payment, public reporting and program monitoring/evaluation).

Process:

- Develop use cases for four MAP categories (ambulatory, inpatient, long term care, dual eligibles) and the three applications.
  - Example: meaningful use quality measure set for ambulatory reporting.
- Run alternative measure sets through candidate measures criteria.
- Evaluate results with a set of key informants from the purchaser & consumer/patient user populations.

Discussion and Questions

Opportunity for Public Comment

Evening Assignment

Evening Assignment

- Are there historical criteria sets that are missing from our inventory?
- Recommend additional strategies to resolve the criteria gaps and conflicts in the existing criteria?
- Recommend elements of the use cases to include in the stress tests:
  - patient populations
  - measure sets
  - payment, reporting, program evaluation applications

Committee Questions

MAP Workgroup Charges and Tasks

Considerations for All Workgroups

- How will the MAP ensure alignment of measures across settings, payers, and populations?
- What can each workgroup do to promote shared accountability?
- What are the key data source issues for each workgroup?
- How do we ensure that the MAP maintains a patient-centered approach?
- How do we ensure that measures and measurement strategies support and inform new delivery models, such as health homes and ACOs?
- What can each workgroup contribute to addressing the quality issues affecting dual eligible beneficiaries?

MAP Clinician Workgroup Charge

The charge of the MAP Clinician Workgroup is to advise the Coordinating Committee on a coordination strategy for clinician performance measurement. The Workgroup will:

- Identify a core set of available clinician performance measures, with a focus on:
  - Clinician measures needed across Federal programs;
  - Electronic data sources;
  - Office setting;
  - Cross cutting priorities from the NQS; and
  - Priority conditions.
- Identify critical clinician measure development and endorsement gaps
- Develop a coordination strategy for clinical performance measurement including:
  - Alignment with other public and private initiatives;
  - HIT Implications;
  - High level transition plan and timeline by month
- Provide input on measures to be implemented through the Federal rulemaking process

Committee Questions

MAP Dual Eligible Beneficiaries Workgroup Charge

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The charge of the MAP Dual Eligible Beneficiaries Workgroup is to advise the MAP Coordinating Committee on performance measures to assess and improve the quality of care delivered to Medicare/Medicaid dual eligible beneficiaries. The Workgroup will:

- Develop a strategy for performance measurement for this unique population and identify the quality improvement opportunities with the largest potential impact.
- Identify a core set of current measures that address the identified quality issues and are applicable to both specific (e.g., Special Needs Plans, PACE) and broader care models (e.g., traditional FFS, ACOs, medical homes).
- Identify gaps in available measures for the dual eligible population, and propose modifications and/or new measure concepts to fill those gaps.
- Advise the Coordinating Committee on a coordination strategy for measuring readmissions and healthcare-acquired conditions across public and private payers and on pre-rulemaking input to HHS on the selection of measures for various care settings.

Committee Questions

Opportunity for Public Comment

MAP Hospital Workgroup Charge

The charge of the MAP Hospital Workgroup is to advise the Coordinating Committee on measures to be implemented through the rulemaking process for hospital inpatient and outpatient services, cancer hospitals, the value-based purchasing program, and psychiatric hospitals. The Workgroup will:

- Provide input on measures to be implemented through the Federal rulemaking process, the manner in which quality problems could be improved, and the related measures for encouraging improvement.
- Identify critical hospital measure development and endorsement gaps.
- Identify performance measures for PPS-exempt cancer hospital quality reporting by:
  - Reviewing available performance measures for cancer hospitals, including clinical quality measures and patient-centered cross-cutting measures;
  - Identification of a core set of performance measures for cancer hospital quality reporting; and
  - Identification of measure development and endorsement gaps for cancer hospitals.

Committee Questions

MAP Post-Acute Care/Long Term Care Workgroup Charge

The charge of the MAP Post-Acute Care/Long-Term Care Workgroup is to advise on quality reporting for post-acute care and long-term care settings. The Workgroup will:

- Develop a coordination strategy for quality reporting that is aligned across post-acute care and long-term care settings by:
  - Identifying a core set of available measures, including clinical quality measures and patient-centered cross cutting measures; and
  - Identifying critical measure development and endorsement gaps.
- Identify measures for quality reporting for hospice programs and facilities;
- Provide input on measures to be implemented through the Federal rulemaking process that are applicable to post-acute settings.

Committee Questions

Opportunity for Public Comment

Summary of Day 1 and Look Forward to Day 2

Evening Assignment

- Are there historical criteria sets that are missing from our inventory?
- Recommend additional strategies to resolve the criteria gaps and conflicts in the existing criteria?
- Recommend elements of the use cases to include in the stress tests:
  - patient populations
  - measure sets
  - payment, reporting, program evaluation applications

Web Meeting Agenda: Day 2

- Welcome and Recap of Day 1
- MAP Measure Selection Criteria Assignment Report Out
- HACs and Readmissions: MAP Ad Hoc Safety Workgroup Composition and Charge
- HACs and Readmissions: Direction for the MAP Workgroups
- Summation and Path Forward for the MAP
- Adjourn

Welcome and Recap of Day 1

MAP Measure Selection Criteria Assignment Report Out

Evening Assignment

- Are there historical criteria sets that are missing from our inventory?
- Recommend additional strategies to resolve the criteria gaps and conflicts in the existing criteria?
- Recommend elements of the use cases to include in the stress tests:
    - Patient populations
    - Measure sets
    - Payment, reporting, program evaluation applications

Healthcare Acquired Conditions (HACs) and Readmissions: MAP Ad Hoc Safety Workgroup Composition and Charge

HACs and Readmissions

HHS has created a new patient safety initiative called the **Partnership for Patients** focusing on improvement in readmissions and HACs

Establishes 2 goals to achieve by the end of 2013:

- Preventable hospital-acquired conditions would decrease by 40-percent compared to 2010
- Preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20-percent compared to 2010

HACs and Readmissions

The Partnership for Patients has identified nine areas of focus for HACs.

- Adverse Drug Events (ADE)
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Central Line Associated Blood Stream Infections (CLABSI)
- Injuries from Falls and Immobility
- Obstetrical Adverse Events
- Pressure Ulcers
- Surgical Site Infections
- Venous Thromboembolism (VTE)
- Ventilator-Associated Pneumonia (VAP)

The Partnership work is not limited to these areas, and will pursue the reduction of all-cause harm as well.

MAP Ad Hoc Safety Workgroup Charge

The charge of the MAP Ad Hoc Safety Workgroup is to advise the Coordinating Committee on a coordination strategy for measuring readmissions and healthcare-acquired conditions (HACs) across public and private payers. The Workgroup will:

- Review current readmission and HAC measures in use by both public and private payers.
- Identify available readmission and HAC measures:
  - In use regionally and nationally;
  - Applicable across a variety of settings
  - For dual eligible beneficiaries in home and community-based service waiver programs.
- Identify critical readmission and HAC measure development and endorsement gaps.
- Develop a coordination strategy of options to ensure maximum collaboration across public and private payers, including:
  - Current and ideal approaches to measurement,
  - HIT implications, and
  - Timeline.

Discussion and Questions

Opportunity for Public Comment

HACs and Readmissions: Guidance for the Workgroups

HACs and Readmissions

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Considerations for MAP Advisory Workgroups

- How to ensure joint accountability and alignment across settings?
  - What measures should be included in measure sets being suggested by other MAP Workgroups to address HACs and readmissions?
- What are the relevant data and infrastructure issues?
  - What are potential issues when measuring across multiple settings and strategies to mitigate those issues?
  - What are potential issues when measuring at different levels (i.e. individual clinician, facility, regionally, nationally) and strategies to mitigate those issues?
- What is needed to support improvement in these areas within the complex dual eligible population?

Discussion and Questions

Opportunity for Public Comment

Summation and Path Forward for the MAP

Committee Scope of Work & Timeline

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May 13, 2011

- Convene an all-MAP web meeting for all workgroups to introduce the workgroups to the MAP project, build understanding of the workgroup charges, and review the readmissions and HACs issues.

June 21-22, 2011

- Conduct an in-person meeting to discuss the Clinician and Dual Eligible Beneficiaries workgroups' input and finalize the decision making criteria and framework for pre-rulemaking input.

August 5, 2011

- Conduct a web meeting to discuss HACs issues as well as other workgroup issues.

Meeting Schedule

All MAP Web Meeting:

May 13, 2011 2:00 pm-4:00 pm EST

Coordinating Committee In-Person Meeting #2:

June 21-22, 2011 (Washington, DC)

Coordinating Committee Web Meeting #2:

August 5, 2011 11:00-1:00pm EST