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Measure Applications Partnership Coordinating Committee

In-Person Meeting #2

June 21-22, 2011
9:00 am – 5:00 pm EST

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Welcome, Introductions, and Review of Meeting Objectives

Meeting Objectives

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- Establish coordination strategy elements
- Adopt a working set of measure selection criteria
- Review interim findings from Clinician, Ad Hoc Safety, and Dual Eligible Beneficiaries Workgroups and a synthesis of themes
- Provide guidance to workgroups on coordination strategies

Meeting Agenda: Day 1

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- Welcome, Introductions, and Review of Meeting Objectives
- Emerging Elements for Coordination Strategies
- Data Sources and HIT Implications
- Measure Selection Criteria
- Clinician Performance Measurement Coordination Strategy across Federal Programs
- Summary of Day 1 and Look-Forward to Day 2
- Adjourn for the day

MAP Coordinating Committee Charge

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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.

MAP Decision-Making Framework

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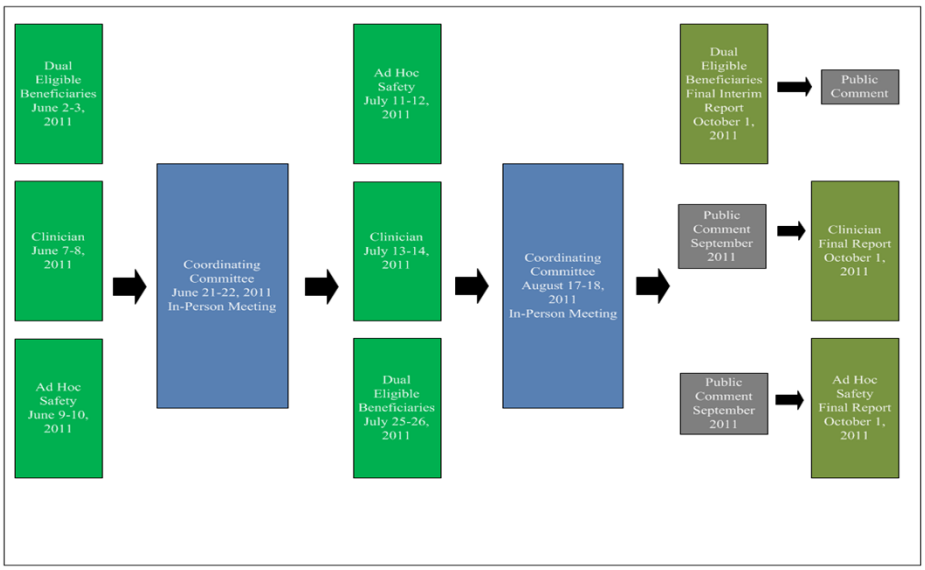
- Overarching principle:
  - The aims and priorities of the National Quality Strategy (NQS) will provide the foundation for MAP decision-making.
- Additional factors for consideration:
  - The two dimensional framework for performance measurement—NQS priorities and high impact conditions —will provide focus.
  - The patient-focused episodes of care model will reinforce patient-centered measurement across settings and time.
  - HHS Multiple Chronic Conditions Framework.
  - Attention to equity across the NQS priorities.
  - Connection to financing and delivery models and broader context (e.g., ACOs).

MAP Coordinating Committee Timeline and Processes – October 1, 2011 HHS Reports



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Emerging Elements for Coordination Strategies

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Emerging Elements for Coordination Strategies

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- Measures and measurement issues
- Data sources and HIT implications
- Alignment
- Special considerations for dual eligible beneficiaries
- Pathway for improving measure application

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Committee Discussion and Questions

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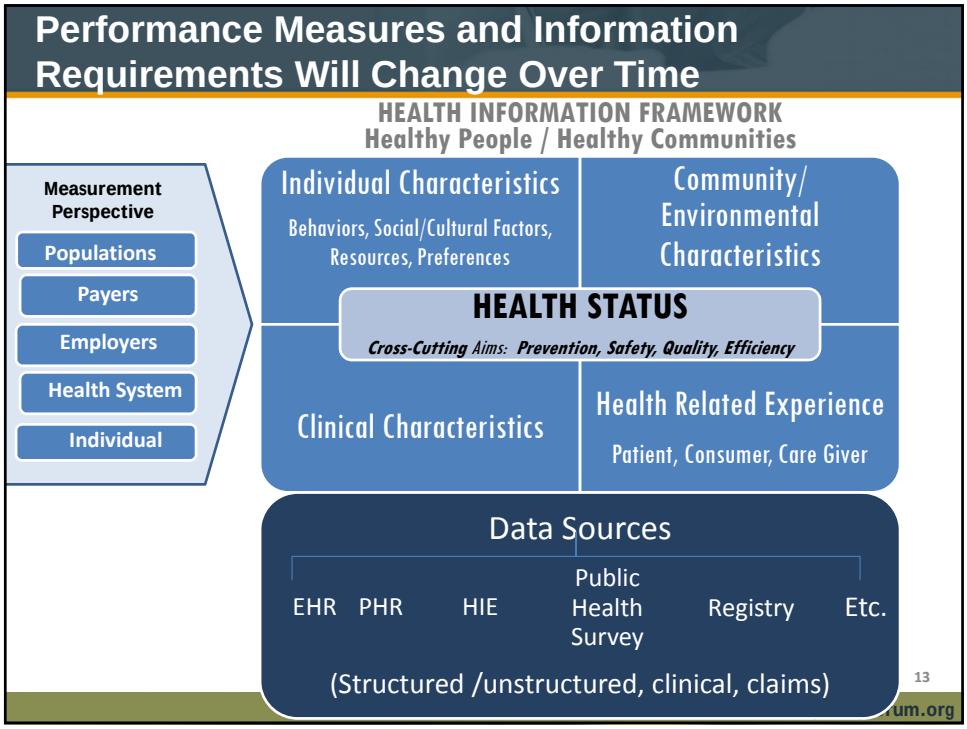
Data Sources and HIT Implications

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 clinicians and other providers with decision support
- **E-Infra structure** → • Publicly report for secondary uses: accountability, payment, public health, and comparative effectiveness


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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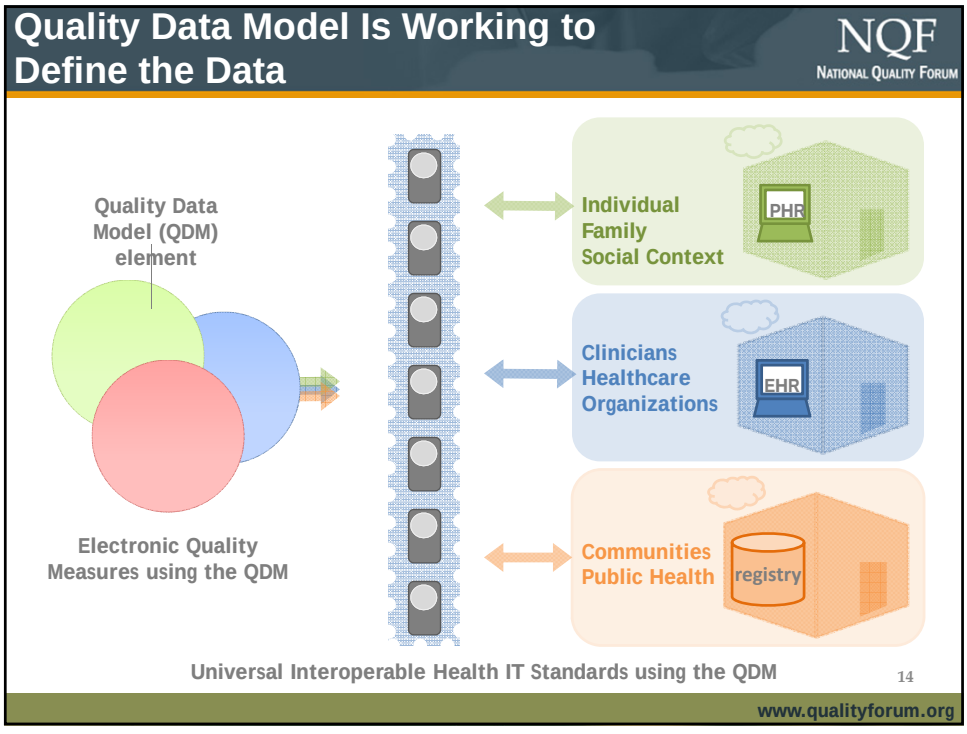
Quality Data Model Is Working to Define the Data
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Quality Data Model (QDM) element
Electronic Quality Measures using the QDM
Individual
Family
Social Context
PHR
Clinicians
Healthcare
Organizations
EHR
Communities
Public Health
registry
Universal Interoperable Health IT Standards using the QDM
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NQF is Helping Build the Necessary Electronic Infrastructure

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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 Data Model

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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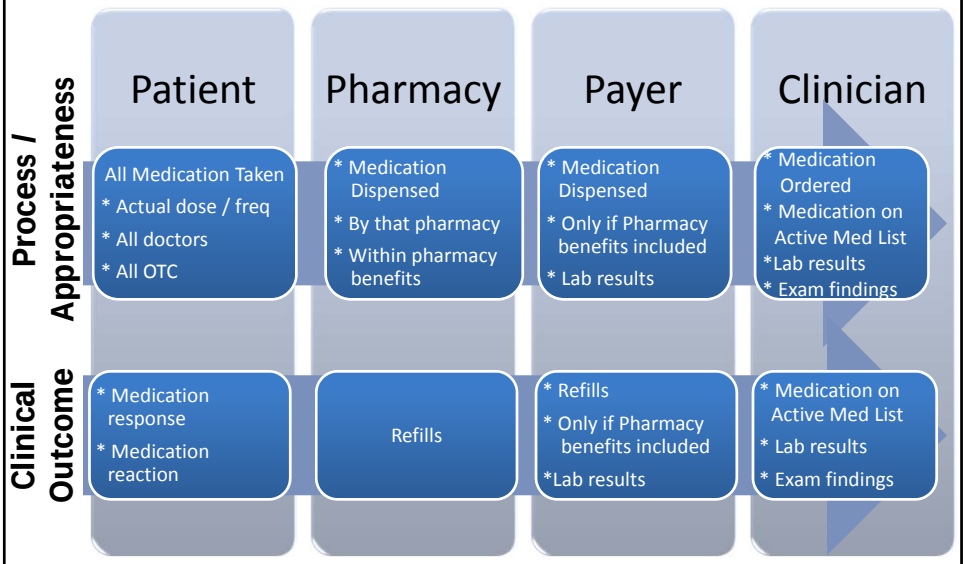

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Key Questions: eMeasures, Data Sources and Platforms, and Stakeholders

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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 Clinician vs. health plan vs. health system vs. community	• 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, and higher levels
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: Public and Private Programs, Measure Reporting Requirements, Data

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Issue	Potential Policy Solutions	HIT Role
Separate reporting processes for the same measures under different public and private programs	• Harmonization of public and private 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 vs. measure calculations with certified EHR technology	• Harmonization of public and private 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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Committee Discussion and Questions

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Opportunity for Public Comment

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Measure Selection Criteria

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Coordinating Committee Role

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Measures to Be Implemented Through the Federal Rulemaking Process

Task Description	Deliverable	Timeline
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 metrics for encouraging such improvement.	Final report containing Coordinating Committee framework for decision-making and proposed measures	Draft Report: January 2012 Final Report: February 1, 2012

Coordinating Committee with input from all workgroups

MAP Coordinating Committee Timeline and Processes – February 1, 2012 Pre-Rulemaking Analysis Report

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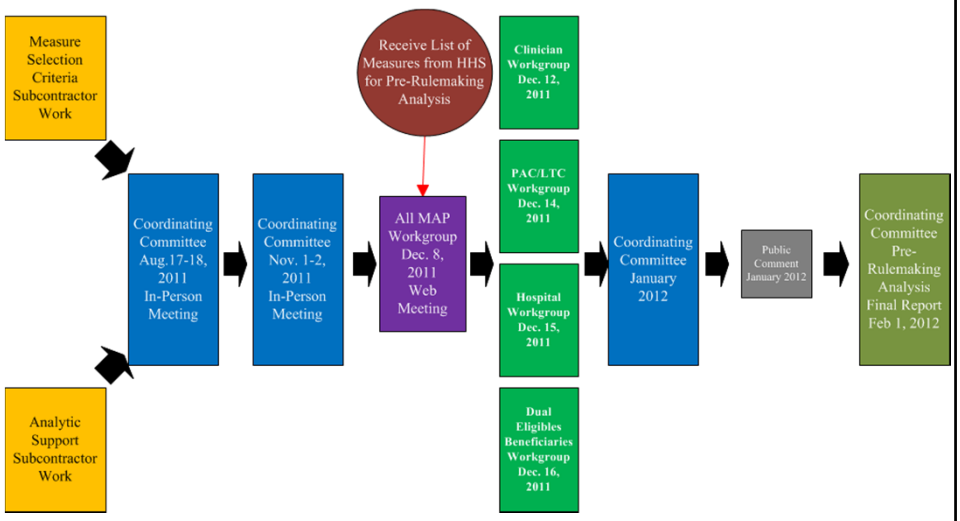

Quality Measurement Enterprise

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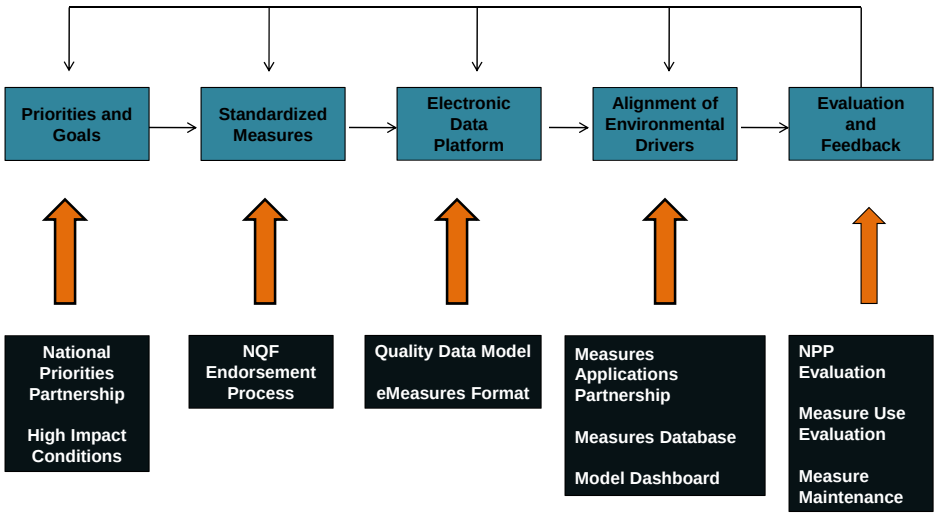


NQF Endorsement Process Evaluation Criteria

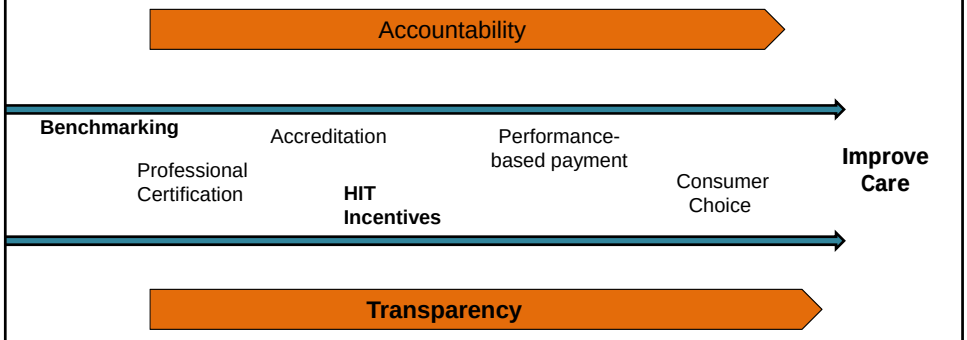
Helen Burstin, MD, MPH
Senior Vice President, Performance Measures
National Quality Forum

MAP Coordinating Committee
June 21-22, 2011

NQF Evaluation Criteria

- **Importance to measure and report**
  - What is the level of evidence for the measure focus?
  - Is there an opportunity for improvement?
  - Relation to a priority area or high impact area of care?
- **Scientific acceptability of the measurement properties**
  - What is the reliability and validity of the measure?
- **Usability**
  - Are the measure results meaningful and understandable to intended audiences and useful for both public reporting and informing quality improvement?
- **Feasibility**
  - Can the measure be implemented without undue burden, capture with electronic data/EHRs?
- **Comparison to related or competing measures**

Using Performance Information



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Endorsement Maintenance Process

- Review of endorsed measure occurs every 3 years
- Conduct full 9-step CDP project (including request for implementation comments)
- New and endorsed measures are reviewed against current measure evaluation criteria
- Review of new measures within the same topic area occurs at the same time with existing measures
  - —Drives toward parsimony in the volume of measures
  - —Supports harmonization of measure specifications

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Expedited Review

- All of the following criteria should be met prior to consideration by the CSAC for an expedited review:
  - the extent to which the measures under consideration have been sufficiently tested and/or in widespread use
  - whether the scope of the project/measure set is relatively narrow
  - time-sensitive legislative/regulatory mandate for measures
- For expedited reviews, each CDP step will be no less than ten business days (instead of 30 calendar days)

Thank You

Helen Burstin, MD, MPH
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Measure Selection Principles from May 3-4 Coordinating Committee Meeting

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- Promotes "systemness" and joint accountability
  - Promotes shared decision making and care coordination
  - Addresses various levels of accountability
- Addresses the patient perspective
  - Helps consumers make rational judgments
  - Incorporates patient preference and patient experience
- Actionable by providers
- Enables longitudinal measurement across settings and time
- Contributes to improved outcomes
- Incorporates Cost
  - Resource use, efficiency, appropriateness
- Promotes adoption of HIT
- Promotes parsimony
  - Applicability to multiple providers, settings, clinicians

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Clinician Workgroup Input

Clinician Workgroup Input- Priority Measure Selection Principles

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- Promote shared accountability and "teamness"
  - Actionable
  - Longitudinal
- Address multiple levels of analysis
  - Individual v. group
  - Cascading measures
- Useful to intended audiences
  - Shared decision making
  - Functional status
  - Quality of life/well-being
- Potential for unintended consequences
- Balance comprehensiveness and parsimony

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Stanford Input

Steps to Identify Candidate Measure Selection Criteria

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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 and suggested additional measure selection criteria needed to meet those requirements

Step 3
- **Perform use cases through application lens (payment, reporting, monitoring)**
- Key informants to identify additional measure selection 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 measure selection criteria for selection to recommend to MAP**
- Research team synthesizes proposed measure selection criteria into a candidate set for applications

Selected Findings from Criteria Scan

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A scan of 35+ criteria sets contributed concepts for measure selection criteria:

Priority and Outcome Focused	➢ Measures should explicitly address aspects of financial impact, accessibility and affordability ➢ Measures address a process that has few intervening care processes before the improved outcome is realized
Program Specific	➢ Measures have been fully tested and validated in the care setting in which they are intended to measure
Unintended Consequences	➢ Measures are insulated from unintended consequences of implementing (e.g., detect exclusion of high risk patients)
Comprehensiveness	➢ Measure sets should address the spectrum of care for a condition or population

Use Case Findings

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- NQF endorsement criteria were used as a baseline
- The team proposed additional measure selection criteria to address requirements for measures to be used in payment, public reporting, or program evaluation
- More information on methods can be found in the Appendix and by request from NQF

Population-based Use Cases

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Setting / Population	Use Case	Associated Measure Set
Ambulatory	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
Hospital	Value-based purchasing in hospitals	Inpatient Quality Reporting measures, HCAHPS
	Public reporting on cardiac surgery	Society of Thoracic Surgeons Adult Cardiac Surgery Measures
	Public reporting on non-Medicare	The Joint Commission Core Measures – Children's Asthma Care, Perinatal Care, etc.
Long Term Care	Monitoring and comparing nursing home quality	Minimum Data Set 3.0 Post Acute measures for nursing homes
		CASPER nurse staffing and nursing home inspections
Dual-Eligibles	Vulnerable elders	Assessing Care of Vulnerable Elders (ACOVE) -3
	Special needs populations	Special Needs Plan – structure and process measures

Use Cases: Cross-cutting Measure Selection Criteria

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- The following selected findings were relevant across all populations
- Where recommended selection criteria fit across multiple criteria domains, the team assigned them to one
- Recommended selection criteria are oriented toward selection of "sets" of measures vs. individual measures

Cost, Quality Alignment

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Example:

Process measures are often focused on correcting for underuse of screenings and preventive care.

Add cost of care and appropriate care measures to address overuse or misuse.

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

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

Weight Measures by User Needs

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Example:

A patient in a LTC setting may assign a high weight to quality of life and functional status measures.

A dual eligibles program manager may assign a high weight to systemness measures.

A payer for ambulatory care may assign a high weight for overuse and episode of care measures.

Potential measure selection criterion:
Assign measure weights based on the users' needs.

Explanation:
An accountability program's measures need to be aligned with the interests of the intended users. The users' voice should be clearly heard in the debates to balance feasibility and other needs against the users' interests in better, more affordable health.

Methods for Alternative Measure Sets

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Example:

Providers with limited IT capability often unable to report lab results.

Diabetes care composite "A" has control measures and composite "B" limited to screening measures.

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

Explanation: 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.

Performance Discrimination

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Example:

The performance thresholds is set to recognize 'top results' at 75th percentile; improvement is recognized as moving from lowest quartile to 50th percentile or higher.

Potential measure selection criterion: *Require that measures be accompanied by a use case -specific method of classifying performance.*

Explanation: Measure set utility for payment & reporting will depend upon performance classification to define meaningful differences among accountable entities. And, a performance classification approach can avert unintended consequences (e.g., recognize improvement and absolute performance).

Measure Aggregation

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Example:

Proposed ACO measures roll-up to 1 of 5 domains and then aggregated to a total quality score.

And 'at-risk' domain organized into 5 condition specific sub-domains.

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.*

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

Specify Applications

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Example:

Payment reduction versus enhancement

Minimum Data Set (MDS) for consumer choice of LTC facility.

Medicare Stars program for consumer choice of health plan.

State hospital reporting for consumer choice of treatment program.

Potential measure selection criterion:
Reporting and payment uses should be explicit to evaluate the proposed measures and methods in the context of the use.

Explanation:
Need to be explicit about the nature of the application. For example:

•Payment programs –distinguish if it is a payment reduction or a payment enhancement mechanism.

•Reporting programs –distinguish if reporting for: i) consumer choice of provider, ii) consumer engagement in treatment decisions, iii) marketplace recognition, iv) physician referral decision support etc.

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Promoting Standardized Measurement

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Example:

The Meaningful Use program requires providers to report certain measures but other measures are drawn from a larger library. As such, there is no standard measures set.

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

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

Explanation: Across accountability programs, the proliferation of similar but distinct measure sets/composites will heighten provider burden & patient confusion. Flexibility can be created through alternative composites (e.g., advanced vs. basic).

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Anticipate Unintended Consequences

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Example:

Post-acute pain reduction measure could spur overprescribing. Include measures in the acute care composite that are a safeguard against such consequences.

Potential measure selection criterion:
Scrutinize measure sets to ensure that measures that are vulnerable to unintended consequences are offset by measures to detect/mitigate such consequences.

Explanation:
Payment and public reporting applications could prompt behaviors that are counter to best care or that exclude high-risk patients.

Multiple Dimensions in Domain

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Example:

Medicare Stars multi-item preventive care composite.

PCMH patient experience captured through multiple domains including coordination, shared decision-making and self care support.

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

Explanation: Given payment & reporting consequences, sets of measures are needed to capture multiple dimensions of the accountability program's quality and cost domains.

National Quality Strategy Aligned

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Example:

- Safe
- Engaged patient
- Coordinated care
- Effective treatment
- Healthy living
- Affordable

Potential measure selection criterion: *Use the 6 NQS domains to define a comprehensive accountability program. As measurement capability evolves, tighten criteria to address all 6 domains.*

Explanation: Accountability programs use a variety of performance dashboards – need a standard gauge of 'comprehensive accountability' to assess these programs and to spur alignment across public and private sector programs.

Setting-Specific Findings

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- Use case findings highlight measure selection criteria issues that are important to the setting/population
  - Ambulatory
  - Inpatient
  - Long-term / Post Acute Care
  - Dual Eligible Beneficiaries

Ambulatory Measure Selection Criteria Considerations

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1) Measure aggregation methods are needed for information to be usable by clinicians, patients, & others.

2) Flexibility to ensure a critical mass of providers participate in accountability programs. Address clinician's IT capacity through alternative measure sets, missing value methods etc.

3) Consider different objectives of shared accountability and consumer use. Systemness measures address important quality gaps but consumers most value relationship with doctor and other health professionals –"systems" are less relevant.

Inpatient Measure Selection Criteria Considerations

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1) More measures (relative to other use cases) are now "topped out," leaving measure sets that lack comprehensiveness.

2) Analytic methods (risk-adjusted outcomes) have been designed to compare a hospital with a national or regional benchmark, but public reporting applications entail ranking or comparisons among competing hospitals.

3) Brevity of inpatient stays can lead to accountability uncertainty & unintended consequences. Hospital care episodes should include pre-admit/post-discharge care to address cross-setting accountability.

LTC/PAC Measure Selection Criteria Considerations

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1) Transitions (from inpatient care, to home care) are not well addressed in existing measure sets and raise concerns about accountability and unintended consequences.

2) Measure selection criteria should recognize that decisions often are made by family members and other patient advocates; not by patients themselves.

3) Patients' individual values determine the goals of care, and raise the importance of specific outcomes and processes to achieve those outcomes (e.g., aggressive pain relief may aggravate delirium).

Duals Measure Selection Criteria Considerations

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1) Recognize, as part of deciding whether care delivery is efficient, that the care must first be appropriate, taking into account patient preferences and prognosis.

2) Recognize that patient experience and preferences may be difficult to obtain in patients with cognitive impairment. This could be addressed by use of surrogates.

3) Recognize that measures of care quality across sites have specific importance to dually eligible patients.

Resolve Measure Selection Criteria Conflicts

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Address overarching conflicts as foundation for measure selection criteria adoption

Innovation vs. continuity	Introducing new, compelling measures vs. retaining continuity of historical measures
Shared vs. individual accountability	Systemness concerns care system or cross-setting performance but consumers value physician-specific information. Components of measure sets will need to be shaped to different users
Understandability, comprehensiveness & science trade-offs	Measure sets contain multiple components that are critical to better health. Need composites for understandability. Composites may not meet psychometric rigor as some important dimensions of care/health not strongly related
Burden: practices' uneven IT capabilities	Set selection criteria to avoid LCD measures: reward advanced measure sets but allow 'starter sets.' Tradeoff re more complex accountability programs for IT/system variation

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Resolve Conflicts: Preventive Care as Illustration

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Preventive care measure sets example: an exercise in measure selection criteria setting to resolve or mitigate conflicts

Innovation vs. continuity	Measures innovation: health status change over time Measures continuity: cancer screening measures set – certain measures topping out/ceiling effect
Shared vs. individual accountability	System level: quit tobacco intervention Doctor level: doctor counsels patient diet/exercise
Understandability, comprehensiveness & science trade-offs	Preventive care composite can be roll-up of discrete quality dimensions: a) avoidable illness, b) screening, c) health status, d) patient counseling
Burden: practices' uneven IT capabilities	Reward advanced measure sets: patient-report health behaviors: nutrition, activity, exercise, alcohol & tobacco Allow 'starter sets': cancer screening measures

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Next Steps

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- Project team will incorporate findings from key informants regarding application – specific use cases
- A final set of candidate measure selection criteria will be recommended to the MAP, including suggestions for resolving selection criteria conflicts

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Synthesis of Inputs

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Committee Discussion and Questions

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Measure Selection Criteria: Small Group Session, Discussion, and Next Steps

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Small Group Session

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Reporting Out from Each Small Group

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Committee Discussion and Questions

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Adoption of a Working Set of Measure Selection Criteria

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Committee Discussion and Questions

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Opportunity for Public Comment

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Clinician Performance Measurement Coordination Strategy across Federal Programs

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Measures for Use in the Improvement of Clinician Performance

Task Description	Deliverable	Timeline
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

Clinician Workgroup will advise the Coordinating Committee

Current Clinician Performance Measurement Programs

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Federal programs included in coordination strategy	Programs for additional consideration
Physician Quality Reporting System (PQRS)	Medicare Advantage/5-star rating
E-Prescribing Incentive Program	CHIPRA Initial Core Set Measures
Electronic Health Records (EHR)-Meaningful Use	Medicaid Core Measure Set
Physician Feedback/Value Modifier – [Previously called The Physician Resource Use Measurement and Reporting (RUR) Program]	ACO Proposed Regulations
Physician Compare	IHA (Integrated Healthcare Association – California Pay for performance Program)
	Blue Cross Blue Shield of Massachusetts Alternative Quality Contract

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Review of Clinician Workgroup Interim Findings

Elements of a Coordination Strategy

- Measures and measurement issues
  - Measure selection principles
  - Identification of measure gaps
  - Measure methodological issues
- Data source and HIT implications
- Special considerations for dual eligible beneficiaries
- Alignment with other settings
- Pathway for improving measure application

Measure and Measurement Issues

- Priority measure selection principles
- Early identification of measure gaps
  - Patient reported measures, including health risk and functional status for individuals and populations
  - Mental illness
  - Physical and mental disabilities*
  - Multiple chronic conditions*
  - Cross-setting and community support*
  - Cultural competence, language, health literacy*

  Starred (*) gaps were noted as areas that differentially impact the dual eligible population
- Measure methodological issues

Priority Measure Selection Principles

- Promote shared accountability and “teamness”
  - Actionable
  - Longitudinal
- Address multiple levels of analysis
  - Individual v. group
  - Cascading measures
- Useful to intended audiences
  - Shared decision making
  - Functional status
  - Quality of life/well-being
- Potential for unintended consequences
- Balance comprehensiveness and parsimony

Data Source and HIT Implications

- Types of data
  - Appropriateness of data source for specific measures, settings
  - Moving beyond clinical data, incorporating patient self-reported and non-clinical data
- Data collection during the course of care
- Promoting HIT adoption
- Timeliness and transparency of data

Elements of a Coordination Strategy

- Alignment with other settings
  - Alignment with other public/private initiatives including new payment and delivery models
  - Federal programmatic alignment issues–data collection and reporting, feedback, and public reporting
- Pathway for improving measure application
  - Few measures address all of the priority measure selection principles
  - Recognition of the limitations of current data systems and potential for measures to promote data integration
  - Consider how to move from current to ideal state for each element of coordination strategy

Coordinating Committee Guidance to the Clinician Workgroup

What opportunities for alignment with other initiatives should the Clinician Workgroup consider?

What challenges should the Clinician Workgroup address in setting a path for moving from the current to the ideal state?

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Next Steps

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Committee Discussion and Questions

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Opportunity for Public Comment

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Summary of Day 1 and Look-Forward to Day 2

Meeting Agenda: Day 2

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- Welcome and Recap of Day 1
- Healthcare-Acquired Conditions and Readmissions Coordination Strategy across Public and Private Payers
- Dual Eligible Beneficiaries Quality Measurement Strategy
- Synthesis of Workgroup Interim Findings and Committee Guidance to Workgroups
- Summation and Path Forward

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Welcome and Recap of Day 1

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Healthcare – Acquired Conditions and Readmissions Coordination Strategy across Public and Private Payers

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Review of Ad Hoc Safety Workgroup Interim Findings

Measurement Strategy for Readmissions and Healthcare-Acquired Conditions (HACs) Across Public and Private Payers

Task Description	Deliverable	Timeline
Provide input to HHS on a coordination strategy for readmission and healthcare-acquired conditions (HACs) measurement across public and private payers.	Final report containing Coordinating Committee input regarding the optimal approach for coordinating readmission and HAC measurement across payers	Draft Report: September 2011 Final Report: October 1, 2011

Ad Hoc Safety Workgroup will advise the Coordinating Committee

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Partnership for Patients

HHS has a new patient safety initiative called the **Partnership for Patients** focusing on improvement in readmissions and healthcare acquired conditions (HACs).

Establishes 2 goals to achieve by the end of 2013:

- Preventable HACs would decrease by 40% 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% compared to 2010

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HACs and Readmissions

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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.

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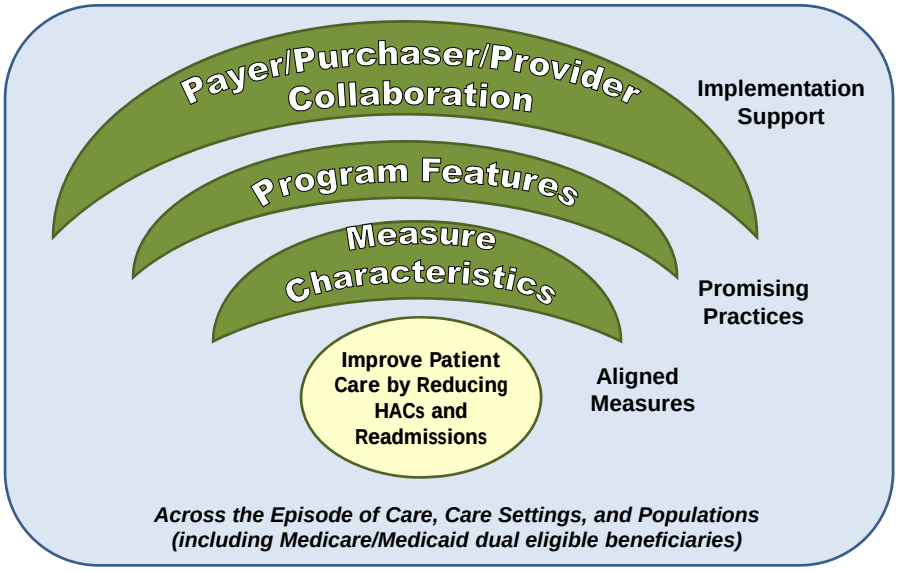
Dimensions of Public-Private Payer Alignment

Dimensions of Payer Alignment



Key Elements of a Coordination Strategy

HACs and Readmissions: Unique Considerations

There were many commonalities identified for an overall payer coordination strategy to reduce HACs and readmissions, though a few unique elements were noted:

HAC discussions focused on
- Data sources
- Processes

Readmissions discussions focused on
- Medical homes
- Patient-centeredness
- Communication systems
- Community

HACs and Readmissions: Collaboration

- Ensure that collaboration extends beyond payers and providers to include purchasers, communities, and patients/families/caregivers
  - Support improvement on the frontlines
  - Establish organizational cultures that encourage reporting safety issues
  - Reinforce teamwork and shared accountability
  - Engage patients in reduction of events (e.g., education using plain language, pharmacist education to prevent adverse drug events)
- Create joint accountability between hospitals, other providers, and community entities
  - Open communication lines between healthcare facilities and community supports
  - Consider impact of patient's home environment and social determinants on health

HACs and Readmissions: Collaboration

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- Share data and information across providers and settings
  - Provide real-time data to improve the care process (e.g., track admissions to different facilities, detect HAC post-discharge, notify whether prescriptions are filled, avoid drug-drug interactions and drug allergies)
  - Identify high risk patients through predictive modeling and share information with providers
  - Utilize the resources and toolkits of payers to advance improvement on the frontlines
  - Create a learning community to share promising practices
  - Provide data to purchasers and consumers to inform decision making

HACs and Readmissions: Program Features

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- Create incentive structures that support better care
  - Alignment of efforts across continuum to send consistent signals
  - Comprehensive care transition business model costs more than the cost of the readmissions penalty
- Bridge transition from hospital to community
  - Discharge planning and follow up both essential
  - Patient education to facilitate self-management
  - Medication reconciliation
  - Communication/collaboration between provider and community entities
  - Home visits
- Transparency is essential to drive improvement

HACs and Readmissions: Measure Characteristics

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- Measure alignment across public programs and public/private payers is essential
  - Consider statutory requirements for public programs (CMS, AHRQ, CDC, states)
  - Public/private payer measure alignment complicated by different populations
- Anticipate and monitor for consequences
  - Beyond unintended consequences, such as cost shifting/cherry picking
  - Length of stay and observation status as balancing measures
  - Optimum rate of readmissions may not be zero
- Attention to disparities
  - Risk adjustment vs. stratification
  - Improvement, as well as achievement; delta measures
- Measures should promote shared accountability (e.g., hospitals, other providers, community entities)

HACs and Readmissions: Measure Characteristics

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- Measures must be meaningful to all stakeholders and actionable
- Move beyond measures of occurrence to promoting preventive activities (e.g., ventilator bundle, central line insertion checklist)
- Consider pros and cons of different approaches to readmission measurement
  - 30 vs. 90 days
  - All payer vs. segmented
  - All cause readmissions vs. exclusions
  - All condition admissions vs. specific conditions
- Account for burden of data collection on providers
  - Volume, reliability, validity
- Measures would ideally be suitable for multiple purposes
  - Driving improvement vs. public reporting vs. payment

Guidance Requested by the Safety Workgroup

- Are there additional considerations related to the 3 dimensions (payer collaboration with purchasers and providers, promising program features, and measure characteristics) identified for payer alignment?
- Are there other opportunities for alignment beyond those identified by the Safety Workgroup?
- As the Safety Workgroup further develops a payer coordination strategy for implementation, are there specific practical considerations the Workgroup should take into account?

Next Steps

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Committee Discussion and Questions

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Opportunity for Public Comment

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Dual Eligible Beneficiaries Quality Measurement Strategy

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Measures that Address the Quality Issues Identified for Dual Eligible Beneficiaries

Task Description	Deliverable	Timeline
Provide input to HHS on identification of measures that address the quality issues for care provided to Medicare-Medicaid dual eligible beneficiaries.	Interim report containing framework for performance measurement for dual eligible beneficiaries	Draft Interim Report: September 2011 Final Interim Report: October 1, 2011
	Final report containing potential new performance measures to fill gaps in measurement for dual eligible beneficiaries	Draft Report: May 2012 Final Report: June 1, 2012

Dual Eligible Beneficiaries Workgroup will advise the Coordinating Committee

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.

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Review of Dual Eligible Beneficiaries Workgroup Interim Findings: Initial Guiding Principles

Guiding Principles

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Workgroup's Initial Vision for High Quality Care:
Individuals should have reliable access to a person-centered, culturally competent support system that helps them reach their personal goals through access to a range of healthcare services and community resources

- The population is defined by its heterogeneity and diversity; the group is best segmented by functional status or position on a trajectory spanning from health/wellness to disability/illness
- Culturally competent care must incorporate many dimensions, including race/ethnicity, language, level of health literacy, accessibility of the environment for people with disability, etc.
- Strategy for performance measurement should emphasize:
  - data exchange through portable, interoperable electronic health records
  - gathering and sharing information with the beneficiary
  - providing feedback to providers in order to facilitate continuous improvement
  - risk adjustment strategy to mitigate potential unintended consequences (e.g., adverse selection, overuse)
- Research needs and information gaps related to quality of care (e.g., high cost/high need patients, patient-reported outcomes)

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High-Leverage Opportunities for Quality Improvement

High-Leverage Improvement Opportunities

- Care coordination
  - Should take place across and within settings where care and community support is provided, across provider types, and across Medicare and Medicaid benefit structures
  - Include process measures, such as presence of a person-centered plan of care and medication reconciliation
  - Include measures of access to multi-disciplinary care team
  - Include measures related to advance planning and/or palliative care
- Quality of life
  - Care and supports are provided to enhance quality of life and enable individual to reach his/her self-determined goals
  - Include measures of functional status, to be evaluated over time
  - Include measures of an individual's ability to participate in his/her community
- Screening and assessment
  - Screening should be thorough and tailored to address the many complexities of the dual eligible beneficiary population to enable effective care
  - Assess home environment and availability of family and community supports
  - Screen for underlying mental and cognitive conditions, drug and alcohol history, HIV status, risk of falling, etc.

Coordinating Committee Guidance to the Dual Eligible Beneficiaries Workgroup

- Should the Workgroup consider additional guiding principles for its strategic approach to performance measurement?
- Are there additional high-leverage opportunities for performance improvement which should be considered by the Workgroup for prioritization?

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Next Steps

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Committee Discussion and Questions

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Opportunity for Public Comment

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Synthesis of Emerging Workgroup Themes and Committee Guidance to Workgroups

MAP Workgroup Initial Findings: Cross-Cutting Themes

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		Clinician	Ad Hoc	Duals	NPP
Key considerations for measurement strategy	Communication/coordination across settings & into community	✓	✓	✓	BC
	Shared decisionmaking	✓		✓	BC
	Functional status	✓		✓	BC & HP
	Patient reported outcomes	✓		✓	BC & HP
	Quality of life/well-being	✓		✓	BC & HP
	Health literacy (care instructions understandable)		✓	✓	BC & HP
	Access to community/caregiver supports		✓	✓	BC & HP
	Medication adherence/reconciliation		✓	✓	BC
	Access to quality care		✓		BC & HP
	Care plan developed & followed			✓	BC
	Depression/mental health screening			✓	HP
	Culturally sensitive care			✓	BC & HP
	Patient experience			✓	BC
Key programmatic considerations	Transparency	✓	✓	✓	BC & HP
	Level of analysis	✓	✓	✓	
	Considering shared accountability/team-ness	✓	✓	✓	BC
	Considering unintended consequences	✓	✓		BC & HP
	Using HIT tools	✓		✓	BC
	Using disparities lens		✓	✓	BC & HP
	Based on multiple chronic conditions framework when necessary			✓	BC

Key Considerations for Measurement Strategy

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Area emphasized by all groups:

- Communication/coordination across settings and into the community

Areas emphasized by only one group:

- Care plans, culturally sensitive care, patient experience, and mental health screening – Dual Eligible Beneficiaries Workgroup
- Access to quality care – Safety Workgroup

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Key Programmatic Considerations

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Areas emphasized by all groups:

- Transparency, level of analysis, and shared accountability/"teamness"

Area emphasized by only one group:

- Use of a multiple chronic conditions measurement framework - Dual Eligible Beneficiaries Workgroup

Discussion Questions

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1. What is your reaction to the emerging themes?
2. Are there missing themes that should be added to the list?
3. What themes deserve more or less emphasis?

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Committee Discussion and Questions

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Summation and Path Forward for the MAP

Committee Scope of Work & Timeline

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August 5, 2011

- Conduct a web meeting to review the workgroups' final findings in advance of the August in-person meeting.

August 17-18, 2011

- Convene an in-person meeting to review and approve the Clinician, Ad Hoc Safety, and Dual Eligible Beneficiaries Workgroups findings and recommendations.

November 1-2, 2011

- Conduct an in-person meeting to review and finalize findings and recommendations from the Post-Acute Care/Long-Term Care Workgroup on a coordination strategy for quality reporting across post-acute care and long-term care settings; prepare for December 2011 pre-rulemaking analysis.

Meeting Schedule

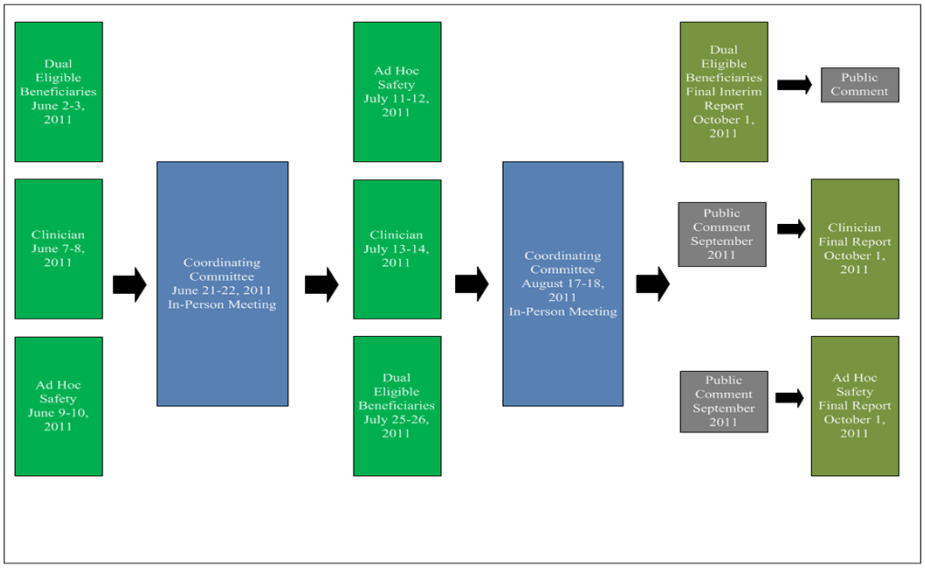
Coordinating Committee Web Meeting #2:
August 5, 2011 11:00 am-1:00 pm EST

Coordinating Committee In-Person #3:
August 17-18, 2011 (Washington, DC)

Public Webinar #1:
October 19, 2011 2:00-4:00 pm EST

Coordinating Committee In-Person Meeting #4:
November 1-2, 2011 (Washington, DC)

MAP Coordinating Committee Timeline and Processes – October 1, 2011 HHS Reports



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Appendix

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Review of Member Terms

Committee Member Terms

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- 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.

Committee Member Terms

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1-Year Term	2-Year Term	3-Year Term
National Partnership for Women and Families, represented by Christine A. Bechtel, MA	Bobbie Berkowitz, PhD, RN, CNAA, FAAN	AHA, represented by Rhonda Anderson, RN, DNSc, FAAN
The Joint Commission, represented by Mark R. Chassin, MD, FACP, MPP, MPH	Joseph Betancourt, MD, MPH	Richard Antonelli, MD, MS
Catalyst for Payment Reform, represented by Suzanne F. Delbanco, PhD	AMCP, represented by Judith A. Cahill	ACP, represented by David Baker, MD, MPH, FACP
HRSA, represented by Victor Freeman, MD, MPP	ABMS, represented by Christine Cassel, MD	NAMD, represented by Foster Gesten, MD
AHIP, represented by Aparna Higgins, MA	AARP, represented byJoyce Dubow, MUP	George Isham, MD, MS
PBGH, represented by William E. Kramer, MBA	Consumers Union, represented by Steven Findlay, MPH	Elizabeth McGlynn, PhD, MPP
MHMC, represented by Elizabeth Mitchell	FAH, represented by Chip N. Kahn	CMS, represented by Karen Milgate, MPP
LeadingAge, represented by Cheryl Phillips, MD, AGSF	AMGA, represented by Sam Lin, MD, PhD, MBA, MPA, MS	Ira Moscovice, PhD
Harold Pincus, MD	ACS, represented by Frank G. Opelka, MD, FACS	AdvaMed, represented by Michael A. Mussallem
Carol Raphael, MPA	AMA, represented by Carl A. Sirio, MD	OPM, represented by John O'Brien
AFL-CIO, represented by Gerald Shea	ONC, represented by Thomas Tsang, MD, MPH	NCQA, represented by Peggy O'Kane, MPH
AHRQ, represented by Nancy J. Wilson, MD, MPH	ANA, represented by Marla J. Weston, PhD, RN	CDC, represented by Chesley Richards, MD, MPH

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Establishment of the MAP Decision Making Framework

HHS Aims for the National Quality Strategy

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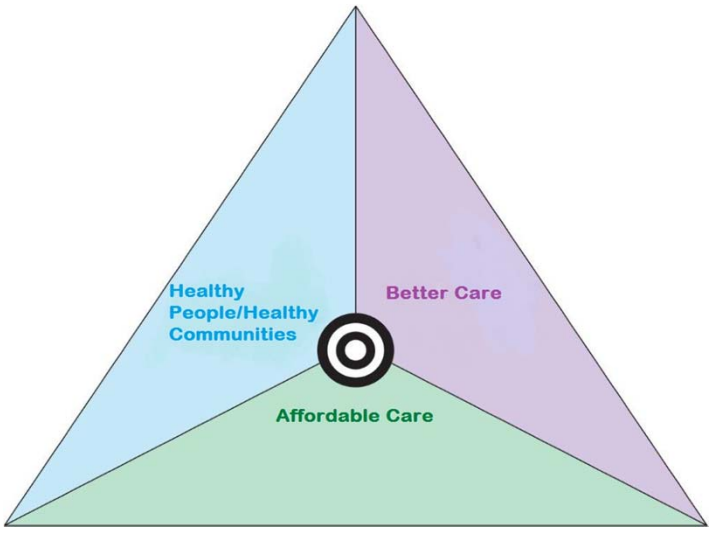

HHS National Quality Strategy

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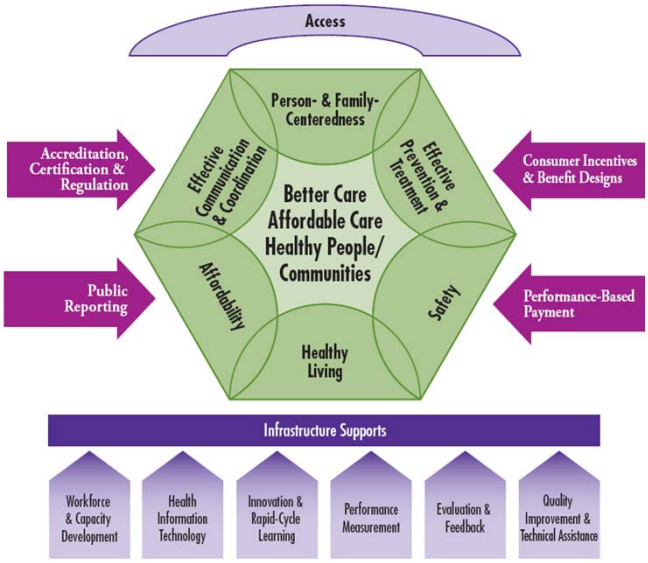

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High Impact Conditions

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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

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Patient-Focused Episodes of Care Model

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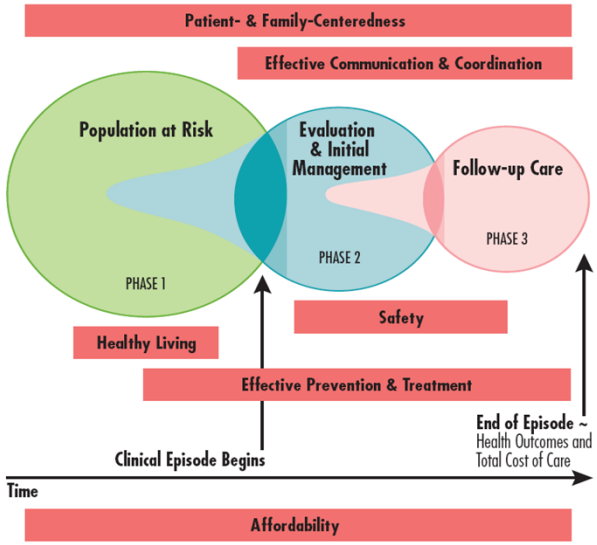

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MAP Decision-Making Framework

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- Overarching principle:
  - The aims and priorities 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.
  - HHS Multiple Chronic Conditions Framework.
  - Attention to equity across the NQS priorities.
  - Connection to financing and delivery models and broader context (e.g., ACOs).

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MAP Workgroup Charges

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
  - 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
  - Health IT Implications
  - High level transition plan and timeline by month
- Provide input on measures to be implemented through the federal rulemaking process.

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
  - Timeline

MAP Dual Eligible Beneficiaries Workgroup Charge

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 performance measurement strategy for this unique population and identify high-leverage opportunities for quality improvement
- 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

MAP Post-Acute Care/Long Term Care Workgroup Charge

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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
  - 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.

MAP Hospital Workgroup Charge

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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
  - Identification of measure development and endorsement gaps for cancer hospitals

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Stanford Input

Purpose

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Provide input to the MAP Coordinating Committee and workgroups on measure selection criteria 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 the NQF measure endorsement criteria.

Major Tasks

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

Conduct use cases with focus on payment, reporting and program evaluation to identify measure selection 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

Project Methods

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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) What is the performance accountability framework for the application? Should the selection criteria domains be prioritized based on the needs of the users of the application?
- b) What methods issues are attendant to sets of measures that are aggregated for an application?
- c) 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) What measurement systems are required to handle the data?
- e) Are there unique requirements for the target population, the data sources, or measure types?
- e) 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 measure selection 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 selection criteria for selection to recommend to MAP

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

Project Team

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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
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- Ted von Glahn, MSPH
- Alana Ketchel, MPP, MPH