Measure Applications Partnership Coordinating Committee

Web Meeting #2

August 5, 2011
11:00 am – 1:00 pm ET

Webinar access: http://www.MyEventPartner.com/NQFwebinar5

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Welcome, Introductions, and Review of Meeting Objectives

Meeting Objectives

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- Review evolution and current draft of measure selection criteria;
- Prepare for August 17-18 in-person Coordinating Committee meeting.

Meeting Agenda

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- Welcome, Introductions, and Review of Meeting Objectives
- Timeline Review and Update on Workgroup Activities
- Measure Selection Criteria
- Next Steps

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Timeline Review and Update on Workgroup Activities

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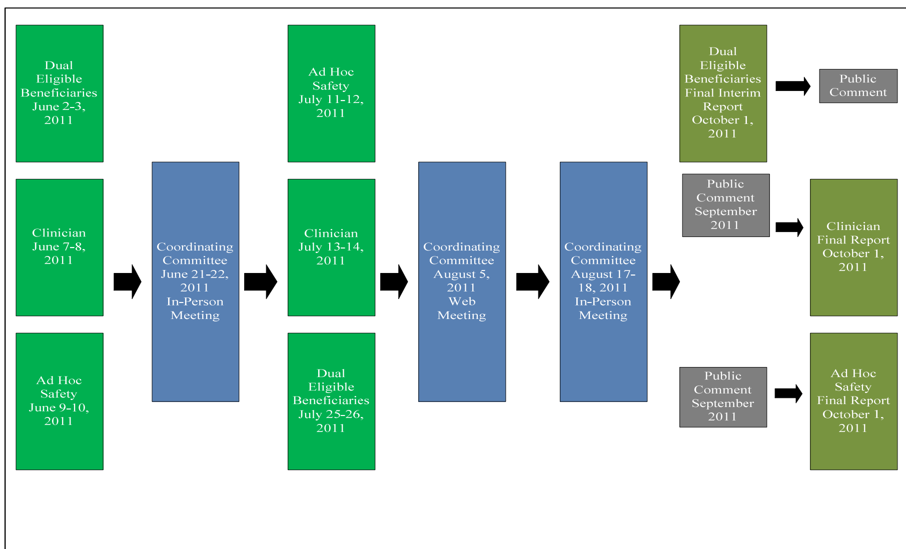
MAP Coordinating Committee Timeline and Processes – October 1, 2011 HHS Reports



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

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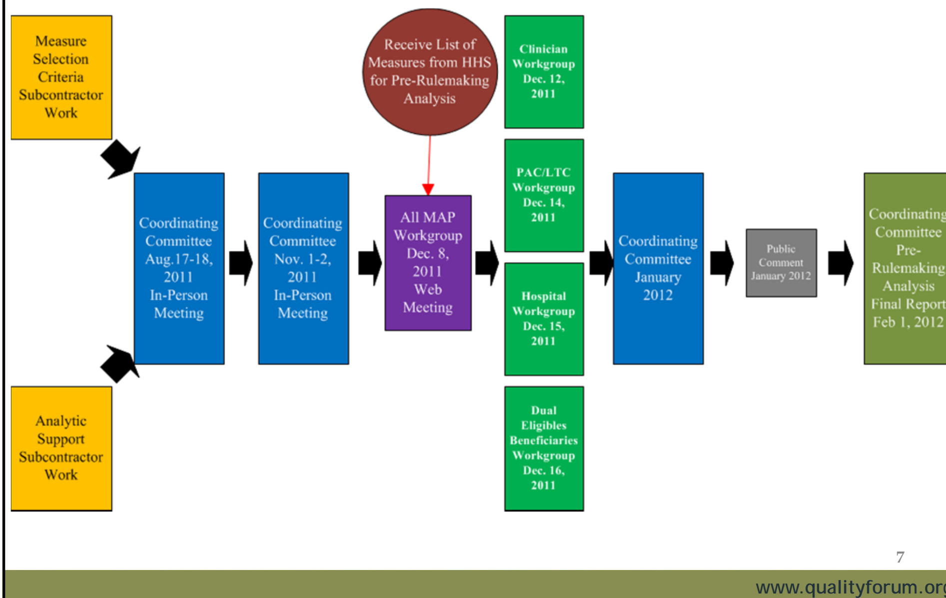

Background Analytics Support for Task 15.1

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- Kick-off meeting held with Avalere Health, LLC July 15, 2011
- Literature review and key informant interview analysis of quality issues in:
  - Hospitals (inpatient, outpatient, cancer hospitals, psychiatric hospitals, and CMS hospital value-based purchasing program)
  - Physician offices
  - Post acute care/long term care (hospice, ESRD facilities, inpatient rehab, long term care hospitals, home health, skilled nursing facilities)
- Literature review and focused case study key informant interviews in two States on quality issues for dual eligible beneficiaries

MAP Ad Hoc Safety Workgroup Update

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Ad Hoc Safety Workgroup met in person on July 11-12:

- Discussed potential coordination strategies including:
  - Measure characteristics
  - Information sharing and decision support
  - Incentive programs
- Discussed collaboration across various stakeholder groups as critical to successful payer coordination. The Workgroup focused on the roles of:
  - Consumers
  - Purchasers
  - Providers
  - Communities

Following the meeting a survey was distributed to workgroup members to rank potential priorities and areas of alignment to improve patient safety by reducing HACs and readmissions

MAP Clinician Workgroup Update

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Clinician Workgroup met on the following dates:

- June 30 web meeting
  - Discussed federal program alignment issues
  - Discussed data collection, transmission, and reporting back issues
- July 13-14 in-person meeting
  - Described characteristics of an ideal measure set
  - Considered data platform principles
- Post meeting exercise and August 1 web meeting
  - Used the set-level MAP Measure Selection Criteria to evaluate the proposed physician value-modifier measures
  - Adopted data platform principles

MAP Dual Eligible Beneficiaries Workgroup Update

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Dual Eligible Beneficiaries Workgroup met on the following dates:

- July 6 web meeting
  - Began an exercise to identify high-need population subgroups
  - Identified opportunities to improve the affordability of care
- July 25-26 in-person meeting
  - Confirmed vision, guiding principles, and strategic approach to performance measurement
  - Discussed co-morbidity, disability, and vulnerability as attributes that interact for high-need subgroups
  - Identified potential example measures related to four high-impact areas
  - Discussed measure development and endorsement gaps

MAP PAC/LTC Workgroup Update

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PAC/LTC Workgroup met in person on June 28:

- Reviewed quality measurement programs in PAC/LTC settings
- Discussed coordination strategy
- Discussed Coordinating Committee measure selection criteria “strawperson”
- Provided input to Ad Hoc Safety Workgroup

Discussion and Questions

Measure Selection Criteria

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Evolution of Measure Selection Criteria

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Application of Measure Selection Criteria

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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

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Measure Selection Criteria Development

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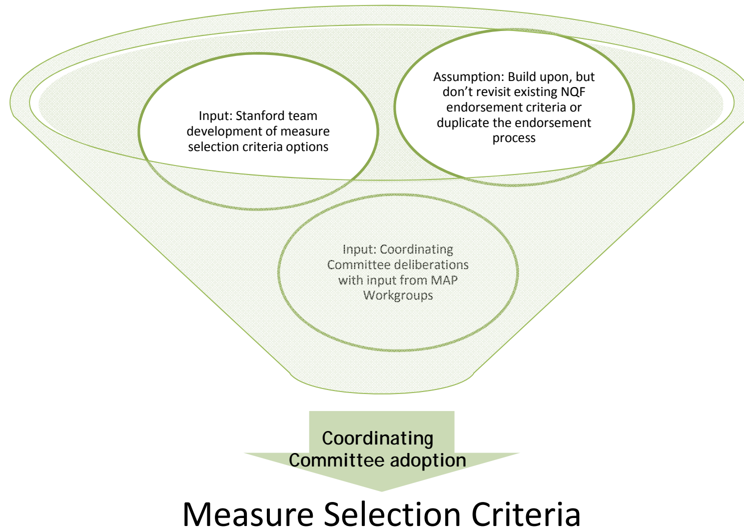

Measure Selection Criteria

Measure Selection Criteria Development

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- Inputs included:
  - MAP Coordinating Committee
  - MAP workgroups
  - Stanford project team
- Measure selection principles first iterated in the May 3-4 Coordinating Committee in-person meeting, further enhanced at the following meetings:
  - June workgroup in-person meetings
  - June 21-22 Coordinating Committee in-person meeting
  - July workgroup in-person meetings
  - August 1 Clinician Workgroup web meeting focused on measure selection exercise
- Current draft of measure selection criteria includes:
  - 6 individual measure criteria
  - 7 measure set criteria

High Priority Measure Set Selection Criteria

Patrick Romano, MD, MPH
August 5, 2011

Arnold Milstein, MD, MPH
Principal Investigator

Key Informant Findings

- Key informants were asked to critique the candidate measures criteria and recommend additional criteria and/or changes to the candidate criteria based on their application lens:
  - payment,
  - public reporting or
  - program monitoring/evaluation
- Selected "key takeaways" from informant feedback follow

Key Informants

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Payment	Public Reporting	Program Monitoring/Evaluation
Anna Fallieras Program Leader, Health Care Initiatives and Policy **General Electric**	Jim Chase President **MN Community Measurement**	Sam Ho, MD Executive Vice President **UnitedHealthcare Clinical Services**
Herb Kuhn President and CEO **Missouri Hospital Association**	Carol Cronin, MSW, MSG Executive Director **The Informed Patient Institute**	Donna Lagarias, PhD Benefits, Quality and Monitoring Healthy Families Program **Managed Risk Medical Insurance Board**
Harold Miller President and CEO **Network for Regional Healthcare Improvement**	Judy Hibbard, DrPH Senior Researcher, Institute for Policy Research and Innovation **University of Oregon**	Patricia MacTaggart, MBA, MMA Lead Research Scientist and Lecturer **George Washington**
Dolores Mitchell Executive Director **Group Insurance Commission of Massachusetts**	John Santa, MD, MPH Consumer Reports Health Ratings Center **Consumers Union**	
Jerry Penso, MD, MBA Medical Director, Continuum of Care **Sharp Rees-Stealy Medical Group**		

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Payment Applications

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- Payment measures should drive organizational performance, through allocation of resources, transparent feedback of data to providers, and targeted interventions to achieve goals
- Providers should be allowed to participate in payment programs even with incomplete data sets
- Performance measures for payment that are most controllable by the participating organization should have higher preference
- The criteria should allow for continuous flexibility to test and revise or remove measures that are not meaningful

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Public Reporting Applications

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- Performance information should be summarized at a level that is meaningful and usable for consumers
- Align cost and quality so the public can see that higher value will not sacrifice quality and outcomes
- Patient-reported data that is actionable should be prioritized
- Measure sets should include measures that address the harms of overuse

Program Monitoring Applications

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- Criteria should strongly encourage use of electronic data
- Criteria should encourage better quality outcome measures to align with cost of care measures (reduce focus on underuse)
- Burden of data collection should be linked to importance and impact of data
- Criteria should not allow perfect to be the enemy of the good when considering unintended consequences

Criteria Prioritization

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- Six "high priority" criteria were identified out of 22 total
- Criteria were prioritized based on the key informant input and project team rankings
- Other criteria were identified as priorities by an individual key informant or project team member but this reflects the shared "short list" to guide MAP decision-making

Performance Discrimination

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Example:

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

Measure selection criterion:
Measures should be accompanied by a method to classify performance that is specific to the intended use. The recommended method should demonstrate performance discrimination that is sufficient to yield meaningful results for the user audience.

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).

Measures Aggregation

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Example:

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

'At-risk' domain organized into 5 condition specific sub-domains

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 user audience. The aggregation method should ensure that compelling quality differences at the individual measure level, which may be masked at the summary level, are readily available to the users.*

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

Outcomes Measures Preferred

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Example:

Extend Special Needs Plan (SNP) measure set to include patient-reported functional status and quality of life measures.

Measure selection criterion:
Outcomes measures are a preferred component of any measure set to ensure that the highest valued performance indicators are deployed – and, in particular, to capture health and cost outcomes across the care system.

Explanation: Measures should encourage systemness – outcomes results are a way to demonstrate that patients' needs are being met across providers and care settings.

Accountability for Transitions

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Example:

Care Transition Model measures to evaluate the information sending and receiving aspects of a transition from inpatient care including the patient care plan and medical record.

Measure selection criterion:
Measure sets for patients whose treatment spans care settings should include continuity of care and/or transition of care measures.

Explanation: Though measures that are within the span of control of the accountable entity are preferred, that provider's responsibility should extend to care transitions as patients move across care settings/providers.

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.

Measure selection criterion:
Measure sets should capture multiple dimensions of a given quality construct. Use groups of measures that address the same construct, condition, procedure or setting.

- *Measure(s) should foster alignment between cost of care and other domains of quality performance.*
- *Efficiency/appropriateness measures should be included in a balanced measure set.*

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

Broad Provider Participation: Methods for Alternative Measure Sets

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Example:

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

Preventive care composite "A" includes weight & nutrition management measures and composite "B" limited to preventive screening measures.

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

* This criterion does not negate the importance of using a core set of measures that are mandatory for all accountable entities – rather, in the context of a core set of required measures, methods should be applied to enable providers to participate with an incomplete dataset (e.g., a limited dataset could be usable through: a) measures scoring techniques that address missing values, or b) performance scoring/classification techniques that limit the payment or reporting opportunities including partial payment formulas).

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.

Evolution of Measure Selection Criteria

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Following the June 21-22 MAP Coordinating Committee in-person Meeting, NQF Staff worked to operationalize the "strawperson" measure principles into a draft rating system:

- Identified high priority measurement concepts
- Recognized that some measurement concepts were more applicable at an individual measure level and others at the greater set-level

Key Concepts Mapped to Criteria

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- The National Quality Strategy (NQS) provides a solid foundation for measurement goals described by the MAP committees:
  - Ensuring that each person and family is engaged as partners in their care (patient-centered)
  - Promoting effective communication and coordination of care (care coordination)
  - Making quality care more affordable (resource use/cost)
- Many MAP committee inputs overlap with NQF endorsement criteria:
  - Importance to measure and report: high impact; performance gap
  - Usability: demonstration that information produced by the measure is meaningful, understandable, and useful
  - Feasibility: data is available in electronic health records or other electronic sources
- Emphasis on patient-focused episodes of care across settings and time, as an example of one way to address "systemness"
- Parsimony – considered in both individual and set level criteria

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Key Concepts Mapped to Criteria (continued)

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Additional emphasis and inputs from July 13-14 MAP Clinician Workgroup:

- Measures should be assessed on whether they are suitable for specific programs, including the extent to which a set covers the accountable entities
- Representation of measure types, relevant to the program (e.g., process, outcomes, patient experience, and cost)
- Avoidance of unintended consequences
- Consideration of disparities

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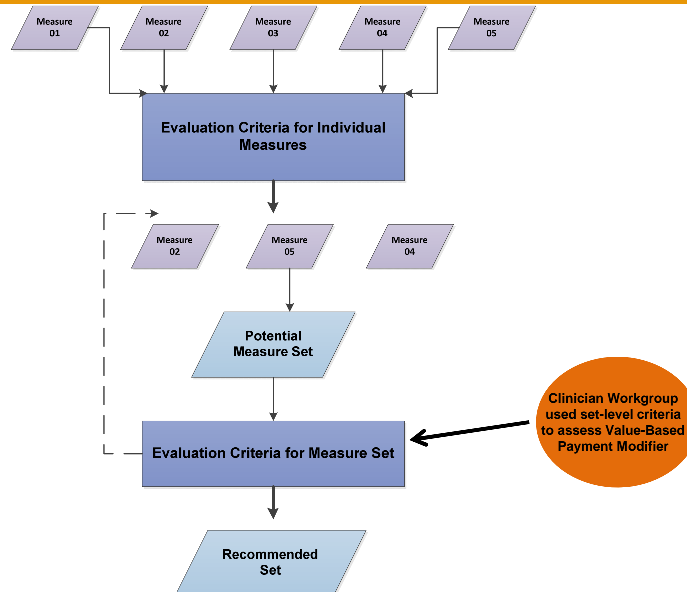
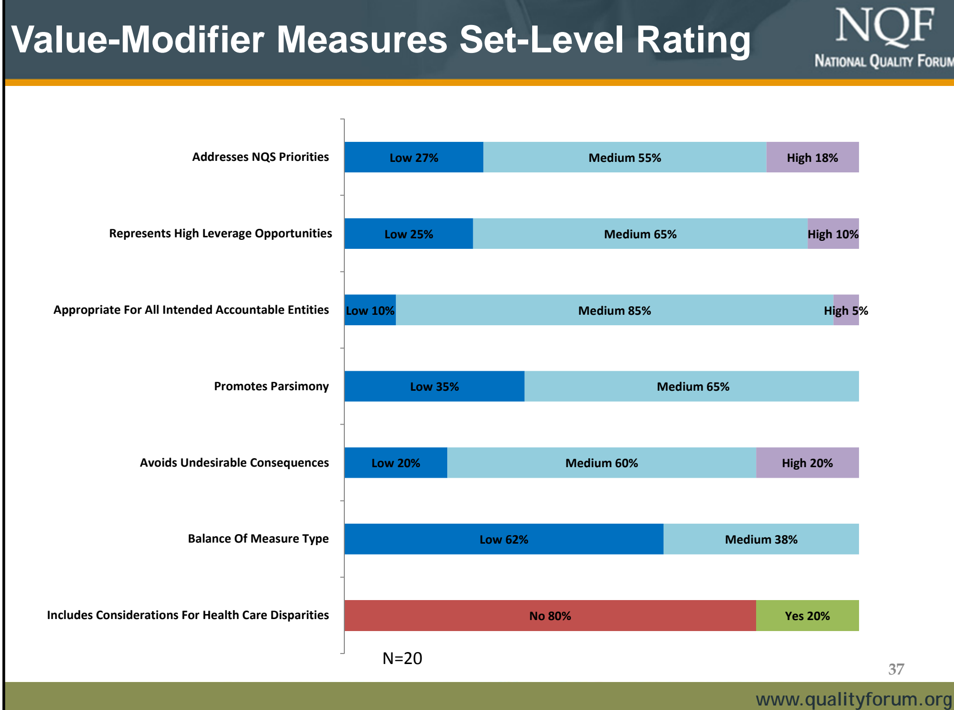
Applying Measure Selection Criteria



MAP Clinician Workgroup Experience

- July 13-14 Clinician Workgroup meeting:
  - Characteristics of an ideal measure set identified and incorporated into measure set level criteria
- Post meeting:
  - Clinician Workgroup members evaluated, via a survey monkey tool, the measure set criteria
  - Context of a federal program (physician value-based modifier proposed measure set – 62 quality measures)


Value-Modifier Measures Set-Level Rating
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Addresses NQS Priorities
Low 27%
Medium 55%
High 18%
Represents High Leverage Opportunities
Low 25%
Medium 65%
High 10%
Appropriate For All Intended Accountable Entities
Low 10%
Medium 85%
High 5%
Promotes Parsimony
Low 35%
Medium 65%
Avoids Undesirable Consequences
Low 20%
Medium 60%
High 20%
Balance Of Measure Type
Low 62%
Medium 38%
Includes Considerations For Health Care Disparities
No 80%
Yes 20%
N=20
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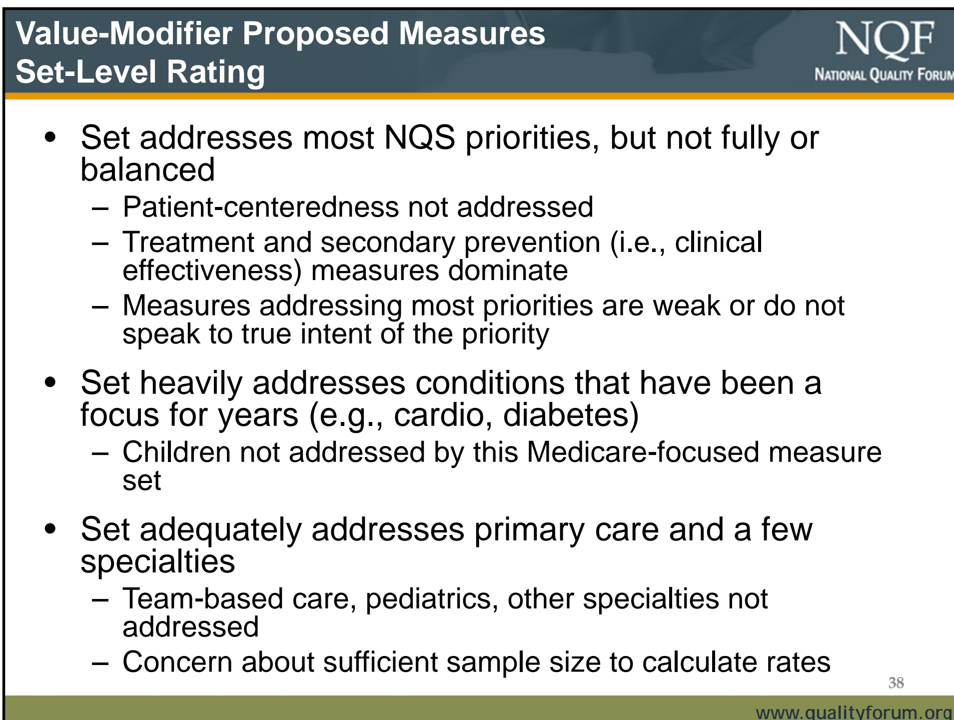
Value-Modifier Proposed Measures Set-Level Rating
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• Set addresses most NQS priorities, but not fully or balanced
– Patient-centeredness not addressed
– Treatment and secondary prevention (i.e., clinical effectiveness) measures dominate
– Measures addressing most priorities are weak or do not speak to true intent of the priority
• Set heavily addresses conditions that have been a focus for years (e.g., cardio, diabetes)
– Children not addressed by this Medicare-focused measure set
• Set adequately addresses primary care and a few specialties
– Team-based care, pediatrics, other specialties not addressed
– Concern about sufficient sample size to calculate rates
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Value-Modifier Proposed Measures Set-Level Rating

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- Lack of cross-cutting measures works against parsimony
  - Focus on individual conditions and provider types, rather than systems of care
  - Data collection burden is high; need to enable measurement through HIT/HIE
  - Some alignment with meaningful use measures, but should be stronger
- Unsure of potential for undesirable consequences and whether disparities addressed by stratification or adjustment
- Measure set is dominated by process measures
  - Outcomes, experience, and cost have minimal or no representation

Value-Modifier Proposed Measure Set Gaps

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- Patient preferences, patient experience, and patient-reported outcomes
- Care coordination, communication with patient/family, social supports
- Function, quality of life, pain, fatigue
- Affordability, overuse, efficiency
- Safety
- Surgical care
- Child health
- Oral health
- Mental and behavioral health

Experience Applying the Set-Level Criteria

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Majority of respondents agree the MAP set-level measure selection criteria are a good starting place for assessing the adequacy of a measure set for a specific purpose

- Strongly Agree – 30%
- Agree – 50%
- Disagree – 20%
- Strongly Disagree – 0%
- N= 20, 71% response rate

Criteria would ideally better ascertain if a set contains the best or right measures to address a given criterion

Experience Applying the Set-Level Criteria

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- Addresses NQS Priorities
  - Difficult determining how completely addressed
- Addresses high-leverage opportunities
  - Different from high-leverage for improvement
  - High-leverage should be defined beyond high- impact conditions
- Appropriate for all intended accountable entities
  - Addressing all intended accountable entities may not encourage “systemness” or shared accountability

Experience Applying the Set-Level Criteria

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- Promotes parsimony
  - Many variables, generally difficult to assess
- Avoids undesirable consequences
  - Difficult to predict, as all measures have some potential for unintended consequences
  - Rating dependent on programmatic features, such as a plan to monitor

Experience Applying the Set-Level Criteria

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- Contains a balance of type of measures
  - Equal representation is not necessarily the goal, rather addressing priorities in parsimonious manner
- Includes considerations for health care disparities
  - Further guidance needed
  - Difficult criterion to meet
    - Disparities measurement is new
    - Stratification at individual clinician level may not be possible due to sample size

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Draft of Measure Selection Criteria

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Measure Selection Criteria

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Individual Measure Review	Measure Set Review
1. Measure addresses National Quality Strategy priorities and high-leverage measurement areas	1. Measure set provides a comprehensive view of quality - NQS
2. Measure meets NQF endorsement criteria	2. Measure set provides a comprehensive view of quality – high leverage opportunities
3. Measure is applicable to multiple populations and providers	3. Measure set is appropriate for all intended accountable entities
4. Measure enables longitudinal assessment of patient-focused episode of care	4. Measure set promotes parsimony
5. Measure is ready for implementation in the context of a specific program	5. Measure set avoids undesirable consequences
6. Measures is proximal to outcomes	6. Measure set has an appropriate representation of measure types
	7. Measure set includes considerations for health care disparities

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Discussion Questions

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- Do the current measure selection criteria capture the most important measure principles/domains?
- Do specific criterion need to be further refined?
  - How can the rating criteria be better defined?
- How best to translate avoidance of unintended consequences and disparities into criteria?
  - Should these be guiding principles instead?
- How best to shape the measure types criterion to ensure appropriate representation of outcomes, process, patient experience, and cost measures within a given program context?

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Discussion and Questions

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Opportunity for Public Comment

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Please send further comments on the measure selection criteria to:

measureapplications@qualityforum.org

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Next Steps

Coordinating Committee Next Steps

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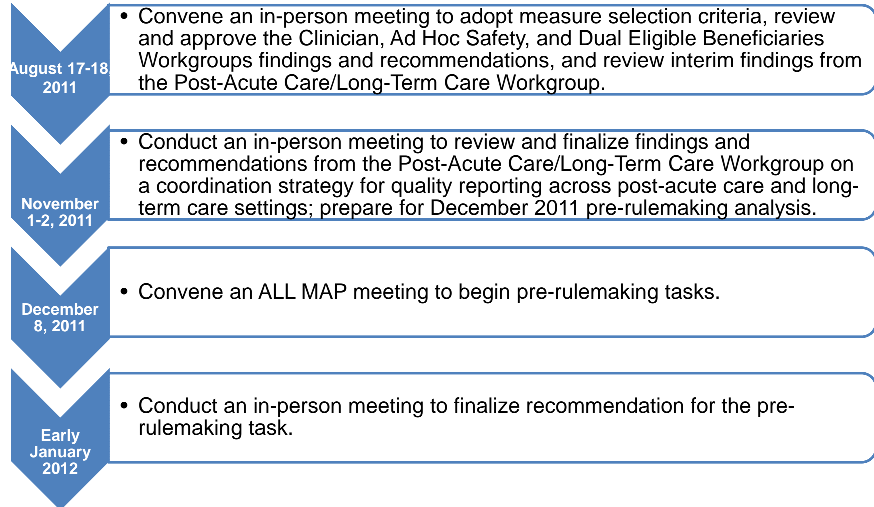
August 17 -18 in-person meeting objectives:

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



MAP Meeting Schedule

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

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

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

ALL MAP Meeting #2
December 8, 2011 1:00-3:00 pm EST

Coordinating Committee In-Person Meeting #5
Early January, 2012 (Washington, DC)

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Discussion and Questions

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Opportunity for Public Comment