Measure Applications Partnership

Coordinating Committee In-Person Meeting

August 14-15, 2012

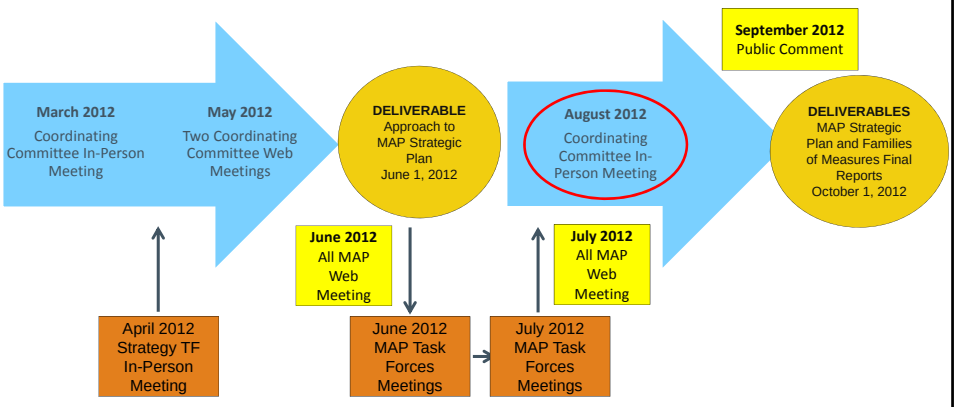
NATIONAL QUALITY FORUM

Welcome and Review of Meeting Objectives

Meeting Objectives

- Review the final draft MAP Strategic Plan
- Review proposed families of measures identified by MAP task forces
- Provide input into the development of a guidance document for MAP pre-rulemaking deliberations about the implementation of readmission measures in specific programs
- Provide input on MAPs role and next steps for gap-filling pathways
- Review uptake of MAP recommendations in federal proposed rules
- Finalize the MAP Strategic Plan and families of measures

MAP October 1 Deliverables



MAP Work for 2012: Key Deliverables

Deliverables	Date Due to HHS
Outline of Approach to MAP Strategic Plan	June 1, 2012
• **MAP Strategic Plan** • **Families of Measures:** **- Cardiovascular Conditions & Diabetes + cost of care implications** **- Patient Safety & Care Coordination + cost of care implications**	**October 1, 2012**
Measures for High-Need Sub-Populations of Dual Eligible Beneficiaries Interim Report	December 28, 2012
MAP Pre-Rulemaking Input	February 1, 2013
Measures for High-Need Sub-Populations of Dual Eligible Beneficiaries Final Report	July 1, 2013
• Families of Measures: Population Health, Patient and Family Engagement, Mental Health, and Cost of Care (e.g., total cost, resource use, appropriateness)	TBD - 2013

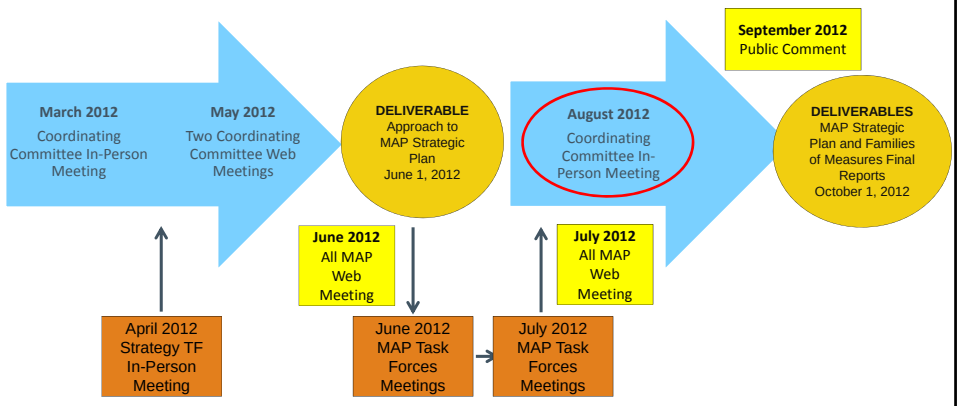
Disclosures of Interest

MAP Strategic Plan

MAP Strategy Taskforce Membership

- **Chip Kahn, Member of MAP Coordinating Committee (co-chair)**
- **Gerry Shea, Member of MAP Coordinating Committee (co-chair)**
- George Isham, MAP Coordinating Committee co-chair
- Beth McGlynn, MAP Coordinating Committee co-chair
- Helen Darling, National Priorities Partnership co-chair
- Bernie Rosof, National Priorities Partnership co-chair
- Alice Lind, MAP Dual Eligible Beneficiaries Workgroup chair
- Mark McClellan, MAP Clinician Workgroup chair
- Frank Opelka, MAP Hospital Workgroup chair
- Carol Raphael, MAP PAC/LTC Workgroup chair
- Christine Bechtel, MAP Coordinating Committee member
- Nancy Wilson, MAP Coordinating Committee member (federal agency liaison)
- Patrick Conway, MAP Coordinating Committee member (federal agency liaison)

MAP Strategic Plan Timeline



Strategic Plan Outline

- MAP Purpose
- MAP Goal and Objectives
- MAP Strategies
  - Strategies
  - Feedback loops along the Quality Measurement Enterprise
- MAP Action Plan:
  - Engagement approach
  - Families of measures and core measure sets
  - Measure gaps
  - Measure implementation phasing strategies
  - MAP analytics plan
  - MAP measure selection criteria
  - MAP evaluation plan
- *MAP Communications Plan (a companion document to the Strategic Plan)*

Purpose of the MAP Strategic Plan

Current Measurement Challenges:

- Current state of performance measurement is hindered by a siloed approach that reflects the siloed delivery system
- Measurement lacks uniformity across federal, state, and private sector programs
- Key measure gaps persist
- Effective data collection, transmission, and sharing mechanisms are lacking

MAP Can Address Issues by:

- Ensuring future federal strategies and measure selection during rulemaking are informed upstream by organizations invested in improving health care quality
- Bringing together many forces to align public- and private-sector uses of performance measures in furtherance of the NQS aims
- **The MAP Strategic Plan establishes an ambitious approach for addressing performance measurement issues**

Objectives, Strategies, and Tactics

Goal: Achieve improvement, transparency, and value, in pursuit of the aims, priorities, and goals of the National Quality Strategy

OBJECTIVE #1	STRATEGIES	TACTICS	MILESTONES
Improve outcomes in high-leverage areas for patients and their families (i.e., progress towards realization of the NQS)	• Ensure recommended performance measures are high-impact, relevant, actionable, and drive toward realization of the NQS • Establish feedback loops to support data-driven decision making and build on other initiatives (e.g., NQS, NPP, private sector efforts) • Provide input on measure sets for specific applications	• Identify Families of Measures and Core Measure Sets • Enhance MAP Measure Selection Criteria • Develop MAP Analytics Function • Define Measure Implementation Phasing Strategies • Create and Execute MAP Evaluation Plan	Program measure sets align with MAP families of measures and core measure sets

Objectives, Strategies, and Tactics (continued)

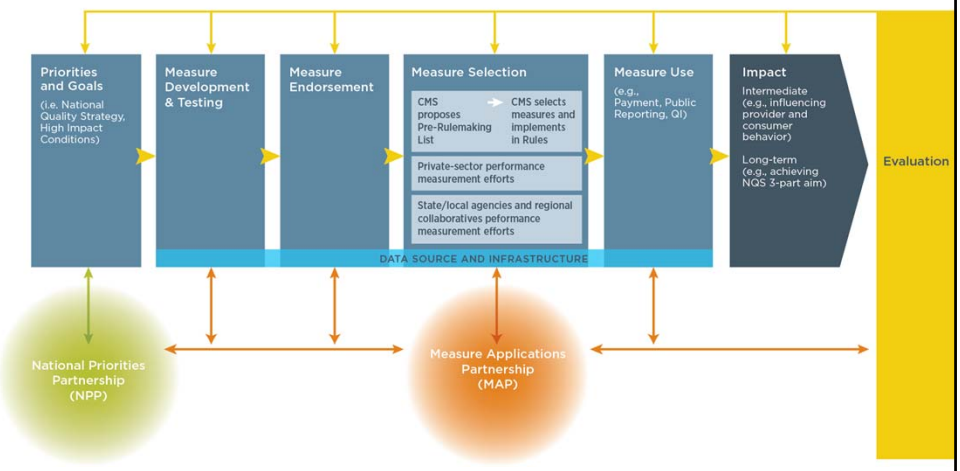
Goal: Achieve improvement, transparency, and value, in pursuit of the aims, priorities, and goals of the National Quality Strategy

OBJECTIVE #2	STRATEGIES	TACTICS	MILESTONES
Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy on value	• Promote alignment of performance measurement across HHS programs and between public and private initiatives • Stimulate gap-filling for high-priority measure gaps • Identify solutions to performance measure implementation barriers	• Identify Families of Measures and Core Measure Sets • Address Measure Gaps • Enhance MAP Measure Selection Criteria • Create and Execute MAP Evaluation Plan	• Funding for measure development and developer efforts focus on the highly-prioritized gaps identified by MAP • Proposed solutions to implementation barriers for existing high-leverage measures are tested in the field • Low-value measures are removed from programs

Objectives, Strategies, and Tactics (continued)

Goal: Achieve improvement, transparency, and value, in pursuit of the aims, priorities, and goals of the National Quality Strategy

OBJECTIVE #3	STRATEGIES	TACTICS	MILESTONES
Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden	• Ensure MAP's recommendations are relevant to public and private implementers and its processes are effective • Establish feedback loops with stakeholders to determine if MAP recommendations are meeting stakeholder needs and are aligned with their goals • Recommend removal of low-value measures from federal programs	• Identify Families of Measures and Core Measure Sets • Enhance MAP Measure Selection Criteria • Establish a MAP Communication Plan • Execute MAP Engagement Plan	• Key purchasers and payers are aware of and engaged in MAP work • MAP recommendations are implemented in public and private sector programs



Feedback Loops

MAP seeks to establish bi-directional collaboration with stakeholders involved in each of the functions of the Quality Measurement Enterprise.

Feedback Loops

- **Priorities and Goals**
  - *Input:* Understand the implications of the NQS priorities and goals and what quality measures are needed for which purposes (NPP, other entities)
  - *Output:* Identify opportunities to enhance the NQS or needed guiding frameworks (NPP, federal partners)
- **Measure Development and Testing**
  - *Input:* Information about measures in the development pipeline and issues that arise when developing measures (measure developers, NQF endorsement process)
  - *Output:* Identification of gaps and gap-filling barriers/solutions (measure developers, NPP, NQF endorsement process, federal partners, private sector stakeholders funding measure development)

Feedback Loops

- **Measure Endorsement**
  - *Input:* Information to support MAP decision-making; signals where attempts to fill high-leverage gaps have occurred (NQF endorsement process)
  - *Output:* Identification of gaps and gap-filling barriers/solutions (measure developers, NPP, NQF endorsement process, federal partners, private sector stakeholders funding measure development)
- **Measure Selection and Use**
  - *Input:* Measures currently used in programs and the rationale for inclusion (federal partners, state/local agencies, regional collaboratives)
  - *Output:* Identification of measures for specific purposes; input on programmatic structure (purchasers, payers, accreditation/certification entities)

Feedback Loops

- **Measure Impact**
  - *Input:* Understand if measures are driving improvement, transparency, and value (federal partners, state/local agencies, regional collaboratives)
- **Evaluation**
  - *Input:* Solicit feedback from stakeholders across the Quality Measurement Enterprise to enhance MAP recommendations and processes (consumers, accreditation/certification entities, federal partners)

MAP Strategic Plan
Action Plan

MAP Action Plan

Tactics, including collaborators, deliverables, and timeline:

1. Engagement approach
2. Families of measures and core measure sets
3. Measure gaps
4. Measure implementation phasing strategies
5. MAP analytics plan
6. MAP measure selection criteria
7. MAP evaluation plan

Approach to Stakeholder Engagement

- Engagement must occur:
  - Within MAP as a group to ensure that MAP has the information it needs to support informed decision-making,
  - Within MAP and with individual stakeholders to ensure that MAP recommendations reflect the perspectives and needs of stakeholders, and
  - With individual stakeholders involved in some aspect of healthcare quality measurement to determine the degree of uptake and use of MAP recommendations and related supporting materials.

Approach to Stakeholder Engagement

Initial Engagement Phase

- Relies heavily on the involvement of MAP members
- MAP will request its members to:
  - Provide practical information MAP needs to inform its decision-making
  - Help disseminate and apply MAP's recommendations in the field
- Timeline: Ongoing

Approach to Stakeholder Engagement

Illustrative example of MAP's Initial Engagement Activities

Overarching Strategy	Action by MAP	Action by MAP Members and Other Stakeholders	Desired Result
Establish feedback loops to support informed decision-making by MAP as a group	Identify or create methods to request and receive insights from stakeholders to then factor into MAP work	Provide comments or insights regarding issues that are important to MAP	MAP's deliverables reflect stakeholder perspectives and help meet key practical needs of those directly involved in measurement and improvement of health and healthcare
Establish feedback loops to support informed decision-making by stakeholders	Identify or create methods to share insights and ideas with stakeholders	Help disseminate insights and ideas from MAP to others involved in measurement and improvement of health and healthcare	MAP output motivates and enables stakeholders to take actions that improve outcomes and align measurement across programs and sectors
		Apply insights and ideas from MAP in their own work in measurement and improvement of health and healthcare	

Approach to Stakeholder Engagement

Subsequent Phase – MAP Engagement Task Force

- Expands MAP's reach to broader audiences
- MAP Engagement Task Force will:
  - Assess information needed to identify additional channels for MAP engagement and participation
  - Determine the most useful content and format for materials to disseminate information to stakeholders
- Timeline
  - Convene the Engagement Task Force in 2013
  - Finalize the approach by mid-2013; phase in the task force's recommendations

Identifying Families of Measures and Core Measure Sets

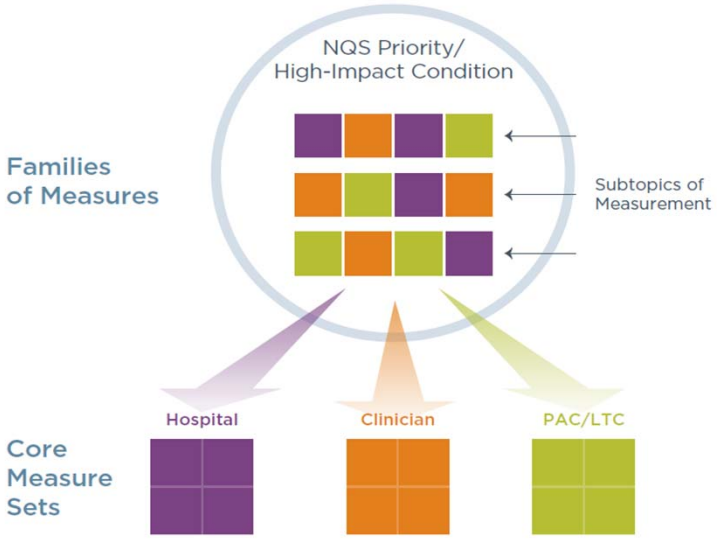
Families of Measures

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

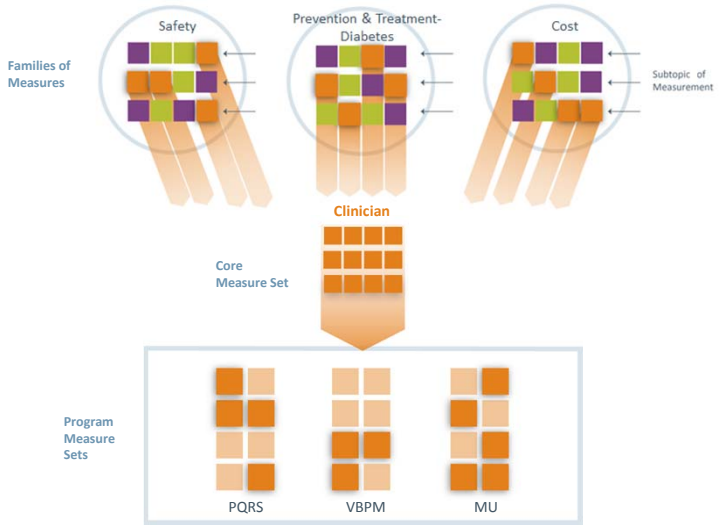
Core Measure Sets

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

Development of Families of Measures and Core Measure Sets



Families of Measures Populating a Core Measure Set



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Proposed Families of Measures

2012
- Patient Safety
- Care Coordination
- Cardiovascular Care
- Diabetes Care

2013
- Affordability
- Population Health
- Patient- and Family-Centered Care
- Mental Health

2014
- Revisit families as needed
- Additional high-impact conditions
- Other?

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Addressing Measure Gaps

MAP will serve as a catalyzing agent for coordinated gap-filling by:

- Identifying gaps, characterizing gaps along the measure life cycle, and proposing options for addressing gaps, such as:
  - Suggest measure ideas for *de novo* measure gaps
  - Signal development and testing gaps for measures that could be expanded to other populations or settings
  - Define implementation strategies for implementation gaps
- Engaging measure developers and those who fund measure development to propose solutions for barriers that may perpetuate measure gaps
- Identifying key stakeholders most aptly positioned to develop measures or implement solutions to gap-filling barriers
- Timeline: Throughout MAPs work, beginning in 2012
- **Note: The Coordinating Committee will discuss MAP's role in gap-filling on Day 2 of this meeting.**

Measure Lifecycle

Defining Measure Implementation Phasing Strategies

- Define how program measure sets transition from current sets to the core sets
- Provide guidance on the implementation of measures in public and private sectors by defining:
  - Measures for immediate inclusion
  - Measures for phased inclusion
  - Measures for phased removal
  - Non-core measures that should remain or be included in measure set
- Timeline
  - Define measure phasing strategies throughout the course of MAP's work
  - Initial phasing strategies will be included in the 2013 MAP Pre-Rulemaking Report

Analytic Support for MAP Decision-Making

- Build on the NQS and broader evidence to identify high-leverage opportunities for improvement
- Utilize measurement information, including available information on measure use and impact
- Refine MAP's decision-making framework over time with experience and information gained from analysis to evaluate MAP's impact
- Timeline
  - Ongoing; MAP has begun collecting and synthesizing readily available information to support the development of initial families of measures
  - MAP will refine process as new information becomes available

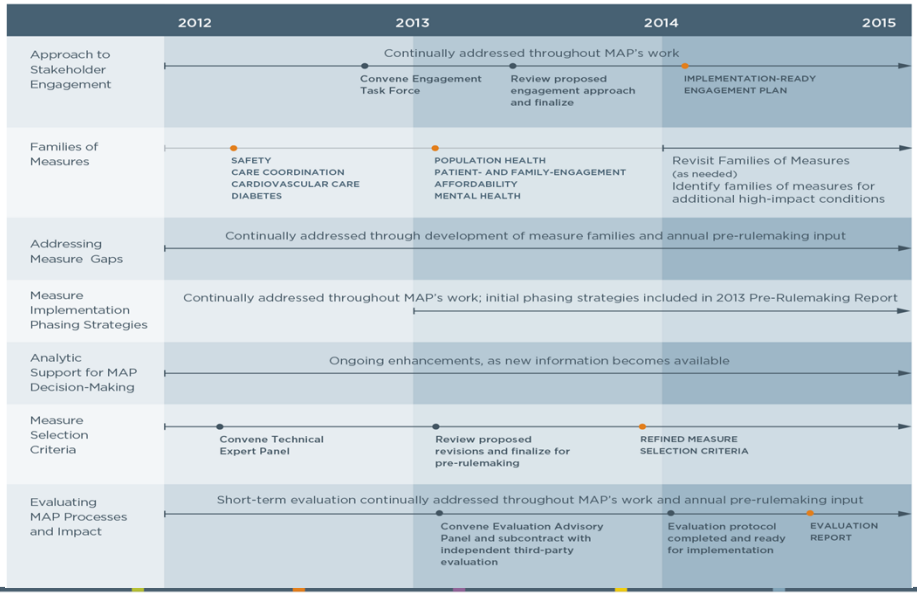
Refining MAP Measure Selection Criteria

- Continue to evolve as MAP gains experience using the criteria
- Planned enhancements include:
  - Addressing different programmatic purposes, such as public reporting and performance-based payment
  - Expanding the high-impact conditions beyond Medicare and pediatric populations with the aid of a Technical Expert Panel
  - Adding measure removal criteria
- Timeline
  - Review proposed revisions and finalize criteria for Pre-Rulemaking activities in mid-2013

Evaluating MAP's Processes and Impact

- **Short-term evaluation** to determine the uptake of MAP's recommendations to inform future MAP's decision-making
- **Long-term evaluation** to assess MAP's impact over time
  - Convene Evaluation Advisory Panel
  - Independent third-party evaluator
- Timeline
  - Short-term evaluation is ongoing and will be reflected in the annual Pre-Rulemaking Report in February of each year
  - Convene the Evaluation Advisory Panel in late 2013
  - Evaluation protocol ready for implementation in 2014

MAP Action Plan Timeline



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MAP Strategic Plan
Communications Plan

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MAP Communications Plan

Goals of the MAP Communication Plan

- Designed to support engagement of key stakeholders
- Help raise awareness of the need for more coordinated use of performance measures to enable better decision-making

Communication Plan Strategy

- Stress the importance of a two-way engagement between MAP and end-users
- Leverage partner assets for communication

MAP Communications Plan

Goals for Reaching Targeted Audiences

- Improving stakeholder engagement by creating or enhancing existing feedback loops
- Increasing participation in MAP processes, as seen in more comments submitted, participation in MAP convenings, etc.
- Increasing awareness of the problems MAP is trying to help solve
- Providing greater clarity of the MAP work's value to both the public and private sectors – specifically those who provide, pay for, and receive healthcare services

MAP Communications Plan

Messaging

- Can be developed centrally, but to be truly effective, will need to be carried forward by variety of messengers
  - MAP members
  - Members of other NQF initiatives (e.g., NPP and endorsement Steering Committees)
  - NQF staff

Tactics

- Will grow and change over the course of three years, but will maintain basic principle of two-way engagement
- Year one will focus on creating basic messaging and materials for all stakeholders and audiences that are designed to be both clear and encouraging of engagement opportunities

Discussion

Areas that have received less attention from the Coordinating Committee to date:

- *Feedback Loops/Engagement Approach*
- *Measure Implementation Phasing Strategies*
- *Evaluating MAP's Processes and Impact*
- *MAP Communications Plan*

Public Comment

Approach to Developing Families of Measures

Approach to Families

- **Families of Measures and Core Measure Sets**
  - Promote measure alignment through selection of families of measures
  - Encourage best use of available measures in core measure sets for specific HHS and private sector programs
- **Address Measure Gaps**
  - Identify and prioritize gaps; label development vs. implementation gaps
  - Create pathways for gap-filling through engaging public and private measure developers, funders, and other stakeholders to identify solutions to barriers
  - Specifically consider eMeasure needs

Families of Measures

Families of Measures and Core Measure Sets to Align Performance Measurement Across Federal Programs and Public and Private Payers

Family of measures – "related available measures and measure gaps for specific topic areas that span programs, care settings, levels of analysis, and populations" (e.g., care coordination family of measures, diabetes care family of measures)

Core measure set – "available measures and gaps drawn from families of measures that should be applied to specified programs, care settings, levels of analysis, and populations" (e.g., PQRS core measure set, hospital core measure set, dual eligible beneficiaries core measure set)

MAP Framework for Aligned Performance Measurement: National Quality Strategy

- Working with communities to promote wide use of best practices to enable healthy living
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
- Ensuring that each person and family are engaged as partners in their care
- Making care safer by reducing harm caused in the delivery of care
- Promoting effective communication and coordination of care
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models

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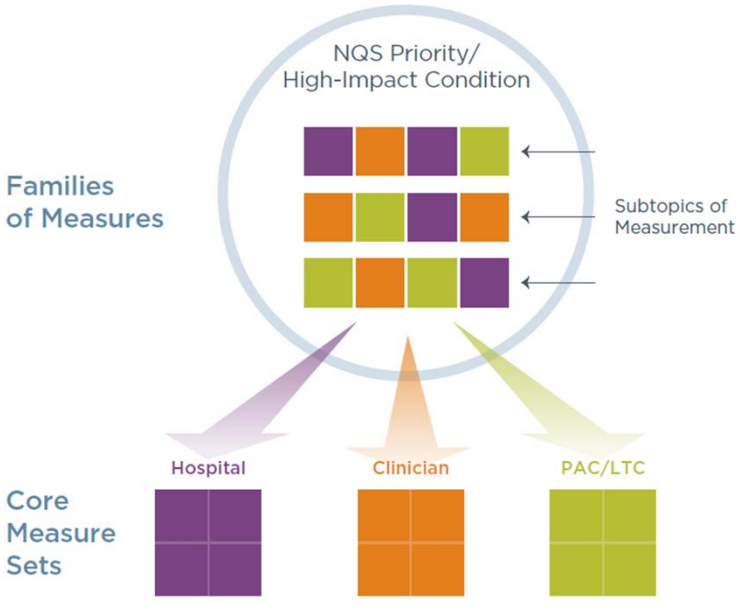

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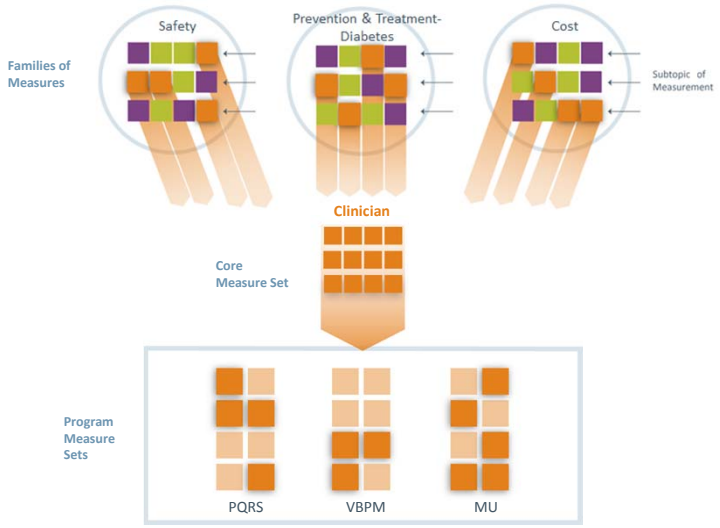
Families of Measures Populating a Core Measure Set



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MAP Measure Selection Criteria

1. Measures are NQF-endorsed or meet the requirements for expedited review
2. Adequately addresses each of the National Quality Strategy (NQS) priorities
3. Adequately addresses high-impact conditions relevant to the program's intended population(s)
4. Promotes alignment with specific program attributes, as well as alignment across programs
5. Includes an appropriate mix of measure types
6. Enables measurement across the person-centered episode of care
7. Includes considerations for healthcare disparities
8. Promotes parsimony

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Approach to Developing Measure Families

1. Identify and Prioritize High-Leverage Opportunities for Measurement

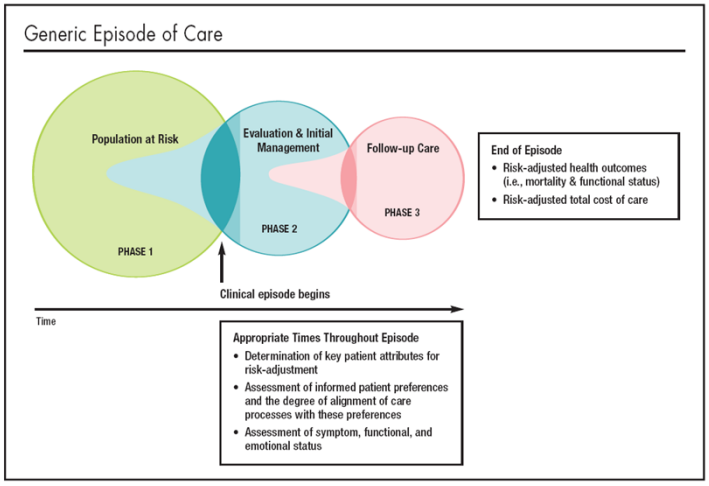
- Identification of high-leverage opportunities
  - National Quality Strategy (MSC 2); high-impact conditions (MSC 3)
  - Public-sector efforts: value-based purchasing programs, Partnership for Patients, Million Hearts Campaign
  - Private-sector efforts
- Prioritization of high-leverage opportunities
  - Impact, improvability, inclusiveness
  - Cost-areas of waste, inefficiency, overuse
- Consider how high-leverage opportunities span the patient-focused episode of care (MSC 6)
  - Do the high-leverage opportunities span settings, levels of analysis?
  - How should measures addressing the high-leverage opportunities vary across settings? (e.g., maintenance of function in outpatient settings, improvement of function in acute settings)

The "3 I's"

IOM overarching criteria for choosing clinical priority areas:

- **Impact**—the extent of the burden—disability, mortality, and economic costs—imposed by a condition, including effects on patients, families, communities, and societies
- **Improvability**—the extent of the gap between current practice and evidence-based best practice and the likelihood that the gap can be closed and conditions improved through change in an area; and the opportunity to achieve dramatic improvements in the six national quality aims identified in the Quality Chasm report
- **Inclusiveness**—the relevance of an area to a broad range of individuals with regard to age, gender, socioeconomic status, and ethnicity/ race (equity); the generalizability of associated quality improvement strategies to many types of conditions and illnesses across the spectrum of health care (representativeness); and the breadth of change effected through such strategies across a range of health care settings and providers (reach)

Patient-Focused Episode of Care Model



Approach to Developing Measure Families

2. Scan of Measures that Address the High-Leverage Opportunities

- NQF-endorsed portfolio of measures (MSC 1)
- Measures in federal programs (current measures, and measures under consideration during first year of pre-rulemaking deliberations)
- Available private sector efforts

Approach to Developing Measure Families

3. Define the Family for Each High-Leverage Measurement Opportunity

- Considerations for defining the family (MSC 4, 5, 6, 8)
  - Do available measures address the relevant care settings, populations, level of analysis?
  - When appropriate, are measures harmonized across settings, populations, levels of analysis?
  - What are the types of measures available for each setting, population, level of analysis? (preference for outcome measures, when available, and process measures that are most closely linked to outcomes)
- Considerations for affordability, disparities, vulnerable populations

Approach to Developing Measure Families

4. Establish Gap-Filling Pathways

- Classification of measure gaps
  - Existing measures
    - » Additional refinements
    - » Testing for application to other settings
    - » Need endorsement
    - » eMeasures not available
    - » Implementation gaps
  - Measure development gap
- Determine opportunities to address measure gaps
  - Development barriers (e.g., funding, data sources)
  - Implementation barriers (e.g., feasibility, burden)

Proposed Diabetes Family of Measures

Cardiovascular/Diabetes Task Force Membership

Task Force Chair: Christine Cassel

Organizational Members

Academy of Managed Care Pharmacy	American Medical Rehabilitation Providers Association
American Academy of Family Physicians	Consumers' CHECKBOOK
American Academy of Nurse Practitioners	Iowa Healthcare Collaborative
American Association for Retired Persons	Minnesota Community Measurement
American College of Cardiology	National Transitions of Care Coalition
American College of Emergency Physicians	Physician Consortium for Performance Measurement
American Hospital Association	Premier, Inc.
American Medical Directors Association	The Alliance

Subject Matter Experts

Population Health: Eugene Nelson
Health IT/Patient Report Outcome Measures: Jim Walker

Federal Government Members

Centers for Medicare & Medicaid Services (CMS)
Office of the National Coordinator for HIT (ONC)
Health Resources and Services Administration (HRSA)

Liaisons

Accreditation/Certification: NCQA
NPP: Peter Briss
CDP: Mary George

NQS Priority: Prevention and Treatment of the Leading Causes of Mortality

Goals:

- Promote cardiovascular health through community interventions that result in improvement of social, economic, and environmental factors.
- Promote cardiovascular health through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan.
- Promote cardiovascular health through receipt of effective clinical preventive services across the lifespan in clinical and community settings.

Cardiovascular and Diabetes Scope

- Aligning with the NQS, MAP's identification of a prevention and treatment family of measures focuses on cardiovascular conditions;
- MAP expanded the scope of the family of measures to address an additional high-impact condition, diabetes;
- Opportunity exists to coordinate prevention efforts for both conditions.

Approach to Developing Measure Families

Public Sector Programs Using Cardiovascular/Diabetes Measures:

- Value-Based Payment Modifier
- Physician Quality Reporting System
- Medicare and Medicaid EHR Incentive Program for Eligible Professionals
- Medicare Shared Savings Program
- Hospital Inpatient Quality Reporting
- Hospital Value-Based Purchasing
- Hospital Outpatient Quality Reporting
- Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs
- Home Health Quality Reporting

Public Sector Programs Not Using Cardiovascular/Diabetes Measures:

- Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting
- Inpatient Psychiatric Facility Quality Reporting
- Ambulatory Surgical Center Quality Reporting
- Nursing Home Quality Initiative and Nursing Home Compare Measures
- Inpatient Rehabilitation Facility Quality Reporting
- Long-Term Care Hospital Quality Reporting
- Hospice Quality Reporting
- End Stage Renal Disease Quality Management

Approach to Developing Measure Families

Sample of Private Sector Programs Considered:

- Choosing Wisely
- Aligning forces for Quality
- eValue8
- Integrated Healthcare Association (IHA)
- Recognition Programs
- Health Plans; HEDIS
- Million Hearts
- PINNACLE

Identification of Measures to Consider for Cardiovascular Conditions and Diabetes Families

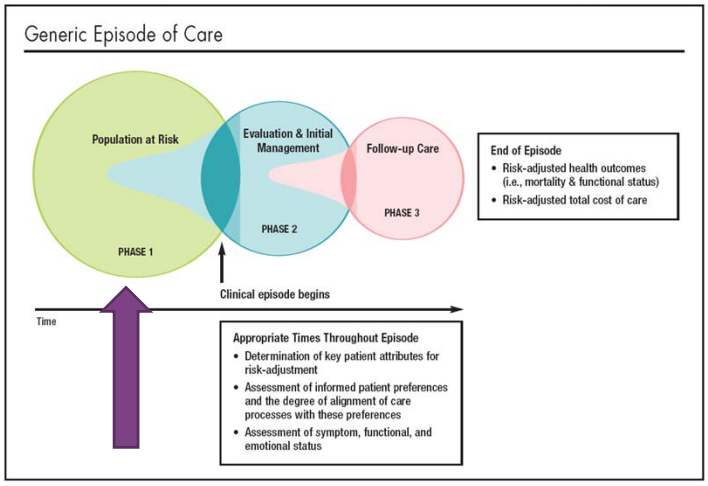
Topic	Subtopic	Measures Available	Measures Selected
Total Measures		225	40
Primary Prevention: Cardiovascular Conditions and Diabetes		35	7
	Smoking Prevention/Cessation		4
	Blood Pressure Control		1
	Lipid Control		0
	Lifestyle Management		2
Cost		5	2
Diabetes Care		59	4
	Evaluation and On-Going Management		2
	Exacerbations and complex treatments		0
	Composite Measures		2
Cardiovascular Conditions		126	29
	Ischemic Heart Disease		15
	Stroke		4
	Atrial Fibrillation		1
	Heart Failure		2
	Mortality		6

Cardiovascular Conditions and Diabetes Families of Measures

Key Themes

- Person-centered approach to measurement
  - Patient-Focused Episode of Care model is a useful framework
- Improving outcomes in the highest-leverage areas
  - Outcome measures focused on control were preferred to process measures assessing screening/testing
  - Time to procedures measures were preferred over process measures assessing steps in care delivery
- Identification of the fewest measures necessary to comprehensively address the high-leverage improvement opportunities
  - Measures with broad denominator populations can be stratified by condition for quality improvement purposes
- Consideration for applicable settings and level of analyses
  - Selection of measures that cross levels of analysis and settings where available

Primary Prevention of Cardiovascular Conditions and Diabetes



Primary Prevention for Diabetes and Cardiovascular Conditions

- "Population at risk" is the first phase of the episode of care
  - Greatest opportunity to identify risk factors and apply interventions to prevent disease
  - Cardiovascular conditions and diabetes have common high-leverage opportunities for prevention
- MAP preferred measures for the entire patient population, regardless of presence or absence of conditions
  - Can stratify by condition for quality improvement activities

Primary Prevention of Cardiovascular Conditions and Diabetes

- MAP identified the highest leverage opportunities
  - Blood pressure control
    - 1 measure selected – NQF#0018
  - Lipid control – gap
  - Smoking prevention/cessation
    - 4 measures selected – NQF #0028, #1406, #1651(Recommended), #1654 (Deferred)
    - Gaps - outcomes
  - Lifestyle management - diet/nutrition, activity/exercise, and weight/obesity
    - 2 measures selected weight/obesity – NQF #0421, #0024
    - Gaps - activity level/exercise, diet/nutrition
- Additional gap:
  - Cardiometabolic risk

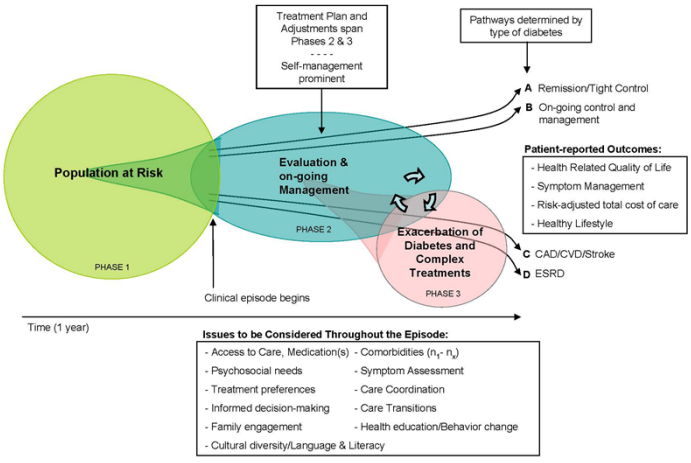
Cost of Cardiovascular Conditions and Diabetes Care

- Common opportunities within both families of measures
- Recognized methodological and implementation issues
  - Few available NQF-endorsed cost of care measures
  - Need to gain experience using cost of care measures
- MAP will identify a cost of care family of measures

Cost of Cardiovascular Conditions and Diabetes Care

- Task force selected 2 cost of care, population-based measures
  - Total Resource Use Population-based PMPM Index (NQF #1598)
  - Total Cost of Care Population-based PMPM Index (NQF #1604)
- Gap
  - Efficiency measures (linking cost and quality measures)

Diabetes Episode of Care Model



Diabetes: Evaluation and Ongoing Management

MAP focused on high-leverage opportunities across the episode of care

- Evaluation and on-going management: Assessing management of diabetes is the highest-leverage opportunity, as focusing on upstream evaluation and ongoing management can prevent downstream complications
- High-leverage opportunities identified
  - Glycemic control - 1 measure for glycemic control selected – NQF #0575
  - Lipid control - 1 measure for lipid control selected – NQF #0064
- Gaps:
  - Glycemic control for complex patients, pediatric patients
  - Lipid control for complex patients

Diabetes: Evaluation and Ongoing Management

MAP focused on high-leverage opportunities across the Episode of Care

- Exacerbations of diabetes and complex treatments: Assessing exacerbations is important, but is best suited for quality improvement.
- Areas of measurement that should be included in an overall diabetes composite: dental health, eye care (i.e., diabetic retinopathy), peripheral neuropathy, nephropathy, weight and obesity, diet and nutrition
- Gaps: Sequelae of diabetes exacerbations

Diabetes Family of Measures- Composites

Task force selected two composites, suggesting they each may be suited for different purposes. Which composite should be used for what?

	NQF #0729 MN Community	NQF #0731 NCQA
SCORING	• All-or-none	• Sum of all numerators over the sum of all denominators
Risk Adjustment	• Case-mix	• None
Glycemic Control	• HbA1c (<8%)	• HbA1c poor control (>9%) • **HbA1c control (<8%)** • HbA1c control (<7%) for selected populations
Lifestyle Management	• Tobacco non-user	• Smoking status and cessation advice or treatment
Blood Pressure Control	• BP (<140/90 mmHg)	• BP control (<140/90 mmHg)
Lipid Control	• LDL- C (<100 mg/dL)	• LDL-C screening • **LDL- C control (<100 mg/dL)**
Eye Care		• Eye exam (retinal) performed
Nephropathy		• Medical attention for nephropathy
Other	• Daily aspirin for patients with IVD	

Coordinating Committee Discussion Points

- For which purposes are the 2 composite measures most appropriate?
- The task force emphasized parsimony in the measures family; have we adequately addressed all high-leverage opportunities (e.g., care settings and levels of analysis)?
- Does the family of measures achieve alignment across public/private sectors?

Proposed Cardiovascular Disease Family of Measures

Identification of Measures to Consider for Cardiovascular Conditions and Diabetes Families

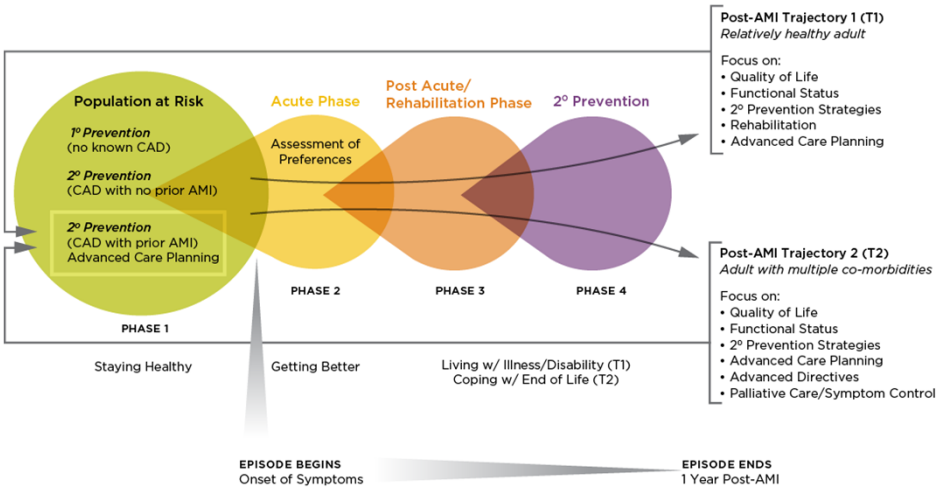
Topic	Subtopic	Measures Available	Measures Selected
Total Measures		225	40
Primary Prevention: Cardiovascular Conditions and Diabetes		35	7
	Smoking Prevention/Cessation		4
	Blood Pressure Control		1
	Lipid Control		0
	Lifestyle Management		2
Cost		5	2
Diabetes Care		59	4
	Evaluation and On-Going Management		2
	Exacerbations and complex treatments		0
	Composite Measures		2
Cardiovascular Conditions		126	29
	Ischemic Heart Disease		15
	Stroke		4
	Atrial Fibrillation		1
	Heart Failure		2
	Mortality		6

Cardiovascular Conditions

- Overarching themes that apply to cardiovascular family of measures:
  - Person-centered approach to measurement
  - Improving outcomes in the highest-leverage areas
  - Identification of the fewest measures necessary to comprehensively address the high-leverage improvement opportunities
  - Consideration for applicable settings and levels of analysis
- Previously identified primary prevention measures and cost measures apply to cardiovascular family of measures

Acute Episode of Care

Context for Considering an AMI Episode



Acute Cardiovascular Conditions: IHD and Stroke/TIA

MAP focused on high-leverage opportunities across the episode of care

- Acute phase
  - Outcomes are preferred, but family should include important process measures to hold entire system accountable (addresses settings with limited offerings of services)
- High-leverage opportunities
  - Diagnostics
    - 1 diagnostics measure identified (stroke) – NQF #0661
    - Gap - composite measure assessing appropriateness of all cardiac imaging
  - Procedures
    - 2 time to procedures measures identified (IHD) – NQF #0289, #0163
    - Gap - appropriateness of CABG and PCI
  - Medications
    - 1 measure identified (stroke)- NQF #0287/0288
- Additional areas
  - 1 complication measure identified (IHD) – NQF #0709

Considerations for Coordinating Committee

- The CV/Diabetes task force was undecided on including the following measures:

0669 Endorsed	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery
0670 Endorsed	Cardiac stress imaging not meeting appropriate use criteria: Preoperative evaluation in low risk surgery patients
0671 Endorsed	Cardiac stress imaging not meeting appropriate use criteria: Routine testing after percutaneous coronary intervention (PCI)
0672 Endorsed	Cardiac stress imaging not meeting appropriate use criteria: Testing in asymptomatic, low risk patients
0355 Endorsed	Bilateral Cardiac Catheterization Rate (IQI 25)

  - Refer to handout for discussion points

Acute Cardiovascular Conditions: IHD and Stroke/TIA

MAP focused on high-leverage opportunities across the episode of care

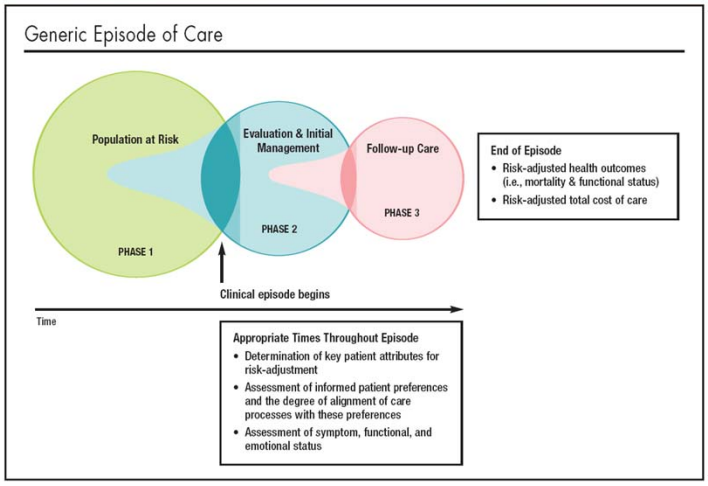
- Post-acute/rehab phase
- High-leverage opportunities
  - Focused on access and outcomes related to rehabilitation services
    - 1 rehabilitation assessment measure (stroke)– NQF #0441
    - 1 referral to rehabilitation measure (IHD) – NQF #0642
  - Gaps:
    - Patient-reported outcomes related to rehabilitation

Acute Cardiovascular Conditions: IHD and Stroke/TIA

MAP focused on high-leverage opportunities across the episode of care

- Secondary prevention phase
  - Focused on medication management, with an emphasis on persistence of medications, rather than ordering of medications, in the acute setting or on discharge
- High-leverage opportunities
  - 3 medication management measures (IHD)- NQF #0068, #0066, #0070
  - 2 medication management measures (Stoke/TIA) - NQF#0437, #0241
- Gaps:
  - Medication persistence - ACE/ARB, beta blocker, statin persistence for IHD; anticoagulants, statins, and anti-hypertensives for stroke

Chronic Episode of Care



Chronic Cardiovascular Conditions: Atrial Fibrillation and Heart Failure

MAP focused on high-leverage opportunities across the episode of care

- Evaluation and initial management phase
  - High-leverage opportunity - identification of patient preferences and care coordination
    - » Addressed by Care Coordination Task Force
    - » Gap - early identification of heart failure decompensation
- Follow up care phase
  - High-leverage opportunity - measures of persistence preferred over measures of ordering/prescribing
    - » 1 medication measure for atrial fibrillation selected – NQF #1525
    - » 2 medication measures for heart failure selected – NQF #0081, #0083
    - » Gaps - medication persistence measures – ACE/ARBs and beta blockers

Cardiovascular Conditions: Mortality

- Mortality indicators are meaningful outcome measures for providers and consumers
  - Preference expressed for 30-day period to extend window of accountability beyond acute hospitalization
  - All-cause rate selected to capture multiple factors that can contribute to death
- Measures by high-leverage opportunities
  - 6 measures of cardiovascular mortality selected –

    NQF #0119, #0122, #0230, #0535, #0536, #0229

Coordinating Committee Discussion Points

- Should the cardiac imaging measures be included in the cardiovascular family of measures? (refer to handout)
- The task force emphasized parsimony in the measures family; have we adequately addressed all high-leverage opportunities (e.g., care settings and levels of analysis)?
- Does the family of measures achieve alignment across public/private sectors?

Public Comment

Proposed Safety Family of Measures

Patient Safety/Care Coordination Task Force Membership

Task Force Chair: Frank Opelka

Organizational Members

Aetna	Iowa Healthcare Collaborative
Alliance of Dedicated Cancer Centers	L.A. Care Health Plan
America's Health Insurance Plans	Memphis Business Group on Health
American Hospital Association	Mothers Against Medical Error
American Organization of Nurse Executives	National Association of Children's Hospitals and Related Institutions
American Society of Health-System Pharmacists	National Association of Medicaid Directors
Blue Cross Blue Shield of Massachusetts	National Rural Health Association
Building Services 32BJ Health Fund	Pacific Business Group on Health
Catalyst for Payment Reform	Premier, Inc.
CIGNA	SNP Alliance
Humana, Inc.	The Alliance

Patient Safety/Care Coordination Task Force Membership

Subject Matter Experts

Health IT: Dana Alexander
Patient Safety: Mitchell Levy
State Medicaid: MaryAnne Lindeblad
Mental Health: Anne Marie Sullivan
State Policy: Dolores Mitchell
Palliative Care: R. Sean Morrison
Mental Health: Rhonda Robinson Beale
Patient Experience: Dale Shaller
Safety Net: Bruce Siegel

Federal Government Members

Agency for Healthcare Research and Quality (AHRQ)
Centers for Disease Control and Prevention (CDC)
Centers for Medicare & Medicaid Services (CMS)
Office of the National Coordinator for HIT (ONC)
Veterans Health Administration (VHA)
Health Resources and Services Administration (HRSA)
Office of Personnel Management/FEHBP (OPM)

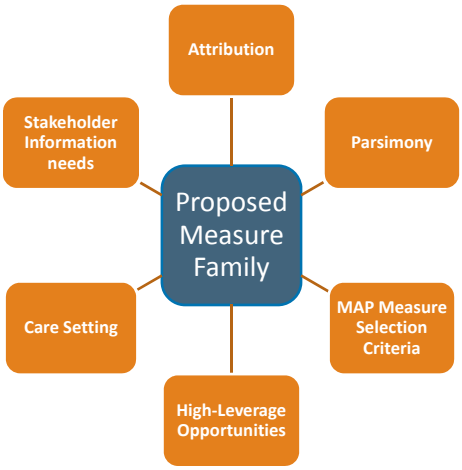
Liaisons

NPP (Safety): Laura Cranston
NPP (Care Coordination): Susan Frampton
CDP (Safety): Bill Conway
CDP (Care Coordination): Gerri Lamb

Safety and Care Coordination Task Force

A Balancing Act

Task force weighed many variables when making decisions about which measures to include within the families



Safety Family of Measures

Task force meeting held on June 19-20

- Identified priority areas for aligning patient safety performance measurement
- Established a safety family of existing measures and gaps to serve as an initial national core measure set
  - Task force considered a total of 316 measures
  - Focused on 9 major safety topic areas
  - 55 measures and a number of gaps were identified by the task force to propose to the MAP Coordinating Committee for the safety measure family
- Discussed measure gaps and potential approaches to address barriers to implementation

Topic	Subtopic
Healthcare-Acquired Infections	Catheter-Associated Urinary Tract Infections (CAUTI)
	Central Line-Associated Blood Stream Infections (CLABSI)
	MRSA
	C. difficile
	Surgical Site Infection
	Sepsis
	Ventilator-Associated Pneumonia (VAP)
Medication/Infusion Safety	Adverse Drug Events
	Blood Incompatibility
	Manifestations of Poor Glycemic Control
Pain Management	Effectiveness, Medication Overuse, Patient Experience
Venous Thromboembolism	Deep Vein Thrombosis (DVT)
	Pulmonary Embolism (PE)
Perioperative/Procedural Safety	Foreign Object Retained After Surgery
	Trauma (burn, shock, laceration, puncture, iatrogenic pneumothorax)
	Air Embolism
Injuries from Immobility	Pressure Ulcers
	Falls
Safety-Related Overuse & Appropriateness	Imaging
	Antibiotics
Obstetrical Adverse Events	Pre-Delivery, Delivery, Post-Delivery
Complications-Related Mortality	Failure to Rescue

Safety Family of Measures

Healthcare Professional and Patient Engagement

- Should create and measure a culture of safety that encourages reporting adverse events
  - Crossing all sites and levels of care
  - Supporting multidisciplinary teamwork
  - Considering patient experience
- Inclusion of patient (and/or caregiver) in treatment planning and decisions is an important aspect of patient safety
  - Matching treatment to patient goals prevents overuse and harm from unwanted/unnecessary treatment and testing

Safety Family of Measures

Reporting Meaningful Safety Information

- Present-on-admission (POA) indicator
  - Important component for many safety measures to ensure accurate information
- Administrative data vs. medical record clinical data abstraction
  - Benefits of additional detail gleaned from clinical data abstracted directly from the medical record may outweigh greater resource use
- Desired inclusion of certain balancing measures to monitor potential undesirable consequences, though less parsimonious
- Preferred outcome measures over process and structural measures for inclusion in the family

Safety Family of Measures

Creation of Safety Composite Measures

- Very rare/low incidence safety events
  - Suggest a single composite measure that encompasses most significant of these events to address concerns regarding small numbers
- Evidence-based process measures
  - Build into composites measuring those care processes tied closely to desired outcomes for improvement
- Composite construct
  - Important to have the ability to report individual scores within a composite to provide meaningful granularity

Safety Family of Measures

Refining the Scope of the Safety Family

- Maternity/healthy newborn
  - Unique area of healthcare – for many, maternity is a healthy condition
  - Role of prenatal care in ensuring a healthy mother and infant at time of delivery
  - Significant portion of healthcare services, with few available measures
- Patient falls
  - Drawing the distinction between patient safety and effective chronic care
    - » Falls screening/assessment and plan of care
    - » Bone density testing

Safety Family of Measures

Safety-Related Mortality Measurement

- Measuring mortality is extremely important, and equally important to measure accurately
- Measure construct requires appropriate:
  - Risk adjustment
  - Exclusions
    - » Consideration given to providers delivering hospice/palliative care
  - POA indicators

Safety Family of Measures

Prioritized Measure Gap Areas

- Advance measurement science to create measures of shared attribution – driving shared accountability across system
- Identify methods for measuring a culture of safety
- Determine if the use of a measure (e.g., public reporting vs. payment) should affect the measure construct
- Increase use of patient-reported outcome measures to assess patient understanding and alignment of treatment with patient goals
- Make measures more meaningful to consumers (e.g., using standard definitions, reporting rates rather than ratios)
- Create a plan for developing and implementing overuse measures related to under-, over-, and mis-diagnosis

Safety Family of Measures

Overall Character of the Family

- Does the family work across public/private sectors?
- Does the family work across settings/levels of analysis?
- Are we really getting to core measures in the family?
- What's missing from the family to promote a culture of safety?

Public Comment

Summary of Day 1

Welcome and Recap of Day 1

Special Session

Implementation of Readmission Measures in the Context of Care Coordination and Shared Accountability

Readmission Measures Special Session

Purpose

- Raise understanding of multifactorial issues regarding use of readmission measures in the context of care coordination and shared accountability

Output

- Develop guidance document to inform MAP pre-rulemaking deliberations about use of readmission measures in specific programs

Readmission Measures Special Session

Agenda

- MAP Role: Board resolution, Care Coordination Family of Measures, Pre-Rulemaking Report
- National Quality Strategy: Care Coordination Priority
- MAP Safety/Care Coordination Task Force Experience
- Multi-Stakeholder Perspectives on Avoidable Readmissions
- Care Coordination and Readmission Measures for Federal Programs

Discussion Parameters

- Not intended to revisit endorsement decisions regarding readmission measures
- Not actually selecting readmission measures for specific programs until pre-rulemaking process

Coordination Among Readmissions Activities

- NPP (Re)admissions Action Team
- NQF All-Cause Readmissions Endorsement Project
- MAP Safety/Care Coordination Task Force and Upcoming Pre-Rulemaking Activities

Please refer to graphic in folder of background materials.

MAP's Role

- NQF Board Resolution
  - MAP requested to convene a special session on implementing care coordination measures, including readmission measures, in programs across all settings that have shared accountability for reducing readmissions
- Care Coordination Family of Measures, Including Readmission Measures
  - Care coordination family of measures report will include guidance document on the use of readmission measures
- Pre-Rulemaking Report
  - Guidance document on the use of readmission measures will inform MAP's deliberations on the selection of readmission measures for specific programs

National Quality Strategy
Care Coordination
Goals and Targets

NATIONAL QUALITY FORUM

August 15, 2012
Helen Darling, NPP Co-Chair

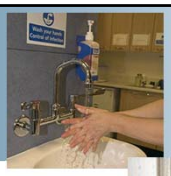
HHS' National Quality Strategy Aims and Priorities

National Priorities Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

108

NQS PRIORITY AREA:

Patient Safety



Goals:

- **Reduce preventable hospital admissions and readmissions**
- Reduce the incidence of adverse healthcare-associated conditions
- Reduce harm from inappropriate or unnecessary care

NQS Key Measures:

- **All-payer 30-day readmissions**
- Incidence of measureable hospital-acquired conditions

NQS PRIORITY AREA:

Effective Communication and Care Coordination

NQS Goals:

- Improve the quality of care transitions and communications across settings
- Improve the quality of life for patients with chronic illness and disability
- Establish shared accountability and integration of communities and healthcare systems

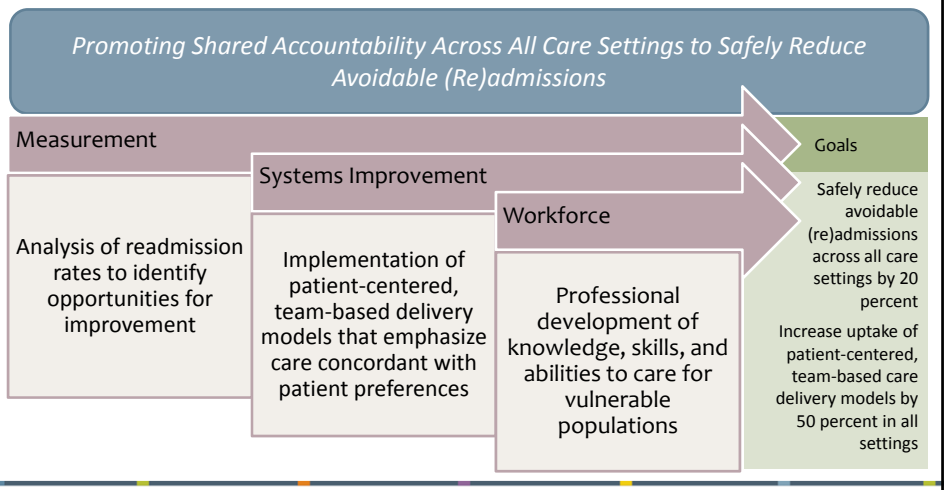
NQS Key Measures:

- Patient-Centered Medical Home for Children and Adolescents (NQF-endorsed #0724)
- 3-Item Care Transition Measure (NQF-endorsed #0228)

NPP (Re)admissions and Care Coordination Measure Concepts

- Hospital admissions for ambulatory-sensitive conditions
- All-cause hospital readmission index
- Experience of care transitions
- Complete transition records
- Chronic disease control
- Care consistent with end-of-life wishes
- Experience of bereaved family members
- Care of vulnerable populations
- Community health outcomes
- Shared information and accountability for effective care coordination

The (Re)admissions Action Pathway



Key Considerations Moving Forward

Does the proposed family of measures drive toward…

- safely reducing readmissions while minimizing unintended consequences?
- shared accountability across all care settings—hospitals, nursing homes, home health, ambulatory—to ensure appropriate care across the continuum?
- shared accountability across all stakeholders—i.e., all healthcare professionals, health plans, patients, and families?
- patient-centered, team-based models of care that support safe reductions in readmissions?
- partnerships across the continuum to ensure patients, families, consumers, purchasers, plans, and policymakers have access to tools and models that support high-quality care?

MAP Safety and Care Coordination Task Force Experience: Avoidable Admissions and Readmissions

Task Force Experience: Avoidable Admissions and Readmissions

Key driver of healthcare system transformation

- Performance improvement requires new approaches that bring clinicians and providers together outside of existing silos
- A challenge to identify standard set of interventions to implement and measure for improvement
  - What is effective in one organization, system, or region may not be effective in another
  - No "one size fits all" approach
- Takes multistakeholder involvement to see positive change

Task Force Experience: Avoidable Admissions and Readmissions

Communication and community resources

- Need effective communication among all clinicians providing healthcare services to patients
- Transfer of clinical responsibility must be clear to receiving clinicians as well as to patients
- Necessary community resources must be available
  - Community pharmacist to educate about medications
  - Primary care clinician follow-up appointment
  - Home health services

Task Force Experience: Avoidable Admissions and Readmissions

Health plans supporting patients through transitions

- Growing role for health plans in communicating with providers
- Contracting with a variety of entities and provider types to support patients' ability to access the necessary services to successfully maintain optimal health
- Monitoring capabilities through billing records provides mechanisms to follow patients between settings and into the community

Task Force Experience: Avoidable Admissions and Readmissions

Active participation of the patient and caregiver is essential

- Patients/caregivers must have good understanding of the diagnosis and mutually agreed upon plan of care – beyond checkbox accountability
- Clinicians need to provide education necessary to enable patients and caregivers to be autonomous
  - Healthcare professionals need training to develop this skill set
- Important to assess patient and caregiver readiness to re-enter the community prior to discharge

Task Force Experience: Avoidable Admissions and Readmissions

Measurement considerations

- Measurement should be expanded to address shared accountability across the entire health system
- Current state-of-the-art of risk adjustment inadequate to address complexity of measurement in this area
- What is the appropriate time window of accountability for readmissions – less than 30 days, more than 30 days?
- Readmission measures should exclude planned readmissions
- Balancing measures could be used – monitoring mortality, average length of stay, observation days, ED visits, patient experience, and post-discharge follow-up

Task Force Experience: Avoidable Admissions and Readmissions

Measurement considerations

- Selected hospital-wide all-cause measure in lieu of multiple condition-specific readmission measures
- Caution raised regarding application of readmission measures
  - Limit comparisons to hospitals or plans serving similar populations
  - Gain a better understanding of how the hospital-wide all-cause measure performs before applying it to performance-based payment programs

Multi-Stakeholder Perspectives on Avoidable Readmissions

Multi-Stakeholder Perspectives

Institutional Providers	Daniel Brotman
Health Professionals	Christine Cassel
PAC/LTC	Cheryl Phillips
Communities	Elizabeth Mitchell
Health Plans	Aparna Higgins
Purchasers	Gerry Shea
Consumers	Christine Bechtel

Readmission Measure Implementation Considerations: Institutional Providers

- Critical interventions:
  - Timely handoff/transmission of admission-related data to outpatient provider(s)
  - Support during transitions for high-risk patients, including access to the discharging team
  - Engage patient / family in the plan of care (education) and assess their willingness and ability to follow-through on the plan of care
- Implementation considerations:
  - Avoiding financial penalties that disadvantage hospitals serving poor communities with suboptimal access to outpatient care
  - Monitor unintended consequences:
    - **Deaths (eg, VA COPD study)**
    - **Delaying planned readmissions (and measuring planned readmissions)**
    - **Gaming the system by changing admission thresholds (admitting less sick patients; Epstein study)**

Health Professionals

Benefits and Risks of Readmission Rates

Benefits	Risks
Hospitals and health systems are held accountable for assuring that a patient is ready for discharge	Attribution at the physician level is difficult; hospital records may list the admitting physician, not the physician at time of discharge
Hospitals and health systems are held accountable for assuring that a patient has appropriate follow-up	Patients may be readmitted for unrelated reasons, such as a hip fracture two weeks after a discharge for heart failure
	Some readmissions are appropriate and necessary for safe, patient-centered care

How well do we measure factors that lead to reduced readmissions?

- ❑ Patients (and family caregivers) who are prepared for discharge
  - Not just discharge instructions, but shared understanding
- ❑ Medications
  - Prescriptions that are not just provided, but filled and taken properly
- ❑ Outpatient follow-up
  - Appointments are not merely advised, but are made and kept
  - Next-providers know about hospital course, tests done, tests pending, and care needed

Readmission Measure Implementation Considerations: Health Professionals (continued)

- Usual measures focus on 30 day period for readmissions.
- What is the science behind this time frame? Many clinical experts suggest a shorter time frame would more appropriately capture issues providers can control.
- Patient centered measures; Intermountain asked patients, and their major concern was not time spent in hospital but total time spent at home.
- Consider unintended consequences of systems placing patients in rehab facilities to avoid rehospitalization, resulting in less time at home.

Readmission Measure Implementation Considerations: Post-Acute and Long-Term Care

- **Critical interventions:**
  - CMS initiative to Reduce Avoidable Hospitalizations among NHs (due 6-14-12); required collaboration with ≥ 15 nursing homes w/in a state
  - Advancing Excellence Campaign: www.nhqualitycampaign.org. Added as 1 of 9 new goals with tool sets, measurement, resources
  - Interact II: www.interact2.net builds in core process and communications structure and tools
- **Implementation considerations:**
  - WIDE diversity of avail resources and skill level between NHs, and even great gap with other LTC setting
  - Risk adjustment must account for signif pop. differences between NHs, as well as pt-specific complexities and functional needs
  - Lack of attention to how and where decisions for re-admissions from LTSS settings are made.

Readmission Measure Implementation Considerations: Communities

- Critical interventions:
  - Pay hospitals and PCPs to prevent readmissions (bundled/global payments)
  - Develop community and practice based care management programs for people with chronic illnesses
- Implementation considerations:
  - Measure Care Transitions and enable ability to determine causes of readmissions
  - Ensure adequate coverage for chronic disease maintenance medications
  - Highlights importance of multistakeholder collaboration and community partnerships

Readmission Measure Implementation Considerations: Health Plans

- Critical interventions:
  - Adequate discharge preparation of patient and family in-hospital*
  - Follow-up visits post-discharge
  - Medication reconciliation
- Implementation considerations:
  - Align measures and incentives across care continuum
  - Tools and technical assistance
  - Assess care processes both within and outside the hospital (health plan or provider)

* Education, demonstration of comprehension of instructions

Readmission Measure Implementation Considerations: Purchasers

- Critical interventions:
  - Purchasers & Consumers Can Play Key Roles in Successfully Reducing Readmissions
  - To Motivate the 162 Million People Who Get Health Coverage Through Work, Purchasers Need to Be Fully Engaged
    - Purchasers can urge consumers to use readmissions data as part of decisions for non-emergency care
  - Widespread Purchaser Participation Hinges on Potential for Lowering Costs
- Implementation considerations:
  - Private Purchasers & Medicare Using the Same Readmissions Measures is Crucial
  - Community Wide Efforts Dedicated to Better Care and Lower Costs Is the Best Framework
  - Addressing the Concerns About Care in Poorer Communities Requires an Aggressive Monitoring Effort with Real Time Reports
  - The Urgency of The Situation & The Lack of Significant Risk Calls For Action Now
  - Greater Performance Variation in Public Reports Would Help Drive Public Engagement

Readmission Measure Implementation Considerations: Consumers

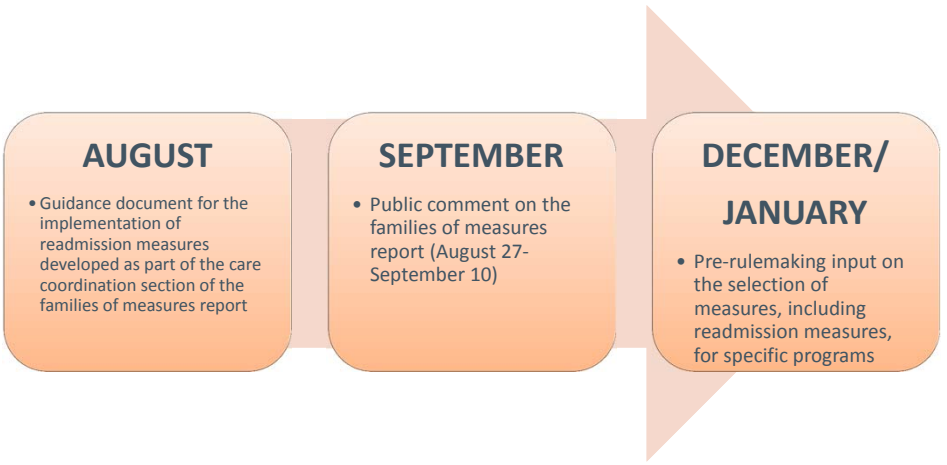
- Critical interventions: *Shared accountability supports system-ness*
  - Significant improvements in patient experience
  - Make care transitions safe, smooth and whole person oriented
    - Understand patient activation level, life circumstances, etc.
- Implementation considerations:
  - Patient partnerships are the foundation for improvement
  - Communities are partners in reducing readmissions

Care Coordination and Readmission Measures for Federal Programs

Patrick Conway
Kevin Larsen

Discussion

Next Steps



Public Comment

Proposed Care Coordination Family of Measures

Care Coordination Family of Measures

Task force meeting held on July 18-19

- Identified priority areas for aligning care coordination performance measurement
- Established a care coordination family of existing measures and gaps
- Task force considered a total of 135 measures
  - Focused on 6 care coordination topic areas
  - 62 measures and a number of gaps were identified by the task force to propose to the MAP Coordinating Committee for the care coordination measure family
- Discussed measure gaps and potential approaches to address barriers to implementation

Topic	Subtopic
Avoidable Admissions and Readmissions	Avoidable Admissions
	Avoidable Readmissions
	Avoidable ED Visits
System Infrastructure Support	Health Information Technology (HIT)
	Medical Homes; Accountable Care Organizations
	Tracking/Reminder Systems
Care Transitions	Effectiveness
	Timeliness
Communication	Patient Communication
	Provider Communication
Care Planning	General
	Condition-Specific
	Patient Preference at End of Life
Patient Surveys Related to Care Coordination	Patient Experience and Perception of Care Coordination

Care Coordination Family of Measures

- Care Coordination is about the space between providers
  - Existing measures specified for one setting or level of analysis can show system success, but fail to capture shared accountability throughout the system, reinforcing silos
- Care coordination is a multidisciplinary team effort and this should be reflected in measurement
- Poor care coordination can lead to overuse, misuse, and inefficiency, driving up costs while simultaneously lowering quality through duplication and unnecessary services

Care Coordination Family of Measures

Patient Engagement and Community Resources

- Patient (and/or caregiver) must be included in care decisions and planning
  - Approach should be tailored to fit the individual
  - Ensure patient and caregiver understanding and agreement with the plan of care
    - » Aligned with patient goals and preferences, including advance care planning
    - » Need for measures of shared-decision making
- Availability of community resources plays vital role in keeping patients independent and receiving the "right" level of care
  - Resources such as home health, telehealth, and community pharmacists are crucial parts of effective care transitions

Care Coordination Family of Measures

Patient-Reported Information

- Patient-reported data related to care coordination to provide a practical viewpoint and help define effective care coordination process
- A comprehensive care coordination survey is needed
  - Existing patient surveys, looking at experience broadly, can capture patient perceptions of some aspects of care coordination
  - Need the ability to cross the episode of care and settings to address transitions and communication
  - Common questions would allow better insights into coordination and patient experiences across the continuum

Care Coordination Family of Measures

Data and Data Sources

- Role of HIT
  - Continued development of interoperable health records that can be exchanged and used for automated, real-time measurement systems
  - Need measures of bi-directional communication that go beyond measuring EHR capacity to show the successful sending and receiving of information
- Patient Survey Reporting – total score vs. composites vs. individual items
  - While entire instrument must be completed and scored, total scores provide insufficient detail to support quality improvement
  - Instruments should be validated to report scores on individual items or composites related to care coordination

Care Coordination Family of Measures: System and Infrastructure Support Measures

The task force **could not reach consensus** on inclusion of two system and infrastructure support measures:

- The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data Elements (NQF #0489)
- Tracking of Clinical Results Between Visits (NQF #0491)

Care Coordination Family of Measures: System and Infrastructure Support Measures

Task force issues:

- Raised the following concerns
  - Both measures look at EHR use, but not effectiveness
  - Address one-sided communication, not bi-directional
- Recognized the significance of having HIT measures
  - Acknowledged that existing measures represent current infrastructure and capabilities
  - Inclusion of these measures in the family, despite their limitations, signals the importance of HIT and infrastructure measurement

Care Coordination Family of Measures: ED Throughput Measures

The task force **could not reach consensus** on inclusion of three measures of ED throughput:

- Median Time from ED Arrival to ED Departure for Admitted ED Patients (NQF #0495)
- Median Time from ED Arrival to ED Departure for Discharged ED Patients (NQF #0496)
- Admit Decision Time to ED Departure Time for Admitted Patients (NQF #0497)

Care Coordination Family of Measures: ED Throughput Measures

Task force issues

- Supported the concepts addressed by these measures
  - ED crowding is a major public health problem – can lead to increased suffering and poor patient outcomes
  - Critical intra-facility care transition issue
  - Very important issue for consumers and measures provide meaningful information to them
- Raised the following concerns
  - Measure specifications may be subject to "gaming"
    - » Admitting a patient does not necessarily mean the patient was transferred to an inpatient room; may be "boarded" in the ED for hours
  - ED timeliness can vary greatly by situation, type of patient, reason for visit

Care Coordination Family of Measures

Prioritized measure gap areas

- Create and implement measures reflecting "systemness"
  - Develop or modify measures to address new accountability entities (ACOs, PCMHs)
- Continue development of interoperable health records gathering enriched data that can be exchanged and used for automated, real-time measurement systems
- Consider the role of care coordination related to measures addressing overuse and appropriateness
  - Unnecessary duplicative services
  - Avoiding potential ED visits
- Determine method for developing measures addressing the role of the community and resources available to patients

Care Coordination Family of Measures

Overall character of the family

- Does the family work across public/private sectors?
- Does the family work across settings/levels of analysis?
- Are we really getting to core measures in the family?
- What's missing from the family to promote systemness?

Care Coordination Family of Measures: System and Infrastructure Support Measures

- The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data Elements (NQF #0489)
- Tracking of Clinical Results Between Visits (NQF #0491)

Decision required by the Coordinating Committee at this time:

- Support the measures for inclusion in the measure family
- Do not support inclusion of these measures

Care Coordination Family of Measures: ED Throughput Measures

- Median Time from ED Arrival to ED Departure for Admitted ED Patients (NQF #0495)
- Median Time from ED Arrival to ED Departure for Discharged ED Patients (NQF #0496)
- Admit Decision Time to ED Departure Time for Admitted Patients (NQF #0497)

Decision required by the Coordinating Committee at this time:

- Support the measures for inclusion in the family now, suggesting future improvements to the specifications
- Do not support inclusion of these measures and identify ED throughput measures as a gap area

Public Comment

Defining MAP's Role and Next Steps for Gap-Filling Pathways

Current Measure Gaps and Gap-Filling Efforts: NQF

NQF Annual Gap Analysis and Report (Task 16)

- Organization-wide measure gaps and barriers identification effort
- Draws information from the findings of:
  - NQF endorsement process
  - Measure Applications Partnership
  - National Priorities Partnership
- Draft report due to HHS December 28, 2012; final report due to HHS February 1, 2013

MAP Strategic Plan

- Proposes to stimulate gap-filling for high-priority measures gaps

Measure Gaps and Gaps-Filling Pathways: Review of Year 1 and Year 2

Year 1

- MAP Coordination Strategy and Pre-Rulemaking Reports identified many high-priority measurement gaps

Year 2

- In contrast to Year 1, MAP is starting to push beyond broad gap identification
  - Task forces identified specific gaps along measure lifecycle
  - Solicited reaction and perspectives from measure developers

Measure Lifecycle

Characterization of gaps along the measure lifecycle can assist in pinpointing where barriers exist

Gaps in Patient-Centered Measures and Bi-Directional Communication

Gaps examples

- Patient and family engagement in end-of-life care decisions
- Patient communication and shared accountability at all stages of care planning/delivery for various settings (e.g., inpatient, outpatient, community-based, and home settings)
- Patient understanding of provider information or provider use of patient information
- Identify and report health care disparities or detect progress toward health equity

Challenges examples

- **Evidence:** More research needed on the most effective care practices
- **Data Sources:** Patient-reported data not consistently collected or integrated
- **Funding:** Incentives are limited for creating new measures to track patient involvement/understanding
- **Attribution:** Challenging to attribute specific breakdowns in care processes

Gaps in Specific Outcome Measures

Gaps examples

- Patient-reported outcomes of functional status
- Injury due to adverse drug events across settings
- Cancer and stage-specific survival rates
- Global cardiovascular risk

Challenges examples

- **Evidence:** Lack of evidence for sub-populations
- **Data Sources:** Feasibility of using EHR extracted clinical practice data for global risk calculations
- **Funding:** Specificity of measure funding (e.g., population, setting)
- **Attribution:** Appropriate attribution for outcomes vs. discrete events/procedures

Gaps in Measures that do not Cover all Desired Populations, Settings, and Levels of Analysis

Gaps examples

- Children or pediatric conditions
- Measures restricted by conditions (e.g., surgery site infections limited to hysterectomy and colorectal surgeries)
- Medication management across settings and providers
- Coordinated palliative and hospice care across settings
- Enhanced measures needed to track care transitions between a variety of settings

Challenges examples

- **Evidence:** Studies often restricted to selected sub-groups
- **Data Sources:** Varying amounts of test data available from different settings
- **Funding:** Developer resources are limited and modifications/testing are costly
- **Attribution:** Complexity of attributing issues across settings and providers

MAP's Role and Next Steps for Gap-Filling

Discussion Questions

1. What role should MAP play within the landscape of existing gap identification, prioritization, and solution efforts?
2. Who should MAP partner with to support and enhance existing gap-filling efforts?
3. Based on the ideal role for MAP, what specific tactics should be undertaken?
   a. Identification of measure gaps along the measure lifecycle?
   b. Prioritization of gap-filling, with consideration for development feasibility and funding needs?
   c. Environmental scan of measure development issues and barriers?
   d. Joint MAP-NPP Gap-Filling Task Force to propose solutions?

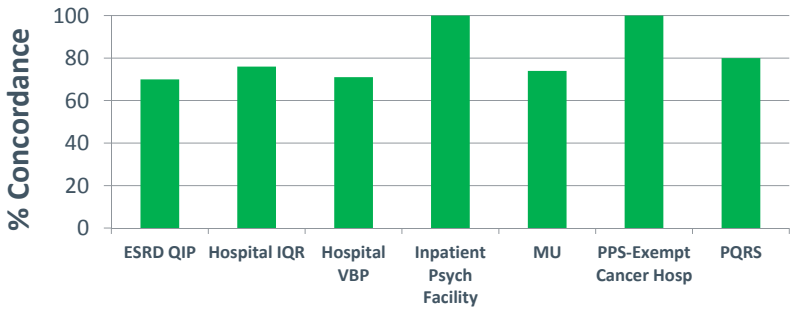
Uptake of MAP Recommendations in 2012 Federal Rules

Objectives

- Summarize uptake of MAP "Support" and "Do Not Support" recommendations in proposed and finalized HHS rules to date
- Discuss MAP recommendation categories and possible refinement going forward
- Review implications of uptake analyses for pre-rulemaking activities

Uptake of MAP Pre-Rulemaking Recommendations

- The MAP 2012 Pre-Rulemaking Report included specific recommendations on measures under consideration by HHS, as well as some previously finalized measures, for use in Federal programs
- Concordance of MAP "Support" and "Do Not Support" recommendations with HHS proposed rules released in 2012 has been fairly high:



MAP Pre-Rulemaking Input – Support Direction

- MAP had "Support Direction" recommendations for all measures on the HHS list of measures under consideration for the following programs:
  - **Long-Term Care Hospital Quality Reporting** (n= 8)
    - » HHS finalized 2 of these measures
  - **Inpatient Rehabilitation Facilities Quality Reporting** (n=8)
    - » HHS did not propose any of these measures
  - **Value-Based Payment Modifier Program** (n=7)
    - » HHS proposed using 6 of these measures alone or as part of composites for the value-based payment modifier for groups of physicians

MAP Pre-Rulemaking Input – Programs with No Measures Under Consideration

- HHS identified no measures under consideration for MAP to review for the following programs:
  - **Ambulatory Surgery Center Quality Reporting**
  - **Home Health Quality Reporting**
  - **Hospital Outpatient Quality Reporting**
  - **Medicare Shared Savings Program**
  - **Nursing Home Quality Initiative & Nursing Home Compare**

HHS Final Rules in 2012

- HHS issued the IPPS final rule August 1, 2012
  - Only two programs had differences in measures compared to the proposed rule:
    - **Hospital Value Based Purchasing** – one initially proposed measure was not finalized (NQF #0639), after the latest data indicated the measure was "topped-out"
    - **Long Term Care Hospital Quality Reporting** – two initially proposed measures were not finalized (NQF #0682 and #0302); one due to a potential guideline change, and the other due to withdrawal from the NQF endorsement process and public comments
- The final rule for the EHR Incentive Program for Eligible Professionals and Hospitals is expected to be issued later this month
- The remaining HHS programs for which MAP reviewed measures are covered in final rules expected to be released in November

Implications for MAP Pre-Rulemaking

- HHS uptake of MAP pre-rulemaking recommendations will continue to be tracked
- Rationale for proposed use or removal of measures by HHS that differs from MAP recommendations is being logged, when available
  - The most common reason for discordance is that a number of proposed measures lacked specifications and/or NQF endorsement
- Uptake information about individual measures will be readily available during MAP pre-rulemaking activities

Refinements for the MAP Pre-Rulemaking Approach

- MAP recommendations, particularly to "Support Direction" of certain measures, need to clearly convey a desired action
- Comments received on the Pre-Rulemaking Report suggested that MAP could better define its recommendation categories, and include more detailed rationale about the readiness of measures for use in programs
- Recommendation category definitions per the 2012 Pre-Rulemaking Report:
  - **Support**—MAP supports the measure for inclusion in the associated federal program during the 2012 rulemaking cycle for that program
  - **Support direction**—MAP supports the measure concept; however, further development, testing, or implementation feasibility must be addressed before inclusion in the associated federal program
  - **Do not support**—Measure is not recommended for inclusion in the associated federal program at this time

Summary

- Concordance of MAP recommendations to support or not support measure use in Federal programs with HHS proposed/finalized rules has been 70-100%, to date
- Conclusive assessment of MAP recommendation uptake for 2012 will be completed when HHS issues the remaining final rules
- Information on MAP recommendation uptake will be available to workgroup and Coordinating Committee members during pre-rulemaking activities
- How should the MAP recommendation categories be refined for clarity prior to the next review cycle?

Discussion

Public Comment

Summary of Meeting and Next Steps

Upcoming Meetings and Activities

Public Comment Period for MAP Strategic Plan and Families of Measures Report

August 27, 2012 – September 10, 2012

Dual Eligible Beneficiaries Workgroup Web Meeting

September 5, 2012, 1-3pm ET

Dual Eligible Beneficiaries Workgroup In-Person Meeting

Meeting October 11-12, 2012