Measure Applications Partnership Hospital Workgroup Ad Hoc Review Meeting Summary

The Department of Health and Human Services (HHS) requested that the Measure Applications Partnership (MAP) conduct an Ad Hoc Review of four measures for hospital programs. To complete the review, two web meetings of the Hospital Workgroup were held on Monday, June 10, 2013 and Thursday, June 13. 2013. For a list of members in attendance, please see Appendix A. An online archive of the meeting and meeting materials are available on the MAP Hospital Workgroup webpage.

Introduction

MAP provides annual input on the selection of performance measures for federal programs to inform federal rulemaking. Additionally, HHS has asked MAP to establish a process outside of the annual review to provide input on measures on an ad hoc basis. In May 2013, MAP received a request for Ad Hoc Review of four measures for two federal programs, the Hospital Acquired Conditions (HAC) Reduction Program and the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR). MAP convened the Hospital Workgroup to consider these four measures.

Prior to the web meeting, NQF asked workgroup members to participate in a pre-meeting exercise using the MAP Measure Selection Criteria and the Guiding Principles for Applying Measures to Hospital Programs to provide initial input on the measures under review.[1] The aim of this exercise was to inform the development of meeting materials and to serve as a starting place for the workgroup's discussions. The workgroup reviewed and discussed the exercise results from 16 respondents during the Ad Hoc Review web meetings.

On June 10, the workgroup participated in a two hour web meeting to discuss the measures. Because the issues underlying the measures were complex and stakeholders had many perspectives to share, the workgroup did not reach agreement on all of the measures under review in the time allotted. The workgroup participated in a one hour follow-up web meeting on June 13 to further discuss and provide recommendations on the remaining measures.

This meeting summary provides the MAP Hospital Workgroup's input on the measures under review and key themes that emerged from the Ad Hoc Review. Please see Appendix B for a summary of the workgroup's conclusions and rationale for each measure.

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[1] National Quality Forum (NQF). *MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS*, Washington, DC: NQF, 2012.

Key Findings

Inpatient Psychiatric Facility Quality Reporting Program

The Hospital Workgroup reviewed one measure under consideration for the Inpatient Psychiatric Facility Quality Reporting Program, a pay-for-reporting program applicable to inpatient psychiatric facilities and psychiatric units paid under the Inpatient Psychiatric Facility Prospective Payment System (PPS). Beginning in FY 2014, inpatient psychiatric hospitals or psychiatric units that do not participate will receive a two percent reduction to their annual PPS market basket update (the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients).CMS has indicated that the IPFQR program measure set should address the six priorities of the National Quality Strategy (NQS) as fully as possible. The program measure set should also include process, structure, outcome, patients' perspectives on care, efficiency, and cost of care measures.

During its 2012/2013 pre-rulemaking review, MAP noted that improving person-centered psychiatric care is a priority measure gap. Specifically, MAP recommended that patient and family/caregiver experience and engagement should be assessed, and relationships with community resources should be established. As a starting place for measurement of these topics, MAP supported the Inpatient Consumer Survey (ICS) measure for inclusion in this program. In the FY 2014 Inpatient Prospective Payment System (IPPS) proposed rule, the Centers for Medicare & Medicaid Services (CMS) noted concern regarding the potential burden of collecting and reporting information for the ICS measure.[2]

Measure Recommendation and Rationale

The Hospital Workgroup reinforced the importance of patient and family engagement in psychiatric care and recommended that a meaningful, feasible measure of patient experience be adopted for psychiatric facilities as expeditiously as possible. The workgroup did not find the MAP decision categories adequate to express their recommendation for the particular measure under review; the group was in agreement on the need to implement a measure of patient experience in the IPFQR program, but divided on whether the measure under review was the best path forward. Therefore, the group's conclusion was split, with some members supporting the direction of the measure and some members not supporting the measure.

The measure under review is a structural measure intended to gather information from facilities and units to determine if they assess patient experience: Did you do a patient experience of care survey on your patients? The measure uses a "yes/no" standardized format; for "yes" answers, CMS requests that the name of the survey be provided. Submission of the information would be completely voluntary and would not affect an IPF's FY 2016 payment determination. In the FY 2014 IPPS proposed rule, CMS stated its intent to make this voluntary request for information a mandatory measure in future rulemaking.[3]

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[2] Medicare Program;Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates;Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation. Fed Registr. 2013;78:27485-27823. Available at https://www.federalregister.gov/articles/2013/05/10/2013-10234/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the. Last accessed June 2013.

[3] Ibid

In discussing the measure, the workgroup affirmed the fundamental importance of gaining the patient's perspective on care provided in psychiatric facilities. Those who supported the direction of the measure suggested that the proposed structural measure could be an interim step toward creating capacity for widespread use of a meaningful patient experience of care survey. There is a clear need to expedite progress on the collection of actionable patient experience information and use of the measure under consideration could send a clear signal to the field about future requirements. The workgroup members who did not support the measure expressed concern that the interim step of using of a structural measure could delay progress in moving toward a more meaningful measure.

To expedite the process of systematically gathering meaningful information from psychiatric hospitals and units about the use of patient experience of care surveys, the American Hospital Association and the National Association of Psychiatric Health Systems stated their willingness to conduct outreach to their members and collect the information sought by CMS. This process could produce results much more quickly, thoroughly, and efficiently than the proposed voluntary reporting of a binary structural measure.

Healthcare Acquired Condition Reduction Program

The Hospital Workgroup reviewed three measures under consideration for the HAC Reduction Program established by Section 3008 of the Affordable Care Act. According to statute, this program should address conditions already selected for the current HAC non-payment policy and any other condition acquired during a hospital stay that HHS deems appropriate. Beginning in FY 2015, hospitals scoring in the quartile with the most HACs compared to the national average will have their Medicare payments reduced by one percent.[4] The IPPS FY 2014 Proposed Rule creates two domains for this program: Domain 1: Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSI), and Domain 2: Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) measures. As proposed, the two domains would be equally weighted to create a total HAC score that will be used to determine payment penalties.[5]

MAP previously reviewed measures for the HAC Reduction Program during its 2013 pre-rulemaking work and used this decision history to support its deliberations for the Ad Hoc Review. MAP noted the need to find a balance between using high-impact measures in multiple programs to sharpen providers' focus on priority improvement areas and avoiding unintended consequences of overlapping penalties. MAP also expressed a preference that a measure be included in another program for at least a year prior to inclusion in the HAC Reduction Program to allow hospitals to gain experience with the measure and to ensure a measure fairly and accurately reflects hospital performance. Given the program structure, MAP carefully considered during its pre-rulemaking work the implications of including measures of relatively rare serious reportable events; the occurrence of one of these events during a year could potentially put a hospital in the quartile to receive the payment reduction. Some MAP members raised concerns about

[4] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §2702, 124 Stat. 119, 318-319 (2010).
[5] 78 FR 27485

the impact this program might have on low-volume and safety-net providers, while other members emphasized the importance of holding all providers accountable to the same standard of safety.[6]

PSI-3: Pressure Ulcer Rate Recommendation and Rationale

Though the Hospital Workgroup reiterated the importance of pressure ulcers as a serious, under-detected, and costly safety concern, the group did not support PSI-3 for inclusion in the HAC Reduction Program. While some workgroup members believed the measure should be included because of the importance of measuring pressure ulcers, the group ultimately concluded that the measure was not the best fit for the payment penalty purpose of this program as it is claims-based and could lead to under-reporting. The group determined instead that NQF-endorsed Pressure Ulcer Prevalence measure #0201, derived from clinical data, is more accurate and would be a better fit for the purpose of the program. The workgroup recommended that CMS take the necessary steps to bring #0201 into the HAC Reduction Program.

MAP previously reviewed PSI-3 for the Safety Family of Measures and had concerns about the reliability of claims data and the validity of the measure. During the review of PSI-3 for the HAC Reduction Program, some workgroup members reiterated these concerns. They noted that while PSI-3 may undercount pressure ulcers, it does not do so uniformly across hospitals and may unfairly penalize hospitals whose physicians are better at identifying and documenting pressure ulcers or those with better coders than hospitals who truly have higher pressure ulcer rates. However, other workgroup members raised concerns that pressure ulcers are under-detected and under-diagnosed and that neglecting to include a measure addressing pressure ulcers in the HAC Reduction Program would shift focus away from this important safety area. Workgroup members also commented that the occurrence of pressure ulcers is highly correlated with the amount of nursing care provided.

Workgroup members agreed that the Pressure Ulcer Prevalence measure (NQF #0201) previously recommended for inclusion in its Safety Family of Measures is a superior measure to PSI-3. The workgroup recommends that measure #0201 should be included in the Inpatient Quality Reporting Program as soon as possible so it can be considered for the HAC Reduction Program. The workgroup felt this measure would provide more accurate information as it is calculated from clinical data rather than claims. Using clinical data also avoids the perverse incentive not to document pressure ulcers and enables fair and reliable comparisons among hospitals. Although it requires more resources for providers to conduct a one-day prevalence study to gather data for this measure, skin assessments are part of the standard of care, and NQF #0201 is currently widely collected and reported. Implementing this measure in place of PSI-3 could help to promote alignment and reduce measurement burden associated with duplicative measures.

PSI-6: Iatrogenic Pneumothorax Rate Recommendation and Rationale

The Hospital Workgroup supported the direction of PSI-6: Iatrogenic Pneumothorax Rate. The workgroup had greater confidence in the reliability and validity of PSI-6 relative to other measures under review. The workgroup noted that of the three measures under consideration for the HAC Reduction Program, only PSI-6 is NQF-endorsed. In addition, iatrogenic pneumothorax is likely to be

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[6] National Quality Forum (NQF). *MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS*. Washington, DC: NQF, 2012.

properly coded as it is a significant acute event. Including PSI-6 in the HAC Reduction Program will focus attention on hospitals' current performance, appropriate procedures for central line insertion, and monitoring of adverse events. The workgroup stressed the importance of publicly reporting this measure to make the data available to consumers and purchasers.

The workgroup expressed concerns with the measure that prevented them from fully supporting it for the HAC Reduction Program. First, the group noted that the denominator should be limited to patients at risk for iatrogenic pneumothorax. The broad denominator currently specified can skew results. Additionally, the workgroup noted that the rarity of iatrogenic pneumothorax events could impact the reliability of the measure. One participant estimated that only 57% of hospitals would have enough data after two years to be accurately measured.

PSI-10: Postoperative Physiologic and Metabolic Derangement Rate

The Hospital Workgroup did not support inclusion of PSI-10 in the HAC Reduction Program. The measure addresses important clinical factors, but workgroup members noted concern that PSI-10 is not NQF-endorsed. In fact, this measure was removed from the PSI-90 composite measure during the composite's most recent NQF review. Without endorsement, the workgroup did not have enough information on the reliability, validity, or accuracy of this measure to support it. Workgroup members suspected that the measure would not provide correct or meaningful information to consumers and purchasers. The workgroup also noted that the conditions addressed by this measure may be unavoidable in certain populations, making it more appropriate for programs that incentivize improvement, such as the hospital Value-Based Purchasing Program. Others expressed that PSI-10 may be better suited for internal quality improvement purposes than public reporting or payment.

Composite Measure Alternate Approach

The FY 2014 IPPS proposed rule included two options—a Proposed Approach and an Alternate Approach—for Domain 1, the AHRQ PSI domain. The Proposed Approach includes six individual PSI measures. The Alternate Approach includes PSI-90, a composite made up of eight component indicators.[7] While HHS did not ask MAP for input on selecting the approach for Domain 1, the Hospital Workgroup discussed the use of composite versus individual measures as context for reviewing the PSI measures. The workgroup noted that the PSI-90 composite has better reliability than its separate parts, so it could provide greater accuracy in determining payment adjustments.

MAP has previously supported the use of composites as they provide a more comprehensive picture of patient care than more narrowly defined stand-alone measures, and they can help overcome small numbers problems for rare events. In addition, composites can provide more meaningful aggregated support for consumer decision-making. However, MAP has cautioned that composites require careful testing and weighting of all individual components to ensure a scientifically rigorous measure. MAP also raised questions about the usefulness of aggregated information to providers that need to parse component scores to determine what aspects of care require improvement.

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[7] 78 FR 27485

The FY 2014 IPPS rule states that "the proposed approach for Domain 1 would provide simpler results to interpret, allow a hospital to use the results to target patient safety improvement efforts, and avoid overlap between the two measure domains."[8] In considering use of the PSI-90 composite for the HAC Reduction Program, workgroup members agreed with the proposed rule's assertion that individual scores are more actionable and meaningful for performance improvement. Additionally, individual results allow variations to be more visible to consumers and purchasers, helping to support their decision-making. Workgroup members also noted that the issue of overlapping conditions between the two domains should be taken into account to avoid counting one incident numerous times.

[8] Ibid

Appendix A. Workgroup Members in Attendance

Name	Organization	Attended June 10	Attended June 13
Frank Opelka	Chair	yes	yes
Dana Alexander	Subject Matter Expert-Health IT	yes	yes
Richard Bankowitz	Premier, Inc.	yes	no
Andrea Benin	Children's Hospital Association	yes	yes
Barbara Caress	Building Services 32BJ Health Fund	yes	yes
Patricia Conway-Morana	American Organization of Nurse Executives	no	yes
Nancy Foster (substitute for Rich Umbdenstock)	American Hospital Association	yes	yes
Floyd Fowler	Subject Matter Expert-Patient Experience	yes	yes
Shaheen Halim	Centers for Medicare & Medicaid Services (CMS)	yes	yes
Helen Haskell	Mothers Against Medical Error	no	yes
Martin Hatlie	Project Patient Care	yes	no
Gail Janes	Centers for Disease Control and Prevention (CDC)	yes	no
Mitchell Levy	Subject Matter Expert-Patient Safety	no	yes
Mary Lehman MacDonald	American Federation of Teachers Healthcare	yes	no
Shekhar Mehta	American Society of Health-System Pharmacists	yes	yes
Dolores Mitchell	Subject Matter Expert-State Policy	yes	no
Sean Morrison	Subject Matter Expert-Palliative Care	yes	yes
Shelley Fuld Nasso	National Coalition for Cancer Survivorship	yes	yes
Pamela Owens	Agency for Healthcare Research and Quality (AHRQ)	yes	yes
Michael Phelan	Subject Matter Expert-Emergency Medicine	yes	yes
Louise Probst	St. Louis Area Business Health Coalition	no	yes
Jean Rexford (substitute for Helen Haskell)	Mothers Against Medical Error	yes	no
Lance Roberts	Iowa Healthcare Collaborative	yes	yes
Bruce Siegel	National Association of Public Hospitals and Health Systems	yes	no
Brock Slabach	National Rural Health Association	yes	yes
Donna Slosburg	ASC Quality Collaboration	yes	yes
Ann Marie Sullivan	Subject Matter Expert-Mental Health	yes	yes
Cristie Travis	Memphis Business Group on Health	yes	no
Ronald Walters	Alliance of Dedicated Cancer Centers	yes	yes
Wei Ying	Blue Cross Blue Shield of Massachusetts	yes	yes

Appendix B. MAP Hospital Workgroup Input on Measures under Consideration for Ad Hoc Review

Measure # and Endorsement Status	Measure Title	Program	Hospital Workgroup Conclusion	Rationale
Not endorsed	Did you do a patient experience of care survey on your patients?	IPFQR	Split between do not support and support direction	This measure could be an interim step toward the goal of a meaningful, feasible patient experience of care survey; however, the workgroup was hesitant to fully support this structural measure to avoid wasted effort and delayed progress.
Not endorsed	PSI-3: Pressure Ulcer Rate	HAC Reduction Program	Do not support	While the workgroup did not support this measure because it is claims-based, they reiterated the importance of pressure ulcers as a safety concern. Instead, the workgroup recommended that the Pressure Ulcer Prevalence measure (NQF #0201) be adopted for the Inpatient Quality Reporting Program measure set as soon as possible so that it can be considered for the HAC Reduction Program.
0346 Endorsed	PSI-6: Iatrogenic Pneumothorax Rate	HAC Reduction Program	Support direction	Though this measure is NQF-endorsed and including it in the HAC Reduction Program would drive attention to rates of iatrogenic pneumothorax as well as attention to best practices for central line insertion and monitoring of adverse events, the workgroup expressed concerns that the denominator should be limited to patients at risk for iatrogenic pneumothorax and that the rarity of these events could impact the reliability of the measure.
Not endorsed	PSI-10: Postoperative Physiologic and Metabolic Derangement Rate	HAC Reduction Program	Do not support	The workgroup raised concerns that without NQF endorsement there was not enough information about the reliability, validity, or accuracy of this measure to support including it in the HAC Reduction Program. The workgroup also noted that the conditions addressed by this measure may not be avoidable in certain populations.