Measure Applications Partnership

All MAP Web Meeting
and
NQF All Member Call

July 23, 2012

NATIONAL QUALITY FORUM

Welcome and Review of Meeting Objectives

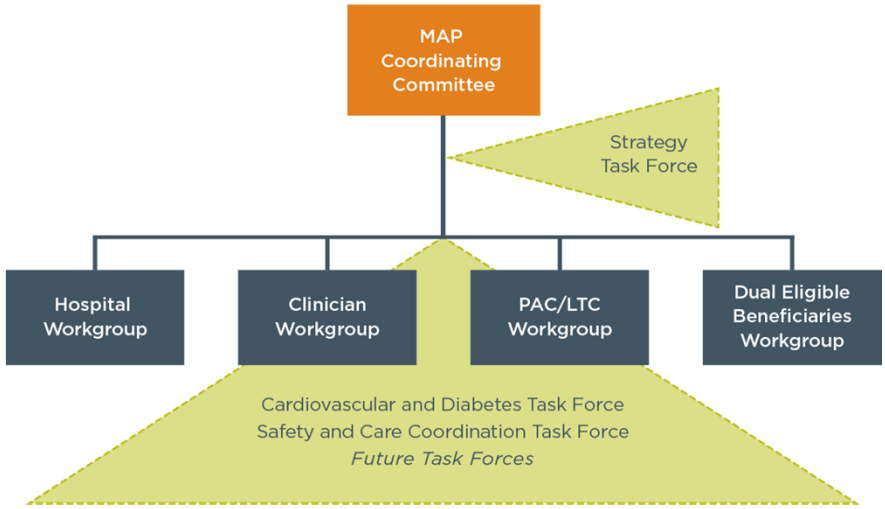
Meeting Objectives

- Review draft MAP Strategic Plan
- Review proposed MAP Families of Measures
- Review uptake of MAP recommendations in federal proposed rules

Purpose of MAP

- Provide input to HHS on the selection of performance measures for use in public reporting, performance-based payment, and other programs
- Identify gaps for measure development, testing, and endorsement
- Encourage alignment of public and private sector programs
- Align measurement across programs, settings, levels of analysis, and populations:
  - Promote coordination of care delivery
  - Reduce data collection burden

MAP Structure



MAP Work for 2012

- Develop MAP 3-year strategic plan for achieving aligned performance measurement that enables improvement, transparency, and value
- Identify families of measures for specific topics and core measure sets composed of available measures and gaps
  - Enhance existing two-tiered structure with topic-focused, time-limited task forces
- Provide pre-rulemaking input to HHS on measures under consideration for rulemaking
  - Expand decision making support for activities
- Delve into measurement issues for dual eligible sub-populations

MAP Work for 2012: Key Deliverables

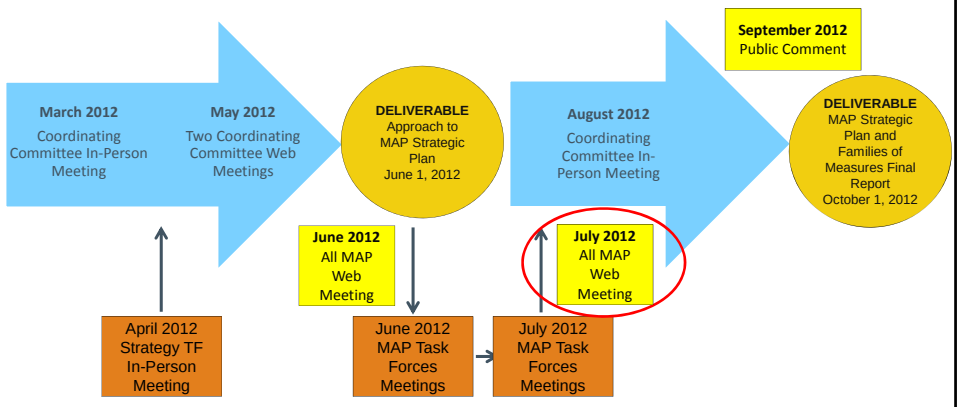
Deliverables	Date Due to HHS
Outline of Approach to MAP Strategic Plan	June 1, 2012
• **MAP Strategic Plan for Aligning Performance Measurement** • **Refined MAP Measure Selection Criteria and High-Impact Conditions** • **Families of Measures:** - **Cardiovascular Health & Diabetes + cost of care implications** - **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
• Cost of care (e.g., total cost, resource use, appropriateness) • Families of Measures: Population Health, Patient and Family Engagement, and Mental Health	TBD - 2013

Draft 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 Goal and Objectives
- Feedback Loops to support collaboration
- Action Plan, including collaborators, deliverables, and timeline

MAP Goal

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

Objectives, Strategies, and Tactics

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…

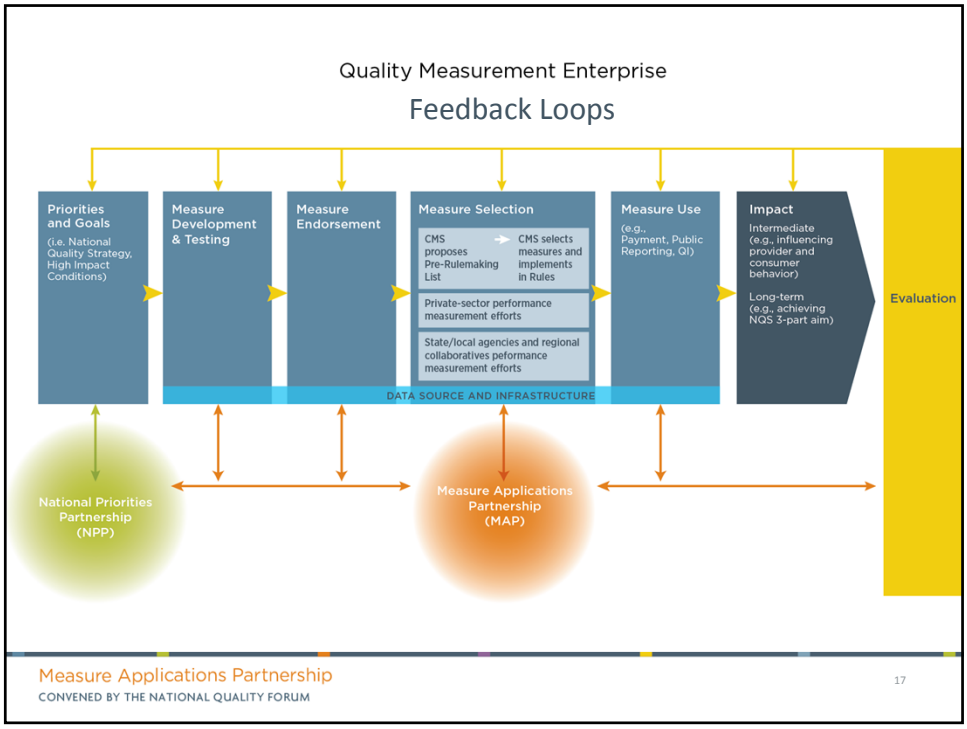
OBJECTIVE #2	STRATEGIES	TACTICS	MILESTONES
Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy on value	• Promote alignment of performance 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…

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 feedback loops with multiple stakeholders to:
  - Support data-driven decision making (inputs)
  - Determine if MAP recommendations are meeting stakeholders needs (outputs)



Feedback Loop	MAP Needed Inputs		MAP Outputs	
	Information	Key Stakeholders	Information	Key Stakeholders
Priorities and Goals	• NQS priorities and goals • Adoption of NQS by federal agencies and entities outside of the federal government	• NPP • Federal partners (AHRQ) • State/local agencies, regional collaboratives	• Signals where national strategies are needed (e.g., disparities)	• NPP • Federal partners (AHRQ)
Measure Development and Testing	• Measures in the development pipeline • Development issues—evidence base, data for testing	• Measure developers • NQF endorsement process	• Identification and prioritization of gaps • Identification of gap-filling barriers	• Measure developers • NPP • NQF endorsement process • Federal partners • Private sector stakeholders funding measure development
Measure Endorsement	• Endorsed measures—important, scientifically acceptable, feasible, usable • Measures not endorsed—signal where gap-filling has been attempted • Implementation challenges from maintenance process	• NQF endorsement process	• Identification and prioritization of gaps • Identification of gap-filling barriers • Solutions to implementation and use barriers	• NQF endorsement process • Measure developers • Federal partners • Private sector stakeholders funding measure development

Feedback Loop	MAP Needed Inputs		MAP Outputs	
	Information	Key Stakeholders	Information	Key Stakeholders
Measure Selection	• Current measures selected for use in programs and rationale • Rationale for accepting/ rejecting MAP input	• Federal partners • State/local agencies, regional collaboratives • Purchasers, payers • Providers, clinicians • Accreditation/certification entities • Other public reporting entities (e.g., Consumer Reports)	• Families of measures and core measure sets • Input on measures for specific programs (e.g., adding/removing measures) • Guidance on implementing MAP recommendations	• Federal partners • State/local agencies, regional collaborative • Purchasers, payers • Providers, clinicians • Accreditation/ certification entities • Other public reporting entities
Measure Use	• Current measures in use, including rationale	• Federal partners • State/local agencies, regional collaboratives • Purchasers, payers • Accreditation/ certification entities • Providers, clinicians • Consumers • Assessments of measure use (e.g., CMS, QASC, AHIP, RWJF, NRHI)	• Measure use for varying payment models (e.g., measure domain weighting, benefit structure) • Input on programmatic structure (e.g., data collection and transmission) • Measure use for accountability • Measure use to support clinical quality improvement • Measure use to support informed choices	• Federal partners • State/local agencies, regional collaboratives • Purchasers, payers • Accreditation and certification entities • Providers, clinicians • Consumers

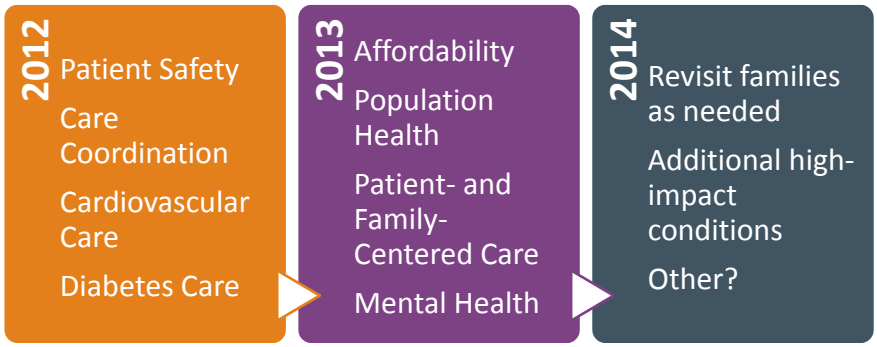
Feedback Loop	MAP Needed Inputs		MAP Outputs	
	Information	Key Stakeholders	Information	Key Stakeholders
Impact	• Current performance • Improvement • Unintended Consequences	• Federal partners • State/local agencies, regional collaboratives • Purchasers, payers • Providers, clinicians • Assessments of measure impact (e.g., CMS, QASC, AHIP)		
Evaluation	• Definitions of MAP's success	• Federal partners • State/local agencies, regional collaboratives • Purchasers, payers • Providers, clinicians • Consumers • Accreditation/certification entities		

MAP Action Plan

Identifying Families of Measures and Core Measure Sets

- Families of Measures and Core Measure Sets to Align Performance Measurement Across Federal Programs and Public and Private Payers and to encourage best use of available measures in specific HHS and private sector programs
  - 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., care coordination family of measures, diabetes care family of measures)

Proposed Families of Measures



Addressing Measure Gaps

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

- Identifying gaps, characterizing gaps along the measure life cycle, prioritizing 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
  - MAP will address gaps throughout its work, starting with the development of the first set of families of measures in 2012

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
  - Begin collecting and synthesizing information (readily available) in 2012 to support the development of first families of measures; refine process as new information becomes available

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

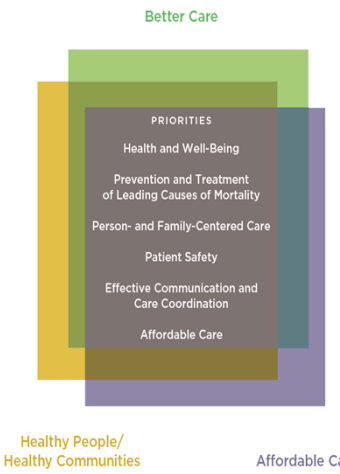
MAP Discussion

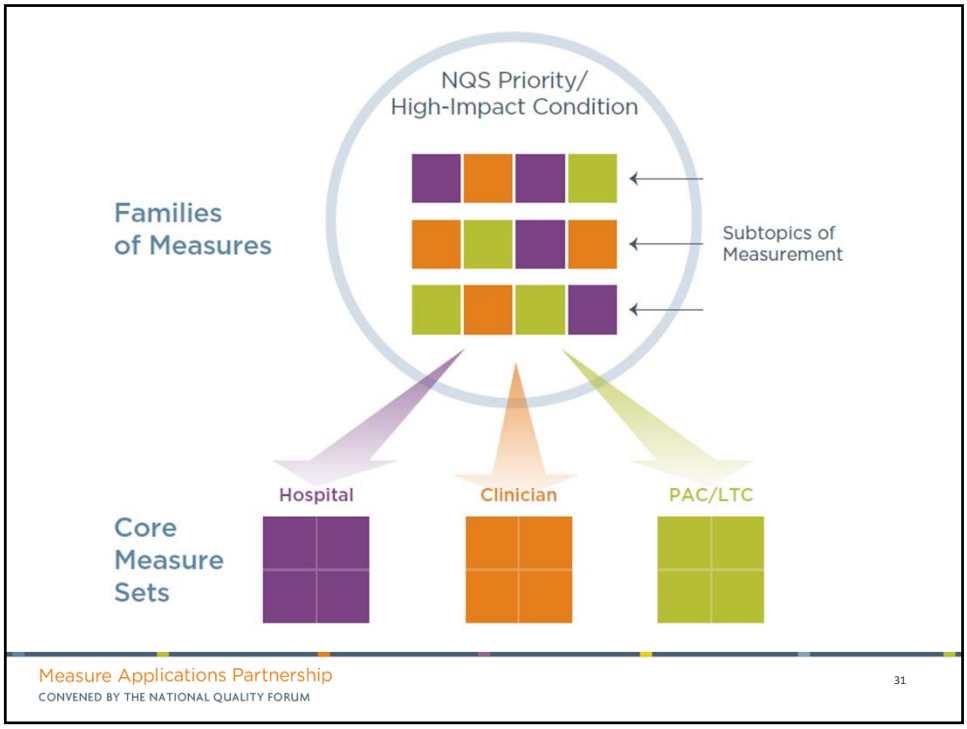
Opportunity for NQF Member and Public Comment

Proposed Families of Measures

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




NQS Priority/
High-Impact Condition
Families
of Measures
Subtopics of
Measurement
Hospital
Clinician
PAC/LTC
Core
Measure
Sets
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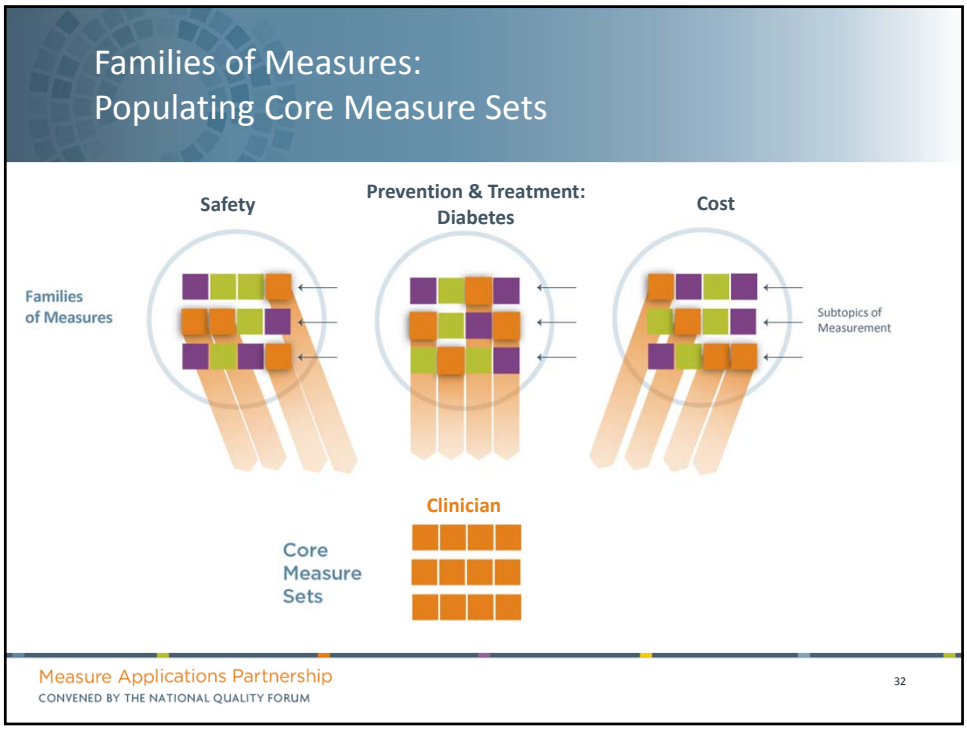
Families of Measures:
Populating Core Measure Sets
Safety
Prevention & Treatment:
Diabetes
Cost
Families
of Measures
Subtopics of
Measurement
Clinician
Core
Measure
Sets
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Approach to Developing Measure Families

1. Identify and Prioritize High-Leverage Opportunities for Measurement
2. Scan of Measures that Address the High-Leverage Opportunities
3. Define the Family for Each High-Leverage Measurement Opportunity
4. Establish Gap-Filling Pathways

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

Proposed Families of Measures:
Patient Safety and Care Coordination

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: David Stevens
CDP (Safety): Bill Conway
CDP (Care Coordination): Gerri Lamb

Safety Measure Family

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 8 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	Sub-topic
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 Measure Family

Building a Safety Measure Family – Key Themes

- 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 unwanted/unnecessary treatment and testing
- May be appropriate to include balancing measures to monitor potential undesirable consequences, though less parsimonious

Safety Measure Family

Building a Safety Measure Family – Key Themes

- Preferred outcome measures over process and structural measures for inclusion in the family
  - Hesitation around process measures where there is no strong evidence base
  - Process measures tied closely to desired outcomes could be built into composites and included in the future
- Preferred medical record abstraction over claims-based measures
- Concerns regarding small numbers related to reporting of "never events"
  - Suggest a single composite measure that encompasses all, or most significant, of these events

Safety Measure Family

Building a Safety Measure Family – Prioritized Gaps

- 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 (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

Care Coordination Measure Family

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
  - 59 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

Care Coordination Measure Family

Topic Areas for Care Coordination Measures:

- Avoidable Admissions and Readmissions
- System and Infrastructure Support
- Patient Surveys related to Care Coordination
- Care Transitions
- Communication
- Care Planning

Care Coordination Measure Family

Building a Care Coordination Measure Family – Key Themes

- Care Coordination is about the space between providers
  - Existing outcome measures can show system success but don't hold the system accountable if only applicable to one setting
  - Current measures reinforce silos within the system and are mostly hospital-centric
- Patient (and/or caregiver) must be included in care decisions and planning – one size doesn't fit all
  - Not only ensuring patient understanding of plan of care, but agreement with the plan
- Care coordination is a multidisciplinary team effort
  - Existing measures are hospital and physician focused and do not address teams

Care Coordination Measure Family

Building a Care Coordination Measure Family – Key Themes

- Provider communication measures need to address both the sending and receiving of information
- Ability of patients to connect to resources available in the community
- Existing patient surveys, looking at experience broadly, can capture patient perceptions of care coordination failures

Care Coordination Measure Family

Building a Care Coordination Measure Family – Prioritized Gaps

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

MAP Discussion

Opportunity for NQF Member and Public Comment

Proposed Families of Measures: Cardiovascular Care and Diabetes Care

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)

Liaisons

- Accreditation/Certification: NCQA
- NPP: Peter Briss
- CDP: Ray Gibbons

Themes

Key Themes from June 21st and July 17th Task Force Meetings

- The episode of care model is a useful framework
- Outcome measures focused on control are preferred to process measures focused on screening/testing
- Measures should have broad denominator populations to help achieve a parsimonious set of measures
  - Measures with broad denominator populations can be stratified by condition for quality improvement purposes

Diabetes Family of Measures*

Task Force Meeting held on June 21

- The task force reviewed:
  - Primary prevention measures for cardiovascular disease and diabetes
  - Measures for diabetes management and exacerbation, in the context of the patient-focused episode of care
- The task force identified:
  - 7 primary prevention measures that apply to both the cardiovascular and diabetes families of measures
  - 4 additional diabetes management measures that apply to the diabetes family of measures only
  - 1 relative resource use measure for diabetes

includes primary prevention of cardiovascular disease and diabetes

Themes

Key Themes – Diabetes

- Assessing management of diabetes is the highest-leverage opportunity for accountability measurement
  - Assessing exacerbations is important, but is best suited for quality improvement measurement

Proposed Diabetes Measure Family and Gaps

	Primary Prevention of Cardiovascular Disease and Diabetes		Evaluation and Ongoing Management of Diabetes		Exacerbation of Diabetes and Complex Treatments	
	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient
Clinician Group/ Individual	• **Smoking Cessation/ Tobacco Use (0028, 1406);** • **Lifestyle Management – Weight/Obesity (0024, 0421)** • **Blood Pressure Control (0018)** • Lipid Control • Lifestyle Management – Diet/nutrition • Lifestyle Management – Activity/Exercise	• Smoking Cessation/Tobacco Use	• **Glycemic control/ HbA1c (0575);** • **Lipid Control (0064)** • **Diabetes Composite (0729, 0731)** • Glycemic control for complex patients • Lifestyle Management – Diet/nutrition • Lifestyle Management – Activity/Exercise • Blood Pressure Control		• Sequelae of diabetes exacerbations	
	• **Relative resource (1557)**					
Provider/ Facility	• **Lifestyle Management – Weight/Obesity (0421)** • **Blood Pressure Control (0018)** • Smoking Cessation/ Tobacco Use • Lipid Control • Lifestyle Management – Diet/nutrition • Lifestyle Management – Activity/Exercise	• **Smoking Cessation/ Tobacco Use (1651, 1654)**	• Glycemic control/ HbA1c • Glycemic control for complex patients • Lipid Control • Lifestyle Management – Diet/nutrition • Lifestyle Management – Activity/Exercise • Blood Pressure Control		• Sequelae of diabetes exacerbations	

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Proposed Diabetes Measure Family and Gaps

	Primary Prevention of Cardiovascular Disease and Diabetes		Evaluation and Ongoing Management of Diabetes		Exacerbation of Diabetes and Complex Treatments	
	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient
System	• **Lifestyle Management-Weight/Obesity (0024)** • **Blood Pressure Control (0018)** • Smoking Cessation/ Tobacco Use • Lipid Control • screening • Lifestyle Management – Diet/nutrition • Lifestyle Management – Activity/Exercise • Cardiometabolic risk	• Smoking Cessation/ Tobacco Use	• **Glycemic control/ HbA1c (0575)** • **Lipid Control (0064)** • **Diabetes Composite (0729, 0731)** • Glycemic control for complex patients • Lipid Control • Lifestyle Management – Diet/nutrition • Lifestyle Management – Activity/Exercise • Blood Pressure Control		• Sequelae of diabetes exacerbations	
	• **Relative resource (1557)**					
Community	• **Smoking Cessation/Tobacco Use (1406, 1651, 1654);** • **Lifestyle Management – Weight/Obesity (0024, 0421)** • **Blood Pressure Control (0018)** • Cardiometabolic risk • Lipid Control • Lifestyle Management –Diet/nutrition • Lifestyle Management – Activity/Exercise		• **Glycemic control/ HbA1c (0575);** • **Lipid Control (0064)** • **Diabetes Composite (0729, 0731)** • Lifestyle Management –Diet/nutrition • Lifestyle Management – Activity/Exercise • Blood Pressure Control		• Sequelae of diabetes exacerbations	
	• **Relative resource (1557)**					

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Diabetes Family of Measures –Prioritized Gaps

Following concepts highlighted as priorities:

- Lifestyle management (weight/obesity, activity/exercise, diet/nutrition)
- Lipid control (across settings, levels of analysis)
- Smoking cessation/tobacco use
- Glycemic control across settings
- Cardiometabolic risk (across settings, levels of analysis)

Cardiovascular Family of Measures

Task Force Meeting held on July 17

- In addition to the previously identified primary prevention measures, the task force identified:
  - 29 additional measures that apply to cardiovascular family of measures
- In the context of the episode of care, the task force reviewed and identified measures for these high-impact conditions:
  - 15 Ischemic Heart Disease measures
  - 4 Stroke measures
  - 1 Atrial Fibrillation measure
  - 2 Heart Failure measures
  - 6 Mortality measures
  - 1 Resource use measure

Themes

Key Themes – Cardiovascular

- Medication measures should focus on persistence of medication, rather than medications ordered in an acute setting or upon discharge
- Patient engagement, patient satisfaction, and care coordination are high leverage opportunities which are not currently included in the family
  - Future MAP Task Force's will address these areas
  - Condition specific measures are not needed for these areas

Proposed Cardiovascular Measure Family and Gaps

Recommended measures are **bolded**
Gaps are non-bolded

	Primary Prevention		Acute Phase		Post Acute/Rehab Phase		Secondary Prevention
	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
Clinician Group/Individual	• **Smoking Cessation/ Tobacco Use (0028, 1406);** • **Lifestyle Management – Weight/Obesity (0024, 0421)** • **Blood Pressure Control (0018)** • Lipid Control • Lifestyle Management – Diet/nutrition • Lifestyle Management – Activity/Exercise	• Smoking Cessation/ Tobacco Use	• **IHD Complications (0709)**	• **IHD Procedures – CABG (0696)** • **Stroke Anticoag for afib at d/c (0241)**	• **IHD Complications (0709)**	• **IHD Rehab (0642)**	• **IHD Medications – Aspirin (0068)** • **IHD Medications – ACE/ARB (0066)** • **IHD Medications – Beta Blocker (0070)** • **IHD Secondary Prevention – Lipids (0075)** • **Afib Medications – anti-coagulation (1525)** • **HF Medications – ACE/ARB (0081)** • **HF Medications – Beta -blocker (0083)**
	• Resource Use (1558)						

Proposed Cardiovascular Measure Family and Gaps

Recommended measures are **bolded**
Gaps are non-bolded

	Primary Prevention		Acute Phase		Post Acute/Rehab Phase		Secondary Prevention
	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
Provider/Facility	• **Lifestyle Management – Weight/Obesity (0421)** • **Blood Pressure Control (0018)** • Smoking Cessation/ Tobacco Use • Lipid Control • Lifestyle Management – Diet/nutrition • Lifestyle Management – Activity/Exercise	• **Smoking Cessation/ Tobacco Use (1651, 1654)**	• IHD **Diagnostic - ECG (0289)** • IHD **Medications - fibrinolysis (0287/ 0288)** • Stroke **Diagnostic - CT (0661)** • IHD **Cardiac imaging (0669, 0670, 0671, 0672)**	• IHD **Diagnostic - ECG (0289)** • IHD **Procedures - PCI(0163)** • IHD **Procedures - CABG (0696)** • IHD **Medications - fibrinolysis (0287/0288)** • IHD **Bilateral cardiac cath (0355)** • IHD Cardiac imaging composite • IHD Appropriateness for CABG and non-emergent PCI • Stroke **Diagnostic - CT (0661)** • Stroke **Medications - Thrombolytic (0437)** • Mortality **– IHD CABG (0119)** • Mortality **– IHD CABG/MV (0122)**	• IHD Outcomes related to rehab • Stroke Anticoagulants, statins, anti-hypertensive • Stroke Obtaining rehab services • Stroke Outcomes related to rehab (includes functional status) • Stroke High risk medication management • HF Functional status • HF ACE/ARB persistence • HF Beta blocker persistence • Mortality **– IHD AMI (0230)** • Mortality **– IHD PCI (535)** • Mortality **– HF (229)**	• IHD Outcomes related to rehab • Stroke **Rehab – assessment (0441)** • Stroke Obtaining rehab services • Stroke Outcomes related to rehab (includes functional status) • HF Functional status • HF ACE/ARB persistence • HF Beta blocker persistence • Mortality **– IHD AMI (0230)** • Mortality **– IHD PCI (535)** • Mortality **– HF (229)**	• IHD **Secondary Prevention – Lipids (0075)** • Stroke Anticoagulants, statins, anti-hypertensive • Stroke Outcomes related to rehab (includes functional status) • HF **Medications – Beta - blocker (0083)** • HF ACE/ARB persistence • HF Beta blocker persistence • HF Early identification of decompensated HF

Proposed Cardiovascular Measure Family and Gaps

Recommended measures are **bolded**
Gaps are non-bolded

	Primary Prevention		Acute Phase		Post Acute/Rehab Phase		Secondary Prevention
	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
System	• **Lifestyle Management- Weight/Obesity (0024)** • **Blood Pressure Control (0018)** • Smoking Cessation/ Tobacco Use • Lipid Control/screening • Lifestyle Management – Diet/nutrition • Lifestyle Management – Activity/Exercise • Cardiometabolic risk	• Smoking Cessation/ Tobacco Use	• IHD **Complications (0709)**	• IHD Cardiac imaging composite • IHD Appropriateness for CABG and non-emergent PCI • Stroke **Medications - Thrombolytic (0437)**	• IHD **Complications (0709)** • IHD outcomes related to rehab • Stroke Anticoagulants, statins, anti-hypertensive Stroke obtaining rehab services • HF Functional status • HF ACE/ARB persistence • HF Beta blocker persistence	• IHD **Rehab (0642)** • IHD outcomes related to rehab • Stroke obtaining rehab services • HF Functional status • HF ACE/ARB persistence • HF Beta blocker persistence	• HF ACE/ARB persistence • HF Beta blocker persistence
	• Resource Use (1558)						
Community	• **Smoking Cessation/Tobacco Use (1406, 1651, 1654);** • **Lifestyle Management – Weight/Obesity (0024, 0421)** • **Blood Pressure Control (0018)** • Cardiometabolic risk • Lipid Control • Lifestyle Management –Diet/nutrition • Lifestyle Management – Activity/Exercise		• IHD **Diagnostic – ECG (0289)** • IHD **Procedures – PCI (0163)** • IHD **Procedures – CABG (0696)** • IHD **Medications – Fibrinolysis (0287/ 0288)** • IHD **Cardiac imaging (0669)** • Stroke **Medications -Thrombolytic (0437)** • Mortality **– IHD – CABG (0119)** • Mortality **– IHD CABG/MV (0122)**		• IHD **Avoidable complication (709)** • IHD Outcomes related to rehab • Stroke **Rehab – assessment (0441)** • Stroke Anticoagulants, statins, anti-hypertensive	
	• Resource Use (1558)						

Cardiovascular Family of Measures –Identified Gaps

Following concepts identified as gaps:

- Obtainment of rehab services (stroke)
- Outcomes related to rehab (stroke)
- Long term medication use (stroke)
- Medication persistence (HF)
- Early identification of decompensated HF (HF)
- Functional Status (HF)
- Cardiac imaging composite (Ischemic Heart Disease)
- Appropriateness for CABG and non-emergent PCI (Ischemic Heart Disease)
- Team based care

Proposed Families of Measures Feedback

Following the web meeting, the families of measures will be located on the MAP website.

Provide email feedback by **COB Friday, July 27**

measureapplications@qualityforum.org

MAP Discussion

Opportunity for NQF Member and Public Comment

Uptake of MAP Recommendations: 2012 Federal Proposed Rules

MAP Pre-Rulemaking Input

- MAP provided feedback on measures under consideration by HHS in the MAP Pre-Rulemaking Report released 2/1/2012.
- Uptake of MAP recommendations for the EHR Stage 2 Incentive Program and in the FY 2013 IPPS proposed rule was shared at the previous All MAP web meeting (6/5/12):
  - **EHR Incentive Program –** overall concordance for MAP "Support" and "Do Not Support" recommendations was 74%, despite only a 3-week interval between the MAP report and proposed rule release.
  - **IPPS –** overall concordance was >80% for MAP "Support" and "Do Not Support" recommendations.

MAP Pre-Rulemaking Input

- HHS continues to propose and finalize measures for use in various programs through federal rulemaking, with several new proposed rules issued in early July 2012.
  - All proposed rules pertinent to MAP pre-rulemaking input for 2012 have now been issued.
- Programs in the newly proposed rules related to MAP's feedback in the Pre-Rulemaking Report include:
  - **Ambulatory Surgery Center Quality Reporting**
  - **End-Stage Renal Disease Quality Incentive Program**
  - **Home Health Quality Reporting**
  - **Hospice Quality Reporting**
  - **Hospital Outpatient Quality Reporting**
  - **Inpatient Rehabilitation Facilities Quality Reporting**
  - **Physician Quality Reporting System**

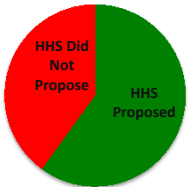
Measures Under Consideration

- HHS provided 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**
- For the remaining four programs, concordance with the proposed rules was assessed for MAP "Support" and "Do Not Support" recommendations for measures on HHS' list of measures under consideration.

Physician Quality Reporting System (PQRS)

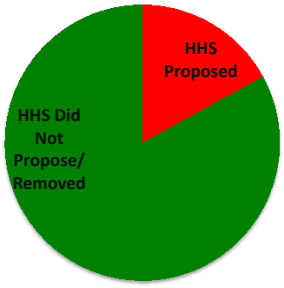
Overall, there was 83% concordance between MAP input and the measures in the HHS proposed rule:

MAP: "Support" (N = 20)



60% concordance between MAP recommendation and HHS proposed rule

MAP: " Do Not Support" or "Remove from measure set" (N = 129)



83% concordance between MAP recommendation and HHS proposed rule

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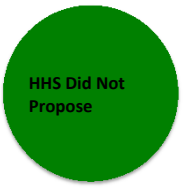
End-Stage Renal Disease Quality Incentive Program

Overall, there was 70% concordance between MAP input and the measures in the HHS proposed rule:

MAP: "Support" (N = 4)

50% concordance between MAP recommendation and HHS proposed rule

MAP: " Do Not Support" (N = 3)



100% concordance between MAP recommendation and HHS proposed rule

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Hospice Quality Reporting

- HHS proposed use of 2 previously finalized measures for the FY 2015 (and subsequent years) payment determination.
- MAP had supported all 6 measures on HHS' list of measures under consideration for addition to the Hospice Quality Reporting Program.
  - These measures were noted in the proposed rule to be "**possible measures**" for future implementation, starting with data collection in 2015.
  - HHS also indicated that work is ongoing to develop and test a standardized data set that could be used to support 5 of these measures.

Inpatient Rehabilitation Facilities (IRF) Quality Reporting

- MAP had supported the direction of all 8 measures on HHS' list of measures under consideration:
  - The measures were felt to address important aspects of care provided in IRFs.
  - However, measures were either lacking specifications, had not been specified/tested in the IRF setting, or were too limited in scope.
  - None of these measures were proposed by HHS.
- Clarification of the MAP "Support Direction" recommendation will be needed in the next review cycle.

Summary

- Overall concordance between HHS' proposed rules and MAP's recommendations on measure use, to date:
  - Meaningful use measures = 74%
  - IPPS measures:
    - Hospital IQR = 76%
    - Hospital VBP = 79%
    - Inpatient Psychiatric Facility Quality Reporting = 100%
    - PPS-Exempt Cancer Hospitals Quality Reporting = 100%
  - PQRS measures = 83%
  - ESRD measures = 70%
- Ongoing assessment of MAP recommendation uptake will continue as HHS issues final rules. Uptake analysis will inform pre-rulemaking activities at the end of 2012.

Summary and Next Steps

Draft MAP Strategic Plan and Proposed Families of Measures Feedback

Following the web meeting, the families of measures will be located on the MAP website.

Provide email feedback by **COB Friday, July 27**

measureapplications@qualityforum.org

Upcoming Meetings