MEASURE APPLICATIONS PARTNERSHIP
AD HOC SAFETY WORKGROUP
Convened by the National Quality Forum

Summary of In-Person Meeting #2

An in-person meeting of the Measure Applications Partnership (MAP) Ad Hoc Safety Workgroup was held on Monday, July 11, and Tuesday, July 12, 2011. For those interested in reviewing an online archive of the web meeting, please click on the link below:

http://www.qualityforum.org/Setting_Priorities/Partnership/Ad_Hoc_Safety_Workgroup.aspx

Workgroup Members in Attendance at the July 11-12, 2011 Meeting:

Frank Opelka, ACS (Chair)	William Kramer, Pacific Business Group on Health
Richard Bankowitz, Premier Inc.	Mitchell Levy [subject matter expert: patient safety]
Andrea Benin, National Association of Children's Hospitals and Related Institutions	Laura Linebach, LA Care Health Plan
John Bott, Agency for Healthcare Research and Quality	MaryAnne Lindeblad [subject matter expert: payer]
Barbara Caress, Building Services 32BJ Health Fund	Leah Marcotte, Office of the National Coordinator for Health Information Technology [substitute for Pamela Cipriano]
Patricia Conway-Morava, American Organization of Nurse Executives	Dolores Mitchell [subject matter expert: state policy]
Suzanne F. Delbanco, Catalyst for Payment Reform	R. Sean Morrison [subject matter expert: palliative care]
Nancy Foster, American Hospital Association (substitute for Richard Umbdenstock)	Chesley Richards, Centers for Disease Control and Prevention
Jane Franke, Blue Cross Blue Shield of Massachusetts	Rhonda Robinson Beale [subject matter expert: mental health]
Elizabeth Gilbertson, Unite Here Health	Richard Salmon, CIGNA
Shaheen Halim, Centers for Medicare & Medicaid Services	Bruce Siegel [subject matter expert: safety net]
Helen Haskell, Mothers Against Medical Error	Ann Marie Sullivan, New York City Health and Hospital Corporation
Aparna Higgins, America's Health Insurance Plans	Kasey Thompson, American Society of Health System Pharmacists
Thomas James, Humana	Cristie Travis, Memphis Business Group on Health
Michael Kelley, Veterans Health Administration	Ronald Walters, Alliance of Dedicated Cancer Centers
Randall Krakauer, Aetna	Mark Xistris, The Alliance (on phone) (substitute for Cheryl DeMars)

This was the second in-person meeting of the Ad Hoc Safety Workgroup. The primary objectives of the meeting were to:

- Consider input from the PAC/LTC Workgroup regarding the public-private payer safety coordination strategy;
- Consider the roles of consumers, purchasers, providers, and communities in the payer safety coordination strategy;
- Review the current NQF-endorsed® safety measures, consider public-private harmonization of measures, and identify measure gaps;
- Discuss the sharing of information by public and private payers and high-leverage uses of that information;
- Discuss design and alignment of incentive structures to reduce HACs and readmissions; and
- Review and finalize report outline and guidance to HHS.

Workgroup Chair, Frank Opelka, began the meeting with a welcome and introductions. Dr. Opelka then reviewed the meeting objectives, summarized the major themes arising from the first meeting of the Safety Workgroup in June, and introduced a draft outline for the final report.

Randall Krakauer from Aetna, who is also a member of the MAP PAC/LTC Workgroup, shared that Workgroup's discussion related to the safety coordination strategy. The following input was received from the PAC/LTC Workgroup:

- Develop person-centered longitudinal care plans that follow the patient across the care continuum, including different levels of care and care settings
- Ensure that patients have the most appropriate post-acute placement at the time of discharge (e.g., rehab vs. skilled nursing vs. home health) and that effective hand-off communication occurs
- Engage hospitalists as facilitators of successful care transitions from the hospital setting
- Encourage effective communication from one setting to the next using binary measures addressing not only the action taken by the "sending" provider, but also the follow up action taken by the "receiving" provider
- Harmonization of measures across settings should account for differences in acuity and risk severity of the patient populations in those settings.
- Collaborative approach across settings to address the issue of accountability for HACs and readmissions
- Address the impact of end of life care on readmissions
- Readmissions are not expected to be zero

The Workgroup raised several key issues during the resulting discussion. The Workgroup emphasized the role of families and caregivers, particularly the need for their involvement in communication and goal-setting. The Workgroup also stressed the need for accountability among all clinicians and providers across the care continuum.

Helen Haskell from Mothers Against Medical Error presented the consumer role in a payer coordination strategy. Ms. Haskell highlighted the consumer's need for extreme transparency, including comprehensive, meaningful, and understandable data on quality and outcomes. She also reported that consumers need a common set of measures across all payers and shared data across providers. She stated that there is a need for increased public awareness of patient safety issues and medical risk as well as the need for assistance, intervention, and investigation when problems occur.

The Workgroup further emphasized the importance of communication and transparency with consumers in their discussion on this topic. Patients need to be involved and informed throughout the care process, including education on the risks they may face and how they can actively participate in their care. The point was raised that clinicians and providers may still be receiving mixed messages around sharing information with patients and caregivers once a safety issue has occurred. Additionally, there is a need to ensure that the education and care recommendations offered to patients do not appear to be methods of denying services, but rather ensuring that patients receive high value, high quality care.

Suzanne Delbanco, Catalyst for Payment Reform, led a discussion on the purchaser role in payer coordination. She reported that purchasers need measures that apply to more than just the Medicare beneficiary population, rather measures that span across all payers are needed. She also discussed the necessity to monitor for potential cost-shifting toward private payers with the implementation of new CMS payment programs. She stated that purchasers can contribute common RFI questions and model contract language that defines purchasers' expectations, signaling to health plans that patient safety and alignment of payment incentives is important.

The Workgroup discussion focused on reiterating the need for a single set of safety measures, applicable to all life stages that can be used by consumers, purchasers, and providers, as well as the need for all-payer data. The importance of safety measurement and public reporting at both the national and local level was stressed by the Workgroup. It was suggested that the federal government has a role in the determination of the single list of measures and that a national strategy for implementation is needed.

Nancy Foster, American Hospital Association, presented the provider role in a payer coordination strategy. She emphasized that providers need to be a partner in improvement strategies. She stated that allowances should be made for development of evidence-based practices for improvement where none currently exist and necessary differences in approaches to improvement should be recognized. She reported that providers are able to identify opportunities to improve care and drive out unnecessary cost as well as identify payment strategies that could get in the way of doing the right thing for patients. She stated that providers can contribute the context and information to turn data into action.

The resulting Workgroup discussion raised several issues. The Workgroup considered how measurement strategies should address care in every setting to promote joint accountability as well as focus on outcome measures. The Workgroup felt that issues such as outliers, palliative care, and risk adjustment should be agreed upon when determining a core set of measures. Additionally, the Workgroup felt that payment policies should be carefully considered to prevent creating a situation where resources are taken from safety net hospitals.

Diane Stollenwerk, Vice President Community Alliances, NQF, presented the community role in a payer coordination strategy in Lance Robert's absence. She reported that communities need public information, national standardization, and data sets that include uninsured patients. She stated that communities are able to play a convener/broker role and have the ability to engage leadership and share information to facilitate continued improvement.

The Workgroup discussion stressed the idea that communities need to play the role of convener and that key stakeholders need to be involved. The Workgroup emphasized the need to have a strong catalyst leader to make change happen at the community level. The discussion also focused on the importance of transparency around both the process and methodology used for reporting of safety measures and how to present the information to get all providers to improve. The Workgroup considered that some smaller communities do not have much choice regarding healthcare providers; therefore, when publicly reporting lower scores on safety measures, the information should be presented in a way that does not raise unnecessary concern among the members of the community.

Andrew Hackbarth from CMS gave a presentation about HHS' Partnership for Patients initiative, focusing on the ways plans, purchasers, employers, and associations can connect with the Partnership. Mr. Hackbarth also reviewed the solicitation for hospital engagement contracts and community-based care transition grants.

The Workgroup raised several concerns with the Partnership for Patients measurement approach. The Workgroup felt this approach might foster the development of homegrown measures and make it difficult to aggregate or compare data. The Workgroup felt that there should be a standardized set of measures that could be balanced with the need to support innovation at the local level.

Heidi Bossley, Vice President, Performance Measure, NQF, gave a presentation on NQF's work in patient safety measurement. She shared that NQF has over 100 endorsed measures related to patient safety and that NQF will be conducting a future safety project that involves bundling serious reportable events (SREs), safe practices, and endorsed measures in a type of toolkit. The Workgroup discussions centered on the need for common, understandable measures, including balancing measures. The Workgroup also stressed the need to include behavioral health measures surrounding HACs and readmissions.

The first day concluded with Frank Opelka and Lindsay Lang providing a summary of the day's themes and an overview of the second day's activities and points of discussion. It was requested that the Workgroup members give further consideration to the draft report outline during the evening as well.

On the second day, Frank Opelka opened the meeting with welcoming remarks and a recap of the first day, touching on the overarching themes that emerged in discussions.

The first topic of the day was Information Sharing and Use. It began with Chesley Richards reporting on the CDC's work on Healthcare-Associated Infection (HAI) reporting. In this presentation, Dr. Richards outlined the National Healthcare Safety Network (NHSN) and the systems used to report HAIs using the NHSN. Dr. Richards discussed the goal of moving from paper to electronic systems of HAI detection and reporting.

Irene Fraser, AHRQ, led a discussion on the Healthcare Cost and Utilization Project (HCUP) and statewide data organizations that measure and report on HACs and readmissions. She reviewed the use of hospital billing data for reporting on HACs and readmissions and the AHRQ quality indicators. She also discussed AHRQ's work in partnering with states to create the capacity to track readmissions.

The resulting conversation among Workgroup members raised a number of issues including the challenges to making data available, the need to audit the data, and measure gaps. There was discussion surrounding an all-payer database versus a federated data model. A desire for integrated data across populations, including both public and private payers was noted. Dr. Fraser responded that state laws and funding are often obstacles to making data available in additional states. Workgroup members also discussed the need for real-time data.

Thomas James from Humana shared Humana's role in the Wisconsin Health Information Exchange (WHIO). He gave an overview of the WHIO and the data contributors. Dr. James discussed the health plan's role as a builder of relationships, as well as a provider and interpreter of data. He discussed the health plans' ability to provide actuarial support as well as open up communication channels.

Mark Xistris from The Alliance also presented on the WHIO. He discussed lessons learned through implementation and reviewed the WHIO data and its applications. He shared how the WHIO has been able to build relationships and trust regarding how the data is going to be used and shared. He also discussed the need to have a strong partnership with a medical society and a physician champion in order to be successful.

Randall Krakauer from Aetna gave a presentation on how payers can share data for clinical decision support and quality improvement. He discussed the use of a "care engine" and how payers can review data to alert providers to potential problems as well as how payers have the ability to review data to help determine the cause of readmissions.

After lunch, there was a series of presentations on incentive structures. The first presentation was by Cristie Upshaw Travis from the Memphis Business Group on Health. She discussed how employers want to motivate employees to use high value services. She discussed that system-level reporting is not meaningful to employees since there can be big differences in quality between individual hospitals within a system. She discussed the idea that purchasers can create incentives through their contracts with health plans. She also stated the need for transparency around payment for consumers, as well as for employers and providers. She also talked about the need for ways to determine if incentive models are having their desired effects in improving care.

Jane Franke, BCBS of Massachusetts, discussed various incentive structure models and reviewed quality measures used to develop the network tiers. She reviewed global payments with quality bonuses, tiered networks, and member engagement. She stated that the BCBS work points to the need for a common set of core measures.

Richard Salmon from Cigna gave a presentation on evaluating and rewarding hospitals for improving quality and safety. He supported the notion of nationally standardized measures and data collection, and discussed potential uses for the data when working with the delivery system. He stated that with standardized measures and reporting, payers will need to compete on customer service and engagement. He also stated that customer choice is the biggest lever for improving hospital performance.

The resulting discussion among Workgroup members raised a number of issues. The group discussed the need for measures that demonstrate variation in quality and cost, not just measures that are convenient to collect. The Workgroup also discussed issues arising from having different incentives. The Workgroup also had questions on the tension between national plans and local customization and how to motivate payers to make changes in different markets, especially in communities where payers have exclusive contracts with specific providers that prevent competition or choice. The Workgroup again raised the issue of keeping measures simple for both providers and consumers to understand.

The Workgroup then reviewed draft advice to the Coordinating Committee. The Workgroup stressed the need to keep the patient at the center of its recommendations. The Workgroup recommended selecting a single set of measures, as well as collecting all patient data rather than all payer data.

The Workgroup then gave feedback on the draft report outline. The group expressed a desire to talk about the ideal and then delve into the input for payers. The group also felt information and data sharing should have its own part of the report.

Following the discussion regarding the draft report, Frank Opelka thanked everyone for their time and participation and adjourned the meeting.