NATIONAL QUALITY FORUM

Agenda

MAP Population Health Task Force
In-Person Meeting
April 9, 2014

Participant Instructions:

Streaming Audio Online

- Direct your web browser to: http://nqf.commpartners.com
- Under "Enter a Meeting" type in the meeting number **304267**
- In the "Display Name" field, type in your first and last name and click "Enter Meeting"

Teleconference

- Committee Member/Speakers: Dial **1-888-802-7237** and use code **11833597**.
- Public: Dial **1-877-303-9138** and use code **11833597**.

If you need technical assistance, you may press *0 to alert an operator or send an email to nqf@commpartners.com.

Meeting Objectives:

- Discuss potential use cases for the MAP Population Health Family of Measures
- Finalize overarching priorities for measure selection
- Choose measures and identify high-priority gaps for the family

8:30 am **Breakfast**
Provided for Population Health Task Force members

9:00 am **Introductions and Review of Meeting Objectives**
Bobbie Berkowitz, Chair

9:15 am **NQF Strategic Direction**
Christine Cassel, President and CEO, NQF

9:30 am **Population Health Projects across NQF**
Karen Adams, Vice President, NQF
Elisa Munthali, Managing Director, NQF

10:00 am **Finalize Overarching Priorities and Discuss Use Cases for Measures**
Bobbie Berkowitz, Chair
Allen Leavens, Senior Director, NQF

10:45 am **Break**

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11:00 am	**Measure Selection: Determinants of Health** *Task Force Discussion*
12:30 pm	**Lunch**
1:00 pm	**Measure Selection: Health Outcomes** *Task Force Discussion*
2:30 pm	**Break**
2:45 pm	**Measure Selection: Health Improvement Activities** *Task Force Discussion*
4:00pm	**Summarize Measure Gaps for the Population Health Family** *Task Force Discussion*
4:45 pm	**Public Comment**
5:00 pm	**Wrap Up and Next Steps** *Bobbie Berkowitz, Chair* *Rachel Weissburg, Project Manager, NQF*

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Population Health Task Force

NATIONAL QUALITY FORUM

In-Person Meeting
April 9, 2014

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Meeting Objectives & Overview

Bobbie Berkowitz, Task Force Chair
Allen Leavens, Senior Director, NQF

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Meeting Objectives

- Discuss potential use cases for the MAP Population Health Family of Measures
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Statutory Authority

Health reform legislation, the Affordable Care Act (ACA), requires HHS to contract with the consensus-based entity (i.e., NQF) to **"convene multi-stakeholder groups to provide input on the selection of quality measures" for public reporting, payment, and other programs.**

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)

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National Quality Strategy

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NQS Priority: Working with communities to promote wide use of practices to enable healthy living

Long-term goals for working with communities:

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

MEASURE FOCUS	KEY MEASURE NAME/DESCRIPTION	CURRENT RATE
Depression	Percentage of adults reported symptoms of a major depressive episode (MDE) in the last 12 months who received treatment for depression in the last 12 months	68.3%*
Obesity	Proportion of adults who are obese	35.7%**

*Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies, National Survey on Drug Use and Health, 2010.
** Source: Centers for Disease Control and Prevention, National Health and Nutrition Examination Survey (NHANES), 2010.

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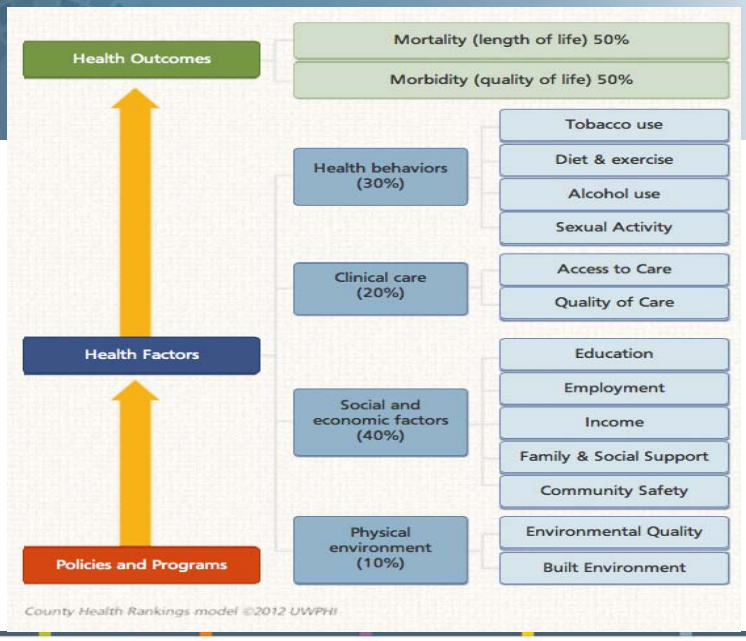

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NQF Strategic Direction

Christine Cassel, President and CEO, NQF

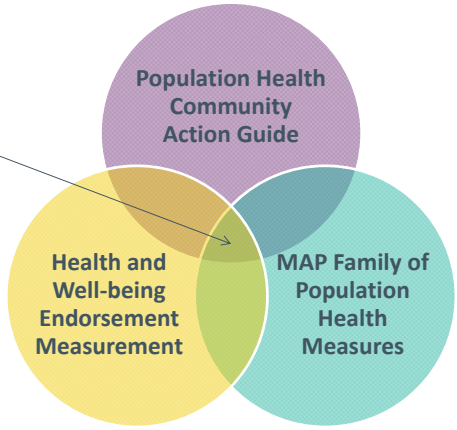
Population Health Projects Across NQF

Karen Adams, Vice President, NQF

Elisa Munthali, Managing Director, NQF

NQF's Current Work on Population Health

- Aligned with NQS' Three-Part Aim
- Focus beyond medical model – increased emphasis on determinants of health and improvement activities
- Address measurement, measure gaps, methodological and other challenges of population health measure development
- Opportunity to leverage population health activities and to exchange ideas between committees



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Population Health Action Guide: Ten Key Elements

1. A self-assessment about readiness to engage in this work
2. Leadership across the region and within organizations
3. An organizational planning and priority-setting process
4. A community health needs assessment and asset mapping process
5. An agreed-upon, prioritized set of health improvement activities
6. Selection and use of measures and performance targets
7. Audience-specific strategic communication
8. Joint reporting on progress toward achieving intended results
9. Indications of scalability
10. A plan for sustainability

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Finalize Overarching Priorities & Discuss Use Cases for Measures

Bobbie Berkowitz, Task Force Chair

Allen Leavens, Senior Director, NQF

Priorities for Population Health Measurement

- In a previous NQF-commissioned environmental scan on approaches to measuring population health*, various strategies were identified for prioritization, such as:
  - Based on demographics (race/ethnicity, age, etc.)
  - By disease category
  - Through determinants of health
- The concept of *preventable burden* can provide guidance
- Examples of approaches mentioned include **3FOUR50**, using the leading causes of death, and community health needs assessment

*http://www.qualityforum.org/Publications/2012/06/An_Environmental_Scan_of_Integrated_Approaches_for_Defining_and_Measuring_Total_Population_Health.aspx

Results of Homework Exercise

- 16 task force members submitted "votes", each choosing between 10 – 48 (median=21) measures and indicators
- Measurement topics with >50% of respondent votes:
  - Childhood immunization
  - Blood pressure control
  - Diabetes control
  - Smoking prevalence
  - Obesity prevalence
  - Colorectal cancer screening
  - Early childhood development screening

Potential Use Cases

- In order to further assist with defining scope, discussing use cases of how the family might be applied may help facilitate prioritization of measures selected for inclusion
- While MAP has used measure families primarily to help guide recommendations on measures for pre-rulemaking up to this point, broader applications could highlight a need for different types of measures

Potential Use Cases: Pre-Rulemaking

Recommendations for Measure Use in Federal Programs for Healthcare Providers

- Types of measures that may be most applicable:
  - Assessment of processes and outcomes related to behaviors amenable to counseling, such as smoking cessation, exercise, and diet
  - Delivery of preventive services to patients, such as cancer screening
  - Monitoring access to quality healthcare

Potential Use Cases – Accountable Care Organizations

- **Accountable Care Organizations (ACOs)** are characterized by a care delivery model and value-based payment system that rely on performance measures applied to a broad population of patients
- Besides traditional measures of healthcare, opportunities exist to focus more on measures that are meaningful to all stakeholders, including health outcomes pertaining to functional health and health risk, such as:*
  - Activities of daily living
  - Mental health assessments
  - Fatigue and pain scores
  - Health risk determinations based on biometric data and lifestyle behaviors

* http://healthaffairs.org/blog/2013/05/09/a-framework-for-accountable-care-measures/

Potential Use Cases – Community Health Needs Assessment (CHNA)

Provisions in the Affordable Care Act require tax-exempt hospitals to:

- Conduct a CHNA at least one every 3 years
- Incorporate input from persons who represent the broad interests of the community, as well as individuals with knowledge or expertise in public health
- Make results of the CHNA publically available
- **Adopt an implementation strategy to meet community needs** identified in the CHNA, and describe any needs that are not being addressed along with the reasons

Potential Use Cases - Community Health Needs Assessment (CHNA)

Measures used for a CHNA might include:

- Key health outcomes not restricted to subpopulations served in healthcare settings
- Linkages between the healthcare delivery system and social services
- Assessing broader determinants of health, such as social and economic conditions for a population

Discussion Questions

- Which use case(s) is/are most desirable for applying the Population Health Family of Measures?
- What are the highest priorities for measure selection to pursue, given the intended "populations" and measures available?
- How should different types of measures be chosen to achieve the right mix?

Measure Selection: Determinants of Health

Bobbie Berkowitz, Task Force Chair

Measure for Determinants of Health

Top vote-getting measures/indicators:

- Adult Current Smoking Prevalence (NQF#2020)
- Adolescents who smoked cigarettes in the past 30 days (TU-2.2)
- Adults who are current cigarette smokers (TU-1.1)
- Adolescents (12-17 years old) using alcohol or any illicit drugs during the past 30 days (SA-13.1)
- Children Age 6-17 Years who Engage in Weekly Physical Activity (NQF#1348)
- Children Who Receive Effective Care Coordination of Healthcare Services When Needed (NQF#0719)
- Persons with medical insurance (AHS-1.1)

Measure Selection:
Health Outcomes

Bobbie Berkowitz, Task Force Chair

Measure for Health Outcomes

Top vote-getting measures/indicators:

- Adults with hypertension whose blood pressure is under control (HDS-12)
  - Controlling High Blood Pressure (NQF#0018)*
- Adult diabetic population with an [hemoglobin] A1c value greater than 9 percent (D-5.1)
  - Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (NQF#0059)*
- Adults who are obese (NWS-9)
- Children and adolescents who are considered obese (NWS-10.4)
- Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI) (NQF#1349)
- Asthma Admission Rate (pediatric) (NQF#0728)
- Low Birth Weight Rate (PQI 9) (NQF#0278)
- Suicides (MHMD-1)
- Number of School Days Children Miss Due to Illness (NQF#0717)

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Measure Selection:
Health Improvement Activities

Bobbie Berkowitz, Task Force Chair

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Measure for Health Improvement Activities

Top vote-getting measures/indicators:

- Childhood Immunization Status (NQF#0038)
- Immunizations by 13 years of age (NQF#1407)
- Children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines (IID-8)
- Adults who receive a colorectal cancer screening based on the most recent guidelines (C-16)
- Colorectal Cancer Screening (NQF#0034)
- Developmental Screening in the First Three Years of Life (NQF#1448)
- Frequency of Ongoing Prenatal Care (FPC) (NQF#1391)
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up (NQF#0421)

Identify Measure Gaps in the Population Health Family

Bobbie Berkowitz, Task Force Chair

Possible Measure Gaps

Early feedback from taskforce members on potential gap areas:

- Social determinants of health, such as early childhood education and poverty
- Measures of population health for the elderly
- HIV incidence
- Smoke-free laws
- Breastfeeding
- Motor vehicle injuries
- Teen pregnancy
- Mental health
- Measures related to disability, particularly co-occurring disabilities
- Special health care needs

Discussion

- **Which high-priority topics are not addressed by currently available measures or indicators?**
- **How should concepts that are not yet fully-developed measures be represented in the family?**

Public Comment

Wrap Up & Next Steps

Rachel Weissburg, Project Manager, NQF

Next Steps

- Draft Report: June 1, 2014
- MAP Coordinating Committee review and public comment: June 2014
- Final Report: July 1, 2014

Adjourn

Bobbie Berkowitz, Chair

MAP Population Health Family of Measures – Use Cases

In order to help guide the selection of measures for the Population Health Family of Measures, three use cases have been developed to describe potential applications:

1) **Recommendations for measure use in federal programs for healthcare providers** – MAP provides input on measures under consideration (MUC) for approximately 20 CMS clinical quality programs. These programs are generally more focused on healthcare providers and settings, such as the Physician Quality Reporting System and Hospital Value-Based Purchasing. However, even within these programs there is a need to support the National Quality Strategy aim of healthy people and healthy communities. As such, the Population Health Family of Measures can be useful during pre-rulemaking as a reliable source of measures that emphasize prevention, health, and well-being. For example, measures may focus on:
    a. Assessment of processes and outcomes related to behavioral determinants of health, such as counseling and rates for smoking cessation, exercise, and healthy diet
    b. Delivery of preventive services to patients, such as cancer screenings
    c. Monitoring access to quality healthcare

2) **Measure use by Accountable Care Organizations (ACOs)** – While MAP also provides input on measures for the Medicare Shared Savings Program, there is potential for the Population Health Family of Measures to be useful more broadly for ACOs and related models. These systems generally seek to create a more collaborative and comprehensive way to provide care for a subpopulation of individuals. Some measures may address topics like counseling by clinicians and preventive clinical services as in the examples above for federal programs, but there has also been an indication that more measures are needed on topics such as:
    a. Functional status of physical and mental health for broad populations
    b. Health risk based on biometric data, behavioral assessment, etc.
    c. Effective coordination of health services across diverse settings

3) **Measures used for Community Health Needs Assessment (CHNA)** – Based on provisions in the Affordable Care Act, nonprofit hospitals need to perform a CHNA at least once every three years as a condition to maintain their federal tax-exempt status. A key component of the CHNA is the ability to produce measureable results that can be used for continuing community improvement efforts. Establishing some recommended population health measures that may apply widely for CHNA in different communities could be an effective way to promote alignment, providing a mechanism to help prioritize key measurement issues as well as make it easier to compare results across a variety of locations. Examples of potential measure topics might include:
    a. Key health outcomes not restricted to subpopulations served in healthcare settings
    b. Linkages between the healthcare delivery system and social services
    c. Assessing foundational determinants of health, such as social and economic conditions for a population