NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

Safety and Care Coordination Task Force
In-Person Meeting #2

National Quality Forum Conference Center
1030 15th Street NW, 9th Floor, Washington, DC 20005

Dial-In: 1-877-303-9138 (press *0 for operator assistance)
Passcode for July 18: 90930555
Passcode for July 19: 90936624
Web-Streaming: http://nqf.commpartners.com
In the "Enter a Meeting" box, type this code for July 18: **755475**
In the "Enter a Meeting" box, type this code for July 19: **324096**

DAY 1 AGENDA: JULY 18, 2012

Meeting Objectives:

- *Review outcomes of safety survey exercise and measures for additional topic areas;*
- *Consider priority areas for aligning care coordination performance measurement across public and private programs;*
- *Discuss shared accountability and identify implementation issues related to use of care coordination/readmission measures across programs and settings;*
- *Establish a care coordination family of measures; and*
- *Create a measure development and implementation pathway to fill care coordination gaps.*

8:30 am **Breakfast**

9:00 am **Welcome and Review of Meeting Objectives**
Frank Opelka, Task Force Chair

9:15 am **Safety Measure Family Follow-Up**
- Safety measure family survey results
- Safety measures related to sepsis and pain

10:30 am **Break**

10:45 am **Aligning Care Coordination Measurement**
- National Quality Strategy (NQS) goals and targets for care coordination
- NQF endorsement work related to care coordination
- High-leverage opportunities for improving care coordination

11:45 am **Public Comment**

12:00 pm **Lunch**

NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

12:30 pm **Shared Accountability: Avoidable Admissions and Readmissions**
- NPP's (Re)admissions Action Team work
- Multi-stakeholder roles and perspectives on avoidable admissions and readmissions

2:15 pm **Break**

2:30 pm **Avoidable Admissions and Readmissions Measures**
- Step 1: Review available measures
- Step 2: Determine measures to be included in the care coordination family
- Step 3: Identify measure gaps

4:00 pm **System and Infrastructure Support Measures**
- Same steps as above

4:40 pm **Patient Surveys Addressing Care Coordination**
- Patient experience surveys addressing aspects of care coordination

5:20 pm **Public Comment**

5:30 pm **Summary of Day 1 and Adjourn**

NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

Safety and Care Coordination Task Force
In-Person Meeting #2

DAY 2 AGENDA: JULY 19, 2012

8:00 am **Breakfast**

8:30 am **Welcome and Recap of Day 1**

9:00 am **Care Transitions**
- Step 1: Review available measures
- Step 2: Determine measures to be included in the safety family
- Step 3: Identify measure gaps

10:15 am **Break**

10:30 am **Communication**
- Same steps as above

11:45 am **Public Comment**

12:00 pm **Lunch**

12:30 pm **Care Planning**
- Same steps as above

1:30 pm **Care Coordination Measure Gaps and Gap-Filling Pathway**
Erin Giovannetti, National Committee for Quality Assurance (NCQA)
Kevin Larsen, Office of the National Coordinator (ONC)
- Care coordination measure gap areas identified by task force
- Barriers to development of measures to fill gaps
- Tactics for overcoming barriers
- Pathway for measure development and implementation

2:40 pm **Public Comment**

2:50 pm **Summary of the Meeting and Next Steps**

3:00 pm **Adjourn**

NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

Safety and Care Coordination Task Force
July 2012 Meeting Discussion Guide

Meeting Objectives:

- Review outcomes of safety survey exercise and measures for additional topic areas;
- Consider priority areas for aligning care coordination performance measurement across public and private programs;
- Discuss shared accountability and identify implementation issues related to use of care coordination/readmission measures across programs and settings;
- Establish a care coordination family of measures; and
- Create a measure development and implementation pathway to fill care coordination gaps.

DAY 1 – July 18

For each of the care coordination topic areas, the task force will follow the steps outlined below:

- Step 1: Review available measures
- Step 2: Determine measures to be included in the safety family
- Step 3: Identify measure gaps

Safety Measure Family Follow-Up [9:15 am – 10:30 am]

Safety Topic Area	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Pain	0050 Endorsed	Osteoarthritis: Function and Pain Assessment	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)	Type of score: Proportion Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis with assessment for function and pain	Clinician Office/Clinic	Clinician: Group/ Practice, Clinician: Individual	Process	Senior Care
Pain	0177 Endorsement Maintenance	Improvement in pain interfering with activity	Centers for Medicare and Medicaid Services	Percentage of home health episodes of care during which the frequency of the patient´s pain when moving around improved.	Home Health	Facility	Outcome	
Pain	0342 Endorsement Maintenance	PICU Periodic Pain Assessment	National Association of Children's Hospitals and Related Institutions	Percentage of PICU patients receiving: a. Pain assessment on admission, b. Periodic pain assessment.	Hospital/Acute Care Facility	Facility	Process	Children's Health
Pain	0420 Endorsed	Pain Assessment Prior to Initiation of Patient Therapy	Centers for Medicare and Medicaid Services	Percentage of patients with documentation of a pain assessment (if pain is present, including location, intensity and description) through discussion with the patient including the use of a standardized tool on each initial evaluation prior to initiation of therapy and documentation of a follow up plan.	Clinician Office/Clinic, Other	Clinician: Individual	Process	
Pain	0524 Time-Limited Endorsed	Pain Interventions Implemented	Centers for Medicare and Medicaid Services	Percent of patients with pain for whom steps to monitor and mitigate pain were implemented during their episode of care	Home Health	Facility, Other	Process	

Safety Topic Area	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Pain	1617 Endorsement Maintenance	Patients Treated with an Opioid who are Given a Bowel Regimen	RAND Corporation	Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed	Clinician Office/Clinic, Hospital/ Acute Care Facility	Facility, Clinician: Group/ Practice, Health Plan, Clinician: Individual	Process	Senior Care
Sepsis (Not previously selected by task force)	0304 Endorsed	Late sepsis or meningitis in Very Low Birth Weight (VLBW) neonates (risk-adjusted)	Vermont Oxford Network	Standardized rate and standardized morbidity ratio for nosocomial bacterial infection after day 3 of life for very low birth weight infants, including infants with birth weights between 401 and 1500 grams and infants whose gestational age is between 22 and 29 weeks.	Hospital/ Acute Care Facility	Facility	Outcome	Children's Health
Sepsis (Previously selected by task force)	0351 Endorsed	Death among surgical inpatients with serious, treatable complications (PSI 4)	Agency for Healthcare Research and Quality	Percentage of cases having developed specified complications of care with an in-hospital death.	Hospital/ Acute Care Facility	Facility	Outcome	Adult
Sepsis	0500 Endorsed	Severe Sepsis and Septic Shock: Management Bundle	Henry Ford Hospital	Initial steps in the management of the patient presenting with infection (severe sepsis or septic shock)	Hospital/ Acute Care Facility	Individual	Composite	

Avoidable Admissions and Readmissions Measures [2:30 pm – 4:00 pm]

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Avoidable admissions	0171 Endorsement Maintenance	Acute care hospitalization (risk-adjusted)	Centers for Medicare and Medicaid Services	Percentage of patients who had to be admitted to the hospital	Home Health	Facility, Other	Outcome	
Avoidable admissions	0173 Endorsement Maintenance	Emergent care (risk adjusted)	Centers for Medicare and Medicaid Services	Percentage of patients who had to use a hospital emergency department	Home Health	Facility	Outcome	
Avoidable admissions	0265 Endorsed	Hospital Transfer/Admission	ASC Quality Collaboration	Rate of ASC admissions requiring a hospital transfer or hospital admission upon discharge from the ASC	Ambulatory Surgery Center (ASC)	Facility	Outcome	Adult
Avoidable admissions	0277 Endorsed	Congestive Heart Failure Admission Rate (PQI 8)	Agency for Healthcare Research and Quality	Percent of county population with an admission for CHF.	Clinician Office/Clinic	County or City, State	Outcome	Adult
Avoidable admissions	0281 Endorsed	Urinary Tract Infection Admission Rate (PQI 12)	Agency for Healthcare Research and Quality	The number of discharges for urinary tract infection per 100,000 population Age 18 Years and Older in a Metro Area or county in a one year time period.	Hospital/ Acute Care Facility	County or City, State	Outcome	Adult/Elderly Care

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Avoidable admissions (CV/Diabetes Task Force did not select)	0272 Endorsement Maintenance	Diabetes Short-Term Complications Admission Rate (PQI 1)	Agency for Healthcare Research and Quality	The number of discharges for diabetes short-term complications per 100,000 Age 18 Years and Older population in a Metro Area or county in a one year period.	Hospital/ Acute Care Facility	County or City, State	Outcome	Adult/Elderly Care
Avoidable admissions (CV/Diabetes Task Force did not select)	0274 Endorsement Maintenance	Diabetes Long-Term Complications Admission Rate (PQI 3)	Agency for Healthcare Research and Quality	The number of discharges for long-term diabetes complications per 100,000 population Age 18 Years and Older in a Metro Area or county in a one year time period.	Hospital/ Acute Care Facility	County or City, State	Outcome	Adult/Elderly Care
Avoidable admissions (CV/Diabetes Task Force did not select)	0638 Endorsement Maintenance	Uncontrolled Diabetes Admission Rate (PQI 14)	Agency for Healthcare Research and Quality	The number of discharges for uncontrolled diabetes per 100,000 population Age 18 Years and Older in a Metro Area or county in a one year time period.	Hospital/ Acute Care Facility	County or City, State	Outcome	Adult/Elderly Care
Avoidable admissions	1381 Endorsed	Asthma Emergency Department Visits	Alabama Medicaid Agency	Percentage of patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period.	Hospital/ Acute Care Facility	County or City, Health Plan	Outcome	Children's Health

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Avoidable readmissions	0330 Endorsed	Hospital 30-day, all-cause, risk-standardized readmission rate following heart failure hospitalization for patients 18 and older	Centers for Medicare and Medicaid Services	The measure estimates a hospital 30-day risk-standardized readmission rate (RSRR), defined as readmission for any cause within 30 days after the date of discharge of the index admission for patients 18 and older discharged from the hospital with a principal diagnosis of heart failure (HF).	Hospital/ Acute Care Facility	Facility	Outcome	Adult
Avoidable readmissions	0505 Endorsed	Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization.	Centers for Medicare and Medicaid Services	The measure estimates a hospital 30-day risk-standardized readmission rate (RSRR). Readmission is defined as readmission for any cause within 30 days after the date of discharge of the index admission, excluding planned readmissions, for patients discharged from the hospital with a principal diagnosis of acute myocardial infarction (AMI). The target population is patients 18 and over. CMS annually reports the measure for patients who are 65 years or older and are either enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals or are hospitalized in Veterans Health Administration (VA) facilities. Since NQF-endorsement, the measure has been tested and shown to perform well in an all-payer population aged 18 and older and has been re-specified for this broader age group.	Hospital/ Acute Care Facility	Facility	Outcome	Senior Care

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Avoidable readmissions	0506 Endorsement Maintenance	Thirty-day all-cause risk standardized readmission rate following pneumonia hospitalization.	Centers for Medicare and Medicaid Services	Hospital-specific 30-day all-cause risk standardized readmission rate following hospitalization for pneumonia among Medicare beneficiaries aged 65 years or older at the time of index hospitalization	Hospital/ Acute Care Facility	Facility	Outcome	
Avoidable readmissions	0695 Endorsed	Hospital 30-Day Risk-Standardized Readmission Rates following Percutaneous Coronary Intervention (PCI)	Centers for Medicare and Medicaid Services	This measure estimates hospital risk-standardized 30-day readmission rates following PCI in patients at least 65 years of age. As PCI patients may be readmitted electively for staged revascularization procedures, we will exclude such elective readmissions from the measure. The measure uses clinical data available in the National Cardiovascular Disease Registry (NCDR) CathPCI Registry for risk adjustment that has been linked with the administrative claims data used to identify readmissions.	Hospital/ Acute Care Facility, Urgent Care	Facility, Population: National	Outcome	Adult (65 years or older)
Avoidable readmissions	0704 Endorsement Maintenance	Proportion of Patients Hospitalized with AMI that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	Bridges to Excellence	Percent of adult population aged 18 – 65 years who were admitted to a hospital with acute myocardial infarction (AMI), were followed for one-month after discharge, and had one or more potentially avoidable complications (PACs). PACs may occur during the index stay or during the 30-day post discharge period.	Hospital/ Acute Care Facility	County or City, Facility, Health Plan, National, Regional, State	Outcome	Adult/Elderly Care

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Avoidable readmissions	0705 Endorsement Maintenance	Proportion of Patients Hospitalized with Stroke that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	Bridges to Excellence	Percent of adult population aged 18 – 65 years who were admitted to a hospital with stroke, were followed for one-month after discharge, and had one or more potentially avoidable complications (PACs). PACs may occur during the index stay or during the 30-day post discharge period.	Hospital/ Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, National, Regional, State	Outcome	Adult (18-65)
Avoidable readmissions	0708 Endorsement Maintenance	Proportion of Patients Hospitalized with Pneumonia that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	Bridges To Excellence	Percent of adult population aged 18 – 65 years who were admitted to a hospital with Pneumonia, were followed for one-month after discharge, and had one or more potentially avoidable complications (PACs). PACs may occur during the index stay or during the 30-day post discharge period.	Hospital/ Acute Care Facility	County or City, Facility, Health Plan, National, Regional, State	Outcome	Adult/Elderly Care

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Avoidable readmissions	0709 Endorsement Maintenance	Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year.	Bridges To Excellence	Percent of adult population aged 18 – 65 years who were identified as having at least one of the following six chronic conditions: Diabetes Mellitus (DM), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Hypertension (HTN), Chronic Obstructive Pulmonary Disease (COPD) or Asthma, were followed for one-year, and had one or more potentially avoidable complications (PACs). A Potentially Avoidable Complication is any event that negatively impacts the patient and is potentially controllable by the physicians and hospitals that manage and co-manage the patient. Generally, any hospitalization related to the patient's core chronic condition or any co-morbidity is considered a potentially avoidable complication, unless that hospitalization is considered to be a typical service for a patient with that condition. Additional PACs that can occur during the calendar year include those related to emergency room visits, as well as other professional or ancillary services tied to a potentially avoidable complication.	Clinician Office/Clinic, Other	County or City, Group/Practice, Health Plan, National, Regional, State	Outcome	Adult/Elderly Care
Avoidable readmissions	1551 Endorsed	Hospital-level 30-day all-cause risk-standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA)	Centers for Medicare and Medicaid Services	This measure estimates hospital 30-day RSRRs following elective primary THA and TKA in patients 65 years and older. The measure uses Medicare claims data to develop a hospital-level RSRR for THA and TKA and will include patients readmitted for any reason within 30 days of discharge date of the index admission. Some patients are admitted within 30 days of the index hospitalization to undergo another elective THA/TKA procedure. These are considered planned readmissions and are NOT counted in the measure as readmissions.	Hospital/ Acute Care Facility	Facility	Outcome	Adult (65 years or older)

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Avoidable readmissions	1768 Endorsed	Plan All-Cause Readmissions	National Committee for Quality Assurance	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/Denominator) 5. Total Variance Note: For commercial, only members 18–64 years of age are collected and reported; for Medicare, only members 18 and older are collected, and only members 65 and older are reported.	Hospital/ Acute Care Facility, Inpatient	Health Plan	Outcome	Adult
Avoidable readmissions	1789 Endorsement Maintenance	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Centers for Medicare and Medicaid Services	This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): surgery/gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. We developed the measure for patients 65 years and older using Medicare fee-for-service (FFS) claims and subsequently tested and specified the measure for patients aged 18 years and older using all-payer data. We used the California Patient Discharge Data (CPDD), a large database of patient hospital admissions, for our all-payer data.	Hospital/ Acute Care Facility	Facility	Outcome	Senior Care

System and Infrastructure Support Measures [4:00 – 4:40 pm]

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
HIT	0489 Time-Limited Endorsed	The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data Elements	Centers for Medicare and Medicaid Services	Documents the extent to which a provider uses certified/qualified electronic health record (EHR) system that incorporates an electronic data interchange with one or more laboratories allowing for direct electronic transmission of laboratory data into the EHR as discrete searchable data elements.	Clinician Office/Clinic, Other	Clinician: Group/ Practice, Clinician: Individual	Structure	
Medical Home	0494 Endorsement Maintenance	Medical Home System Survey	National Committee for Quality Assurance	Percentage of practices functioning as a patient-centered medical home by providing on-going, coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with: a. Improved access and communication b. Care management using evidence-based guidelines c. Patient tracking and registry functions d. Support for patient self-management e. Test and referral tracking f. Practice performance and improvement functions	Clinician Office/Clinic, Other	Facility, Clinician: Group/ Practice	Structure	Children's Health

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Medical Home	0724 Endorsement Maintenance	Measure of Medical Home for Children and Adolescents	Child and Adolescent Health Measurement Initiative on behalf of the Maternal and Child Health Bureau	This composite measure assesses whether or not children and adolescents (age 0-17 years) receive health care within a medical home according to the survey respondent (almost always the child's parent). The medical home measure is based on six of the seven components of care first proposed by the American Academy of Pediatrics (AAP)—health care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. (Note: "accessible" is the one component of medical home that is not directly addressed in this composite measure. This will be explained in a later section) The AAP policy statement emphasizes that a medical home is "not a building, house, or hospital, but rather an approach to providing continuous and comprehensive primary pediatric care from infancy through young adulthood, with availability 24 hours a day, 7 days a week, from a pediatrician or physician whom families trust," and this composite measure of medical home is designed to assess the receipt of quality health care using the AAP´s recommended care guidelines.	Other	National, Regional, State	Patient Engagement / Experience	Children's Health, Special Healthcare Needs
Tracking/ Reminder System	0491 Time-Limited Endorsed	Tracking of Clinical Results Between Visits	Centers for Medicare and Medicaid Services	Documentation of the extent to which a provider uses a certified/qualified electronic health record (EHR) system to track pending laboratory tests, diagnostic studies (including common preventive screenings) or patient referrals. The Electronic Health Record includes provider reminders when clinical results are not received within a predefined timeframe.	Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Other	Clinician: Group/ Practice, Clinician: Individual	Structure	

Patient Surveys Addressing Care Coordination [4:40 – 5:20 pm]

Patient Survey	Communication	Care Planning	Transitions	Avoidable admissions/ readmissions	System and Infrastructure Support
Clinician and Group CAHPS (CG-CAHPS) Care Setting: Clinician Office	Getting Timely Appointments, Care, and Information How Well Doctors Communicate With Patients Follow-up on Test Results		Getting Timely Appointments, Care, and Information		
In-Center Hemodialysis CAHPS (ICH CAHPS) Care Setting: Dialysis Facility	Nephrologists' Communication and Caring Quality of Dialysis Center Care and Operations Providing Information to Patients	Providing Information to Patients			

Patient Survey	Communication	Care Planning	Transitions	Avoidable admissions/ readmissions	System and Infrastructure Support
Experience of Care and Health Outcomes (ECHO) Care Setting: Clinician Office	Getting Treatment Quickly How Well Clinicians Communicate Informed about treatment options Told about medication side effects Information to manage condition Patient rights information Privacy	How Well Clinicians Communicate Informed about treatment options	Getting Treatment Quickly Treatment after benefits are used up		
Inpatient Consumer Survey (ICS) Care Setting: Hospital, IRF	Private and confidential care Communication and Experience of Care	Participation Other medical conditions treated	Participation		
Young Adult Health Care Survey (YAHCS) Care Setting: Clinician Office	Private and confidential care Communication and Experience of Care				

Patient Survey	Communication	Care Planning	Transitions	Avoidable admissions/ readmissions	System and Infrastructure Support
Family Evaluation of Hospice Care (FEHC) Care Setting: Hospice	Attending to Family Needs for Information Coordination of Care Communicate about illness and outcomes	Provide care that respected patient's wishes Died on own terms			
HCAHPS* Care Setting: Hospital	Communication with Nurses Communication with Doctors Communication Regarding Medications Discharge Information Transitions of Care (CTM-3)	Discharge Information Transitions of Care (CTM-3)			
Home Health Care CAHPS (HH CAHPS) Care Setting: Home Health	Communications between Providers and Patients Specific Care Issues				
CAHPS Health Plan Survey with NCQA Supplemental Items Care Setting: Clinician Office	How Well Doctors Communicate Health Plan Information and Customer Service Coordination of Care	Shared Decision Making	Getting Needed Care Getting Care Quickly		

Patient Survey	Communication	Care Planning	Transitions	Avoidable admissions/ readmissions	System and Infrastructure Support
Nursing Home CAHPS (NH CAHPS): Long Stay Resident Care Setting: Nursing Home	Communication & respect				
NH CAHPS: Family Member Survey Care Setting: Nursing Home	Nursing Home Provides Info/ Encourages Respondent Involvement	Nursing Home Provides Info/ Encourages Respondent Involvement			
NH CAHPS: Discharged Resident Survey: Care Setting: Nursing Home	Communication & respect		Transitions		
Consumer Assessments and Reports of End of Life (CARE) Care Setting: Home Health, Hospice, Hospital, Nursing Home	Supported Share Decision Making Attended to Needs of the Family Coordinated Care				
Pediatric Inpatient Experience Survey (PIES) Care Setting: Hospital	Care from your child's nurses Care from your child's doctors Working together Your Child's Medication Arriving and Leaving the Hospital	Your Child's Medication Arriving and Leaving the Hospital	Arriving and Leaving the Hospital		

NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

DAY 2 – July 19

Care Transitions [9:00 – 10:15 am]

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Effectiveness	0228 Endorsed	3-Item Care Transition Measure (CTM-3)	University of Colorado Health Sciences Center	Uni-dimensional self-reported survey that measures the quality of preparation for care transitions.	Hospital/ Acute Care Facility	Facility	Patient Engagement/ Experience	Adult
Effectiveness	0335 Endorsement Maintenance	PICU Unplanned Readmission Rate	National Association of Children's Hospitals and Related Institutions	The total number of patients requiring unscheduled readmission to the ICU within 24 hours of discharge or transfer.	Hospital/ Acute Care Facility	Facility	Outcome	Children's Health
Effectiveness	0336 Endorsement Maintenance	Review of Unplanned PICU Readmissions	National Association of Children's Hospitals and Related Institutions	Periodic clinical review of unplanned readmissions to the PICU that occurred within 24 hours of discharge or transfer from the PICU.	Hospital/ Acute Care Facility	Facility	Process	Children's Health

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Effectiveness	0576 Endorsement Maintenance	Follow-Up After Hospitalization for Mental Illness	National Committee for Quality Assurance	This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1. The percentage of members who received follow-up within 30 days of discharge Rate 2. The percentage of members who received follow-up within 7 days of discharge.	Clinician Office/ Clinic, Inpatient, Outpatient	Clinician: Group/Practice, Health Plan, Clinician: Individual, Integrated Delivery System, Population: National, Population: Regional, Population: State	Process	Children's Health
Effectiveness	0698 Endorsement Maintenance	30-Day Post-Hospital AMI Discharge Care Transition Composite Measure	Centers for Medicare and Medicaid Services	This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay having a primary diagnosis of heart failure for three types of events: readmissions, ED visits and evaluation and management (E&M) services. These events are relatively common, measurable using readily available administrative data, and associated with effective coordination of care after discharge. The input for this score is the result of measures for each of these three. Each of these individual measures is a risk-adjusted, standardized rate together with a percentile ranking. This composite measure is a weighted average of the deviations of the three risk-adjusted, standardized rates from the population mean for the measure across all patients in all hospitals. Again, the composite measure is accompanied by a percentile ranking to help with its interpretation.		National	Composite	

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Effectiveness	0699 Endorsement Maintenance	30-Day Post-Hospital HF Discharge Care Transition Composite Measure	Centers for Medicare and Medicaid Services	This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay having a primary diagnosis of heart failure for three types of events: readmissions, ED visits and evaluation and management (E&M) services. These events are relatively common, measurable using readily available administrative data, and associated with effective coordination of care after discharge. The input for this score is the result of measures for each of these three events. Each of these individual measures is a risk-adjusted, standardized rate together with a percentile ranking. This composite measure is a weighted average of the deviations of the three risk-adjusted, standardized rates from the population mean for the measure across all patients in all hospitals. Again, the composite measure is accompanied by a percentile ranking to help with its interpretation.			Composite	

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Effectiveness	0707 Endorsed	30-day Post Hospital Pneumonia Discharge Transition Composite Measure	Centers for Medicare and Medicaid Services	This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay having a primary diagnosis of heart failure for three types of events: readmissions, ED visits and evaluation and management (E&M) services. These events are relatively common, measurable using readily available administrative data, and associated with effective coordination of care after discharge. The input for this score is the result of measures for each of these three events. Each of these individual measures is a risk-adjusted, standardized rate together with a percentile ranking. This composite measure is a weighted average of the deviations of the three risk-adjusted, standardized rates from the population mean for the measure across all patients in all hospitals. Again, the composite measure is accompanied by a percentile ranking to help with its interpretation.			Composite	
Effectiveness	0718 Endorsement Maintenance	Children Who Had Problems Obtaining Referrals When Needed	Child and Adolescent Health Measurement Initiative on behalf of the Maternal and Child Health Bureau	The measure aims to ascertain the perceived difficulty in obtaining referrals to other doctors or for other services among children when such referrals were needed for optimum health.		National, Regional, State	Patient Engagement/ Experience	Children's Health, Special Healthcare Needs

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Effectiveness	1340 Endorsed	Children with Special Health Care Needs (CSHCN) who Receive Services Needed for Transition to Adult Health Care	Maternal and Child Health Bureau, Health Resources & Services Administration	Whether children with special health care needs (CSHCN) ages 12-17 have doctors who usually/always encourage increasing responsibility for self-care AND (when needed) have discussed transitioning to adult health care, changing health care needs, and how to maintain insurance coverage	Other	National, Regional, State	Outcome	Children's Health
Timeliness (Under consideration by CV/Diabetes Task Force)	0163 Endorsed	AMI–8a Timing of receipt of primary percutaneous coronary intervention (PCI)	Centers for Medicare and Medicaid Services	Percentage of acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving primary percutaneous coronary intervention (PCI) during the hospital stay with a time from hospital arrival to PCI of 90 minutes or less.	Hospital/ Acute Care Facility	Facility, Population: Regional, Population: National	Process	Adult
Timeliness (Under consideration by CV/Diabetes Task Force)	0164 Endorsed	AMI-7a- Fibrinolytic Therapy received within 30 minutes of hospital arrival	Centers for Medicare and Medicaid Services	Percentage of acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving fibrinolytic therapy during the hospital stay and having a time from hospital arrival to fibrinolysis of 30 minutes or less.	Hospital/ Acute Care Facility	Facility, Population: Regional, Population: National	Process	Adult

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Timeliness (Under consideration by CV/Diabetes Task Force)	0287 Endorsement Maintenance	Median to Fibrinolysis	Centers for Medicare and Medicaid Services	Percentage of patients with extended median time from emergency department arrival to administration of fibrinolytic therapy in ED patients with ST-segment elevation or left bundle branch block (LBBB) on the electrocardiogram (ECG) performed closest to ED arrival and prior to transfer.	Hospital/ Acute Care Facility	Facility	Process	Adult
Timeliness (Under consideration by CV/Diabetes Task Force)	0288 Endorsed	OP-2: AMI Emergency Department acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving Fibrinolytic therapy during the stay and having a time from ED arrival to fibrinolysis of 30 minutes or less.	Centers for Medicare and Medicaid Services	Emergency Department acute myocardial infarction (AMI) patients receiving fibrinolytic therapy during the ED stay and having a time from ED arrival to fibrinolysis of 30 minutes or less.	Hospital/ Acute Care Facility, Urgent Care	Facility, Population: National	Process	Adult

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Timeliness (Under consideration by CV/Diabetes Task Force)	0289 Endorsed	Median Time to ECG	Centers for Medicare and Medicaid Services	Median time from emergency department arrival to ECG (performed in the ED prior to transfer) for acute myocardial infarction (AMI) or Chest Pain patients (with probable cardiac chest pain).	Hospital/ Acute Care Facility, Urgent Care	Facility, Population: National	Process	Adult
Timeliness (Under consideration by CV/Diabetes Task Force)	0290 Endorsed	Median Time to Transfer to Another Facility for Acute Coronary Intervention	Centers for Medicare and Medicaid Services	Median time from emergency department arrival to time of transfer to another facility for acute coronary intervention.	Hospital/ Acute Care Facility, Urgent Care	Can be measured at all levels, Facility, National	Process	Adult
Timeliness (Under consideration by CV/Diabetes Task Force)	0661 Endorsed	OP-23: ED-Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation Within 45 minutes of Arrival	Centers for Medicare and Medicaid Services	Emergency Department Acute Ischemic Stroke or Hemorrhagic Stroke patients who arrive at the ED within 2 hours of the onset of symptoms who have a head CT or MRI scan performed during the stay and having a time from ED arrival to interpretation of the Head CT or MRI scan within 45 minutes of arrival.	Clinician Office/ Clinic, Hospital/ Acute Care Facility	Facility	Process	Adult

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Timeliness	0495 Endorsed	ED–1 Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the hospital	Centers for Medicare and Medicaid Services	Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department	Hospital/ Acute Care Facility	Facility	Outcome	Adult
Timeliness	0496 Time-Limited Endorsed	Median Time from ED Arrival to ED Departure for Discharged ED Patients	Centers for Medicare and Medicaid Services	Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department	Hospital/ Acute Care Facility	Facility	Outcome	Adult
Timeliness	0497 Time-Limited Endorsed	ED–2 Median time from admit decision to time of departure from the emergency department for emergency department patients admitted to the inpatient status	Centers for Medicare and Medicaid Services	Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status	Hospital/ Acute Care Facility	Facility	Patient Engagement/ Experience	Adult
Timeliness	0526 Time-Limited Endorsed	Timely Initiation of Care	Centers for Medicare and Medicaid Services	Percent of patients with timely start or resumption of home health care	Home Health	Facility, Other	Process	

Communication [10:30 – 11:45 am]

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Measure Use	Target Population
Patient Communication	0647 Time-Limited Endorsed	Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care) (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements.	Hospital/Acute Care Facility, Inpatient Rehabilitation Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, Integrated Delivery System	Process		Children's Health
Patient Communication	0649 Time-Limited Endorsed	Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care])	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)	Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements	Hospital/Acute Care Facility, Inpatient Rehabilitation Facility	Facility, Integrated Delivery System	Process	OQR (suspended)	Children's Health

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Measure Use	Target Population
Provider Communication	0291 Endorsement Maintenance	Administrative Communication	University of Minnesota Rural Health Research Center	Percentage of patients transferred to another acute hospitals whose medical record documentation indicated that administrative information was communicated to the receiving hospital within 60 minutes of departure	Hospital/Acute Care Facility	Facility	Process		Children's Health
Provider Communication	0294 Endorsement Maintenance	Patient Information	University of Minnesota Rural Health Research Center	Percentage of patients transferred to another acute hospitals whose medical record documentation indicated that patient information was communicated to the receiving hospital within 60 minutes of departure	Hospital/Acute Care Facility	Facility	Process		Children's Health
Provider Communication	0295 Endorsement Maintenance	Physician Information	University of Minnesota Rural Health Research Center	Percentage of patients transferred to another acute hospitals whose medical record documentation indicated that physician information was communicated to the receiving hospital within 60 minutes of departure	Hospital/Acute Care Facility	Facility	Process		Children's Health
Provider Communication	0296 Endorsement Maintenance	Nursing Information	University of Minnesota Rural Health Research Center	Percentage of patients transferred to another acute care hospital whose medical record documentation indicated that nursing information was communicated to the receiving hospital within 60 minutes of departure	Hospital/Acute Care Facility	Facility	Process		Children's Health

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Measure Use	Target Population
Provider Communication	0297 Endorsement Maintenance	Procedures and Tests	University of Minnesota Rural Health Research Center	Percentage of patients transferred to another acute care hospital whose medical record documentation indicated that procedure and test information was communicated to the receiving hospital within 60 minutes of departure	Hospital/Acute Care Facility	Facility	Process		Children's Health
Provider Communication	0648 Time-Limited Endorsed	Timely Transmission of Transition Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	Hospital/Acute Care Facility, Inpatient Rehabilitation Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, Integrated Delivery System	Process		Children's Health
Provider Communication	0719 Endorsement Maintenance	Children Who Receive Effective Care Coordination of Healthcare Services When Needed	Child and Adolescent Health Measurement Initiative on behalf of the Maternal and Child Health Bureau	This is a composite measure used to assess the need and receipt of care coordination services for children who required care from at least two types of health care services which may require communication between health care providers, or with others involved in child´s care (e.g. school).	Other	National, Regional, State	Outcome		Children's Health, Special Healthcare Needs

Care Planning [12:30 – 1:30 pm]

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Condition Specific	0338 Endorsement Maintenance	Home Management Plan of Care Document Given to Patient/Caregiver	The Joint Commission	Documentation exists that the Home Management Plan of Care (HMPC) as a separate document, specific to the patient, was given to the patient/caregiver, prior to or upon discharge.	Hospital/Acute Care Facility	Facility	Process	Children's Health
Condition Specific	0418 Endorsed	Screening for Clinical Depression	Centers for Medicare and Medicaid Services	Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool and follow up plan documented.	Clinician Office/Clinic, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility	Clinician: Individual	Process	Adult
Condition Specific	0557 Endorsement Maintenance	HBIPS-6 Post discharge continuing care plan created	The Joint Commission	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-7: Post discharge continuing care plan transmitted to next level of care provider upon discharge.	Hospital/Acute Care Facility, Inpatient	Facility	Process	Adult/Elderly Care, Children's Health

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Condition Specific	0558 Endorsement Maintenance	HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	The Joint Commission	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-6: Post discharge continuing care plan created.	Hospital/Acute Care Facility, Inpatient	Facility	Process	Adult/Elderly Care, Children's Health
General	0420 Endorsed	Pain Assessment Prior to Initiation of Patient Therapy	Centers for Medicare and Medicaid Services	Percentage of patients with documentation of a pain assessment (if pain is present, including location, intensity and description) through discussion with the patient including the use of a standardized tool on each initial evaluation prior to initiation of therapy and documentation of a follow up plan.	Clinician Office/Clinic, Other	Clinician: Individual	Process	Adult
General	0421 Time-Limited Endorsed	Adult Weight Screening and Follow-Up	Centers for Medicare and Medicaid Services	Percentage of patients aged 18 years and older with a calculated BMI documented in the medical record AND if the most recent BMI is outside the parameters, a follow up plan is documented. Parameters: age 65 and older BMI > or = 30 or < 22; age 18-64 BMI > or = 25 or< 18.5	All settings	Can be measured at all levels	Process	Adult

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Patient Preference at End-of-Life	0211 Endorsement Maintenance	Proportion with more than one emergency room visit in the last days of life	National Cancer Institute	Percentage of patients who died from cancer with more than one emergency room visit in the last days of life	Hospice	Facility	Outcome	
Patient Preference at End-of-Life	0212 Endorsement Maintenance	Proportion with more than one hospitalization in the last 30 days of life	National Cancer Institute	Percentage of patients who died from cancer with more than one hospitalization in the last 30 days of life	Hospice	Facility	Outcome	
Patient Preference at End-of-Life	0213 Endorsement Maintenance	Proportion admitted to the ICU in the last 30 days of life	Institute for Clinical and Evaluative Sciences	Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life	Hospital/Acute Care Facility	Facility	Outcome	
Patient Preference at End-of-Life	0214 Endorsement Maintenance	Proportion dying from Cancer in an acute care setting	Institute for Clinical and Evaluative Sciences	Percentage of patients who died from cancer dying in an acute care setting	Hospital/Acute Care Facility	Facility	Outcome	
Patient Preference at End-of-Life	0215 Endorsement Maintenance	Proportion not admitted to hospice	National Cancer Institute	Percentage of patients who died from cancer not admitted to hospice	Hospice	Facility	Outcome	
Patient Preference at End-of-Life	0216 Endorsement Maintenance	Proportion admitted to hospice for less than 3 days	National Cancer Institute	Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there	Hospice	Facility	Outcome	

Subtopic	NQF Number and Status	Title	Steward	Description	Care Setting	Level of Analysis	Measure Type	Target Population
Patient Preference at End-of-Life	0326 Endorsement Maintenance	Advance Care Plan	National Committee for Quality Assurance	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	Clinician Office/Clinic	Clinician: Individual	Process	Adult (65 years or older)
Patient Preference at End-of-Life	1626 Endorsed	Patients Admitted to ICU who Have Care Preferences Documented	RAND Corporation	Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.	Hospital/Acute Care Facility	Facility, Health Plan, Integrated Delivery System	Process	Senior Care

MAP Safety & Care Coordination Task Force

In-Person Meeting

July 18-19, 2012

NATIONAL QUALITY FORUM

Welcome and Review of Meeting Objectives

Meeting Objectives

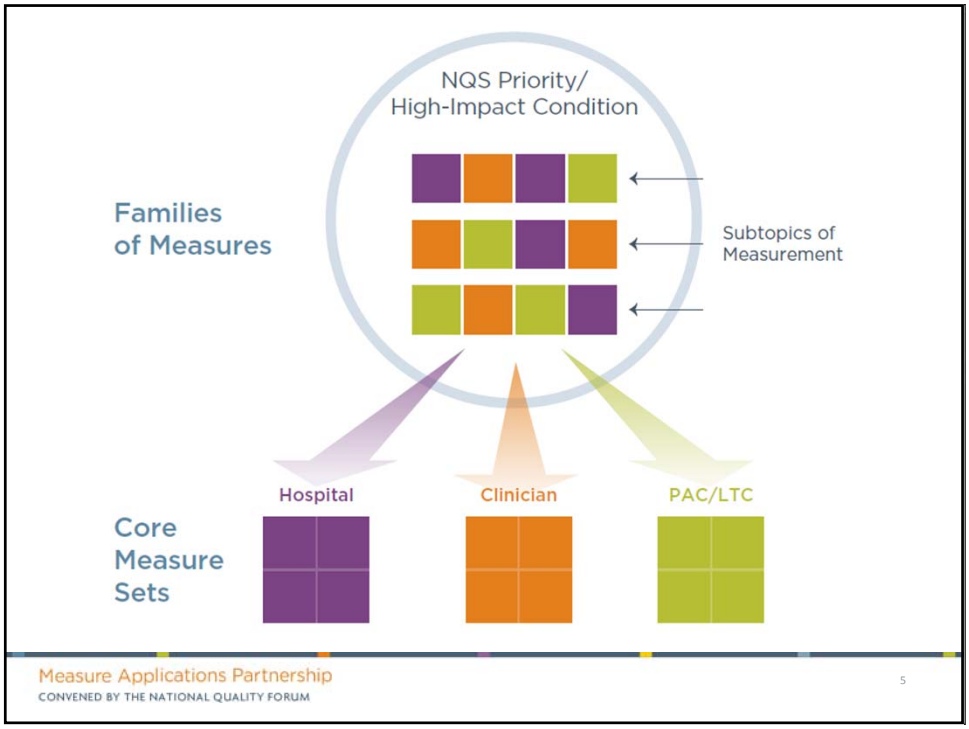
- *Review outcomes of safety survey exercise and measures for additional topic areas;*
- *Consider priority areas for aligning care coordination performance measurement across public and private programs;*
- *Discuss shared accountability and identify implementation issues related to use of care coordination/readmission measures across programs and settings;*
- *Establish a care coordination family of measures; and*
- *Create a measure development and implementation pathway to fill care coordination gaps.*

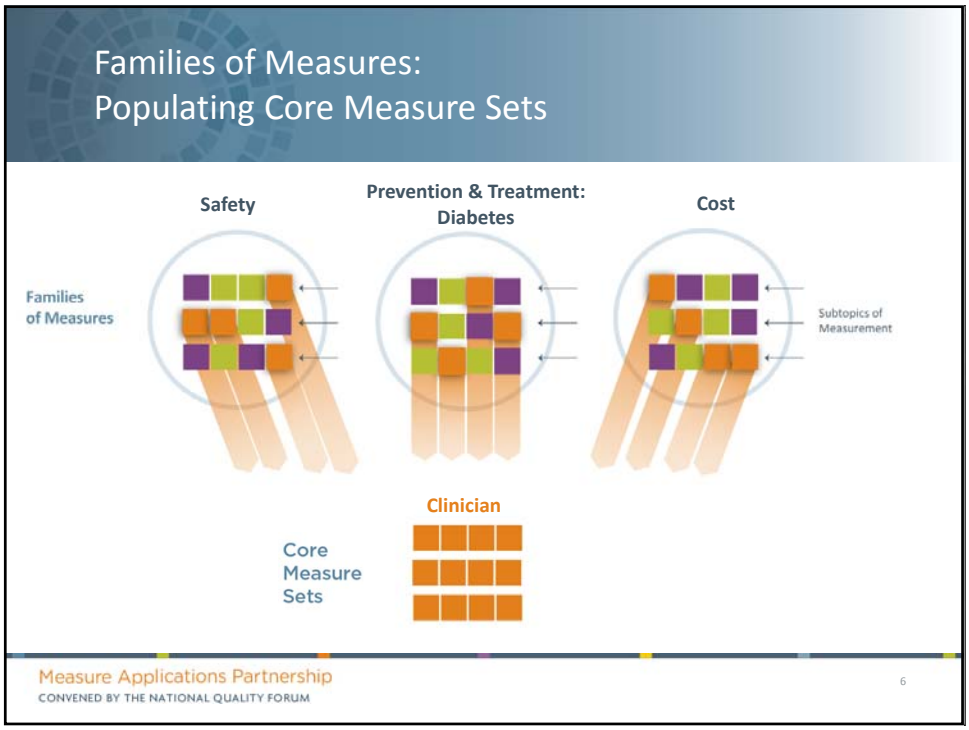
Families of Measures

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

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

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


NQS Priority/
High-Impact Condition
Families
of Measures
Subtopics of
Measurement
Hospital
Clinician
PAC/LTC
Core
Measure
Sets
Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM
5


Families of Measures:
Populating Core Measure Sets
Safety
Prevention & Treatment:
Diabetes
Cost
Families
of Measures
Subtopics of
Measurement
Clinician
Core
Measure
Sets
Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM
6

Safety Measure Family Follow-Up

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
	Ventilator-Associated Pneumonia (VAP)
Medication/Infusion Safety	Adverse Drug Events
	Blood Incompatibility
	Manifestations of Poor Glycemic Control
Venous Thromboembolism	Deep Vein Thrombosis (DVT)
	Pulmonary Embolism (PE)
Perioperative/Procedural Safety	Foreign Object Retained After Surgery
	Trauma (burn, shock, laceration, puncture, iatrogenic pneumothorax, etc.)
	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 Follow-Up

- 46 measures and a number of gaps were identified by the task force to propose to the MAP Coordinating Committee for the safety measure family
- More information gathered on measures
  - NQF #0477 Under 1500g infant Not Delivered at Appropriate Level of Care
  - NQF #0716 Healthy Term Newborn
  - Complications-related mortality measures (NQF #0351, 0352, 0353)
- Pain and Sepsis measures will be discussed today

Healthy Term Newborn (NQF #0716)

- California Maternal Quality Care Collaborative (CMQCC) measure
- Includes maternal obstetrical conditions (e.g. HTN, prior caesarean, malpresentation) unless there was evidence of an effect on the fetus prior to labor
- Denominator exclusions:
  - Selected fetal or maternal conditions likely to have existed prior to labor (e.g. multiple gestations, preterm infant, and congenital anomalies)
- No risk adjustment or risk stratification.
  - There is consideration for stratification by birthing unit size based on the total denominator after exclusions.
- No publicly reported performance data found

Under 1500g Infant Not Delivered at Appropriate Level of Care (NQF # 0477)

- California Maternal Quality Care Collaborative (CMQCC) measure
- Denominator exclusions:
  - Stillbirths
  - Live births <24 weeks gestation
- CMQCC website offers this explanation regarding the lack of a risk model for this measure:

  "this is a simple rate of a condition that simply should not occur (except for women who present in advanced labor without time to transport to a higher level of care), there is no risk model."
- No publicly reported performance data found

Death among surgical inpatients with serious, treatable complications [PSI4] (NQF #0351)

- AHRQ measure
- No specific exclusion for POA codes
- Denominator exclusions:
  - individuals >90 years old
  - patients transferred from an acute care facility
  - cases of key missing information, and/or certain diagnosis-specific criteria.
- Utilize risk adjustment model
- Per Hospital Compare (accessed 7/2/12), the U.S. National Rate for this measure is 115.70 per 1,000 patient discharges.

Failure to Rescue In-Hospital Mortality and 30-Day Mortality (NQF #0352 and 0353)

- Children's Hospital of Philadelphia (CHOP) measures
- No specific exclusion for POA codes
- Denominator exclusions:
  - Exclude individuals >90 years or < 18 years old
- Utilize risk adjustment models
- No publicly reported performance data found

Aligning Care Coordination Measurement

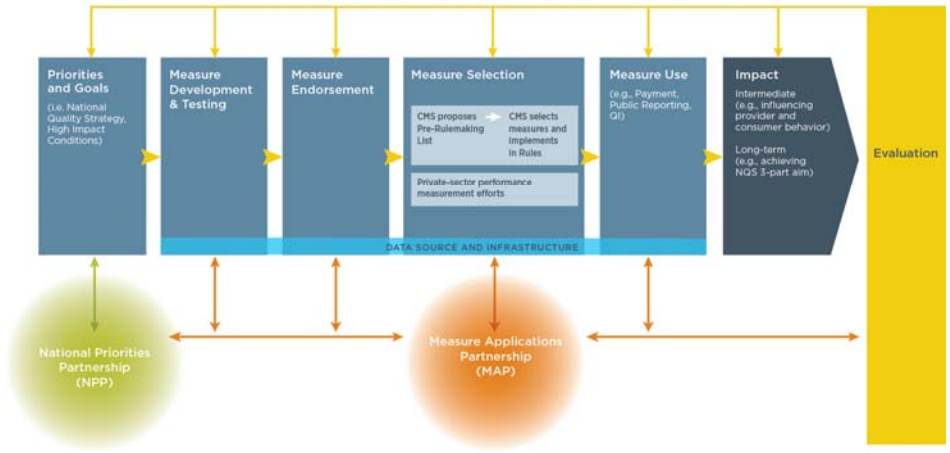
National Quality Strategy Goals & Targets for Care Coordination

NATIONAL QUALITY FORUM

Karen Adams, PhD,
Vice President, National Priorities

July 18, 2012

Quality Measurement Enterprise



Where We Came From

- NPP's 2008 report, *Aligning Our Efforts to Transform America's Healthcare*, identified care coordination as a national priority and emphasized the need for improved measurement in the following areas:
  - Patient experience of care transitions
  - Medication safety
  - 30-day readmission rates
  - Emergency department visits

NPP's Care Coordination Focus Continues

- In 2010, the NPP Care Coordination Workgroup convened to identify actions to achieve reductions in 30-day readmissions
- The workgroup identified enhancing performance measures that address care coordination and transitional care as a primary objective
- The following action steps were identified:
  - Achieving consensus on what constitutes avoidable, preventable or unplanned readmissions
  - Identifying and considering for endorsement additional measures that reflect high-value care coordination and transitional care
  - Endorsing composite measures of care coordination based on the consensus process and the application of NQF's Composite Measure Evaluation Framework

HHS' National Quality Strategy Aims and Priorities

NQS PRIORITY AREA:

Effective Communication and Care Coordination

NQS Goals:

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

NQS Key Measures:

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

NPP Care Coordination Measure Concepts

- Experience of care transitions
- Complete transition records
- Chronic disease control
- Care consistent with end-of-life wishes
- Experience of bereaved family members
- Care of vulnerable populations
- Community health outcomes
- Shared information and accountability for effective care coordination

Performance Measures:
Care Coordination

Gerri Lamb, PhD, RN, FAAN
Associate Professor, Arizona State University College of Nursing and Health Innovation and NQF Care Coordination CDP Steering Committee Co-chair

July 18, 2012

NATIONAL QUALITY FORUM

Previous Work

- NQF-Endorsed Definition and Framework for Measuring and Reporting Care Coordination (2006)
  - Domains identified:
    - Healthcare "home"
    - Proactive plan of care and follow up
    - Communication
    - Information systems
    - Transitions or "hand-offs"
- Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination (2010)
  - Endorsed:
    - 10 measures
    - 25 Preferred Practices

Care Coordination Endorsement Maintenance: Project Purpose and Goals

- To understand issues that limit measurement and quality improvement of care coordination
- To identify and endorse measures for accountability and quality improvement addressing care coordination

Project Overview

- Phase I
  - Environmental scan to identify measure gaps
  - Commissioned paper to examine HIT capabilities to support care coordination and care transitions
  - Development of a Pathway Forward to advance the field of care coordination measurement and inform the Call for Measures; essential components include:
    - » Broad-based measures that are not limited by condition or setting
    - » Process measures that are proximal to patient-centered outcomes
    - » Measures that address specific needs of high-risk populations
    - » Measures related to a shared Plan of Care
    - » Measures that allow understanding of resource use and cost-savings potentials

Project Overview (cont'd)

- Phase II
  - Evaluation of 15 maintenance measures
  - Identification of future areas for measure development

Measures Overview

- No new measures were submitted, despite targeted outreach and an extended Call for Measures
- 15 maintenance measures under consideration
  - Included 12 process measures, 2 outcome measures, and 1 composite measure
  - 12 measures were recommended
    - 2 measures are paired
  - 3 measures were not recommended
    - All three did not meet Importance to Measure and Report

Overarching Issues

- Limited evidence base for several measures
- Testing of reliability and validity did not always match specifications
  - Testing typically conducted only for one data source/setting/level of analysis
- Feasibility
  - Paper records abstraction or manipulation of EHRs
- Terminology and lack of standardized definitions
- Competing and related measures

Recommendations: Future Measure Development

- Call for measure maturity/complexity
- "Both sides of the handshake" measures that capture the entire process
- Use of measurement to drive practice
- Identification and prioritization of measurement concepts
  - Patient-reported outcomes
  - Linkages between patient goals, relevant interventions, and relevant outcomes
  - Continuity within the plan of care
  - Accessibility and functionality of plan of care
  - Adverse events as markers of poor care coordination
- Identified potential future uses for the 25 Care Coordination Preferred Practices

Questions?

High-leverage Opportunities for Improving Care Coordination

Allen Leavens, MD
Senior Director, Strategic Partnerships

July 18, 2012

Overview

NQF definition of Care Coordination

Care coordination is a function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time. Coordination maximizes the value of services delivered to patients by facilitating beneficial, efficient, safe, and high-quality patient experiences and improved healthcare outcomes.

Relationship to the National Quality Strategy

- Care Coordination aligns with the third priority in the NQS:
  "Promoting effective communication and coordination of care"
- Long-term goals noted in the NQS for promoting effective communication and coordination of care:
  - Improve the quality of care transitions and communications across care settings.
  - Improve the quality of life for patients with chronic illness and disability by following a current care plan that anticipates and addresses pain and symptom management, psychosocial needs, and functional status.
  - Establish shared accountability and integration of communities and health care systems to improve quality of care and reduce health disparities.

Care Coordination Performance Measurement

Topic areas for Care Coordination measures:

- Avoidable Admissions and Readmissions
- System Infrastructure Support
- Care Transitions
- Communication
- Care Planning

Avoidable Admissions and Readmissions

Impact

- Approximately 19% of Medicare beneficiaries (~ 2 million/ year) who are discharged from a hospital are readmitted within 30 days (IOM, 2011)
- In non-obstetric Medicaid patients ages 21-64 hospitalized in 2007, about 1 in 10 had >=1 readmission within 30 days (Statistical Brief #89 HCUP, 2010)
- Across all insured patients, about 11% of readmissions are estimated to be avoidable; costs of avoidable hospital readmissions may be as high as $25 billion per year (NPP Compact Action Brief, 2010)

Avoidable Admissions and Readmissions

- Some concerns have been raised over what is truly an "**avoidable**" readmission
  - More focus may need to be put on unplanned readmissions that are related to the reason of initial admission (AHA, 2011)
  - There are challenges accounting for patient factors such as income status, social support structure, underlying disability, race, English proficiency, etc.
- Some studies have indicated that there may be an inverse relationship between mortality and readmissions (AHA, 2011)
- Potential unintended consequences could occur if hospitals that provide good quality of care to disproportionate numbers of vulnerable patients are penalized for excess readmissions

Avoidable Admissions and Readmissions

- Certain practices may be more likely to help avoid avoidable admissions and readmissions
  - Review of Medicare Coordinated Care Demonstration projects indicated that 6 approaches practiced by care coordinators were more commonly associated with reduced hospitalizations in enrollees at **high risk** (Brown et al, 2012):
    - » Supplementing patient telephone calls with frequent in-person meetings
    - » Occasional in-person meetings with providers
    - » Acting as a communications hub for providers
    - » Delivering evidence-based education to patients
    - » Providing strong medication management
    - » Providing timely and comprehensive transition care after hospitalizations

Avoidable Admissions and Readmissions

- Timely follow-up after discharge may play an important role in preventing readmissions; for example, in a study among Medicare patients with HF, early follow-up was associated with lower 30-day readmission (Hernandez et al, 2010)
- Certain transitional care interventions, such as those focusing on patient self-management, may reduce readmissions up to 6 or 12 months after the initial discharge (Naylor, 2011)
- Individual hospital efforts (AHA 2011):
  - » Metro Health Hospital - cut CHF readmission rate in half over 6 months
  - » Rush University Med Center – participating patients had 15% lower 30-day readmission rates, and 24% lower 60-day readmission rates
  - » Boston University Med Center – Project RED with 30% few readmissions

System Infrastructure Support

Medical Homes

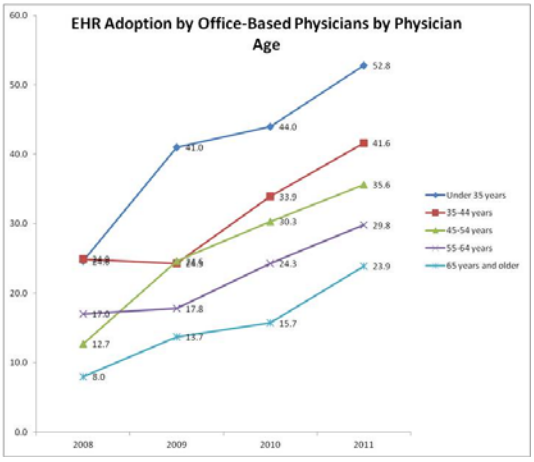
- A **healthcare home** should be the usual source of care selected by a patient, and function as the central point for coordinating care around the patient's needs and preferences (NQF Care Coordination Framework, 2006)
- **Medical homes** are practices that deliver patient-centered care, coordinate care across providers and settings, and have robust information technology to facilitate information transfer (MedPAC, 2008)
- A systematic review of early evidence on effectiveness of the **patient-centered medical home (PCMH)** found varied interventions, but most were not fundamental practice transformations; "some favorable effects" were observed on the triple aim outcomes for certain interventions, with a few negative effects on costs, but mostly inconclusive results (AHRQ, 2012)

System Infrastructure Support

Health Information Technology (HIT)

- "Successful deployment of healthcare information systems provides the critical link to improving care coordination" (NQF Consensus Report, 2010)
- Electronic health information systems have potential to improve communication across settings and providers; however, it is essential that systems be **interoperable**, with communication protocols established between providers and the ability to share all relevant patient information (MedPAC, 2012)
- Increasing evidence is becoming available that HIT can help prevent adverse events, improve quality, enhance communication, and facilitate lower administrative costs (HealthIT.gov website, accessed July 2012)

System Infrastructure Support



http://www.healthit.gov/buzz-blog/meaningful-use/ehr-adoption-rates-and-achieving-meaningful-use/. (last accessed July, 2012)

Care Transitions

- NQF has defined transitional care as a **"hand-off" or transition between settings of care** (NQF Consensus Report, 2010)
- Transitions can be a critical phase; hand-offs are estimated to be a factor in about 35% of The Joint Commission's sentinel events (NQF Quality Connections, 2010; Runy et al, 2008)
- An example program, The Care Transitions Intervention® led to a 30% reduction in hospital readmissions in a RCT, and further study indicates it can be effective in real-world implementation (Voss et al 2011)
- Incorporating the patient's perspective and ensuring needs are met during transitions may help reduce subsequent hospitalization (Coleman et al, 2006)

Communication

- **Communication** involves all healthcare team members working within the same shared plan of care, ready availability of consultation notes and progress reports, shared decision-making with the patient and family, use of various communication methodologies, and maintenance of privacy with access to information (NQF, 2010)
- Surveys have indicated that millions of patients receive inconsistent information from providers; self-reported poor communication with providers is more common among patients who are older or who have more severe conditions (MedPAC, 2012)
- Evidence exists that communication between providers and across settings also needs much improvement, particularly when considering that most patients with chronic conditions receive care from multiple providers (Bodenheimer, 2008)

Care Planning

- **Proactive Plan of Care and Follow-up** involves an established and current care plan that anticipates routine needs and actively tracks up-to-date progress on the patient's and family's long- and short-term goals (NQF, 2006 and 2010)
- Plans of care are particularly important for patients with chronic diseases, and are vital during transitions for facilitating communication, tracking meds, follow-up, etc. (NQF Quality Connections, 2010)
- Research on the isolated effect of care planning is limited and shows somewhat mixed results, with studies tending to focus on specific conditions (e.g. cancer care: Merport et al 2012; Nekhlyudov and Schnipper, 2011; Grunfeld et al 2011)

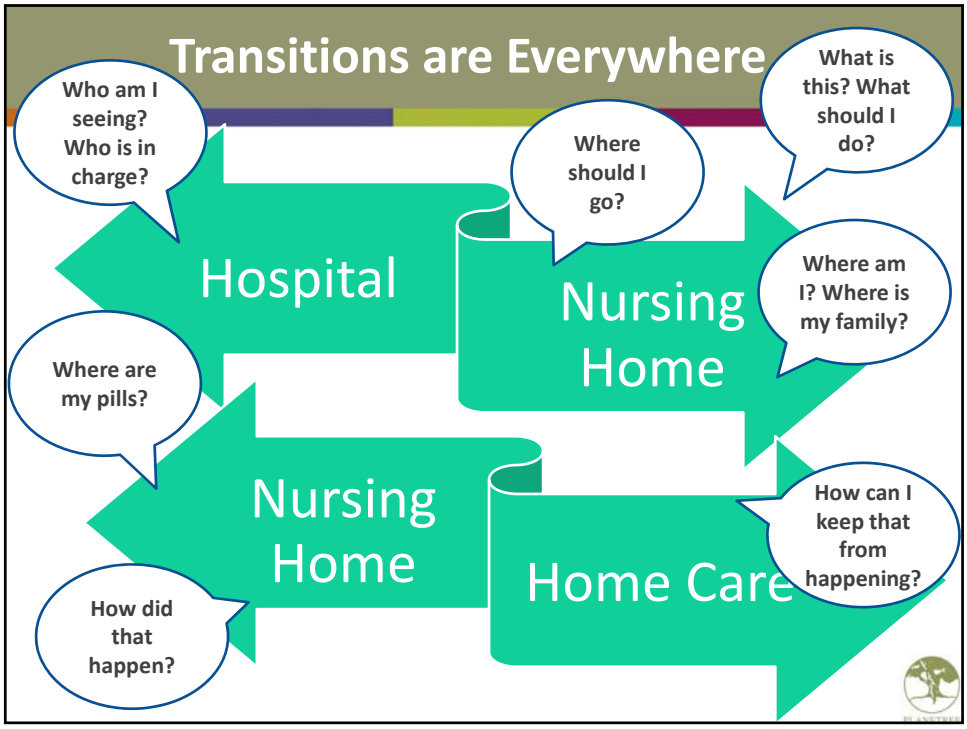
Shared Accountability: Avoidable Admissions and Readmissions

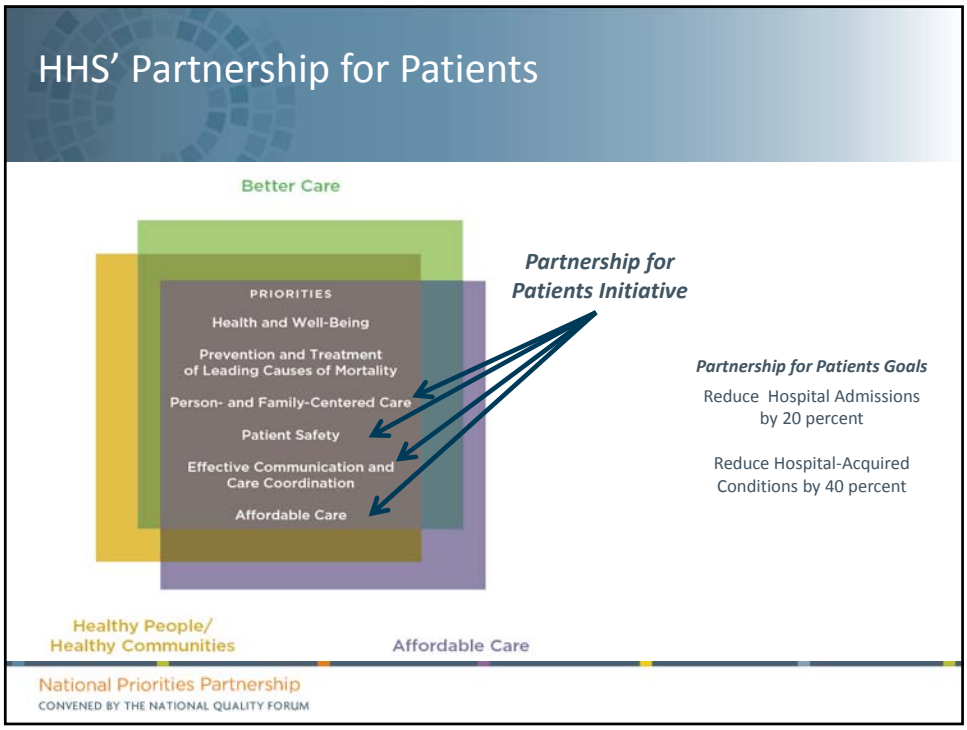
Shared Accountability: Avoidable Admissions and Readmissions

Susan Frampton, PhD
President, Planetree and
NPP (Re)admissions Action
Team Co-Chair

July 18, 2012

NATIONAL QUALITY FORUM


Transitions are Everywhere
Who am I seeing? Who is in charge?
Where should I go?
What is this? What should I do?
Hospital
Nursing Home
Where am I? Where is my family?
Where are my pills?
Nursing Home
Home Care
How can I keep that from happening?
How did that happen?


HHS' Partnership for Patients
Better Care
PRIORITIES
Health and Well-Being
Prevention and Treatment of Leading Causes of Mortality
Person- and Family-Centered Care
Patient Safety
Effective Communication and Care Coordination
Affordable Care
Partnership for Patients Initiative
Partnership for Patients Goals
Reduce Hospital Admissions by 20 percent
Reduce Hospital-Acquired Conditions by 40 percent
Healthy People/ Healthy Communities
Affordable Care
National Priorities Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

(Re)admissions Action Pathway

Promoting Shared Accountability Across All Care Settings to Reduce Avoidable (Re)admissions

Support Implementation of Patient-Centered, Team-Based Care Delivery Models that Provide Care Concordant with Patient. Family, and Caregiver Preferences

1. Analyze readmission rates and quality metrics to identify high-leverage partnership opportunities to reduce avoidable readmissions in high-risk populations across care settings

2. Support and implement team-based care delivery models that emphasize screening and management of high-risk patients, identification of patient preferences, patient engagement in care planning, and patient self-management across acute care, long-term care and community-based settings

3. Improve workforce knowledge, skills and abilities to implement and work within care delivery models

Goals

Reduce avoidable hospital admissions and readmissions across all care settings by 20 percent

Increase uptake of patient-centered team-based, care delivery models by 50 percent in all settings

National Priorities Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Promoting Shared Accountability Across All Care Settings to Reduce Avoidable (Re)admissions

Implementation of Patient-Centered, Team-Based Care Delivery Models that Provide Care Concordant with Patient, Family, and Caregiver Preferences

	Workforce Development, Accreditation & Certification	System Redesign	Public Reporting	Payment/Contracting	Informed Consumer Decisionmaking
National Organizations & Federal Agencies	Promote uptake of patient-centered, team-based care delivery models to reduce readmissions across settings—*professional societies, associations, boards*		Include readmission rates for all settings in public reporting programs—*CMS Compare websites, state reporting programs, community collaboratives*		
States & Communities		Incorporate long-term care and home care into information exchanges (e.g., Beacon)			
Healthcare Providers	Provide education, training and recognition programs that encourage implementation of patient-centered, team-based care delivery models—*hospital, LTC, and HH associations*	Implement models of care to manage highest-risk patients in all settings—*all healthcare organizations and their respective associations*	Use readmission rates and quality measures to identify opportunities for strategic collaboration to reduce avoidable admissions and readmissions—*all healthcare organizations and professionals and their respective associations and societies*		Implement models that support appropriate levels of care and care concordant with patient, family, and caregiver preferences—*all healthcare organizations and professionals and their respective associations and societies*
Healthcare Professionals	Through certification and licensure promote workforce development to implement and work within patient-centered, team-based care delivery models—*professional societies*				
Health Plans & Private & Public Purchasers				Require access to patient-centered models as condition of preferred provider status for hospitals, NH, HH, PCMH—*purchasers, plans*	
Patients, Families, & Consumers		Promote consumer engagement in governance committees to ensure the implementation of patient-centered models—*all healthcare organizations, consumer groups*			Promote consumer awareness of avoidable admissions and readmissions and their role in preventing them–*all healthcare organizations, professionals, and consumer groups*

Levers of Change: Growing Evidence-Base for Consistent Practices Across Models

- Medication list/reconciliation and adherence assessment
- Transitions summary at discharge
- Follow-up visit with PCP/Specialist
- Care Plan
- Coaching with patient and family caregivers
- Post transition call and/or visit
- Accountability for sending and receiving communication

Levers of Change: Patient Experience Perspectives –Results of Focus Group Analysis

Top Three Concerns:

1. Dismissal / trivialization of the patient voice
2. Absence of caring attitudes from providers
3. Lack of continuity in care

*Analysis of patient and family focus groups: 2007-2010

Developing "Best in class" Measures for NQF Endorsement

- Measures to be compared across control and intervention groups
  - Patient Activation Measure
    - *I am confident I can help prevent or reduce problems associated with my health*
  - Care Transitions Measures
    - *When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.*
  - General items
    - *How confident are you that you can control and manage most of your health problems?*

Patient engagement can improve transitions of care at the community level…

Personalize, Humanize, Demystify

P H D

"Every element of a patient's transition between care settings will be assessed based on whether it enhances or detracts from personalizing, demystifying, and humanizing the experience."

Avoidable Admissions and Readmissions Measures

System and Infrastructure Support Measures

Patient Surveys Addressing Care Coordination

Care Transitions

Medication Reconciliation

Measures Proposed by the Task Force for the Safety Measure Family

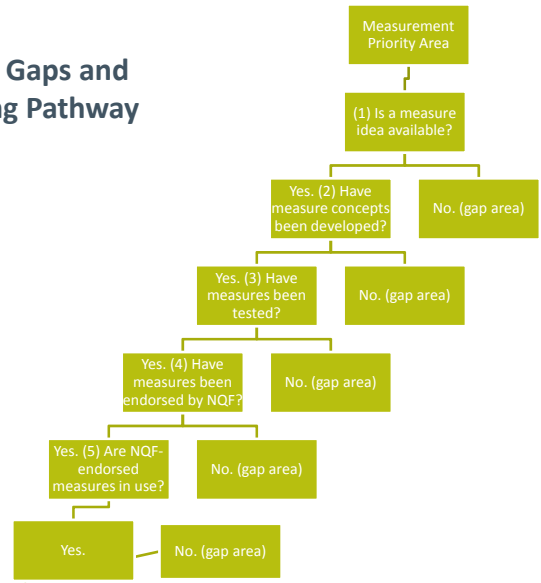
NQF Number & Status	Measure Name
#0419 Endorsed	Documentation of Current Medications in the Medical Record
#0646 Endorsed	Reconciled Medication List Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)
#0554 Endorsed	Medication Reconciliation Post-Discharge (MRP)
#0486 Endorsed	Adoption of Medication e-Prescribing
#0293 Endorsed	Medication Information

Communication

Care Planning

Care Coordination Measure Gaps and Gap-Filling Pathway

Measure Gaps and Gap-filling Pathway



Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

63

National Priorities Partnership

convened by the NATIONAL QUALITY FORUM

To: Frank Opelka, Measure Applications Partnership Safety and Care Coordination Task Force Chair

From: Susan Frampton and Helen Darling, National Priorities Partnership (Re)admissions Action Team Co-Chairs

Re: MAP Safety and Care Coordination Task Force Consideration of Care Coordination Measures

Date: July 18, 2012

On behalf of the National Priorities Partnership, please allow us to provide an update on NPP's (Re)admissions Action Team to offer support for ongoing alignment as you consider a family of care coordination measures for payment and public reporting. Building upon the need to further operationalize the concept of shared accountability, we would like to highlight the Action Team's strategies in this area as they relate to reducing avoidable admissions and readmissions across all care settings. Through an emphasis on broad implementation of patient-centered, team based care delivery models—such as Interact II and Advanced Illness Management programs—the Action Team seeks to ensure the integration of care planning, patient engagement, palliative care, functional status, and quality of life across all settings of care, including acute, long-term and home care.

Background

In March 2011, the Department of Health and Human Services (HHS) released the National Quality Strategy (NQS) and identified six priorities to achieve the overarching national aims of healthy people and communities, better care, and affordable care. In support of the NQS, HHS launched the Partnership for Patients initiative to advance the priority areas of safety, care coordination, and affordability and to achieve two goals by the end of 2013:

1. Decrease preventable hospital-acquired conditions by 40 percent compared to 2010.
2. Decrease preventable hospital readmissions by 20 percent compared to 2010.

To achieve broad stakeholder engagement and action to achieve these goals, HHS requested the National Quality Forum (NQF) to convene NPP in a leadership role to bring together critical thought leaders and organizations and identify high-leverage strategies to accelerate system-level change. In support of this work and building on NPP's long-standing relationship with the long-term care community, NPP identified frequent and avoidable admissions and readmissions from long-term care, and home- and community-based settings as an opportunity to leverage NPP's action catalyst role and facilitate meaningful change in support of the NQS aims and the PfP.

NPP convened a multistakeholder Action Team, comprised of nearly two-dozen public and private stakeholders, to develop an action pathway aimed at promoting shared accountability across the continuum of care to reduce avoidable (re)admissions . To support the execution of the pathway, the Action Team identified three primary strategies that will be operationalized through multistakeholder action and consideration of strategic partnerships across care settings:

- Analyzing readmission rates and quality metrics to identify high-leverage partnership opportunities to reduce avoidable readmissions in high-risk populations across care settings;
- Supporting and implementing team-based care delivery models that emphasize screening and management of high-risk patients, identification of patient preferences, patient engagement in care planning, and patient self-management across acute care, long-term care and community-based settings; and
- Improving workforce knowledge, skills, and abilities to implement and work within care delivery models.

These three interrelated strategies build on the NQS care coordination goals and can offfer further guidance for the selection of measures that address NPP's identified measure concepts, all of which reinforce the importance of shared accountability and consistent measurement across the continuum of care. These include:

- Experience of care transitions
- Complete transition records
- Chronic disease control
- Care consistent with end-of-life wishes
- Experience of bereaved family members
- Care of vulnerable populations
- Community health outcomes
- Shared information and accountability for effective care coordination

We look forward to ongoing collaboration with the MAP Safety and Care Coordination Task Force to ensure a cohesive approach to identifying the best possible measurement strategies for improving health and healthcare and achieving the goals of the National Quality Strategy.

MAP Safety Measure Family
Selected Measures and Gaps

VTE Selected Measures

Measure	NQF # and Status	Measure Type	Target Population	Care Setting	Notes
PSI 12: Post-operative PE or DVT	#0450 Endorsed	Outcome	Adult/Elderly Care	Hospital/ Acute Care Facility	Expand to medical patients
VTE-6: Incidence of Potentially-Preventable VTE	#0376 Endorsed	Process	Adult/Elderly Care	Hospital/ Acute Care Facility	Should reflect updated evidence (non-mechanical interventions)
Deep Vein Thrombosis Anticoagulation >= 3 Months	#0581 Endorsed	Process		Clinician Office/Clinic	Requires pharmacy plan & expand to include maintained in therapeutic range, could combine with #0593
Pulmonary Embolism Anticoagulation >= 3 Months	#0593 Endorsed	Process		Clinician Office/Clinic	Requires pharmacy plan & expand to include maintained in therapeutic range, could combine with #0581

VTE Priority Gap Areas:

- Adherence to VTE medications, monitoring of therapeutic levels and medication side effects
- Monitoring for VTE recurrence
- VTE outcome measures for ASCs, PAC and LTC settings

HAI Selected Measures

Measure	NQF # and Status	Measure Type	Target Population	Care Setting	Notes
National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	#1717 Submitted	Outcome	Adult/ Elderly Care, Pediatric	Behavioral Health/Psychiatric : Inpatient, Dialysis Facility, Hospital/Acute Care Facility, Post-Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post-Acute/Long Term Care Facility: Inpatient Rehabilitation Facility	Pending NQF endorsement
National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	#0138 Endorsed	Outcome	Adult, Pediatric	Hospice, Hospital/Acute Care Facility, Inpatient, Long Term Acute Care Hospital, Nursing Home/Skilled Nursing Facility	Expand beyond current settings
National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	#0139 Endorsed	Outcome	Adult, Pediatric	Hospice, Hospital/Acute Care Facility, Inpatient, Long Term Acute Care Hospital, Nursing Home/Skilled Nursing Facility	Expand beyond current settings
National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	#1716 Submitted	Outcome	Adult/ Elderly Care, Pediatric	Behavioral Health/Psychiatric : Inpatient, Dialysis Facility, Hospital/Acute Care Facility, Post-Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post-Acute/Long Term Care Facility : Inpatient Rehabilitation Facility	Pending NQF endorsement
American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	#0753 Endorsed	Outcome	Adult	Hospital/Acute Care Facility	Expand to include additional procedures and settings as well as pediatric population.
SCIP INF–3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)	#0529 Endorsed	Process	Adult	Hospital/Acute Care Facility	Expand to ASC and office-based procedures
Influenza Vaccination Coverage among Healthcare Personnel	#0431 Endorsed	Process	Adult/ Elderly Care	Ambulatory Surgery Center (ASC), Urgent Care, Clinician Office/Clinic, Dialysis Facility, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility	

HAI Priority Gap Areas:

- Sepsis and VRE
- Ventilator associated events for acute, PAC, LTCH and home health settings
- Post-discharge follow up on infections in ambulatory settings
- Special considerations for measurement in the pediatric population related to ventilator associated events and C. difficile

Injuries from Immobility Selected Measures

Measure	NQF # and Status	Measure Type	Target Population	Care Setting	Notes
Patient Fall Rate	#0141 Endorsed (paired with #0202)	Outcome	Adult	Hospital/ Acute Care Facility	
Falls with injury	#0202 Endorsed (paired with #0141)	Outcome	Adult	Hospital/ Acute Care Facility, Inpatient Rehabilitation Facility	
ASC-2: Patient Fall	#0266 Endorsed	Outcome	All ages	Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility	
Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	#0674 Endorsed	Outcome		Nursing Home/Skilled Nursing Facility	
Increase in Number of Pressure Ulcers	#0181 Endorsed	Outcome	Adult	Home Health	
Pressure ulcer prevalence	#201 Endorsed	Outcome	All ages	Hospital/Acute Care Facility, Inpatient Rehabilitation Facility, Long Term Acute Care Hospital, Nursing Home/Skilled Nursing Facility	

Injuries from Immobility Priority Gap Areas:

- Standard definition of a fall across settings
- Evaluating bone density, prevention and treatment of osteoporosis in ambulatory settings

Perioperative /Procedural Safety Selected Measures

Measure	NQF Number and Status	Measure Type	Target Population	Care Setting	Notes
Accidental puncture or laceration (PDI 1) (risk adjusted)	#0344 Endorsed	Outcome	Pediatric	Hospital/ Acute Care Facility	Should be expanded to include all procedural settings
PSI 15: Accidental puncture or laceration	#0345 Endorsed	Outcome	Adult	Hospital/ Acute Care Facility	Should be expanded to include all procedural settings
ASC-1: Patient Burn -Percentage of ASC admissions experiencing a burn prior to discharge	#0263 Endorsed	Outcome	All ages	Ambulatory Surgery Center (ASC), Hospital/ Acute Care Facility	Should be expanded to include all procedural settings
ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	#0267 Endorsed	Outcome	All ages	Ambulatory Surgery Center (ASC), Hospital/ Acute Care Facility	Should be expanded to include all procedural settings
Foreign Body Left in During Procedure (PSI 5)	#0363 Endorsed	Outcome	Adult	Hospital/ Acute Care Facility	Should be expanded to include all procedural settings
Foreign Body left after procedure (PDI 3)	#0362 Endorsed	Outcome	Pediatric	Hospital/ Acute Care Facility	Should be across all procedural settings
Safe Surgery Checklist	Not Endorsed	Process			Should be brought to NQF for endorsement

Perioperative /Procedural Safety Priority Gap Areas:

- A single composite measure including the various outcome measures above
- Iatrogenic Pneumothorax measures: narrow the denominator to the “at risk” population
- Anesthesia events (inter-op MI, corneal abrasion, broken tooth, etc.)
- Perioperative respiratory events
- Perioperative blood loss or transfusion/over-transfusion
- Altered mental status in Perioperative period

Adverse Drug Events Selected Measures

Measure	NQF # and Status	Measure Type	Target Population	Care Setting	Notes
Improvement in Management of Oral Medications	#0176 Endorsed	Outcome	Adult/ Elderly Care	Home Health	Expand to clinician office/clinic
Documentation of Current Medications in the Medical Record	#0419 Endorsed	Process	Adult	Clinician Office/Clinic, Home Health, Nursing Home/Skilled Nursing Facility, Other	Expand to include acute care facility
Reconciled Medication List Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	#0646 Endorsed	Process		Hospital/Acute Care Facility, Inpatient Rehabilitation Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	
Medication Reconciliation Post-Discharge (MRP)	#0554 Endorsed	Process		Clinician Office/Clinic, Other	Consider shortened time window for reconciliation
Adoption of Medication e-Prescribing	#0486 Endorsed	Structure		Clinician Office/Clinic, Other	e-Prescribing use is minimum – should include how it's used
Medication Information	#0293 Endorsed	Process		Hospital/Acute Care Facility	Limited as this measure is related only to discharges from the ED
Drugs to be avoided in the elderly: a. Patients who receive at least one drug to be avoided, b. Patients who receive at least two different drugs to be avoided.	#0022 Endorsed	Process	Adults over 65	Clinician Office/Clinic	Expand beyond ≥65 population

Adverse Drug Events Priority Gap Areas:

- Outcomes and patient-reported measures of understanding medications (purpose, dosage, side effects, etc.)
- Administration of wrong medication, wrong dosage, drug-allergy or drug-drug interactions
- Role of community pharmacist or home health in reconciliation
- Polypharmacy and use of unnecessary medications for all ages, especially with high-risk medications
- Injury/mortality related to inappropriate drug management
- Blood Incompatibility

Obstetrical Adverse Events Selected Measures

Measure	NQF Number and Status	Measure Type	Target Population	Care Setting	Notes
PC-02 Cesarean Section	#0471 Endorsed	Outcome	Infant, Maternal Health	Hospital/ Acute Care Facility	
PC-01 Elective delivery prior to 39 completed weeks gestation	#0469 Endorsed	Process	Infant, Maternal Health	Hospital/ Acute Care Facility	Contraindications list should be expanded

Obstetrical Adverse Events Priority Gap Areas:

- Obstetrical adverse event index
- Overall complications composite measure
- Measures using NHSN definitions for infections in newborns

Overuse Selected Measures

Measure	NQF # and Status	Measure Type	Target Population	Care Setting	Notes
Low Back Pain: Use of Imaging Studies	#0052 Endorsed	Process	Adult, Excludes over 50	Clinician Office/Clinic	Expand age
Inappropriate Pulmonary CT Imaging for Patients at Low Risk for Pulmonary Embolism	#0667 Endorsed	Process		Hospital/Acute Care Facility, Other	
Appropriate Head CT Imaging in Adults with Mild Traumatic Brain Injury	#0668 Endorsed	Process		Hospital/Acute Care Facility, Other	
Appropriate Cervical Spine Radiography and CT Imaging in Trauma	#0755 Endorsed	Process	Adult, excludes 65 or older	Hospital/Acute Care Facility	
Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use	#0058 Endorsed	Process	Adult, excludes 65 and older	Urgent Care, Clinician Office/Clinic	
Appropriate treatment for children with upper respiratory infection (URI)	#0069 Endorsed	Process	Pediatric	Urgent Care, Clinician Office/Clinic	
LBP: Appropriate Use of Epidural Steroid Injections	#0309 Endorsed	Process	Adult	Clinician Office/Clinic	
Otitis Media with Effusion: Systemic corticosteroids – Avoidance of inappropriate use	#0656 Endorsed	Process	Pediatric	Urgent Care, Clinician Office/Clinic	
Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials	#0657 Endorsed	Process	Pediatric	Ambulatory Surgery Center (ASC), Urgent Care, Clinician Office/Clinic	
Appropriate testing for children with pharyngitis	#0002 Endorsed	Process	Pediatric		
LBP: Surgical Timing	#0305 Endorsed	Process	Adult	Clinician Office/Clinic	
Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	#0659 Endorsed	Process	Adult	Ambulatory Surgery Center (ASC), Urgent Care, Clinician Office/Clinic, Hospital/Acute Care Facility	

Overuse Priority Gap Areas:

- Consistency in scoring for public reporting: should be clear if high or low scores are desired
- Chemotherapy appropriateness, including dosing
- Antibiotic use for sinusitis
- Over diagnosis, under diagnosis, misdiagnosis
- Use of sedatives, hypnotics, atypical anti-psychotics, pain medications (with chronic pain management)
- Treatment given that is not matched to patient goals, especially with palliative and end-of-life care

Mortality Selected Measure

Measure	NQF Number and Status	Measure Type	Target Population	Care Setting	Notes
Death among surgical inpatients with serious, treatable complications (PSI 4)	#0351 Endorsed	Outcome	Adult	Hospital/Acute Care Facility	Should include POA indicators

Mortality Priority Gap Areas:

- Preferably expressed as a ratio instead of percentage
- Questions of how to accommodate small numbers
- Expand to PAC/LTC settings