MEASURE APPLICATIONS PARTNERSHIP
Safety and Care Coordination Task Force
Convened by the National Quality Forum

Meeting Summary
June 19-20, 2012

An in-person meeting of the Measure Applications Partnership (MAP) Safety and Care Coordination Task Force was held on Tuesday, June 19 and Wednesday, June 20. For those interested in reviewing an online archive of the meeting, please click on the following link:
http://www.qualityforum.org/Setting_Priorities/Partnership/Task_Forces/MAP_Task_Forces.aspx.

Task Force Members Attending the June 19-20 Meeting:

Frank Opelka, ACS (Chair)	Randall Krakauer, Aetna
Richard Bankowitz, Premier, Inc.	Bill Kramer, Pacific Business Group on Health
Andrea Benin, National Association of Children's Hospitals and Related Institutions	Kevin Larsen, Office of the National Coordinator for Health Information Technology
Richard Bringewatt, SNP Alliance	Laura Linebach, LA Care Plan
Barbara Caress, Building Services 32BJ Health Fund	Dan Mareck, Health Services and Resources Administration
Patricia Conway-Morana, American Organization of Nurse Executives *(phone)*	Shekhar Mehta, American Society of Health System Pharmacists
Andrea Dilweg, Catalyst for Payment Reform [substitute for Suzanne Delbanco]	Dolores Mitchell, Massachusetts Group Insurance Commission [subject matter expert: state policy]
Nancy Foster, American Hospital Association [substitute for Richard Umbdenstock]	R. Sean Morrison, Mt. Sinai School of Medicine [subject matter expert: palliative care]

Jane Franke, Blue Cross Blue Shield of Massachusetts	Amy Moyer, The Alliance [substitute for Cheryl DeMars]
Foster Gesten, National Association of Medicaid Directors (*phone)*	Chesley Richards, Centers for Disease Control and Prevention
Helen Haskell, Mothers Against Medical Error	Lance Roberts, Iowa Healthcare Collaborative
Aparna Higgins, America's Health Insurance Plans	Ann Marie Sullivan, New York City Health and Hospital Corporation [subject matter expert: mental health]
Thomas James, Humana	Ronald Walters, Alliance of Dedicated Cancer Centers

This was the first meeting of the MAP Safety and Care Coordination Task Force. The meeting objectives were:

- *Review task force charge, role within MAP, and plan to complete the tasks;*
- *Identify priority areas for aligning patient safety performance measurement across public and private programs;*
- *Establish a patient safety family of measures to serve as a national core measure set; and*
- *Create a measure development and implementation pathway to fill patient safety measure gaps.*

Task Force Chair, Frank Opelka, began the meeting with a welcome and review of the meeting objectives. Ann Hammersmith, General Counsel, National Quality Forum (NQF), explained issues of conflicts of interest for MAP members and led disclosures of interest from the task force.

Tom Valuck, Senior Vice President, NQF, and Connie Hwang, Vice President, Measure Applications Partnership, NQF, provided an overview of how the task force's work relates to the National Quality Strategy and the larger quality measurement enterprise, as well as MAP's approach for establishing a safety family of measures.

Allen Leavens, Senior Director, NQF, presented information regarding impact, improvability, and inclusiveness of a number of potential high-leverage opportunities to improve patient safety. The task force then discussed patient safety measurement priorities. The scope of safety topics discussed in the meeting is demonstrated in the table below:

Topic	Subtopic
Healthcare-Acquired Infections	Catheter-Associated Urinary Tract Infections (CAUTI)
	Central Line-Associated Blood Stream Infections (CLABSI)
	Methicillin-Resistant Staphylococcus aureus (MRSA)
	C. difficile
	Surgical Site Infection
	Sepsis
	Ventilator-Associated Pneumonia (VAP)
Medication/Infusion Safety	Adverse Drug Events
	Blood Incompatibility
	Manifestations of Poor Glycemic Control
Pain Management	Effectiveness, Medication Overuse, Patient Experience
Venous Thromboembolism	Deep Vein Thrombosis (DVT)
	Pulmonary Embolism (PE)
Perioperative/Procedural Safety	Foreign Object Retained After Surgery
	Trauma (burn, shock, laceration, puncture, iatrogenic pneumothorax)
	Air Embolism
Injuries from Immobility	Pressure Ulcers
	Falls
Safety-Related Overuse & Appropriateness	Imaging
	Antibiotics
Obstetrical Adverse Events	Pre-Delivery, Delivery, Post-Delivery
Complications-Related Mortality	Failure to Rescue

Frank Opelka then facilitated discussion throughout the day about selection of measures and identification of gaps for the safety family of measures for each of the topic areas above. The following tables contain the existing measures selected by the task force, as well as the identified measure gap areas proposed for the measure family.

Venous Thromboembolism Measures and Gaps for the Safety Family of Measures

NQF # and Status	Measure	MAP Findings

#0376 Endorsed	VTE-6: Incidence of Potentially-Preventable VTE	Measure should reflect updated evidence (use of pharmacologic versus mechanical interventions).
#0450 Endorsed	PSI 12: Post-Operative PE or DVT	Measure should be expanded to include medical patients.
#0581 Endorsed	Deep Vein Thrombosis Anticoagulation >= 3 Months	Measure requires pharmacy plan and should be expanded to include maintained in therapeutic range. Could combine measure with #0593.
#0593 Endorsed	Pulmonary Embolism Anticoagulation >= 3 Months	Measure requires pharmacy plan and should be expanded to include maintained in therapeutic range. Could combine measure with #0581.
Venous Thromboembolism Priority Gap Areas	• Adherence to VTE medications, monitoring of therapeutic levels and medication side effects • Monitoring for VTE recurrence • VTE outcome measures for ASCs and PAC/LTC settings	

Healthcare-Acquired Infections Measures and Gaps for the Safety Family of Measures

NQF # and Status	Measure	MAP Findings
#0138 Endorsed	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Measure should be expanded beyond current settings.
#0139 Endorsed	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	Measure should be expanded beyond current settings.
#0431 Endorsed	Influenza Vaccination Coverage among Healthcare Personnel	Measure should be expanded to all personnel working at healthcare facilities.
#0529 Endorsed	SCIP INF–3 Prophylactic Antibiotics Discontinued within 24 Hours after Surgery End Time (48 hours for cardiac surgery)	Measure should be expanded to ASC and office-based procedures.
#1716 Submitted	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	Measure should be included pending receipt of NQF endorsement.
#1717 Submitted	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Measure should be included pending receipt of NQF endorsement.

NQF # and Status	Measure	MAP Findings
Healthcare-Acquired Infections Priority Gap Areas	• VRE outcome measure • Ventilator-associated events for acute, PAC, LTCH and home health settings • Post-discharge follow up on infections in ambulatory settings • Special considerations for the pediatric population related to ventilator associated events and C. difficile • Infection measures reported as rates, rather than ratios (more meaningful to consumers)	

Injuries from Immobility Measures and Gaps for the Safety Family of Measures

NQF # and Status	Measure	MAP Findings
#0141 Endorsed (paired with #0202)	Patient Fall Rate	
#0181 Endorsed	Increase in Number of Pressure Ulcers	
#0201 Endorsed	Pressure Ulcer Prevalence	
#0202 Endorsed (paired with #0141)	Falls with Injury	
#0266 Endorsed	ASC-2: Patient Fall	Measures 0141 and 0202 should be harmonized.
#0674 Endorsed	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	
Injuries from Immobility Priority Gap Areas	• Standard definition of falls across settings to avoid potential confusion related to two different fall rates • Evaluating bone density, prevention and treatment of osteoporosis in ambulatory settings	

Perioperative /Procedural Safety Measures and Gaps for the Safety Family of Measures

NQF # and Status	Measure	MAP Findings
#0263 Endorsed	ASC-1: Patient Burn -Percentage of ASC admissions Experiencing a Burn Prior to Discharge	Measure should be expanded to include all procedural settings.

#0267 Endorsed	ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	Measure should be expanded to include all procedural settings.
#0344 Endorsed	Accidental Puncture or Laceration (PDI 1) (risk adjusted)	Measure should be expanded to include all procedural settings.
#0345 Endorsed	PSI 15: Accidental Puncture or Laceration	Measure should be expanded to include all procedural settings.
#0362 Endorsed	Foreign Body Left after Procedure (PDI 3)	Measure should be expanded to include all procedural settings.
#0363 Endorsed	Foreign Body Left in During Procedure (PSI 5)	Measure should be expanded to include all procedural settings.
Not Endorsed	Safe Surgery Checklist	Measure should be brought to NQF for endorsement.
Perioperative/Procedural Safety Priority Gap Areas	• Single composite measure that encompasses all, or most significant, "never events" • Iatrogenic Pneumothorax measures: modify denominator to include patients receiving treatments putting them at risk for this complication • 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	

Medication/Infusion Safety Measures and Gaps for the Safety Family of Measures

NQF # and Status	Measure	MAP Findings
#0176 Endorsed	Improvement in Management of Oral Medications	Measure should be expanded to clinician office/clinic.

#0419 Endorsed	Documentation of Current Medications in the Medical Record	Measure should be expanded to include acute care facility.
#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)	Consider a shortened time window for reconciliation for this measure.
#0486 Endorsed	Adoption of Medication e-Prescribing	Measure should be expanded to include how e-prescribing is used.
#0293 Endorsed	Medication Information	Measure should be expanded beyond discharges from the ED.
#0022 Endorsed	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.	
Medication/Infusion Safety Priority Gap Areas	• Outcomes – injury/mortality related to inappropriate drug management • Patient-reported measures of understanding medications (purpose, dosage, side effects, etc.) • Total number of adverse drug events that occur within all settings (including administration of wrong medication, wrong dosage, drug-allergy or drug-drug interactions) • Polypharmacy and use of unnecessary medications for all ages, especially with high-risk medications • Comprehensive medication review • Role of community pharmacist or home health in reconciliation • Blood Incompatibility •Manifestations of Poor Glycemic Control •Air Embolism	

Obstetrical Adverse Events Measures and Gaps for the Safety Family of Measures

NQF # and Status	Measure	MAP Findings

#0469 Endorsed	PC-01 Elective Delivery Prior to 39 Completed Weeks Gestation	The contraindications list should be expanded for this measure.
#0471 Endorsed	PC-02 Cesarean Section	
Obstetrical Adverse Event Priority Gap Areas	• Obstetrical adverse event index • Overall complications composite measure • Measures using NHSN definitions for infections in newborns	

Safety-Related Overuse and Appropriateness Measures and Gaps for the Safety Family of Measures

NQF # and Status	Measure	MAP Findings
#0002 Endorsed	Appropriate Testing for Children with Pharyngitis	
#0052 Endorsed	Low Back Pain: Use of Imaging Studies	Measure should be expanded to include individuals over 50 years old.
#0058 Endorsed	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use	
#0069 Endorsed	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	
#0305 Endorsed	LBP: Surgical Timing	
#0309 Endorsed	LBP: Appropriate Use of Epidural Steroid Injections	
#0656 Endorsed	Otitis Media with Effusion: Systemic Corticosteroids – Avoidance of Inappropriate Use	
#0657 Endorsed	Percentage of Patients Aged 2 months through 12 years with a Diagnosis of OME who were not Prescribed Systemic Antimicrobials	
#0659 Endorsed	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	
#0667 Endorsed	Inappropriate Pulmonary CT Imaging for Patients at Low Risk for Pulmonary Embolism	
#0668 Endorsed	Appropriate Head CT Imaging in Adults with Mild Traumatic Brain Injury	

NQF # and Status	Measure	MAP Findings
#0755 Endorsed	Appropriate Cervical Spine Radiography and CT Imaging in Trauma	
Safety-Related Overuse & Appropriateness Priority Gap Areas	• Consistency in scoring for public reporting: should be clear if high or low scores are desired • Chemotherapy appropriateness, including dosing • 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 • Antibiotic use for sinusitis • Use of cardiac CT and stenting	

Complications-Related Mortality Measure and Gaps for the Safety Family of Measures

NQF # and Status	Measure	MAP Findings
#0351 Endorsed	Death among Surgical Inpatients with Serious, Treatable Complications (PSI 4)	Measure should include POA indicators.
Complications-Related Mortality Priority Gap Areas	• Preferably expressed as a ratio instead of percentage • Questions of how to accommodate small numbers • Expand to PAC/LTC settings • Failure to Rescue	

The task force requested more information about several specific measures, which they would then reconsider for inclusion in the safety family of measures during the July meeting:

- Under 1500g Infant Not Delivered at Appropriate Level of Care (NQF #0477)
- Healthy Term Newborn (NQF #0716)
- Complications-Related Mortality Measures (NQF #0351, 0352, 0353)

The meeting closed with a presentation and discussion about gap-filling pathways for the safety measure gaps that the task force had identified. Mark Antman, Physician Consortium for Performance Improvement (PCPI), and Erin Giovannetti, National Committee for Quality Assurance (NCQA), gave presentations regarding current measure development in the area of patient safety. They reviewed barriers their organizations have encountered in developing measures, including lack of a strong evidence-base, complex risk adjustment needs, small sample sizes, and limited financial resources. They emphasized priority areas in measure development that could potentially address important gaps in safety, such as creating measures addressing clinician education of and communication with the patient, designing measures that integrate into existing workflows to eliminate unnecessary burden, and finding a new ways for gathering patient-reported outcomes information (e.g., personal health records).

Dr. Opelka summarized themes from the meeting and then adjourned the meeting.