National Quality Strategy Webinar
Using Measurement for Quality Improvement

September 17, 2014
Housekeeping

- Submit technical questions via chat
- If you lose your Internet connection, reconnect using the link emailed to you
- If you lose your phone connection, re-dial the phone number and re-join
- ReadyTalk support: 800-843-9166
Agenda

• Welcome
  Heather Plochman, Facilitator

• Introduction to the National Quality Strategy
  Nancy Wilson, Executive Lead
  National Quality Strategy

• Centers for Medicare & Medicaid Services
  Kate Goodrich, Director, Quality Measurement and Health Assessment Group

• Office of the National Coordinator for Health Information Technology
  Kevin Larsen, Medical Director, Meaningful Use

• Questions and Answers
  Presenters
The National Quality Strategy: Using Measurement for Quality Improvement

Nancy Wilson, B.S.N., M.D., M.P.H.
The National Quality Strategy unites efforts to improve health and health care for all Americans. The above graphic provides a high-level view of how the National Quality Strategy works to provide better, more affordable care for the person and the community.
Quality Can Be Measured and Improved at Multiple Levels

Community
- Population-based denominator
- Multiple ways to define denominator (e.g., county, HRR)
- Applicable to all providers

Practice setting
- Denominator based on practice setting (e.g., hospital, group practice)

Individual physician
- Denominator bound by patients cared for
- Applies to all physicians
- Greatest component of a physician’s total performance

Increasing individual accountability
Increasing commonality among providers
Rationale for Addressing Measure Proliferation

• Proliferation of measures used by HHS Agencies for numerous programs and initiatives

• Redundancies and overlaps leading to provider/data collector burden, conflicting results, inefficient use of HHS resources, and lost opportunities to drive improvement through reinforcing program use of key measures

• No formal systematic mechanism to align, coordinate, and approve development, maintenance, implementation, and retirement of measures across HHS programs

• Precedent work done by Million Hearts™, Partnership for Patients, internal CMS Quality Measures Task Force, and MU2
HHS Measurement Policy Council (MPC)

- Assembled in spring 2012 with membership representative across HHS Agencies

- Establishes and operationalizes policies for HHS-wide measure development and implementation

- Work to date has focused on:
  - Reviewing publicly available HHS Measures Inventory and tackling topics around nine measure areas
  - Developing a coordination plan for future measure development
  - Piloting rules for categorizing measures across the Federal Government and multi-stakeholder groups
MPC Guiding Principles

• Focus on measures and policies that maximize quality improvement, minimize provider burden, and allow for assessment of the health of populations
• Deliberately align with National Quality and Prevention Strategies (and others when relevant)
• Leverage lessons learned from related HHS and external activities
• Develop consensus on standard definitions for data components of measures as well as measures themselves
• Maintain a portfolio of easily accessed artifacts from MPC deliberations
• Recognize alignment may not always be appropriate, but document justification when this occurs
• Use Measure Applications Partnership (MAP) to measure selection criteria
MPC Scope of Work: Short-Term

- To date, the Measurement Policy Council has reviewed and prioritized measures in nine major areas:
  - Hypertension
  - Depression
  - Smoking Cessation
  - Hospital-Acquired Conditions
  - Care Coordination (closing the referral loop)
  - Patient Experience of Care
  - HIV/AIDS
  - Perinatal
  - Obesity/BMI
MPC Scope of Work: Long-Term

- **Measure alignment**
  - Develop criteria on when it is appropriate/not appropriate to align measures within HHS
  - Develop consensus on the measure aspects on which to align (concepts, specifications, data sources, etc.)

- **New measure development and implementation**
  - Implement strategic direction for future measurement priorities
  - Coordinate measure submissions to the MAP
  - Coordinate measure development contracts

- **Measurement policy/management**
  - Manage measure domains
  - Identify measure selection, removal, and retirement criteria
  - Create core sets of measures
Kate Goodrich, M.D., M.H.S.
Director, Quality Measurement and Health Assessment Group

Centers for Medicare & Medicaid Services
Mission
What do we exist to do?

Vision
What is our picture of the future?

Goals
What are our main focus areas for improvement? What results are needed to satisfy stakeholders?

Objectives & Desired Outcomes
What continuous improvements are needed to get results?

Performance Measures and Targets
How will we know if we are achieving desired results?

Initiatives
What actions could contribute to the desired results?

Activities
What will support the initiatives?
The Strategy is to Concurrently Pursue Three Aims

Better Care
- Improve overall quality by making health care more patient-centered, reliable, accessible, and safe

Healthy People / Healthy Communities
- Improve population health by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care

Affordable Care
- Reduce the cost of quality health care for individuals, families, employers, and government
Measures should be patient-centered and outcome-oriented whenever possible.

Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures.
Make Care Safer

Objectives

<table>
<thead>
<tr>
<th>Goal 1</th>
<th>Goal 2</th>
<th>Goal 3</th>
<th>Goal 4</th>
<th>Goal 5</th>
<th>Goal 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve support for a culture of safety</td>
<td>Reduce inappropriate and unnecessary care</td>
<td>Prevent or minimize harm in all settings</td>
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Promote Effective Prevention and Treatment

Objectives

Goal 1: Increase appropriate use of screening and prevention services

Goal 2: Strengthen interventions to prevent heart attacks and strokes

Goal 3: Improve quality of care for patients with multiple chronic conditions

Goal 4: Improve behavioral health access and quality care

Goal 5: Improve perinatal outcomes
CMS’ Vision for Quality Measurement

- Align measures with the National Quality Strategy and six measure domains/priorities
- Implement measures that fill critical gaps within the six domains, particularly patient experience and patient-reported outcomes
- Align measures across CMS programs whenever possible
- Promote parsimonious and core sets of measures
- Remove measures that are no longer appropriate (e.g., topped out)
- Align measures with external stakeholders, including private payers, boards, and specialty societies
- Improve measures over time (a major aim)
Landscape of Quality Measurement

- Historically a silo approach to quality measurement
  - Different measures within each quality program
  - Different reporting criteria for each quality program
- No clear measure development strategy
- Typically disease-specific measures
- Confusing and burdensome to stakeholders
- Burdensome to CMS, with stovepipe solutions to quality measurement
The Future of Quality Measurement for Improvement and Accountability

- Transition meaningful quality measures away from setting-specific, narrow snapshots
- Reorient and align measures around patient-centered outcomes that span across settings
- Base measures on patient-centered episodes of care
- Capture measurement at three main levels (individual clinician, group/facility, population/community)
- Why do we measure?
  - Improvement

CMS Activities on Patient-Reported Outcome Measures (PROMs)

• In 2012, CMS funded the NQF to develop guidance on development of PROMs
• CMS currently uses a number of PROMs in our clinician reporting programs (e.g., depression, functional status)
• CMS and HHS are working to identify existing PROMs that can be rapidly incorporated into our quality reporting programs, including the ACO program and CMMI models
• CMS and ONC are currently developing PROMs for the hospital and outpatient setting
  – Disease-specific functional status
  – General functional status
• CMS now includes patients in all measure development work in order to understand the outcomes that are most important to patients and families
Kevin Larsen, M.D., FACP
Medical Director, Meaningful Use
Office of the National Coordinator for Health Information Technology
Health Information Exchange
“I am the expert about me.”

Patient-Reported Outcomes
INTEROPERABILITY

**Patient:** John Doe
**Age:** 38
**Notes:** Presented with acute abdominal pain

**Nom%:** To-awoi& *A0l} 2x--
**2Qxwo:** (*U*ej ap9 w8u2 3oj9P af >w8zVo8w”ao
Common Data Elements: The Future

Sex: □ M
□ F
□ Unknown

Gender: □ Male
□ Female

S: □ 01
□ 02
□ 03

Putting the i in Health IT
www.HealthIT.gov
OVERALL: Of the 1.1 million Americans living with HIV, only 25 percent are virally suppressed.

HIV Cascade

- Diagnosed: 82%
- Linked to Care: 66%
- Retained in Care: 37%
- Prescribed ART: 33%
- Virally Suppressed: 25%

Source: CDC, July 2012
Current

MU, PQRS, IQR, ACO, VBP, HRSA, CDC

Unified Outcome Measures

EHR as primary reporting platform, with secondary reporting from registry, claims
Only those who provide care can improve care
Clinical Decision Support: CDS 5 Rights

• To improve targeted health care decisions/outcomes, information interventions (CDS) must provide:
  – The right information
  – To the right people
  – Via the right channels
  – In the right formats
  – At the right times

• Optimize information flow: what, who, where, when, how
### Test Patient Data

<table>
<thead>
<tr>
<th>Provider</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADAM, Gino</td>
<td>69%</td>
<td>18 (26)</td>
</tr>
<tr>
<td>CANON, Michael</td>
<td>71%</td>
<td>20 (28)</td>
</tr>
<tr>
<td>COOPER, Edmund</td>
<td>61%</td>
<td>13 (21)</td>
</tr>
<tr>
<td>COOPER, George</td>
<td>68%</td>
<td>15 (22)</td>
</tr>
<tr>
<td>COOPER, Jane</td>
<td>75%</td>
<td>18 (24)</td>
</tr>
<tr>
<td>DARLING, Duane</td>
<td>79%</td>
<td>23 (29)</td>
</tr>
<tr>
<td>EDWARDS, Robert</td>
<td>78%</td>
<td>22 (28)</td>
</tr>
<tr>
<td>MYERS, Jamie</td>
<td>81%</td>
<td>27 (33)</td>
</tr>
</tbody>
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**MEASURE NAME:**
NQF0028 Preventive Care and Screening: Tobacco - (a) Use Assessment

**REPORTING PERIOD:**
07/31/2010 - 10/31/2010

**DESCRIPTION:**
Percentage of patients aged 18 years or older who have been seen for at least 2 office visits, who were queried about tobacco use one or more times within 24 months. If identified as tobacco users, patient received cessation intervention.
“Small data is our short-term focus.”

—Dr. Joe Kimura
Future State: HIT-Enabled QI Toolkit

Value Set Authority Center (Public Domain)

- Unambiguous human readable
- Unambiguous machine readable

Stakeholders:
- EHR Certification Tools
- Population Health Tool
- Electronic Health Records
- Clinical Registries
- Clinical Decision Support
- CMS Quality Reporting
- Other HIT Tools
How to Find More Tools and Resources

[Image of the NATIONAL QUALITY STRATEGY]

Working for Quality Web Site

CMS Quality Strategy

[Image of the Office of the National Coordinator for Health Information Technology]

Meaningful Use
Questions and Answers

Presenters
Questions and Answers

• For users of the audio broadcast, submit questions via chat

• For those who dialed into the meeting, dial 14 to enter the question queue
Thanks for attending today’s event

The presentation archive will be available at www.ahrq.gov/workingforquality within 2 weeks