Quality Measurement Update
Heather M. Young, PhD, RN, FAAN
Jonathan M. Evans, MD, MPH

Advancing Meaningful Measurement of Transitional Care Delivered to Older Adults Receiving LTSS Recommendations of the Long-Term Quality Alliance Measurement Workgroup

Quality Measurement Workgroup
Heather M. Young, UC Davis Health System (co-chair)
Greg Pawlson, (co-chair through June 2011)
Lyne Teinberg, AARP
Joe Francis, Department of Veterans Affairs
James Grothender, The Council on Quality Leadership
David Giliberti, American Health Care Association
David Eshkovski, Harvard Medical School, Dept of Health Care Policy
Jenifer Chen Hansen, American Geriatrics Society
Bill Hartzang, American Health Care Association
Ellen Kurtzman, George Washington University School of Nursing
Dave Kolly, National Center for Assisted Living
Katie Malese, Institutes of Medicine
Mark McCullough, Engberg Center for Health Care Reform, Brookings Institution
Paul McCann, Centers for Medicare and Medicaid Services
Diane Metz, Center to Advance Palliative Care
Vincent Miller, Brown University School of Medicine
Abigail Morgan, Office of Policy Analysis and Development, Administration on Aging
Joseph Ouslander, Charles E. Schmidt College of Medicine, Florida Atlantic University
Susan Reimbard, AARP
Martina Roes, University of Pennsylvania School of Nursing (through August 2011)
Alison Reinthrom, Alliance for Quality Nursing Home Care
Dw Rasco, CARF Research and Quality Improvement (RQI) department
Lisa Schumgeier, SCAN Foundation
Mark Teles, Duke University School of Nursing
Tom Valuck, National Quality Forum
Measurement Framework:
Key Domains

<table>
<thead>
<tr>
<th>Key Domains for Measuring Transitions in LTSS</th>
<th>IOM Aims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1 Person- and Family-Centeredness</td>
<td>Safe, Efficient</td>
</tr>
<tr>
<td>Domain 2 Transitional Care Processes</td>
<td>Patient-Centered</td>
</tr>
<tr>
<td>Domain 3 Performance Outcomes</td>
<td>Timely, Equitable</td>
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</tbody>
</table>

Approach to Measure Selection

<table>
<thead>
<tr>
<th>Phase 1 – Identify candidate measures</th>
<th>Establish conceptual framework and define key terms</th>
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<tbody>
<tr>
<td>Establishment of assessment domains</td>
<td>Establish performance measurement and establish a set of measures based on criteria</td>
</tr>
<tr>
<td>Expert opinion to validate and refine results and key domains</td>
<td>Phase 4 – Finalize measure recommendations</td>
</tr>
<tr>
<td>Survey 1 – Solicit feedback on measures</td>
<td>Phase 3 – Survey 2 – Expert opinion to validate and refine previous results and key domains</td>
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<tr>
<td>(n = 104)</td>
<td>(n = 100)</td>
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<tr>
<td>(n = 38)</td>
<td>(n = 12)</td>
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</tbody>
</table>

Recommended Measures

1. **Person and Family Centered Care**
   - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)(NQF 166)
   - Client Perceptions of Coordination Questionnaire (CPQ)

2. **Transitional Care**
   - 3-Item Care Transition Measure (CTM-3)(PCPI®)(NQF 228)
   - Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months (AQUA/NQAMQI/PCTP)
   - Percent of Medicare members 65 years of age and older who received at least two different high-risk medications (NQF 2030)
   - Percent of discharges from Jan 1st to Dec 1st of the measurement year for members 65 years of age and older for whom medications were reconciled on or within 30 days of discharge (NQF 350)
   - Mean change score for basic mobility of patient in a post-acute-care setting assessed (AM- PAC)(CREcare)(NQF 419)
**Recommended Measures**

1. **Transitional Care (continued)**

   - Mean change score in daily activity of patient in a post-acute-care setting assessed (AM-PAC)
     
   - Percent of patients, who need urgent, unplanned medical care (HIEC) (NCQA (NQF 430))

   - Percent of patients, regardless of age, discharged from an inpatient facility to home/any other site of care from whom a transition record was transmitted to the facility. (Primary physician/other health care professional to follow-up care within 24 hours of discharge) (FCHP) (NQF 468)

2. **Performance Outcomes**

   - All-cause readmission (risk-adjusted) (NQF 329) (HEDIS 2013)

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**Gaps in Transitional Care Measurement**

- Person and family-centeredness (beyond clinical outcomes)
- Process and outcome measures for older adults with cognitive impairment and those receiving palliative care
- Transitional care management across episodes of care
- Discharge readiness and social support
- Preventive care
- Access to, cost and cost-effectiveness of transitional care
- Disparities and measures reflective of unique subpopulations
- Performance of measure “bundle”

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**Next Steps**

- These consensus-based recommendations synchronize and align with the work of NQF and Measures Application Partnership’s (MAP) roles in recommending measures to CMS
- Initial testing of this set of measures can begin through additional LTQA programs including the launch of the Innovative Communities Initiative
- Further research is needed to develop and test measures that address LTSS priorities
Questions?
Comments?

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Dean, Betty Irene Moore School of Nursing
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Doug Pace
Executive Director, Long-Term Quality Alliance
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Applying Performance Measures to Improve Quality and Demonstrate Value
Long-Term Quality Alliance Annual Meeting
February 16, 2012

Tom Valuck, MD, JD
Senior Vice President, Strategic Partnerships

Quality Measurement Enterprise
Applying Performance Measurement Information

- Accountability
- Transparency
- Quality improvement
- Public health/disease surveillance
- Accreditation and regulation
- Performance-based payment
- HIT incentive payments
- Public Reporting

Purpose of MAP

- Provide input to HHS on the selection of performance measures for use in public reporting, performance-based payment, and other programs
- Identify gaps for measure development, testing, and endorsement
- Encourage alignment of public and private sector programs
- Align measurement across levels of analysis and settings to:
  - Promote coordination of care delivery
  - Reduce data collection burden

MAP Two-Tiered Structure

Coordinating Committee

- Hospital Workgroup
- Clinician Workgroup
- PAC/HC Workgroup
- Dual Eligible Beneficiaries Workgroup

Ad Hoc Safety Workgroup

More than 60 major stakeholder organizations, 40 individual experts, and 9 federal agencies are represented on the MAP.
### Measure Applications Partnership Initial Tasks

#### Performance Measurement Coordination Strategies

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Date Submitted</th>
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</thead>
<tbody>
<tr>
<td>Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries Intention</td>
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<tr>
<td>Performance Measurement Coordination Strategy for Post-Acute Care and Long-Term Care</td>
<td>February 1, 2012</td>
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Reports can be found on the NQF website.

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#### Measure Applications Partnership Initial Tasks

#### Annual Pre-rulemaking Input to HHS

<table>
<thead>
<tr>
<th>Report</th>
<th>Date Submitted</th>
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<tbody>
<tr>
<td>MAP Pre-Rulemaking Report</td>
<td>February 1, 2012</td>
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Report can be found on the NQF website.

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### Person- and Family-Centered Measurement

Measuring what is important to patients and construction of measures specific to patient populations rather than provider settings or diseases.

<table>
<thead>
<tr>
<th>Category</th>
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<tbody>
<tr>
<td>Better Care</td>
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<td>Healthy People/Healthy Communities</td>
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<td>Affordable Care</td>
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### Care Coordination Performance Measures Across Settings

<table>
<thead>
<tr>
<th>Category</th>
<th>Measure</th>
<th>Clinician</th>
<th>Hospital</th>
<th>Post-Acute Care/Long-Term Care</th>
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</thead>
<tbody>
<tr>
<td>Transitions</td>
<td>Support the inclusion of CTSI 3 measure and urge for it to be included in the existing HCAHPS survey</td>
<td>Support Do Not Support Support Do Not Support Support Do Not Support</td>
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<tr>
<td>Readmissions</td>
<td>Support the inclusion of readmission measures that crossed conditions and skin conditions that are condition specific</td>
<td>Support the inclusion of readmission measures that crossed conditions and skin conditions that are condition specific</td>
<td>Support Do Not Support Support Do Not Support Support Do Not Support</td>
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<tr>
<td>Medication Reconciliation</td>
<td>Recognize the importance of medication reconciliation upon both admission and discharge, particularly with the dual eligible beneficiaries and psychiatric populations</td>
<td>Recognize the importance of medication reconciliation upon both admission and discharge, particularly with the dual eligible beneficiaries and psychiatric populations</td>
<td>Support Do Not Support Support Do Not Support Support Do Not Support</td>
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### Federal Program for MAP Pre-Rulemaking Input

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<thead>
<tr>
<th>Program</th>
<th>Clinician Workgroup</th>
<th>Hospital Workgroup</th>
<th>PAC/LTC Workgroup</th>
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<tr>
<td>Value-Based Payments Incentive</td>
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<td>Physician Quality Reporting System</td>
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<td>Medicare and Medicaid EHR Incentive Program for Eligible Professionals</td>
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<td>Medicare Shared Savings Program</td>
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<td>Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs</td>
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<td>Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting</td>
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<td>Inpatient Psychiatric Facility Quality Reporting</td>
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<td>Ambulatory Surgical Center Quality Reporting</td>
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<td>Home Health Quality Reporting</td>
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<td>Nursing Home Quality Initiative and Nursing Home Compare Measures</td>
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<td>Inpatient Rehabilitation Facility Quality Reporting</td>
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<td>Long-Term Care Hospital Quality Reporting</td>
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<td>Hospice Quality Reporting</td>
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<td>End Stage Renal Disease Quality Management</td>
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### PAC-LTC Performance Measurement Programs

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<thead>
<tr>
<th>PAC-LTC Program</th>
<th>Measures Under Consideration</th>
<th>Support</th>
<th>Do Not Support</th>
<th>Support Direction</th>
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<tbody>
<tr>
<td>Nursing Home Compare</td>
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<td>Home Health Quality Reporting</td>
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Gaps Across the Measurement Spectrum

Upcoming MAP Reports

Performance Measurement Coordination Strategies

Ways to Participate in MAP Activities

- Visit the NQF website
- Attend MAP committee and workgroup meetings
  - All meetings are open to NQF members
  - Upcoming Meetings:
    - Dual Eligible Beneficiaries Workgroup In-Person Meeting, February 21-22, 2012
    - Coordinating Committee In-Person Meeting, March 15-16, 2012
  - Materials located on NQF website
- Public comment periods for reports
- Annual nomination process for new MAP members
Thank You!

Tom Valuck, MD, JD
Senior Vice President
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Quality of what?
- Medical care? Nursing care? Life? Health?
- Says who?
- How can you tell?
- Quality compared to what? Whom?
- Overall poor quality of health care, health in US compared to other nations
- Lack of data on medical treatment in very elderly
- Good quality at one age poor quality at another (e.g. diabetes control)
- What can you tell about quality when health and function decline?
- Quality of death?
- Getting what you want and not what you don't
Quality Issues (Cont’d)

- Too Much and Too Little treatment, often at same time
  - Medications in elderly
  - Age-appropriate Care
- Patient-Centered Care
  - Measurement issues
  - Surrogate decision making
  - Biases
- Unintended consequences
  - Measuring outcomes can result in cherry-picking, gaming the system, blaming patients

Measuring and Rewarding What Matters

- Will prolonging life always take precedence over quality of life?
  - Quality of life and quality of care cannot be opposites.
- We need to be able to measure how well people feel and how well they are getting what they want
- The best care requires the concerted effort of many people working together and communicating effectively with patients, families, and each other. We need to directly encourage that.
- Consistently good outcomes require good processes of care. Need to evaluate processes of care?
  - The efficient use of scarce or expensive resources

The Quality I Want

- Comfort, dignity, the relief of suffering, maximizing and maintaining function, promoting and preserving autonomy, helping people feel better through words and deeds- these are probably the truest measures of performance in health care but perhaps the most difficult to objectify and compare. They reflect the quality of caring, if not the quality of care itself.