Quality Measures for Stage 2/3 Meaningful Use

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Mary Patton Wheatley
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Clarification

• To qualify for HIT incentive payments requires data submission for HIT functional measures as well as quality measures

• The stage 2/3 MU functional measures will be released for public comment in January

• This call is focusing only on the QUALITY measures for stage 2/3
**Background**

- For stage 1 MU hospitals and physicians must calculate and submit quality measure data through attestation
- Stage 2 and 3 quality measures must be submitted via EMRs
- Quality subcommittee of HIT Policy Committee developed a framework for identifying measures for stage 2/3
  - Aligned with National Priorities Partnership
  - Aspirational
  - Stage 2 meant as foundation for stage 3
Framework

• NPP domains
  • Care coordination, efficiency, patient safety, patient and family engagement, population and public health

• Tiger teams built out each domain with sub-domains and measure concepts

• Quality committee released request for comment to primarily to identify measures that address the measure concepts

• Comments due December 23\textsuperscript{rd}
  • https://www.altarum.net/survey/qmrfc.aspx
## Domain: Patient and Family Engagement

<table>
<thead>
<tr>
<th>Category</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Management/ Activation</strong></td>
<td>Measures of patient activation, including skills, knowledge, and self-efficacy</td>
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<tr>
<td></td>
<td>Measures of patient self-management</td>
</tr>
<tr>
<td><strong>Honoring Patient Preferences and Shared Decision Making</strong></td>
<td>Measures of shared decision making or decision quality that address a combination of patient knowledge and incorporation of patient preferences</td>
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<td>Measures of patient preferences/experiences of care</td>
</tr>
<tr>
<td><strong>Patient Health Outcomes</strong></td>
<td>Measures of patient health outcomes, including health risk status, functional health status, and global measures of patient health</td>
</tr>
<tr>
<td><strong>Community Resources Coordination/Connection</strong></td>
<td>Measures of patient access to community resources for improved/sustainable care coordination</td>
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## Domain: Clinical Appropriateness

<table>
<thead>
<tr>
<th>Appropriate/Efficient Use of Facilities</th>
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<tbody>
<tr>
<td>Measures of all cause readmissions and length of stay</td>
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<tr>
<td>Measures assessing ambulatory care-sensitive preventable admissions</td>
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<thead>
<tr>
<th>Appropriate/Efficient Use of Diagnostic Tests</th>
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<tbody>
<tr>
<td>Measures assessing the appropriate use of diagnostic imaging procedures, with measures for redundancy, cumulative exposure, and appropriateness</td>
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<tr>
<th>Appropriate/Efficient Treatment of Chronic Disease across Multiple Sites of Care</th>
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<tbody>
<tr>
<td>Measures assessing the development of co-morbidities as a result of uncontrolled chronic disease (sequelae of uncontrolled diabetes)</td>
</tr>
<tr>
<td>Measures assessing reconciliation of the care plan for chronic disease patients across care settings and multiple specialists (process measure)</td>
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<th>Appropriate/Efficient Use of Medications</th>
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<tbody>
<tr>
<td>Measures assessing appropriate medication treatments, including overuse and/or underuse</td>
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<tr>
<td>Measures of medication use linked to adherence outcomes</td>
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<tr>
<td>Measures assessing usage rates for generic vs. brand name medications</td>
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<tr>
<td>Measures assessing the appropriate use of cardioprotective medications (aspirin, angiotensin-converting enzyme inhibitors, and statins) in individuals at high risk of experiencing heart attacks and strokes.</td>
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## Domain: Care Coordination

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<tr>
<th>Effective Care Planning</th>
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<tbody>
<tr>
<td>Measures assessing adherence to a comprehensive care plan in the EHR with an up to date problem list and care plan that reflects goals of care</td>
</tr>
<tr>
<td>Measures of an Advance Care Plan as a product of shared decision making</td>
</tr>
<tr>
<td>Measures of the success of a self management plan for patients with conditions where a self management plan might reasonably be considered to benefit them</td>
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<th>Care Transitions</th>
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<tr>
<td>Measures of reconciliation of all medications when receiving a patient from a different provider</td>
</tr>
<tr>
<td>Measures of patient and family experience of care coordination across a care transition (e.g. questions within HCAHP surveys)</td>
</tr>
<tr>
<td>Composite measures assessing receipt by both the care team members and the patient/caregiver of a comprehensive clinical summary after any care transition</td>
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<th>Appropriate and Timely Follow-Up</th>
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<td>Measures assessing timeliness of provider response, and appropriate response, to clinical information, including lab and diagnostic results</td>
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</table>
## Domain: Patient Safety

### Medication Safety
- Measures of adverse drug event (ADE) reporting
- Measures monitoring drug safety for patients who are on chronic medical therapy
- Measures of patient reported adverse events

### Hospital Associated Events
- Measures of process and outcome improvement of hospital associated infections
- Measures of venous thromboembolism (VTE) prophylaxis and VTE rates
- Measures of falls events and screening
## Domain: Population/Public Health

### Healthy Lifestyle Behaviors

Measures of use/availability of services that promote healthy lifestyles (smoking cessation, body mass index management, patient health literacy):

A) Smoking cessation - focused specifically on quit rate for patients within a reporting period.

B) Body Mass Index - focused specifically on tracking longitudinal change to determine patient outcome.

Measures of screening for alcohol use using a validated tool.

### Effective Preventative Services

Measures of mental health screening using a validated instrument.

Measures of blood pressure focused specifically on tracking longitudinal change to determine patient outcome.

Measures of glucose monitoring focused specifically on tracking longitudinal change to determine patient outcome.

### Health Equity

Measures with no discrepancy when comparing health outcomes among those within priority populations to those not within the priority populations.
### Other

| Measures that assess preventable ED visits |
| Measures that assess adherence to clinical practice standards (appropriate cardiac/cancer treatments) |
| Measures that assess combined quality and cost measures at each level and site of care reflecting potential defects in care |
| Measures of medication error near misses |
| Measures of patient identification errors and near misses |
| Measures of common EHR-related errors (mechanism to report EHR related errors and delays in care to improve EHRs) |
Feedback for Members

- Thoughts about the framework/domains?

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<td>Appropriate/ Efficient Use of: •Facilities •Dx Tests •Medication</td>
<td>Effective Care Planning</td>
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<td>Healthy Lifestyle Behaviors</td>
</tr>
<tr>
<td>Pt. Preference/Shared Decision Making</td>
<td>Appropriate/ Efficient Treatment of chronic diseases across sites of care</td>
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AAMC Principles

• Use measures that are specified and tested for EHRs and NQF endorsed
• Measures should improve care
• Streamline reporting across programs
• Do not “double count” results
  ▪ Ex. readmissions, HAC
• Balance of idealism/realism
  ▪ Lack of evidence, measures, etc.
  ▪ Natural link to HIT
  ▪ Do not stifle innovation
Other preliminary thoughts

- List should be focused/narrowed
  - Some ideas covered in meaningful use functionality

- Perhaps focus on diseases or sets of comorbidities
  - Framework could evaluate breadth of measure or set of measures
  - More natural way of thinking about evidence/care?
Other Ideas?

• Contact

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Comments due Thursday 12/23