Outpatient Quality Reporting Program

Support Contractor

The Lifecycle of Healthcare Quality Measures

Presentation

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Elizabeth Bainger: Hi, everyone. Thank you for coming today. My name is Elizabeth Bainger, and I'm a nurse consultant for CMS. I am also the program lead for the Outpatient Quality Reporting Program.

I do want to let you know that this webinar has been prerecorded. If you tuned in to the Outpatient Quality Reporting Final Rule webinar last month, you might recall that my Internet connection failed, and I couldn't see the slides.

To avoid those types of technical difficulties, I recorded this presentation. However, I am on live, and I will be trending questions so that I can respond to those at the end of the presentation.

Before we move forward, let me share a little more about myself. I'm a nurse. I've been a nurse for 30 years. About five or six years ago, I entered the quality arena. I became a performance improvement coordinator at a community hospital, and as I learned about quality measures and quality improvement, I wished that I had known the things that I learned as PI coordinator when I was a nurse giving direct patient care. I think I would have been a better care provider. Then, about a

year and a half ago, I came to CMS, and I got that same feeling again. I was seeing quality improvement at an even higher level, and I wished I'd known then when I was a PI coordinator what I know now. I would like to share a little with you about what I've learned.

When I came to CMS, a year and a half ago, I was immediately immersed into rule-writing. This was brand new to me. I hadn't been around for the proposed rule that was done by my predecessor. I came in during the public comment period, and I saw firsthand how public comment impacted the final rule.

The program had proposed to remove a measure, believing it was topped out. That is to say, we believe that the performance was already so good that there was negligible room for improvement, but many commenters felt that the measure should be retained. This caused us to take a deeper dive into the data, and we discovered that there was, in fact, still room for improvement, especially among hospitals with the smaller numbers of cases. And we ended up retaining that measure.

In another case, for that same rule, a single commenter made a suggestion regarding a proposed change in our validation method. It was a really good suggestion, and based on that one comment, we refined our proposal.

That first experience with rule-writing made a profound impression on me, and it made me wonder about the other ways the public could impact the measure management system here at CMS.

Now, I want to let you know I'm also a doctoral student at the University of Maryland School of Nursing. And about a year ago, I took this idea both to the school and to CMS. My first experience with rule-writing laid the foundation for today's presentation. For my scholarly project, I wanted to explain the measure management process in non-technical

terms. But, even more, I have two personal goals: first, I'm hoping to share with you opportunities where you can impact the CMS measures management system, and second, I'm hoping to inspire you to actually do it.

So, I shared with you my two personal goals for this presentation, but let's take a look at the participant objectives. As you know, if you complete and submit the post-test, you'll be awarded continuing education credit.

Okay, I promise, this is the only slide that I'll read. The objectives for today's presentation include recognizing the historical and legislative context of CMS hospital quality reporting programs, describing the National Quality Strategy and how it frames the CMS measures management system, understanding the five stages of the quality measure lifecycle and recognizing opportunities to impact it, and finally, addressing the Institute of Medicine's mandate to identify measures in terms of structure, process, and outcomes.

This slide is meant to provide a very brief snapshot of the historical context and legislative mandate for CMS hospital quality measurement program.

At the turn of the century, the Institute of Medicine, or IOM, issued two seminal reports. *To Err is Human* revealed that as many as 98,000 patient deaths per year were attributable to preventable causes. It was quickly followed by *Crossing the Chasm* which described the gap – the huge gap, the chasm – between quality healthcare and the care patients actually received.

In 2001, Secretary Thompson of the U.S. Department of Health and Human Services announced his quality initiative. This was his

commitment to improve the quality of care for all Americans through accountability and public disclosure.

The initiative was launched in 2002 as the Nursing Home Quality Initiative and expanded in 2003 with the Hospital Quality Initiative which included voluntary reporting of data on a starter set of 10 quality measures for three conditions: acute myocardial infarction, heart failure, and pneumonia. Participation in the voluntary quality initiative program was lackluster until Section 501B of the Medicare Prescription Drug Improvement and Modernization Act of 2003 mandated a reimbursement reduction for hospitals electing not to report quality data. The law further stipulated that the data would be used for public reporting purposes, and, in 2005 the first core set of process of care measures were displayed on the Hospital Compare website.

Now, as I indicated earlier, this slide only represents a brief snapshot of the start of the Hospital Quality Reporting Program. Certainly, there is more recent legislation which affects quality reporting, including the Affordable Care Act of 2010 which provided CMS the authority to develop and implement quality reporting programs across multiple settings. There is also the IMPACT Act of 2014 and MACRA, which was passed earlier this year in 2015. But I wanted to give you a quick idea of where we were coming from, what the initial drivers were for CMS quality reporting.

We just touched on this, the purpose of measures and hospital quality reporting programs. To close the chasm, healthcare organizations began focusing on quality measurement, tying from the business saying that you can't improve what you don't measure. CMS incentivized the reporting of quality measures in two ways: by linking it through reimbursement and by publicly reporting results. There was a twofold rationale for the Hospital Compare website, which is often referred to in literature as online report cards. First was transparency; it empowered

patients to make informed choices about their care based on hospital and provider and performance. Second, it served as a powerful incentive for hospitals and clinicians to identify and address opportunities for quality improvement.

In 2010, the Affordable Care Act required HHS to develop a National Quality Strategy, NQS, for improvement in healthcare. First published in 2011, it frames the CMS measures management system. The NQS focuses on three aims: better care, smarter spending, and healthier people and communities.

To accomplish these aims, the NQS focuses on six domains or priorities: making care safer, strengthening patient and facility engagement, promoting effective communication and care coordination, promoting effective prevention and treatment, working with communities to promote best practices of healthy living, and making care affordable. Measure developers are tasked with ensuring performance measures align with NQS priorities, and CMS is tasked with incorporating measures within each of the six domains into all of its public reporting and payment program. That's really key, so let me repeat it.

Measure developers are tasked with ensuring performance measures align with NQS priorities, and CMS is tasked with incorporating measures within each of the six domains into all of its public reporting and payment programs.

As a program lead, I can tell you that at least a couple times a year we take a very close look at our current measure set in relation to the six domains of the National Quality Strategy. We look for gaps and look to see if there are opportunities for measure development or implementing existing measures, and we consider the National Quality Strategy domains when we consider removing measures.

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CMS has refined the National Quality Strategy to address our organization's specific mandates. Now, if you have a QR Reader installed on your Smartphone or mobile device, you can scan this symbol and learn more about the CMS Quality Strategy. The website has been recently revised and now includes a 2016 update. And if you go there, you'll be able to learn more about how CMS embeds four foundational principles within each of the six domains. Those four principles are: elimination of racial and ethnic disparities, strengthening infrastructure and data systems, enabling local innovation tailored to individual settings, and fostering learning organizations to promote continuing learning about best practices.

Now, I don't want to go too deep in the weeds here because I could usually do an entire webinar devoted just to the National Quality Strategy and the CMS Quality Strategy, but I did want to point you toward these resources.

For your reference, here are the three aims and six domains of the NQS. I wanted to clearly point this out for you because, as I mentioned, this is what frames the measures management system.

Sometimes, in the quality reporting literature, you'll see those three aims sometimes referred to as the Triple Aim. It's been refined through the years, but this is what's they're referring to: better care, smarter spending, and healthier people and communities.

But where do the measures come from? How are they conceptualized, implemented and managed? The answers can be found in a 470 page electronic book entitled, *A Blueprint for the CMS Measures Management System*. CMS provides detailed information about how healthcare quality measures are developed, implemented, and maintained. The document is highly technical because its primary purpose is to inform measure developers how to develop strong

measures that are suitable for both provider accountability and for public reporting. Because this is written with measure developers in mind, it's extremely technical, as I said. The blueprint is evolving; I'm linking you to version 11.1 which came out in August, and version 11.2 will be coming out later in December or early January. Though the blueprint received a comprehensive annual update by the measures manager, continuous improvements are incorporated in quarterly updates as needed. But to date, CMS has not provided a practical translation for the general healthcare quality improvement community. I'm hoping to do that here.

Here's a very high-level view of the measures lifecycle. The CMS measure lifecycle has five phases: conceptualization; specification; testing; implementation; and use, continuing evaluation, and maintenance.

Although this slide depicts the flow of the measure lifecycle in a linear fashion, the process is iterative and may loop back on itself, or some steps may be conducted concurrently.

During the first stage of the CMS measure lifecycle, measure conceptualization, we consider whether the concept is an important one. Can it be measured, and should it be measured?

The importance criterion is the first and highest priority question. This is the one that developers and government have to defend to the consensus endorsement entity, the provider community, and to the patients and consumers. We need to present considerable evidence to support this. This evidence comes from the literature, providers, patients, and consumers. If we cannot prove importance, we get a hard stop.

Developers also need to identity the extent to which we can measure the concept. The closer we can get to the actual concept, the more accurate and valuable the measure will be. Proxies sometimes work, too. In addition, the easier it is to measure the concept, the better.

Should it be measured? This goes back to the importance, but from a different perspective. The ultimate answer to this question is whether measuring the concept can be used to improve it. Will measuring it add value to the patient's care? If the answer is yes, continue. If not, we'll have a hard stop.

Let's move on to the "How." The evidence base is established via reviews of the literature and clinical practice guidelines, and interviews with subject matter experts and stakeholder organizations. Sometimes CMS posts a call for measures as part of the environmental scan.

I'd like to point out the little icons I have attached throughout the slide. Up here, if you click this, you'll find I embedded a Web link. If there were a call for measures, it would be posted in this page. Developers will then need to develop and defend a business case. Here, each measure is evaluated against five criteria: importance, scientific acceptability, feasibility, usability, and related or competing measures. In addition, this is the time to consider the prevalence of a condition in the Medicare population and develop cost statistics. The measure developers will relate the cost of implementing the measure against the savings that result from implementing it.

The next step is to develop an initial list of measures based on the results of the previous steps. This list may consist of adopted, adapted or new measures, or measure concepts. It is reviewed and narrowed to create a list of potential measures that might be included in quality reporting programs.

Now, we're moving on to evaluation by a technical expert panel, or TEP. A TEP is a group of stakeholders and experts who contribute direction and thoughtful input to the measure developer during measure development and maintenance. It's important that the TEP includes a broad representation across the spectrum, so we want to include measurement experts (like statisticians), providers (like doctors and nurses), and patients or their caregivers. We've even had a caregiver serve as the chair of a TEP before. I'm going to talk about this more about this under the “Who” section.

So, let's move down to that section and look at the “Who” involved in the measure conceptualization. We already talked about Congress; they passed the ACA in 2010 and established the National Quality Strategy. Legislation often provides the impetus for measure development; for example, Congress mandated Hospital Value-Based Purchasing, and so new measures were conceptualized and developed with that refocusing from volume to value.

There are a number of stakeholder groups that develop quality measures. CMS, of course, develops quality measures, and so do our federal partners, such as the Agency for Healthcare Research and Quality, AHRQ.

You're probably aware of The Joint Commissions' involvement. In addition, professional organizations develop measures. Healthcare associations develop measures; medical societies, such as the American Medical Association, develop measures. In this past final rule for the OQR Program, we adopted a measure that was developed by the American Society of Radiation Oncology.

So, if you're a part of a professional organization, then one way that you can become involved is by encouraging your organization to support research that aligns with the NQS. And I’ve talked about public

comment to CMS, but if you are a member of a professional organization, make your views known to them as well. But the two other ways to become involved in this stage of measure development are right here (I have Web links again): TEP panels and public comment.

Let's look at the TEP Web link. Here you'll find all the calls are out for various technical expert panels. You can see there's quite a lot out right now. This one just ended in October 12, so you do need to take a look the date. It will provide for you the overview of the objectives, the requirements. I want you to take a look at this because here is where you can find out if there might be a role for you. It also provides for you the document. I'm trying to find one where – see here this one, I don't know if you're able to see what I'm moving here. This one is actually looking for the patient and family perspective.

So, you may be an expert in quality improvement or healthcare delivery and be able to apply to be part of the TEPs, but either you or a loved one may have been a patient that they're looking for. You might be able to join a TEP, taking on that patient caregiver role, so I want you to be aware of that and take a look at these pages.

Now, let's look at opportunities for public comment at this very early stage of measure conceptualization. Again, I have a Web link. Public comment ensures that measures are developed using a transparent process with balanced input from relevant stakeholders and other interested parties. During a public comment period, measure developers may receive critical suggestion that were not previously considered by the measure developer and the TEP. It's very important that you avail yourself with this opportunity to make public comment.

So, to recap, you can impact the measures management system even at the infancy of measure development when the concept is first being explored. Make your views known to your congressional representative

and to your professional organization. Be involved, nominate yourself to be part of a TEP, and be sure to provide comment to CMS. I mentioned the five criteria that CMS uses to evaluate a concept. When you comment to CMS, address those criteria. It will give your comment more weight. So for example, if you think that a concept isn't feasible, tell us why.

During the second stage of the CMS measure lifecycle, measure specifications, we identified the population that is to be measured, whether it's children, patients with multiple chronic conditions, and so on. At this stage, we also decide on how that measure should be reported. Should we use claims data, or should we use electronic health records? And we also need to think about if are there measures that could harmonize with it. This stage is an iterative process that results in the development of detailed and precise technical specifications which can ensure consistent and reliable data collection.

I'm going to run through the “How” section quickly because most of this audience isn't going to be involved in measure specification. First, measure developers must draft precise technical specifications, including very clear definitions of the numerator and denominator.

Next, they must define the data source. If the measure is calculated from more than one data source, they have to develop detailed specifications for each data source. And it's important that we collect evidence that the results calculated from different data sources are comparable.

Next, we specify the code sets. Most CMS measures rely, at least in part, on the use of various code sets for classifying healthcare provided in United States. For example, there’s the Current Procedural Terminology, or CPT, code sets; those are owned and maintained by the AMA,

And finally, the measure developers construct data collection protocols. They define key terms, data elements, level of analysis, sampling, risk adjustment, scoring, and they may develop any needed algorithms.

So let's look at the "Who." Unless if you're at a research facility, it's unlikely that most of the people listening in right now will be part of this because it includes measure developers and the organizations that I already discussed.

During the third stage, measure testing, both formative and field testing is completed to ensure the valid and reliable implementation of the measure across organizations. The testing phase generates empirical evidence to assess the strengths and weaknesses against the five criteria that I previously listed: importance, scientific acceptability, feasibility, usability, and related or competing measures. We're considering whether the data can be collected or if it's feasible, do the results make sense or are they valid and reliable, and is the information important.

Moving in to the "How" section, we need to develop the testing work plan. This is going to include alpha and beta testing, considering the data collection methodology, test population, sampling methods, and so forth. You can see how this stage, testing, builds on the previous specification stage.

Alpha tests, also called formative tests, are of limited scope since they usually occur before detailed specifications are fully developed. Alpha testing often focuses on feasibility. Here the measure developers are determining if individual data elements are available and if the form in which they exist is consistent with the intent of the measure.

Beta testing, also called field testing, generally occurs after the initial technical specifications have been developed and is usually larger in scope than alpha testing. In addition to gathering further information

about feasibility, beta tests serve as the primary means to assess scientific acceptability and the usability of a measure.

Once all the data are gathered from the test site, the measure developers conduct a series of analyses to characterize the feasibility, integrity, and face validity of the measures. The measure developer may need to modify the measure specifications, the data collection instructions, and the calculation method. For example, following alpha testing, they need to – may need to re-specify the measure in order to overcome implementation barriers. Following beta testing, they might make adjustments in the definition of a population.

So let's look at the "Who." Measure developers. Again, this might involve you if you are at a research facility.

The TEP, if changes and refinements are made, whenever there is a significant change, it's important to consult the TEP. So, if you have been – part of the TEP at the start, you'll probably see this measure all the way through and be brought in if there are changes.

And then pilot sites. These are facilities that take part in the alpha and beta testing. Now, how do you become a pilot site? CMS has already established relationships with many research facilities, but sometimes a call for a pilot site is put out in the *Federal Register*. In addition, if you want to be considered as pilot site, contact me and I can put you in touch with the right people. I do want to point out, though, that pilot sites are not paid. They are not compensated in any way. This is done for the good of the profession, for altruistic reasons. TEPs, on the other hand, might be compensated for your time or for your travel.

During the implementation phase, CMS is considering whether there is consensus to adopt the measures. So what that does mean?

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To increase the transparency, the Affordable Care Act required the establishment of pre-rulemaking process for the selection of healthcare quality measures. Pre-rulemaking was a significant change; it marked the first time the federal government collaborated with public and private sectors in advance of regulatory rule-making with regard to the selection of performance measures.

Since 2011, the National Quality Forum, NQF, an independent and non-partisan organization, has utilized a formal consensus development process to review and provide feedback on the measures under consideration by the Department of Health and Human Services.

To ensure consensus, the NQF convenes a multi-stakeholder panel, the Measures Application Partnership, or MAP. The MAP brings together diverse representatives – including patients, clinicians, businesses, and governmental entities – to inform the selection of quality measures used for public reporting and performance-based payment programs. CMS must consider MAP input. All MAP meetings are open to the public. Their reports and other materials are also made available on the NQF website. Public comments are sought on the MAP recommendations, and like CMS, the MAP reviews and considers every comment it receives. So, there is another opportunity to get involved. Attend those meetings, if you have availability, and certainly take advantage of the opportunity to provide comment to NQF.

So, we've looked at the “What” and even the first two elements under the “Who.” Let's look more at the “How.” Again, you can see items embedded from Web links. When you click the first link, it takes you to the pre-rulemaking page at CMS.gov.

When I first came to CMS, my division director told me to always remember that measures move from the MUD to the MUC. MUD refers to measures under development and MUC refers to measures under

consideration. So the measures that CMS is considering, the measures under consideration, they are fully developed, and now they're being considered for inclusion into the quality reporting programs.

By December 1st of each year, CMS needs to make the list of measures under consideration public. Then a couple of months later, by February 1st, the NQF will provide its input regarding the selection of those measures.

Now, a few things could happen. The NQF may endorse a measure, and CMS may decide that it's going to include that measure in the current rule-making cycle. Or CMS might decide that this isn't the right time, and they may choose to propose or adopt that measure in a subsequent rule-making cycle. Or CMS may decide that this really isn't the right measure at all, and never propose the measure for inclusion in a quality reporting program. So, just because the measure received NQF endorsement doesn't mean CMS is going to include it in a quality reporting program.

What if the NQF decides that it doesn't want to endorse a measure? Well, CMS must consider that recommendation, and if CMS decides that it wants to propose the measure despite the lack of NQF endorsement, then CMS must publish its rationale. Also, if measure specifications significantly change, then the changed measure must be submitted for each applicable quality reporting program.

This next Web link provides the same information, but it takes you to the NQF website, so I just wanted you to be aware of this website. The same information, just from a different perspective.

The next website that I want to show you is regulations.gov. Now, I shared with you at the beginning of the presentation about how I was so personally affected, to see the impact of public comment on CMS rule-

making. Regulations.gov is the website that you can go to submit public comment. Remember, one comment can have an impact. And to add weight to your comment, go back to those five criteria. If you think we have the science wrong, tell us.

After a measure has been adopted, CMS will roll out the measure. This includes addressing data management and validation concerns, appeals processes, and so on. Depending upon the measure, this might include a dry run to address any potential concerns.

Now, if you're in the OQR or ASC Program, you're familiar that we're wrapping up a dry run for the colonoscopy measure. The purpose of the dry run is to finalize all methodologies related to case identification and selection, data collection, and measurement calculation. It verifies that the measure design works as intended, and it begins to identify unintended consequences. It also gives facilities a chance to become familiar with the reports of the measure results. Findings from a dry run are not publicly reported or used for payment, though CMS may decide to use them as the baseline measurement.

With every measure, CMS will provide education and outreach to the applicable hospitals, providers, ASCs, and so on to ensure that you know where to access measure specifications and how to properly extract the measure data.

That brings us to the final phase of the CMS measures management system, and that is measure use, continuing evaluation, and maintenance. During this phase, we're always asking if the measure is working. The program is always monitoring the measure performance, responding to ongoing feedback, and continuously scanning the environment.

Every measure undergoes an annual update. This is a limited review of the measure specifications, and it also includes a review of the reliability and validity of the data elements.

Every measure undergoes a triennial reevaluation, and in a lot of ways, this evaluation parallels the measure development process. So when an environmental scan is completed, a TEP might be convened, and the business case is updated. NQF also conducts a three-year maintenance review, so the CMS triennial review is timed to just precede that. This allows CMS an opportunity to review the findings and recommendations prior to the submission to NQF. And this also a good time for CMS to assess for related or competing measures, and efforts can be made to harmonize measure specifications with other measures.

Ad hoc reviews occur when there's a significant and unforeseen problem with the measure, such as when there is a major change in the scientific evidence supporting the measure.

So, there's an annual update, and the triennial reviews happen with every measure, but the ad hoc reviews only occur when there's a significant or unforeseen problem with the measure.

Now, there are a few potential outcomes from this evaluation. We could choose to retire the measure. This only applies to measures that are owned by CMS, and it means that we won't continue to maintain those measures. We'll cease the collection and reporting of the measure indefinitely. We could choose to retain the measure. In that case, we're going to keep the measure active with its current specifications or with just minor changes. We can choose to revise the measure, so we're going to update the measure's current specifications to reflect new information. Remember, I said if there's a significant revision, it goes back to NQF. We could choose to suspend the measure which means we're going to cease to report it, or we could choose to remove a

measure which means it's no longer included in a particular CMS program set.

Remember, sometimes these measures are used across programs and still could be removed in one quality reporting program but retained in another. It just depends upon the setting, sometimes.

I have one Web link on the slide, and it takes you to the webpage for the *National Impact Assessments*. These reports were mandated by the ACA and are required at least every three years. The reports provide a quality check for CMS. Are we making progress toward achieving the three aims: the better care, smarter spending, and healthier people? The first report was published in 2012, and the most recent report came out earlier this year. While scrolling down, you can see where those reports are listed and future concerns. The next report is due in 2018, and the TEP has already been convened that includes individuals representing patients and caregivers. I really want to point that out. CMS is really putting a strong emphasis on including patients and caregivers. I would like you to get that message out for us, if you could.

Looking at the "Who," remember that I said these evaluations are continual, and a comprehensive evaluation takes place every three years which parallels the measure development processes. That means all stakeholders that came into play in previous slides also have a role in this stage, so you can look for opportunities to participate in a TEP, to attend NQF meetings, to submit public comment.

So let me recap. As I see it, you have three avenues to impact the measure management system: through CMS, through your professional organization, and through the National Quality Forum. And you can take different paths within each.

At CMS, we invite you to be part of our TEPs. If you're in a hospital, maybe you would like to become a pilot site for measure testing. And of course, we welcome your comments both individually and through your organization. Also, please read the reports that we make available, like the *Impact Assessment*. Stay informed so that you can be better involved.

Next, the professional organizations. If you can, become involved in measure development at your professional organization level. At least, encourage your organization to pursue measure development that aligns with the NQF so that we're all headed in the same direction.

And again, make public comment both through your organization and individually.

And finally, I talked about the NQF. So before, I was talking about the National Quality Strategy, the NQS; now, I'm talking about the NQF. Their meetings are open to the public. Stay informed, read their reports, make public comment. If your professional organization is active in the NQF, and I bet it likely is, be part of that. Make your views known to your organizational representatives. These are just some of the ways that you can impact the measure development process.

This slide puts it all together. I copied it directly out of the *Blueprint*, so you can see the citation there. The elements in red are accomplished by CMS. The other elements, you might be involved in, but the measure developers are definitely involved in.

I mentioned that this presentation is part of my scholarly project for my doctoral studies, so I need to address an IOM concern. In a 2003 report, the IOM delineated core competencies that all healthcare professionals should possess, regardless of discipline. Among these is the ability to

apply QI methodology as evidenced by understanding and measuring quality in terms of structure, process, and outcomes.

Measures can be categorized in many ways, such as by National Quality Strategy priority. So for instance, the measure has fallen into the category of making it safer or care coordination, and so on. By type – which we're going to talk about – structure, process, outcome, etc. By data source, by setting of care provided, and level of analysis.

Back in the 1960s, Donabedian, who was a health researcher at the University of Michigan, proposed a structure-process-outcome framework for evaluating healthcare. His model was very linear in fashion; each component directly influenced the next. So, strong organizational structure leads to improved processes which promote better patient outcomes. As this theory has evolved, it's being seen more as a triad rather than a linear relationship. As a result, outcome measures, which were once thought to be way too downstream to be relevant, are now becoming more prevalent because, when viewed as a triad, we can recognize that by measuring outcomes, we may also see opportunities for improvement in process or structure, and vice versa.

Structural characteristics refer to the fixed attributes of the organizational setting and of the healthcare providers. This may include staffing levels or the equipment in a hospital, when you look at our measure sets I've included on here. An example of a structural measure is: “Does the healthcare organization use computerized physician order entry?” And that's a Meaningful Use core objective.

Process measures are evidence-based. They may describe the technical steps that are involved in the provision of care. And again, I offered an example here, the percentage of AMI patients who received aspirin within 24 hours before or after hospital arrival.

Outcome measures broadly denote a change in the health status of patients and populations. These may include mortality rates or results from a blood test.

Again, keep in mind that Donabedian's model is just one way for categorizing measures. CMS has added to this model the patient's experience of care which is just as it sounds – a measure of the patient or caregiver's perception of care. HCAHPS is a perfect example of that.

Okay. I did say that the only slide I would read was the one addressing participant objectives, but this slide is pretty self-explanatory. It's where we want to go with performance measurement, and we're making great strides. We are all working toward aligning measures across programs and filling the gaps that we identify in the NQS domains. We're also trying to remove measures that are no longer appropriate, and we always consider provider burden when we're implementing new measures.

These are just a few of our considerations. We also want to increase the adoption of healthcare information technology systems and the sharing of records across an enterprise. We want to embrace team-based care and care coordination across settings. And of course, more work is needed to identify and measure the outcomes that matter most to patients, caregivers, providers, and communities. There's a strong emphasis on the need to incorporate and respect patient and caregiver preferences.

Before I open up for questions, I'd like to ask you to consider completing this optional survey. Just click the URL, and it will take you directly to the survey. You can only provide once response per question, but you don't have to answer every question. If you're uncomfortable with the question, skip it. If you don't want to complete the survey at all, that's okay, too. As I said, this is voluntary.

The first two survey questions have to do with my goals that I talked about at the start. First, I hope I was successful in sharing with you opportunities where you can impact the CMS measure management system. Second, I'm hoping I inspired you to actually do it.

Then, you'll notice that I'm also asking some demographic questions – again, completely voluntary. There are people involved in quality that are from so many vary backgrounds and disciplines, and they're all working together to improve patient care. The National Association of Healthcare Quality polled its members, and about half responded. Of those, half were nurses like me. The QI professionals also include doctors, healthcare administrators, project managers, researchers, and more. I'd appreciate it if you could give me a better idea of who's in this audience today. I'll be sharing this information with the University of Maryland School of Nursing because it is part of my scholarly project for my doctor of nursing practice. I'm also looking ahead to publication, which I think will mostly focus on the content of this presentation, but there's a chance that I might include this information and publication as well.

Again, it's completely voluntary. You do not need to complete this in order to get your continuing education credit. If you do complete the survey and click the submission button, it will take you to the qualityreportingcenter website. If you see that, you know your survey was accepted, and please know that I appreciate it. Also, if you're viewing this with others, you can each use the same URL; just submit the survey and then return to the URL for the next person, and so on. I'll be leaving it open for the next few days.

Now, I'm going to live questions. As for answering questions, I'm going to move along the reference slides that I provided and my contact information slide just so you can see those. But then, I'm going to settle back on the slide of the survey link.

Karen VanBourgondien: Elizabeth, thank you so much, and we appreciate your taking questions. I do have a quick question here. I would like to ask this first, and the question is: "Does pre-rulemaking apply to all quality reporting programs?"

Elizabeth Bainger: Karen, I'm having a little trouble hearing you, but I think you asked: "Does pre-rulemaking apply to all quality reporting programs?"

Karen VanBourgondien: Yes.

Elizabeth Bainger: Actually no, it doesn't. It – I geared this presentation to this particular audience, so while pre-rulemaking doesn't apply to all quality reporting programs, it – for example, it doesn't apply to Medicaid, but it does apply to the Ambulatory Surgical Center Quality Reporting Program and also to both the Inpatient and Outpatient side of the Hospital Quality Reporting Program. But there are other steps that I didn't describe that you might find in other settings.

Karen VanBourgondien: Okay, great, Elizabeth. Thank you.

I do have another question here, and I will respond to this question, if you don't mind, because we do get this a lot. This question came in a lot at the beginning and continues through. The question is: "Where we can get the slides?"

We always have all of the slides posted prior to any given webinar, and they are always posted on qualityreportingcenter.com. You just click on the event that you are interested in, and the slides are posted. Additionally, the slides – once your register for an event, those slides are always attached to the reminder email that you get.

I would like to also mention that on this particular presentation, all of the links that Elizabeth clicked on during this presentation are also live links on that version of the slides that you have access to, so you should be

able to click, as Elizabeth did, and have access to all of the websites that she spoke to.

Another question we have, Elizabeth, is: "What are the time frames for each of the five stages of measure development?"

Elizabeth Bainger: Sure. You might want to go back to one of those slides where I had all five stages listed. There were a couple of slides where I did that. It takes around three months for the first stage for a measure to be conceptualized, and then figure that it is going to take probably another year or so for a measure to be specified.

Then again, it's going to take maybe another up to nine months for measure testing to take place, and so all totals we get up from measure conceptualization until the time the measure is implemented will take about 27 months, approximately.

It takes, you know, it's a good bit of time, two to three years for a measure to go from conceptualization until you actually see it being implemented, and sometimes longer.

Karen VanBourgondien: Okay. Thank you. We are kind of running out of time, so I believe this is going to be our last question. Before I give you this last question, all of the questions in the chat box, if you did not get a response, all of those will be answered and posted on our website with a full word-for-word transcript of this presentation. Again, that will be on qualityreportingcenter.com.

So I think that we'll wrap up it. I'm going to give you this last question, Elizabeth. The question is: "You mentioned something about the MUD and MUC, what did you mean?"

Elizabeth Bainger: Okay. So, the MUD is measure under development, M-U-D, measure under development; that's – that period of time while it's being

conceptualized and specified and they're determining what the numerator and the denominator is and they're refining the population. Once a measure is fully developed, then it could be put on to the measure under consideration list. That's the MUC list, M-U-C; and that those are a list of measures that quality reporting programs are considering.

Now, there's a lot more measures on the MUC list than what the quality reporting programs actually adopt, but it – these are fully developed measures that are under consideration.

And I did want to quickly mention, just, I see a few people asking about whether or not we're going to get rid of chart-abstracted measures. I can only speak for the OQR Program. I can't see that we're going to eliminate chart- abstracted measures. There may be a perfect measure out there that addresses a gap but impacts a large percentage of our patients, and so we really find a measure that is valuable and that we need to include in a program. However, we do want to reduce burden, so we are looking at claims-based measures, and we are looking toward eCQMs in the future. We know that that's going to take time to implement.

And I also saw people asking about how they can become involved in TEPs and in pilot programs. There were links about how to become involved in TEPs that I embedded, and again, if you download that PDF, you can click on all those links, including the link to my survey. I'd really appreciate it if you did that.

As far as the pilot programs, we often put out calls in the *Federal Register*. We do have formalized relationships already with some research hospitals, but if you're interested in becoming a pilot site, let me know, and I can put you in touch with the right people. If you download the PDF, my contact information is on the last slide.

Karen VanBourgondien: Thank you, Elizabeth. I really appreciate that. That's going to do it for the live questions. I'm going to go ahead and hand it back to you to finish out the presentation. Thanks a lot, Elizabeth.

Elizabeth Bainger: Thank you for your questions. I just want to scroll quickly through these reference slides just so that you have them. And also, here, you'll see my contact information.

Again, if you're interested in becoming a pilot hospital or have any questions about the measures lifecycle, please let me know. I'll make sure – if I can't answer your question, I'll put you in touch with somebody who can. I'm going to pass this back to Karen while she talks about the continuing education requirements, and at the end, we'll show that link one more time with the URL for the voluntary survey.

END.