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Connecticut SIM: Payment model reference materials

Updated for workgroup #4
July 1, 2013

Agenda

Review of progress to date

Background: Reward structure

Background: Quality measurement

Background: Provider/payer landscape and consumer attribution

The care delivery work group decided not to be prescriptive in defining the leader, or composition, of care teams

- The care delivery work group recommends that care teams have a set of "core providers" who provide primary care (e.g., PCPs, APRNs)
- The care delivery work group does not provide any other limitations on structure or exact composition of the care team, e.g.,
 - The entity can define a structure for itself, as long as it is capable of fulfilling the responsibilities of our medical home model
 - Specialists, behavioral health providers¹, and physician extenders can be included on the care team as the entity deems necessary
 - "Leader" of the care team can be selected by each entity; leadership may be fluid and vary with consumer's health needs

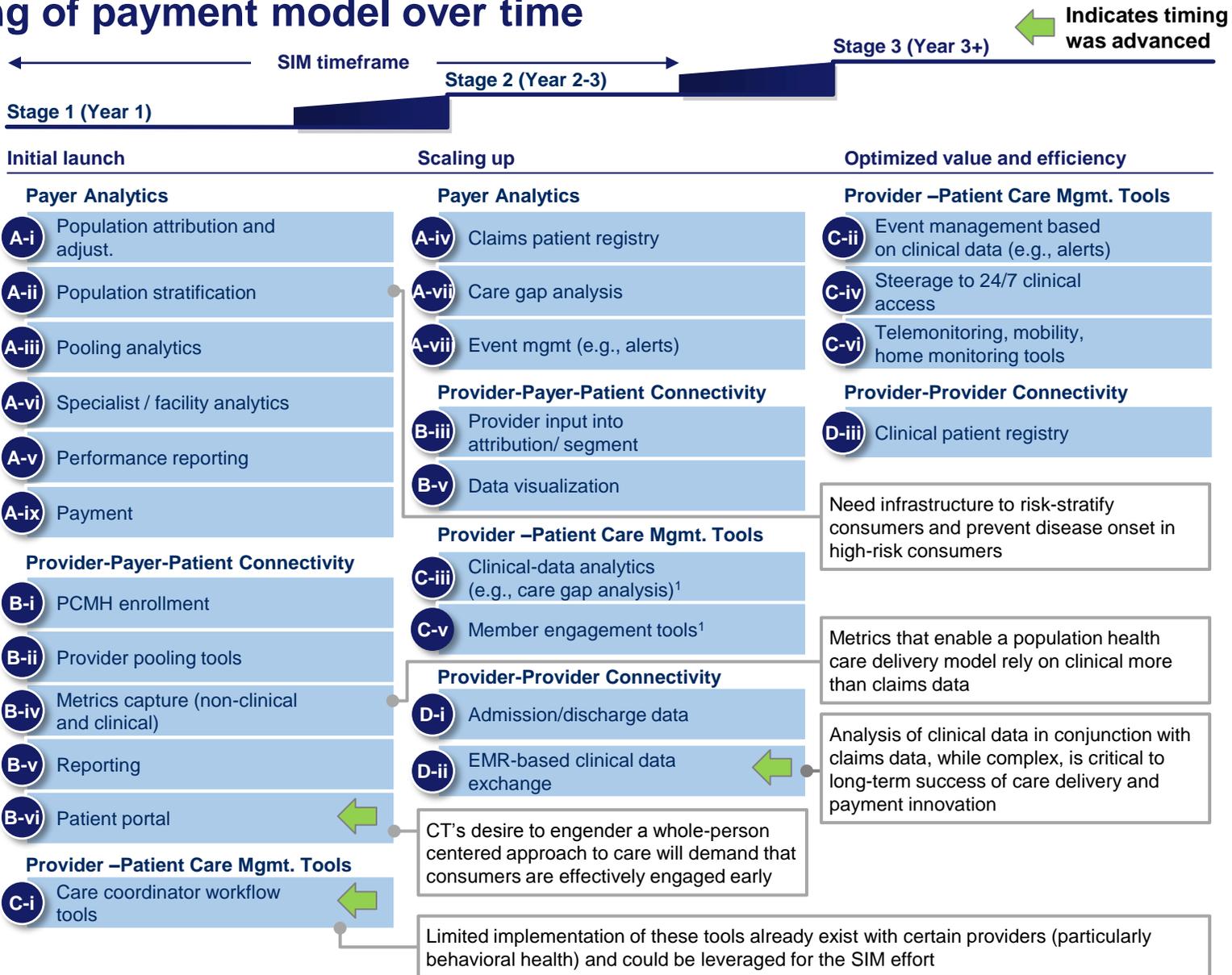


¹ If not part of care team, at minimum a close working relationship will be required

The CDWG began to discuss the criteria to pre-qualify entities to take part in model; a sub-team will convene to finalize the recommendation

Options	Considerations	Examples
1 PCMH certification by established accreditation body	<ul style="list-style-type: none"> ▪ PCMH certification may not be truly indicative of advanced care delivery ▪ Well known by providers, and achieved by several already ▪ Potentially onerous for providers 	<ul style="list-style-type: none"> ▪ Vermont's multi-payer Blueprint for Health uses NCQA standards to determine practice eligibility ▪ Maine's Aligning Forces for Quality (AF4Q) uses NCQA standards to certify primary care practices
2 PCMH certification by established accreditation body plus select CT specific interventions/guidelines	<ul style="list-style-type: none"> ▪ As above ▪ May place additional burden on providers as well as state entity to certify ▪ More tailored to CT's goals and needs 	<ul style="list-style-type: none"> ▪ Massachusetts' Medicaid Primary Care Payment Reform Initiative requires participants to achieve NCQA certification and additional criteria of behavioral health integration and medical home transformation
3 CT specific criteria (e.g., self-reported and validated with audits or claims based process metrics)	<ul style="list-style-type: none"> ▪ More tailored to CT's goals and needs ▪ May place additional burden on state entity/ payors to certify ▪ Can be designed in "less onerous" method for providers if relies largely on claims/ shorter set of self-reported criteria 	<ul style="list-style-type: none"> ▪ Oregon uses own standards to determine if practices are considered a Patient-Centered Primary Care Home (overseen by advisory committee) <ul style="list-style-type: none"> – If practice is a NCQA accredited PCMH, it only needs to fill out subset of application¹
4 Other		

The HIT work group has defined a capability road map that will influence the phasing of payment model over time



¹ While local implementation exists (e.g. DMHAS), availability at initial launch will depend on scalability/flexibility in design

The HIT work group has also defined a capability road map that will influence the phasing of payment model over time

ILLUSTRATIVE



Initial launch

Meet minimum requirements rapidly through lower tech/cost solutions without interrupting day-to-day operations

Scaling up

Build tech-enabled solutions to further enhance information transparency and capture most value

Optimized value and efficiency

Complete system-wide connectivity to maximize efficiency of care

A Payer Analytics

- Automated **claims-based algorithms** for foundational analytics:
 - Episodes
 - Patient attribution, stratification and pooling
 - Performance and payment

- Enhanced analytics that identifies high priority patients for **targeted intervention**:
 - Care gaps analyses
 - Alert generation

- **System level** public health/epidemic analyses
- **Patient 360** view enabled by integration of claims and clinical data

B Provider - payer – patient connectivity

- **Multi-payer online** portal for providers to download static electronic performance reports

- **Bi-directional** portal that allows data exchange between payers and providers
- Patient portal providing cost transparency and

- **HIE-enabled** bidirectional communication and data exchange

C Provider-patient care management

- **Low-tech** care management support, e.g., :
 - Excel list of disease specific high risk/cost patients
 - Care management training modules/playbooks

- **Certified** care management vendors and/or workflow tools
- **Local EMR** data integrated into care management tool

- Enhanced **care management** tools:
 - Automated patient comm
 - Direct linkage to payer alert
 - 24/7 clinical acces
- **Remote monitoring and tele-medicine**

D Provider-provider connectivity

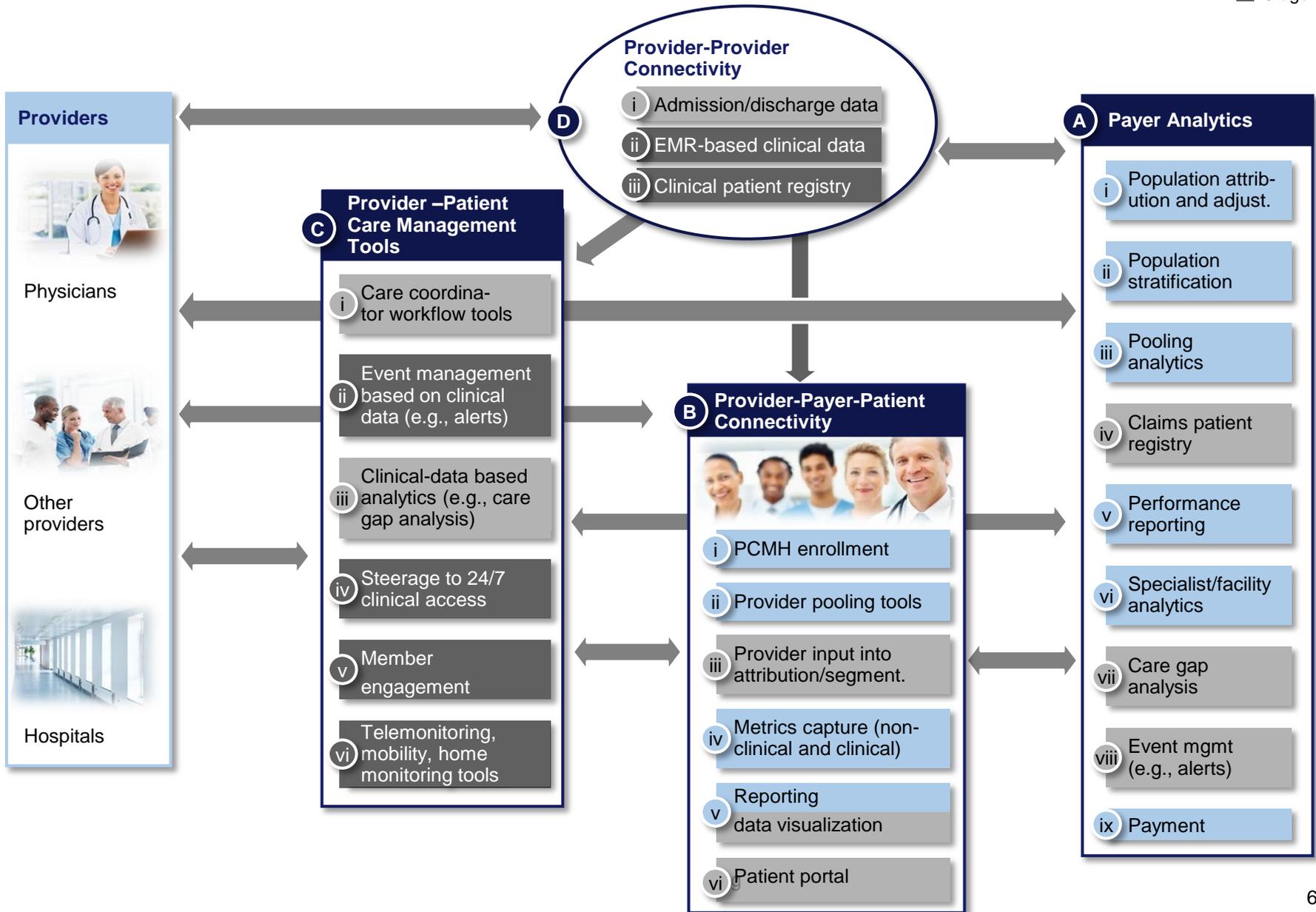
- **Low-tech** solutions (e.g., telephone) to allow information exchange between providers to deliver care to same patient

- **Admission/discharge** data sharing between hospitals and PCPs

- **Clinical patient registry**
- **HIE-enabled** bidirectional communication and data exchange

Typical solution architecture for payer and system infrastructure

- Stage 1
- Stage 2
- Stage 3



Four categories of HIT capabilities were identified across stakeholders to support components of the population health model

Category	Description	Typical tech pathway
A Payer analytics	<ul style="list-style-type: none"> Analytics and reports to determine and share provider performance in program – based on quality, cost, and utilization metrics 	<ul style="list-style-type: none"> Heavy upfront development/sourcing followed by incremental enhancement
B Provider - payer - patient connectivity	<ul style="list-style-type: none"> Channels (e.g., portal) for providers and patients to access and submit information, data and analytics required to support care delivery and payment models 	<ul style="list-style-type: none"> Start with basic or low tech solutions to allow time for development or sourcing of tech-enabled enhancement
C Provider – patient care mgmt.	<ul style="list-style-type: none"> Provider tools (e.g., workflow, event management) that support providers as they coordinate the medical services for a patient 	
D Provider-provider connectivity	<ul style="list-style-type: none"> Integrated clinical data exchange among doctors, hospitals, and other health care providers through a secure, electronic network 	<ul style="list-style-type: none"> Highly dependent on state-specific starting point

Payer analytics

A Payer analytics	Description
i Population attribution and adjust.	<ul style="list-style-type: none"> Claim analytics to attribute patients to PCMH and adjust PCMH's PMPM and gainsharing based on patients' claim history
ii Population stratification	<ul style="list-style-type: none"> Claim analytics used to segment a PCMH's patient population based on expected utilization of health resources, and help providers identify patients most likely to benefit from increased care coordination
iii Pooling analytics	<ul style="list-style-type: none"> Claim analytics to determine overall population risk and adjusted total cost of care for a group of providers forming a PCMH
iv Claims patient registry	<ul style="list-style-type: none"> Registry of patients attributed to each PCMH, associated patient claims, and series of analytics used to identify patients by disease state, recent utilization, ect.
v Performance reporting	<ul style="list-style-type: none"> Analytics and reports to determine and share provider performance in program – based on quality, cost, and utilization metrics
vi Specialist / facility analytics	<ul style="list-style-type: none"> Analytics to identify specialist / facility that demonstrate the highest performance for treating a given condition
vii Care gap analysis ¹	<ul style="list-style-type: none"> Claim analytics to identify gaps in care (e.g., missing cholesterol screening for patient with cardiac disease)
viii Event mgmt (e.g., alerts) ¹	<ul style="list-style-type: none"> Alerts issued based on recent events (e.g., discharge from hospital) or care gap analyses (e.g., two claims submitted for drugs with serious interactions)
ix Payment	<ul style="list-style-type: none"> Analytics and systems used to calculate PCMH shared savings and make payment

¹ May be performed by care coordination systems

Provider-Payer-Patient connectivity

B Provider-Payer - Patient Connectivity

i PCMH enrollment

- Web-based form that allows provider to enter information about themselves and express interest in participating in the PCMH program

ii Provider pooling tools

- Web-based tool that allows providers to explore population size, risk mix, and shared savings potential from partnering with other providers to form a PCMH

iii Provider input into attribution/ segment

- Web-based tool that allows providers to react to patient attribution / segmentation for PCMH

iv Metrics capture (non-clinical and clinical)

- Web interface that allows providers to input clinical and non-clinical information used for performance reporting

v Reporting and data visualization

- Web interface that gives providers access to static reports and ability to visualize underlying data claims and / or clinical data dynamically

vi Patient portal

- Web interface that allows enrollees to track claims and account activity, find doctors and services, access health advice and get answers to coverage questions

Provider care management tools & analytics

C Provider care mgmt. tools and analytics

i Care coordinator workflow tools

ii Event management based on clinical data (e.g., alerts)

iii Clinical-data based analytics (e.g., care gap analysis)

iv Steerage to 24/7 clinical access

v Communication support tools

vi Telemonitoring, mobility, home monitoring tools

Description

- Set of tools to help care coordinators prioritize patient outreach efforts based on patient demographic and disease state, urgency and complexity of issues, and overall value of intervention; also record care coordination activities/ interactions
- Clinical analytics used to send provider alerts when patient requires intervention (e.g., vaccination reminders) and automatically create follow-up activities with data and activity dependences
- Claim analytics to determine overall population risk and adjusted total cost of care for a group of providers forming a PCMH
- Telephone support for patients to get 24/7 clinical advice from providers who have access to the patient's clinical history
- Set of tools to send reminders / updates through email, text message, or mail to select patient populations at appropriate times (e.g., timely reminder for annual eye visit)
- Remote monitoring capabilities for patients with select diseases (e.g., wireless scale for CHF patients)

Provider-provider connectivity

D Provider-provider connectivity

i Admission/discharge data

Description

- Web (and potentially API) based tool that supports either direct data entry or batch upload of admission and discharge data to be input by hospitals daily. Fields may include patient ID, patient name, admit and discharge dates, major procedures, and admitting diagnosis. Information to be exchanged daily with either payors or provider portal (One entity will be responsible for parsing data by PCMH and their corresponding patient attribution)

ii EMR-based clinical data

- API based communication that supports exchange of all clinical information contained in EMRs

iii Clinical patient registry

- Searchable data store that collects and integrates data from all available sources in HIE (and other data stores) and makes information available in a push or pull format

Summary of HIT capability standardization/consolidation proposed across stakeholders for Connecticut

HIT Components

Concluded level of standardization/consolidation

Provider-Payer-Patient Connectivity

█ Mostly consolidated across payers

- Need for a **single provider/patient interface** (e.g., portal) and standardized reporting format to reduce operational complexity and user confusion (providers and consumers)

Payer Analytics (complemented by provider analytics)

▣▣▣ Standardized but not consolidated

- Highly **standardized** metrics/analytics/reports created by payers' **independent** infrastructure
- Claims-based analytics complemented by **provider analysis of clinical data** to better manage quality of care delivery and outcomes
- Mandatory provider analytics prescribed keeping **varied levels** of provider's HIT capabilities in mind to ensure compliance

Provider care management tools

▣▣█ Not standardized or consolidated

- **Flexibility/options** for providers to select from available care management tools/technology
- Potential options for the state to take an **active role** in supporting provider adoption:
 - Develop population health **playbook** and/or **training** that includes application of HIT capabilities (e.g. using excel to risk stratify the population)
 - Pre-qualify **technology vendors** and/or **service providers** with pre-negotiated pricing to simplify the evaluation and procurement process
 - Develop a shared-service model that providers could plug-into to access enhanced care management tools

Provider-Provider connectivity

▣▣▣ Standardized but not consolidated

- Exchange of health information between providers being a **key enabler** of a population health model
- **HITE-CT** leading/facilitating provider-provider connectivity in Connecticut
 - Focus currently on accelerating adoption of **direct messaging** that will facilitate point-to-point exchange of health data
 - Eventual goal to transition to a clearing house model for health information exchange between provider groups (**HIE**)

We have revised our targets for our remaining two meetings to address the remaining strategic design considerations

**MODIFIED TO
REFLECT JUNE 17
WORK GROUP
DISCUSSION**

Workshop title

Description

May 20: Overview and guiding principles

- Review vision for care delivery and payment innovation
- Align on guiding principles for payment innovation
- Understand scope of payment model options and design parameters
- Discuss strategic payment model design considerations

June 3: Strategic payment model design decisions

- Review synthesis of strategic payment model design decisions
- Discuss data around industry/ provider landscape (e.g., fragmentation)

June 17: Reward structure and metrics

- Align on aspirational reward structure and timeframe for provider transition
- Discuss how providers will be supported to participate in care delivery and payment model
- Discuss structures, processes, outcomes, care experience and/or cost/resource use metrics to measure under new payment model (e.g., metrics)

July 1: Approach to member attribution and risk management

- Discuss plan for phasing reward structure over time
- Align on level of performance we wish to reward
- Discuss changes/ adjustments required to balance metrics across domain types
- Discuss member attribution and implications on patient panel sizes

July 15: Operationalizing the payment model

- Understand rationale for using different tools to mitigate volatility (MSRs, virtual pooling, accruals, joint venture, etc.)
- Align on payment implementation plan with phasing, including plan to support provider transition

Agenda

Review of progress to date

Background: Reward structure

Background: Quality measurement

Background: Provider/payer landscape and consumer attribution

Two high level questions will determine our decision on which reward structure to select

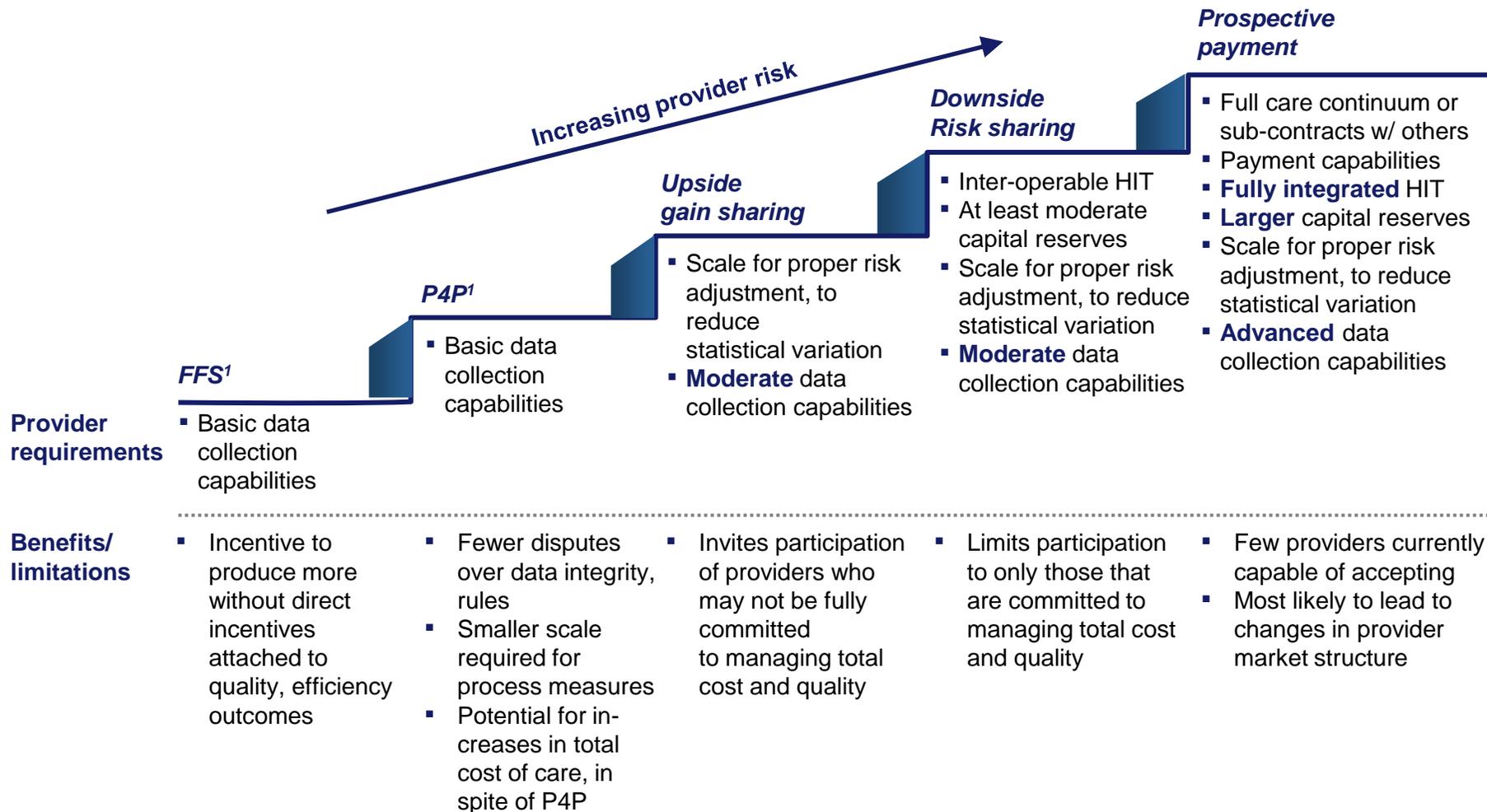
What is our aspirational reward structure?

- **Options**
 - Prospective payment
 - Risk sharing (upside and downside)
 - Gain sharing (upside only)
 - Pay for performance
 - Some combination of the above
 - ... any others?

How will providers be set-up for success in the aspirational reward structure?

- **Support may be needed for:**
 - Clinical integration
 - Financial integration
 - Financial capabilities
 - HIT capabilities
 - Care coordination
 - ...any others?
- **Illustrative types of financial support**
 - Upfront investment
 - In-kind support
 - PMPM fees
 - FFS enhancements
 - ... any others?

There are a range of reward structures that can be used to hold providers accountable...



Some models also incorporate per-member-per-month fees for care coordination and/or practice transformation. These may be structured as a form of P4P, FFS, or transitional subsidies, depending on the criteria used to qualify for the fees

...and a set of guiding principles can inform our working hypothesis on the reward structure

ILLUSTRATIVE

Key considerations for choosing reward structure

Considerations for our reward structure aspiration

- Will the reward structure drive a set of changes in behaviors that address the needs of the whole-person and improve health outcomes?
- Is the reward structure sufficiently material to motivate changes in behavior?
- How receptive are stakeholders to the reward structure (e.g., are stakeholders open to accepting downside risk)?

Considerations for enabling the reward structure

- How feasible is the reward structure (e.g., are panels at sufficient scale to mitigate volatility, can providers sustain financial risk)?
- Does necessary infrastructure exist for the reward structure (e.g., technological capabilities, data collection)?
- How quickly can the reward structure be rolled-out to meet sufficient scale for impact?
- How capable are stakeholders of managing total cost of care accountability, and how might that affect the ramp-up to end-state payment model (e.g., P4P evolving into upside gain sharing by year 3)
- How important is payer alignment on the reward structure to ultimate reward structure design?

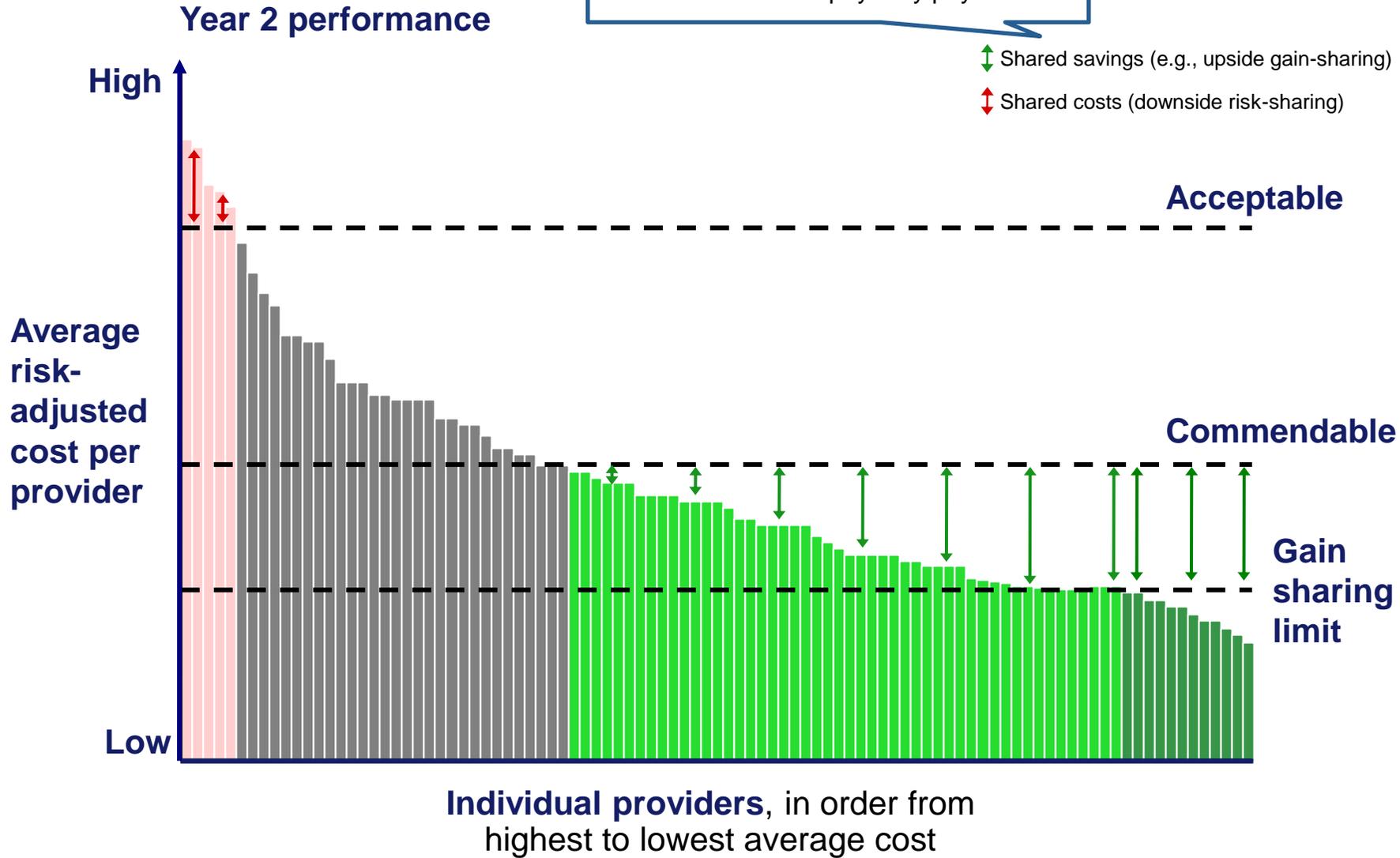
Examples of total cost of care payment models

A	Shared savings relative to projected cost	<ul style="list-style-type: none"> ▪ Claims paid by payer to each provider based of fee schedules ▪ Cost of care tracked against projected costs (based on historical trend) ▪ Percentage of savings shared with accountable provider ▪ Payer absorbs any excess costs relative to baseline or projected cost
B	Shared savings net of minimum savings	<ul style="list-style-type: none"> ▪ <i>Claims paid by payer to each provider based of fee schedules</i> ▪ <i>Cost of care tracked against projected costs (based on historical trend)</i> ▪ Initial X percentage points of savings retained by payer ▪ Percentage of net savings shared with accountable provider ▪ <i>Payer absorbs any excess costs relative to baseline or projected cost</i>
C	Shared risk relative to projected cost	<ul style="list-style-type: none"> ▪ <i>Claims paid by payer to each provider based of fee schedules</i> ▪ <i>Cost of care tracked against projected costs (based on historical trend)</i> ▪ <i>Percentage of savings shared with accountable provider</i> ▪ Percentage of excess costs shared with accountable provider ▪ <i>Payer absorbs any excess costs relative to baseline or projected cost</i>
D	Full risk relative to target cost	<ul style="list-style-type: none"> ▪ <i>Claims paid by payer to each provider based of fee schedules</i> ▪ Cost of care tracked against target cost ▪ 100% of savings or excess costs borne by accountable provider
E	Prospective capitation	<ul style="list-style-type: none"> ▪ Capitation payment paid to accountable provider ▪ Accountable provider responsible for paying 100% of downstream costs based on own contracts with other providers ▪ 100% of savings or excess costs borne by accountable provider

A demonstration of risk sharing (both upside and downside)

ILLUSTRATIVE

Providers shared in costs or savings with payers at a percentage (e.g., 50/50) that is determined on a payer by payer basis



Defining level of performance to reward: Example of upside calculated based on performance improvement

Determine physician improvement	Assign physician to payment group	Estimate total savings	Translate to max % increase to professional fees
<ul style="list-style-type: none"> ▪ Decide on a set of efficiency metrics and their relative significance ▪ Calculate % improvement in each efficiency metric <ul style="list-style-type: none"> – e.g., 5% decrease in IP admissions ▪ Calculate weighted average improvement percentage across all metrics 	<ul style="list-style-type: none"> ▪ Use weighted average improvement percentage to set efficiency level: <ul style="list-style-type: none"> – Level 1: Moderate improvement percent – Level 2: High improvement percent 	<ul style="list-style-type: none"> ▪ Multiply efficiency improvement percent by proportion of total specialty spend captured by metrics ▪ For example if oncology metrics cover 45% of total oncology spend, then estimated cost savings = 45% of the efficiency improvement percent 	<ul style="list-style-type: none"> ▪ Translate total savings on specialty cost of care to potential increase in professional fees to ensure sustainability of program

Defining level of performance to reward: example of setting quality levels based on performance against absolute targets

ILLUSTRATIVE

Establish absolute quality targets	Analyze physician performance	Assign physician to quality level	Use quality level to set % savings to share with doc
<ul style="list-style-type: none"> Decide on a set of quality metrics Set quality targets based on national guidelines or previous year's network performance Hold targets constant for several years 	<ul style="list-style-type: none"> Compare practice performance on metrics to targets Determine how many practice metrics meet minimum and/or high thresholds 	<ul style="list-style-type: none"> Assigned practice to a performance level <ul style="list-style-type: none"> – Level 1: moderate quality performance – Level 2: high quality performance 	<ul style="list-style-type: none"> Based on level designation, share a portion of value pool coming from efficiency savings: <ul style="list-style-type: none"> – Level 1: share smaller percentage – Level 2: share larger percentage

Option 1: Few metrics & require that all are met

Option 2: More metrics and require that a minimum number are met

What are the types of provider support required to transition to the aspirational reward structure?

What types of support are required?

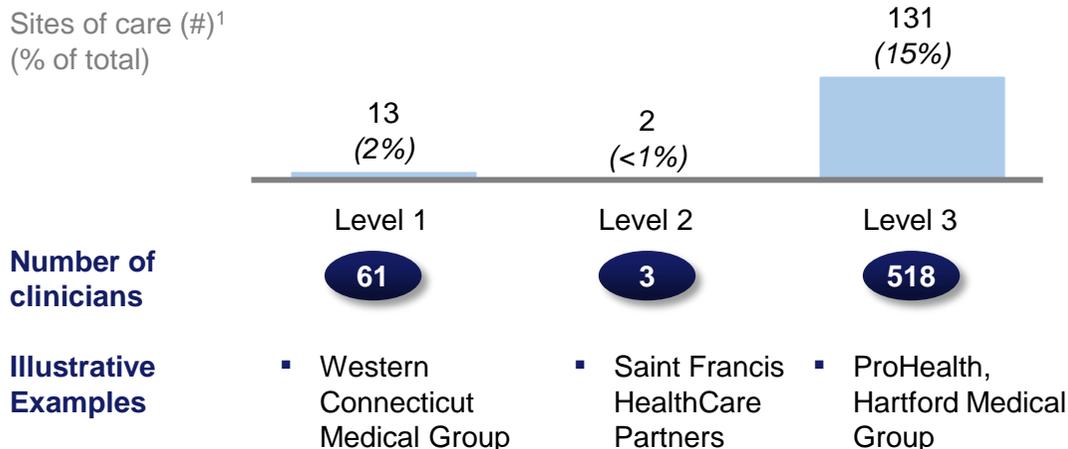
- What is the level of **clinical integration** that providers will require to coordinate care effectively?
- What is the level of **financial integration** providers will require to create pools of patients that are statistically significant?
- What **data, analytical capabilities, and reports** will providers require to succeed within the new model?
- What other **HIT** capabilities will providers require to be set-up for success in the reward structure?
- What **care coordination** supports will providers require to coordinate care effectively?

Options for financial support

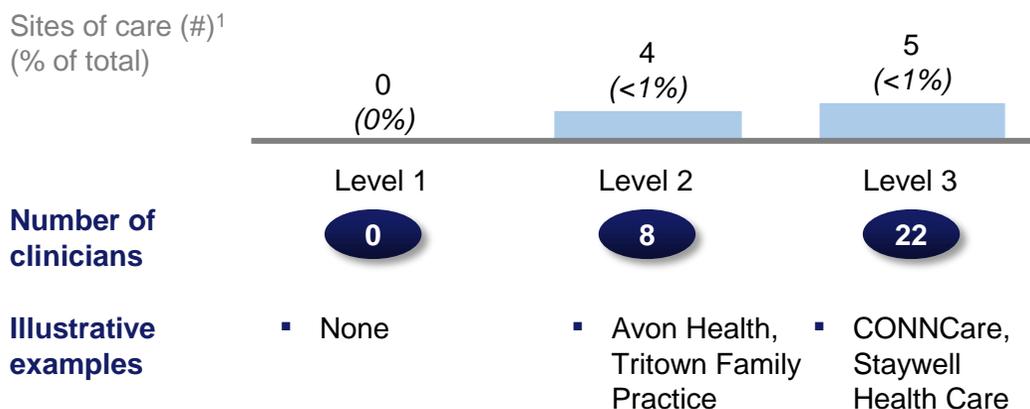
- Practice transformation payments (e.g., PMPM for initial years, lump sum grants)
- Care coordination payments (e.g., PMPM)
- In-kind support (e.g., care coordination support/tools)
- FFS enhancements (e.g., additional billing codes for phone consultations, telemedicine)

Some providers are already participating in population-health based payment innovations

NCQA Physician Practice Connections – PCMH 2008 Recognition



NCQA PCMH 2011 Recognition



Additional capabilities

- **CMS** has recognized several ACOs in Connecticut under Medicare Shared Savings (e.g., Hartford HealthCare, ProHealth Physicians, Saint Francis HealthCare Partners, Primed LLC) and its Advanced Payment ACO program (e.g., MPS ACO Physicians, Primed LLC)
- **Commercial payers** are also participating in innovation: Anthem (e.g., episodes pilot, PCMH pilot), CIGNA (e.g., accountable care initiatives with Day Kimball, New Haven Community Group, ProHealth), and Aetna (e.g., coordinated care collaboration with ProHealth)
- The **State of Connecticut** has also launched a number of innovative initiatives including the State employee/Medicaid PCMH pilot, the ICI Duals initiative, HEP, and SPMI health homes
- Roughly 40% of Connecticut physicians have transitioned to **electronic medical records**

¹ ~900 sites of care in Connecticut that have at least one PCP

Note: NCQA PPC-PCMH 2008 standards revised in PCMH2011 standards. New applications will be subjected to PCMH2011 standards

SOURCE: NCQA, 2012 Health Leaders InterStudy Report, CMS, SK&A data (methodology: information collected from medical trade associations, phone books, medical school alumni directories, and are phone verified twice a year. Estimated to cover 98.5% of all US physicians)

Agenda

Review of progress to date

Background: Reward structure

Background: Quality measurement

Background: Provider/payer landscape and consumer attribution

At our last meeting, we reviewed a core set of CMMI measures and made CT-specific additions

ILLUSTRATIVE

Structures

Definition

- Features of a healthcare organization or clinician relevant to the capacity to provide healthcare. This may include, but is not limited to, measures that address HIT, provider capacity, systems and other healthcare infrastructure supports

Processes

- A healthcare service provided to, or on behalf of, a patient. This may include, but is not limited to, measures that may address adherence to recommendations for clinical practice based on evidence or consensus

Outcomes

- The health state of a patient (or change in health status) resulting from healthcare –desirable or adverse

Care experience

- Patient and their care givers' experience of care

Cost and resource use

- Counting the frequency of units of defined health system services or resources; some may further apply a dollar amount (e.g., allowable charges, paid amounts, or standardized prices) to each unit of resource use (i.e., monetize the health service or resource use units)

CMMI core measure weighting

N=66

Domain type	Percent
Structure	5%
Process	59%
Outcome	17%
Care experience	5%
Cost & resource use	15%

Weighting with work group additions

N=85

Domain type	Percent
Structure	12%
Process	54%
Outcome	13%
Care experience	6%
Cost & resource use	15%

BREAKOUT GROUP 1: Updated after break out

ILLUSTRATIVE

1

Whole-person-centered care and population health management

- Understand the whole-person context, i.e. the full set of medical, social, behavioral, cultural, and socioeconomic factors that contribute to a consumer's health
- Assess and document consumer risk factors to identify high risk consumers

Prioritized interventions after care delivery work group 4

- Identify consumers with high-risk or complex care needs
- Conduct whole person assessments that identify consumer/family strengths and capacities, risk factors¹, behavioral health and other co-occurring conditions, and ability to self-manage care

CMMI core measures and work group additions

Structure

- Care plan/learning collaborative

Process

- Screening for clinical depression
- Follow-up hospitalization after mental illness
- Initiation and engagement of alcohol and other drug dependence treatment
- Tobacco use assessment and tobacco cessation intervention
- Primary care quality measures
- Quality index
- Assessment completion rates

Outcome

- CARE Tool
- CARE-F and CARE-C assessment tools for nursing facilities, day rehabilitation programs, and other ambulatory settings in the community

Care experience

- CAHPS surveys

Cost/ resource use

- Total medical cost per member

BREAKOUT GROUP 2: Updated after break out

ILLUSTRATIVE

2

Enhanced access to care (structural and cultural)

- Provide consumers access to culturally and linguistically appropriate routine/ urgent care and clinical and mental health advice during and after office hours
- Care should be accessible in-person or remotely (e.g. clinic visits, telephonic follow-up, video-conferencing, email, website, community/ home-based services)

Prioritized interventions after care delivery work group 4

- Improve access to primary care through a) extended hours (evenings/weekends), b) convenient, timely appointment availability including same day (advanced) access, c) providing non-visit-based options for consumers including telephone, email, text, and video communication
- Enhance access to specialty care through non-visit-based consultations: eConsults between specialists and primary care providers
- Provide information on where consumers should go to meet their care needs (e.g., appropriate physician locations and hours)

CMMI core measures and work group additions

Structure

- Patient portal
- E-consult capability
- Provider website

Process

- Proportion of Days covered: 5 rates by therapeutic category
- Well-child visits in first 15 months of life
- Well-child visits in the 3rd, 4th, 5th, and 6th years of life
- Access to care outside normal billing hours
- Time of discharge until next visit

Outcome

Care experience

- Patient surveys
- Translation services

Cost/ resource use

- Hospital ED visit rate that did not result in hospital admission, by condition

BREAKOUT GROUP 3: Updated after break out

ILLUSTRATIVE

3 Team-based, coordinated, comprehensive care

- Leverage multi-disciplinary teams and enhanced data sharing to improve care planning, diagnosis, treatment, and consumer coaching
- Ensure consumer adherence to care plan and successful care transitions across care settings and care disciplines (e.g., medical, social, behavioral)

Prioritized interventions after care delivery work group 4

- Provide team-based care from a prepared, proactive team
- Coordinate across all elements of a consumer's care¹
 - Coordinate care across all disciplines including sub-specialty, inpatient, oral health, behavioral health, and complementary medicine
 - Emphasize pre-visit planning to ensure all care needs are met
 - Assess consumer progress toward treatment goals and address consumer barriers
 - Use intensive case management across time and care settings for highest complexity consumers
 - Track, follow-up on and coordinate laboratory tests, diagnostic imaging, and specialty referrals
 - Provide post hospital discharge transition care management
 - Reconcile consumer meds at visits and post-hospitalization
 - Engage/coordinate with community resources and other non-medical services (e.g., housing, domestic violence resources) and other support groups (e.g., collaboratives) as appropriate
 - Ensure consumer adherence with medications, lifestyle changes, and other care plan goals
- Develop and execute against a whole-person-centered treatment plan¹
- Integrate behavioral and primary care with “warm hands offs” between BH and primary care practitioners (on-site if possible)
 - Deliver care at sites of intervention conducive to consumers' environment (e.g., community centers) to be most effective
 - Leverage peer support for consumers with chronic conditions or behavioral health issues

CMMI core measures and work group additions

Structure

- Ability for providers with HIT to receive laboratory data electronically

Process

- Post-discharge continuing care plan created
- Post-discharge continuing plan transmitted to next level of care provider upon discharge
- Follow-up after hospitalization for mental illness
- 3-item care transition measure
- Care transition record transmitted to health care professional
- Transition record with specified elements received by discharged patients
- Medication reconciliation

Outcome

- CARE Tool
- Care-F and CARE-C Tools

Care experience

Cost/ resource use

BREAKOUT GROUP 1: Updated after break out

ILLUSTRATIVE

4 Consumer engagement

- Appropriately educate and encourage consumers to engage in healthy behaviors and reduce risky behaviors
- Encourage consumers to partner with the provider to follow-through on care plans, and administer self-care as needed

Prioritized interventions after care delivery work group 4

- Raise consumer awareness about health care decision making and provide information—broad based, targeted, and at the point of care to foster informed choice, enabled by:
 - Use “Choosing wisely” campaign as a means to raise broad awareness; possibly other supplementary health education materials developed jointly by insurers
 - Use “Choosing wisely” campaign and other treatment option information provided at the point of care
 - Ensure provision of quality and cost information when consumer chooses treatment type, setting and provider
- Use whole person centered care planning methods to develop and support implementation of self-management care plan ²
 - Ensure self-management care plan takes into consideration individual strengths, co-morbidities, risk factors, individual and cultural factors (e.g., health literacy, English as a second language, cultural norms, cognitive limitations), and barriers to adherence (e.g., stigma, transportation)
- Support consumer general health education, ease of access to personal health information, communication with care delivery team, wellness management and illness self-management with a patient health care portal

CMMI core measures and work group additions

Structure

Process

- Transition record with specified elements received by discharged patients

Outcome

- CARE-F and CARE-C Tool

Care experience

- CAHPS survey
- Family evaluation of hospice

Cost/ resource use

BREAKOUT GROUP 2: Updated after break out

ILLUSTRATIVE

5

Evidence-informed clinical decision making

- Make decisions on clinical care that reflect an in-depth, up-to-date understanding of evidenced-based care reflecting clinical outcomes and cost-effectiveness

Prioritized interventions after care delivery work group 4

- Use consumer risk stratifiers to enable targeted effort based on evidence (e.g., chronic disease progression)
- Use multi-layer, diverse team to enable data synthesis, reconciliation, and use by practice – ensure data is actionable and timely
- Maintain disease registry
- Implement evidence-based guidelines¹

CMMI core measures and work group additions

Structure

- Adoption of medication e-prescribing
- Adoption of HIT
- Ability for providers with HIT to receive laboratory data electronically
- Standardized care pathways
- Bidirectional sharing of information

Process

- Preventive process measures (e.g., adult weight screening, childhood immunization status)
- Clinical care measures (e.g., chronic disease testing and care, mental health)
- Medication reconciliation
- Ongoing review and validation of current standards
- Medication compliance
- Medication interactions

Outcome

- Mortality, morbidity, functional health status change and patient safety outcomes metrics

Care experience

Cost/ resource use

- Admission statistics by chronic condition (e.g., COPD)
- Appropriate use of procedures

¹ Added or edited after syndication with break out groups to reflect interventions fundamental to element of model

BREAKOUT GROUP 3: Updated after break out

ILLUSTRATIVE

6

Performance management

- Collect, integrate, and disseminate data for care management and performance reporting on cost and quality effectiveness of care
- Use performance and consumer experience data to identify opportunities to improve and compare performance with other providers

Prioritized interventions after care delivery work group 4

- Track utilization measures (e.g., rates of hospitalizations and ER visits) and drivers (e.g., after hours visits) and compare to external benchmarks¹
- Use performance and consumer experience data to continuously improve whole person centeredness
- Establish learning collaboratives to disseminate best practices

CMMI core measures and work group additions

Structure

- Adoption of medication e-prescribing
- Adoption of HIT
- Ability for providers with HIT to receive laboratory data electronically

Process

Outcome

Care experience

- CAHPS surveys
- Family evaluation of hospice

Cost/ resource use

- Admissions by chronic condition (e.g., COPD, CHF)
- ED visit rate that did not result in hospital admission, by condition
- Total Medicare Part A and B cost calculation recommendations
- Medicare spending per beneficiary, risk-adjusted and price standardized

A range of approaches can be used to hold providers accountable for performance

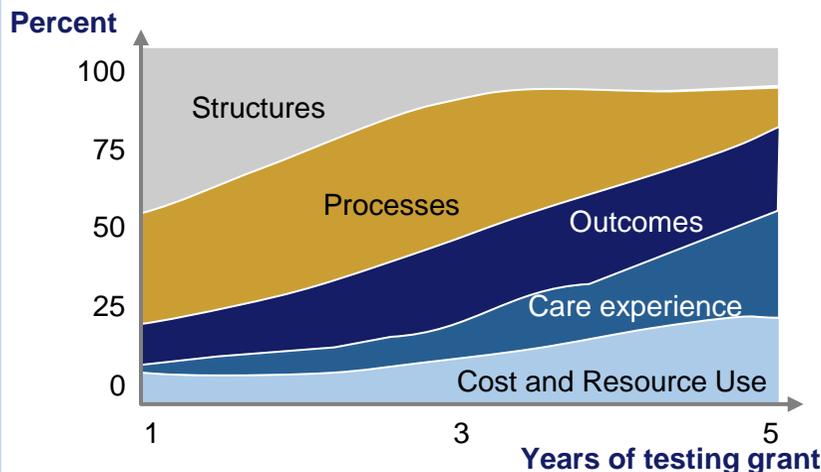
ILLUSTRATIVE

Approaches	Description	Illustrative examples
Reporting	<ul style="list-style-type: none"> ▪ Capturing and reporting of metrics to patients, other providers, and/or to the broader community 	<ul style="list-style-type: none"> ▪ Provider report cards
Condition for participation	<ul style="list-style-type: none"> ▪ Limitation of provider participation in care delivery and payment models to the adoption of or adherence to specific structures, processes, outcomes, care experience and/or cost and resource use metrics 	<ul style="list-style-type: none"> ▪ EMRs that meet meaningful use as a pre-requisite to participate in payment model ▪ Participation in coordinated care team
Contingency for reward	<ul style="list-style-type: none"> ▪ Specifies an outcome or action that is required to receive a specific reimbursement (e.g., a PMPM, fee for service enhancements, P4P bonus) 	<ul style="list-style-type: none"> ▪ Quality baseline to participate in gain-sharing
Consideration when setting reward level	<ul style="list-style-type: none"> ▪ Determines the size of reimbursement (e.g., percent of shared savings, level of PMPM, size of P4P bonus) 	<ul style="list-style-type: none"> ▪ PMPM based on risk-adjusted characteristics of patient panel ▪ P4P bonus pegged to scale of quality or efficiency metrics

The respective weight of metrics can shift over time

ILLUSTRATIVE

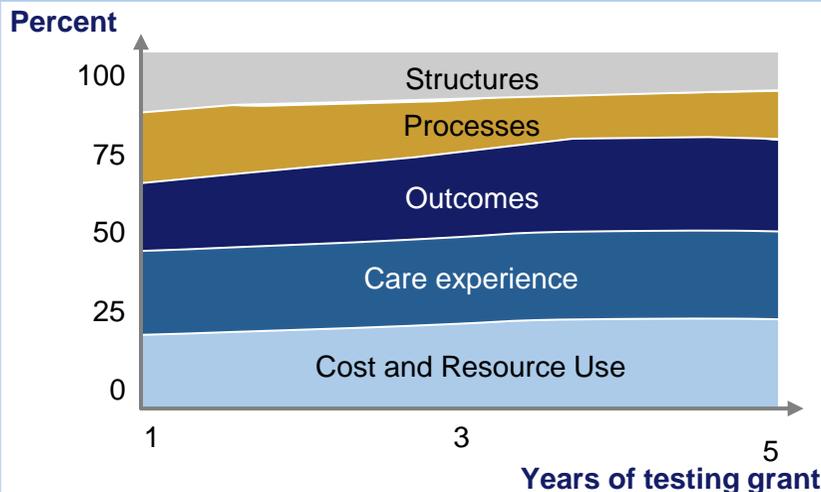
Illustrative option: Potential phasing of payments tied to metrics domains



Potential rationale

- Invest in **structures** in early years to support and encourage providers in their transition to managing total cost of care
- Consistently invest in **processes** to manage adoption of new care delivery model
- Ultimately focus predominantly on **outcomes, care experience, and cost/resource use** – weighted heavily towards later years to allow providers time to adopt to new care delivery and payment models

Illustrative option: Potential phasing of payments tied to metrics domains



Potential rationale

- Consistently invest in **structures** to provide level of ongoing support to providers adopting innovative reforms (e.g., care coordination teams)
- Consistently invest in **processes** to create clear associations between desired behaviors and rewards
- Predominantly hold providers accountable for **outcomes, care experience, and cost/resource use** (with risk adjustment) to place focus on outcomes-oriented whole person centered care

NQF Quality measurements (1/22)

Domains

Measures

Structure

- Participation by a physician or other clinician in systematic clinical database registry that includes consensus endorsed quality measures
- Participation in a National Database for Pediatric and Congenital Heart Surgery
- Participation in a Systematic Database for Cardiac Surgery
- Participation in a Systematic National Database for General Thoracic Surgery
- Participation in a Systematic National Dose Index Registry
- Reminder System for Mammograms
- Skill mix (Registered Nurse [RN], Licensed Vocational/Practical Nurse [LVN/LPN], unlicensed assistive personnel [UAP], and contract)
- The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data Elements

Process

- (Pediatric) ESRD Patients Receiving Dialysis: Hemoglobin Level < 10g/dL
- 30-Day Post-Hospital AMI Discharge Care Transition Composite Measure
- 30-Day Post-Hospital HF Discharge Care Transition Composite Measure
- 30-day Post-Hospital PNA (Pneumonia) Discharge Care Transition Composite Measure
- 3-Item Care Transition Measure (CTM-3)
- ACE/ARB Therapy at Discharge for ICD implant patients with LVSD
- ACEI or ARB for left ventricular systolic dysfunction - Heart Failure (HF) Patients
- ACEI or ARB for left ventricular systolic dysfunction- Acute Myocardial Infarction (AMI) Patients
- Acute Otitis Externa: Systemic antimicrobial therapy – Avoidance of inappropriate use
- Acute Otitis Externa: Topical therapy
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Adherence to Chronic Medications
- Adherence to Chronic Medications for Individuals with Diabetes Mellitus
- Adherence to Statin Therapy for Individuals with Coronary Artery Disease
- ADHERENCE TO STATINS
- Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis to patients under the age of 80 with AJCC III (lymph node positive) colon cancer
- Adjuvant hormonal therapy
- Administrative Communication
- Adult Kidney Disease: Hemodialysis Adequacy: Solute
- Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute
- Adult(s) taking insulin with evidence of self-monitoring blood glucose testing.

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (2/22)

Domains

Measures

Process (Cont'd)

- Adult(s) with diabetes mellitus that had a serum creatinine in last 12 reported months.
- Advance Care Plan
- Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement
- Age-Related Macular Degeneration: Dilated Macular Examination
- Ambulatory initiated Amiodarone Therapy: TSH Test
- Ambulatory surgery patients with appropriate method of hair removal
- Anesthesiology and Critical Care: Perioperative Temperature Management
- Annual cervical cancer screening or follow-up in high-risk women
- Annual Dental Visit
- Antidepressant Medication Management
- Anti-Lipid Treatment Discharge
- Anti-Platelet Medication at Discharge
- Antipsychotic Use in Persons with Dementia
- Appropriate DVT prophylaxis in women undergoing cesarean delivery
- Appropriate Cervical Spine Radiography and CT Imaging in Trauma
- Appropriate Head CT Imaging in Adults with Mild Traumatic Brain Injury
- Appropriate Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision – Cesarean section.
- Appropriate Testing for Children With Pharyngitis
- Appropriate treatment for children with upper respiratory infection (URI)
- APPROPRIATE WORK UP PRIOR TO ENDOMETRIAL ABLATION PROCEDURE
- Aspirin at Arrival
- Aspirin at arrival for acute myocardial infarction (AMI)
- Aspirin prescribed at discharge for AMI
- Assessment of Health-related Quality of Life (Physical & Mental Functioning)
- Assessment of Thromboembolic Risk Factors (CHADS2)
- Asthma Medication Ratio (AMR)
- Asthma: Pharmacologic Therapy for Persistent Asthma
- At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.
- Atherosclerotic Disease - Lipid Panel Monitoring
- Atherosclerotic Disease and LDL Greater than 100 - Use of Lipid Lowering Agent
- Atrial Fibrillation - Anticoagulation Therapy

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (3/22)

Domains

Measures

Process (Cont'd)

- Audiological Evaluation no later than 3 months of age (EHDI-3)
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Back Pain: Advice Against Bed Rest
- Back Pain: Advice for Normal Activities
- Back Pain: Appropriate Imaging for Acute Back Pain
- Back Pain: Appropriate Use of Epidural Steroid Injections
- Back Pain: Initial Visit
- Back Pain: Mental Health Assessment
- Back Pain: Patient Reassessment
- Back Pain: Physical Exam
- Back Pain: Recommendation for Exercise
- Back Pain: Repeat Imaging Studies
- Back Pain: Shared Decision Making
- Back Pain: Surgical Timing
- Barrett's Esophagus
- Beta Blockade at Discharge
- Beta Blocker at Discharge for ICD implant patients with a previous MI
- Beta-blocker prescribed at discharge for AMI
- Bilateral Cardiac Catheterization Rate (IQI 25)
- Bipolar antimanic agent
- Bipolar Disorder and Major Depression: Assessment for Manic or hypomanic behaviors
- Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
- Bipolar Disorder: Appraisal for risk of suicide
- Bipolar Disorder: Assessment for diabetes
- Bipolar Disorder: Level-of-function evaluation
- Blood Pressure Screening by 13 Years of Age
- Blood Pressure Screening by 18 Years of Age
- Breast Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade
- C0559: Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer.
- CAC-1: Relievers for Inpatient Asthma
- CAC-2 Systemic corticosteroids for Inpatient Asthma

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (4/22)

Domains

Measures

Process (Cont'd)

- Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery
- Cardiac Rehabilitation Patient Referral From an Inpatient Setting
- Cardiac Rehabilitation Patient Referral From an Outpatient Setting
- Cardiac stress imaging not meeting appropriate use criteria: Preoperative evaluation in low risk surgery patients
- Cardiac stress imaging not meeting appropriate use criteria: Routine testing after percutaneous coronary intervention (PCI)
- Cardiac stress imaging not meeting appropriate use criteria: Testing in asymptomatic, low risk patients
- Cardiac Surgery Patients With Controlled Postoperative Blood Glucose
- Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications
- Cardiovascular monitoring for people with cardiovascular disease and schizophrenia (SMC)
- Care for Older Adults – Medication Review
- Cervical Cancer Screening
- Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation
- Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
- Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI)
- Childhood Immunization Status
- Chlamydia Screening and Follow Up
- Chlamydia screening in women
- Chronic Anticoagulation Therapy
- Chronic Liver Disease - Hepatitis A Vaccination
- Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry
- Chronic Stable Coronary Artery Disease: ACE Inhibitor or ARB Therapy--Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)
- Chronic Stable Coronary Artery Disease: Antiplatelet Therapy
- Chronic Stable Coronary Artery Disease: Beta-Blocker Therapy--Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)
- Chronic Stable Coronary Artery Disease: Lipid Control
- Colorectal Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade
- Colorectal Cancer Screening
- Comprehensive Diabetes Care
- Comprehensive Diabetes Care: Eye Exam
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing
- Comprehensive Diabetes Care: LDL-C Screening
- Comprehensive Diabetes Care: Medical Attention for Nephropathy

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (5/22)

Domains

Measures

Process (Cont'd)

- COPD: inhaled bronchodilator therapy
- COPD: spirometry evaluation
- Counseling for Women of Childbearing Potential with Epilepsy
- Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity
- Depression Assessment Conducted
- Depression Screening By 13 years of age
- Depression Screening By 18 Years of Age
- Depression Utilization of the PHQ-9 Tool
- Developmental Screening in the First Three Years of Life
- Developmental Screening in the First Three Years of Life
- Developmental screening using a parent completed screening tool (Parent report, Children 0-5)
- Diabetes and Elevated HbA1C – Use of Diabetes Medications
- Diabetes monitoring for people with diabetes and schizophrenia (SMD)
- Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD)
- Diabetes with Hypertension or Proteinuria - Use of an ACE Inhibitor or ARB
- Diabetes with LDL-C greater than 100 – Use of a Lipid Lowering Agent
- Diabetes: Appropriate Treatment of Hypertension
- Diabetes: Foot exam
- Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation
- Diabetic Foot & Ankle Care, Ulcer Prevention – Evaluation of Footwear
- Diabetic Foot Care and Patient Education Implemented
- Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
- Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
- Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Documentation of Current Medications in the Medical Record
- Dyslipidemia new med 12-week lipid test
- EHR with EDI prescribing used in encounters where a prescribing event occurred.
- Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain
- Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Syncope
- Emergency Medicine: Aspirin at Arrival for Acute Myocardial Infarction (AMI)
- Empiric Antibiotic for Community-Acquired Bacterial Pneumonia

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (6/22)

Domains

Measures

Process (Cont'd)

- Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use
- External Beam Radiotherapy for Bone Metastases
- Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls
- Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
- Fibrinolytic Therapy received within 30 minutes of hospital arrival
- Flu Shots for Adults Ages 50 and Over
- Follow-Up After Hospitalization for Mental Illness
- Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)
- Follow-Up Care for Children Prescribed ADHD Medication (ADD)
- Frequency of Adequacy Measurement for Pediatric Hemodialysis Patients
- Frequency of Ongoing Prenatal Care
- HBIPS-2 Hours of physical restraint use
- HBIPS-3 Hours of seclusion use
- HBIPS-6 Post discharge continuing care plan created
- HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge
- Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival.
- Hearing screening prior to hospital discharge
- Heart Failure - Use of ACE Inhibitor (ACEI) or Angiotensin Receptor Blocker (ARB) Therapy
- Heart Failure - Use of Beta Blocker Therapy
- Heart Failure (HF) : Assessment of Clinical Symptoms of Volume Overload (Excess)
- Heart Failure : Beta-blocker therapy for Left Ventricular Systolic Dysfunction
- Heart Failure Symptoms Addressed
- Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction
- Heart Failure: Left Ventricular Ejection Fraction Assessment (Outpatient Setting)
- Hemoglobin A1c (HbA1c) Testing for Pediatric Patients
- Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge
- Hepatitis C: HCV RNA Testing at No Greater Than Week 12 of Treatment
- Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia
- High Risk for Pneumococcal Disease - Pneumococcal Vaccination
- HIV SCREENING: MEMBERS AT HIGH RISK OF HIV

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (7/22)

Domains

Measures

Process (Cont'd)

- HIV/AIDS: CD4 Cell Count or Percentage Performed
- HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis
- HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis
- HIV/AIDS: Tuberculosis (TB) Screening
- Hospice and Palliative Care -- Dyspnea Screening
- Hospice and Palliative Care -- Dyspnea Treatment
- Hospice and Palliative Care -- Pain Assessment
- Hospice and Palliative Care -- Pain Screening
- Hospice and Palliative Care – Treatment Preferences
- Human epidermal growth factor receptor 2 (HER2) testing in breast cancer
- Human Papillomavirus Vaccine for Female Adolescents
- Hydroxychloroquine annual eye exam
- Hyperlipidemia (Primary Prevention) - Lifestyle Changes and/or Lipid Lowering Therapy
- Immunizations for Adolescents
- Inappropriate Pulmonary CT Imaging for Patients at Low Risk for Pulmonary Embolism
- Inappropriate Use of “Probably Benign” Assessment Category in Mammography Screening
- Influenza Immunization
- Influenza Immunization
- Influenza Immunization
- Influenza Immunization in the ESRD Population (Facility Level)
- Influenza Immunization Received for Current Flu Season (Home Health)
- INFLUENZA VACCINATION COVERAGE AMONG HEALTHCARE PERSONNEL
- Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Intensive Care Unit Venous Thromboembolism Prophylaxis
- Intervention no later than 6 months of age
- Intrapartum Antibiotic Prophylaxis for Group B Streptococcus (GBS)
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- KRAS gene mutation testing performed for patients with metastatic colorectal cancer who receive anti-epidermal growth factor receptor monoclonal antibody therapy
- Lack of Monthly INR Monitoring for Individuals on Warfarin
- Lithium Annual Creatinine Test in ambulatory setting

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (8/22)

Domains

Measures

Process (Cont'd)

- Lithium Annual Lithium Test in ambulatory setting
- Lithium Annual Thyroid Test in ambulatory setting
- Major Depressive Disorder (MDD): Diagnostic Evaluation
- Major Depressive Disorder (MDD): Suicide Risk Assessment
- Male Smokers or Family History of Abdominal Aortic Aneurysm (AAA) - Screening for AAA
- Maternal Depression Screening
- MDS: Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy
- Measure of Medical Home for Children and Adolescents
- Measurement of nPCR for Pediatric Hemodialysis Patients
- Measurement of Serum Phosphorus Concentration
- Medical Assistance With Smoking and Tobacco Use Cessation
- Medication Information
- Medication Management for People with Asthma (MMA)
- Medication Reconciliation
- Medication Reconciliation Post-Discharge
- Melanoma Continuity of Care – Recall System
- Method of Adequacy Measurement for Pediatric Hemodialysis Patients
- Methotrexate: CBC within 12 weeks
- Methotrexate: Creatinine within 12 weeks
- Methotrexate: LFT within 12 weeks
- MI - Use of Beta Blocker Therapy
- Monitoring hemoglobin levels below target minimum
- Monthly Hemoglobin Measurement for Pediatric Patients
- MRI Lumbar Spine for Low Back Pain
- Multifactor Fall Risk Assessment Conducted in Patients 65 and Older
- Multiple Myeloma – Treatment with Bisphosphonates
- Myelodysplastic Syndrome (MDS) and Acute Leukemias – Baseline Cytogenetic Testing Performed on Bone Marrow
- Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection
- New Atrial Fibrillation: Thyroid Function Test
- New Rheumatoid Arthritis Baseline ESR or CRP within Three Months
- Newborn Hearing Screening

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (9/22)

Domains

Measures

Process (Cont'd)

- Non-Diabetic Nephropathy - Use of ACE Inhibitor or ARB Therapy
- Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
- Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
- Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)
- Oncology: Radiation Dose Limits to Normal Tissues
- Oncology: Treatment Summary Communication – Radiation Oncology
- Oncology: Cancer Stage Documented
- Osteoarthritis (OA): Assessment for use of anti-inflammatory or analgesic over-the-counter (OTC) medications
- Osteoarthritis: Function and Pain Assessment
- Osteopenia and Chronic Steroid Use - Treatment to Prevent Osteoporosis
- Osteoporosis - Use of Pharmacological Treatment
- Osteoporosis Management in Women Who Had a Fracture
- Osteoporosis testing in older women
- Osteoporosis: Communication with the Physician Managing On-going Care Post Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older
- Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older
- Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older
- Osteoporosis: Screening or Therapy for Women Aged 65 Years and Older
- Otitis Media with Effusion: Antihistamines or decongestants – Avoidance of inappropriate use
- Outpatient hearing screening of infants who did not complete screening before hospital discharge (EHDI-1c)
- Pain Assessment and Follow-Up
- Paired Measure: HCV Genotype Testing Prior to Treatment (paired with 0395)
- Paired Measure: Hepatitis C Ribonucleic Acid (RNA) Testing Before Initiating Treatment (paired with 0396)
- Paired Measure: Hepatitis C: Hepatitis A Vaccination (paired with 0400)
- Patient(s) 2 years of age and older with acute otitis externa who were NOT prescribed systemic antimicrobial therapy.
- Patient(s) with hypertension that had a serum creatinine in last 12 reported months.
- Patients Treated with an Opioid who are Given a Bowel Regimen
- Patients with Advanced Cancer Screened for Pain at Outpatient Visits
- Patients with an ICD implant who receive prescriptions for all medications (ACE/ARB and beta blockers) for which they are eligible for at discharge
- Patients with breast cancer and negative or undocumented human epidermal growth factor receptor 2 (HER2) status who are spared treatment with trastuzumab
- Patients with metastatic colorectal cancer and KRAS gene mutation spared treatment with anti-epidermal growth factor receptor monoclonal antibodies

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (10/22)

Domains

Measures

Process (Cont'd)

- Pediatric Symptom Checklist (PSC)
- Periodic Assessment of Post-Dialysis Weight by Nephrologists
- Perioperative Anti-platelet Therapy for Patients undergoing Carotid Endarterectomy
- Perioperative Care: Selection of Prophylactic Antibiotic: First OR Second Generation Cephalosporin
- Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)
- Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)
- Physical Therapy or Nursing Rehabilitation/Restorative Care for Long-stay Patients with New Balance Problem
- PN3a--Blood Cultures Performed Within 24 Hours Prior to or 24 Hours After Hospital Arrival for Patients Who Were Transferred or Admitted to the ICU Within 24 Hours of Hospital Arrival
- Pneumococcal Immunization (PPV 23)
- Pneumococcal Polysaccharide Vaccine (PPV) Ever Received (Home Health)
- Post breast conservation surgery irradiation
- Post MI: ACE inhibitor or ARB therapy
- Prenatal & Postpartum Care
- Pre-op beta blocker in patient with isolated CABG (2)
- Preoperative Beta Blockade
- Pre-School Vision Screening in the Medical Home
- Prescription of HIV Antiretroviral Therapy
- Pressure Ulcer Prevention and Care
- Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
- Primary Caries Prevention Intervention as Part of Well/III Child Care as Offered by Primary Care Medical Providers
- Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
- Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care
- Primary Prevention of Cardiovascular Events in Diabetics – Use of Aspirin or Antiplatelet Therapy
- Procedures and Tests
- Prophylactic antibiotic received within 1 hour prior to surgical incision
- Prophylactic antibiotic selection for surgical patients
- Prophylactic antibiotics discontinued within 24 hours after surgery end time
- Proportion of Days Covered (PDC): 5 Rates by Therapeutic Category
- Proportion of infants 22 to 29 weeks gestation screened for retinopathy of prematurity.
- Pulmonary Function Tests Before Major Anatomic Lung Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy)

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (11/22)

Domains

Measures

Process (Cont'd)

- Quantitative HER2 evaluation by IHC uses the system recommended by the ASCO/CAP guidelines
- Radical Prostatectomy Pathology Reporting
- Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- Recording of Clinical Stage Prior to Surgery for Lung Cancer or Esophageal Cancer Resection
- Recording of Performance Status prior to Lung or Esophageal Cancer Resection
- Rh immunoglobulin (Rhogam) for Rh negative pregnant women at risk of fetal blood exposure.
- Rheumatoid Arthritis Annual ESR or CRP
- Rheumatoid Arthritis New DMARD Baseline CBC
- Rheumatoid Arthritis New DMARD Baseline Liver Function Test
- Rheumatoid Arthritis New DMARD Baseline Serum Creatinine
- Risky Behavior Assessment or Counseling by Age 13 Years
- Risky Behavior Assessment or Counseling by Age 18 Years
- Screening for Clinical Depression
- Secondary Prevention of Cardiovascular Events - Use of Aspirin or Antiplatelet Therapy
- Selection of Antibiotic Prophylaxis for Cardiac Surgery Patients
- Severity-Standardized Average Length of Stay -- Routine Care (risk adjusted)
- Statin Prescribed at Discharge
- Statin Therapy at Discharge after Lower Extremity Bypass (LEB)
- Stenosis measurement in carotid imaging studies
- Stent drug-eluting clopidogrel
- Steroid Use - Osteoporosis Screening
- STK 02: Discharged on Antithrombotic Therapy
- STK 04: Thrombolytic Therapy
- STK 05: Antithrombotic Therapy By End of Hospital Day Two
- STK-01: Venous Thromboembolism (VTE) Prophylaxis
- STK-03: Anticoagulation Therapy for Atrial Fibrillation/Flutter
- STK-06: Discharged on Statin Medication
- STK-10: Assessed for Rehabilitation
- Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge
- Stroke and Stroke Rehabilitation: Deep Vein Thrombosis (DVT) Prophylaxis for Ischemic Stroke or Intracranial Hemorrhage
- Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (12/22)

Domains

Measures

Process (Cont'd)

- Stroke and Stroke Rehabilitation: Rehabilitation Services Ordered
- Stroke and Stroke Rehabilitation: Screening for Dysphagia
- Suboptimal Asthma Control (SAC) and Absence of Controller Therapy (ACT)
- Sudden Infant Death Syndrome Counseling
- Therapy with aspirin, P2Y12 inhibitor, and statin at discharge following PCI in eligible patients
- Thorax CT: Use of Contrast Material
- Time to Intravenous Thrombolytic Therapy
- Timely Initiation of Care
- Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- Timing of Prophylactic Antibiotics - Administering Physician
- Tracking of Clinical Results Between Visits
- Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
- Trastuzumab administered to patients with AJCC stage I (T1c) – III and human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy
- Tympanostomy Tube Hearing Test
- Ultrasound determination of pregnancy location for pregnant patients with abdominal pain
- Ultrasound guidance for Internal Jugular central venous catheter placement
- Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
- Vascular Access—Functional Arteriovenous Fistula (AVF) or AV Graft or Evaluation for Placement
- Venous Thromboembolism (VTE) Prophylaxis
- Venous Thromboembolism Patients with Anticoagulant Overlap Therapy
- Venous Thromboembolism Prophylaxis
- Warfarin - INR Monitoring
- Warfarin_PT/ INR Test
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (13/22)

Domains

Measures

Outcome

- 30-day all-cause risk-standardized mortality rate following Percutaneous Coronary Intervention (PCI) for patients with ST segment elevation myocardial infarction (STEMI) or cardiogenic shock
- 30-day all-cause risk-standardized mortality rate following percutaneous coronary intervention (PCI) for patients without ST segment elevation myocardial infarction (STEMI) and without cardiogenic shock
- Abdominal Aortic Aneurysm (AAA) Repair Mortality Rate (IQI 11)
- Abdominal Aortic Aneurysm (AAA) Repair Volume (IQI 4)
- Accidental Puncture or Laceration Rate (PSI 15)
- Accidental Puncture or Laceration Rate (PDI 1)
- Acute Myocardial Infarction (AMI) Mortality Rate
- Acute Stroke Mortality Rate (IQI 17)
- Adult Current Smoking Prevalence
- American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure
- Anesthesiology and Critical Care: Prevention of Catheter-Related Bloodstream Infections (CRBSI) – Central Venous Catheter (CVC) Insertion Protocol
- Bloodstream Infection in Hemodialysis Outpatients
- CARE - Consumer Assessments and Reports of End of Life
- Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
- Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
- Change in Basic Mobility as Measured by the AM-PAC:
- Change in Daily Activity Function as Measured by the AM-PAC:
- Children Age 6-17 Years who Engage in Weekly Physical Activity
- Children Who Are Exposed To Secondhand Smoke Inside Home
- Children Who Attend Schools Perceived as Safe
- Children Who Had Problems Obtaining Referrals When Needed
- Children Who Have Dental Decay or Cavities
- Children Who Have Inadequate Insurance Coverage For Optimal Health
- Children Who Live in Communities Perceived as Safe
- Children Who Receive Effective Care Coordination of Healthcare Services When Needed
- Children Who Receive Family-Centered Care
- Children Who Receive Preventive Medical Visits
- Children Who Received Preventive Dental Care
- Children With a Usual Source for Care When Sick

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (14/22)

Domains

Measures

Outcome (Cont'd)

- Children With Inconsistent Health Insurance Coverage in the Past 12 Months
- Children with Special Health Care Needs (CSHCN) who Receive Services Needed for Transition to Adult Health Care
- Chronic obstructive pulmonary disease (PQI 5)
- Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
- Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
- Comprehensive Diabetes Care: LDL-C Control <100 mg/dL
- Congestive Heart Failure (CHF) Mortality Rate (IQI 16)
- Controlling High Blood Pressure
- COPD - Management of Poorly Controlled COPD
- Death among surgical inpatients with serious, treatable complications (PSI 4)
- Death Rate in Low-Mortality Diagnosis Related Groups (PSI 2)
- Deep Vein Thrombosis Anticoagulation >= 3 Months
- Diagnosis of attention deficit hyperactivity disorder (ADHD) in primary care for school age children and adolescents
- Dialysis Facility Risk-adjusted Standardized Mortality Ratio
- Duration of Antibiotic Prophylaxis for Cardiac Surgery Patients
- Endoscopy/Poly Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients
- Evaluation of Left ventricular systolic function (LVS)
- Exposure time reported for procedures using fluoroscopy
- Failure to Rescue 30-Day Mortality (risk adjusted)
- Failure to Rescue In-Hospital Mortality (risk adjusted)
- Fall Risk Management
- Falls with injury
- Foreign Body left after procedure (PDI 3)
- Foreign Body Left During Procedure (PSI 5)
- Functional Capacity in COPD patients before and after Pulmonary Rehabilitation
- Functional status change for patients with elbow, wrist or hand impairments
- Functional status change for patients with foot/ankle impairments
- Functional status change for patients with general orthopedic impairments
- Functional status change for patients with hip impairments

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (15/22)

Domains

Measures

Outcome (Cont'd)

- Functional status change for patients with knee impairments
- Functional status change for patients with lumbar spine impairments
- Functional status change for patients with shoulder impairments
- Gap in HIV medical visits
- GERD - Upper Gastrointestinal Study in Adults with Alarm Symptoms
- HBIPS-4: Patients discharged on multiple antipsychotic medications.
- HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification
- Health Care-Associated Bloodstream Infections in Newborns
- Health literacy measure derived from the health literacy domain of the C-CAT
- Health-related Quality of Life in COPD patients before and after Pulmonary Rehabilitation
- Healthy Physical Development by 13 Years of Age
- Healthy Physical Development by 18 Years of Age
- Healthy Physical Development by 6 Years of Age
- Healthy Term Newborn
- Hemodialysis Adequacy Clinical Performance Measure III: Hemodialysis Adequacy--HD Adequacy-- Minimum Delivered Hemodialysis Dose
- Hemodialysis Vascular Access- Maximizing Placement of Arterial Venous Fistula (AVF)
- Hemodialysis Vascular Access- Minimizing use of catheters as Chronic Dialysis Access
- Hip Fracture Mortality Rate (IQI 19)
- HIV medical visit frequency
- HIV viral load suppression
- Hospital Risk-Standardized Complication Rate following Implantation of Implantable Cardioverter-Defibrillator (ICD)
- Hospital specific risk-adjusted measure of mortality or one or more major complications within 30 days of a lower extremity bypass (LEB).
- Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated
- Iatrogenic Pneumothorax Rate (PDI 5)
- Iatrogenic Pneumothorax Rate (PSI 6)
- Improvement in Ambulation/locomotion
- Improvement in bathing
- Improvement in bed transferring
- Improvement in management of oral medications
- Improvement in pain interfering with activity
- Improvement in status of surgical wounds

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (16/22)

Domains

Measures

Outcome (Cont'd)

- Incidence of Episiotomy
- Increase in number of pressure ulcers
- In-hospital mortality following elective open repair of AAAs
- In-hospital mortality following elective EVAR of AAAs
- INR for Individuals Taking Warfarin and Interacting Anti-Infective Medications
- Intensive Care: In-hospital mortality rate
- Ischemic Vascular Disease (IVD): Blood Pressure Control
- Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL-C Control <100 mg/dL
- Late HIV diagnosis
- Late sepsis or meningitis in Very Low Birth Weight (VLBW) neonates (risk-adjusted)
- Low Birth Weight Rate (PQI 9)
- Management of attention deficit hyperactivity disorder (ADHD) in primary care for school age children and adolescents
- Median Time to ECG
- Median Time to Pain Management for Long Bone Fracture
- Median Time to Transfer to Another Facility for Acute Coronary Intervention
- Minimum spKt/V for Pediatric Hemodialysis Patients
- Mortality for Selected Conditions
- National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure
- National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure
- National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure
- National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure
- Neonatal Blood Stream Infection Rate (NQI #3)
- Number of School Days Children Miss Due to Illness
- Operative Mortality Stratified by the Five STS-EACTS Mortality Categories
- Optimal Diabetes Care
- Optimal Vascular Care
- Pancreatic Resection Mortality Rate (IQI 9)
- Pancreatic Resection Volume (IQI 2)
- Patient Burn
- Patient Fall
- Patient Fall Rate

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (17/22)

Domains

Measures

Outcome (Cont'd)

- Patient Information
- Patient Safety for Selected Indicators
- Patients on Erythropoiesis Stimulating Agent (ESA)--Hemoglobin Level > 12.0 g/dL
- PC-01 Elective Delivery
- PC-02 Cesarean Section
- PC-03 Antenatal Steroids
- PC-05 Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother's Choice
- PCI mortality (risk-adjusted)©
- Pediatric Cardiac Surgery Stratified Mortality and Volume Pair
- Pediatric Heart Surgery Volume (PDI 7)
- Pediatric Patient Safety for Selected Indicators
- Percent of High Risk Residents with Pressure Ulcers (Long Stay)
- Percent of Low Risk Residents Who Lose Control of Their Bowels or Bladder (Long-Stay)
- Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (Long-Stay)
- Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (Long-Stay)
- Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
- Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)
- Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay)
- Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)
- Percent of Residents Who Have Depressive Symptoms (Long-Stay)
- Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (Long-Stay)
- Percent of Residents Who Lose Too Much Weight (Long-Stay)
- Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay)
- Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay)
- PICU Standardized Mortality Ratio
- Pneumonia Mortality Rate (IQI #20)
- Pneumonia vaccination status for older adults
- Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate (PSI 12)
- Postoperative Respiratory Failure Rate (PSI 11)
- Postoperative Stroke or Death in Asymptomatic Patients undergoing Carotid Artery Stenting (CAS)
- Postoperative Stroke or Death in Asymptomatic Patients undergoing Carotid Endarterectomy

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (18/22)

Domains

Measures

Outcome (Cont'd)

- Pressure ulcer prevalence (hospital acquired)
- Pressure Ulcer Rate (PDI 2)
- Primary PCI received within 90 minutes of Hospital Arrival
- Prophylactic Intravenous (IV) Antibiotic Timing
- Proportion admitted to hospice for less than 3 days
- Proportion admitted to the ICU in the last 30 days of life
- Proportion not admitted to hospice
- Proportion of infants covered by Newborn Bloodspot Screening (NBS)
- Proportion of Patients Hospitalized with AMI that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)
- Proportion of Patients Hospitalized with Pneumonia that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)
- Proportion of Patients Hospitalized with Stroke that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)
- Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year.
- Proportion of patients with hypercalcemia
- Proportion receiving chemotherapy in the last 14 days of life
- Proportion with more than one emergency room visit in the last days of life
- Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients
- Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients
- Pulmonary Embolism Anticoagulation \geq 3 Months
- RACHS-1 Pediatric Heart Surgery Mortality
- Radiation Dose of Computed Tomography (CT)
- Rate of Lower-Extremity Amputation Among Patients With Diabetes (PQI 16)
- Restraint prevalence (vest and limb)
- Risk Adjusted Case Mix Adjusted Elderly Surgery Outcomes Measure
- Risk Adjusted Colon Surgery Outcome Measure
- Risk Adjusted Urinary Tract Infection Outcome Measure After Surgery
- Risk-Adjusted Average Length of Inpatient Hospital Stay
- Risk-Adjusted Deep Sternal Wound Infection Rate
- Risk-Adjusted Morbidity and Mortality for Esophagectomy for Cancer
- Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer
- Risk-Adjusted Morbidity: Length of Stay >14 Days After Elective Lobectomy for Lung Cancer

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (19/22)

Domains

Measures

Outcome (Cont'd)

- Risk-Adjusted Operative Mortality for Aortic Valve Replacement (AVR)
- Risk-Adjusted Operative Mortality for Aortic Valve Replacement (AVR) + CABG Surgery
- Risk-Adjusted Operative Mortality for CABG
- Risk-Adjusted Operative Mortality for Mitral Valve (MV) Repair
- Risk-Adjusted Operative Mortality for Mitral Valve (MV) Replacement
- Risk-Adjusted Operative Mortality for MV Repair + CABG Surgery
- Risk-Adjusted Operative Mortality MV Replacement + CABG Surgery
- Risk-Adjusted Post-operative Renal Failure
- Risk-Adjusted Prolonged Intubation (Ventilation)
- Risk-Adjusted Stroke/Cerebrovascular Accident
- Risk-Adjusted Surgical Re-exploration
- Standardized adverse event ratio for children < 18 years of age undergoing cardiac catheterization
- Standardized Hospitalization Ratio for Admissions
- Standardized mortality ratio for neonates undergoing non-cardiac surgery
- Surgery patients on beta blocker therapy prior to admission who received a beta blocker during the perioperative period
- Surgery Patients Who Received Appropriate Venous Thromboembolism (VTE) Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery End Time
- Surgery patients with appropriate hair removal
- Surgery Patients with Perioperative Temperature Management
- Surgical Volume for Pediatric and Congenital Heart Surgery: Total Programmatic Volume and Programmatic Volume Stratified by the Five STS-EACTS Mortality Categories
- Survival Predictor for Abdominal Aortic Aneurysm (AAA)©
- Survival Predictor for Esophagectomy Surgery©
- Survival Predictor for Pancreatic Resection Surgery©
- The STS CABG Composite Score
- Transfusion Reaction (PDI 13)
- Transfusion Reaction (PSI 16)
- Under 1500g infant Not Delivered at Appropriate Level of Care
- Urinary catheter removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with day of surgery being day zero.
- Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment
- Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older
- Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (20/22)

Domains

Measures

Outcome (Cont'd)

- Use of appropriate medications for people with asthma
- Use of High Risk Medications in the Elderly
- Use of Imaging Studies for Low Back Pain
- Use of Internal Mammary Artery (IMA) in Coronary Artery Bypass Graft (CABG)
- Use of Iron Therapy for Pediatric Patients
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Ventriculoperitoneal (VP) shunt malfunction rate in children
- Vital Signs
- Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

Care experience

- Bereaved Family Survey
- CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys)
- CAHPS Health Plan Survey v 3.0 children with chronic conditions supplement
- CAHPS Health Plan Survey v 4.0 - Adult questionnaire
- CAHPS In-Center Hemodialysis Survey
- CAHPS® Home Health Care Survey
- Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set
- Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy
- Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment
- Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Discharged Resident Instrument
- Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Family Member Instrument
- Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument
- Cross-cultural communication measure derived from the cross-cultural communication domain of the C-CAT
- Cultural Competency Implementation Measure
- Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)
- Family Evaluation of Hospice Care
- HCAHPS
- Individual engagement measure derived from the individual engagement domain of the C-CAT
- Inpatient Consumer Survey (ICS) consumer evaluation of inpatient behavioral healthcare services
- L1A: Screening for preferred spoken language for health care
- L2: Patients receiving language services supported by qualified language services providers
- Language services measure derived from language services domain of the C-CAT

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (21/22)

Domains

Measures

Care experience (Cont'd)

- Leadership commitment measure derived from the leadership commitment domain of the C-CAT
- Medical Home System Survey (MHSS)
- NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)
- Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey
- Patients Admitted to ICU who Have Care Preferences Documented
- Practice Environment Scale - Nursing Work Index (PES-NWI) (composite and five subscales)
- Promoting Healthy Development Survey (PHDS)
- Validated family-centered survey questionnaire for parents' and patients' experiences during inpatient pediatric hospital stay
- Workforce development measure derived from workforce development domain of the C-CAT
- Young Adult Health Care Survey (YAHCS)

Cost and resource use

-
- Acute care hospitalization (risk-adjusted)
 - Admit Decision Time to ED Departure Time for Admitted Patients
 - Asthma Emergency Department Visits
 - Asthma in Younger Adults Admission Rate (PQI 15)
 - Bacterial Pneumonia Admission Rate (PQI 11)
 - Casemix-Adjusted Inpatient Hospital Average Length of Stay
 - Dehydration Admission Rate (PQI 10)
 - Depression Remission at Six Months
 - Depression Remission at Twelve Months
 - Diabetes Long-Term Complications Admission Rate (PQI 3)
 - Diabetes Short-Term Complications Admission Rate (PQI 1)
 - Emergency Department Use without Hospitalization
 - Esophageal Resection Mortality Rate (IQI 8)
 - Esophageal Resection Volume (IQI 1)
 - ETG Based HIP/KNEE REPLACEMENT cost of care measure
 - ETG Based PNEUMONIA cost of care measure
 - Heart Failure Admission Rate (PQI 8)
 - Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization.
 - Hospital 30-Day Risk-Standardized Readmission Rates following Percutaneous Coronary Intervention (PCI)
 - Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization for patients 18 and older.
 - Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

NQF Quality measurements (22/22)

Domains

Measures

Cost and resource use (Cont'd)

- Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF) hospitalization for patients 18 and older.
- Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following pneumonia hospitalization
- Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization
- Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following heart failure hospitalization
- Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization
- Hospital Transfer/Admission
- Hospital-level 30-day, all-cause risk-standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)
- Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA)
- Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)
- Intensive Care Unit (ICU) Length-of-Stay (LOS)
- Laboratory Testing (Lipid Profile)
- Median Time from ED Arrival to ED Departure for Admitted ED Patients
- Median Time from ED Arrival to ED Departure for Discharged ED Patients
- Nursing Hours per Patient Day
- Nursing Information
- Oncology: Chemotherapy for Stage IIIA through IIIC Colon Cancer Patients
- Otitis Media with Effusion: Systemic antimicrobials – Avoidance of inappropriate use
- Otitis Media with Effusion: Systemic corticosteroids – Avoidance of inappropriate use
- Overutilization of Imaging Studies in Melanoma
- Patient(s) with an emergency medicine visit for non-traumatic chest pain that had an ECG.
- Patient(s) with an emergency medicine visit for syncope that had an ECG.
- Perforated Appendix Admission Rate (PQI 2)
- Physician Information
- PICU Severity-adjusted Length of Stay
- PICU Unplanned Readmission Rate
- Plan All-Cause Readmissions
- Relative Resource Use for People with Asthma
- Relative Resource Use for People with Cardiovascular Conditions
- Relative Resource Use for People with COPD
- Relative Resource Use for People with Diabetes (RDI)
- Total Cost of Care Population-based PMPM Index
- Total Resource Use Population-based PMPM Index
- Uncontrolled Diabetes Admission Rate (PQI 14)
- Urinary Tract Infection Admission Rate (PQI 12)

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: NQF

Agenda

Review of progress to date

Background: Reward structure

Background: Quality measurement

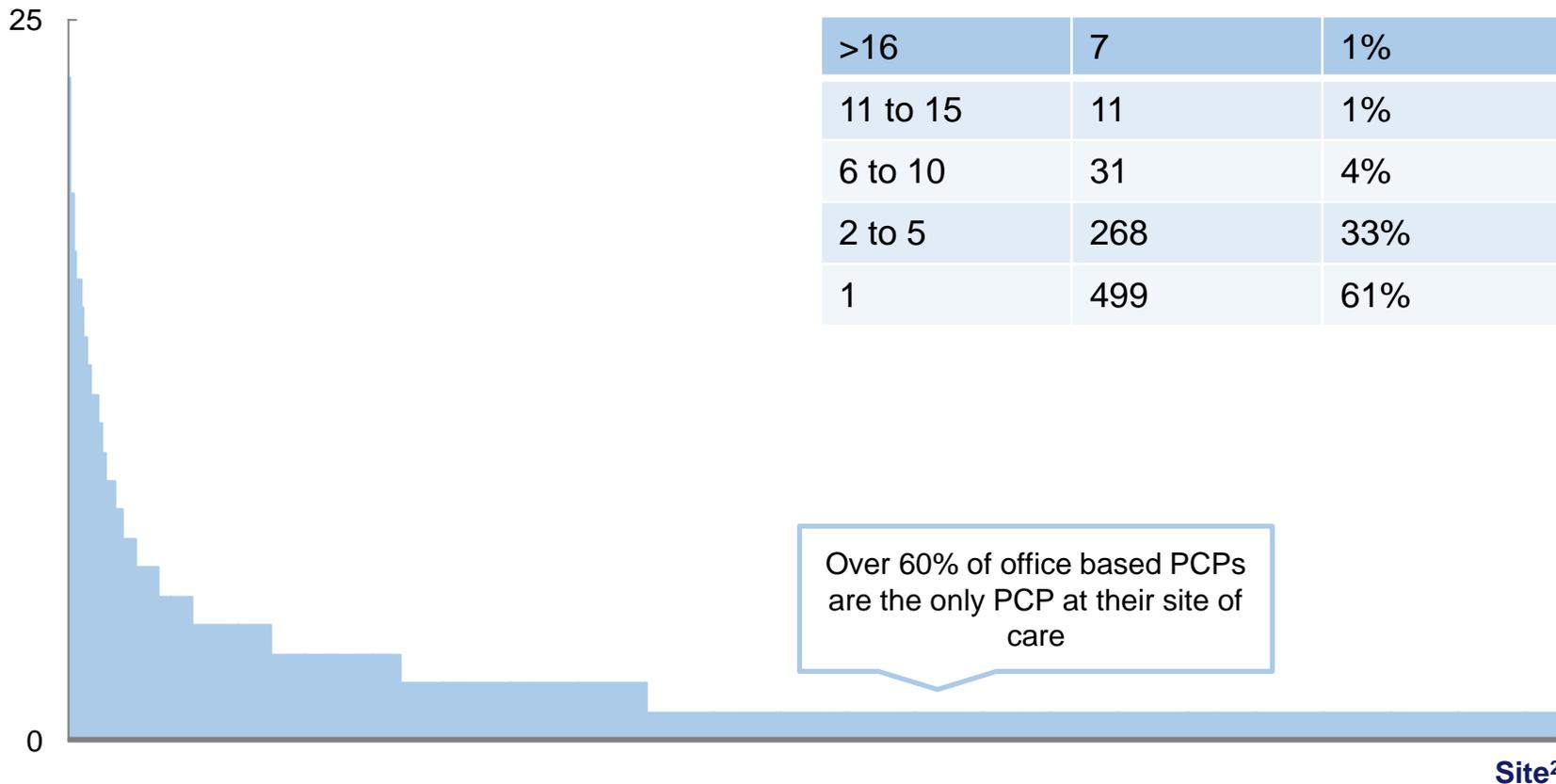
Background: Provider/payer landscape and consumer attribution

Long tail of sites of care with a single PCP

PCP fragmentation¹

PCPs per site in Connecticut (n=~800 sites, ~1740 PCPs)

PCPs on site



Over 60% of office based PCPs are the only PCP at their site of care

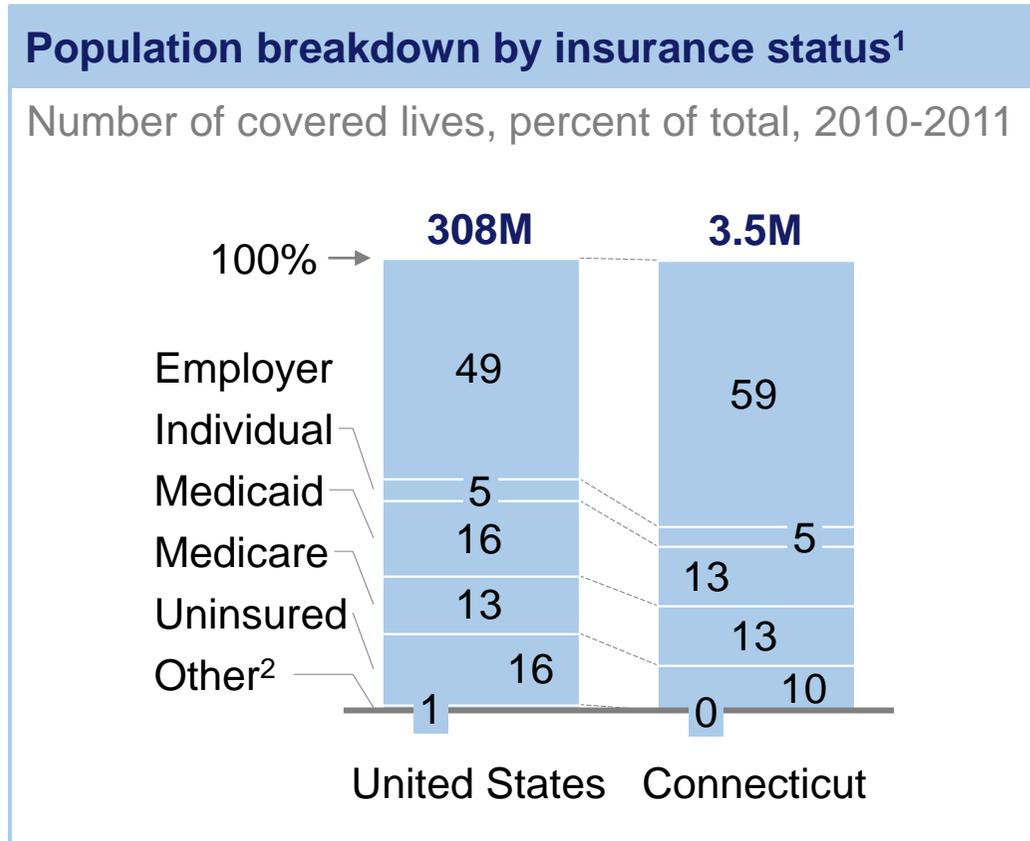
Site²

¹ PCPs include family practitioners, general practitioners, internal medicine/pediatrics, and internists

² Total number of sites = ~800 sites in Connecticut with at least one PCP. Does not separate sites with same parent company

SOURCE: SK&A data (~800 sites captured). Methodology: information collected from medical trade associations, phone books, medical school alumni directories, and are phone verified twice a year. Estimated to cover 98.5% of all US physicians

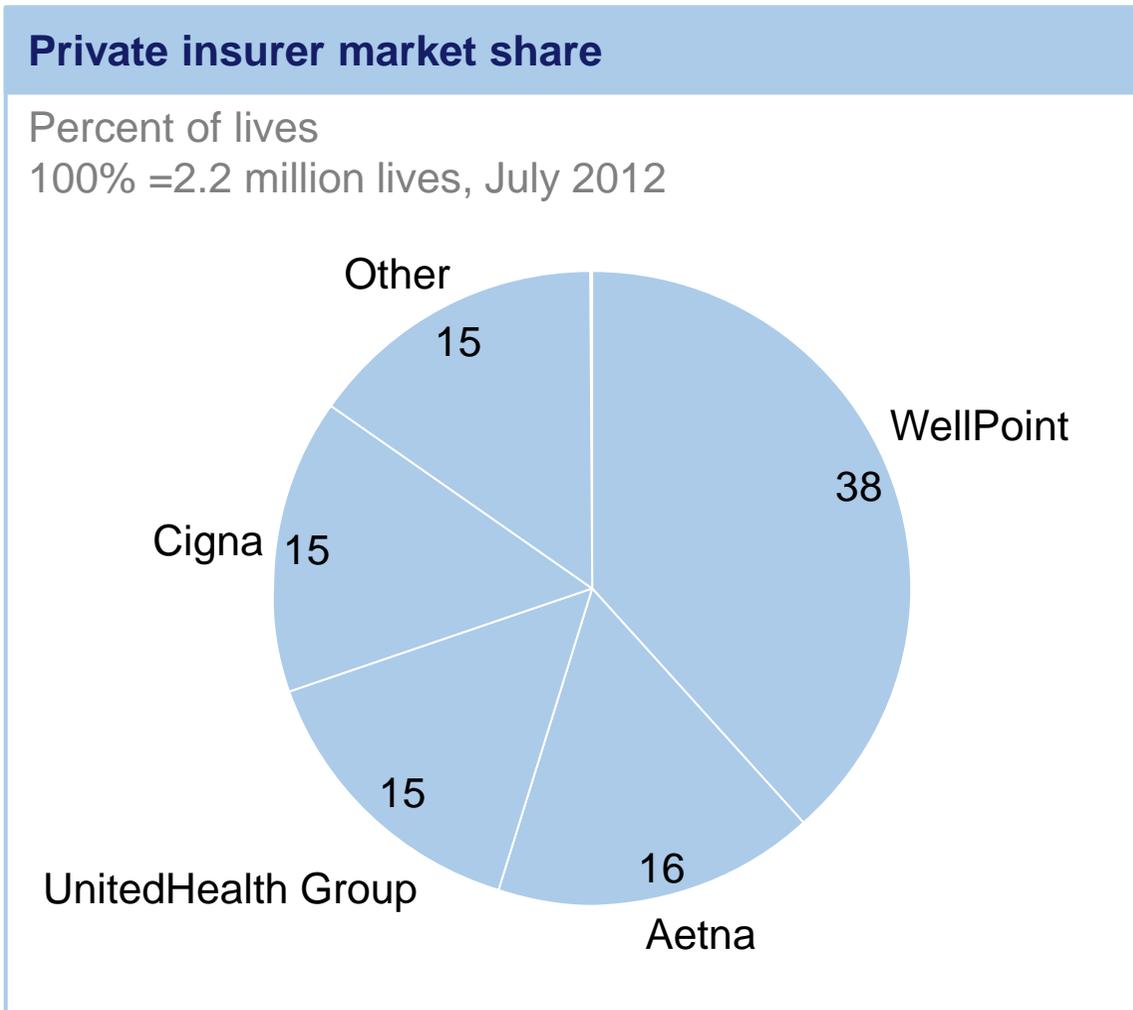
Connecticut residents get 64% coverage through commercial market, with 13% coverage from each of Medicare and Medicaid



¹ All two-year health coverage estimates were produced by Kaiser Family Foundation based on the Annual Social and Economic Supplement (ASEC) to the US Census Bureau's Current Population Survey (CPS). For current Medicaid and Medicare enrollment figures, please refer to slide 30 in the Medicaid section, which report enrollment data from the Centers for Medicare and Medicaid Services (CMS).

² "Other" Public includes individuals covered through the military or Veterans Administration in federally-funded programs such as TRICARE (formerly CHAMPUS) as well as some non-elderly Medicare enrollees.

Connecticut's commercial population is concentrated and mostly covered by WellPoint, Aetna, UnitedHealth, and Cigna



Guiding principles for selecting consumer attribution methodology

ILLUSTRATIVE

Key considerations for selecting a consumer attribution strategy

- Leverage consumer attribution methodology to promote equality of access to a PCP across patients from range of payer populations
- Consider implications of consumer attribution methodology on resultant risk profiles of consumer panels across PCPs (i.e., balance risk across providers or promote specialization)
- Promote consumer choice to select providers who meet their needs
- Consider needs of Connecticut's desired reward structure and its implications on the minimum consumer panel sizes required for providers to participate
- Promote clear sense of accountability and ownership of providers over consumers on their panel
- Consider complexity and feasibility of implementation for desired approach
- Determine importance of payer consistency across consumer attribution methodologies
- Timing and frequency (e.g., monthly, quarterly) of informing providers about consumers attributed to them

- Do these align with your beliefs regarding consumer attribution?
- Are there any other key considerations we should consider?

Consumers can potentially be attributed to a range of provider types

Provider types	Potential rationale
<ul style="list-style-type: none"> Primary care physicians (e.g., internal medicine, family practice physician, pediatrician) 	<ul style="list-style-type: none"> Have broadest level of insight and control over primary care needs of individual consumers Able to provide clinical expertise on how care for specified individual needs to be coordinated across providers
<ul style="list-style-type: none"> OB/GYN, Nurse midwives 	<ul style="list-style-type: none"> Optimally positioned to support consumers on women's health related issues
<ul style="list-style-type: none"> Other physicians (e.g., geriatrics, endocrinologist, cardiologist, psychiatrist) 	<ul style="list-style-type: none"> Have deep insight into needs of patient sub-populations with specific set of comorbidities/ existing conditions
<ul style="list-style-type: none"> Nurse practitioners, APRNs, PAs 	<ul style="list-style-type: none"> Have potential to relieve access issues based on PCP shortage Will require some level of clinical oversight from a licensed physician Potentially requires changes to licensure/ scope of practice
<ul style="list-style-type: none"> FQHC, CHC 	<ul style="list-style-type: none"> Aware of consumer's broader context that impact health and health outcomes

What is your ingoing hypothesis on which providers should have consumers attributed to them?

There are several standard methodologies for consumer attribution

Description

Prospective consumer selection

- Allows consumers to select the provider responsible for their care in advance of a defined evaluation period (e.g., 12 months)

Prospective auto-assignment

- Uses historical claims data to assign a consumer to a providers' consumer roster prior to the start of a defined evaluation period (typically used when a consumer does not select a provider within a specified period of time)

Retrospective claims based attribution

- Assigns consumers to providers based on historical claims data at the end of a defined evaluation period after the consumer has received care from their accountable provider

Illustrative example: Technical questions to be answered if a retrospective claims-based attribution methodology is selected

- What will be the administrative rule for assigning an individual to a provider based on utilization (e.g., plurality of visits, paid claims, allowed claims, charges)?
- Will E&M codes be in-scope?
- What will be the timeframe over which frequency of utilization will be considered to attribute a patient to a provider?
- Is there a minimum number of visits within the specified timeframe?
- If a patient does not meet the selected attribution criteria, is there an alternative, more flexible attribution rule that is used?