Issue 3: Industry News – October 2016

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NQF Issues 2016 Recommendations for Medicaid and CHIP Core Measures

National Quality Forum (09/07/16)

The National Quality Forum has released three new reports from its Measure Applications Partnership (MAP) that provide recommendations for improving state reporting of Medicaid and Children's Health Insurance Program (CHIP) core measures. In the first report, "Strengthening the Core Set of Healthcare Measures for Adults Enrolled in Medicaid, 2016," MAP recommends the addition of six measures to the Adult Core Set—including substance abuse, diabetes care for people with mental illness, and medication management for people with asthma—to help address high-priority areas. In its second report, "Strengthening the Core Set of Health Care Measures for Children Enrolled in Medicaid and CHIP, 2016," MAP calls for the phased addition of five measures to the Child Core Set, including maternity care, behavioral health, and care for individuals with sickle cell disease. MAP also recommends the removal of two measures due to limited effectiveness and opportunity for improvement and suggests adding a Child Core Set medication management measure for people with asthma to the Adult Core Set. The third report from MAP, "Advancing Person-Centered Care for Dual Eligible Beneficiaries through Performance Measurement, 2016," recommends the addition of four measures to address pressure ulcer monitoring, patient-reported functional status, and kidney care—all of which can significantly impact an individual's ability to remain healthy and independent.

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Beyond Clinical Engagement

BMJ Quality and Safety (09/01/2016) Vol. 25, No. 9, P. 716; Pannick, Samuel; Sevdalis, Nick; Athanasiou, Thanos

While quality improvement (QI) efforts have great potential to improve healthcare delivery, it has proven

difficult to replicate well-publicized research successes outside of the trial setting. Though the reasons why are not clearly understood, two factors—difficulty engaging clinicians in QI work and the context in which it takes place—are frequently cited. In a narrative review of literature, British researchers contend this focus on clinicians has been counterproductive, while the role of managerial staff in QI implementation has been underestimated. The researchers identified specific factors that affect the coordination of front-line staff and managers in QI and integrated these factors into a new model: The model of alignment. They used this model to explore the implementation of an interdisciplinary intervention in a recent trial, describing various participation incentives and obstacles for different staff groups. "Although there are few hard barriers to either group's participation in QI, competing demands force clinicians and managers to rationalize their efforts, and in some cases consciously relinquish other priorities," the researchers conclude. "Developing effective and sustainable QI interventions may depend on our ability to align the two groups' divergent interests."

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Leveraging EHR Documentation for Failure Mode and Effects Analysis Team Identification

Journal of the American Medical Informatics Association (09/01/16) Kricke, Gayle Shier; Carson, Matthew B.; Lee, Young Ji

Quality improvement projects can be strengthened through the use of process maps of clinical workflows. A widely used quality improvement method that uses process maps is Failure Mode and Effects Analysis (FMEA). In this study, researchers sought to examine if the secondary use of clinical documentation collected by an electronic health record during daily practice could reveal additional details about a high-risk process and enhance the accuracy of process maps. The study used discharge data from an inpatient cardiology unit as an example of a high-risk process that would be suitable for improvement using the FMEA approach. Researchers used data from the Northwestern Medicine Enterprise Data Warehouse for admissions to Northwestern Memorial Hospital's inpatient cardiology unit between July 1, 2014 to Dec. 31, 2014. The final dataset included 34,939 activities across 2,222 encounters, with providers completing an average 16 activities per encounter. The findings indicate that clinical documentation may identify discrepancies between expectations identified on the process map and activities as they occur in daily practice. Based on the analysis, the researchers' re-drawn process map was able to pinpoint where different perspectives may be available. According to the researchers, FMEA leaders were able to use information represented in the new process map for informing team creation, devising specific questions to ask during the FMEA, and directing where specific questions should be asked. This information can be used to improve the accuracy and validity of an FMEA of a high-risk process, the authors conclude.

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Plans for the Quality Payment Program in 2017: Pick Your Pace

CMS Blog (09/08/16) Slavitt, Andy

For the Quality Payment Program, set to begin on Jan. 1, 2017, the Centers for Medicare & Medicaid Services (CMS) will allow physicians to pick their own pace of participation, reports Andy Slavitt, Acting Administrator of CMS. Feedback on the agency's April proposal for implementing the program indicated that providers want a system that is right for the patient. Clinicians also noted how technology can help with patient care and that excessive reporting can distract from patient care. Next year, eligible clinicians and other clinicians will have several options for participation in the program. The first option is to test the Quality Payment Program, with the physician submitting some data after the start date to ensure that the system is working and that he or she is prepared for broader participation in 2018 and 2019 as they learn more. The second option is to participate for part of the calendar year, while the third option is to participate for the full calendar year and the fourth option is to participate in an Advanced Alternative Payment Model. Choosing one of these options would

ensure physicians do not receive a negative payment adjustment in 2019. These options and other supporting details will be described fully in the final rule, which will be released by Nov. 1, 2016, according to Slavitt.

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Implementation of a Value-Driven Outcomes Program to Identify High Variability in Clinical Costs and Outcomes

Journal of the American Medical Association (09/13/16) Vol. 316, No. 10, P. 1061; Lee, Vivian S.; Kawamoto, Kensaku; Hess, Rachel

New research shows that the implementation of a multifaceted value-driven outcomes tool helped to reduce costs and improve quality for three clinical projects in a large healthcare system. Investigators, led by Vivian S. Lee, MD, PhD, MBA, from the University of Utah, Salt Lake City, measured quality and outcomes relative to cost from 2012 to 2016 at University of Utah Health Care. The three clinical improvement projects examined were total hip and knee joint replacement, hospitalist laboratory utilization, and management of sepsis. While working with process improvement experts, physicians were given access to a tool with information about outcomes, costs, and variation. Measures examined included total and component inpatient and outpatient direct costs across departments, cost variability for Medicare severity diagnosis-related groups, and care costs and composite quality indexes. From July 1, 2014, to June 30, 2015, there were 1.7 million total patient visits, including 34,000 inpatient discharges. Professional costs accounted for nearly 25 percent of total costs for inpatient episodes and 41.9 percent of total costs for outpatient visits. For total joint replacement, compared with the baseline year, mean direct costs were 7 percent lower in the implementation year and 11 percent lower in the post-implementation year. In addition, the composite quality index for total joint replacement increased from 54 percent at baseline to 80 percent one year into the implementation. The mean cost per day for hospitalist laboratory testing declined from $138 to $123, with no significant change in the average length of stay. Meanwhile, the pilot sepsis intervention saw the mean time to anti-infective administration following fulfillment of systemic inflammatory response syndrome criteria in patients with infection drop from 7.8 hours at baseline to 3.6 hours in the evaluation period. The researchers suggest that individual physicians may benefit from understanding the actual care costs (not charges) and outcomes for individual patients with defined clinical conditions.

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