



# Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

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### Quality Measures at CMS: A Closer Look at the Measure Development Lifecycle and CMS' Meaningful Measures Initiative

#### Presentation Transcript

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**Evette Robinson:** Hello everyone and welcome to today's webinar entitled *Quality Measures at CMS: A Closer Look at the Measure Development Lifecycle and CMS' Meaningful Measures Initiative*. My name is Evette Robinson and I am the Project Lead with the VIQR Support Contractor for the Inpatient Psychiatric Facility Quality Reporting Program. I am delighted to introduce to you our guest speaker for today's presentation, Kimberly Rawlings. Kimberly manages the Measure and Instrument Development and Support Measures Management System Contracts at the Centers for Medicare & Medicaid Services. She has been with CMS for over three years, where she leads the MMS work including, but not limited to, the publication of the MMS Blueprint, website, and outreach effort. Ms. Rawlings received her Master's in Public Policy degree from the University of Maryland, College Park.

The purpose of today's webinar is to provide those in attendance with information about the basics of quality measures and their components, the five phases of the measure development lifecycle, resources for further learning, as well as information about CMS' Meaningful Measures Initiative.

By the end of this presentation, attendees will be able to describe the components of a quality measure, provide examples of how quality measures are used, identify the five phases of the measure development lifecycle, locate resources for further learning, and describe the Meaningful Measures framework.

This slide provides a list of the acronyms that will be referenced in this presentation.

Now, I will turn the presentation over to our guest speaker, Kimberly Rawlings.

**Kimberly  
Rawlings:**

Thank you so much for this opportunity to present to our audience today. I'm going to be covering a lot of information as you guys just heard, and my goal is to really give an overview of quality measurement here at CMS and the quality measure development process. So, I'm going to give a high-level overview and definitely have some resources at the end for you to refer to.

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There are a lot of slides and a lot of topics that are going to be covered, so I'm not going to be able to go into each one in depth, but I wanted to still include them in the presentation for your reference.

So, I promise I won't read off every slide; however, I think that this one is really worth reading verbatim. So, quality measures are tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structures, and/or systems that are associated with the ability to provide high-quality healthcare and/or that relate to one or more quality goals for healthcare. These goals include effective, safe, efficient, patient-centered, executable, and timely care.

Quality measurement is a step in improving healthcare quality, and quality measures help drive that improvement by offering consistent and accountable, evidence-based approach. They allow us to monitor health outcomes and assure accountability, with the end result being an increase in transparency. And so, how we see that in the public forum, then, is through our payment programs, our quality reporting programs, public reporting programs, quality improvement activities, and others.

So, just to go over and give some context to this, I wanted to give an example that you're probably familiar with and probably reporting on yourself. This is the Alcohol and Other Drug Use Disorder Treatment at Discharge measure. Basically, what this does is, it describes only those who receive a prescription for FDA-approved medications for alcohol or drug use disorder or referral for addictions treatment. So, at a very simple level, a quality measure is really a fraction. It has a numerator, which is your goal, the outcome that you're trying to achieve. Then, it has your denominator, which is your entire population that you're referencing. And here, the entire population is a number of hospitalized inpatients, 18 years or older, that have been identified with an alcohol or drug use disorder and the goal here is to make sure that these patients received a prescription at discharge for medication for treatments or referral for addictions treatment. So, that's going to be our goal, which is our numerator. And of course, there are exclusions to this. Sometimes there are people that you don't count in your population and that's where denominator exclusions come in.

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So, there are multiple types of quality measures. I'm going to just go over the top three that we generally see, but there are few others listed here. And there are others not mentioned on this slide as well, and I'll give you some resources at the end to learn more if you're interested. So, the most basic, and kind of the first types of quality measures, are or were structural measures. And what they really do is they focus on the organization itself and the organization's capacity to provide healthcare quality. Then, you have process measures which are slightly more complicated and that really focuses on a particular activity and whether that activity was performed in that care setting. These are the most common types of measures and, like I said, they tend to be pretty straightforward and are pretty prolific in our programs. Then we have a more complicated type of measure, which is our outcome measure. And again, at a very high-level and not getting into a lot of details, outcome measures focus on a health state of a patient resulting from various healthcare processes and procedures, et cetera. And so, this is really our goal because it's not measuring whether or not an activity was done, but it's really measuring that patient's state of health after they've received the care. And so, like I said, they are more complicated, but they're really the goal in what we're trying to achieve more and more as we develop our measures.

You all are probably very familiar with this and probably know about these a bit better than I do from a practical standpoint, but there are many different data resources that quality measures pull the data from. There are administrative data, medical records, patient surveys, electronic health records, a few different programs use assessment instruments, et cetera. And, just to note here, that different data sources can offer different types of data and different frequencies of data and, what's most important when measure developers are developing the measure is really identifying what data source is most reliable for providing the information. Which data sources are most feasible or most accessible to most clinicians and what brings about the least amount of burden in data collection? And so, they kind of, you know, try and factor all of those aspects in when developing a measure.

So, let's start to get in to the measure development lifecycle a little bit and talk about the five phases of measure development. So, first you have

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measure conceptualization, which is basically where you're brainstorming what type of measure you would like to develop and starting to think through. Is that measure going to be important, is there a gap, is there room for improvement, et cetera? Once you have that basic concept and you know the area of the measure that you're trying to develop, you move into measure specification where you start to draft the details and define the specifications of the measure and conduct initial testing. Next, we have measure testing, which is where you develop and execute a comprehensive measure testing plan to make sure that the measure is feasible, reliable, relevant, et cetera. Next, you have measure implementation, which is where you're rolling it out. In our case, it's CMS where you're rolling it out to the entire nation through federal rulemaking. And then, it's also where you do a lot of education and outreach along with, in most cases, seek NQF enforcement. And lastly, you want to make sure that your measure continues to be relevant. And so, the last measure development phase is measure use, continuing evaluation, and maintenance.

And this timeline here at the bottom is approximate, but generally we say it takes anywhere from two to three years from start to finish. Start to finish being from conception to implementation. It takes about two to three years to finish developing a measure and, then, the measure use, continuing evaluation, and maintenance continues periodically throughout the entire life of that measure. So, that's ongoing. And, I mean, we could probably have an hour long. In fact, I think have seen and been part of hour-long presentations on each of these. But, in the next couple of slides, we're going to move a little bit quickly, but I want to make sure to just go a little bit more in depth on each of them.

But before I get into that, I want to bring into play one new nuance with this. So, we traditionally have looked at the measure development lifecycle as a linear process but, in the last two or three years in talking with our measure developers, we started to see it as really a cyclical process where measure conceptualization really is at the center of it. So, what this diagram here is trying to depict is that, you're always revisiting your initial measure concept. If you start defining your, you know, if you start defining the various

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specifications and details of the measure and it's not quite adding up, or you're getting your measure testing data back and it's not great because it's not very feasible, et cetera, then you always have to continually revisit that initial concept and sometimes make tweaks. Sometimes you can make a tweak and kind of go right back into testing, depending on how large that tweak is. Other times, you have to go back from testing and then back up to specification. And so, as this diagram shows, it's quite a linear process but it's a bit more, a bit more cyclical than that.

But as I mentioned, we're going to take an in-depth look into these measure development phases.

So, going back to measure conceptualization, again, here is where we just define the measurement concept, the general ideas, trying to identify what's meaningful and what's important to patients, what's important to collect, what's important to clinicians, et cetera. And that's really the purpose of the measure of conceptualization phase. And what that looks like in practice is doing some information gathering, developing a business case, convening a TEP, which is a Technical Expert Panel. I'll touch on that a little bit later but, basically, it's a diverse group of stakeholders that provide input to the measure developer on their measure. And then, we also solicit public comment.

Information gathering is where we're asking a couple of very basic early questions. Where are the gaps in this specialty or in this setting, in this care setting, et cetera? Why is it important? Is it important to collect? Are there clinical practice guidelines that help us get to this quality improvement that we want to make? And so, it's really about obtaining information that will guide the prioritization of various topics and conditions and helping to develop that initial business case. And so, in information gathering, we do that through a mixture of an environmental scan, which can take the form of a literature review, like I said, a clinical practice guideline search, interviews of experts, or patients or clinicians, et cetera, as well as some empirical data analysis.

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I think of the business case as trying to tell the story of the importance of that measure and making sure that we get a return of investment on the resources, of not only developing the measure but implementing the measure, both from the perspective of CMS but, more importantly, from the perspective of clinicians, providers, patients, et cetera. The goal here is to make sure that the potential improvements to the healthcare quality outweighs the cost and efforts to collect that data and compute the measure score. Coming back to a few very basic questions, it's making the argument of "Is this worth it?" What are the costs? What are the benefits? What are the unintended consequences of this measure, and how do those factors compare? And again, really asking, "Is it worth it to develop and implement a measure?" And, as you can imagine, while the business case is drafted at this point, we're adding to this argument. We're adding to this document throughout the entire measure development lifecycle.

So, next once we have our basic concept, everyone's agreed, and you know, by everyone again, I mean CMS, the measure developer, clinicians, patients, et cetera. Once everyone has kind of come to an agreement and, you know, we've gotten positive feedback through public comment, or TEP, et cetera, we start to actually develop the measure itself and present them for review and engage our stakeholders in getting feedback on that measure. And, you know, so the measure specification is really about drafting those measure details.

So, this might be a little small to read for some, so I included it on the next page as well, so it's a little bit larger in text.

But here are kind of the steps, or how we develop a full, develop a full measure technical specification. And the key pieces here are defining the data source, specifying the code systems, and constructing the data protocols, and, of course, in the case of CMS, you know, obtaining approval from CMS or the person that holds that contract.

And here are the components the developers seek to define. Again, you'll see some, you know, familiar words from our earlier example as far as numerator, denominator, exclusions, et cetera. But then we also have data

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sources assessing whether or not risk adjustment is something to explore, you know, what's the time window, et cetera.

So, we've come up with a concept. We've drafted the initial specifications for it. Now, we get to measure testing, which is particularly important with the case of CMS because we're talking about, you know, implementing this measure into a national program that often has, you know, either a payment or some sort of reporting implication. And so, the purpose of measure testing is to really evaluate whether the measure will support the intended quality program successfully.

And so, the subsequent testings are very basic, I think, very intuitive, when we look at it at a very high level. It's about developing a testing work plan, implementing that work plan, and analyzing the testing results, and then, kind of going back a little back to our cyclical representation of the measure development lifecycle. We also, we sometimes, need to then go back and refine the measure, either the basic concept or, you know, just tweak a couple of the fields defined in the measure specification phase as well. And then, lastly, we put together a report on measure testing.

So, we'll go through the next two slides fairly quickly, but this just lists the components of a measure of a basic measure testing work plan.

And then, this lays out the process. I think the two important things to note here are that there are multiple places, both in step two and down at the bottom between step 7 and 8, where CMS does get involved and make sure that we are in the process, throughout the process, making sure that we are, you know, approving that measure and involved in the testing to make sure that it's tested thoroughly, and then, kind of meets are criteria. Of course, this process is assuming that we're working with CMS, our CMS contractors, and CMS developers. The other thing just to note and, you know, to reiterate what you've seen on the previous slides, is step five. That we are continually refining the measure at this point and taking that data, using the testing data, to continue to make sure that the measure is seeking its purpose.

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Now, again, we can probably have an entire hour on reliability and validity. Those two words come up a lot when we're talking about measures. But, in summary, reliability testing is about making sure that the results are repeatable and wanting to make sure that the measure results are the same, or that the measure is producing the same results, in a high proportion of the time when assessing the same population in the same time period. Validity testing is slightly different. Validity testing is really getting at, "Are you measuring what you're intending to measure?" Is the logic sound and valid in talking about to the degree to which evidence, clinical judgment, and theory support the interpretation of the measure score? So, again, two very important issues of measure testing or pieces of measure testing that are always brought up when we're talking about evaluating the measure testing phase and just evaluating a measure in general. So, you'll see these words again when we talk about the criteria, the evaluation criteria.

Our fourth phase in the measure development lifecycle is measure implementation and that's the rollout to healthcare providers who will collect and report the new measures.

So, this process, the process of measuring implementation, can vary depending upon a number of factors and, you know, including, but not limited to, the scope of the measure implementation, the data collection process, the program measures being added to it, et cetera. All of the time, really, I guess, it generally includes three main steps, but kind of the sub-steps of each of these bullet points is what really looks different based on program and measure, et cetera. So, generally, our measures, we seek NQF endorsement for our measures, and we'll talk about that a little bit later. But we can think of NQF endorsements as a gold standard or a stamp of approval that says that this is a good measure. Measure selection, which is about figuring out which measures to put into a program, and then, measure rollout, which is the actual implementation and rolling it out to healthcare providers to be measured and collected and reported.

So, NQF endorsement, like I said, is really considered the gold standard. NQF, or the National Quality Forum, is a consensus-based entity. And so, what happens very simply is, CMS and others will bring measures to this

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consensus-based entity for review. And they use a very rigorous set of criteria to ensure that measures are addressing the various aspects of care that are important and feasible to measure, provide consistent and credible information. That's kind of getting back to our reliability and validity, and also, that they can be used for quality improvements and decision making.

The pre-rulemaking process is a process where we collect all of the measures from CMS measure developers, as well as any external measure developers for about 20 or so programs, outlines, and ACA (Affordable Care Act) Section 3014. Basically, what it is, it's publishing a list of measures by December 1st that CMS intends to consider in any of their rulemaking programs. So, the purpose of this pre-rulemaking process is to allow for additional stakeholder engagement through the Measures Application Partnership, which is a different component and a different process than endorsement, but still a consensus-based process where we can get additional stakeholder feedback from them, as well. There are opportunities for public comment as well. Then, every year, very quick turnaround, by February 1st, the MAP provides recommendations to the Secretary of HHS for consideration. And so, at the end of this, again, it's really just CMS getting feedback from various stakeholders on measures it's considering. It's not actually going into a program just yet.

And I believe, while your program does go through pre-rulemaking, I think that it is worth noting that not every program does. There's some Medicaid programs that do not, that use measures, that do not go through approval making, as well as the Marketplace Quality Initiatives. So, they have their own process and I'll give you some resources where you can read more about that if you are interested.

So, pre-rulemaking is really where the measures get finalized in the program and that's where, multiple times throughout the process, we engage stakeholders and offer opportunities for public comments. There's a lot more information about that on our website that I'll show you later as well.

So, finally, we have measure maintenance, use, and evaluation. And so, at this point, we've created, well, we've kind of conceptualized and

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brainstormed the measure. We've created the measure. We've defined the measure. We've tested the measure. We've implemented the measure and, now, we really want to make sure that it continues to support the program as it was originally designed to support the quality program and we want to make sure that we're looking for any opportunities to tweak or repurpose the measure to make sure that it's continually increasing the value of the quality program measurement results.

Again, this is a little small, so I made it a little bit bigger for us to go through. But basically, when we do measure maintenance, use, and evaluation, we are collecting data, we are reporting measure results, going back to the original kind of steps in the information gathering steps from measure conceptualization and doing an environmental scan and a literature review, et cetera, to make sure that things haven't changed. You know, clinical guidelines, clinical practice guidelines can change frequently for some procedures and in some specialties. And so, we want to make sure that our measure is keeping up the data and making sure that it's continuing to be reliable, valid, continuing to be feasible, really continuing to improve quality and be up to date. To summarize, I guess, the real purpose then of this step is to ensure that the measure remains sound by showing strong evidence, as well as providing evidence to maintain the consensus endorsement process or maintain NQF endorsement. Depending on the measure, you know, we look at measures typically every year and, then, the NQF endorsement is maintained every three years.

I think that this kind of reiterates most of what I've just said but it's really about making sure that the measure continues to be unique or best in class. Sometimes, in measure maintenance, use, and evaluation, like I said, sometimes the clinical guidelines will change, and the measure will need to be updated or, sometimes, we'll see new uses for that measure and that can, you know, drive changes. Maybe we find out that it could be a great measure for an additional setting, et cetera, and so we go and revisit that measure to see if it can be tweaked.

Of course, as with everything, there are some challenges to measure development. There's a long list here, but I do just want to highlight a couple

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that I think are of particular importance to us. They're all very important and I think we're trying to address them all. But a couple to note is definitely reducing clinician burden for data collection for measure reporting. We've realized that this is an issue and I'm going to get to one of the initiatives at the end of this presentation, Meaningful Measures, that talks about that a little bit. But that's something that there's definitely a challenge, and we're working to address. Similarly, making sure that we have the most meaningful outcome measures possible, going to the back to the different measure types, we have a lot of process measures and they definitely play a role. You know, to some extent, we are still developing process measures because perhaps we don't, we aren't in a place to develop an outcome measure yet. But the ultimate goal is really to have meaningful outcome measures that get at the heart of the issue, which isn't just the process that the provider's doing, but the ultimate goal is to really make sure that that patient, the person, has improved in their healthcare. Also, another very important point or challenge that we're working towards is increasing our partnerships with the patient, frontline clinicians, specialty societies, patient advocacy groups, facilities, and others. By doing that, we believe that that will get us to more meaningful outcomes, that we will learn more and, by working with these groups, be able to reduce clinician burn out. I'm sorry, clinician burdens, et cetera.

So, it is important once the measure is developed, like I mentioned before, to evaluate that measure and make sure that we're getting feedback on that measure throughout the entire process.

And so, we have a couple of criteria by which we evaluate our measures, and these are really industry standards. They are not specific to CMS and they align directly with the NQF endorsement criteria as well. So, first, and this kind of lends itself to that initial measure conceptualization phase and the business case, we have the importance to measure and report, which is about making sure that there's an opportunity for improvement. Next, we have scientific acceptability and feasibility, which directly links to our measure testing phase. You see those words underlined again, reliability and validity, are very important to the scientific acceptability criteria. And then, we also have usability, which is making sure that the measure is meaningful and

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useful to the targeted audience. And then, we have harmonization. This starts to get at the issue and challenge of burden. So, we want to make sure that our measures are aligned in the measure set, but also align to make sure that we don't have four and five measures that are measuring the same thing, that make sure that there is harmony between those and that we're having the fewest possible measures and that there's harmonization between very similar measures to decrease the burden.

Stakeholder engagement. I've mentioned public reporting and Technical Expert Panel several times when reviewing the measure development lifecycle. Those are the main ways that we get stakeholder input and engage stakeholders to get that feedback and it's really important for us to do that because it helps us improve quality and improve our quality measures. It's useful to consumers in making sure that we are developing measures that matter and making sure that the measures are effective for accountability. And overall, it's helping to ensure that the value we add with this measure outweighs any burden from the collection or the development process. And it helps you get that information by, of course, receiving input and engaging those that are being held accountable for the quality measures.

I will say that Person and Family Engagement, and I would also add clinician engagement in here as well, has evolved over time. I think, you know, five or 10 years ago the traditional approach was to bring these groups and bring stakeholders in at the end of the measure development process and really show them, you know, here's what the display of the measure is going to look like. Here's what the reporting of it is going to look like. What do you think about this, does this make sense to you? The approach that we've had for the last five years I guess or so has been to make sure that a person or a family representative or a clinician is involved in the Technical Expert Panel that's evaluating the measure throughout the measure development lifecycle. And then, our most current approach, and I think where we actively are now and are continuing to go, is really making sure that there are as many opportunities as possible in creating some person-only or patient-only focus groups, work groups, online panels, TEPs, et cetera, that really focus on the person or the patient and really focus on the clinician. So, it's kind of in this

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evolution of continually getting more and more engagement from frontline clinicians and persons and families.

Finally, there are some resources. Like I said, I realize that this is a lot of information, but I think it's important to have some resources to go to if anything in particular has peaked your interest.

The main resource that we have under the Measures Management System is the Blueprint. Just to back up, I guess, for one second. The Measures Management System is a system of tools, resources, processes, et cetera, that help to standardize and align all measure development across CMS and we publish all these processes. So, external stakeholders will sometimes use our resources as well. One of those main resources is the MMS Blueprint, which documents the course of these business processes and decision-making criteria for measure development. And there are some various meetings and learning opportunities, et cetera, that I'll get into in a minute that help break that, break this document down a little bit. It was about 500 pages a few years ago. We've gotten it down to about 350. That's still quite a lot, but I don't, unless you're developing measures, I wouldn't expect anyone to read it. So, what we've done is try and break that information, those 350 pages, break it down to smaller, more digestible, and accessible articles so that people can really try and hone in on the particular pieces that you're interested in. So, we have a monthly newsletter through Govdelivery that you can sign up for on the website that just has a couple of short, easily digestible articles that touch on various quality measurement topics every month and we only send it out once. So, hopefully that's not too burdensome for people to read.

Then, we also have our website, which I'm very excited about. We re-did it. I guess it's about six or seven months ago now, but our website has a ton of resources on it, ranging from PowerPoints, all those times where I said there's an hour-long PowerPoint, it's on the website. Ranging from PowerPoints to one-pagers, there's a mix of resources there. Some are for people that are new to measures and they're just starting to learn about quality measures and, then, there are a lot of resources there for people who are very advanced in their quality measurement knowledge or are developing

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measures themselves. So, there's a real range for people to explore and read. And, you know, as you'll see, we have a whole section called "New to Measures" that really just outlines the basics very simply.

Also, on this website, there's a particular interest, I think, under the "Measure System Overview." There's a link to our Measures Inventory Page. We've just released, in the last several months, a public-facing, web-based measures inventory tool that we're calling CMIT, CMS Measures Inventory Tool, that houses all of the measures that CMS is using across all of the programs. There's lots of filtering capabilities, et cetera. So, you could go in there and look up substance abuse and see what kind of measures are correlated with substance abuse or you could look into what programs have a particular measure. So, you can see, you can look up one measure and see, okay, this one measure is in three or four programs or, vice versa, you can look up a program and see what measures are currently active for that program. So, that is a great a tool and a great resource. So, I've mentioned several times, that we are continuing, that all of this work that we're doing around quality measures is about trying to make sure that the measures are most meaningful to our patients and to our providers and getting the most out of each measure that we can, to decrease burden, and make sure that the quality measures we're developing align with what's important to the patients and what, you know, where there are gaps in quality, et cetera.

So, I feel like there's been several announcements over the last three or four months about the new initiative, Meaningful Measures. The general goals of CMS include empowering patients and doctors to make decisions about their healthcare. Second, ushering in a new era of state flexibility and local leadership. Third, to support innovative approaches to improve quality, accessibility, and affordability, and finally, to improve the CMS customer experience. Meaningful Measures has been an outgrowth of these goals.

So, the goal of Meaningful Measures is to focus everyone's efforts on the same quality areas and lend specificity, which can help identify measures that are more meaningful. What do I mean by this? So, by meaningful, we define that as, you know, the following bullet points: Making sure that the measure is high impact. Making sure that it's meaningful to patient, clinicians, and

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providers. We come back to outcome measures, making sure they're outcome-based and really getting at is it improving the healthcare of that patient. Minimizing the burden for providers. Making sure that there is an opportunity for improvement. Addressing measure needs for population-based payment through alternative payment models. And then, trying to align measures across programs and, where possible, aligning measures with other payers as well. And so, through Meaningful Measures, we have created a framework that defines each of these kind of high impact areas. Like I've said, we've been working on this for several months and have been kind of outspoken about Meaningful Measures, but this effort was launched much before that. So, since mid-December 2016, this effort, we launched this effort by examining historical trends, in measure proliferation gaps and alignments, and think about how we could reorganize them to provide meaningful guidelines and tracking of outcomes that matter. And so, we drew on work that was completed through National Quality Forum, National Academies of Medicine, and the Healthcare Payment Learning and Action Network, et cetera. We refer to these high impact areas as Meaningful Measures. We also wanted to be sure to include the perspectives from experts and other external stakeholders, such as the Agency for Healthcare Research and Quality and the Core Quality Measure Collaborative, as well, to help develop criteria around measures being meaningful to patients and actual providers. We developed these overarching measure areas and organized them into this framework to help achieve the goals of high quality healthcare and meaningful outcomes for patients.

So, here we have the diagram of the Meaningful Measures framework itself and I think that this will help make the framework a bit more clear. So, you can see the linkage between our CMS goals and our values linked to our general quality priorities and then down to these Meaningful Measure areas that we've identified as key focal points to develop measures in. And so, at the center of this, we have a depiction of a patient and a provider because they truly are at the center of everything that we do here at CMS. That is surrounded by CMS' four strategic goals that we reviewed a few slides earlier to also depict that they are the center of the framework and work together with conjunction, or this works, works together to achieve those four

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goals. Then, in our bullet points, we have the 19 Meaningful Measure areas that arranged under the six quality priorities, one in each color. Just to take one as an example, so that we can kind of track that lineage, so to speak. So, as an example, we have the quality priority of Promote Effective Prevention and Treatment of Chronic Disease and this includes five Meaningful Measure areas. So, those five bullet points: preventive care; management of chronic conditions; prevention, treatment, and management of mental health; prevention and treatment of opioid and substance abuse disorders; and then risk-adjusted mortality. So, those are the five Meaningful Measure areas associated with that quality priority. So, if we look specifically at, if we look specifically at, the prevention and treatment of opioid and substance use disorders, you know, we can see clearly how that, you know, just is very relevant to all of the work that's been done at CMS and across HHS to address the opioid crisis that's been declared a public health emergency. Therefore, it's a high priority focus area for measurements. And so, I think that this example demonstrates how the alignment of the cross-cutting criteria of safeguarding public health and the overarching quality category of quality priority of Promote Effective Prevention and Treatment of Chronic Disease will function to address this important public health issue. And so, by honing in on this Meaningful Measures area, CMS can, you know, they can work to identify existing gaps in measurement and improve efforts and just focus our efforts with partnerships, including states and communities, et cetera, in combating the opioid crisis.

So, while this is the overall diagram, the next several slides, I'm not going to go over them I depth, but what they do is, they pull out individual quality priority areas, kind of the arch here with the picture in the center of the various individual Meaningful Measure areas. And then, it gives a few examples. These are just illustrated examples, there are many more. But then, giving examples of a couple of measures that apply to that Meaningful Measure area. And so, there are several slides that you can walk through to see how these specific measures tie to the meaningful areas, or that tie to the quality priority.

# Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

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The Meaningful Measures is a relatively new initiative and framework. So, there's a few key things I think to point out. Part of the intention of this is to increase measure alignment across programs, as well as hopefully eventually across payers as well, through CMS programs, public initiatives, as well private initiatives. It's also to point out high priority areas like opioid use and substance abuse, point out high priority areas where there may be gaps in available quality measures. The Meaningful Measure areas are not to replace any existing programs or create any new requirements or mandate any new measures, et cetera. It's really about helping programs identify and select individual measures by prioritizing those areas and gaps and trying to create some alignment. The hope is that, and the intention is that, the initiative through the prioritization will help reduce burden for clinicians and providers by focusing on patients and improving quality of care in ways that are meaningful, instead of for reporting or for paper work sake. As I mentioned throughout the presentation, we hope that through this initiative, it also prioritizes the use of outcome measures. And lastly, what does this mean for clinicians, including specialists? Is it really intended to capture the most impactful and high-priority quality improvement areas for all clinicians, including specialists? Perhaps not every single program or every single clinician is going to respond to all 19 of these measures. They may not apply, but the idea is to make them all a priority for CMS so that we can make sure that we are aligned in our thinking and having clear priorities when we're adding measures, et cetera, to our program.

This is a new initiative and we are definitely looking for feedback. There is a Meaningful Measures website. I encourage you to Google it and check it out. We would love for your feedback on it. There's a few PowerPoints, a video, various resources, et cetera, to help teach you more about Meaningful Measures and this initiative. There's also an email that you can feel free to provide any feedback, comments, et cetera.

And so, with that, I'd like to thank you for your time and your attention to this presentation. Again, there are plenty of resources between these two websites. I encourage you to seek them out and, of course, if you have any questions, I would be happy to receive emails and answer. Thank you.

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**Evette Robinson:** Thank you, Kimberly, for presetting today's topic *Quality Measures at CMS: A Closer Look at the Measure Development Lifecycle and CMS' Meaningful Measures Initiative*.

As indicated at the beginning of today's presentation via the chat tools, we do not recognize the raised-hand feature during webinars. Questions related to the topic of this webinar that are submitted via the chat tool will be reviewed and documented in a Q&A transcript. This transcript will be available on the *QualityNet* and *Quality Reporting Center* websites at a later date.

As we wind down today's webinar, I will just take a few minutes to review some helpful IPFQR Program resources. CMS recommends that IPFs refer to the most recent IPFQR Program Manual for information pertaining the IPFQR Program. The manual is located on the *QualityNet* and *Quality Reporting Center* websites. It contains information about the program requirements, measures for the upcoming fiscal year 2019 payment determination, as well as links to helpful optional paper tools pertinent to the data submission process.

If you happen to have a question that is not related to the content of this webinar, we recommend that you go to the *QualityNet* Q&A tool, which you can access using the link in the top left of the table on this slide. Additional active links on this slide are available for you to send us your questions about the IPFQR Program, as well as access to a variety of resources. For example, you can click on the title of the table to access the IPFQR Program resources web page on the *QualityNet* website. Also, be sure to let us know of any contact changes by completing and sending back to us the hospital contact change form. A link to this form is available in the lower right portion of the table.

On this slide, we have a list of upcoming educational webinar events that are planned through the second quarter of 2018. Be sure to monitor your emails to ensure that you receive information regarding these webinars via the IPFQR Program ListServe. This concludes today's webinar. I will now turn the presentation over to Deb Price who will describe the continuing education process for this event.

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**Deb Price:** Thank you. This event has been approved for one continuing education credit. You must report your own credit to your respective boards. Complete your survey and then register for your certificate. Registration is automatic and instantaneous; therefore, if you do not get a response right away, there is a firewall blocking your link. You will need to register as a new user, using your personal email and phone number.

If you are a new user or have had any problems getting your credits, use the New User link. If you have not had any issues getting your credits, use the Existing User link.

Thank you for joining us today. We hope you learned something. All questions will be answered and posted on our *QualityReportingCenter.com* website at a later day. Enjoy the rest of your day. Good-bye.