



TO: Consensus Standards Approval Committee (CSAC)
FR: All-cause Admissions and Readmissions Project Team
RE: NQF-Endorsed Measures for All-cause Admissions and Readmissions, Phase II
DA: June 30, 2017

CSAC Action Required:

The CSAC will review recommendations from the All-cause Admissions and Readmissions project at its July 11-12, 2017 meeting and vote whether to uphold the recommendations from the Committee.

This memo includes a summary of the project, recommended measures, and themes identified from and responses to the public and member comments. NQF Member voting on these recommended measures closed on June 22, 2017.

Accompanying this memo are the following documents:

1. [All-cause Admissions and Readmissions Draft Report](#). The draft report has been updated to reflect the changes made following Standing Committee discussion of public and member comments. The complete draft report and supplemental materials are available on the project page.
2. [Comment Table](#). Staff has identified themes within the comments received. This table lists 35 comments received during the post meeting comment period and the NQF/Standing Committee responses.

Background

For this project, the 26-member [Admissions and Readmissions Standing Committee](#) evaluated two measures against NQF's standard evaluation criteria. The Committee recommended both measures for endorsement.

Draft Report

The All-cause Admissions and Readmissions Draft Report presents the results of the evaluation of two measures considered under the Consensus Development Process (CDP). Both measures are recommended for endorsement.

The measures were evaluated against the 2015 version of the [measure evaluation criteria](#).



	Maintenance	New	Total
Measures under consideration	0	2	2
Measures recommended for	0	2	2
Measures recommended for inactive endorsement with reserve status	0	0	0
Measures approved for trial use	0	0	0
Measures not recommended for	0	0	0
Measures withdrawn from	0	0	0

CSAC ACTION REQUIRED

Pursuant to the CDP, the CSAC is asked to consider endorsement of two candidate consensus measures.

The All-Cause Admissions and Readmissions Committee Recommended for Endorsement:

- [2515: Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate \(RSRR\) following coronary artery bypass graft \(CABG\) surgery](#) (Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE))
 - Overall Suitability for Endorsement: **Y-18; N-2**
- [3188: 30-Day Unplanned Readmissions for Cancer Patients](#) (Alliance of Dedicated Cancer Centers)
 - Overall Suitability for Endorsement: **Y-15; N-4**

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments prior to the evaluation of the measures via an online tool located on the project webpage. Third, NQF opens a 30-day comment period to both members and the public after measures have been evaluated by the full committee and once a report of the proceedings has been drafted.

Pre-evaluation comments

The pre-evaluation comment period was open from February 2-17, 2017 for the two measures under review. NQF received one pre-evaluation comment. The pre-evaluation comment was provided to the Committee prior the Committee's web meeting. The Committee reviewed all comments received and considered the pre-meeting comments prior to making an endorsement recommendation.

Post-evaluation comments

The Draft Report went out for Public and Member comment from April 05, 2017 - May 04, 2017. During this commenting period, NQF received 35 comments¹ from 14 member organizations:

Consumers – 0	Professional – 1
Purchasers – 0	Health Plans – 0
Providers – 9	QMRI – 1
Supplier and Industry – 0	Public & Community Health - 2

A complete [table of comments](#), submitted pre- and post-evaluation, along with the responses to each comment and the actions taken by the Standing Committee, are posted to the project page on the NQF website, along with the measure [submission forms](#). The Committee responded to all post-evaluation comments.

Comments and their Disposition

Three major themes were identified in the post-evaluation comments, as follows:

1. Support for the Validity of Measure #3188
2. Adjustment for Social Risk Factors
3. Acceptable Levels of Reliability

Theme 1 - Support for the Validity of Measure #3188

During the initial review, consensus was not reached on the validity of measure #3188: 30-Day Unplanned Readmissions for Cancer Patients. Public commenters expressed support for measure #3188 noting that currently endorsed readmission measures do not include cancer patients and this measure would fill a critical measurement gap. Commenters recognized the need to improve cancer care quality and believed that use of this measure could help avoid unnecessary hospitalizations.

Commenters believed the measure is valid. Commenters expressed support for the statistical model of the measure, the specified exclusions, and the risk adjustment strategy.

After the post-comment call, the committee re-voted on the measure's Validity (H-1 M-14; L-3; I-1) and Overall Endorsement (Y-15; N-4). As a result, the committee recommends the measure for endorsement.

¹ One comment was received after the measure submission deadline on 5/11 and is not included in this tabulation.

Developer Response:

We appreciate commenters' support for this measure, as currently specified and validated. We will continue to work with stakeholders to identify opportunities to refine the risk adjustment in the future.

Committee Response:

Thank you for your feedback on measure #3188. The committee took these comments into account during the post-comment conference call.

Theme 2 - Adjustment for Social Risk Factors

Commenters expressed concern regarding potentially insufficient adjustments made for social risk factors for measure #2515. Commenters disagreed with the measure developer's assertion that adjustment for social risk is unnecessary, and questioned the potential disagreement with recent findings by ASPE as well as the developer's interpretation of the decomposition analysis. Comments noted that CABG readmission rates are higher among patients who are dually eligible for Medicare and Medicaid, as well as those scoring highly on the AHRQ SES index. As a result, the American Hospital Association expressed concern that "hospital effects" may be a result of community-level variables, such as hospital location and population, reducing the measure's ability to accurately assess quality of care within the hospital's control. Commenters called for new analyses to assess the impact of social risk factors that they felt were not adequately addressed by the developer in the measure submission. Some commenters also noted the importance of having the capacity to update the factors used for social risk factor adjustment in the future, allowing measures to factor in new information and changing methods as the science continues to evolve.

Developer Response:

As previously acknowledged, we agree that patients' socioeconomic status (SES) affects health and health outcomes in important ways. In the conceptual model presented to the Committee, we explain that many patients with low SES indicators may have poorer health status at the start of an index admission that increases their risk of readmission. The decrease in the strength of the association between SES variables and the readmission outcome when we added patients' comorbidities to the risk model supports this proposed mechanism. Additionally, the results presented showed that the effect of SES variables on readmission rates in the multi-variate or fully adjusted model was significant but small. However, inclusion of these variables did not change hospitals risk-standardized readmission rates or their performance on the measures. We explained that the remaining small effect of SES in the risk models could be a hospital-level effect, if patients with low SES indicators more often receive care at lower quality hospitals. Alternatively, it could be a patient-level effect, if patients have other unmeasured factors that increase their risk of readmission that are beyond the hospitals' control or if they receive inappropriate care from hospitals due to bias or discrimination. The results of the decomposition analyses we performed confirmed that most of the small residual effect of SES variables on readmission rates is a hospital-level effect, suggesting that it is due to the clustering of patients with low SES indicators and low quality hospitals. We acknowledge that the large hospital effects could represent a larger community context and note that hospitals can influence the community factors in important ways. In light of these results, we concluded that the evidence did not support including SES variables in the measures risk models.

Finally, we would like to underscore Yale-CORE's commitment to examining alternative solutions that better reflect the balance of hospital- and patient-level influences on hospital outcome measures and to considering appropriate ways to incorporate community factors into the outcomes measures.

We performed the decomposition analysis to assess whether the effects of specific socioeconomic status (SES) variables were primarily at the patient level (within hospital) or at the hospital level (between hospital). We did this assessment to evaluate the appropriateness of including SES variables as patient level factors in the model. Our results showed that the effects of SES variables were primarily exerted at the hospital level and thus it may not be appropriate to include as patient level variables. We did not address the question of whether the corresponding hospital level factor should be included in the model. We agree that the large hospital effects could represent a larger community context and note that hospitals can influence the community factors in important ways. We performed the decomposition analyses for only a sample of the clinical risk variables for the CABG readmission measure because these analyses require significant time and resources. As noted by the AHA, our findings do suggest that most variables have some mixed hospital-level and patient-level effect. However, the conceptual model is what is unique for SES compared to clinical variables. In contrast to clinical and basic sociodemographic variables like age, there is evidence and a strong conceptual framework that supports concerns about differential access to high quality care for low SES populations. For example, there is no evidence that older patients tend to cluster in poor quality hospitals.

Concerning the issue of using race as a proxy for socioeconomic status (SES), we agree with the AHA and with the NQF's guidance suggesting that race should not be used as a proxy for SES. Race was not used in the analyses as a proxy for SES but as an important comparator with SES variables. Although the NQF Expert Panel on Risk Adjustment for Sociodemographic (SDS) Factors did not provide clear guidance regarding the inclusion of race in measure's risk models, the panel did broaden the term from SES to SDS to account for consideration of racial disparities, and we feel it is useful to understand the pattern of racial disparities along with SES disparities. We believe it is helpful to show analyses with race, not as a proxy, but as a point of comparison with SES variables. The conceptual rationale for not including SES variables in the measures' risk models has important parallels with race in that both SES and race are associated with access to differential quality hospitals and can lead to differential care within hospitals. These comparisons can be helpful in understanding causal pathways and for making decisions about incorporating SES variables in risk-adjustment models.

Committee Response:

The Committee reviewed these comments and appreciated the input. The Committee acknowledges research which demonstrates the adverse impact of social risk factors. However, the Committee recognizes that developers face challenges in obtaining accurate data on these factors, which can lead to a discrepancy between the conceptual basis for including social risk factors and the empirical analyses demonstrating their impact. The Committee recognizes that developers may make a determination about whether or not to include SDS factors based on whether the factors was related to hospital quality versus a person's intrinsic risk of readmission. However, the Committee also notes the need to maximize the predictive value of a risk adjustment model and ensure that hospitals serving vulnerable populations are not penalized unfairly.

While the Committee generally accepted the findings of the analyses conducted by the developer, the Committee agrees that more work is needed to identify more robust data elements and methods to isolate and account for patients' unmeasured clinical and social risk. The Committee encourages the developer to continue testing the risk adjustment model with additional SDS factors in an effort to better understand unmeasured patient risk.

Theme 3 - Acceptable Levels of Reliability

Commenters raised questions on what is an appropriate level of reliability. In particular, commenters expressed concern for the level of reliability demonstrated by measure #2515. Commenters noted that reliability is a "must pass" criterion for NQF endorsement, yet believed the measure demonstrated low test-retest reliability, indicating only "fair" agreement. Commenters believed these low levels of agreement fall short of what should be accepted for a national standard and should not be used as measures to judge provider performance.

Developer Response:

We used the Inter-Class Correlation (ICC) method to establish the reliability of the measure score. This is a test/re-test approach using two randomly split samples from a single 3-year measurement period. This is a purposefully conservative approach to assessing reliability and traditional thresholds for acceptability do not apply to interpreting these results.

The national standards referred to by AHA are not appropriate for this particular analytic approach. Other guidelines or reference values for ICC should be used. In the absence of empirically supported standards, our position is that 'acceptability' depends on context. For simple concepts or constructs, such as a patient's weight, the expectation is that the test-retest reliability of a measure of that construct should be quite high. However, for complex constructs, such as clinical severity, patient comorbidity, or symptom profiles used to identify a condition or clinical state, reliability of measures used to define these constructs is quite a bit lower. We have cited the more appropriate convention, which describes the ICC values as moderate (0.41-0.60) for this measure when the estimate was adjusted for low case volumes (Landis JR and Koch GG. The Measurement of Observer Agreement for Categorical Data. *Biometrics* 1977; 33:159-174).

We would also like to refer the AHA to the memo on measure reliability we provided as part of our responses to the Appeal for the All-Cause Admissions and Readmissions Project in February 2017. In this memo, we offer several examples of the reliability of measures of complex constructs using the ICC. These examples provide the necessary context for interpreting the acceptability of ICC values in the ranges found for the readmission measures. These empirical findings indicate that our reported ICC value for CAGB readmission (NQF # 2515) is consistent with those in similar contexts.

Committee Response:

The Committee has reviewed your comment and appreciated your input. The Committee struggled with determining what acceptable thresholds for reliability testing should be. Although NQF does not maintain set thresholds for reliability, the Committee has discussed the need to ensure measures are acceptable for accountability purposes and distinguish performance between hospitals to identify quality improvement opportunities. The Committee recognized the payment implications of several measures

used in the Hospital Readmissions Reduction Program and stressed the need to ensure measures accurately reflect and distinguish performance.

The Committee believes the level of reliability demonstrated for measure #2515 represents an acceptable benchmark and sufficient levels of agreement for use for accountability purposes.

NQF Member Voting Results

The two recommended measures were approved with 60% approval or higher. Representatives of 18 member organizations voted; no votes were received from the Health Plan or Public/Community Health Agency Councils. Results for each measure are provided in [Appendix B](#).

[Appendix A – Measures Not Recommended for Endorsement](#)

No measures were not recommended for endorsement.

Appendix B – NQF Member Voting Results

NQF MEMBER VOTING RESULTS

The two recommended measures were approved with 60% approval or higher. Representatives of 18 member organizations voted; no votes were received from the Health Plan or Public/Community Health Agency Councils. Results for each measure are provided below.

NQF Member Council	Voting Organizations	Eligible to Vote	Rate
Consumer	2	38	5%
Health Plan		21	0%
Health Professional	1	104	1%
Provider Organizations	10	110	9%
Public/Community Health Agency		15	0%
Purchaser	2	22	9%
QMRI	2	74	3%
Supplier/Industry	1	35	3%
All Councils	18	419	4%

Measure #2515 Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	2			2	100%
Health Plan				0	
Health Professional	1			1	100%
Provider Organizations	3	4	3	10	43%
Public/Community Health Agency				0	
Purchaser	2			2	100%
QMRI	1	1		2	50%
Supplier/Industry			1	1	
All Councils	9	5	4	18	64%
Percentage of councils approving (>60%)					60%
Average council percentage approval					79%

Measure #3188 30-day Unplanned Readmissions for Cancer Patients

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	2			2	100%
Health Plan				0	
Health Professional	1			1	100%
Provider Organizations	8	1	1	10	89%
Public/Community Health Agency				0	
Purchaser	2			2	100%
QMRI			2	2	
Supplier/Industry			1	1	
All Councils	13	1	4	18	93%
Percentage of councils approving (>60%)					100%
Average council percentage approval					97%

VOTING COMMENTS**Measure #2515 Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery**

America's Essential Hospitals: America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to providing high-quality care to all people. Filling a vital role in their communities, our more than 300 member hospitals provide a disproportionate share of the nation's uncompensated care and devote approximately half of their inpatient and outpatient care to Medicaid or uninsured patients. Our members provide state-of-the-art, patient-centered care while operating on margins substantially lower than other hospitals—a zero percent aggregate operating margin, compared with 8.3 percent for all hospitals nationwide. Reducing preventable readmissions is of paramount concern to America's Essential Hospitals and its members. We believe that any program directed at reducing readmissions must target readmissions that are preventable, and readmissions measures must include appropriate risk-adjustment. The evidence-based link between sociodemographic factors and patient outcomes has been shown in a growing body of work, including the NQF's own landmark expert panel report on sociodemographic adjustment. Most recently, this connection was clearly shown in a report to Congress from the Office of the Assistant Secretary for Planning and Evaluation (ASPE), and in the National Academy of Medicine's (NAM) series of reports on accounting for social risk factors in Medicare programs. Both reports provide evidence-based confirmation of what hospitals and other providers have long known – patients' sociodemographic and other social risk factors matter greatly when trying to assess the quality of health care providers. The impact of social risk factors on a person's risk for hospital admission or readmission continued to be of concern to essential hospitals—those serving the

most vulnerable among us. Identifying which social risk factors might drive outcomes and how to best measure and incorporate those factors into measure development and endorsement is a complex task, but doing so is necessary to ensure better outcomes and accuracy in quality measurement. Patients who lack reliable support systems after discharge are more likely to be readmitted to a hospital or other institutional setting. These readmissions result from factors beyond the control of providers and health systems and do not reflect the quality of care provided. For this reason, we believe community-level factors must also be examined, in addition to patient-level. Risk adjusting measures for these factors will ensure that patients receive accurate information about a hospital's performance. America's Essential Hospitals votes "No" on endorsement of Measure #2515—30-day, all-cause, unplanned, readmission rate for CABG. We strongly encourage NQF to remove endorsement of this CABG measure until appropriate adjustment for social risk factors is addressed in the measure.

Association of American Medical Colleges: The AAMC opposes endorsement of the CABG readmissions measure due to concerns that it does not account for sociodemographic status (SDS) factors in the risk adjustment methodology. Recent reports by the Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academy of Medicine (NAM) have provided evidence-based confirmation that accounting for patients' sociodemographic and other social risk factors is critical in validly assessing the quality of providers. The committee even noted in the draft report that "more work is needed to identify more robust data elements and methods to isolate and account for unmeasured clinical and social risk for patients." Since this measure is used in the Hospital Readmissions Reduction Program (HRRP), and hospitals may be financially penalized due to inadequate risk adjustment, we urge NQF to withhold endorsement at this time.

Federation of American Hospitals: The Federation of American Hospitals (FAH) appreciates the Standing Committee's discussion of ongoing concerns related to the adequacy of adjustment for social risk factors. However, the FAH does not agree with the recommendation to continue endorsement of measure #2515. The Disparities Standing Committee's robust discussion a week ago highlighted more work needing to be done on the social risk factor issue, particularly to integrate community factors where there is clear evidence that the lack of or reduced access to factors such as transportation, food, and pharmacies can impact readmission rates. The FAH strongly believes the measures in this project did not adequately identify and test these factors where there is evidence and data that currently exists. Developers must be responsive to what was outlined by the NQF Board of Directors and executed in the Sociodemographic status Trial Period. As a result, without the testing/assessment for the risk factors identified above, the FAH must vote NO on endorsement of #2515 at this time.

American Hospital Association: This measure clearly needs to be adjusted for sociodemographic factors, as the Steering Committee recognized. While we appreciate that measure developers may be challenged to find and use information to do risk adjustment for readmission measures, the fact that some developers have been able to risk adjust measures for SDS factors and have them endorsed by NQF suggests that the task is not impossible. Further, the challenges for the measure developers pale in comparison to the challenges hospitals and other health care

providers encounter in trying to use inadequately adjusted measures to further their quality improvement efforts and to deal with the budget impacts of the payment penalties imposed unfairly by these inadequately adjusted measures. Those challenges impact the resources available to care for patients. Thus, the ramifications of these inadequately adjusted measures impose challenges on patients, too. Steering committees must feel empowered not to support the endorsement of measures when developers fail to address issues so fundamental to the measures' scientific acceptability and implementation in the field.

University of Texas - MD Anderson Cancer Center: Well designed. Opportunity for improvement

MHA Keystone Center for Patient Safety and Quality: While 30 day readmission measures are important to understand opportunities for improved care, the risk adjustment for socio-economic factors remains woefully incomplete. The use of two factors, African-American and dual enrolment in Medicare/Medicaid are insufficient and do not speak to other factors such as those individuals that are living in rural underserved locations, are not dual eligible or are not African American, such as Hispanic. Until a rigorous and effective risk adjustment methodology is in place, the measure remains incomplete.

Measure #3188 30-Day Unplanned Readmissions for Cancer Patients

Dana-Farber Cancer Institute: Great measure that allows Cancer readmissions to be dissected and compared more accurately. I also think that this measure will more immediately impact the ability for centers to create improvement activities around their readmissions.

Memorial Sloan-Kettering Cancer Center: Memorial Hospital for Cancer and Allied Diseases (Memorial) supports the adoption of the 30-Day Unplanned Readmissions for Cancer Patients (3188) and believes it offers a significant step toward addressing the measurement gap in cancer care. Although reducing readmissions has been CMS's priority for over ten years, extant readmissions measures, such as the hospital-wide all-condition readmissions developed by Yale, exclude PPS-exempt cancer hospital patients by design given the complexity of their patient population. Until recently, no cancer-specific readmissions measure existed for benchmarking or to identify opportunities for improvement.

National Coalition for Cancer Survivorship: There are few outcome measures for cancer. From a patient/consumer/caregiver perspective, this is a critically important measure. Cancer patients need appropriate management of symptoms and side effects to avoid unnecessary hospitalizations.

University of Texas - MD Anderson Cancer Center: Unique to cancer. Important and gap oriented

Appendix C – Measure Evaluation Summary Tables

Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable; Y=Yes; N=No

Measures Recommended

2515 Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery
<p>Submission Specifications</p> <p>Description: The measure estimates a hospital-level risk-standardized readmission rate (RSRR), defined as unplanned readmission for any cause within 30 days from the date of discharge of the index CABG procedure, for patients 18 years and older discharged from the hospital after undergoing a qualifying isolated CABG procedure. The measure was developed using Medicare Fee-for-Service (FFS) patients 65 years and older and was tested in all-payer patients 18 years and older.</p> <p>An index admission is the hospitalization for a qualifying isolated CABG procedure considered for the readmission outcome.</p> <p>Numerator Statement: The outcome for this measure is 30-day all-cause readmission. We define all-cause readmission as an unplanned inpatient admission for any cause within 30 days after the date of discharge from the index admission for patients 18 years and older who were discharged from the hospital after undergoing isolated CABG surgery. If a patient has one or more unplanned admissions (for any reason) within 30 days after discharge from the index admission, only one is counted as a readmission.</p> <p>Denominator Statement: This claims-based measure can be used in either of two patient cohorts: (1) patients aged 65 years or older or (2) patients aged 18 years or older. We have tested the measure in both age groups.</p> <p>The cohort includes admissions for patients a) who receive a qualifying isolated CABG procedure and b) with a complete claims history for the 12 months prior to admission. For simplicity of implementation and as testing demonstrated, closely correlated patient-level and hospital-level results using models with or without age interaction terms, the only recommended modification to the measure for application to all-payer data sets is replacement of the “Age-65” variable with a fully continuous age variable.</p> <p>Exclusions: In order to create a clinically coherent population for risk adjustment and in accordance with existing NQF-approved CABG measures and clinical expert opinion, the measure is intended to capture isolated CABG patients (i.e., patients undergoing CABG procedures without concomitant valve or other major cardiac or vascular procedures).</p> <p>For all cohorts, hospitalizations are excluded if they meet any of the following criteria, for admissions:</p> <ol style="list-style-type: none"> 1. Without at least 30 days post-discharge enrollment in FFS Medicare 2. Discharged against medical advice (AMA) 3. Admissions for subsequent qualifying CABG procedures during the measurement period <p>Adjustment/Stratification: Statistical risk model; "Our approach to risk adjustment is tailored to and appropriate for a publicly reported outcome measure, as articulated in the American Heart Association (AHA) Scientific Statement, “Standards for Statistical Models Used for Public Reporting of Health Outcomes” (Krumholz et al., 2006).</p> <p>Level of Analysis: Facility</p> <p>Setting of Care: Hospital : Acute Care Facility, Hospital</p> <p>Type of Measure: Outcome</p> <p>Data Source: Claims (Only)</p>

<p>2515 Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery</p>
<p>Measure Steward: Centers for Medicare & Medicaid Services</p>
<p>STANDING COMMITTEE MEETING [3/06/2017]</p> <p>1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u> (1a. Evidence, 1b. Performance Gap) 1a. Evidence: Y-20; N-0; 1b. Performance Gap: H-2; M-16; L-1; I-1</p> <p><u>Rationale:</u></p> <ul style="list-style-type: none"> • The developer states a number of recent studies have demonstrated that improvements in care at the time of patient discharge can reduce 30-day readmission rates. The developer noted a variety of research studies that revealed readmission rates are influenced by the quality of care provided within the health system and, specifically, that interventions such as improved discharge planning, reconciling patient medications, and improving communications with outpatient providers can reduce readmission rates. • The developer noted this readmission measure was developed to identify institutions, whose performance is better or worse than expected based on patient case-mix. • The Committee agreed that a relationship exists between measured health outcome and at least one health care action, and that there are quality improvement activities that hospitals can undertake to reduce readmissions following CABG surgery. • The Committee expressed concern about the literature cited by the measure developer noting that more contemporary articles should be considered. The developer responded by noting that the measure was undergoing review for initial endorsement. As such, the developer collected evidence at the initiation of the endorsement process (2015) but would consider updates to this section in the future. • The Committee concluded that there is a performance gap based on the 0.5 to 1 percent readmission rate difference in the interquartile range.
<p>2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u> (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity) 2a. Reliability: H-1; M-16; L-3; I-0 2b. Validity: H-1; M-16; L-3; I-0</p> <p><u>Rationale:</u></p> <ul style="list-style-type: none"> • The reliability of the measure was assessed at both the measure score and data element levels. • The developers state that they tested the face validity of the measure’s critical data elements using the CMS audit process to ensure accuracy of claims coding as these data elements are consequential for payment. NQF guidelines require a systematic assessment of face validity. NQF requires a systematic and transparent process to evaluate the face validity by experts who are not involved in measure development. The developers also compared variable frequencies and odds ratios from logistic regression models across the three years of data. • The developers take a “test-retest” approach to measuring reliability. The developers randomly spilt the dataset into two equal subsets and calculated the RSRR for each sample. The developers use a metric of agreement known as an intra-class correlation coefficient (ICC) to measure agreement between the two samples. The

2515 Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery

initial ICC between the two RSRRs for each hospital submitted by the developer was 0.331.

- The developer clarified that since their initial submission, they applied the Spearman Brown Prophecy formula to the Interclass Correlation Coefficient. This approach adjusts the estimate for the low case volume generated by splitting the three-year sample into 2 halves for the reliability analysis. By applying this formula the ICC increased to 0.50, which is generally considered moderate. The Committee generally accepted this approach as appropriate.
- The developer performed several validity tests. First, the developer asserted the validity of claims-based measures noting that prior measures for alternate conditions have been endorsed and used for public reporting. Prior measures have been tested against their authoritative source to demonstrate that the underlying data elements are valid. However, NQF requirements require validity testing be conducted with the measure as specified. The developer noted that the measure is valid since it was developed based on measure development guidelines. While following measure development guidelines is highly encouraged, NQF requires testing on either data elements or the measure score. The developer explained that the measure was assessed by external groups providing results of a systematic assessment of face validity. The developers surveyed their technical expert panel. A systematic assessment of face validity generally requires an assessment of experts not involved in the development of the measure. Finally, the developer evaluated the validity of the measure cohort and risk adjustment model with registry data validation.
- The developer tested three SDS and race variables in their analysis: dual eligible status, African American race, AHRQ SES index.
 - These variables were tested based on four potential pathways that were considered:
 - Relationship of socioeconomic status factor to health at admission
 - Use of low-quality hospital
 - Differential care within a hospital
 - Influence of SES on readmission risk outside of hospital quality and health status
 - When the SDS and race variables were tested in a multivariate model, the effect size of each of the variables was modest. The c-statistic was unchanged, and the model with the SDS factors had little to no effect on hospital performance.
 - The developers also undertook a decomposition analysis. They found that patient-level race and low AHRQ SES index effects were not appreciably different from zero. However, hospital-level race and low AHRQ SES effects were significant. Based on these findings the developer noted that inclusion of SDS factors could potentially limit the measure's ability to distinguish hospital quality.
- The Committee was generally satisfied with the measure validity, however the Committee reiterated that its decision to endorse a measure without sociodemographic factors included in its risk adjustment model is not the same as saying that they do not make an important contribution to the outcome of the measure.

<p>2515 Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery</p>
<ul style="list-style-type: none"> While beyond the requirements of a CDP review, Committee members suggested that stakeholders would be interested in an assessment demonstrating the financial impact of including SDS risk adjustment on the HRRP cut-off in order to support the developer claim that the impact would be limited.
<p>3. Feasibility: H-17; M-3; L-0; I-0 <i>(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)</i> <u>Rationale:</u></p> <ul style="list-style-type: none"> This measure is calculated using administrative claims data from defined data fields in electronic claims. Thus, the measure’s required data elements are routinely collected as part of the facilities billing process. The Committee acknowledged that the measure is currently in use. As such, the Committee agreed that the measure is feasible.
<p>4. Usability and Use: H-8; M-11; L-1; I-0 <i>(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)</i> <u>Rationale:</u></p> <ul style="list-style-type: none"> The measure is currently used in CMS’ Hospital Inpatient Quality Reporting (IQR) Program. Based on the number of participating hospitals, the risk-standardized readmission rate (RSRR) was reported for 4,663 hospitals across the United States for 2015 public reporting. The final index cohort included 925,315 admissions. The measure has also been used in CMS’ Hospital Readmission Reduction (HRRP) Program. The number of accountable entities participating in the HRRP program varies by reporting year. The Committee noted that the measure is usable given its use for multiple purposes.
<p>5. Related and Competing Measures</p> <ul style="list-style-type: none"> The Committee previously discussed potentially related and competing measures during the All-Cause Admissions and Readmissions 2015 project. Additional details on the Committees deliberations can be found it the report on that project.
<p>Standing Committee Recommendation for Endorsement: Y-18; N-2 <u>Rationale</u></p> <ul style="list-style-type: none"> The Committee agreed that this measure meets all the NQF criteria for endorsement.
<p>6. Public and Member Comment</p> <ul style="list-style-type: none"> Commenters expressed concern for the level of reliability demonstrated by measure #2515. Commenters noted that reliability is a “must pass” criterion for NQF endorsement, yet believed the measure demonstrated low test-retest reliability, indicating only “fair” agreement. Commenters expressed concern regarding potentially insufficient adjustments made for sociodemographic status (SDS) factors for measure #2515. Commenters disagreed with the measure developer’s assertion that sociodemographic adjustment is unnecessary, and questioned the potential disagreement with recent findings by ASPE as well as the developer’s interpretation of the decomposition analysis. Comments noted that CABG readmission rates are higher among patients

<p>2515 Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery</p>
<p>who are dually eligible for Medicare and Medicaid, as well as those scoring highly on the AHRQ SES index. As a result, commenters expressed concern that “hospital effects” may be a result of community-level variables, such as hospital location and population, reducing the ability for the measure to accurately assess quality of care within the hospital’s control. Commenters called for new analyses to assess the impact of SDS factors that they felt were not adequately addressed by the developer in the measure submission. Some commenters also noted the importance of having the capacity to update the factors used for SDS adjustment in the future, allowing measures to factor in new information and changing methods as the SDS adjustment field evolves.</p>
<p>7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X</p>
<p>8. Board of Directors Vote: Y-X; N-X</p>
<p>9. Appeals</p>

3188 30-Day Unplanned Readmissions for Cancer Patients
Submission Specifications
<p>Description: 30-Day Unplanned Readmissions for Cancer Patients measure is a cancer-specific measure. It provides the rate at which all adult cancer patients covered as Fee-for-Service Medicare beneficiaries have an unplanned readmission within 30 days of discharge from an acute care hospital. The unplanned readmission is defined as a subsequent inpatient admission to a short-term acute care hospital, which occurs within 30 days of the discharge date of an eligible index admission and has an admission type of “emergency” or “urgent.”</p> <p>Numerator Statement: This outcome measure demonstrates the rate at which adult cancer patients have unplanned readmissions within 30 days of discharge from an eligible index admission. The numerator includes all eligible unplanned readmissions to any short-term acute care hospital—defined as admission to a PPS-Exempt Cancer Hospital (PCH), a short-term acute care Prospective Payment (PPS) hospital, or Critical Access Hospital (CAH)—within 30 days of the discharge date from an index admission that is included in the measure denominator. Readmissions with an admission type (UB-04 Uniform Bill Locator 14) of “emergency = 1” or “urgent = 2” are considered unplanned readmissions within this measure. Readmissions for patients with progression of disease (using a principal diagnosis of metastatic disease as a proxy) and for patients with planned admissions for treatment (defined as a principal diagnosis of chemotherapy or radiation therapy) are excluded from the measure numerator.</p> <p>Denominator Statement: The denominator includes inpatient admissions for all adult Fee-for-Service Medicare beneficiaries where the patient is discharged from a short-term acute care hospital (PCH, short-term acute care PPS hospital, or CAH) with a principal or secondary diagnosis (i.e., not admitting diagnosis) of malignant cancer within the defined measurement period.</p> <p>Exclusions: The following index admissions are excluded from the measure denominator:</p> <ol style="list-style-type: none"> 1) Less than 18 years of age; 2) Patients who died during the index admission; 3) Patients discharged AMA; 4) Patients transferred to another acute care hospital during the index admission; 5) Patients discharged with a planned readmission; 6) Patients having missing or incomplete data; and, 7) Patients not admitted to an inpatient bed. <p>Adjustment/Stratification: Statistical risk model; Rate/proportion</p> <p>Level of Analysis: Facility</p> <p>Setting of Care: Hospital : Acute Care Facility</p> <p>Type of Measure: Outcome</p> <p>Data Source: Claims (Only)</p> <p>Measure Steward: Seattle Cancer Care Alliance</p>
<p>STANDING COMMITTEE MEETING [2/27/2017]</p> <p>1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u> (1a. Evidence, 1b. Performance Gap) 1a. Evidence: Y-23; N-0; 1b. Performance Gap: H-10; M-11; L-0 I-0</p>

3188 30-Day Unplanned Readmissions for Cancer Patients

Rationale:

- As a rationale for measuring this health outcome, the developer lists several studies from peer-reviewed journals explaining that cancer is the second cause of death in the United States, with nearly 600,000 cancer-related deaths expected this year.
- The developer explains that this measure intends to reflect the unique clinical aspects of oncology patients and to yield readmission rates that may be obscured by a broader readmission measure, such as the Hospital-Wide All-Cause Unplanned Readmission Measure (HWR). The developer notes that there are several clinical actions that can be taken by the accountable entity to improve the outcome of 30-day readmissions. Specifically, the logic model notes that providers can ensure that patients are clinically ready for discharge with clear and appropriate follow-up care planned. These actions will help foster improved patient care, better population health, and reduce readmission risk.
- The Committee agreed that the measure was supported by the literature and reflects critical aspects of cancer care for patients. The Committee also agreed that there are numerous clinical actions that can be taken to impact the result of the measure.
- The developer studied 4,975 acute care hospitals and evaluated their potential performance gap over three years. The Committee noted that differences in performance across quartiles (Average: 16.54; 25th percentile: 12.5, 50th percentile: 17.32, and 75th percentile: 20.80) demonstrated a significant opportunity for improvement on the measure.
- Committee members noted that there was a disparity by race (i.e. black patients had a higher readmission rate). Committee members also supported the developers decision not to include race in the risk adjustment model due to potential concerns about masking disparities.
- One committee member questioned the assumption that scheduled care is high quality by definition and questioned the evidence base for the assumption. The committee member noted that there are many readmissions that are scheduled that are not patient-centered or protocol-driven, but instead based on timing issues with specialty providers, etc.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-17; L-5; I-0** 2b. Validity: **H-0; M-11; L-11; I-0 (Consensus Not Reached)** Revote Post-Comment: **H-1 M-14; L-3; I-1**

Rationale:

- This outcome measure demonstrates the rate at which adult cancer patients have unplanned readmissions within 30 days of discharge from an eligible index admission.
- The numerator includes all eligible unplanned readmissions to any short-term acute care hospital—defined as admission to a PPS-Exempt Cancer Hospital (PCH), a short-term acute care Prospective Payment (PPS) hospital, or Critical Access Hospital (CAH)—within 30 days of the discharge date from an index admission that is included in the measure denominator. Readmissions with an admission type (UB-04 Uniform Bill Locator 14) of “emergency = 1” or “urgent = 2” are considered unplanned readmissions within this measure. Readmissions for patients with progression of

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- disease (using a principal diagnosis of metastatic disease as a proxy) and for patients with planned admissions for treatment (defined as a principal diagnosis of chemotherapy or radiation therapy) are excluded from the measure numerator.
- The denominator includes inpatient admissions for all adult Fee-for-Service Medicare beneficiaries where the patient is discharged from a short-term acute care hospital (PCH, short-term acute care PPS hospital, or CAH) with a principal or secondary diagnosis (i.e., not admitting diagnosis) of malignant cancer within the defined measurement period.
 - The measure is specified for a facility level of analysis and the hospital setting.
 - The Committee discussed the specifications of the measure's numerator and denominator. Committee members agreed that it was appropriate to specify the numerator using emergency and urgent codes and excluding codes that relate to planned admissions. One committee member questioned if use of emergency/urgent codes varied across hospitals based on documentation processes.
 - The Committee noted that there were several exclusions from the denominator—including transfer patients, the missing data patients and the patients not admitted. A Committee member expressed concern about patient-level exclusions, and noted that up to 20% of data in the numerator would not be included due to exclusions. The developer clarified that the exclusions are important to the measure. The developer noted that planned readmissions for chemotherapy, radiation oncology and disease progression are important, otherwise the measure would just closely resemble a measure for all-cause readmission for cancer patients.
 - A Committee member noted that the exclusion based on progression might lead to biases by cancer type. Some cancers are more likely to be metastatic in terms of their behavior than others. Another committee member suggested that the use of metastatic codes identified through medical records might help address the issue. Committee members also noted that the distribution of metastatic patients may be variable across hospitals. The developer clarified that the measure includes risk adjustment for solid tumor without metastasis and then a separate metastasis adjuster. The developer noted that they did not exclude patients with metastatic cancer from the measure itself but are excluding patients have a principal guidance of metastatic disease on the readmission claim—to differentiate between quality of care and disease status.
 - The Committee noted that the measure only looks at hospitals with more than 50 readmissions, so low-volume hospitals would not be included in the measure. Committee members commented that they would like to see sensitivity analysis for excluded data at the hospital level. The developer clarified that they were interested in including as many hospitals as possible in the measure, but noted that smaller volume hospitals would have less reliability. Their analysis found that 50 readmissions seemed to be the point where they were able to generate strong validity and reliability scores. The developer also noted that they did conduct sensitivity analysis around three cut points: 50, 75 and 100.
 - Reliability was tested at the measure score level. To demonstrate measure score reliability, the developer conducted a test/retest analysis to evaluate the measure's ability to generate consistent results with randomly selected subset of patients over time. The developers calculated two metrics of agreement – the intraclass correlation coefficient (ICC) and the Spearman-Brown Prophecy Formula (S-B). The ICC is

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- estimated from a random effects model producing risk adjusted rates. The S-B formula projects correlation as if the full sample is used and not spilt randomly.
- The reliability testing results for the three-year period (CY2013-CY2015) produced an ICC of 0.570 (95% CI: 0.567, 0.572) and 0.482 (95% CI: 0.479, 0.485), for unadjusted and risk-adjusted values, respectively. The developer notes that this result may be interpreted as “fair” reliability. The mean S-B for the same period was 0.726 (95% CI: 0.724, 0.728) for unadjusted rates and 0.650 (95% CI: 0.648, 0.653) for risk-adjusted rates. The developer notes that both of these values are significantly higher than the 0.5 that indicates a large effect size with p-values < 0.001. When applied to each year individually, the S-B analysis exceeded 0.50 (p-values<0.001) in 2013 and 2014 but not 2015.
 - Committee members asked if the measure was meant to be calculated using three years of data, as that reliability testing was implemented using this timeframe. The developer clarified that the measure is intended to be an annual measure. They tested the three-year period in total but also evaluated each calendar year independently.
 - A Committee member suggested that the measure should consider including observation stays and emergency room visits.
 - The developer assessed validity at both the measure score and data element levels.
 - The developer conducted two analyses to test the validity of the measure score. These analyses were:
 - 1) evaluating the sensitivity and specificity of the UB-04 inpatient admission type code. This analysis was previously conducted using a manual chart review.
 - 2) correlation between this measure and NQF #1789 CMS Hospital-Wide All-Cause Readmissions measure.
 - The results of the two analysis are as follows:
 - The previous data element validity testing generated a global sensitivity and specificity score of 0.879 and 0.896, respectively.
 - The overall correlation between NQF #1789 and NQF #3188 was 0.2769 with a p-value of <0.001. This is a statistically significant positive correlation between the two measures.
 - Committee members noted that the correlation with the all cause readmissions measure (NQF #1789) was on the low end, but still significant to provide sufficient evidence of validity.
 - A Committee member asked about the relationship of the measure with 30 day mortality rates after noting that patient populations 85 and older had the lowest readmission rates, perhaps due to out of hospital deaths. The developer noted that six percent of patients in the denominator had been excluded because they expired during the index admission.
 - The Committee raised several concerns around the methods for risk adjustment used. First, the Committee was concerned about collapsing multiple comorbidities into a single risk adjustment variable. Committee members were concerned that quaternary centers who serve the most clinically complex patients may not be accurately characterized using this method. Further, the Committee noted that not all comorbidities have an equal impact on readmissions. Second, the Committee was concerned with the use of age 65 and less as the reference age for the model. Third, the Committee was concerned with the use of ‘hospitalization in the prior 60 days’ as

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a proxy for frequent admitters. The Committee was concerned that the risk adjusting for patients who are high utilizers could possibly inadvertently adjust for the hospital's quality, as high utilization is a poor outcome in itself.

- The developers noted that there was a conceptual and empirical rationale for adjustment based on dual-eligibility status. Dual-eligibility can serve as a proxy for low income status and other measures of SDS. Several studies were referenced that note that low SDS factors are a risk factor for later-state cancer diagnosis, delayed health care receipt, and higher utilization of hospital-based care.
- The patient-level observed 30-Day Unplanned Readmissions for Cancer Patients rate was 22.49%, compared with an 18.32% observed rate for all other patients. "Dual-Eligible Status" was associated with a Chi-Square of 5547.9628 ($p < 0.001$). "Dual-Eligible Status" was included in the risk adjustment model.
- Ultimately, the Committee did not reach consensus on the validity sub criterion.
- The Committee requested feedback from the member and public comment period and discussed the measure during the post-comment call.
- The developers presented additional information to address the Committee's previous questions and support the validity of the measure.
- Committee members discussed the challenges of determining an appropriate population for this measure given the heterogeneous nature of cancer. Committee members wanted to include as many patients as possible but recognized the need to ensure the measure reflects readmissions due to quality of care.
- Committee members also raised concerns about the lack of granularity on the adjustment for co-morbidity.
- Ultimately, the Committee determined the measure met the validity subcriterion.

3. Feasibility: H-19; M-2; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- This measure is calculated using administrative claims data from established data fields. Thus, the measure's required data elements are routinely generated as part of the facilities billing process.
- Committee members believed that the feasibility is high as all data are available through the administrative claims.

4. Usability and Use: H-4; M-15; L-3; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- The measure is publically reported by Vizient, Inc. with external benchmarking to multiple organizations.
- The developer notes that the measure is also used in quality improvement applications at the City of Hope Comprehensive Care Center, University of Miami Sylvester Comprehensive Cancer Care, Seattle Cancer Care Alliance
- The measure is used in the Annual Hospital Ratings for Colon and Lung Cancer Surgery.
- The measure is used in an ACO payment program at Moffitt Cancer Center with Florida Blue.

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<ul style="list-style-type: none"> Committee members noted that the measure is current used in both QI and accountability applications at several health centers, and would be under consideration for possible future rulemaking as early as FY 2018.
5. Related and Competing Measures <ul style="list-style-type: none"> No related or competing measures noted.
Standing Committee Recommendation for Endorsement: Y-15; N-4 <u>Rationale</u> <ul style="list-style-type: none"> The Standing Committee did not conduct a vote for Overall Suitability for Endorsement during the February 27, 2017 webinar because Consensus was Not Reached on the Validity criterion. The Standing Committee discussed and re-voted on the Validity criterion during the Post-Comment Call on May 16, 2017. The Standing Committee agreed the measure meets the Validity criterion, and then also then voted Yes on Overall Suitability for Endorsement.
6. Public and Member Comment <ul style="list-style-type: none"> Public commenters expressed support for measure 3188. Commenters noted that currently endorsed readmission measures do not include cancer patients and this measure would fill a critical measurement gap. Commenters recognized the need to improve cancer care quality and believe that use of this measure could help avoid unnecessary hospitalizations. Commenters believed the measure is valid. Commenters expressed support for the statistical model of the measure, the specified exclusions, and the risk adjustment strategy.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

All-Cause Admissions and Readmissions Measures

*Consensus Standards Approval Committee
Review and Recommendations*

July 11-12, 2017

Co-Chairs:

John Bulger
Cristie Travis

NQF Staff:

Erin O'Rourke
Kate McQueston
Miranda Kuwahara
Taroon Amin



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All-Cause Admissions and Readmissions Measures

- For this project, the 26-member Admissions and Readmissions Standing Committee evaluated two newly submitted measures against NQF's standard evaluation criteria.
- The Committee recommended both measures for endorsement.

All-Cause Admissions and Readmissions Measures

The All-Cause Admissions and Readmissions Committee Recommended for Endorsement:

- 2515: Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery (Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE))
 - Overall Suitability for Endorsement: **Y-18; N-2**
- 3188: 30-Day Unplanned Readmissions for Cancer Patients (Alliance of Dedicated Cancer Centers)
 - Overall Suitability for Endorsement: : **Y-15; N-4**

All-Cause Admissions and Readmissions Measures *Before Member and Public Commenting*

	Maintenance	New	Total
Measures under consideration	0	2	2
Measures recommended for endorsement	0	1	1
Measures where consensus is not yet reached	0	1	1



Comments Received

Comments Received:

- The pre-evaluation comment period was open from February 2-17, 2017.
 - NQF received one pre-evaluation comment.
- The Draft Report went out for Public and Member comment from April 05, 2017 - May 04, 2017.
 - NQF received 35 comments from 14 member organizations.

Comments Received:

- Three major themes were identified in the post-evaluation comments, as follows:
 - Support for the Validity of Measure #3188
 - Adjustment for Social Risk Factors
 - Acceptable Levels of Reliability

Support for the Validity of Measure #3188

- Consensus was not reached on #3188 during the initial review
- Commenters expressed their support for the measure:
 - Noted the need to improve cancer care quality
 - Believed the measure is valid
- During the post-comment call the Committee re-voted and agreed the measure is valid and recommended it for endorsement
- **Developer Response:** We appreciate commenters' support for this measure, as currently specified and validated. We will continue to work with stakeholders to identify opportunities to refine the risk adjustment in the future.

Adjustment for Social Risk Factors

- Commenters expressed concerns that #2515 does not include social risk factors in its risk adjustment model
- Commenters noted that readmission rates are higher among patients who are dually eligible and those scoring highly on the AHRQ SES Index
- AHA expressed concern that hospital effects may be a result of community-level variables, such as hospital location and population
- Commenters called for new analyses and updates to the factors tested as the data available and measurement science continues to evolve

Adjustment for Social Risk Factors

- **Developer Response:**

We performed the decomposition analysis to assess whether the effects of specific socioeconomic status (SES) variables were primarily at the patient level (within hospital) or at the hospital level (between hospital). We did this assessment to evaluate the appropriateness of including SES variables as patient level factors in the model. Our results showed that the effects of SES variables were primarily exerted at the hospital level and thus it may not be appropriate to include as patient level variables. We did not address the question of whether the corresponding hospital level factor should be included in the model. We agree that the large hospital effects could represent a larger community context and note that hospitals can influence the community factors in important ways. We performed the decomposition analyses for only a sample of the clinical risk variables for the CABG readmission measure because these analyses require significant time and resources. As noted by the AHA, our findings do suggest that most variables have some mixed hospital-level and patient-level effect. However, the conceptual model is what is unique for SES compared to clinical variables. In contrast to clinical and basic sociodemographic variables like age, there is evidence and a strong conceptual framework that supports concerns about differential access to high quality care for low SES populations. For example, there is no evidence that older patients tend to cluster in poor quality hospitals.

Acceptable Levels of Reliability

- Commenters expressed concern for the level of reliability demonstrated by #2515.
- The Committee struggled with determining acceptable levels of reliability as NQF does not maintain set thresholds.
- The Committee agreed the measure believes the level of reliability demonstrated for measure #2515 represents an acceptable benchmark and sufficient levels of agreement for use for accountability purposes.

Consensus Not Reached Follow Up

- Committee reviewed new memo, and then revoted on the measure at the post-comment call.
- 3188: 30-Day Unplanned Readmissions for Cancer Patients (Alliance of Dedicated Cancer Centers) was recommended for endorsement during the post-comment call.

All-Cause Admissions and Readmissions Measures *After Member and Public Commenting*

	Maintenance	New	Total
Measures under consideration	0	2	2
Measures recommended for endorsement	0	2	2

Project Timeline and Next Steps

Process Step	Timeline
Appeals Period	July 14th-August 14th, 2017
Adjudication of Appeals	August 15 th -September 12 th , 2017
Final Report	September 26, 2017

Questions?



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