CALL FOR NOMINATIONS TO ADMISSIONS AND READMISSIONS STANDING COMMITTEE

BACKGROUND

The unpredictable nature of a patient's path once they are discharged from the hospital is a byproduct of a fragmented healthcare delivery system. This is especially true for patients who suffer from chronic and comorbid conditions. Previous studies have shown that nearly one in five Medicare patients are readmitted to the hospital within 30 days of discharge, including many patients returning via the emergency room, costing upwards of $26 billion annually.[1,2]

The causes of readmissions are complex and not well understood. One report by the Robert Wood Johnson Foundation suggests that communities and health systems with higher underlying admission rates also have higher readmission rates, since patients in these communities are more like likely to rely on the hospital as a site of care in general.[3] Other risk factors include environmental and patient characteristics, including socioeconomic status.[4,5] A 2013 MedPAC report suggests that to succeed in reducing readmissions, policies must encourage hospitals to look beyond their walls and improve care coordination (i.e. medication reconciliation, use of case managers, discharge planning) across providers. The report suggests that reducing avoidable readmissions by 10 percent could achieve a savings of $1 billion or more.[6]

NQF has undertaken a number of projects addressing admissions and readmissions that are condition or setting-specific. Past measure endorsement projects have included the consideration of six condition-specific readmission measures, as well as measures of acute care hospitalization from the home health and dialysis settings. NQF's most recent work in this area, which concluded in April 2012, was the Readmissions Endorsement Maintenance project, which resulted in the endorsement of two, new all-cause readmissions measures.

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[1] Dartmouth Atlas Project, PerryUndem Research & Communications. The Revolving Door: A Report on U.S. Hospital Readmissions. Princeton, NJ:Robert Wood Johnson Foundation; 2013. Available at http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/02/the-revolving-door--a-report-on-u-s--hospital-readmissions.html

[2] Medicare Payment Advisory Committee (MEDPAC). Report to the Congress: Medicare and the Health Care Delivery System, DC: MedPAC; 2013. Available at http://medpac.gov/documents/Jun13_EntireReport.pdf.

[3] Dartmouth Atlas Project, PerryUndem Research & Communications. The Revolving Door: A Report on U.S. Hospital Readmissions. Princeton, NJ:Robert Wood Johnson Foundation; 2013. Available at http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/02/the-revolving-door--a-report-on-u-s--hospital-readmissions.htmlRWJF

[4] Joynt KE, Orav EJ, Jha AK. Thirty-day readmission rates for Medicare beneficiaries by race and site of care. JAMA 2011 Feb 16;305(7):675-81.

[5] Arbaje AI, Wolff JL, Yu Q, Powe NR, Anderson GF, Boult C. Postdischarge environmental and socioeconomic factors and the likelihood of early hospital readmission among community-dwelling Medicare beneficiaries. Gerontologist 2008 Aug;48(4):495-504.

[6] Medicare Payment Advisory Committee (MEDPAC). Report to the Congress: Medicare and the Health Care Delivery System, DC: MedPAC; 2013. Available at http://medpac.gov/documents/Jun13_EntireReport.pdf.

In addition to measure endorsement projects, NQF has pursued other work related to admissions and readmissions. NQF's Measure Applications Partnership (MAP) recommended that readmission measures should be part of a suite of measures promoting a system of patient-centered care coordination. This conclusion recognized that multiple entities and individuals are jointly accountable for reducing avoidable readmissions, that assessment of performance should include measures of both avoidable admissions and readmissions, and additionally should address important care coordination processes and readmissions.[7]

As we move towards a model of accountable care organizations using readmissions measures as part of a suite in conjunction with quality measures looking at admissions and length of stay, we can achieve greater efficiencies and improvements in quality (e.g., reductions in readmissions and mortality).

COMMITTEE CHARGE

A multi-stakeholder Standing Committee will be established to evaluate newly submitted measures and measures undergoing maintenance review and make recommendations for which measures should be endorsed as consensus standards. This Committee will work to identify and endorse new performance measures for accountability and quality improvement that specifically address admissions and readmissions across all settings of care. Measures including outcomes, treatments, diagnostic studies, interventions, or procedures associated with admissions and readmissions will be considered. Additionally, the Committee will evaluate consensus standards previously endorsed by NQF due for maintenance review.

The Standing Committee's primary work is to evaluate the submitted measures against NQF's standard measure evaluation criteria and make recommendations for endorsement. The Committee will also:

- oversee the portfolio of admissions and readmissions measures
- identify and evaluate competing and related measures
- identify opportunities for harmonization of similar measures
- recommend measure concepts for development to address gaps in the portfolio
- provide advice or technical expertise about the subject to other committees (i.e. cross cutting committees or the Measures Application Partnership)
- ensure input is obtained from relevant stakeholders
- review draft documents
- recommend specific measures and research priorities to NQF Members for consideration under the Consensus Development Process (CDP).

To learn more about the work of NQF's CDP Standing Committees, review our Committee Guidebook.

STANDING COMMITTEE

This Committee will be seated as a standing committee comprised of 20-25 individuals, with members serving terms that may encompass multiple measure review cycles.

[7] MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS. Washington, DC: National Quality Forum; 2013 Feb. Available at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=72746

Terms

Standing Committee members will initially be appointed to a 2 or 3 year term. Each term thereafter would be a 3 year term, with Committee members permitted to serve two consecutive terms. After serving two terms, the Committee member must step down for one full term (3 years) before becoming eligible for reappointment. For more information, please reference the Standing Committee Policy.

Participation on the Committee requires a significant time commitment. To apply, Committee members should be available to participate in all currently scheduled calls/meetings. Over the course of the Committee member's term, additional calls will be scheduled or calls may be rescheduled; new dates will be set based on the availability of the majority of the Committee.

Each measure review cycle generally runs about 7 months in length.

Committee participation includes:

- Review measure submission forms during each cycle of measure review
  - Each committee member will be assigned a portion (1-5) of the measures to fully review (approx. 1-2 hours/measure) and provide a preliminary evaluation on a workgroup call
  - Each committee member should familiarize themselves with all measures being reviewed (approx. 1 hour/measure)
- Participate in the orientation call and tutorial call (2 hours)
- The option to attend one of two NQF staff-hosted measure evaluation Q &A calls (1 hour)
- Review measures with the full Committee by participating in one of three workgroup calls (2 hours); workgroup assignments will be made by area of expertise;
- Attendance at scheduled in-person meetings (2 full days in Washington, DC)
- Complete measure review by attending the post-meeting conference call (2 hours)
- Attend conference call following public commenting to review submitted comments (2 hours)
- Complete additional measure reviews via webinar
- Participate in additional calls as necessary
- Complete surveys and pre-meeting evaluations
- Present measures and lead discussions for the Committee on conference calls and in meetings

Table of scheduled meeting dates

Meeting	Date/Time
Orientation Call (2 hours)	January 14, 2014 12:00-2:00pm EST
Measure Evaluation Q & A (1 hour)	January 28, 2014 1:00-2:00pm EST or February 7, 2014 3:00-4:00pm EST
Workgroup Call (2 hours)	February 12, 2014 1:00-3:00pm EST or February 17, 2014 2:00-4:00pm EST or February 26, 2014 1:00-3:00pm EST
In-person meeting (2 days in Washington, DC)	March 6 2014 at 8:30AM-5:00PM EST to March 7, 2014 at 8:30AM-3:00PM EST

Post-Meeting Conference Call (2 hours)	March 21, 2014 1:00-3:00pm EST
Post Draft Report Comment Call (2 hours)	June 2, 2014, 12:00-2:00pm EST

Preferred Expertise & Composition

Standing Committee members are selected to ensure representation from a variety of stakeholders, including consumers, purchasers, providers, professionals, plans, suppliers, community and public health, and healthcare quality experts. Because NQF attempts to represent a diversity of stakeholder perspectives on committees, a limited number of individuals from each of these stakeholder groups can be seated onto a committee.

Nominees should possess relevant knowledge and/or proficiency in process and outcome quality measurement and/or clinical expertise in the evaluation, treatment, diagnostic studies, imaging, interventions, or procedures associated with admissions and readmissions, across multiple care settings. NQF is seeking nominees with a variety of clinical experience, including physicians, nurses, therapists, case managers, unit managers, and executives. We also are seeking expertise in disparities and care of vulnerable populations.

Please review the NQF Conflict of interest policy to learn about how NQF identifies potential conflict of interest. All potential Steering Committee members must disclose any current and past activities prior to and during the nomination process in order to be considered.

CONSIDERATION AND SUBSTITUTION

Priority will be given to nominations from NQF Members when nominee expertise is comparable. Please note that nominations are to an individual, not an organization, so “substitutions” of other individuals from an organization at conference calls, meetings or for voting is not permitted. Committee members are encouraged to engage colleagues and solicit input from colleagues throughout the process.

APPLICATION REQUIREMENTS

Self-nominations are welcome. Third-party nominations must indicate that the individual has been contacted and is willing to serve. To be considered for appointment to the Steering Committee, please submit the following information:

- a completed online nomination form, including:
    - a brief statement of interest
    - a brief description of nominee expertise highlighting experience relevant to the committee
    - a short biography (maximum 750 characters), highlighting experience/knowledge relevant to the expertise described above and involvement in candidate measure development;
    - curriculum vitae or list of relevant experience (e.g., publications) *up to 20 pages*

- a completed disclosure of interest form. This will be requested upon your submission of the nominations form for Committees actively seeking nominees.
- confirmation of availability to participate in currently scheduled calls and meeting dates. Committees or projects actively seeking nominees will solicit this information upon submission of the online nomination form.

DEADLINE FOR SUBMISSION

All nominations *MUST* be submitted by **6:00 pm ET on November 12, 2013.**

QUESTIONS

If you have any questions, please contact Andrew Lyzenga, MPP, Senior Project Manager, Performance Measurement or Adeela Khan, MPH, Project Manager, Performance Measurement, at 202-783-1300 or email us readmissions@qualityforum.org.

Thank you for your interest.