Health Information Systems, Inc.
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June 19, 2014

Dr. Christine Cassel, President
National Quality Forum
1030 15th Street NW
Suite 800
Washington DC 20005

Dear Dr. Cassel:

Earlier this year on April 1, 2014, 3M HIS submitted the attached in-depth comments on the pediatric lower respiratory infection readmission measure #2414 and the pediatric all-conditions readmission measure #2393. We expressed our strong concern about the continued focus on an all-cause readmission model. We also expressed a number of specific concerns about the definitions, risk adjustment, and testing of the proposed pediatric measures. These concerns were not addressed as part of the Steering Committee's deliberations during its April 16 or May 5-6 meetings, and there was no indication that they would be addressed through the remainder of the adoption processes. In this letter, we will speak to the approach, criteria, and future directions of NQF measures and 3M's continued engagement with these processes.

As you are aware 3M's Potentially Preventable Readmission (PPR) system is one of the most widely used readmission measures. In 2009 we submitted PPRs to NQF for endorsement. At that time in a letter to Karen Pace dated March 2, 2009, we expressed our disappointment with the lack of familiarity of the technical panel with categorical models and their application. Ultimately, PPRs were not endorsed because as indicated in a letter from Karen Pace dated March 17, 2009, PPRs were considered a comprehensive system and at that time NQF was only considering "specific quality measures of outcomes" for endorsement and not comprehensive systems. Subsequently, in 2011 we considered submitting PPRs for endorsement under the all cause readmission expedited review project. In a letter to you dated October 27, 2011 we decided not to submit because the readmission measures were being restricted to all cause measures.

Since 2011 we have been reconsidering whether to submit PPRs. We decided to submit detailed comments on the pediatric readmission measures in part to better understand the current approach of the technical panel evaluating the measures. Unfortunately, there wasn't any discussion about the all-cause approach or specific pediatric concerns we had raised, or changes occurring throughout the field. The discussion noted that the two

proposed pediatric measures were consistent and complementary with NQF adult measures, but did not address issues with the underlying model. To say the least we were quite disappointed.

To briefly restate, our fundamental concern with the all-cause approach is that it does not include a method for excluding readmissions are unrelated to the prior admission and therefore not potentially preventable. Only a subset of planned readmissions are excluded. We believe mixing preventable and largely non-preventable readmissions will undermine the quality improvement potential of any payment policy related to readmissions. The output from the system also does not include any clinical categorization of hospitalizations that are considered index admissions and readmissions, thus further limiting its interpretability and use as a system for quality improvement.

In terms of specific concerns with the two pediatric measures, there were two fundamental issues. The risk adjustment methodology omitted key variables (reason for admission, acuity of hospitalization, and impact of specific complex chronic conditions), and instead used clinically less specific variables (age, gender, presence of any chronic condition and count of "body systems"). The testing was very limited and did not include any assessment of whether the readmissions captured were clinically related and preventable, or any evaluation of actual-to-expected results for subgroups of children or hospitals that might be expected to have higher or lower readmission rates. Altogether, it wasn't possible to discern how the proposals would provide a fair and accurate basis for measuring hospital performance, or a targeted and useful approach for performance improvement.

We are especially perplexed because we cannot understand how an all-cause readmission measure can possibly be considered to meet the NQF measure evaluation criteria for validity. There are large numbers of unrelated and very low preventability readmissions. The NQF validity criteria states that the "measure score correctly reflects the quality of care provided, adequately identifying differences in quality". We do not understand how the inclusion of a readmission for trauma incurred in a traffic accident or an attack of appendicitis could be construed to reflect the quality of care. Similarly, malignancy related readmissions such as for neutropenia, aplastic anemia, and infections reflect the underlying malignancy and immune-compromised state, not quality of care. On the adult side, a readmission for a stroke following an admission for pneumonia is similarly not preventable and doesn't reflect issues pertaining to quality of care. The criteria further require that the measure be able to identify "practically/clinically meaningful differences in performance." A readmission due to any of these causes has no practical or clinically meaningful relationship to quality of care. They also distort hospital comparisons in these instances, especially for major cancer centers.

The NQF validity criteria also state that "Exclusions are supported by the clinical evidences; otherwise, they are supported by evidence of sufficient frequency of occurrence so that results are distorted without the exclusion". By implication the

converse must also be true that the lack of exclusions should be supported by evidence of insufficient frequency of occurrence so that the results are not distorted. PPRs consider approximately 40 percent of all readmissions to not be potentially preventable (Goldfield, 2008). A recent study by the VA published in *Medical Care* concluded that the exclusion of non-preventable readmissions had a significant impact on the evaluation of a hospital's readmission performance (Mull, 2013). We would have expected that such evidence would receive careful consideration given all the readmissions proposals the panel was evaluating. Unfortunately, that was not the case.

There was also no discussion of the direction of legislation and regulations at the state level regarding readmissions as it relates to the issue of using all cause based readmission measures. Clearly the trend is to require any readmissions used for evaluating hospital performance to be clinically related and potentially preventable.

- New York State regulations require that readmissions be "clinically related to the prior admissions" and "could reasonably have been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post-discharge follow-up period."
- Texas law requires require that readmissions must result "from deficiencies in the care or treatment provided during a previous hospital stay or from deficiencies in post-hospital discharge follow-up."
- Illinois Department of Healthcare and Family Services requires that readmissions be "clinically related to an initial admission."
- Massachusetts Medicaid requires that readmissions be "clinically related to the initial admission."

At the Federal level, the ACA legislation stipulates that readmissions used to evaluate hospital performance are to "have exclusions for readmissions unrelated to the prior discharge." Although CMS has ignored this directive from Congress, the clear and consistent direction from policy makers is to restrict the readmissions used for assessing hospital performance to preventable readmissions. Despite all of these policy initiatives throughout the field, there was no revisiting of the basic acceptability of an all cause readmission measure by the NQF panel.

On the private sector side, the Minnesota Hospital Association's Reducing Avoidable Readmissions Effectively (RARE) program was awarded the National Quality Forum's Eisenberg Award for Patient Safety and Quality. The RARE program was based only on preventable readmissions. Yet there was no discussion at the technical panel of what attributes of a readmission measures make it practical and clinically meaningful so that it

could lead to behavior changes in real world applications. Indeed the NQF criteria does not place enough emphasis on when whether the application of a measure has actually led to measureable changes in behavior that resulted in improved quality.

Based on our experiences with readmissions measure #2414 and #2393, we are unlikely to submit PPRs or any of our other quality measures to NQF. This is unfortunate given the rapid adoption of PPRs and proven real world positive impact on quality. We will still monitor NQF activities and hope that at some point there will be changes in the NQF approach to these measures. We would also appreciate hearing from you if the NQF decides to change its approach to readmissions and other quality measurement systems.

Sincerely,

Richard Averill
Director
Clinical and Economic Research

Norbert Goldfield, MD
Medical Director

Enclosures: 2

cc: Helen Burstin, Karen Pace

Goldfield, N.I., McCullough, E.C., Hughes, J.S., Tang, A.M., Eastman, E., Rawlins, L.K., Averill, R.F., "Identifying Potentially Preventable Readmissions", *Health Care Financing Review*, 30(1): 75-91, Fall 2008.

Mull, H.J., Chen, Q., O'Brien, W.J., Shwartz, M., Borzecki, A.M., Hanchate, A., Rosen A.K., "Comparing Two Methods of Assessing 30-Day Readmissions: What Is the Impact on Hospital Profiling in the Veterans Health Administration?" *Medical Care*, July 2013