# National Consensus Standards for Admissions and Readmissions

Standing Committee Orientation

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NATIONAL QUALITY FORUM

# Welcome and Introductions

# NQF Project Staff

- Erin O'Rourke
  - Senior Director
- Taroon Amin, PhD, MPH
  - Consultant
- Zehra Shahab, MPH
  - Project Manager
- Severa Chavez
  - Project Analyst

# Standing Committee

- John Bulger, DO, MBA *(co-chair)*
- Cristie Travis, MSHHA *(co-chair)*
- Katherine Auger, MD, MSc
- Frank Briggs, PharmD, MPH
- Jo Ann Brooks, PhD, RN
- Mae Centeno, DNP, RN, CCRN, CCNS, ACNS-BC
- Helen Chen, MD
- Ross Edmundson, MD
- William Wesley Fields, MD, FACEP
- Steven Fishbane, MD
- Paula Minton Foltz, RN, MSN
- Brian Foy, MHA
- Laurent Glance, MD
- Anthony Grigonis, PhD
- Bruce Hall, MD, PhD, MBA
- Leslie Kelly Hall
- Paul Heidenreich, MD, MS, FACC, FAHA
- Karen Joynt, MD, MPH
- Sherrie Kaplan, PhD
- Keith Lind, JD, MS, BSN
- Paulette Niewczyk, PhD, MPH
- Carol Raphael
- Pamela Roberts, PhD, MSHA, ORT/L, SCFES, FAOTA, CPHQ
- Derek Robinson, MD, MBA, FACEP, CHCQM
- Thomas Smith, MD, FAPA

# Agenda for the Call

- Overview of NQF and the Consensus Development Process
- Admissions and Readmissions Portfolio of Measures
- Role of the Standing Committee, co-chairs, and staff
- Overview of Measure Evaluation Criteria
- SDS Trial Period Overview
- SharePoint Tutorial
- Next steps

# The National Quality Forum: A Unique Role

Established in 1999, NQF is a non-profit, non-partisan, membership-based organization that brings together public and private sector stakeholders to reach consensus on healthcare performance measurement. The goal is to make healthcare in the U.S. better, safer, and more affordable.

**Mission**: To lead national collaboration to improve health and healthcare quality through measurement

- An Essential Forum
- Gold Standard for Quality Measurement
- Leadership in Quality

# NQF Activities

- **Measure Endorsement**
  - 600+ NQF-endorsed measures across multiple clinical areas
  - 11 empaneled standing expert committees
- **Measure Application Partnership**
  - Advises HHS on selecting measures for 20+ federal programs, Medicaid, and health exchanges
- **Measurement Science**
  - Convenes private and public sector leaders to reach consensus on complex issues in healthcare performance measurement
- **National Quality Partners**
  - Convenes stakeholders around critical health and healthcare topics
  - Spurs action on patient safety, early elective deliveries, and other issues

# NQF Consensus Development Process (CDP)

## 8 Steps for Measure Endorsement

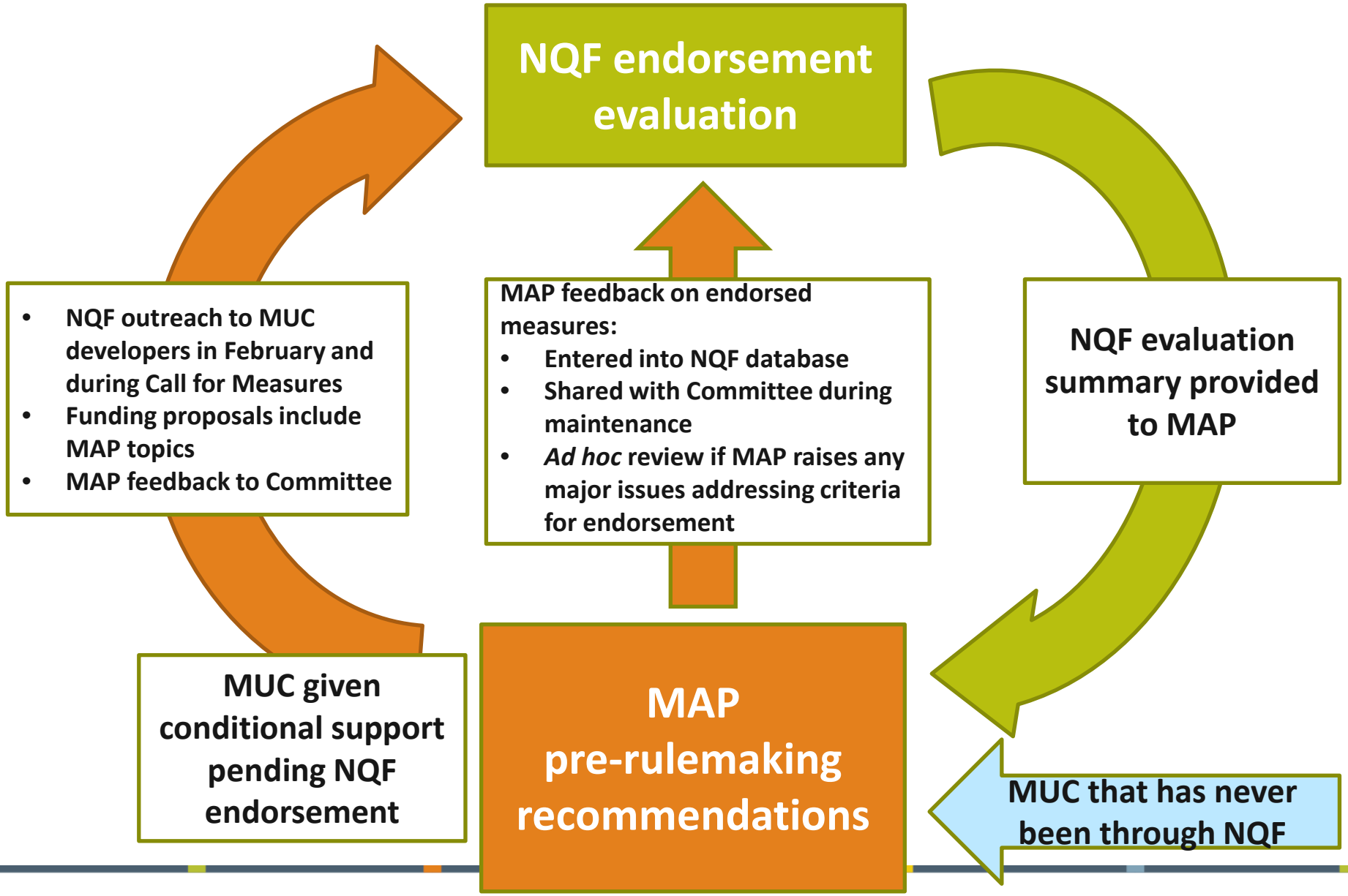
- Call for nominations for Standing Committee
- Call for candidate standards (measures)
- Candidate consensus standards review
- Public and member comment
- NQF member voting
- Consensus Standards Approval Committee (CSAC) decision
- Board Ratification
- Appeals

# Measure Application Partnership (MAP)

In pursuit of the National Quality Strategy, the MAP:

- Informs the selection of performance measures to achieve the goal of improvement, transparency, and value for all
- Provides input to HHS during pre-rulemaking on the selection of performance measures for use in public reporting, performance-based payment, and other federal programs
- Identifies gaps for measure development, testing, and endorsement
- Encourages measurement alignment across public and private programs, settings, levels of analysis, and populations to:
  - Promote coordination of care delivery
  - Reduce data collection burden

# CDP-MAP INTEGRATION – INFORMATION FLOW



# Admissions/Readmissions Portfolio of NQF-endorsed measures

*Measures for maintenance evaluation

Hospital

- #0330 Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following heart failure (HF) hospitalization
- #0505 Hospital 30-day all-cause RSRR following acute myocardial infarction (AMI)
- #0506 Hospital 30-day, all-cause, RSRR following pneumonia hospitalization*
- #0695 Hospital 30-Day RSRR following Percutaneous Coronary Intervention (PCI)
- #1551 Hospital-level 30-day, all-cause RSRR following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)*
- #1789 Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)*
- #1891 Hospital 30-Day, All-Cause, RSSR following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization*
- #2393 Pediatric All-Condition Readmission Measure
- #2414 Pediatric Lower Respiratory Infection Readmission Measure
- #2513 Outcome Hospital 30-Day All-Cause RSRR following Vascular Procedures
- #2514 Risk-Adjusted Coronary Artery Bypass Graft (CABG) Readmission Rate
- #2515 Hospital 30-day, all-cause, unplanned, RSRR following coronary artery bypass graft (CABG) surgery

# Admissions/Readmissions Portfolio of NQF-endorsed measures

*Measures for maintenance evaluation

## Skilled Nursing Facility

- #2375 PointRight ® Pro 30™
- #2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)

## Home Health

- #0171 Acute Care Hospitalization During the First 60 Days of Home Health*
- #0173 Emergency Department Use without Hospitalization During the First 60 Days of Home Health*
- #2380 Rehospitalization During the First 30 Days of Home Health
- #2505 Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health

## Inpatient Rehabilitation Facility (IRF)

- #2502 All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs

## Long Term Care Hospitals

- #2512 All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from LTCHs

## Hospital Outpatient Departments/Ambulatory Surgery Centers

- #2539 Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

# Admissions/Readmissions Portfolio of NQF-endorsed measures

*Measures for maintenance evaluation

## Ambulatory Surgery Centers

- #0265All-Cause Hospital Transfer/Admission*

## Health Plan

- #1768 Plan All-Cause Readmissions (PCR)

## Population Based

- #2503 Hospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries
- #2504 30-day Rehospitalizations per 1000 Medicare FFS Beneficiaries

# MAP Measures Under Consideration

## 2014-2015

- 30 Day Unplanned Readmissions for Cancer Patients

## 2015-2016

- Standardized Hospitalization Ratio - Modified (dialysis facilities)
- Standardized Readmission Ratio (SRR) for dialysis facilities
- Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy
- Risk-standardized hospital visits within 7 days after hospital outpatient surgery
- Thirty-day all-cause unplanned readmission following psychiatric hospitalization in an IPF

# MAP Measures Under Consideration

**2015-2016 continued…**

- Potentially Preventable 30-Day Post-Discharge Readmission Measure for Home Health Quality Reporting Program
- Potentially Preventable 30-Day Post-Discharge Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program
- Potentially Preventable 30-Day Post-Discharge Readmission Measure for Long-Term Care Hospital Quality Reporting Program
- Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility Quality Reporting Program
- Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure (SNFPPR)

# Role of the Standing Committee, Co-Chairs, and Staff

# Role of the Standing Committee

- Act as a proxy for the NQF multi-stakeholder membership
- Serve 2-year or 3-year terms
- Work with NQF staff to achieve the goals and action items of the project
- Respond to public comments

# Role of the Standing Committee Co-Chairs

- Co-facilitate Standing Committee (SC) meetings
- Work with NQF staff to achieve the goals of the project
- Assist NQF in anticipating questions and identifying additional information that may be useful to the SC
- Keep SC on track to meet goals of the project without hindering critical discussion/input
- Represent the SC at CSAC meetings and Coordinating Committee meetings
- Participate as a SC member

# Role of NQF Staff

- **NQF project staff works with SC to achieve the goals of the project:**
  - Organize and staff SC meetings and conference calls
  - Guide the SC through NQF policy and procedures
  - Prepare materials for Committee review
  - Draft and edit reports for SC review
  - Ensure communication among all Committee Members
  - Facilitate necessary communication and collaboration between different NQF projects

# Role of NQF Staff

*Communication*

- Respond to NQF member or public queries about the project
- Maintain documentation of project activities
- Post project information to NQF website
- Work with measure developers to provide necessary information and communication
- Publish final project report

# Activities and Timeline

***All times ET**

| Meeting | Date/Time |
|---|---|
| Orientation Call | February 16, 2016 [2-4 pm ET] |
| SDS Webinar #2 | March 8, 2016 [2-4 pm ET] |
| Q&A Call | April 27, 2016 [1-2 pm ET] |
| SDS Webinar #3 | May 13, 2016 [12-2 pm ET] |
| In-Person Meeting (2 days in Washington, D.C.) | June 8-9, 2016 [8:30 am-5:00 pm ET both days] |
| Post-Meeting Follow-up Call | June 21, 2016 [2-4 pm ET] |
| Post- Draft Report Call | October 5, 2016 [12-2 pm ET] |

# Measure Evaluation Criteria Overview

# NQF Measure Evaluation Criteria for Endorsement

**NQF endorses measures for accountability applications (public reporting, payment programs, accreditation, etc.) as well as quality improvement**.

- Standardized evaluation criteria
- Criteria have evolved over time in response to stakeholder feedback
- The quality measurement enterprise is constantly growing and evolving – greater experience, lessons learned, expanding demands for measures – the criteria evolve to reflect the ongoing needs of stakeholders

# Major Endorsement Criteria

*Hierarchy and Rationale (page 32)*

- **Importance to measure and report**: Goal is to measure those aspects with greatest potential of driving improvements; if not important, the other criteria are less meaningful (***must-pass***)
- **Reliability and Validity-scientific acceptability of measure properties** : Goal is to make valid conclusions about quality; if not reliable and valid, there is risk of improper interpretation (***must-pass***)
- **Feasibility**: Goal is to, ideally, cause as little burden as possible; if not feasible, consider alternative approaches
- **Usability and Use**: Goal is to use for decisions related to accountability and improvement; if not useful, probably do not care if feasible
- Comparison to related or competing measures

# Criterion #1: Importance to Measure and Report (page 36-38)

1. **Importance to measure and report -** Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance.

   **1a. Evidence:** the measure focus is evidence-based

   **1b. Opportunity for Improvement:** demonstration of quality problems and opportunity for improvement, i.e., data demonstrating considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
   disparities in care across population groups (pages 41-42)

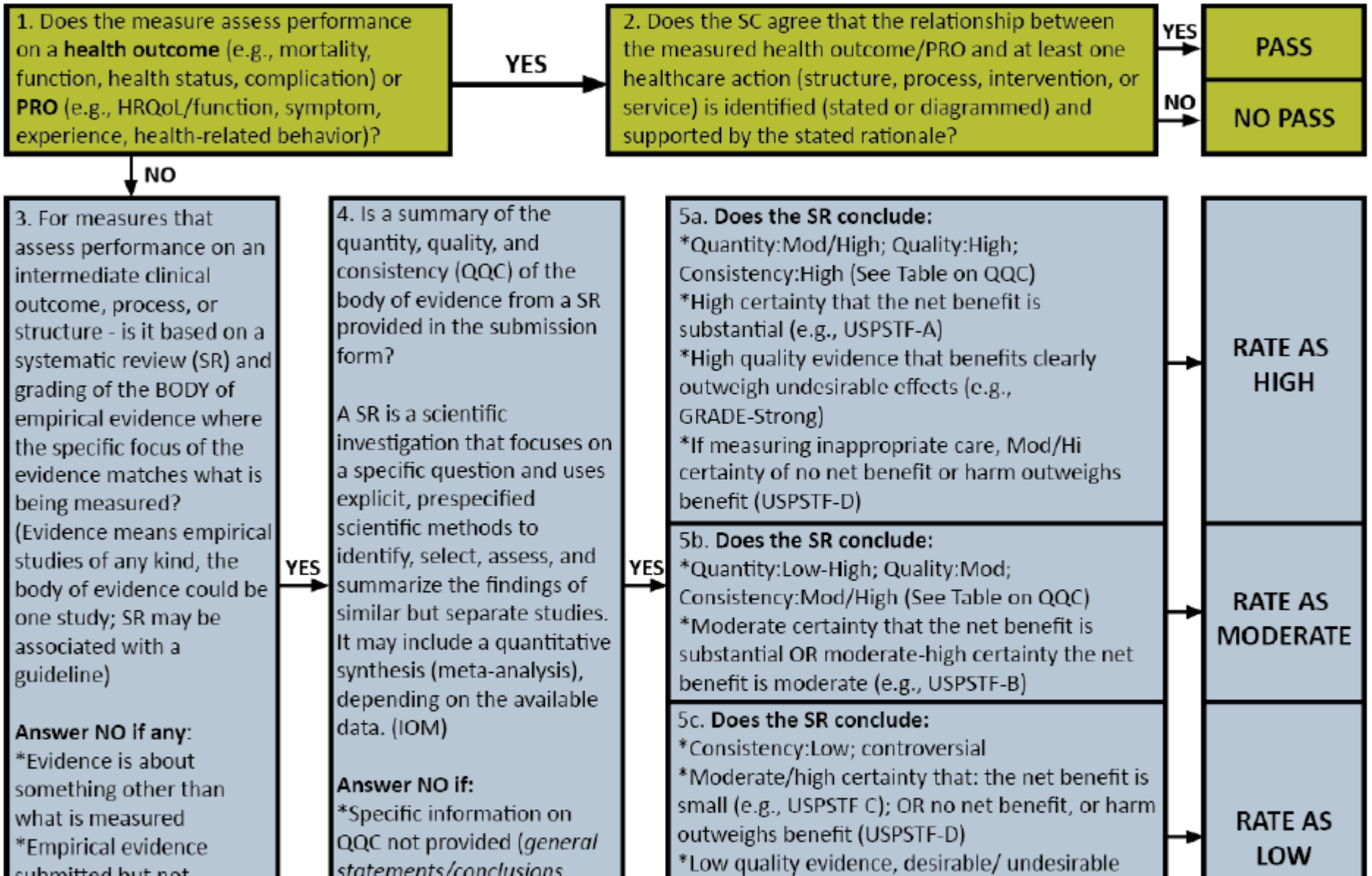
   **1c. Quality construct and rationale** (composite measures only)

# Subcriteron 1a: Evidence (page 36-37)

- Outcome measures
  - A rationale (which often includes evidence) for how the outcome is influenced by healthcare processes or structures.
- Process, intermediate outcome measures
  - the quantity, quality, and consistency of the body of evidence underlying the measure should demonstrate that the measure focuses on those aspects of care known to influence desired patient outcomes
    - » Empiric studies (expert opinion is not evidence)
    - » Systematic review and grading of evidence
      - *Clinical Practice Guidelines – variable in approach to evidence review*

# Rating Evidence: Algorithm #1 – page 38

## Algorithm #1. Guidance for Evaluating the Clinical Evidence



# Criterion #1: Importance to measure and report

## Criteria  emphasis is different for new vs maintenance measures

| New measures | Maintenance measures |
|---|---|
| • Evidence – Quantity, quality, consistency (QQC)<br>• Established link for process measures with outcomes | **DECREASED EMPHASIS**: Require measure developer to attest evidence is unchanged evidence from last evaluation; Standing Committee to affirm no change in evidence<br><br>IF changes in evidence, the Committee will evaluate as for new measures |
| • Gap – opportunity for improvement, variation, quality of care across providers | **INCREASED EMPHASIS**: data on current performance, gap in care and variation |

# Criterion #2: Reliability and Validity– Scientific Acceptability of Measure Properties (page 43 -46)

**Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of health care delivery**

2a. **Reliability (must-pass)**

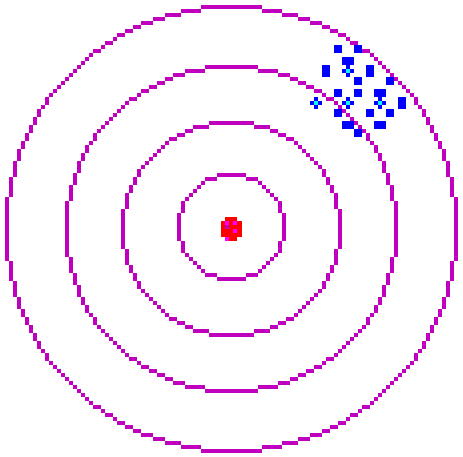
- 2a1. Precise specifications including exclusions
- 2a2. Reliability testing—data elements or measure score

2b. **Validity (must-pass)**

- 2b1. Specifications consistent with evidence
- 2b2. Validity testing—data elements or measure score
- 2b3. Justification of exclusions—relates to evidence
- 2b4. Risk adjustment—typically for outcome/cost/resource use
- 2b5. Identification of differences in performance
- 2b6. Comparability of data sources/methods
- 2b7. Missing data

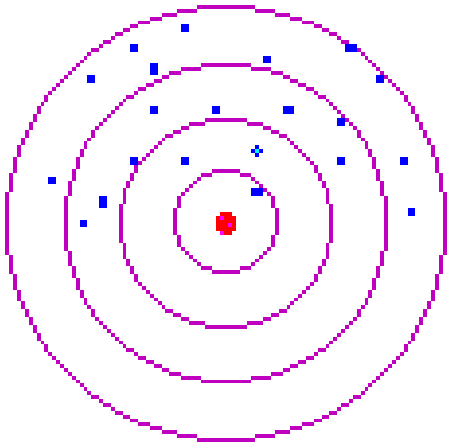
# Reliability and Validity (page 45)

**Assume the center of the target is the true score…**



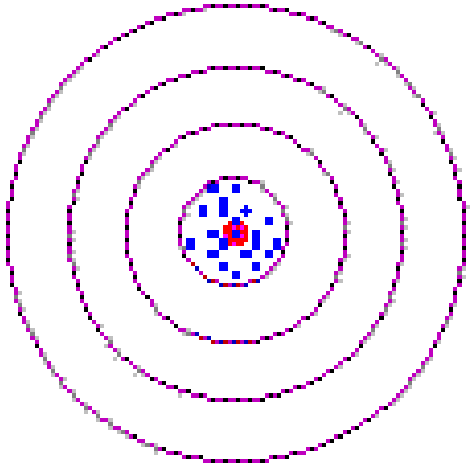
**Reliable Not Valid**

Consistent, but wrong



**Neither Reliable Nor Valid**

Inconsistent & wrong



**Both Reliable And Valid**

Consistent & correct

# Measure Testing – Key Points (page 46)

**Empirical analysis** to demonstrate the reliability and validity of the *measure as specified,* including analysis of issues that pose threats to the validity of conclusions about quality of care such as exclusions, risk adjustment/stratification for outcome and resource use measures, methods to identify differences in performance, and comparability of data sources/methods.

# Reliability Testing (page 46)
# Key points - page 47

- Reliability of the ***measure score*** refers to the proportion of variation in the performance scores due to systematic differences across the measured entities in relation to random variation or noise (i.e., the precision of the measure).
  - Example - Statistical analysis of sources of variation in performance measure scores (signal-to-noise analysis)

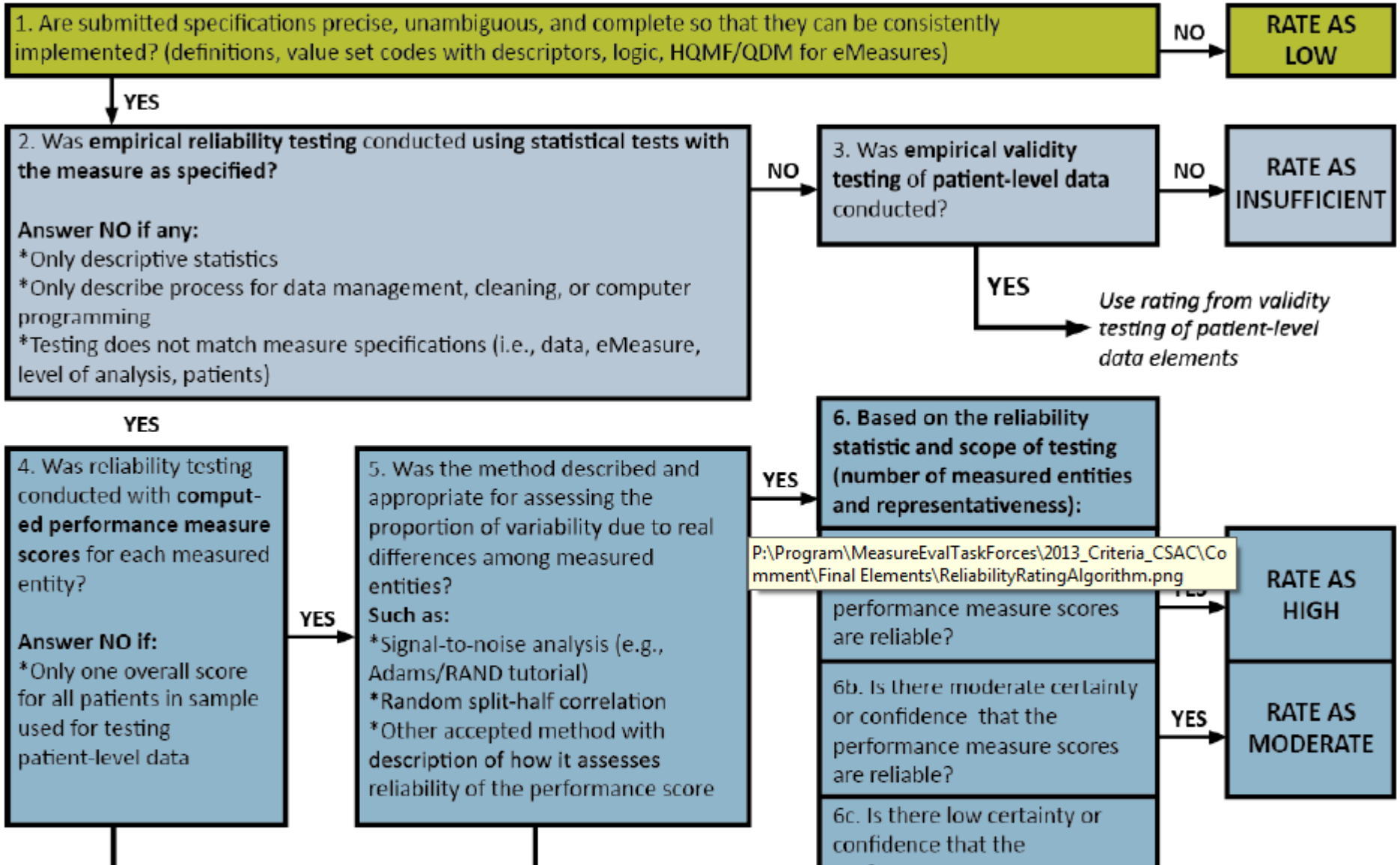
- Reliability of the ***data elements*** refers to the repeatability/reproducibility of the data and uses patient-level data
  - Example –inter-rater reliability

- Consider whether testing used an appropriate method and included adequate representation of providers and patients and whether results are within acceptable norms

- Algorithm #2 – page 48

# Rating Reliability: Algorithm #2 – page 48

## Algorithm #2. Guidance for Evaluating Reliability

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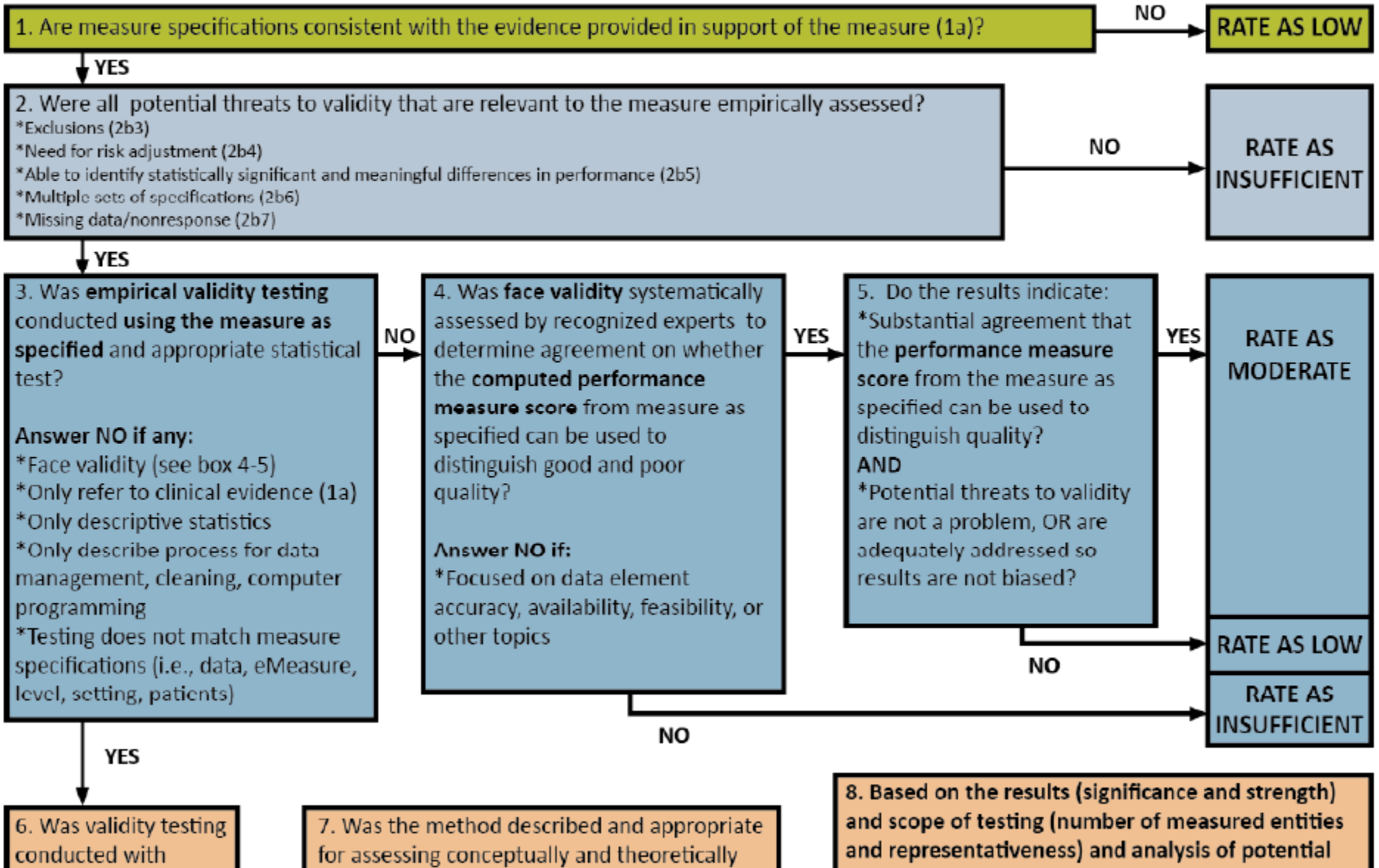
# Validity testing (pages 49 - 50)
# Key points – page 51

- **Empirical testing**
  - *Measure score* – assesses a hypothesized relationship of the measure results to some other concept; assesses the correctness of conclusions about quality
  - *Data element* – assesses the correctness of the data elements compared to a "gold standard"
- **Face validity**
  - Subjective determination by experts that the measure appears to reflect quality of care

# Rating Validity: Algorithm #3 – page 52

## Algorithm #3. Guidance for Evaluating Validity



# Threats to Validity

- Conceptual
  - Measure focus is not a relevant outcome of healthcare or not strongly linked to a relevant outcome
- Unreliability
  - Generally, an unreliable measure cannot be valid
- Patients inappropriately excluded from measurement
- Differences in patient mix for outcome and resource use measures
- Measure scores that are generated with multiple data sources/methods
- Systematic missing or “incorrect” data (unintentional or intentional)

# Criterion #2: Scientific Acceptability

| New measures | Maintenance measures |
|---|---|
| • Measure specifications are precise with all information needed to implement the measure | NO DIFFERENCE: Require updated specifications |
| • Reliability<br>• Validity (including risk-adjustment) | **DECREASED EMPHASIS**: If prior testing adequate, no need for additional testing at maintenance with certain exceptions (e.g., change in data source, level of analysis, or setting)<br>Must address the questions for SDS Trial Period |

# Criterion #3: Feasibility (page 53)
# Key Points – page 54

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement.

**3a: Clinical data generated during care process**

**3b: Electronic sources**

**3c: Data collection strategy can be implemented**

# Criterion #4: Usability and Use (page 54) Key Points – page 55

Extent to which potential audiences (e.g., consumers, purchasers, providers, policymakers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

**4a: Accountability and Transparency:** Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement

**4b: Improvement:** Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated

**4c: Benefits outweigh the harms:** The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

# Criteria #3-4: Feasibility and Usability and Use

| New measures | Maintenance measures |
|---|---|
| **Feasibility** | |
| • Measure feasible, including eMeasure feasibility assessment | NO DIFFERENCE: Implementation issues may be more prominent |
| **Usability and Use** | |
| • Use: used in accountability applications and public reporting | **INCREASED EMPHASIS**: Much greater focus on measure use and usefulness, including both impact and unintended consequences |
| • Usability: impact and unintended consequences | |

# Criterion #5: Related or Competing Measures (page 55-56)

**If a measure meets the four criteria and there are endorsed/new related measures (same measure focus or same target population) or competing measures (both the same measure focus and same target population), the measures are compared to address harmonization and/or selection of the best measure.**

- 5a. The measure specifications are harmonized with related measures **OR** the differences in specifications are justified.
- 5b. The measure is superior to competing measures (e.g., is a more valid or efficient way to measure) **OR** multiple measures are justified.

# Evaluation process

- **Preliminary analysis**: To assist the Committee evaluation of each measure against the criteria, NQF staff will prepare a preliminary analysis of the measure submission.
  - This will be used as a starting point for the Committee discussion and evaluation
- **Individual evaluation assignments:** Each Committee member will be assigned a subset of measures for in-depth evaluation.
  - Those who are assigned measures will lead the discussion of their measures with the entire Committee
- **Measure evaluation and recommendations at the in-person meeting:** The entire Committee will discuss and rate each measure against the criteria and make recommendations for endorsement.

# SDS Trial Period Overview

# Background

- NQF convened an **SDS Expert Panel** to consider if, when, and how outcome performance measures should be adjusted for socioeconomic status (SDS) or related demographic factors
- There are at least two diverging perspectives on SDS adjustment:
  - Adjusting for sociodemographic factors will mask disparities
  - Adjusting for sociodemographic factors is necessary to avoid making incorrect inferences in the context of comparative performance assessment
- The Panel recommended, and the NQF Board approved, a **two-year trial period** during which adjustment of measures for SDS factors will no longer be prohibited

# Background

- Each measure must be assessed individually to determine if SDS adjustment is appropriate
  - Not all outcomes should be adjusted for SDS factors (e.g., central line infection would not be adjusted)
  - Need conceptual basis (logical rationale, theory) and empirical evidence
- Efforts to implement SDS adjustment may be constrained by data limitations and data collection burden

# Scope

## Newly-submitted measures

- **ALL measures submitted to NQF after April 15, 2015 will be considered part of the trial period**, and Standing Committees may consider whether such measures are appropriately adjusted for SDS factors as part of their evaluation.

## Previously-endorsed measures

- **Measures undergoing endorsement maintenance review during the trial period** will also be considered "fair game" for consideration of SDS adjustment.
- Other paths for evaluation of SDS adjustment for endorsed measures:
  - Ad hoc requests
  - Conditional endorsement (e.g., Readmissions, Cost & Resource Use)

# SDS Trial Period Evaluation Process

- The Standing Committee will continue to evaluate the measure as a whole, including the appropriateness of the risk adjustment approach used by the measure developer
- The Standing Committee will continue to use the validity criterion to evaluate the appropriateness of the sociodemographic factors, as well as the clinical factors, used in the risk adjustment model
- NQF Staff has completed preliminary analyses of the measures submitted in this project and will identify areas where the Committee should focus to ensure that requirements under the NQF SDS trial period have been met

# Standing Committee Evaluation

- The Standing Committee will be asked to consider the following questions:
  - Is there a conceptual relationship between the SDS factor and the measure focus?
  - What are the patient-level sociodemographic variables that were available and analyzed during measure development?
  - Does empirical analysis (as provided by the measure developer) show that the SDS factor has a significant and unique effect on the outcome in question?
  - Does the reliability and validity testing match the final measure specifications?

# A more in-depth look: Conceptual Description

- The Standing Committee should review the information provided by developers and consider the following questions:
  - Is there a conceptual relationship between the SDS factor(s) and the measure focus?
  - Is the SDS factor(s) present at the start of care?
  - Is the SDS factor(s) caused by the care being evaluated?

# A more in-depth look: Data and Variables

- The Standing Committee should review the patient-level sociodemographic variables that were available and analyzed during measure development
- The Standing Committee should consider the following questions:
  - How well do the SDS variables that were available and analyzed align with the conceptual description provided?
  - Are these variables available and generally accessible for the measured patient population?

# A more in-depth look: Empirical Analysis

- The Standing Committee should examine the two sets of empirical analyses provided by the developer.
  - First, review the analyses and interpretation of the importance of the SDS variables in their risk adjustment model
  - Second, for the trial period, the measure developer must report and compare performance scores with and without SDS factors in the risk adjustment model. Formal hypothesis testing is not required but there should be a discussion about whether the differences in the scores are substantial.

# Testing and Specifications for Stratification

- The measure developer should provide updated reliability and validity testing of the measure as specified
- If a performance measure includes SDS variables in its risk adjustment model, the measure developer must provide the information required to stratify a clinically-adjusted-only version of the measure results by the relevant SDS variables.
- For more information, please see the project webpage: http://www.qualityforum.org/Risk_Adjustment_SES.aspx

# Admissions and Readmissions SDS Trial Period

- 17 admission and readmission measures endorsed with the condition they be reviewed for the need for SDS adjustment
- The Standing Committee determined that 16 measures should enter the trial period (conceptual rationale webinar – Jan. 26, 2015)
- The Standing Committee met in September to review the SDS factors/variables that developers plan to test in empirical analysis of the risk adjustment model – September 14, 2015
- Upcoming - Empirical analysis discussions – March 8, 2016 and May 13, 2016 (measures split up into two groups)
- CSAC and the Board will review the Standing Committee's recommendations.
- An appeals period will follow the BOD decision.

# Questions?

NATIONAL QUALITY FORUM

# SharePoint Overview

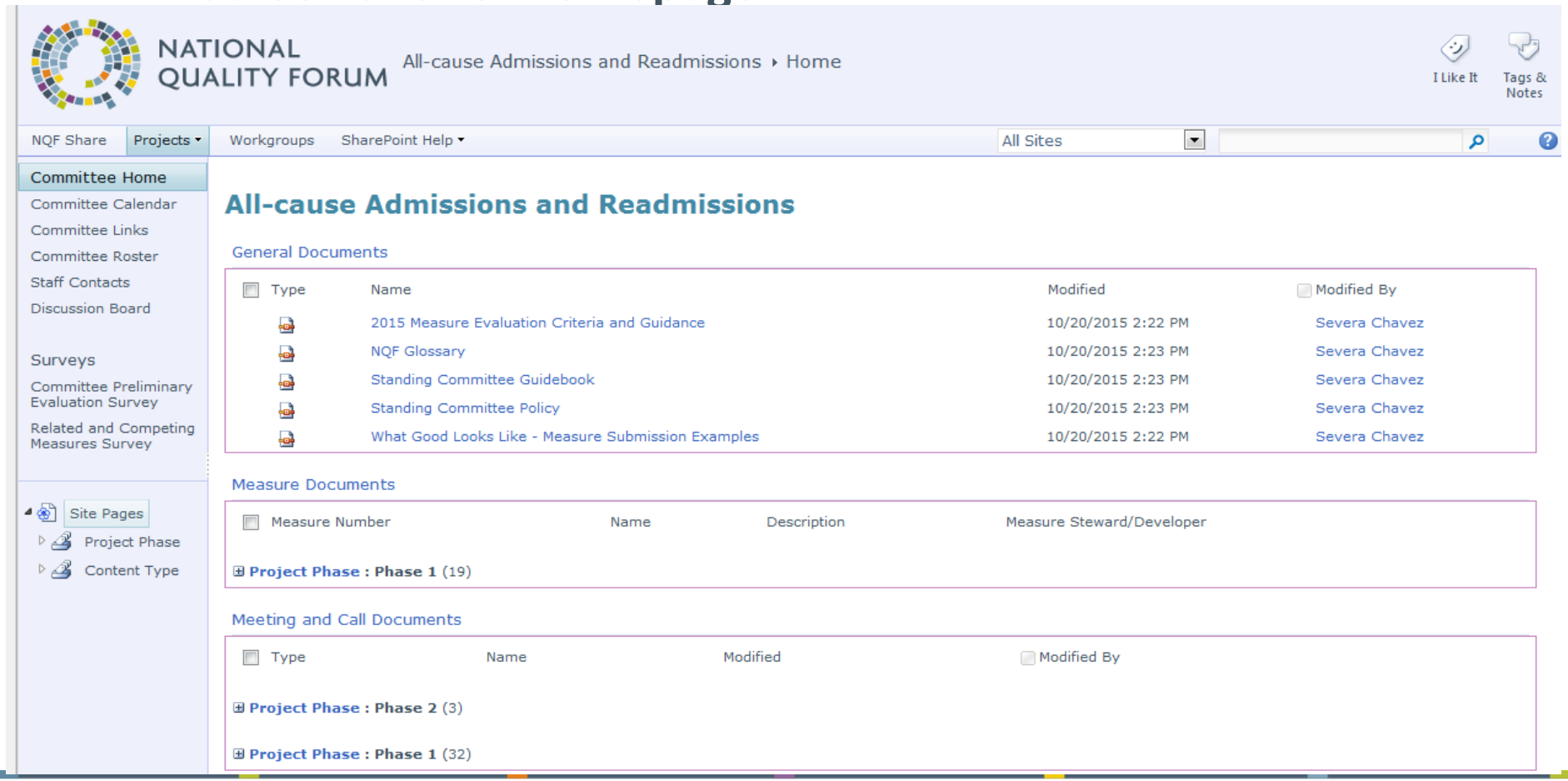
# SharePoint Overview

http://share.qualityforum.org/Projects/Disparities/SitePages/Home.aspx

- Accessing SharePoint
- Standing Committee Policy
- Standing Committee Guidebook
- Meeting and Call Documents
- Committee Roster and Biographies
- Calendar of Meetings

# SharePoint Overview

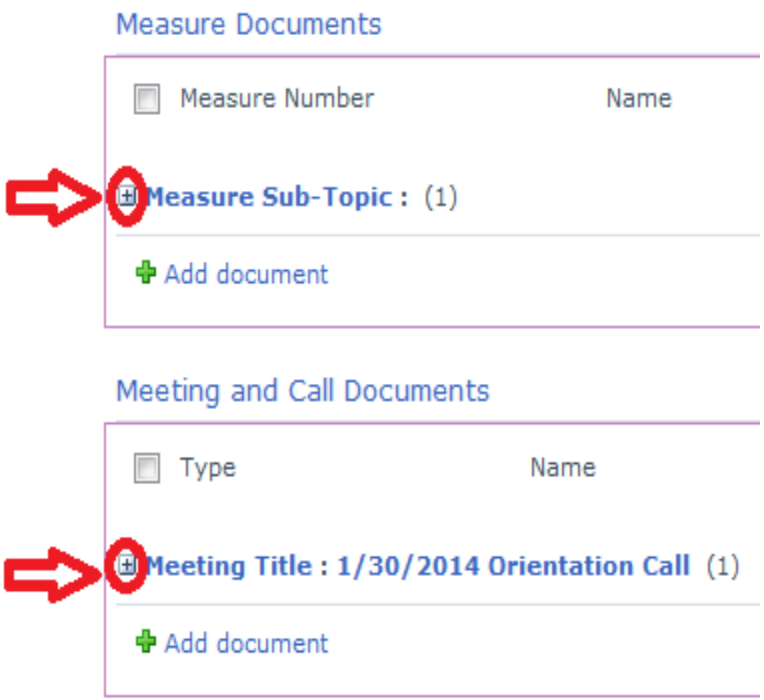
- Screen shot of homepage:

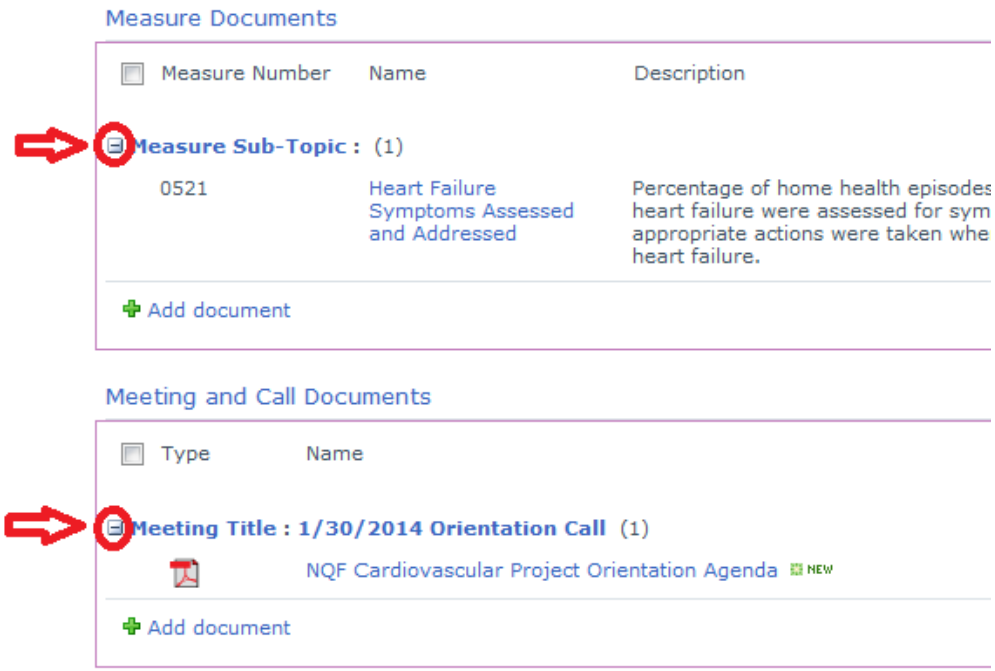


# SharePoint Overview

## Please keep in mind:

- + and – signs :



# Next Steps

# Next Steps/Upcoming Dates

| Meeting | Date/Time |
|---|---|
| SDS Webinar #2 | March 8, 2016 [2-4 pm ET] |
| Q&A Call | April 27, 2016 [1-2 pm ET] |
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| Post- Draft Report Call | October 5, 2016 [12-2 pm ET] |

# Project Contact Info

- Email: readmissions@qualityforum.org
- NQF Phone: 202-783-1300
- Project page: https://www.qualityforum.org/Project_Pages/All-Cause_Admissions_and_Readmissions_2015-2017.aspx
- SharePoint site: http://share.qualityforum.org/Projects/admissions_readmissions/SitePages/Home.aspx

# Questions?

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