NATIONAL QUALITY FORUM

Moderator: Readmissions Standing Committee
February 16, 2016
2:00 p.m. ET

OPERATOR: This is Conference #: 46847057

Operator: Welcome everyone. The webcast is about to begin. Please note, today's call is being recorded. Please standby.

Erin O'Rourke: Hello everyone, welcome to our Standing Committee Orientation for the National Consensus Standards for Admissions and Readmissions.

My name is Erin O'Rourke. I'm a senior director here at NQF. I'm new to this project and I'm looking forward to working with all of you. I've primarily been involved in the work of the Measure Applications Partnership, so I'm excited to have this opportunity to get involved with our measure endorsement work.

With that, I'd like to have the rest of our team introduce themselves. Taroon?

Taroon Amin: Hi, this is Taroon Amin. I am a consultant to NQF. And I've been working on readmissions, and cost and resource use activities. So, welcome to all the new members and good to talk to all the returning members on today's call.

Zehra Shahab: Good afternoon, everyone. My name is Zehra Shahab and I'm the project manager for this project. I've been at NQF for about two and a half years. And this readmissions project was my first project. So, I know almost all of you really well. And I also wanted to welcome our three new Standing Committee members. So, I look forward to work – continue working with you all.

Severa Chavez: Good afternoon, everyone. This is Severa Chavez and I'm the project analyst for the team. And just like Erin, I'm new to this project as well. And this is my second consensus development project. Primarily, I've been busy just working with Measure Applications Partnership work. And I'm excited to be part of the team.

Erin O'Rourke: Thanks, everyone. Next slide.

So with that, we'd like to have the committee go through and introduce themselves. First, I would also like to welcome our three new committee members, Brian Foy, Derek Robinson and Keith Lind.

I'd also like to welcome – a special welcome to John Bulger and Cristie Travis who agreed to serve as our co-chairs for this phase of work. And before we turn it over to introduction, a very special thank you to Bruce Hall and Sherrie Kaplan for their leadership and guidance these past years, they've done phenomenal work in this committee and we are excited that they've agreed to stay on and serve as Standing Committee members for the work going forward.

So, with that, I don't believe John was able to join us but Cristie, if you wouldn't mind kicking off introduction?

Cristie Upshaw Travis: Sure. And I want to add my thanks to Bruce and Sherrie as well. I'm sure that John and I do have big shoes to fill and I'm glad to know that both of you all are still involved in the committee and will be continuing to be a big asset.

I am Cristie Travis. I'm the CEO of the Memphis Business Group on Health. And I'm not sure what else you would want me to say, Erin.

Erin O'Rourke: Cristie, you could add, how long you've been on the committee.

Cristie Upshaw Travis: Oh, goodness. I think from the beginning. And I – you know, that would be difficult to know how long that's actually been, but I think I have

served on this committee from the beginning and have really learned a lot from that participation as well as the others on the committee as well.

Erin O'Rourke: Thank you so much, Cristie. And thank you for agreeing to serve as co-chair this go-round.

Cristie Upshaw Travis: Thank you.

Erin O'Rourke: So with that, Katherine Auger?

(Off-mike)

Erin O'Rourke: Frank Briggs?

Frank Briggs: Hi, Frank Briggs. I am the vice president and chief quality officer at WVU Medicine in Morgantown, West Virginia. I've been on the committee, I'm going to say, two years.

Erin O'Rourke: Great. Thank you. Jo Ann Brooks?

Jo Ann Brooks: Hi, my name is Jo Ann Brooks. I'm the system vice president for Safety and Quality at Indiana University Health in Indianapolis. And I guess this is my second term on the committee.

Erin O'Rourke: Mae Centeno?

Mae Centeno: Hi, this is Mae Centeno. I'm the vice president for Chronic Care Continuum for the Baylor Scott & White Health-North Texas Division. And this is my second year in this committee.

Erin O'Rourke: Helen Chen?

Helen Chen: Hi, Helen Chen. I'm the chief medical officer for Hebrew SeniorLife in Boston. And this is my second year on this committee.

Erin O'Rourke: Ross Edmundson?

Ross Edmundson: Yes, I'm Ross Edmundson. I'm V.P. medical director and chief medical officer in the Adventist Health System. And, I've been on the committee for about two years. And I'm actually just have a new responsibility as a chief medical officer in one of the affiliated hospitals outside the Orlando-area called Waterman.

Erin O'Rourke: William Wesley Fields?

Steven Fishbane? Paula Foltz?

Paula Minton Foltz: Yes. Good morning, this is Paula Minton Foltz. And I am the assistant administrator for Patient Care Services at Harborview Medical Center and the lead for UW Medicine on readmissions. I'm also – I was on the original readmissions NQF task force and this is my second year on this particular appointment.

Erin O'Rourke: Brian Foy?

Brian Foy: Hello everyone. My name is Brian Foy. I'm the vice president of Product Development at Q-Centrix. And I'm total neophyte to this committee and frankly on all of NQF committees. So, be gentle on me, please.

Erin O'Rourke: Laurent Glance?

Laurent Glance: Hi. This is Laurent Glance. I've been on this committee since the beginning. I'm at the University of Rochester where I am professor and vice-chair of the Department of Anesthesiology. I also have a secondary appointment at RAND Health.

Erin O'Rourke: Anthony Grigonis?

Anthony Grigonis: Hi, this is Tony Grigonis. I'm vice president of Quality and Healthcare Analytics at a large post-acute care corporation, Select Medical, which has over 100 long-term acute care hospitals and inpatient, rehab hospitals and outpatient centers. And this is my second term. And I'm looking forward to participating again.

Erin O'Rourke: Bruce Hall?

Bruce Hall: Hi. Bruce Hall. I'm – it's been my pleasure to co-lead this committee so far with Sherrie and I was on the – also on the original Admissions and Readmissions Committee and I've been on this committee since this committee was constituted.

And, while I appreciate the thanks from the others that have already been expressed, I'd like to express also on behalf of Sherrie, I don't know if she's on the call but certainly Sherrie and I have really appreciated the privilege of leading discussions and appreciate the thoughtfulness and diligence of everyone who has contributed to this group.

Erin O'Rourke: Leslie Hall was not able to join us today. Paul Heidenreich?

Paul Heidenreich: Hello, this is Paul Heidenreich. I'm professor and a vice-chair for Quality in the Department of Medicine at Stanford University School of Medicine. And this is my second term on the committee.

Erin O'Rourke: Karen Joynt?

Karen Joynt: Hi, this is Karen Joynt. I'm a cardiologist and professor at Harvard Medical School and the Harvard School of Public Health. I'm actually on-leave right now from this position, working down in D.C. at HHS specifically in AFI, in the Office of Health Policy in the section of quality and outcome.

Erin O'Rourke: Sherrie Kaplan? Keith Lind?

Keith Lind: Yes, I'm Keith Lind, Senior Policy Advisor with AARP's Public Policy Institute, and I cover a lot of variety of Medicare issues.

Erin O'Rourke: Paulette Niewczyk? Carol Raphael?

Carol Raphael: Hi. I've been on the committee for two years. And I was the CEO of the Visiting Nurse Service of New York for over 20 years.

Erin O'Rourke: Pamela Roberts?

Pamela Roberts: I'm the director of Physical Medicine and Rehabilitation at Cedars-Sinai Medical Center in Los Angeles, California. And this is my second year on the committee.

Erin O'Rourke: Derek Robinson?

Derek Robinson: Good afternoon, this is Derek Robinson. I'm vice president for Quality and Accreditation at Health Care Service Corporation with is a five-state Blue Cross Blue Shield plan based in the Chicago area and emergency medicine physician by training.

Erin O'Rourke: And Thomas Smith?

Tom, we're able to see you on the webinar.

Thomas Smith: Oops, sorry, I was muted. Thomas Smith, psychiatrist on the faculty of Columbia University Medical Center. And I am the medical director for the New York State Office of Mental Health Division of Managed Care.

Erin O'Rourke: Great. Thank you, everyone. Go into the next slide.

I'll give you a quick overview of our agenda today, this will be a bit of a refresher for most of you. On this call, we plan to give you an overview of the National Quality Forum, the Consensus Development Process or the CDP, and our current portfolio of Admissions and Readmissions Measures. We'll also go over the major project activities and the timeline. Orient you to the roles of the committee, the co-chairs, and NQF staff. We'll present a high-level introduction to our Measure Evaluation Criteria. Then, we'll give you an update about our ongoing SDS trial period and the special role of the Admissions and Readmissions Committee has been playing in this work.

And then finally, we'll show you where and how to access the information that you'll need for the project and discuss our next steps.

So established in 1999, NQF is a non-profit, non-partisan, membership-based organization that is recognized and funded in part by Congress, and entrusted with the important public service responsibility of bringing together various

public and private stakeholder organizations to reach consensus on how to measure quality and health care as the nation works to make it better, safer and more affordable.

We like to stress that NQF is a forum. We have about 430 organizational memberships. Our membership is diverse and includes hospitals and medical groups, health plans, physician societies and nursing organizations, purchasers, patients and consumers, public and community health agencies, local and state-based agencies and health organizations, biopharmaceutical research companies, medical devices companies and federal agency partners.

We have more than 800 expert volunteers collaborate in our processes annually. And we like to stress transparency in everything that we do. Everything is open to member participation and all materials are accessible on our website.

Next slide.

So, NQF undertakes activities in a number of key quality measurement areas. First is the work that we do to endorse performance measures. If we use an eight-step process that typically requires 9 to 12 months to complete.

Measures must meet NQF standard evaluation criteria that is, they must be important to measure and report. The measure property must be scientifically acceptable. Measures must be feasible. They must demonstrate usability and use. And finally, we consider competing or related measures.

As you are aware, we've switched to having 11 empanelled standing expert committees to allow greater continuity in our work and to reduce some of the timelines to complete our projects.

In addition to you all as the Admissions and Readmissions Standing Committee, we have other groups in behavioral health, cardiovascular, care coordination, cost and resource use, endocrine, head, ears, eyes, nose and throat, health and well-being, muscular skeletal, patient- and family-centered care, renal safety and surgery.

Next, NQF provides input on the selection of measure through the Measure Applications Partnership, aka the MAP.

NQF is created the MAP in response to the Affordable Care Act in 2010. MAP convenes public and private sector organizations with a stake in measure improvement for federal health programs. MAP provides input to HHS annually on the selection of measures for public reporting, performance based-payment and other federal quality initiative programs.

MAP works to encourage alignment across public program and between the public and private sector. MAP has also provided feedback on Medicare program, core measures sets for adults and children in Medicaid, health insurance exchanges, and dual eligible beneficiary. And MAP currently involves about 150 individuals and 90 different organizations.

Additionally, NQF convenes stakeholders around critical health and health care topics through the National Quality Partners Action Teams.

And finally, NQF convenes public and private sector leaders to reach consensus on complex issues and health care performance measurement such as attribution, alignment and sociodemographic status, aka SDS adjustment.

NQF endorses performance measures through an eight-step consensus development process. We first do a call for nominations for the Standing Committee as well as a call for candidate standards, measures that is.

We then turn it over to you all really for the hard work of reviewing those candidate consensus standards and making an initial recommendation about whether or not they should receive NQF endorsement.

After the Standing Committee meets and makes its recommendations, we put them out for a public and member comment period, as well as an NQF member voting period.

The Consensus Standards Approval Committee then reviews and ratifies the Standing Committee's decision and it turns it to the Board of Directors for ratification. Finally, there is an appeals period following the Board's decision.

So, we did want to provide you a little bit more information about how NQF makes recommendations on the selection of measures. In pursuit of the National Quality Strategy, the Measure Applications Partnership works to inform the selection of measures to achieve the goal of improvement, transparency, and value for all.

Mainly, MAP does this through its annual pre-rulemaking process. Each year, HHS send over a list of measures that they are considering implementing in their various pay for performance and pay for reporting program. And the MAP goes through those measures and makes a recommendation about whether it would support the use each one in the program.

Additionally, MAP works to identify gaps for measure development, testing, and endorsement. And encourages measurement alignment across public and private sector programs, settings, levels of analysis, and population to help promote the coordination of care delivery and reduce the collection – the data collection burden that measurement can entail on providers.

Next slide.

So, something new for this cycle is that we are really trying to better integrate the CDP and MAP processes, recognizing that these two processes are really intertwined and need to build on each other to ensure optimal outcomes for both. This is something that perhaps has been a bit broken in the past. So, staff will be actively working to bring the Standing Committee information about what MAP has recommended, particularly around measures of admissions and readmissions.

I will also be feeding back the decisions that this committee makes around measure endorsement to the MAP for them to consider when they're reviewing measures for possible use in federal programs.

Next slide.

So, we wanted to give you a very high-level overview of the current portfolio of NQF-endorsed measures relating to admissions and readmissions.

I won't go through this in detail but we do have a fairly rich portfolio covering a wide variety of settings and disease areas. I will just quickly go through so that you can see them, but we'll leave it to you to study them on your own.

So, on this slide, you can see some of the measures that MAP has recently considered related to admissions and readmissions. We wanted to bring this to the Standing Committee to help keep you informed of what's going on about potential use of admissions and readmissions measures as well as measures that are still in the development process that may be coming to this committee for measure endorsement in future years.

So I think with that, I will turn it over to Zehra to review our roles.

Zehra Shahab: Thanks, Erin. So, I'm going to give you a quick overview of the role of the Standing Committee, you all, the co-chairs and staff.

So, some general responsibilities, the Standing Committee acts as a proxy for the NQF multi-stakeholder membership. They serve a term of either two or three year terms. You all work with NQF staff to achieve the goals and action items of the project. You also evaluate measures against the measure evaluation criteria as we will delve into that a little bit later and describe to you the criteria.

You help us respond the comments that are submitted during the review period, the pre-meeting and the post-comment call, and then, respond to any directions from the CSAC.

So on the next slide, here are the role of the Standing Committee co-chairs. The co-chairs help facilitate the Standing Committee meeting. They work with NQF staff to achieve the goals of the project. And they assist us in anticipating any questions that either the Standing Committee or developers or members of the public may have and help identify information that may be useful to share with the Standing Committee.

They help keep Standing Committee on track to meet the goals, both at the in-person meeting and the web meeting. And they represent the Standing

Committee at the CSAC meetings, and also participate as Standing Committee members and Standing Committee voting members.

OK, so, NQF staff. What do we do? We want to be there to help you achieve these goals. So, we're going to be working with you side by side, also behind the scenes to achieve the goals of the project.

We will organize meetings and the conference calls. We'll help guide you through the NQF policy and procedures. We do – we take the first draft of the report and we draft and edit them and sent them to you for your review and put them out for public and member comment. And we make sure that there's communication among all the committee members, the developers, members of the public, NQF staff.

We also facilitate any communication between projects at NQF. So, for example, if there's something that happens at the attribution project and the readmissions project, we make sure that it's coordinated and both the staff and the committees know the work that is – the results of one of the – either of the committees.

In addition, some communication roles that I was just describing are, we will to respond to NQF member and pubic questions, e-mails, comments. We will maintain the – all of the documents for the project. And we make sure that we post everything to the NQF website as Erin was referring to earlier. We want to be as transparent as possible. So, we put everything on our NQF website.

Additionally, NQF staff work with measure developers to provide any necessary information and communication, especially since we are also – we have the SDS webinars, which we'll describe a little bit later. We are working constantly with developers to make sure that the Standing Committee knows what the developers are working on and vice versa.
And finally, we help publish the final report.

So, this slide is going to show you some activities and timeline. The first meeting is the orientation call, and that's kicking off this year's activities.

Upcoming, we will have the SDS webinar, that's on March 8. And, then, we will have a Q&A call which we will review the criteria and a potential measure before we do the actual measure evaluation during the in-person meeting.

We will have another SDS webinar as well and we'll describe this a little bit more later in our presentation. And, we will have a post-meeting follow-up call which is after the in-person meeting. This could be – if we don't finish reviewing all of the measures at the in-person meeting, then we may use that for that. And, then there's also be a post-draft report call which will be after the draft report goes out for public and member comment, we will meet with you, the Standing Committees, on a webinar to review the comments and respond to them.

So, with that, I would like to turn it over to Taroon for an overview of the measure evaluation criteria.

Taroon Amin: Thank you very much, Zehra. So, I – this may be, obviously, a review for many of you on the call but for those newer members of the Admissions and Readmissions Committee, we wanted to review the Measure Evaluation Criteria which are the standard evaluation criteria that we use to evaluate candidate measures that are considered for endorsement.

The most recent guidance was established in 2011. And the criteria really haven't changed, but the guidance on how to evaluate the measures against the criteria has changed, particularly raising the rigor of the evaluation process. Because many measures have been previously endorsed, it does not automatically mean that they will be continued to meet endorsement on the new endorsement criteria.

So, NQF endorses measures for accountability applications particularly public reporting, payment applications, accreditation as well as quality improvement.

We use standardized evaluation criteria and those criteria have evolved overtime based on multi-stakeholder feedback.

The quality measurement enterprise is constantly growing and evolving with greater experience and lessons learned, which you can see reflected in the Measure Evaluation Criteria.

The major evaluation endorsement criteria follow a hierarchy, and we've included the page numbers here, each of these slides that you can reference that to the committee guidebook, where additional information is presented on each of this criteria to help you as you start to look at this as we have an individual measures that are submitted for endorsement.

The first is the importance to measure and report. The goal is that measures should measure all aspects, greatest aspects of potential of driving improvement for quality. And the other criteria are little less meaningful in the sense that – well, the other criteria are a little less as important as the importance to measure criteria.

The second is to look at the reliability and validity of measures particularly the scientific acceptability of measure properties. With the goal of being able to make valid predictions and conclusions about quality, if a measure is not reliable and valid, there is serious risk of improper interpretation.

Additionally, there's the feasibility criterion which is to cause as little burden as possible in terms of measurement. And then finally, consider the measure usability and use. The goal is to be able to use these measures for decisions related to accountability and improvement. And then finally looking at related and competing measures.

So, first, looking at the importance to measure and report criteria, we evaluate the extent to which a measure focus is evidence-based, and whether or not they achieve goals of the health care system.

In particular, what we're looking for, because many of these measures are outcome measures, is the rationale of how those being measured can actually improve the outcomes – improve the outcome that's being measured.

There's subcriterion of evidence, outcome measures as just I described, what we're really looking for here is a rationale for how the outcome can be

influenced by health care process or structure. If we're looking at measures that are more process or intermediate outcome measures, there's a more thorough evaluation of the quality, quantity and consistency of the body of evidence underlying the measure construct.

On the next slide, what you'll see is a detailed algorithm which you'll find also for the scientific evaluation process.

And while I won't go into the tremendous detail, you'll see that the algorithm here really focuses on the top green boxes, which is the health outcome really being able to demonstrate that there is something that the health care process or health care system can do to influence the outcome of interest, which, in our case, would be readmissions and admissions measures.

So, again, I won't go into as much detail here because for new measures, we're looking at the evidence. But, again, there's a little bit of – this is really more focused on process measures not really something.

So, on the next slide.

Yes. So, here, with maintenance measures, there's a little bit of a decrease emphasis on the quantity, quality and consistency evaluation process for process measures. But this is a little bit less of a focus for the measures that are under evaluation, the (PDPs), since we're looking at both the outcome measures.

Secondly, we're looking at the gap, whether there's an opportunity for improvement variation or quality of care across providers. And here, we're really looking for an increased emphasis for measure maintenance for measures that are currently under maintenance or currently endorsed measures, to be able to demonstrate data on current performance, gap in care and variation.

Secondly, the second major criteria is the evaluation of the reliability and validity, particularly the scientific acceptability of the measure properties. So here, we're looking to assess the extent to which the measure specified

produces consistent and credible results about the quality of health care delivered.

So here, we're looking at two main constructive reliability, and how we look at reliability to ensure that there's precise specification. And there's reliability testing at the data element level or the measure score level.

For validity, we're looking at whether the specifications are consistent with the evidence, the extent of the validity testing, the justification of exclusion, the risk adjustment approach, and then whether the measure is able to identify differences in performance and comparability of data sources, if there is multiple methods specified in the measure.

Moving to the next slide, when we're looking at reliability and validity, we want to make – just reaffirm our concepts here to make sure that the center of this score is the true score, if that's the true – the true indicator of quality.

It could be reliable indicators, which are all like sort of – you see in a blue dot here or on the top right of the circles. And – but they're not really getting to our center true score. So, they're consistent but they're potentially wrong.

Another potential threat here is that it's neither reliable or valid in which you'll see that there's – the blue score or the blue dots are inconsistently across the blue – the circles here and it's not actually hitting our true north here.

And then finally, what we're looking for is to assess the reliability and validity to ensure that it's consistent and correct in terms of assessments of provider performance.

Some key points for regarding measure testing, empirical evidence demonstrate the extent at which the measure is reliable and valid, as specified and whether there's the – any of the – there's any pose threat to the validity of the conclusions of quality care.

And again, we sort of pointed out the major elements of what we're looking at in terms of both reliability and validity, including exclusion, the risk adjustment approach as such.

So, some key points about reliability testing. So, again, just to reiterating here that the reliability of the measure score refers to the proportion of variation of the measure scores that are true differences across measured entities in relation to the random noise or variation.

So an example of statistical testing that can be use here is looking at the signal-to-noise. If we're looking at the reliability of the underlying data elements, we're assessing whether there's repeatability or reproducibility of the underlying data elements that are being used to generate the measure, for example, inter-rater reliability.

And so what we ask is for you to consider whether the test that is used is appropriate, and include an adequate representation of providers and patients.

So, when you look at the next algorithm here, again, this is a way that we sort of walk you through an approach of how to actually look at the reliability of the proposed measures, to look at whether there is differences in terms of how the measure is actually tested, whether if it's at measure data element level or if it's at the measures score level.

And so again, I encourage you to take a look at this algorithm as you're preparing for evaluation measures, it won't get to the meeting.

And finally, I'll sort of touch on some key points as it relates to validity testing. And, so that could be empirical testing or face validity testing. Empirical testing would allow measure – either testing at the measure score level in which assesses whether there's a hypothesized relationship between the measures result to some other concept that we believe would assess the correctness of conclusions about quality.

Additionally, there could be a validity assessment of the data elements and whether there's an assessed correctness of the underlying data elements compared to a gold standard.

And finally, face validity is also an acceptable standard for validity testing for measures that are submitted.

And so again, just pointing out the algorithm that's provided here on page 52, that really walks you through this step by step.

So there is some threat to validity. There might be conceptual threat, meaning the measure's focus is not relevant – is not a relevant outcome of health care or it's not strongly linked to a relevant outcome. But generally can be – the measure could be unreliable. The patients can be inappropriately excluded for measurement. And there may be differences in patient mix or across the various outcome measures.

And finally, there also could be differences in the underlying data source which may result in differences in the measure score, which is not actually true differences in the measure score.

So, finally again, when we look at the updated maintenance process, there aren't – there are just two main areas that we wanted to focus. The first is to identify that – for measures that – we want to make sure for measures that are specified that are new, that they are precise with all of the information needed to implement the measure.

And there's really no difference there in terms of the maintenance measures. And then, for new measures, we want to assess the reliability and the validity. And there's a decreased emphasis here since, if there's prior testing is adequate, no additional testing at maintenance is required.

And so finally, I will just point out the two additional criteria looking at the feasibility to the extent in which the required data elements are readily available and retrievable without undue burden. And so, what we're looking for here is whether the data elements or the clinical data elements are generated during the care process, whether the required data elements are available in electronic health records or other electronic sources, and whether the demonstration of the data collection strategy, the source timing frequency, can be actually implemented.

So finally, the criteria four that we'll point out here is the usability and use criteria. And, so here, we're looking at the extent to which potential

audiences, consumers, purchasers, providers, and policymakers are using or can use the performance results in both accountability. And I just want to stress both accountability and performance improvement.

And this is assessed in three different elements, particularly accountability and transparency results are within one accountability application within three years, whether there's demonstrated progress or achieving high-quality, efficient health care and whether the benefits outweigh the harms.

And so again, with the update and maintenance process, there is no difference in the feasibility evaluation for use and usability. There is an increased emphasis on ensuring there's a greater focus on measure use and the usefulness both in term of impact and unintended consequences.

So, finally, I'll just point out that we'll look at also the related and competing measures to ensure the – whether the measure is – if there are any other measures that have the same measure focus or target population. And if so, evaluating whether or not the measures are harmonized to the extent possible.

And finally, just want to point out as part of the evaluation process and enhancement, there will be a preliminary analysis done by staff to assist the committee in the evaluation of each of the measure against these criteria. And staff will present and prepare a preliminary analysis of the measure submission.

This should be used as a starting point or a guide for the committee, but not intended to limit the score cycle of the evaluation of the committee.

Second, where we asking folks on the committee to do an individual evaluation of the measures. But they will also be asked to take the lead in terms of individual evaluation assignment on a subset of measures for an in-depth evaluation for the benefit of the entire committee.

You know, just also, finally, point out here the measure evaluation and recommendations at the in-person committee meeting. The entire committee will discuss and rate each of the measures against the criteria and make a recommendation for endorsement.

So, I know I covered quite a bit there, but I'll turn it over to Erin to discuss the SDS trial period. And certainly, we welcome questions at the later part of the orientation. Erin?

Erin O'Rourke: Thanks, Taroon. Also maybe we should just pause for a few minutes here to see if anyone has question since that was a lot to go through.

Operator, could you make sure the committee members have open lines for question?

Operator: All committee members' lines are open.

Erin O'Rourke: Great, great. Thank you.

So, if there's no questions, I can go ahead with the SDS trial period overview, and we can pause again after that and see if there's any thoughts before we wrap up.

To give you a bit of background, NQF convened an expert panel to consider if and when, and how outcome performance measures should be adjusted for socioeconomic status and other demographic factors, what we've been referring to as SDS.

There are at least two diverging perspectives on adjusting measures for sociodemographic factors. Some feel that adjusting the measures for SDS factors will mask disparities. However, others feel it is necessary to avoid making incorrect inferences in the context of comparative performance measurement.

The expert panel recommended, and the NQF Board approved, a two-year trial period during which we'll be lifting the former prohibition on adjusting measures for these SDS factors, and they can be considered in the risk adjustment models when measures are reviewed for NQF endorsement.

Each measure must be assessed individually to determine if it should be adjusted for SDS factors. It's important to note that not all outcome measures should be adjusted for these factors. For example, a measure on central line

infection would not need to be adjusted. There needs to be a conceptual basis, that is the logical rationale or theory as well as empirical evidence on the impacts of SDS factors on the outcome being measured.

And efforts to implement SDS adjustment may be constrained by current data limitations and data collection burden.

So all measures submitted to NQF after April 15th, 2015 will be considered part of the trial period, and the Standing Committee may consider whether such measures are appropriately risk adjusted for SDS factors as part of their evaluation of the measure for endorsement.

This includes newly-submitted measures, previously-endorsed measures that are undergoing maintenance review. Measures with conditional endorsement, for example, the ones that the Admissions and Readmissions Standing Committee has been involved in reviewing, but we'll cover that a bit later in the program, as well as some of the cost and resource use measures that were recently endorsed as well as measures undergoing in ad hoc review.

So, 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 clinical and sociodemographic factors used in the risk adjustment model.

NQF staff will complete a preliminary analyses of each measure submitted for the project as Taroon mentioned. And we will identify areas where the committee should focus to ensure that the requirements of the NQF SDS trial period have been met.

When reviewing a measure, the Standing Committee is asked to consider if there are conceptual relationship between the SDS factor and the measure focus, what patient level SDS variables were available and analyzed during measure development. Does the empirical analysis show that the SDS factor has a significant and unique effect on the outcome of the measure? And

finally, does the reliability and validity testing match the final measure specifications?

Next slide.

So we wanted to give you a bit more clarity about what we mean by a conceptual description, essentially, the measure developer must provide a description that is a logical rationale or theory informed by the literature and/or a content expert of the conceptual relationship between patient sociodemographic factor, patient clinical factor, quality of care and the measure focus.

The Standing Committee is asked to consider if there is a relationship between the SDS factor and the measure focus, if the SDS factor is present at the start of care, and if the SDS factor caused the care – is caused by the care being evaluated.

Next slide.

So the measure developers must describe what patient-level SDS variables were available and analyzed during measure development. The Standing Committee will be asked to consider how well the SDS variables that were available and analyzed align with the conceptual description provided. And are asked to consider if these variables are available and generally accessible for the measured patient population.

The Standing Committee will be asked to examine two sets of empirical analyses provided by the developer. First, the measure developer must provide the analyses and interpretation of the importance of the SDS variables in their risk adjustment model.

These analyses may include variation in problems of the SDS variables across the measured entities, empirical association of the SDS factor with the outcome. Contribution of the SDS factor to unique variation and the outcome, typically to a multi-variable statistical model, and assessment of between-unit effects versus within unit effects to evaluate whether the effect is due to poor

quality, that is potential clustering of disadvantaged patients in lower quality units.

This type of analysis can help produce a better measure and help avoid incorrect inferences if there is concern that disadvantaged patients are cared for primarily by low quality providers. This is real fear of some stakeholders. Specifically, it can help distinguish if SDS is a proxy for poor quality or represent other patient characteristics that are not captured by other risk factors. If SDS is a proxy for poor quality, it should not be included in the risk adjustment approach. If SDS represents a measure severity, then it should be included.

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.

So, changing from a non-SDS adjusted risk adjustment model to one that is SDS adjusted, the measure developer should provide updated reliability and validity testing of the measure evidence currently being specified.

If a performance measure include SDS variable 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 development SDS variables.

And then finally, we wanted to give a bit of history for our new Standing Committee members of the Admissions and Readmissions Standing Committee has already been very involved in the work of the trial period to date.

During the last of review of admissions and readmissions measures for NQF endorsement, 17 were endorsed with the condition that they be reviewed for the need for SDS adjustment, because evaluation of these measures began and ended prior to the start of the trial period.

The Standing Committee was not able to consider SDS factors as part of the risk adjustment approach during their initial review. However, the NQF Board of Directors wanted to consider the potential impact on the outcomes of these measures, given the impending start of the trial period.

To meet this condition for endorsement, the Standing Committee met in January 2015 and determined that 16 of the measures had a potential conceptual rationale for SDS adjustment and should enter the trial period.

The Standing Committee meet again in September to review what SDS factors and variables developers plan to test in the empirical analysis of the risk adjustment model.

And as they are noted, we have two upcoming web meetings in March and May 2016, where we'll be asking you to review the empirical analysis and make a recommendation about the continuing endorsement of the measures.

Following that, the CSAC and Board will review the Standing Committee's recommendations, and there will be an appeals period following the Board's decision.

Next slide.

So with that, happy to take any questions on anything we've covered so far.

If not, please feel free to e-mail us individually or if anything comes up afterwards. Otherwise, I'll turn to Severa to give you a brief demonstration of the SharePoint site that you'll be using to get information for the project.

Severa Chavez: Thank you, Erin. So, I'm going to actually screen share our actual SharePoint page for the committee. Just bear with me until I get that page set up.

So what you should be seeing on your screen now is the landing page for the all-cause admissions and readmissions SharePoint page. And as Erin mentioned earlier, SharePoint is how we share information with the committee members.

So, as an overview – actually, let me stop and remind everybody that for the news – for our three new members, you should have received your IMS log-ins about two weeks ago. So you will be using that user name and password that came with that e-mail to access this page. If you haven't, please e-mail the team, let us know and so we can forward that information.

And for our existing committee members, you should be – you will be using the same user name and password that you've been using in the past.

So, as an overview, here is the landing page and under committee home, you would get these three document libraries as we call them. Our documents are separated by general documents, measure documents and meeting and call documents.

And focusing on the left side part of the page, we also have the committee calendar. And by clicking on it, you will see all our upcoming meetings and as was mentioned earlier, you will see here the upcoming SDS webinars and our webinar that is happening in April.

So, under committee links, we have our project page link and then we will also be adding meeting playbacks there in the future such as a recording of this orientation call.

Under committee roster, we have everyone's name and information. If you'd like to get in touch with one of the committee members, all of these are available in this page. And to get in touch with staff, we have all our information here as well.

And so going back to the landing page, under general documents is where we post mainly the roster and this is where you'll find the Standing Committee guidebook and the Standing Committee policy document.

We may be adding some resources, some information that the other committee members or the staff may wish to share with the committee at a later date.

Under the measure documents, please pay attention to the plus sign. So, right now, we don't have any measure documents yet for this phase, but you will

see that all the measures for phase one are here, separated by sub-topic categories.

Before our April Q&A call, we should have the preliminary analysis documents as mentioned earlier as part of our evaluation process. We would have measure folders here with measure worksheets in each of them.

And under meeting and call documents, most of you are quite probably familiar with this already. We have our documents in individual meeting folders, such as today's meeting. By clicking on the plus sign again, you will see that we have the agenda and the presentation slides.

We will add here later the transcript for this call. And just for background information, if you'd like to review the materials for the first SDS webinar back in September, they're here as well.

So, I'll stop there and see if you have any questions.

And again, as a reminder, we would be sending you an e-mail every time we post new documents on the page.

OK. If we have no – there are no questions, I'll pass it on to Zehra for next steps.

Zehra Shahab: Thank you, Severa. So, quickly, I'm going to remind everyone of the upcoming dates for the meetings which is the SDS webinar coming up in March 8. I will be sending out the materials about a week in advance through the committee members, so you will have time to review them before the webinar.

And as Erin was describing earlier, you will review the empirical analysis portion of that on this webinar. But we will also provide you with the conceptual analysis information that was provided from the developers and as Severa was just showing you already on your SharePoint page. So, we'll make sure you have those pieces of information for this webinar.

Additionally, we have a Q&A call in April, April 27th. And then we will have the second webinar. So the reason – just to remind the existing Standing Committee members and let the new ones know, the reason we have two separate webinars is because we couldn't cover all 16 measures on one webinar. So the measures are broken up.

There is about six measures in webinar two and nine measures on webinar three.

So – and then finally, we will have – not finally, but next, we'll have the in-person meeting which will be two days in Washington, D.C., and this is scheduled for June 8th and 9th. And please plan for it to be almost all day both days since we will be reviewing several measures. And you will receive travel logistics information from the meeting's department about a month in advance. So, please look for that early May. They will send that out to you and that's how you can book your flight and let them know if you need a hotel room as well.

And then after the in-person meeting, we will have the post-meeting follow-up call that I was mentioning. And this, we will review any remaining measures that we have, and that will be June 21st and then we will have the post-draft report call after we've written the draft report and it is put out for public and member comment. We will have a call to review those comments in October.

So, on the next slide, you will see our e-mails, the e-mail is readmissions@qualityforum.org. Pretty easy to remember. And I'm going to be the main point of contact. So you can just e-mail me and then you can also e-mail the readmissions mailbox and I'll be happy to answer any questions. You can also call us at the NQF number listed.

There is a link to the project page, which – where we will be posting all of the information for materials for the committee and then also for the developers and public and any individual (who's) like have access to it.

And the SharePoint site that Severa just showed you is reserved for committee members. So, you all can click on that link and you will go directly to the

Admissions and Readmissions SharePoint where we will also have the materials there.

And with that, I will ask once again for questions. We did review a lot of material on this call, so I want to make sure – first, I want to give the committee members an opportunity to ask any questions they may have about anything that we reviewed today or even if it's not, something we've reviewed today.

I don't think I'm hearing any questions. I did want to also open it up for anyone else who joined the call. Operator, can you see if anyone who would like make a comment or have any questions for us, whether it's a developer or any member of the public?

(Nan), can you please open up the lines?

Operator: Thank you. At this time, if you have a question or a comment, please press star then the number one on your telephone keypad. We'll pause for just a moment.

And there are no questions or comments at this time.

Zehra Shahab: OK. Thank you, (Nan).

So, it looks like we covered two hours worth of material in an hour and not hearing any question. I just wanted to thank everyone for joining the call.

We are really excited and we look forward to continuing this work and we're looking forward to getting to know you all further.

With that, I just wanted to see if any of my team members would like to say anything or Cristie would like to add anything as well.

Erin O'Rourke: No, thanks, Zehra. Again, a special welcome to our three new members and to our new co-chairs, and a special thank you to Sherrie and Bruce for all their service and leadership over the years, and we're looking forward to convening again in March for the SDS empirical analysis review webinar.

Cristie Upshaw Travis: And this is Cristie, I want to thank everybody. And I'm sure that a lot of the information that we have just been provided will become even more real to us as we actually begin our work.

So, please don't hesitate if something you heard today kind of comes back to you as we start our work and you'd like some clarification or additional information because that's when we'll see how it really works and where we may have some additional needs. And thank you all for joining the call today.

Zehra Shahab: Thank you, Cristie. One additional thing I will add is, I would encourage everyone to review the Standing Committee guidebook if you have any questions and then also just reach out to any of us, we'll be happy to set up a conversation, a call or an e-mail. We'll definitely be happy to set that up and provide any additional clarification. Thank you, everyone. Bye-bye.

Female: Bye.

END