NATIONAL QUALITY FORUM
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Meeting Summary

All-Cause Admissions & Readmissions Renal Technical Expert Panel (TEP) Call

The National Quality Forum (NQF) convened a public web meeting for the All-Cause Admissions & Readmissions Renal Technical Expert Panel (TEP) Call on April 30, 2020.

Welcome, Introductions, and Review of Web Meeting Objectives

Matthew Pickering, NQF Senior Director, began by welcoming participants to the web meeting. Dr. Pickering provided opening remarks and reviewed the following meeting objective:

- Discuss the Renal TEP responses to the Input Forms for the following Spring 2020 measures:
  - Standardized Hospitalization Ratio (SHR) for Dialysis Facilities (1463)
  - Standardized Readmission Ratio (SRR) for Dialysis Facilities (2496)
  - Standardized Emergency Department Encounter Ratio (SEDR) for Dialysis Facilities (3565)
  - Standardized Ratio of Emergency Department Encounters Occurring Within 30 Days of Hospital Discharge (ED30) for Dialysis Facilities (3566)

Apryl Clark, Acting Vice President, Quality Measurement, conducted a roll call of the Renal TEP members and requested each member to disclose any conflicts of interest. None of the TEP members had disclosures that prohibited them from participating. Prior to the meeting, each member completed a TEP Input Form that had several questions focused on the clinical aspects of the measure. Dr. Pickering facilitated the TEP's discussions of the renal measures based on the responses from the TEP Input Forms. Dr. Pickering iterated that the purpose of the TEP was to gather input for the All-Cause Admissions & Readmissions Standing Committee measure endorsement evaluations and that consensus from the TEP on the Input Form responses is not needed. Below is the summary of those discussions for each measure. The developer, University of Michigan Kidney Epidemiology and Cost Center, was on the call and responded to questions, as needed.

Standardized Hospitalization Ratio (SHR) for Dialysis Facilities (1463)

The TEP members agreed that evidence shows interventions can be performed by dialysis facilities that can impact hospitalizations. However, some members believe more information is needed on the impact of these interventions on the measure itself and that there should be a distinction between expected and unexpected hospitalizations. Some TEP members had concerns regarding the measure attribution, stating that not all causes of hospitalization are due to dialysis care. The TEP questioned how hospitalizations for this measure were defined, specifically if they exclude observation stays. The developer responded and confirmed that this measure does exclude observation stays. With respect to validity testing, the TEP agreed that the magnitudes and directions of the correlations were clinically appropriate with dialysis care but may be disrupted as new innovations in dialysis care are introduced.

TEP members asked how the case mix of a facility is captured without requiring index hospitalization to be eligible. The developer stated that they risk-adjusted for comorbidity across the population by using 2017-18 incident comorbidity data, as well as an indicator variable in their modeling to adjust for the

proportion of Medicare Advantage patients in the facility. TEP members expressed concerns about the developer not including SDS factors (e.g., race, ethnicity, geographic location). Apryl Clark stated that NQF is gathering data to prepare future policies on social risk adjustments for quality measures.

Standardized Readmission Ratio (SRR) for Dialysis Facilities (2496)

Some TEP members agreed that the evidence shows interventions can be performed by dialysis facilities that can impact hospitalizations. However, some TEP members expressed how hospitals tend to prematurely discharge renal patients, which might have a negative impact on dialysis facilities. A member raised the question of whether a sensitivity analysis was performed by developers to determine if overall readmission rates for various facilities differ from those involving dialysis related complications, as it might address issues around attribution. The developer mentioned that they did not conduct this analysis. One TEP member stated that there are differences in specialized patterns of care to serve more local facilities in rural areas in comparison to urban areas in various cities. In addition, some TEP members felt that some patients are unable to access services that would prevent them from readmission, beyond what is provided by the dialysis facility. Further, TEP members stated how there is a limited amount of days for care for certain treatments and access to certain treatments can be limited.

On the topic of measure specifications, some TEP members were concerned that the measure carries bias from its complexity, making it less actionable for the facilities to reproduce the results themselves. One member asked whether Medicare Advantage beneficiaries were included, as they account for a significant number of renal patients. The developer confirmed that Medicare Advantage patients were included.

With respect to validity testing, the TEP agreed that the magnitudes and directions of the correlations for were clinically appropriate with dialysis care, but the measure should consider excluding hospitalizations that are not dialysis-related. There was some discussion regarding risk-adjustment from the TEP. Since the measure uses inpatient claims, the TEP requested clarity on how the developer accounts for a facilities patient case mix when only comorbidities of inpatients are considered. The developer stated that only patients with a qualifying index hospitalization are being risk-adjusted and included in the denominator of the measure. The developer stated that the impact of limiting comorbidities for inpatient claims compared to all Medicare claims was very small and allowed for maintaining the inclusion of Medicare Advantage patients in the dialysis population. Lastly, the TEP members expressed similar concerns about not including SDS factors (e.g., race, ethnicity, geographic location).

Standardized Emergency Department Encounter Ratio (SEDR) for Dialysis Facilities (3565)

Some TEP members agreed that the evidence is strong in that there are interventions that can be performed by dialysis facilities that can impact emergency department (ED) visits. However, some TEP members expressed concerns regarding attribution, stating that not all ED visits are due to dialysis care and that the measure should distinguish what is dialysis-related.

There was some discussion regarding the measure specifications. Some TEP members asked whether Hemodialysis and Peritoneal dialysis patients were separated or combined for this measure, as they require different types of care. The developer stated that both are included as the measure is calculated at the facility level and includes all patients within the facility regardless of their modality. One TEP

member asked for clarity regarding the use of the $1200 figure. The developer stated that the $1200 is used in the measure as criteria to establish that the patient is a Medicare beneficiary, as it represents two weeks of Medicare dialysis claims. One member was concerned that not including ED visits that result in a hospitalization may lead to unintended consequences of hospitalizations, such as increased observation stays. The TEP recommended that the measure should not be viewed as a stand-alone measure, as there could be an incomplete understanding of the broad resource use by patients at a given facility. The developer stated that the measure identifies ED encounters as well as observation stays and is complementary to the SHR (discussed previously), which does not account for observation stays. The TEP asked if the measure accounts for urgent care encounters. The developer stated that urgent care encounters are not included.

Like the previous measures (1463 and 2496), the TEP agreed that the magnitudes and directions of the correlations for were clinically appropriate with dialysis care, but the measure should consider excluding ED visits that are not dialysis-related. One TEP member expressed concern regarding the reliability testing and that the measure differentiation is limited to about 6% of dialysis facilities. The TEP also expressed similar concerns about not including SDS factors (e.g., race, ethnicity, geographic location).

Standardized Ratio of Emergency Department Encounters Occurring Within 30 Days of Hospital Discharge (ED30) for Dialysis Facilities (3566)

With respect to evidence, one member commented that there was not enough evidence suggesting that there are interventions to reduce ED visits following a hospitalization. Some TEP members questioned which facility would be assigned the discharge if a patient were to switch facilities during hospitalization. The developer responded that the receiving facility would be assigned the discharge in their denominator for this measure for those 30 days. One TEP member questioned whether this was fair to the receiving facility. The developer stated that the rationale is this measure primarily concerns coordination of care in the post discharge period, further incentivizing facilities to make early contact with patients to identify points of care that can help reduce the ED 30-day readmission rate. The TEP expressed concern that one visit to the outpatient dialysis facility does not allow for meaningful impact on care to avoid a repeat ED visit. One member commented that the measure needs to exclude hospitalizations that are not dialysis-related.

There was concern that the measure could only determine differences in about 4% of dialysis facilities and that reliability should be carefully considered in addition to validity. Like the previous measures (1463, 2496, and 3565), the TEP had concerns about not including SDS factors (e.g., race, ethnicity, dual status, area deprivation). The TEP commented that the validity testing showed correlations that are clinically appropriate and consistent with dialysis care, but the determination of who gets counted in the measure is complex.

Public Comment

Oroma Igwe, NQF Project Manager, opened the web meeting to allow for public comment. One comment was received for measure 2496, which questioned what behavior the measure was attempting to change. The developer responded that they believed they discussed the evidence supporting the dialysis facilities role in their submitted documents and would reserve any further responses until the meeting summary is drafted from this meeting.

Next Steps

Ms. Igwe concluded the meeting stating that a meeting summary for the call would be shared with all members and the public. NQF staff will incorporate TEP feedback on the measures, which will be shared

with the All-Cause Admissions & Readmission Standing Committee in preparation for the Standing Committee's measure evaluation web meeting on June 22, 2020, 9:00am-5:00 pm ET.