NATIONAL QUALITY FORUM

Readmissions Off-Cycle Webinar #2

Feedback on the SES Annual Update for Readmissions Measures, Introduction to the Equity Program, SES Trial 2.0, and Attribution Project

February 6, 2018

Welcome

Agenda for the Call

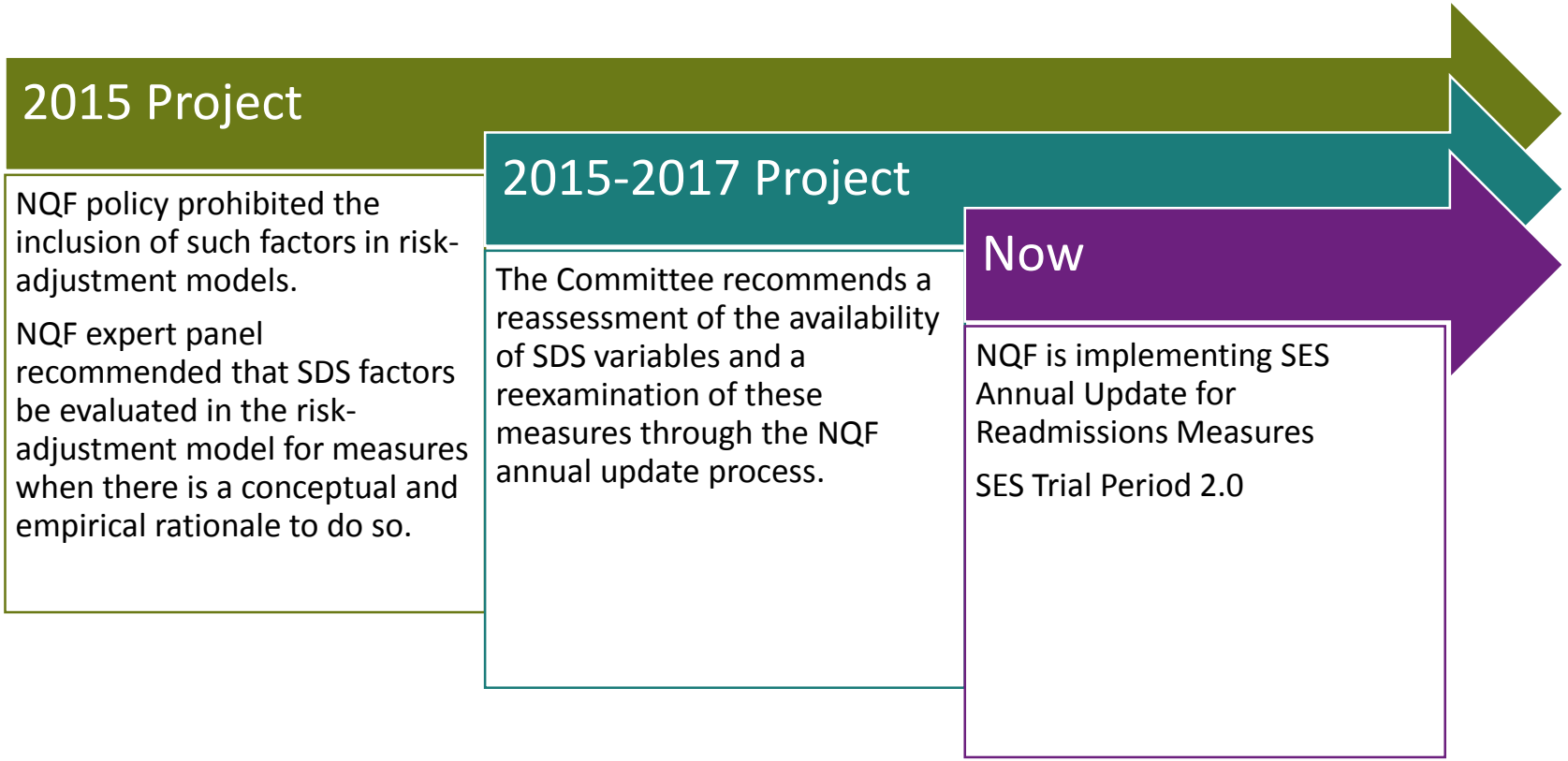
- Obtain feedback from the Readmissions Standing Committee regarding the SES annual update for readmissions measures
- Introduce NQF's Equity Program and SES Trial 2.0
- Obtain feedback from the Readmissions Standing Committee on ongoing NQF work related to attribution
- Public comment
- Next steps

Standing Committee

- John Bulger, DO, MBA *(co-chair)*
- Cristie Travis, MSHA *(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
- Susan Craft, RN
- 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 Maddox, MD, MPH
- Sherrie Kaplan, PhD
- Keith Lind, JD, MS, BSN
- Paulette Niewczyk, PhD, MPH
- Carol Raphael, MPA
- Mathew Reidhead, MA
- Pamela Roberts, PhD, MSHA, ORT/L, SCFES, FAOTA, CPHQ
- Derek Robinson, MD, MBA, FACEP, CHCQM
- Thomas Smith, MD, FAPA

Feedback on SES Annual Update for Readmissions Measures

Adjustment for Sociodemographic Factors



Readmissions Committee Discussion on Risk Adjustment

Due to potential impact of social risk factors on measure results, there is a need to ensure appropriate risk adjustment.

- Need to assess each measure **individually**
- Conceptual basis and empirical evidence to support inclusion
- Explore the use of community variables and characteristics

Recap of CSAC Decision from 2015-2017 Project

- On November 9, 2016, the CSAC voted on the measures endorsed with conditions in 2015:
  - The CSAC included a statement with the recommendations describing its concerns with endorsing the readmissions measures without risk adjustment for social risk factors.

> "At this time, the CSAC supports continued endorsement of the hospital readmission measures without SDS adjustment based on available measures and risk adjustors. The CSAC recognizes the complexity of the issue and that it is not resolved."

Recap of CSAC Decision from 2015-2017 Project

The CSAC recommended the following:

- SDS adjustor availability should be considered as part of the annual update process;
- NQF should focus efforts on the next generation of risk adjustment, including social risk as well as consideration of unmeasured clinical complexity;
- Given potential unintended effects of the readmission penalty program on patients, especially in safety net hospitals, the CSAC encourages MAP and the NQF Board to consider other approaches; and
- Directs the Disparities Standing Committee to address unresolved issues and concerns regarding risk-adjustment approaches, including potential for adjustment at the hospital and community levels.

Adjustment for Sociodemographic Factors in Readmissions Portfolio

- All 17 measures evaluated by the Committee in the 2015 project analyzed SES factors; one (2858) included a social risk factor in the final risk-adjustment model
- Each of the two measures evaluated by the Committee in the 2017 project analyzed SES factors, but one (3188) included a social risk factor in the final risk-adjustment model
- Measures with Adjustment for Social Risk:
  - 3188 30-Day Unplanned Readmissions for Cancer Patients
    - » Dual-Eligible Status
  - 2858 Discharge to Community
    - » Marital status

Phase	#	Measure Title	What were the SDS factors available and analyzed? Please list.
Phase 2	0171	Acute Care Hospitalization During the First 60 Days of Home Health	Race/ethnicity, disability status, rural location, and sex
Phase 2	0173	Emergency Department Use without Hospitalization During the First 60 Days of Home Health	Race/ethnicity, disability status, rural location, and sex
Phase 2	0330	Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following heart failure (HF) hospitalization	African-American race, dual-eligible status-i.e. enrolled in both Medicare and Medicaid, and AHRQ-validated SES index score
Phase 2	0506	Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization	African-American race, dual-eligible status-i.e. enrolled in both Medicare and Medicaid, and AHRQ-validated SES index score
Phase 2	1789	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	African-American race, dual-eligible status-i.e. enrolled in both Medicare and Medicaid, and AHRQ-validated SES index score
Phase 2	1891	Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following chronic obstructive pulmonary disease (COPD)	African-American race, dual-eligible status-i.e. enrolled in both Medicare and Medicaid, and AHRQ-validated SES index score
Phase 2	2860	Thirty-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF)	Medicaid status (dual status), original enrollment in Medicare for disability, unemployment, median household income of census tract, low educational attainment in census tract, race/ethnicity, limited English speaking households, and rural-urban community area (RUCA).
Phase 2	2879	Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data	African-American race, dual-eligible status-i.e. enrolled in both Medicare and Medicaid, and AHRQ-validated SES index score
Phase 2	2880	Excess days in acute care (EDAC) after hospitalization for heart failure	African-American race, dual-eligible status-i.e. enrolled in both Medicare and Medicaid, and AHRQ-validated SES index score
Phase 2	2881	Excess days in acute care (EDAC) after hospitalization for acute myocardial infarction (AMI)	African-American race, dual-eligible status-i.e. enrolled in both Medicare and Medicaid, and AHRQ-validated SES index score
Phase 2	2882	Excess days in acute care (EDAC) after hospitalization for pneumonia	African-American race, dual-eligible status-i.e. enrolled in both Medicare and Medicaid, and AHRQ-validated SES index score
Phase 2	2886	Risk-Standardized Acute Admission Rates for Patients with Heart Failure	African-American race, dual-eligible status-i.e. enrolled in both Medicare and Medicaid, and AHRQ-validated SES index score
Phase 2	2887	Risk-Standardized Acute Admission Rates for Patients with Diabetes	African-American race, dual-eligible status-i.e. enrolled in both Medicare and Medicaid, and AHRQ-validated SES index score
Phase 2	2888	Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions	African-American race, dual-eligible status-i.e. enrolled in both Medicare and Medicaid, and AHRQ-validated SES index score
Phase 3	2515	Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CA	Dual eligible status; African American race; AHRQ SES index
Phase 3	3188	30-Day Unplanned Readmissions for Cancer Patients (Phase 3)	The developers noted that there was a conceptual and empirical rationale for adjustment based on dual-eligibility status. Dual-eligibility can serve as a proxy for low income status and other measures of SDS. Several studies were referenced that note that low SDS factors are a risk factor for later-state cancer diagnosis, delayed health care receipt, and higher utilization of hospital-based care.

Overview of the Annual Update Process

What is annual update?

- Following the new or continued endorsement of a measure, NQF requires measure stewards to submit a status report of the measure specifications to NQF on an annual basis. NQF reviews annual updates on a quarterly schedule.

What is included in annual update?

- The report will either affirm that the measure specifications remain the same since the time of endorsement or last update, or outline changes/updates made to the endorsed measure

Annual Update Questions Related to SES Adjustment

- Was this measure endorsed with conditions based on the need for review under the NQF Trial Period or SES adjustment?
  - If so:
    - Have the conditions been met?
- Have any SES variables become available for analysis since the last time this measure has gone through the annual update process?
  - If so:
    - What are the variables?
      - What is the conceptual rationale for using the variable in adjustment?
    - What is the data source?
      - Are there any concerns regarding the data source?
    - What are the results of exploratory adjustment using the variable?
    - Is it recommended that the variable be included in the measure specifications?
      - Why or why not?

Committee Discussion

- Is there additional information NQF should ask for at the annual update?

Introduction to the Equity Program

NQF work on Health Equity, Disparities, and SDOH

Measure Selection and Endorsement	Measurement Frameworks	Principles and Best Practices	Implementation Guidance
▪ Healthcare Disparities & Cultural Competence ▪ Health and Well-being ▪ Prevention and Population Health ▪ MAP Adult and Child Core Sets ▪ Measure Prioritization	▪ Population Health ▪ Rural Health ▪ Home and Community-Based Services ▪ **Food Insecurity and Housing Instability** ▪ Cultural Competency	▪ Disparities-Sensitive Measure Criteria ▪ Guiding Principles for Culturally Competent Care ▪ Community Action Guide ▪ Risk Adjustment for Socioeconomic Status (SES)	▪ **Approach for Taking Action on Social Determinants of Health (SDOH)** ▪ Roadmap to Promote Health Equity and Eliminate Disparities

A Roadmap for Promoting Health Equity and Reducing Disparities

Identify
and Prioritize Reducing Health Disparities

Incentivize
the Reduction of Health Disparities and Achievement of Health Equity

Implement
Evidence-Based Interventions to Reduce Disparities

Invest
in the Development and Use of Health Equity Performance Measures

NQF's Health Equity Program

IDENTIFY disparities and at-risk populations

INFLUENCE performance measurement

INSPIRE implementation of best practices

INFORM payment

Identify Disparities and Those Affected by Health Inequity

NQF Will:

- Promote a common understanding and standardized language around health equity to address data and infrastructure challenges
- Gather innovative strategies for social risk factor data collection and use

Projects:

- Approaches to address data challenges
- Identification, showcase of innovative examples from the field
- SDOH measurement frameworks

Influence Performance Measurement

NQF Will:

- Facilitate development of needed measures to promote health equity and reduce disparities
- Drive toward the systematic approach laid out in the NQF Health Equity Roadmap for using measures to eliminate disparities and promote health equity

Projects:

- Measure concepts to fill measurement gaps
- Facilitation of measure development and testing
- Technical expertise on high-priority measures

Inspire Implementation of Best Practices through Innovative Approaches

NQF Will:

- Lead and engage strategic partners to implement effective interventions and best practices
- Disseminate effective interventions, best practices, and lessons learned
- Facilitate use of innovative, successful interventions

Projects:

- Practical, applied implementation guidance
- Education and peer forums to share resources and solutions

Inform Payment

NQF Will:

- Convene experts to address the impact of payment on health equity
- Spur resource allocation to those meaningfully affecting change
- Create tools and resources to facilitate uptake of payment models that promote health equity
- Explore emerging issues related to risk adjusting performance measures for social risk factors

Projects:

- Continuing work on SDS Trial
- Convening experts to develop payment guidance

Questions?

SES Trial 2.0

Inform Payment
Continuation of the SDS Trial/Social Risk Factor Initiative

- April 2015, NQF began a two-year, self-funded trial of a policy change that allowed risk adjustment of performance measures for social risk factors.

- Findings from the trial (April 2015 to April 2017):
  - adjustment may be feasible but remains challenging
  - limited availability of adequate social risk factors data
  - significant heterogeneity of social risk data and modeling approaches

Inform Payment

Continuation of the SDS Trial/Social Risk Factor Initiative

- NQF Board approved a new 3-year initiative, where NQF will continue to allow the inclusion of social risk factors in outcome measures.

Through the continuation of the SDS Trial, NQF will:

- Identify preferred methodologies to link the conceptual basis for adjustment with the analyses to support it
- Develop guidance for measure developers
- Explore alternative data sources and provide guidance to the field on how to obtain and use advanced social risk factors data
- Evaluate risk models for appropriate social and clinical factors
- Explore the impact of social risk adjustment on reimbursement and access to care

Inform Payment

Continuation of the SDS Trial/Social Risk Factor Initiative

INFORM payment

As part of the implementation of the SDS Trial, NQF will:

- Continue to consider if an outcome measure includes the appropriate social and clinical factors in its risk model.

- Convene the new Scientific Methods Panel and Disparities Standing Committee to provide guidance on the methodological questions that arose during the initial trial period.

Questions?

Attribution Project

Phase 1 Work

Current Landscape

- Recent legislation such as IMPACT and MACRA demonstrate the continued focus on value-based purchasing to drive improvements in quality and cost by re-aligning incentives.
- Implementing pay-for-performance models requires knowing who can be held responsible for the results of the quality and efficiency measures used to judge performance.
  - *Increasingly challenging as quality is assessed on outcome measures rather than process or structural measures.*
- Attribution can be defined as the methodology used to assign patients, and their quality outcomes, to providers or clinicians.
  - *Attribution models help to identify a patient relationship that can be used to establish accountability for quality and cost.*
- Moving the system away from fee-for-service payment to alternative payment models has highlighted the need to better understand how patient outcomes and costs can be accurately attributed in a system increasingly built on shared accountability.

Environmental Scan Highlights

- Models categorized by:
  - Program stage
  - Type of provider attributed
  - Timing
  - Clinical circumstances
  - Payer/programmatic circumstances
  - Exclusivity of attribution
  - Measure used to make attribution
  - Minimum requirement to make attribution
  - Period of time for which provider is responsible
- 163 models in use or proposed for use
  - 17% currently in use
  - 89% use retrospective attribution
  - 77% attribute to a single provider, mainly a physician

Commissioned Paper Findings

- Best practices have not yet been determined
  - *Existing models are largely built off of previously used approaches*
  - *Trade-offs in the development of attribution models should be explored and transparent*
- No standard definition for an attribution model
- Lack of standardization across models limits ability to evaluate

Challenges

- Greater standardization among attribution models is needed to allow:
  - *Comparisons between models;*
  - *Best practices to emerge.*
- Little consistency across models but there is evidence that changing the attribution rules can alter results.
- Lack of transparency on how results are attributed and no way to appeal the results of an attribution model that may wrongly assign responsibility.

Addressing the Challenges

- To address these challenges, the Committee:
  - *Developed guiding principles*
  - *Made recommendations*
  - *Created the Attribution Model Selection Guide*
- These products allow for greater standardization, transparency, and stakeholder buy-in:
  - *Allow for evaluation of models in the future*
  - *Lay the groundwork to develop a more robust evidence base*

Guiding Principles Preamble

- Acknowledge the complex, multidimensional challenges to implementing attribution models as the models can change depending on their purpose and the data available.
- Grounded in the National Quality Strategy (NQS) as attribution can play a critical role in advancing these goals.
- Recognize attribution can refer to both the attribution of patients for accountability purposes as well as the attribution of results of a performance measure.
- Highlighted the absence of a gold standard for designing or selecting an attribution model; must understand the goals of each use case.
- Key criteria for selecting an attribution model are actionability, accuracy, fairness, and transparency.

Guiding Principles

1. Attribution models should fairly and accurately assign accountability.
2. Attribution models are an essential part of measure development, implementation, and policy and program design.
3. Considered choices among available data are fundamental in the design of an attribution model.
4. Attribution models should be regularly reviewed and updated.
5. Attribution models should be transparent and consistently applied.
6. Attribution models should align with the stated goals and purpose of the program.

Attribution Model Selection Guide

- **Current state:**
  - *Tension between the desire for clarity about an attribution model's fit for purpose and the state of the science related to attribution*
  - *Desire for rules to clarify which attribution model should be used in a given circumstance, but not enough evidence to support the development of such rules at this time.*
- **Goals of the Attribution Model Selection Guide:**
  - *Aid measure developers, measure evaluation committees, and program implementers on the necessary elements of an attribution that should be specified.*
  - *Represent the minimum elements that should be shared with the accountable entities*

The Attribution Model Selection Guide

What is the context and goal of the accountability program?	• What are the desired outcomes and results of the program? • Is the program aspirational? • Is the program evidence-based? • What is the accountability mechanism of the program? • Which entities will participate and act under the accountability program?
How do the measures relate to the context in which they are being used?	• What are the patient inclusion/exclusion criteria? • Does the model attribute enough individuals to draw fair conclusions?
Who are the entities receiving attribution?	• Which units are eligible for the attribution model? • Can the accountable unit meaningfully influence the outcomes? • Do the entities have sufficient sample size to meaningfully aggregate measure results? • Are there multiples units to which the attribution model will be applied?
How is the attribution performed?	• What data are used? Do all parties have access to the data? • What are the services that drive assignment? Does the use of those services assign responsibility to the correct accountable unit? • What are the details of the algorithm used to assign responsibility? • Has the reliability of the model been tested using multiple methodologies? • What is the timing of the attribution computation?

Recommendations for Attribution Models

- Build on the principles and Attribution Model Selection Guide.
- Intended to apply broadly to developing, selecting, and implementing attribution models in the context of public and private sector accountability programs.
- Recognized the current state of the science, considered what is achievable now, and what is the ideal future state for attribution models.
- Stressed the importance of aspirational and actionable recommendations in order to drive the field forward.

Use the Attribution Model Selection Guide to evaluate the factors to consider in the choice of an attribution model

- No gold standard; different approaches may be more appropriate than others in a given situation.
- Model choice should be dictated by the context in which it will be used and supported by evidence.
- Measure developers and program implementers should be transparent about the potential trade-offs between the accountability mechanism, the gap for improvement, the sphere of influence of the accountable entity over the outcome, and the scientific properties of the measure considered for use.

Attribution models should be tested

- Attribution models of quality initiative programs must be subject to some degree of testing for goodness of fit, scientific rigor, and unintended consequences.
  - *Degree of testing may vary based on the stakes of the accountability program; attribution models would be improved by rigorous scientific testing and making the results of such testing public.*
- When used in mandatory accountability programs, attribution models should be subject to testing that demonstrates adequate sample sizes, appropriate outlier exclusion and/or risk adjustment to fairly compare the performance of attributed entities, and sufficiently accurate data sources to support the model in fairly attributing patients/cases to entities.

Attribution models should be subject to multistakeholder review

- Given the current lack of evidence on the gold standard for attribution models, perspectives on which approach is best could vary based on the interests of the stakeholders involved.
- Attribution model selection and implementation in public and private sectors, such as organizations implementing payment programs or health plans implementing incentive programs should use multistakeholder review to determine the best attribution model to use for their purposes.

Attribution models should attribute care to entities who can influence care and outcomes

- Attribution models can unfairly assign results to entities which have little control or influence over patient outcomes.
- For an attribution model to be fair and meaningful, an accountable entity must be able to influence the outcomes for which it is being held accountable either directly or through collaboration with others.
- As care is increasingly delivered by teams and facilities become more integrated, attribution models should reflect what the accountable entities are able to influence rather than directly control.

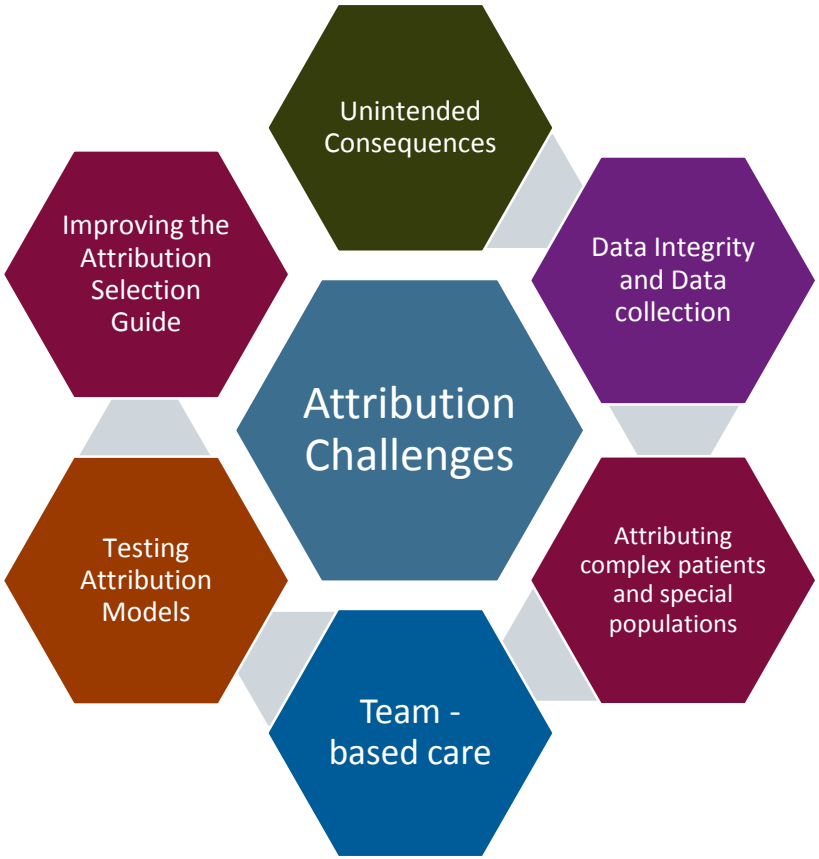
Attribution models used in mandatory public reporting or payment programs should meet minimum criteria

- In order to be applied to mandatory reporting or payment programs, attribution models should:
  - *Use transparent, clearly articulated, reproducible methods of attribution;*
  - *Identify accountable entities that are able to meaningfully influence measured outcomes;*
  - *Utilize adequate sample sizes, outlier exclusion, and/or risk adjustment to fairly compare the performance of attributed entities;*
  - *Undergo sufficient testing with scientific rigor at the level of accountability being measured;*
  - *Demonstrate accurate enough data sources to support the model in fairly attributing patients/cases to entities;*
  - *Be implemented with adjudication processes, open to the public, that allow for timely and meaningful appeals by measured entities.*

Current Phase

Project Purpose and Objectives

- Develop a white paper to provide continued guidance to the field on approaches to attribution



To accomplish these goals, NQF will:

1. Convene a multistakeholder advisory panel to guide and provide input on the direction of the white paper
2. Hold two webinars and four conference calls with the panel
3. Conduct a review of the relevant evidence related to attribution
4. Perform key informant interviews
5. Develop a white paper that summarizes the evidence review, interviews, and recommendations
6. Develop a blueprint for further development of the Attribution Selection Guide
7. Examine NQF processes for opportunities to address attribution in measure evaluation and selection

Standing Committee Discussion

- Doe the Standing Committee have any guidance for the Expert Panel?
- Should the CDP process more explicitly consider attribution?
- What evidence or testing for an attribution model would you expect to see?

Public Comment

Next Steps

Next Steps
Spring 2018 Meeting Dates

Meeting	Date/Time
Measure evaluation tutorial web meeting (1 hour)	Tuesday, May 8, 2018, 1-2 pm EST
Measure evaluation web meeting #1 (2 hours)	Thursday, June 21, 2018, 12-2 pm EST
Measure evaluation web meeting #2 (2 hours)	Friday, June 22, 2018, 12-2 pm EST
Measure evaluation web meeting #3 (2 hours)	Tuesday, June 26, 2018, 12-2 pm EST
Measure evaluation post-meeting web meeting (2 hours)	Tuesday July 10, 2018, 12-2 pm EST
Post-comment web meeting (2 hours)	Tuesday, August 21, 2019, 11 am- 1 pm EST

Project Contact Info

- Email: readmissions@qualityforum.org
- NQF Phone: 202-783-1300
- Project page: http://www.qualityforum.org/All-Cause_Admissions_and_Readmissions_2017.aspx
- SharePoint site: http://share.qualityforum.org/Projects/admissions_readmissions/SitePages/Home.aspx

Thank You