NATIONAL QUALITY FORUM

All Cause Admissions and Readmissions, Fall 2018 Measure Review Cycle

Standing Committee Meeting

Erin O'Rourke, Senior Director
Suzanne Theberge, Senior Project Manager
Miranda Kuwahara, Project Manager
Taroon Amin, Consultant

February 7, 2019

Executive Session

Welcome

- Restrooms
  - *Exit main conference area, past elevators, on right.*
- Breaks
  - *10:30 am – 15 minutes*
  - *12:00 pm – Lunch provided by NQF*
  - *2:15 pm – 15 minutes*
- Laptops and cell phones
  - *Wi-Fi network*
    - User name: **guest**
    - Password: **NQFguest**
  - *Please mute your cell phone during the meeting*

NQF Staff

- Project staff
  - *Erin O'Rourke, Senior Director*
  - *Suzanne Theberge, Senior Project Manager*
  - *Miranda Kuwahara, Project Manager*
  - *Taroon Amin, Consultant*
- NQF Quality Measurement leadership staff
  - *Elisa Munthali, Senior Vice President*

Introductions and Disclosures of Interest

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
- 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

Scientific Methods Panel Review

NQF Scientific Methods Panel Review

- The Scientific Methods Panel independently evaluated the Scientific Acceptability of nine measures:
  - NQF 3366 *Hospital Visits after Urology Ambulatory Surgical Center Procedures*
  - NQF 3470 *Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures*
  - NQF 3449 *Hospitalization for Ambulatory Care Sensitive Conditions for Dual Eligible Beneficiaries*
  - NQF 3456 *Admission to an Institution from the Community*
  - NQF 3457 *Minimizing Institutional Length of Stay*
  - NQF 3443 *All-cause emergency department utilization rate for Medicaid beneficiaries with complex care needs and high costs (BCNs)*
  - NQF 3445 *All-cause inpatient admission rate for Medicaid beneficiaries with complex care needs and high costs (BCNs)*
  - NQF 2539 *Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy*
  - NQF 3458 *Successful Transition after Long-Term Institutional Stay*
- The Panel, consisting of individuals with methodologic expertise, was established to help ensure a higher-level evaluation of the scientific acceptability of complex measures.

NQF Scientific Methods Panel Review

- Two of nine measures did not pass the SMP review
  - NQF 2539 *Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy*
  - NQF 3458 *Successful Transition after Long-Term Institutional Stay*
- Scientific Acceptability is a must-pass criterion; because the panel did not view these measures as methodologically sound for reliability and/or validity, the measures are removed from the current evaluation cycle and are not forwarded to the Standing Committee for evaluation.
- The Panel's comments and concerns are provided to developers to further clarify and update their measure submission form with the intent of strengthening their measures to be evaluated by the Standing Committee in a future submission.

Project Introduction and Overview of Evaluation Process

Roles of the Standing Committee *During the Evaluation Meeting*

- Act as a proxy for the NQF multistakeholder membership
- Work with NQF staff to achieve the goals of the project
- Evaluate each measure against each criterion
  - *Indicate the extent to which each criterion is met and rationale for the rating*
- Make recommendations regarding endorsement to the NQF membership
- Oversee portfolio of Readmissions measures

Ground Rules for Today's Meeting

During the discussions, Committee members should:

- Be prepared, having reviewed the measures beforehand
- Base evaluation and recommendations on the measure evaluation criteria and guidance
- Remain engaged in the discussion without distractions
- Attend the meeting at all times (except at breaks)
- Keep comments concise and focused
- Avoid dominating a discussion and allow others to contribute
- Indicate agreement without repeating what has already been said

Measure Evaluation Criteria Overview

Major Endorsement Criteria
(page 28-29 in the SC Guidebook)

- ***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 31-39)

1. Importance to measure and report - Extent to which the specific measure focus is evidence-based and important to making significant gains in healthcare quality 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*

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

Subcriteron 1a: Evidence (page 32-38)

- Outcome measures
  - *Empirical data demonstrate a relationship between the outcome and at least one healthcare structure, process, intervention, or service. If not available, wide variation in performance can be used as evidence, assuming the data are from a robust number of providers and results are not subject to systematic bias.*
- Structure, 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*
    - » Empirical studies (expert opinion is not evidence)
    - » Systematic review and grading of evidence
      - *Clinical Practice Guidelines – variable in approach to evidence review*
- For measures derived from patient (or family/parent/etc.) report
  - *Evidence should demonstrate that the target population values the measured outcome, process, or structure and finds it meaningful.*
  - *Current requirements for structure and process measures also apply to patient-reported structure/process measures.*

Rating Evidence: Algorithm #1 *(page 35)*

[Screen share Evidence algorithm]

Criterion #2: Reliability and Validity–Scientific Acceptability of Measure Properties
(page 40 -50)

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. Validity testing—data elements or measure score

2b2. Justification of exclusions—relates to evidence

2b3. Risk adjustment—typically for outcome/cost/resource use

2b4. Identification of differences in performance

2b5. Comparability of data sources/methods

2b6. Missing data

Rating Reliability: Algorithm #2 *(page 44)*

[Screen share Reliability algorithm]

Rating Validity: Algorithm #3 *(page 49)*

[Screen share Validity algorithm]

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 #3: Feasibility
(page 50-51)

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 51-52)

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.

Use (4a) Now must-pass for maintenance measures

4a1: 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.*

4a2: Feedback by those being measured or others: *Those being measured have been given results and assistance in interpreting results; those being measured and others have been given opportunity for feedback; the feedback has been considered by developers.*

Usability (4b)

4b1: Improvement: *Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated.*

4b2: 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).*

Criterion #5: Related or Competing Measures (page 52-53)

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.

Questions?

Consideration of Candidate Measures

NQF 3366 Hospital Visits after Urology Ambulatory Surgical Center Procedures

- **Measure Steward:** Centers for Medicare & Medicaid Services (CMS)
- **Measure Developer:** Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE)
- **Measure Description:** Facility-level risk-standardized rate of acute, unplanned hospital visits within 7 days of a urology procedure performed at an ambulatory surgical center (ASC) among Medicare Fee-For-Service (FFS) patients aged 65 years and older. An unplanned hospital visit is defined as an emergency department (ED) visit, observation stay, or unplanned inpatient admission.

Break

Consideration of Candidate Measures

NQF 3470 Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures

- **Measure Steward:** CMS
- **Measure Developer:** YNHHSC/CORE
- **Measure Description:** Facility-level risk-standardized rate of acute, unplanned hospital visits within 7 days of an orthopedic procedure performed at an ambulatory surgical center (ASC) among Medicare fee-for-service (FFS) patients aged 65 years and older. An unplanned hospital visit is defined as an emergency department (ED) visit, observation stay, or unplanned inpatient admission.

Public Comment

Lunch

Consideration of Candidate Measures

NQF 3449 Hospitalization for Ambulatory Care Sensitive Conditions for Dual Eligible Beneficiaries

- **Measure Steward:** CMS
- **Measure Developer:** Mathematica Policy Research
- **Measure Description:** For dual eligible beneficiaries age 18 years and older, rates of hospital admissions for ambulatory care sensitive conditions (ACSC) per 1,000 beneficiaries for ACSC by chronic and acute conditions. This measure has three rates reported as both observed and risk-adjusted rates:
  1. Chronic Conditions Composite
  2. Acute Conditions Composite
  3. Total (Acute and Chronic Conditions) Composite

  This rate is stratified and reported for three populations: (1) community-dwelling home and community-based services (HCBS) users; (2) community-dwelling non-HCBS users; or, (3) non-community-dwelling (institutionalized) population.

NQF 3456 Admission to an Institution from the Community

- **Measure Steward:** Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services (CMCS)
- **Measure Developer:** Mathematica Policy Research
- **Measure Description:** The number of managed long-term services and supports (MLTSS) plan enrollee admissions to an institution (nursing facility or intermediate care facility for individuals with intellectual disabilities [ICF/IID]) from the community that result in a short-term (1 to 20 days), medium-term (21 to 100 days), or long-term stay (greater than or equal to 101 days) during the measurement year per 1,000 enrollee months [truncated for brevity]

NQF 3457 Minimizing Institutional Length of Stay

- **Measure Steward:** CMCS
- **Measure Developer:** Mathematica Policy Research
- **Measure Description:** The proportion of admissions to an institutional facility (e.g., nursing facility, intermediate care facility for individuals with intellectual disabilities [ICF/IID]) for managed long-term services and support (MLTSS) plan enrollees that result in successful discharge to the community (community residence for 60 or more days) within 100 days of admission. This measure is reported as an observed rate and a risk-adjusted rate.

Break

Consideration of Candidate Measures

NQF 3443 All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCNs)

- **Measure Steward:** CMCS
- **Measure Developer:** Mathematica Policy Research
- **Measure Description:** All-cause emergency department (ED) utilization rate for adult Medicaid beneficiaries who meet BCN population eligibility criteria. For the purpose of this measure, BCNs are defined as Medicaid beneficiaries who are age 18 to 64 during the measure testing period and who have at least one inpatient admission and at least two chronic conditions, as defined by the Chronic Conditions Data Warehouse (CCW), in the past 12 months. Beneficiaries dually enrolled in Medicaid and Medicare and beneficiaries who had fewer than 10 months of Medicaid eligibility in the previous 12 months are not included in the analytic sample because we did not have enough utilization data to include them in testing. The measure is calculated as the number of ED visits per 1,000 member months.

NQF 3445 All-Cause Inpatient Admission Rate for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCNs)

- **Measure Steward:** CMCS
- **Measure Developer:** Mathematica Policy Research
- **Measure Description:** All-cause inpatient admission rate for adult Medicaid beneficiaries who meet BCN population eligibility criteria. For the purpose of this measure, BCNs are defined as Medicaid beneficiaries who are age 18 to 64 during the measure testing period and who have at least one inpatient admission and at least two chronic conditions, as defined by the Chronic Conditions Data Warehouse (CCW), in the past 12 months. Beneficiaries dually enrolled in Medicaid and Medicare and beneficiaries who had fewer than 10 months of Medicaid eligibility in the previous 12 months are not included in the analytic sample because we did not have enough utilization data to include them in testing. The measure is calculated as the number of inpatient admissions per 1,000 member months.

Public Comment

Next Steps

Activities and Timeline

Process Step	Timeline
Post-meeting call	February 14, 2-4 pm
Draft report posted for public and NQF member comment	March 18-April 16, 2019
Post-comment call	May 16, 2019, 12-2 pm ET

Project Contact Info

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

Adjourn