NATIONAL QUALITY FORUM

Meeting Summary

All-Cause Admissions and Readmissions Standing Committee—Post-Comment Web Meeting

The National Quality Forum (NQF) convened the All-Cause Admissions and Readmissions Standing Committee for a web meeting on October 2, 2019 to consider the comment received in the spring 2019 cycle.

Welcome, Introductions, and Review of Meeting Objectives

NQF Senior Project Manager Suzanne Theberge welcomed the Standing Committee and participants to the web meeting and NQF Project Analyst Asaba Mbenwoh Nguafor conducted roll call. Following roll call, Ms. Theberge summarized the measures reviewed in the project and the results of the comment period.

Discussion of Comments

Ms. Theberge turned facilitation over to NQF consultant, Taroon Amin, and Committee Co-chairs Cristie Travis and John Bulger. Dr. Amin summarized the single comment received on measure 3495 *Hospital-Wide 30-Day, All-Cause, Unplanned Readmission (HWR) Rate,* which was recommended at the clinician group level of analysis, but not at the individual clinician level of analysis.

The American Medical Association submitted a comment raising both process concerns and measure concerns. The process concerns noted the lack of quorum during the Committee measure evaluation webinar on June 21 and the posting of a draft report that omitted vote counts. Dr. Amin noted NQF's ongoing efforts to ensure all stakeholders are represented on calls and explained the process for voting by Committee members who are not on the call; he also noted that the missing votes were an oversight, and NQF replaced the report with the correct version as soon as the comment was received, before the end of the comment period. The AMA raised several concerns with the measure's evidence; the assignment of responsibility to multiple physicians and practices; the measure's reliability, especially with the minimum case number of 25 patients; and the conceptual basis used to explain which social risk factors were tested. Co-chair Travis asked the developer to briefly respond to the concerns raised.

Yale/CORE, the developer, noted that the measure is a tool that allows interventions to be developed but that providing targeted interventions that correspond to the measure is beyond the scope of their work. The developer further explained that attribution to multiple physicians for this measure was driven almost entirely by stakeholder feedback, including provider and patient working groups, noting that responsibility for a readmission is typically shared among many providers and that attribution to more than one provider would incentivize coordinated care. The developer noted that recommendation for endorsement at the group level only should deal with the volume issue, as groups should have enough patients to report reliable results. Yale/CORE also noted that their reliability results included results for a range of case volumes. Finally, they stated that testing had followed NQF guidance and looked at two social risk factors

and found that inclusion had very little impact on the scores. They believed the SDS factors should not be included since doing so did not improve model performance meaningfully.

In response to a question on case volumes from the Committee, the developer stated that all the volume cutoff results were above 0.7; the reliability results for individual clinicians had a mean signal-to-noise ratio of 0.967; and the group mean signal-to-noise ratio is 0.996 at the 25-volume cutoff. A Committee member noted that those reliability levels seem unusually high and requested that the calculations be shared. The developer that noted the measure passed the Scientific Methods Panel. The Committee said that the mean reliability wasn't low, but the lower ranges were very low. The average for the smaller volume end was skewed right. The developer noted that for all providers who have at least 25 patients, the mean reliability is 0.96. The Committee member responded that 0.96 seems implausibly high, and a second Committee member agreed, further noting that this does not provide any information for low-volume providers.

The Committee requested that the data be provided and then made transparent. The developer referred to the testing form, section 2a2.3 and noted the minimum for CV was 0.39, the median was 0.63, and max was 0.94. The Committee observed that these numbers were not consistent with what was stated previously, and the developer agreed and referred to the response for 2a2.4, which indicate that the mean signal-to-noise reliability scores for the clinician groups range from 0.45 to 0.65, depending on cohort, while the individual clinician results range from 0.55 to 0.77. The developer agreed to provide the additional testing data that they had presented verbally and a clarification of the differences between data provided in the submission form and those provided verbally.

A Committee member asked whether the different types of physicians needed to be included (discharging, outpatient, etc.). The developer stated that they did not assume that the same types of physicians are always included in the attribution model, and a Committee member noted consistency is important for the measure. The developer assumes that the discharging physician should be coordinating with the primary care physician even if they are in a different practice and that this measure should incentivize such coordination. The Committee member stated that if this is true, then the measure should be recommended at the individual level as well. Committee members noted that the continued implementation of EHRs will help improve performance in the future.

Committee members noted the improvement in scores with greater numbers of providers, which is one reason why the measure was not recommended at the individual level, as too many were excluded at that level due to low volume. Dr. Amin requested clarification on whether the recommendation at the group level was based more on attribution or reliability scores. The developer then noted that this is a re-specification of a measure that has a 200-case minimum, only includes outpatient providers, and is already used in MIPS.

Dr. Amin summarized the Committee's previous discussion to confirm that the decision to split the measure and recommend at the group level only was conceptual and reiterated that transparency of reliability information is helpful. The Committee agreed and stated that for low case volumes, reliability is lower, and considering this along with concerns about attribution, the Committee had recommended only at the group level to mitigate these concerns. However, they

noted that the developer needs to clarify differences between verbally stated testing performance and the information provided in the testing form.

One Committee member moved to reconsider the measure, stating that the four points raised by the commenter were not adequately addressed, and he still had questions on unintended consequences for the HRRP program, leading to general concerns about readmissions measures. Another Committee member noted this is the first measure that attempts to test if incentivization changes behavior, something long requested. Such measurement can show if desired change happens when methods of payment encourage desired behavior.

A Committee co-chair noted that many of these conversations occurred during the previous discussion in June, and he observed that the issues raised in the comment had been discussed and adjudicated already. He further noted that reconsideration should be reserved for concerns that had not been previously discussed. He also noted that if there had been "big holes" in the Committee's discussion, many comments would have been received, which did not happen. The Committee voted on whether or not to reconsider the measure. NQF process requires that 60 percent of a quorum of the Committee vote in favor of reconsideration in order for a measure to be reconsidered. Only 42 percent of the Committee voted to reconsider, and 57 percent of the Committee voted against reconsidering, so the Committee's previous decision to recommend endorsement of this measure at the physician group level only stands.

Public Comment

No public or NQF member comments were provided during the measure evaluation meeting.

Next Steps

NQF staff and the Committee co-chairs thanked the 15 Committee members whose terms are concluding this month. Ms. Nguafor briefed the Committee on the fall 2019 cycle. Because no measures were submitted, the Committee will have a topical webinar in March. The Committee will next meet on January 13, 2020, for the orientation call for the fall 2019 cycle.