NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Cardiovascular Standing Committee – Fall 2020 Measure Evaluation Web Meeting

The National Quality Forum (NQF) convened the Cardiovascular Standing Committee (link to slides) for a web meeting on February 9, 2021, to evaluate two maintenance measures.

Welcome, Introductions, and Review of Meeting Objectives

Amy Moyer, NQF director, welcomed the Standing Committee and participants to the web meeting. NQF staff reviewed the meeting objectives. The Standing Committee members each introduced themselves and disclosed any conflicts of interest. No Cardiovascular Standing Committee members were recused for either of the two measures under review for the Fall 2020 Cycle.

Some Standing Committee members were unable to attend the entire meeting. There were early departures and late arrivals. The vote totals reflect members present and eligible to vote. Quorum (17 out of 25 Standing Committee members) was met and maintained for the entirety of the meeting.

Topic Area Introduction and Overview of Evaluation Process

NQF staff provided an overview of the topic area and the current NQF portfolio of endorsed measures. There are currently 41 endorsed measures in the Cardiovascular portfolio. Additionally, NQF reviewed the Consensus Development Process (CDP) and the measure evaluation criteria. A measure is recommended for endorsement by the Standing Committee when the vote margin on all must-pass criteria (Importance, Scientific Acceptability, Use), and overall, is greater than 60 percent of voting members in favor of endorsement. A measure is not recommended for endorsement when the vote margin on any must-pass criterion or overall is less than 40 percent of voting members in favor of endorsement. The Standing Committee has not reached consensus if the vote margin on any must-pass criterion or overall is between 40 and 60 percent, inclusive, in favor of endorsement. When the Standing Committee has not reached consensus, all measures for which consensus was not reached will be released for NQF member and public comment. The Standing Committee will consider the comments and re-vote on those measures during a webinar convened after the commenting period closes.

Measure Evaluation

During the meeting, the Cardiovascular Standing Committee evaluated two maintenance measures for endorsement consideration. NQF solicits comments for four weeks prior to the measure evaluation meeting. For this evaluation cycle, the commenting period opened on December 17, 2020. Two comments were submitted by the pre-meeting deadline (January 21, 2021) and shared with the Standing Committee prior to the measure evaluation meeting. Those comments are included at the end of this summary. A summary of the Standing Committee deliberations will be compiled and provided in the draft technical report. NQF will post the draft technical report on March 30, 2021, for public comment on the NQF website. The draft technical report will be posted for 30 calendar days.

Rating Scale: H – High; M – Medium; L – Low; I – Insufficient; NA – Not Applicable

NQF #0229 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization (Centers for Medicare & Medicaid Services (CMS)/Yale Center for Outcomes Research & Evaluation (CORE))

Description: The measure estimates a hospital-level 30-day, all-cause, risk-standardized mortality rate for patients discharged from the hospital with a principal diagnosis of HF. Mortality is defined as death for any cause within 30 days after the date of admission for the index admission. CMS annually reports the measure for patients who are 65 years or older and enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals or are patients hospitalized in Veterans Health Administration (VA) facilities.; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Inpatient/Hospital; **Data Source**: Claims, Enrollment Data, Other

Measure Steward/Developer Representatives at the Meeting

Duwa Amin, MPH – Yale CORE
Darinka Djordjevic, PhD – Yale CORE
Jacky Grady, MS – Yale CORE
Kashika Sahay, PhD, MPH – Yale CORE
Anna Sigler, MPH – Yale CORE
Huihui Yu, PhD – Yale CORE
Sapha Hassan, MPH – Yale CORE
Kristina Gaffney, BS – Yale CORE
Doris Peter, PhD – Yale CORE
Karen Dorsey, MD, PhD – Yale CORE
James Poyer, MS, MBA – CMS

Standing Committee Votes

- Evidence: Pass-19; No Pass-0 (denominator = 19)
- Performance Gap: H-4; M-15; L-0; I-0 (denominator = 19)
- This measure is deemed as complex and Scientific Acceptability was evaluated by the NQF Scientific Methods Panel.
    - The NQF Scientific Methods Panel's rating for Reliability: Moderate (H-4; M-4; L-3; I-0)
    - The Standing Committee accepted the NQF Scientific Methods Panel's rating: Yes-19; No-0 (denominator = 19)
    - The NQF Scientific Methods Panel's rating for Validity: Moderate (H-0; M-6; L-1; I-1)
    - The Standing Committee accepted the NQF Scientific Methods Panel's rating: Yes-19; No-0 (denominator = 19)
- Feasibility: H-13; M-6; L-0; I-0 (denominator = 19)
- Use: Pass-18; No Pass-0 (denominator = 18)
- Usability: H-8; M-9; L-1; I-0 (denominator = 18)

Standing Committee Recommendation for Endorsement: Yes-18; No-0 (denominator = 18)

The Standing Committee recommended the measure for continued endorsement.

The Standing Committee noted that the evidence provided is directionally the same and stronger than what was submitted during the previous endorsement cycle. The Standing Committee concluded that

the evidence clearly demonstrated actions that providers can take to reduce HF mortality and passed the measure on evidence. The Standing Committee agreed that this is an important focus area of measurement and observed that the measure still has a performance gap and variation in results with room for improvement.

While the Standing Committee voted unanimously to accept the Scientific Methods Panel's (SMP) moderate ratings for both reliability and validity, it raised a couple of issues for discussion. The Standing Committee noted that the specifications had been updated to exclude patients with left ventricular assist devices (LVAD) and was supportive of this change. A Standing Committee member raised the question of whether patterns in admissions could account for part of the variation in performance, stating that some areas or providers may only admit severely ill patients, resulting in a higher mortality rate among those admissions. The developer responded that they have not performed that analysis but could include it in their next re-evaluation list. The Standing Committee urged the developer to consider the extensive discussions of the SMP regarding the inclusion of social risk factors in risk adjustment and the circular nature of the validity analyses using the Medicare Star Ratings, noting that measure #0229 is included as part of the star rating calculation. The developer noted for the Standing Committee that results on this measure are negatively correlated with dual eligibility, meaning that dual-eligible patients have lower mortality rates than non-dual eligible patients. They noted that adjusting for dual eligibility would result in a penalty to providers with a higher proportion of dual-eligible patients.

The Standing Committee had no concerns regarding the feasibility of the measure. It also had no concerns regarding use of the measure, noting it is both publicly reported and used in CMS programs. A Standing Committee member raised the question of how patients and patient advocates can use this measure to make care decisions, noting that if a patient is transported via ambulance, they may not have a choice of hospital. The developer noted that as part of the CMS Care Compare program, results of this measure are publicly available for use by the public and groups that publish hospital ratings. Other Standing Committee members shared that leadership in their organizations pays close attention to the results and implements corrective action, as necessary. The Standing Committee noted improvement in the measure results over time and no significant unintended consequences. Discussion of related measures was deferred to the post-comment meeting.

NQF #0230 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization (CMS/Yale CORE)

Description: The measure estimates a hospital-level 30-day risk-standardized mortality rate (RSMR) for patients discharged from the hospital with a principal diagnosis of AMI. Mortality is defined as death for any cause within 30 days after the date of admission for the index admission. CMS annually reports the measure for patients who are 65 years or older and are either Medicare fee-for-service (FFS) beneficiaries and hospitalized in non-federal hospitals or are hospitalized in Veterans Health Administration (VA) facilities.; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Inpatient/Hospital; **Data Source**: Claims, Enrollment Data, Other

Measure Steward/Developer Representatives at the Meeting

Duwa Amin, MPH – Yale CORE
Darinka Djordjevic, PhD – Yale CORE
Jacky Grady, MS – Yale CORE
Kashika Sahay, PhD, MPH – Yale CORE
Anna Sigler, MPH – Yale CORE
Huihui Yu, PhD – Yale CORE
Sapha Hassan, MPH – Yale CORE

Kristina Gaffney, BS – Yale CORE
Doris Peter, PhD – Yale CORE
Karen Dorsey, MD, PhD – Yale CORE
James Poyer, MS, MBA – CMS

Standing Committee Votes

- Evidence: Pass-17; No Pass-0 (denominator = 17)
- Performance Gap: H-14; M-2; L-1; I-0 (denominator = 17)
- This measure is deemed as complex and Scientific Acceptability was evaluated by the NQF Scientific Methods Panel.
    - The NQF Scientific Methods Panel's rating for Reliability: Moderate (H-0; M-5; L-3; I-0)
    - The Standing Committee accepted the NQF Scientific Methods Panel's rating: Yes-17; No-0 (denominator = 17)
    - The NQF Scientific Methods Panel's rating for Validity: Moderate (H-0; M-6; L-1; I-1)
    - The Standing Committee accepted the NQF Scientific Methods Panel's rating: Yes-15; No-2 (denominator = 17)
- Feasibility: H-11; M-6; L-0; I-0 (denominator = 17)
- Use: Pass-16; No Pass-1 (denominator = 17)
- Usability: H-5; M-12; L-0; I-0 (denominator = 17)

Standing Committee Recommendation for Endorsement: Yes-17; No-0 (denominator = 17)

The Standing Committee recommended the measure for continued endorsement.

All participants agreed that most of the discussion of the previous measure (#0229) also applies to this measure (#0230). The Standing Committee noted that the evidence is directionally the same and stronger than what was submitted during the previous endorsement cycle. The Standing Committee agreed that the measure passes the evidence sub-criterion. The Standing Committee noted that, despite the tendency for risk-standardization to narrow performance range, the results still demonstrate a range of performance and room for improvement. The Standing Committee did not express any concerns and passed the measure on performance gap.

This measure was evaluated by the SMP, which rated both reliability and validity as moderate. The Standing Committee was satisfied with the SMP's rating and review of reliability and accepted the SMP results unanimously. Although the Standing Committee accepted the SMP's moderate rating on validity, it highlighted concerns similar to those raised during the discussion of measure #0229. The Standing Committee noted concerns regarding the correlation analysis utilized by the developers, which establishes concurrent validity but does not demonstrate construct or empirical validity. The Standing Committee questioned whether the developers had tested against the star ratings with the AMI mortality measure pulled out. This would address the concern about circularity due to AMI mortality being included in the ratings. The developers clarified that the version of star ratings referenced is based on a latent variable model, which makes pulling out AMI mortality challenging and could be the reason that the correlation with measure #0230 is lower than it was for measure #0229. The developers also noted challenges in using process measures to validate because they are often topped out. The developers further noted that the lack of data availability makes demonstrating empirical validity

challenging. Some Standing Committee members questioned whether the exclusion of patients with an inpatient stay of less than two days would exclude lower-risk patients from the measure. The Standing Committee also noted that the diagnostic criteria for AMI have changed, with AMI being diagnosed at lower troponin levels than in the past. The developer responded that they will include an analysis of the effect of these changes on their re-evaluation list for next year.

The Standing Committee had no concerns regarding the feasibility of this claims-based measure. In its discussions related to usability and use, the Standing Committee noted that the measure would not be usable by individual patients in acute decision making; nonetheless, the measure is reported on CMS' Care Compare website and used in CMS' Hospital Value-Based Purchasing Program. The Standing Committee noted improvement over time with no significant unintended consequences and passed the measure on use and usability.

The Standing Committee discussion on related and competing measures will take place during the post-comment web meeting on May 27, 2021.

Public Comment

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

Next Steps

NQF will post the draft technical report on March 30, 2021, for public comment for 30 calendar days. The continuous public commenting period with member support will close on April 28, 2021. NQF will cancel the second measure evaluation meeting that was scheduled for February 17, 2021, since the Standing Committee was able to review and discuss both measures under review in this meeting. NQF will reconvene the Standing Committee for the post-comment web meeting on May 27, 2021.

Pre-Evaluation Comments

Comments received as of January 21, 2021.

Topic	Commenter	Comment
NQF #0229 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization	Submitted by American Medical Association	The American Medical Association (AMA) appreciates the opportunity to comment on #229, Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF) hospitalization. We are disappointed to see the minimum measure score reliability results of 0.34 using a minimum case number of 25 patients. We believe that measures must meet minimum acceptable thresholds of 0.7 for reliability. In addition, the AMA is extremely concerned to see that the measure developer used the recommendation to not include social risk factors in the risk adjustment models for measures that are publicly reported as outlined in the recent report to Congress by Assistant Secretary for Planning and Evaluation (ASPE) on Social Risk Factors and Performance in Medicare's Value-based Purchasing program (ASPE, 2020). We believe that while the current testing may not have produced results that would indicate

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		incorporation of the two social risk factors included in testing, this measure is currently used both for public reporting and value-based purchasing. A primary limitation of the ASPE report was that none of the recommendations adequately addressed whether it was or was not appropriate to adjust for social risk factors in the same measure used for more than one accountability purpose, which is the case for here. This discrepancy along with the fact that the additional analysis using the American Community Survey is not yet released must be addressed prior to any measure developer relying on the recommendations within this report. We request that the Standing Committee evaluate whether the measure meets the scientific acceptability criteria. Reference: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Second Report to Congress on Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program. 2020. https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs
NQF #0230 Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization	Submitted by American Medical Association	The American Medical Association (AMA) appreciates the opportunity to comment on #0230, Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization. We are disappointed to see the minimum measure score reliability results of 0.20 using a minimum case number of 25 patients and the intraclass correlation coefficients (ICC) was 0.428. We believe that measures must meet minimum acceptable thresholds of 0.7 for reliability and require higher case minimums to allow the overwhelming majority of hospitals to achieve an ICC of 0.6 or higher. The AMA is also extremely concerned to see that the measure developer used the recommendation to not include social risk factors in the risk adjustment models for measures that are publicly reported as outlined in the recent report to Congress by Assistant Secretary for Planning and Evaluation (ASPE) on Social Risk Factors and Performance in Medicare's Value-based Purchasing program (ASPE, 2020). We believe that while the current testing may not have produced results that would indicate incorporation of the two social risk factors included in testing, this measure is currently used both for public

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		reporting and value-based purchasing. A primary limitation of the ASPE report was that none of the recommendations adequately addressed whether it was or was not appropriate to adjust for social risk factors in the same measure used for more than one accountability purpose, which is the case for here. This discrepancy along with the fact that the additional analysis using the American Community Survey is not yet released must be addressed prior to any measure developer relying on the recommendations within this report. In addition, the AMA questions whether the information provided as a result of this measure is truly useful for accountability purposes and for informing patients on the quality of care provided by hospitals. Specifically, our concern relates to the relatively limited amount of variation across facilities. Only 28 facilities out of the 2,284 facilities were identified as performing Better than the National Rate; and 16 facilities performed Worse than the National Rate. Endorsing a measure that currently only identifies such a small number of outliers does not enable users to distinguish meaning differences in performance and limits a measure's usability. We request that the Standing Committee evaluate whether the measure meets the scientific acceptability criteria. Reference: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Second Report to Congress on Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program. 2020. https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs