NATIONAL QUALITY FORUM

TO: NQF Members

FR: NQF Staff

RE: Voting on addendum to *National Voluntary Consensus Standards for Cardiovascular Disease: Endorsement Maintenance, 2010*

DA: November 17, 2011

BACKGROUND

In NQF's project, Cardiovascular Endorsement Maintenance, 2010 three endorsed outcome measures for acute myocardial infarction mortality (0230), heart failure mortality (0229) and heart failure readmission (0330) were evaluated. Stakeholders have urged expanding these measure from the original specifications for ages 65 years and older to include all patients. On September 12, 2011, the Cardiovascular Endorsement Maintenance Steering Committee reviewed revised specifications that have been tested to apply to all patients, not just those over 65 years. The revised submissions include all payer data testing results and have been evaluated as an addendum to the draft report for Cardiovascular Endorsement Maintenance 2010. The three revised measures are recommended for endorsement.

Comments and Addendum Voting Report

The comment period for the addendum to the draft report opened on October 6, 2011 and concluded on October 21, 2011. NQF received 7 comments from 5 organizations on the revised measures (Health plans -1; Public-Community Agency -1; Provider – 3).

A table of complete comments submitted during the comment period, with the responses to each comment and the actions taken by the Steering Committee, is posted to the Cardiovascular Endorsement Maintenance project page on the NQF website, along with the measure submission forms.

COMMENTS AND THEIR DISPOSITION

Comments about specific measure specifications and rationale were forwarded to the measure developers, who were invited to respond. After review of comments and responses, the Steering Committee maintained their recommendation of the measures without revisions.

0330: Hospital 30-day, all-cause, risk-standardized readmission rate following heart failure hospitalization (Yale/CMS)

Summary of Comment from American Hospital Association (see comment table for full comment):

"The Centers for Medicare and Medicaid Services (CMS) has finalized this HF readmission measure for application in the readmission penalty program. Rather than using the Hospital Compare methodology for determining HF readmission performance, the readmission penalty program will be using a point estimate of an individual hospital's performance using an observed to expected methodology. A component of this methodology will consider the national average for HF readmissions. The literature (see attachments) has very clearly documented that African-Americans have a statistically higher level of readmissions that all other race/ethnicities. This is why we have been asking for proper stratification of the HF readmission measure. "

Summary of Developer Response (see comment table for full response):
"We agree that the use of the point estimate in the Readmission Reduction Program will result in different profiles for hospitals than the approach originally used for public reporting of these measures (i.e. performance categorized as better, worse or no different than national rate). We also agree that unadjusted rates of readmission for African-American patients are higher than those for Caucasian patients. However, neither of these issues are a compelling reason to stratify the measures. Our fundamental contention is that there is no inherent clinical reason that African-American patients should have higher readmission rates once the measures account for differences in clinical status, and that many hospitals perform well on the measure despite caring for a high proportion of African-American patients."

Steering Committee response:
The Steering Committee carefully reviewed the comments and the measure developer response. Committee members generally agreed that AHA raised interesting questions but did not change their recommendation for the measure. Several members support stratification of an individual hospital's data for race/ethnicity to assist their understanding of their performance. Specifically members noted:

- General agreement with the measure developer's (Yale) response. Racial disparities should not be "adjusted out" before the data are seen or published.
- There is no reason to believe that there is some unidentified reason that African Americans should have higher readmit rates.
- The risk-adjustment that already exists in the measure, as written, should account for the greater disease burden among African-Americans.
- Stratifying by race/ethnicity may be useful in understanding an individual hospital's overall HF readmission rate. However, measuring all hospitals' HF readmission rate by the same method, regardless of their patients' racial/ethnic mix would hold all hospitals to the same standard (and risk of penalty), regardless of the racial/ethnic composition of their patient population. In addition, it would uncover any racial/ethnic disparities that need to be addressed and eliminated.
- Race/ethnicity data are not as solid as we'd like, but favor stratification even with its limitations because without paying attention to this element we won't deal with disparities.
- Income status or education level may be better stratifiers than race based on the 2010 AHRQ Disparities report. Differential access to care can significantly affect readmission rates and this would be more cross-cutting than simply stratifying by race/ethnicity. Having a usual source of care and health insurance status are more significantly related to

poverty and education al status per AHRQ. While I think that AHA is correct to question this issue based on the lack of use of sociodemographic factors in the model, I think using poverty would be a more logical stratifier for HF readmissions. Poverty is related to presence of health insurance and access to care, and related to having a usual source of care; both important factors in HF readmissions.

While the Committee has made disparities a high priority throughout this project and supports reporting of data on disparities, Committee members do not support stratification for the purpose of adjusting the payment based on the racial/ethnic mix of a hospital's patient population.

NQF STAFF NOTE: NQF's ongoing project on Healthcare Disparities and Cultural Competency is addressing measurement issues around disparities. A commissioned paper looking at various measurement issues outlines the pros and cons of stratification.

0230: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization for patients 18 and older

0229: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF) hospitalization for patients 18 and older

Comment:
"Clarify the data sources that were used in the all payer data testing".

Developer Response:
"The data source used to complete the all payer testing was the state of California's Patient Discharge Database (PDD) which contains records for all discharges from all non-Federal hospitals located in California. California is a diverse state, and, with more than 37 million residents, California represents 12% of the US population. In 2006, there were approximately 3 million adult discharges from more than 450 hospitals. Records are linked by a unique patient identification number, allowing us to determine patient history from previous hospitalizations and to evaluate rates of both readmission and mortality. Specifically, patients from this database are linked to the California Death Statistical Master File (DSMF) using social security number in order to validate and record deaths."

The Steering Committee agreed that the developer answered the comment.

Information for electronic voting has been sent to NQF Member organization primary contacts. Accompanying comments must be submitted via the online voting tool.

Please note that voting concludes on December 5, 2011, at 6:00 pm ET—no exceptions.