NATIONAL QUALITY FORUM

Memo

TO: Consensus Standards Approval Committee (CSAC)

FR: Peg Terry, Katie Goodwin, May Nacion, Yetunde Ogungbemi

RE: Care Coordination Measures, 2016-2017

DA: June 14, 2017

CSAC ACTION REQUIRED: The CSAC will review recommendations from the Care Coordination project at its June 21, 2017 meeting and vote on whether to uphold the recommendations from the Committee.

This memo includes a summary of the project, recommended measure, themes identified from the Committee, and responses to the public and member comments.

NQF Member voting on the recommended measure closed on Tuesday, June 13, 2017.

Accompanying this memo are the following documents:

1. **Care Coordination 2016-2017 Draft Report.** Staff updated the draft report to reflect the changes made following Standing Committee discussion of public and member comments. The complete draft report and supplemental materials are available on the project page.
2. **Comment Table.** This table lists 20 comments received during the post-meeting comment period, the NQF Standing Committee responses and identified themes.

BACKGROUND

On February 22, 2017, the 20-member Care Coordination Standing Committee met during a one-day in-person meeting to evaluate seven measures against NQF's standard evaluation criteria. The Committee evaluated two new measures and five measures undergoing maintenance review. The Committee recommended one maintenance measure for endorsement. The Committee did not recommend the remaining six measures for endorsement.

DRAFT REPORT

The Care Coordination draft report presents the results of the evaluation of seven measures considered under the Consensus Development Process (CDP). The measures were evaluated against the 2016 version of the measure evaluation criteria.

	Maintenance	New	Total
Measures under consideration	5	2	7
Measures recommended for endorsement	1	--	1
Measures not recommended	4	2	6
Measures withdrawn from consideration	1	--	1
Reasons for not recommending	Importance-2 Scientific Acceptability-2 Overall-0 Competing Measure-0	Importance-1 Scientific Acceptability-1 Overall-0 Competing Measure-0	

CSAC ACTION REQUIRED

Pursuant to the CDP, the CSAC will consider endorsement of one candidate consensus measure.

Care Coordination Measure Recommended for Endorsement:

- 0326: Advance Care Plan
  Overall Suitability for Endorsement: Y-15; N-0

Care Coordination Measures Not Recommended (See Appendix A for the Committee's votes and rationale)

- 0646: Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- 0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- 0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- 0649: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
- 3170: Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit
- 3171: Percentage of Asthma ED visits followed by Evidence of Care Connection

COMMENTS AND THEIR DISPOSITION

NQF received 20 comments from six organizations (including six member organizations) pertaining to the general draft report and to the measures under consideration.

A table of comments submitted during the comment period, with responses to each comment

and actions taken by the Standing Committee and measure developers, is available on the Care Coordination project page under the Public and Member Comment section.

Comment Themes and Committee Responses

NQF staff forwarded comments about specific measure specifications and rationale to the measure developers for their comments.

The Standing Committee reviewed all of the submitted comments (general and measure specific) and developer responses. Committee members focused their discussion on measures or topic areas with the most significant and recurring issues.

Theme 1 –Implementation Challenges and Unintended Consequences for measure #0326

Measure #0326: *Advance Care Plan* received two comments supporting the Committee's endorsement recommendation. However, these commenters noted the implementation challenges and unintended consequences of using claims data to reliably capture care plans and the lack of consistency with providers billing for this service. During the in-person meeting, the Committee did not express any concerns with the validity of the measure or any unintended consequences or potential harms to patients because of this measure.

Developer Response: We appreciate your support of endorsement for #0326: Advance Care Plan as a clinician/group practice level measure. We understand the challenges of retrieving this information, through claims data, and have expanded the list of codes that count toward the numerator for this measure. This list includes the CPT II codes: 1123F, 1124F and the CPT codes 99497, or 99497 and 99498. Medicare began allowing reimbursement for advance care planning discussions through codes 99497 and 99498 effective January 1, 2016. We expect this will encourage more physicians to record these codes when providing this service.

Theme 2 – Transition of Care Measures

Two commenters expressed their disappointment with the Committee's decision not to recommend four transition of care measures for continued endorsement: #0646 *Reconciled Medication List Received by Discharged Patients*, #0647 *Transition Record with Specified Elements Received by Discharged Patients*, #0648 *Timely Transmission of Transition Record* and #0649 *Transition Record with Specified Elements Received by Discharged Patients*.

Committee Response: The Committee recognizes the importance of transitions of care measures. The Committee did not recommend the four transition of care measures for continued endorsement because the developer did not provide updated performance data and sufficient reliability testing data for each measure as required per NQF's current measure evaluation criteria. The Committee notes that the performance gap requirements include demonstrating quality problems and opportunity for improvement. As part of NQF's maintenance of endorsement process, there is an increased emphasis on data for current performance, gaps in care, and variation. The Committee encourages the developer to continue collecting data to demonstrate that the measures meet NQF criteria for performance gap, which is a must-pass subcriterion. The Committee looks forward to the possibility of re-evaluating

these important transitions of care measures in the future.

NQF Response: Performance scores on the measure as specified are required for maintenance of endorsement per NQF criteria. In addition, the developer did not submit disparities data as required by NQF. Please note that NQF does not require additional testing for maintenance measures if prior testing is adequate; however, prior testing must meet current NQF evaluation criteria.

Theme 3 – Submission of Additional Data

Measure #3170 *Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection before the ED Visit* and #3171 *Percentage of Asthma ED Visits Followed by Evidence of Care Connection* received two comments expressing their concern with the developer's intent to present reliability testing results to the Committee at the post-comment call. The developer did not provide measure score reliability testing data as required for composite measures. The commenters state that presenting new information at the end of the public and member commenting period that could lead to a change in the Committee's recommendations would comply with NQF's Consensus Development Process (CDP). The commenters recommend a second public and member commenting period if new data are presented.

Committee Response: During the comment period, the developer did not submit new data as stated at the in-person meeting. Due to the lack of new data, the measures will not undergo further review. Because measure level testing was unavailable, the measures as currently specified do not meet NQF's measure evaluation criteria and are not recommended for endorsement. The Committee looks forward to re-evaluating these measures in the future.

NQF MEMBER VOTING RESULTS

The one recommended measure was 100% approved by the six member councils that voted. Representatives of 11 member organizations voted; no votes were received from the Public/Community Health Agency or the Supplier/Industry Councils. Results for the measure are available in Appendix B.

REMOVAL OF ENDORSEMENT

One measure previously endorsed by NQF has not been re-submitted and has been withdrawn from maintenance of endorsement:

Measure	Measure Description	Reason for Removal of Endorsement
0526 Timely Initiation of Care	Percentage of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date, whichever is later.	Developer states, "the measure currently exhibits limited variability and would likely fail the 1b. Performance Gap section of the NQF endorsement process."

Appendix A – Measures Not Recommended for Endorsement

The table below lists the Committee's vote and rationale for measures not recommended for endorsement.

LEGEND: Y = Yes; N = No; H = High; M = Moderate; L = Low; I = Insufficient

Measure	Voting Results	Standing Committee Rationale
0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	**Evidence** H-0; M-0; L-1; I-15 **Insufficient Evidence with Exception** Y-13; N-3 **Gap** H-0; M-3; L-4; I-9; **Revote** H-0; M-6; L-4; I-6	• During the 2012 review, the developer cited the evidence base from the 2006 Transitions of Care Consensus Conference (TOCCC) development of principles, guidelines, and standards. The developer did not provide a systematic review of the body of evidence that matches the measure focus; evaluation of the quantity, quality, or consistency of the evidence provided; or reconciled medication lists at the time of discharge. The TOCCC expert opinion based guidelines were ungraded and were based on evidence related to transitions of care between the inpatient and outpatient settings. • For the current evaluation, the developer attested that there have been no changes in the evidence since the 2012 review. • The Committee acknowledged the absence of updated, empirical evidence for this measure, but acknowledged that the measure is important and the evidence presented is still relevant. The Committee decided to vote and pass the subcriterion on the exception to evidence. • The developer stated there are no available performance scores. The California Department of Health Care Services administered this measure in the CMS Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program in 2016. The developer noted that there is a two-year delay before data are available to measure developers. • The developer provided additional evidence during the in-person meeting regarding medication discrepancies by gender (Lindquist et al., 2013). Although the developer provided disparities data, the Committee agreed that there was still insufficient evidence on disparities. • Due to the absence of performance scores and insufficient disparities data, this measure did not pass the performance gap subcriterion.

0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	**Evidence** H-0; M-0; L-1; I-15 **Insufficient Evidence with Exception** Y-15; N-1 **Gap** H-0; M-8; L-3; I-4 **Reliability** H-0; M-4; L-6; I-5	• For the 2012 evaluation, the evidence provided by the developer included the 2009 Transitions of Care Consensus Conference (TOCCC) development of standards. The standards were a result of a consensus conference convened in 2006 by the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM), with representation from the Emergency Medicine community. The TOCCC expert opinion based guidelines were ungraded and were based on evidence related to transitions of care between the inpatient and outpatient settings. • One Committee member noted that, although the evidence provided is not specific to the measure focus, it does support that the process of providing an inclusive discharge summary and reviewing the content with the patient/caregiver is one component of programs that are successful in reducing negative post-discharge events. The Committee noted that communication of essential patient information is critical to continuity of appropriate and quality care. Committee members stated that this should be a basic standard of practice and agreed that empirical evidence is not needed to hold providers accountable for the measure. Considering the absence of empirical evidence provided to support this important measure concept, the Committee decided to vote and pass the subcriterion on the exception to evidence. • The developer was not able to provide any data on current performance of the measure. To demonstrate opportunity for improvement, the developer provided a summary of data from the literature showing that delayed or insufficient transfer of discharge information between hospital-based providers and primary care physicians remains common. However, Committee members noted that the data from the literature was not recent. • Performance scores on the measure as specified (current and over time) at the level of analysis are required for maintenance of endorsement. The Committee was unable to reach consensus on the performance gap subcriterion.

		• For the 2012 endorsement evaluation, data from a report automatically generated from one EHR was compared to manual abstraction from patient records to calculate parallel forms of reliability for the measure. One overall statistic was provided (88% agreement, kappa=.69). Because it was unclear what the overall statistic was referring to, the developer provided additional testing results on the numerator, denominator and exceptions. • Committee members noted concerns with the generalizability of the validity testing, as the empirical testing used customized data from only one site's EHR to facilitate the review and printing of the transition record. The developer clarified that the measure was not specified as an eMeasure because every facility may have a different template for a transition record in their EHR. The Committee noted that the measure was likely intended for implementation in EHRs; however, EHR systems have changed since measure testing was conducted, with great variation in documentation across EHR systems. • The Committee encouraged the developer to conduct updated testing that would include multiple sites to demonstrate how the measure would perform on a national scale versus just one facility. The Committee did not find the reliability testing to be sufficient to pass the reliability subcriterion.
0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	**Evidence** H-0; M-0; L-1; I-14 **Insufficient Evidence with Exception** Y-13; N-2 **Gap** H-0; M-7; L-1; I-7 **Reliability** H-0; M-4; L-4; I-7	• The developer provided the same evidence, the 2009 Transitions of Care Consensus Conference (TOCCC) development of standards, as in measure 0647. The TOCCC expert opinion based guidelines were ungraded and were based on evidence related to transitions of care between the inpatient and outpatient settings. • Committee members agreed that the evidence supporting this measure demonstrates that providing an inclusive discharge summary and reviewing the content with the patient/caregiver is one component of programs that are successful in reducing negative post-discharge events. The Committee recognized that the evidence is not specific to the focus of the measure. Considering the absence of empirical evidence provided to support this important measure concept, the

		Committee agreed to invoke the exception to the evidence subcriterion. • Similar to measure 0647, the developer was not able to provide any data on current performance of the measure. To demonstrate opportunity for improvement, the developer provided a summary of data from the literature showing that delayed or insufficient transfer of discharge information between hospital-based providers and primary care physicians remains common. However, Committee members noted that the data from the literature was not recent. • A Committee member noted that, although no performance data was provided for this specific measure, data does exist that demonstrates there are performance gaps in this area of measurement. The Committee was unable to reach consensus on the performance gap subcriterion. • For the 2012 endorsement evaluation, data from a report automatically generated from one EHR was compared to the manual abstraction from patient records to calculate parallel forms of reliability for the measure. One overall statistic was provided (95% agreement, kappa=.49). Because it was unclear what the overall statistic was referring to, the developer provided additional testing results for the numerator, denominator and exceptions prior to the Committee meeting. • The Committee agreed to apply the previous discussion about the reliability testing for measure #0647 to this measure, as the testing methodology was the same. The Committee remained concerned about the small sample size (1 facility and 377 patients) and did not pass the measure on the reliability subcriterion.
0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self	**Evidence** H-0; M-2; L-1; I-12 **Insufficient Evidence with Exception** Y-11; N-4 **Gap** H-0; M-2; L-1; I-12	• For the 2012 evaluation, the evidence provided by the developer included the 2009 Transitions of Care Consensus Conference (TOCCC) development of standards. The standards were a result of a consensus conference convened in 2006 by the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM), with representation from the Emergency Medicine community. The TOCCC expert opinion based guidelines were ungraded and were based on evidence related to transitions of care between the inpatient and outpatient settings. • Committee members agreed that the evidence supporting this measure demonstrates that providing an inclusive discharge summary and

Care] or Home Health Care)		reviewing the content with the patient/caregiver is one component of programs that are successful in reducing negative post-discharge events. The Committee noted that the evidence is not specific to the measure focus. Considering the absence of empirical evidence provided to support this important measure, the Committee agreed to vote and pass the subcriterion on the exception to the evidence. • Similar to measures #0647 and #0648, the developer was not able to provide any data on current performance of the measure. The Committee was also concerned that data on emergency department discharges were not available to support an opportunity for improvement. Ultimately, the measure did not pass the performance gap subcriterion.
3170 Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit	**Evidence** H-1; M-10; L-5; I-1 **Gap** H-4; M-11; L-1; I-1 **Composite** H-1; M-10; L-6; I-0 **Reliability** H-0; M-2; L-1; I-14	• The evidence base for this composite measure is the connection to the primary care system, including use of primary care services and medications prior to an ED visit/hospitalization for children with asthma. Composite measures require that the evidence subcriteria (1a.) is met is for each component. The Guidelines from the National Asthma Education and Prevention Programs (NAEPP) provided graded evidence for regular follow up and the medication management approach. • Three additional studies to support the use of primary care; primary care with medication management; and asthma guidelines to improve care and reduce ED use, were also provided. The Committee agreed that the performance rate for the measure, at 16.5% based on 2009-2011 data from New York State (NYS) Medicaid, demonstrated a substantial opportunity for improvement. • Additionally, data on disparities specifically by race, urbanicity and poverty demonstrated differences in these population groups. • The developer described the three components of this all-or-none measure as “key determinants” of connections to the primary care system that can occur prior to ED visits/hospitalizations. • The Committee discussed whether the measure could be broader and include other elements such as the effects of the environment. Members also

		discussed whether these are the best components for the construct. Other Committee members commented that this measure is a "good start" and the components are available and feasible to obtain. • NQF requires composite measures be tested for reliability at the measure score level. The developer indicated that testing is complete at both the county and plan level in New York State. However, the developer was unable to provide this testing during the in-person meeting. • The developer confirmed plans to present these data to the Committee at the post comment call; however, the developer did not provide the data as intended. Because measure level testing was not available, the measure did not pass on reliability, a must pass criteria.
3171 Percentage of Asthma ED visits followed by Evidence of Care Connection	**Evidence** H-2; M-14; L-1; I-0 **Gap** H-0; M-8; L-2; I-6 **Composite** H-0; M-6; L-9; I-2	• This composite measure includes two components: visit(s) to a primary care provider that occurred within 14 days following the ED visit and have at least one fill of an asthma controller medication within 2 months after the ED visit (including the day of visit). • The Guidelines from the National Asthma Education and Prevention Programs (NAEPP) provided graded evidence for regular follow up and the medication management approach. Specifically, evidence supporting periodic assessment and ongoing monitoring (at 1-6 month) intervals of asthma control was graded at a category B and C. Evidence (graded at a category A) was provided to support the daily use of long-term control medications on a long-term basis to achieve and maintain control of persistent asthma. • The developer provided additional studies that support the use of primary care for asthma management. The studies focused on primary care with medication management; asthma guidelines to improve care and reduce ED use, especially for minority children; and several studies support follow-up with a primary care physician for ongoing management after an exacerbation. • During the Committee discussion, one member noted that a strength of the measure is that it assesses a subsequent event of care provided --a substantive event. • The performance rate for the measure was 16.5% based on 2009-2011 data from New York State (NYS) Medicaid. However, the Committee raised concerns about the accuracy of these data. The

		developer suggested that further data would clarify the information on this measure and confirmed plans to provide these data at the post-comment call. • Additionally, data on disparities specifically by race, urbanicity and poverty demonstrated differences between subpopulation groups. • The developer described the two components of this all-or-none measure as "key determinants" of connections to the primary care system that can occur following ED visits for children with asthma. • The Committee discussed the components of the composite measure. One member suggested that some patients may receive medications in locations that do not bill for these prescription refills such as an ED and another member offered that some patients might not need a refill as early as two months. Other members discussed the importance of an asthma care plan and feasibility of obtaining one. Additionally, one member suggested that the measure may improve if the two components in this measure were constructed as an "Or" instead of an "And". Due to the multiple concerns by members of the Committee on the components and because the measure was an all-or-none composite, the measure failed on 1c. Composite construct, a must pass criterion.

Appendix B – NQF Member Voting Results

NQF MEMBER VOTING RESULTS

The one recommended measure was 100% approved by the six member councils that voted. Representatives of 11 member organizations voted; no votes were received from the Public/Community Health Agency or the Supplier/Industry Councils. Results for the measure are provided below.

NQF Member Council	Voting Organizations	Eligible to Vote	Rate
Consumer	1	38	3%
Health Plan	2	21	10%
Health Professional	2	105	2%
Provider Organizations	3	110	3%
Public/Community Health Agency	0	15	0%
Purchaser	2	22	9%
QMRI	1	75	1%
Supplier/Industry	0	35	0%
All Councils	11	421	3%

0326 Advance Care Plan

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	1	0	0	1	100%
Health Plan	2	0	0	2	100%
Health Professional	2	0	0	2	100%
Provider Organizations	3	0	0	3	100%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	1	0	0	1	100%
Supplier/Industry	0	0	0	0	
All Councils	11	0	0	11	100%
Percentage of councils approving (>60%)					
Average council percentage approval					

*equation: Yes/ (Total - Abstain)

Voting Comments

Hospice and Palliative Nurses Association: Why is the age set at 65 there are many patients with a serious illness that are younger than 65?

Appendix C – Measure Evaluation Summary Tables

Measure Recommended

0326 Advance Care Plan

Submission | **Specifications**

Description: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

Numerator Statement: Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

Denominator Statement: All patients aged 65 years and older.

Exclusions: N/A

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Clinician: Group/Practice, Clinician: Individual

Setting of Care: Clinician Office/Clinic

Type of Measure: Process

Data Source: Claims (Only), EHRs Hybrid

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING [02/22/2017]

1. Importance to Measure and Report: The measure meets the Importance to Measure and Report criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted;** 1b. Performance Gap: **H-4; M-12; L-1; I-0**

Rationale:

- In the 2012 evaluation, the developer provided evidence by the National Hospice and Palliative Care Organization (NHPCO) that an advance care plan (ACP) positively affects the quality of end of life care.
- For the current review, the developers referenced a 2014 systematic review that evaluates the effect of ACP on hospitalization and length of stays. Evidence from the 21 studies showed that use of an ACP is linked to a decreased rate of hospitalizations.
- Committee members acknowledged the importance of ACP, and referenced updated information. This additional information supported the prior evidence. The Committee agreed that the updated evidence is directionally the same since the last NQF endorsement evaluation. The Committee accepted the prior evaluation of this criterion without further discussion or vote because the evidence is still relevant.
- Some Committee members expressed concern that there is missing disparities information.
- The Committee strongly encouraged the developer to collect and provide the disparities information in the future, but noted this lack of information does not change the evidence supporting the performance gap, which showed increased performance rates from 62.3% to 67.2% on documentation of the advance care plan from 2012 to 2014.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

0326 Advance Care Plan

2a. Reliability: **Previous Reliability Evaluation Accepted;** 2b. Validity: **Previous Validity Evaluation Accepted**

Rationale:

- The Developers did not provide updated reliability testing for this maintenance review. Committee members noted that the previous testing is from a small sample of records from only four sites of care. However, the results indicated strong reliability with an overall kappa score of 0.97.
- Although the Committee noted that the previous testing was based a small number of testing sites to conduct testing, they agreed the results indicated strong reliability of the measure and the Committee accepted prior evaluation of the reliability subcriterion without further discussion.
- The Committee accepted a motion to carry over votes from the previous evaluation on reliability.
- An expert panel of 33 members assessed face validity of the measure. The panel rated their agreement based on the statement, "the scores obtained from the measure as specified will accurately differentiate quality across providers." Results from the expert panel indicated an average rating of 4.35 on a 5-point scale.
- Several Committee members noted that a significant reconsideration of validity was not warranted unless there is evidence that the use of CPT codes for ACP have changed substantially since testing was first conducted.
- The Committee accepted a motion to carry over votes from the previous evaluation on validity.

3. Feasibility: H-1; M-13; L-2; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- This measure is currently in use in the CMS Medicare Physician Quality Reporting System (PQRS); Committee members expressed no concerns with the measure's feasibility.

4. Usability and Use: H-1; M-14; L0-; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- The measure is in use in both CMS' Medicare PQRS and the Quality Payment Program Merit-Based Incentive Payment System (MIPS). Members noted that the results from the measures used in an accountability program could advance goals of high quality healthcare.
- The developers noted an increased rate of performance (62.3% to 67.2%) from the eligible physicians who reported continuously from 2012-2014, which suggests physicians are initiating and documenting discussion of ACP with patients, family, and caregivers at a higher rate.
- The Committee did not voice concerns about unintended consequences or potential harms to patients because of this measure.

5. Related and Competing Measures

- This measure is related to two other measures:
    - 1626: Patients Admitted to ICU who Have Care Preferences Documented
    - 1641: Hospice and Palliative Care –Treatment Preferences

The Committee discussed some pertinent issues including that the information on advance care planning moves across settings. The suggestion that harmonization of the these measures through standardizing the terminology at the numerator level between all three measures might allow for capturing information across the continuum of care regarding an individual's preferences in their advanced care decisions and planning. The Committee suggested that this could be the first step towards making a plan portable.

0326 Advance Care Plan
Standing Committee Recommendation for Endorsement: **Y-15; N-0**
6. Public and Member Comment • NQF received two post-evaluation comments supporting the Committee's recommendation to endorse the measure. However, one commenter noted that claims data do not reliably capture the care plan and the physician does not always bill for this service. Another commenter suggested being mindful of implementation challenges and any unintended consequences. **Developer Response:** We appreciate your support of endorsement for #0326: Advance Care Plan as a clinician/group practice level measure. We understand the challenges of retrieving this information through claims data and have expanded the list of codes that count toward the numerator for this measure. This list includes the CPT II codes: 1123F, 1124F and the CPT codes 99497, or 99497 and 99498. Medicare began allowing reimbursement for advance care planning discussions through codes 99497 and 99498 effective January 1, 2016. We expect this will encourage more physicians to record these codes when providing this service.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Appeals

Measures Not Recommended

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Submission | **Specifications**
Description: Percentage of discharges from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, in which the patient, regardless of age, or their caregiver(s) received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories **Numerator Statement**: Discharges in which the patient or their caregiver(s) received a reconciled medication list at the time of discharge including, at a minimum, medications in the following categories: Medications TO BE TAKEN by Patient - Continued* Medications prescribed before inpatient stay that patient should continue to take after discharge, AND - Changed* Medications prescribed before inpatient stay with a change in dosage or directions after discharge that differs from what the patient was taking prior to the inpatient stay, AND - New* Medications started during inpatient stay that are to be continued after discharge and newly prescribed medications that patient should begin taking after discharge * Prescribed dosage, instructions, and intended duration must be included for each continued, changed and new medication listed Medications NOT TO BE TAKEN by Patient - Discontinued Medications taken by patient before the inpatient stay that should be discontinued or held after discharge, AND - Allergies and Adverse Reactions

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Medications administered during the inpatient stay that caused an allergic reaction or adverse event and were therefore discontinued

Denominator Statement: All discharges for patients, regardless of age, from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care

Exclusions: Patients who died

Patients who left against medical advice (AMA) or discontinued care

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility, Integrated Delivery System

Setting of Care: Hospital : Acute Care Facility, Ambulatory Surgery Center, Hospital : Critical Care, Hospital, Behavioral Health : Inpatient, Inpatient Rehabilitation Facility, Long Term Acute Care, Nursing Home / SNF

Type of Measure: Process

Data Source: EHRs Hybrid, Paper Records

Measure Steward: PCPI

STANDING COMMITTEE MEETING [02/22/2017]

1. Importance to Measure and Report: <u>The measure does not meet the Importance to Measure and Report criteria</u>

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-0; L-1; I-15**; 1b. Performance Gap: **H-0; M-3; L-4; I-9;** Revote**: H-0; M-6; L-4; I-6;** Evidence Exception: **Y-13; N-3**

<u>Rationale</u>:

- During the 2012 review, the developer cited the evidence base from the 2006 Transitions of Care Consensus Conference (TOCCC) development of principles, guidelines, and standards. The developer did not provide a systematic review of the body of evidence that matches the measure focus or reconciled medication lists at the time of discharge, or on the quantity, quality, or consistency of the evidence provided. The TOCCC expert opinion based guidelines were ungraded and based on evidence related to transitions of care between the inpatient and outpatient settings.
- For the current evaluation, the developer attested that there have been no changes in the evidence since the 2012 review. During the Committee review, a Committee member identified several studies (Mueller et al., 2012, Vedel and Khanassov 2015, Kansagara 2015, Michaelsen 2015, and Mekonnen et al., 2016) that were relevant to the measure focus. However, the developer noted that the updated studies were discussing different types of interventions and not specifically discussing the current measure— reconciled medication list received by the patient.
- The Committee acknowledged the absence of updated, empirical evidence for this measure. However, the measure is important and the evidence presented is still relevant. The Committee agreed to invoke the exception to the evidence subcriterion.
- The developer stated there are no available performance scores. The California Department of Health Care Services administered this measure in the CMS Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program in 2016. The developers noted that there is a two-year delay before data is available to measure developers.
- The developer provided additional evidence during the in-person meeting regarding medication discrepancies by gender (Lindquist et al., 2013). Although the developer provided disparities data, the Committee agreed that there was still insufficient evidence on disparities.
- Due to the absence of performance scores and insufficient disparities data, this measure ultimately did not pass the performance gap subcriterion.

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

2. Scientific Acceptability of Measure Properties:

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-X**; **M-X**; **L-X**; **I-X**; 2b. Validity: **H-X**; **M-X**; **L-X**; **I-X**

Rationale:

-

3. Feasibility: H-X; M-X; L-X; I-X

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

-

4. Usability and Use: H-X; M-X; L-X; I-X

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

-

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **Y-X**; **N-X**

Rationale

-

6. Public and Member Comment

- NQF received three post-evaluation comments regarding this measure. One of the commenters supported the decision of the Committee not to endorse the measure. Two of the commenters supported the measure.

  Committee Response: The Committee recognizes the importance of transitions of care measures and encourages the developer to monitor the performance of these measures. The Committee did not recommend the four transition of care measures for continued endorsement because the developer did not provide updated performance data and sufficient reliability testing data for each measure as required per NQF's current measure evaluation criteria. The Committee recognizes the importance of these transition of care measures in the coordination of care. The Committee notes that the performance gap requirements include demonstrating quality problems and opportunity for improvement. As part of NQF's endorsement maintenance process, there is an increased emphasis on data for current performance, gaps in care, and variation. The Committee encourages the developer to continue collecting data to demonstrate that the measures meet NQF criteria for performance gap, which is a must-pass subcriterion. The Committee looks forward to the possibility of re-evaluating these important transitions of care measures in the future.

  NQF Response: Performance scores on the measure as specified are required for maintenance of endorsement per NQF criteria. In addition, the developer did not submit disparities data as required by NQF. Please note that NQF does not require additional testing for maintenance measures if prior testing is adequate; however, prior testing must meet current NQF evaluation criteria.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

8. Appeals

0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Submission | Specifications

Description: Percentage of discharges from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, in which the patient, regardless of age, or their caregiver(s), received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements

Numerator Statement: Discharges in which the patient or their caregiver(s) received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the following elements:

Inpatient Care

- Reason for inpatient admission, AND
- Major procedures and tests performed during inpatient stay and summary of results, AND
- Principal diagnosis at discharge

Post-Discharge/ Patient Self-Management

- Current medication list, AND
- Studies pending at discharge (eg, laboratory, radiological), AND
- Patient instructions

Advance Care Plan

- Advance directives or surrogate decision maker documented OR
- Documented reason for not providing advance care plan

Contact Information/Plan for Follow-up Care

- 24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND
- Contact information for obtaining results of studies pending at discharge, AND
- Plan for follow-up care, AND
- Primary physician, other healthcare professional, or site designated for follow-up care

Denominator Statement: All discharges for patients, regardless of age, from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care

Exclusions: Patients who died

Patients who left against medical advice (AMA) or discontinued care

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility, Integrated Delivery System

Setting of Care: Hospital : Acute Care Facility, Ambulatory Surgery Center, Hospital : Critical Care, Hospital, Behavioral Health : Inpatient, Inpatient Rehabilitation Facility, Long Term Acute Care, Nursing Home / SNF

Type of Measure: Process

Data Source: EHRs Hybrid, Paper Records

Measure Steward: PCPI

STANDING COMMITTEE MEETING [02/22/2017]

1. Importance to Measure and Report: This measure did not reach consensus on the Importance to Measure and Report criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-0; L-1; I-15**; 1b. Performance Gap: **H-0; M-8; L-3; I-4;**

0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Evidence Exception: **Y-15; N-1**

Rationale:

- For the 2012 evaluation, the evidence provided by the developer included the 2009 Transitions of Care Consensus Conference (TOCCC) development of standards. The standards were a result of a consensus conference convened in 2006 by the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM), with representation from the Emergency Medicine community. The TOCCC expert opinion based guidelines were ungraded and based on evidence related to transitions of care between the inpatient and outpatient settings.
- One Committee member noted that, although the evidence provided is not specific to the measure focus, it does support that the process of providing an inclusive discharge summary and reviewing the content with the patient/caregiver is one component of programs that are successful in reducing negative post-discharge events. The Committee noted that communication of essential patient information is critical to continuity of appropriate and quality care. Committee members stated that this should be a basic standard of practice and agreed that empirical evidence is not needed to hold providers accountable for the measure. Considering the absence of empirical evidence provided to support this important measure concept, the Committee agreed to invoke the exception to the evidence subcriterion.
- The developer was not able to provide any data on current performance of the measure. To demonstrate opportunity for improvement, the developer provided a summary of data from the literature showing that delayed or insufficient transfer of discharge information between hospital-based providers and primary care physicians remains common. However, Committee members noted that the data from the literature was not recent.
- The developer also summarized a prospective study that tracked the frequency of occurrence of certain elements that are included within the measure. Although performance scores varied on whether the required elements were provided to patients or not, Committee members noted that the sample size of the study was small (1 facility and 377 patients) and remained concerned that data was not provided on the measure as specified. Performance scores on the measure as specified (current and over time) at the specified level of analysis are required for maintenance of endorsement. The Committee was unable to reach consensus on the performance gap subcriterion.

2. Scientific Acceptability of Measure Properties: The measure does not meet the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-4; L-6; I-5;** 2b. Validity: **H-X**; **M-X**; **L-X**; **I-X**

Rationale:

- For the 2012 endorsement evaluation, data from a report automatically generated from one EHR was compared to manual abstraction from patient records to calculate parallel forms of reliability for the measure. One overall statistic was provided (88% agreement, kappa=.69). Because it was unclear what the overall statistic was referring to, the developer provided additional testing results on each data element prior to the meeting (numerator, denominator and exceptions).
- Committee members noted concerns about the generalizability of the validity testing, as the empirical testing of the measure was used data from only one site's EHR, which was customized to facilitate the review and printing of the transition record. The developers clarified that the measure was not specified as an eMeasure because every facility may have a different template for a transition record in their EHR. The Committee noted that the measure is most likely to be implemented in EHRs, much has changed around EHRs since the time the testing was conducted, and there is much variation in terms of how things are documented within EHRs.

0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

- The Committee encouraged developers to conduct updated testing that would include multiple sites to demonstrate how the measure would perform on a national scale versus just one facility. The Committee did not find the reliability testing provided sufficient to pass the reliability subcriterion.

3. Feasibility: H-X; M-X; L-X; I-X

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

-

4. Usability and Use: H-X; M-X; L-X; I-X

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

-

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **No**

Rationale

-

6. Public and Member Comment

- NQF received three post-evaluation comments regarding this measure. One of the commenters supported the decision of the Committee not to endorse the measure. Two of the commenters supported the measure.

  Committee Response: The Committee recognizes the importance of transitions of care measures and encourages the developer to monitor the performance of these measures. The Committee did not recommend the four transition of care measures for continued endorsement because the developer did not provide updated performance data and sufficient reliability testing data for each measure as required per NQF's current measure evaluation criteria. The Committee recognizes the importance of transition of care measures in the coordination of care. The Committee notes that the performance gap requirements include demonstrating quality problems and opportunity for improvement. As part of NQF's endorsement maintenance process, there is an increased emphasis on data for current performance, gaps in care, and variation. The Committee encourages the developer to continue collecting data to demonstrate that the measures meet NQF criteria for performance gap, which is a must-pass subcriterion. The Committee looks forward to the possibility of re-evaluating these important transitions of care measures in the future.

  NQF Response: Performance scores on the measure as specified are required for maintenance of endorsement per NQF criteria. In addition, the developer did not submit disparities data as required by NQF. Please note that NQF does not require additional testing for maintenance measures if prior testing is adequate; however, prior testing must meet current NQF evaluation criteria.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

8. Appeals

0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Submission | Specifications

Description: Percentage of discharges from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, of patients, regardless of age, for which a transition record was transmitted to the facility or primary physician or other healthcare professional designated for follow-up care within 24 hours of discharge

Numerator Statement: Discharges in which a transition record was transmitted to the facility or primary physician or other healthcare professional designated for follow-up care within 24 hours of discharge

Denominator Statement: All discharges for patients, regardless of age, from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care

Exclusions: Patients who died

Patients who left against medical advice (AMA) or discontinued care

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility, Integrated Delivery System

Setting of Care: Hospital : Acute Care Facility, Ambulatory Surgery Center, Hospital : Critical Care, Hospital, Behavioral Health : Inpatient, Inpatient Rehabilitation Facility, Long Term Acute Care, Nursing Home / SNF

Type of Measure: Process

Data Source: EHRs Hybrid, Paper Records

Measure Steward: PCPI

STANDING COMMITTEE MEETING [02/22/2017]

1. Importance to Measure and Report: The measure did not reach consensus on the Importance to Measure and Report criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-0; L-1; I-14**; 1b. Performance Gap: **H-0; M-7; L-1; I-7;**

Evidence Exception: **Y-13; N-2**

Rationale:

- For the 2012 evaluation, the evidence provided by the developer included the 2009 Transitions of Care Consensus Conference (TOCCC) development of standards. The standards were a result of a consensus conference convened in 2006 by the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM), with representation from the Emergency Medicine community. The TOCCC expert opinion based guidelines were ungraded and based on evidence related to transitions of care between the inpatient and outpatient settings.
- Committee members agreed that the evidence supporting this measure demonstrates that providing an inclusive discharge summary and reviewing the content with the patient/caregiver is one component of programs that are successful in reducing negative post-discharge events. The Committee recognized that the evidence is not specific to the focus of the measure. Considering the absence of empirical evidence provided to support this important measure concept, the Committee agreed to invoke the exception to the evidence subcriterion.
- Similar to measure 0647, the developer was not able to provide any data on current performance of the measure. To demonstrate opportunity for improvement, the developer provided a summary of data from the literature showing that delayed or insufficient transfer of discharge information

0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

between hospital-based providers and primary care physicians remains common. However, Committee members noted that the data from the literature was not recent.

- A Committee member noted that, although performance data was not provided for this specific measure, data does exist that demonstrates there are performance gaps in this area of measurement. The Committee was unable to reach consensus on the performance gap subcriterion.

2. Scientific Acceptability of Measure Properties: <u>The measure does not meet the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-4; L-4; I-7;** 2b. Validity: **H-X**; **M-X**; **L-X**; **I-X**

<u>Rationale</u>:

- For the 2012 endorsement evaluation, data from a report automatically generated from one EHR was compared to manual abstraction from patient records to calculate parallel forms of reliability for the measure. One overall statistic was provided (95% agreement, kappa=.49). Because it was unclear what the overall statistic was referring to, the developer provided additional testing results on each data element prior to the Committee's meeting (numerator, denominator and exceptions).
- The Committee agreed to apply the previous discussion about the reliability testing for measure #0647 to this measure, as the testing methodology was the same. The Committee remained concerned about the small sample size (1 facility and 377 patients) and did not pass the measure on the reliability subcriterion.

3. Feasibility: H-X; M-X; L-X; I-X

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

-

4. Usability and Use: H-X; M-X; L-X; I-X

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

<u>Rationale</u>:

-

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **Y-X**; **N-X**

<u>Rationale</u>

-

6. Public and Member Comment

- NQF received three post-evaluation comments regarding this measure. One of the commenters supported the decision of the Committee not to endorse the measure. Two of the commenters supported the measure.

  Committee Response: The Committee recognizes the importance of transitions of care measures and encourages the developer to monitor the performance of these measures. The Committee did not recommend the four transition of care measures for continued endorsement because the developer did not provide updated performance data and sufficient reliability testing data for each measure as required per NQF's current measure evaluation criteria. The Committee recognizes the

0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
importance of these transition of care measures in the coordination of care. The Committee notes that the performance gap requirements include demonstrating quality problems and opportunity for improvement. As part of NQF's endorsement maintenance process, there is an increased emphasis on data for current performance, gaps in care, and variation. The Committee encourages the developer to continue collecting data to demonstrate that the measures meet NQF criteria for performance gap, which is a must-pass subcriterion. The Committee looks forward to the possibility of re-evaluating these important transitions of care measures in the future. **NQF Response:** Performance scores on the measure as specified are required for maintenance of endorsement per NQF criteria. In addition, the developer did not submit disparities data as required by NQF. Please note that NQF does not require additional testing for maintenance measures if prior testing is adequate; however, prior testing must meet current NQF evaluation criteria.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Appeals

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
Submission | Specifications
Description: Percentage of discharges from an emergency department (ED) to ambulatory care or home health care, in which the patient, regardless of age, or their caregiver(s), received a transition record at the time of ED discharge including, at a minimum, all of the specified elements **Numerator Statement**: Discharges in which the patient or their caregiver(s) received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements: - Summary of major procedures and tests performed during ED visit, AND - Principal clinical diagnosis at discharge which may include the presenting chief complaint, AND - Patient instructions, AND - Plan for follow-up care (OR statement that none required), including primary physician, other healthcare professional, or site designated for follow-up care, AND - List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each **Denominator Statement**: All discharges for patients, regardless of age, from an emergency department (ED) to ambulatory care (home/self care) or home health care **Exclusions**: Exclusions: Patients who died Patients who left against medical advice (AMA) or discontinued care Exceptions: Patients who declined receipt of transition record Patients for whom providing the information contained in the transition record would be prohibited by state or federal law **Adjustment/Stratification**: No risk adjustment or risk stratification **Level of Analysis:** Facility, Integrated Delivery System **Setting of Care:** Emergency Department

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

Type of Measure: Process

Data Source: EHRs Hybrid, Paper Records

Measure Steward: PCPI

STANDING COMMITTEE MEETING [02/22/2017]

1. Importance to Measure and Report: <u>The measure does not meet the Importance to Measure and Report criteria</u>

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-2; L-1; I-12**; 1b. Performance Gap: **H-0; M-2; L-1; I-12;**

Evidence Exception: **Y-11; N-4**

<u>Rationale</u>:

- For the 2012 evaluation, the evidence provided by the developer included the 2009 Transitions of Care Consensus Conference (TOCCC) development of standards. The standards were a result of a consensus conference convened in 2006 by the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM), with representation from the Emergency Medicine community. The TOCCC expert opinion based guidelines were ungraded and were based evidence related to transitions of care between the inpatient and outpatient settings.
- Committee members agreed that the evidence supporting this measure demonstrates that providing an inclusive discharge summary and reviewing the content with the patient/caregiver is one component of programs that are successful in reducing negative post-discharge events. The Committee recognized that the evidence is not specific to the focus of the measure. Considering the absence of empirical evidence provided to support this important measure concept, the Committee agreed to invoke the exception to the evidence subcriterion.
- Similar to measures #0647 and #0648, the developer was not able to provide any data on current performance of the measure. The Committee was also concerned that data looking at emergency department discharges related to this measure were not available to support an opportunity for improvement. Ultimately, the measure did not pass the performance gap subcriterion.

2. Scientific Acceptability of Measure Properties:

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-X**; **M-X**; **L-X**; **I-X;** 2b. Validity: **H-X**; **M-X**; **L-X**; **I-X**

<u>Rationale</u>:

-

3. Feasibility: H-X; M-X; L-X; I-X

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

-

4. Usability and Use: H-X; M-X; L-X; I-X

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

<u>Rationale</u>:

-

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **Y-X**; **N-X**

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

Rationale

-

6. Public and Member Comment

- NQF received three post-evaluation comments regarding this measure. One of the commenters supported the decision of the Committee not to endorse the measure. Two of the commenters supported the measure.

  Committee Response: The Committee recognizes the importance of transitions of care measures and encourages the developer to monitor the performance of these measures. The Committee did not recommend the four transition of care measures for continued endorsement because the developer did not provide updated performance data and sufficient reliability testing data for each measure as required per NQF's current measure evaluation criteria. The Committee recognizes the importance of these transition of care measures in the coordination of care. The Committee notes that the performance gap requirements include demonstrating quality problems and opportunity for improvement. As part of NQF's endorsement maintenance process, there is an increased emphasis on data for current performance, gaps in care, and variation. The Committee encourages the developer to continue collecting data to demonstrate that the measures meet NQF criteria for performance gap, which is a must-pass subcriterion. The Committee looks forward to the possibility of re-evaluating these important transitions of care measures in the future.

  NQF Response: Performance scores on the measure as specified are required for maintenance of endorsement per NQF criteria. In addition, the developer did not submit disparities data as required by NQF. Please note that NQF does not require additional testing for maintenance measures if prior testing is adequate; however, prior testing must meet current NQF evaluation criteria.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

8. Appeals

3170 Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit

Submission | **Specifications**

Description: This measure describes the incidence rate of emergency department visits for children ages 2 to 21 who are being managed for identifiable asthma. This measure characterizes care that precedes Emergency Department visits for children ages 2- 21 who can be identified as having asthma, using the specified definitions. The developers sought to identify children with ongoing asthma who should be able to be identified by their healthcare providers and/or healthcare plans as having asthma. The operational definition of an identifiable asthmatic is a child who has utilized healthcare services that suggest the healthcare system has enough information to conclude that the child has an asthma diagnosis that requires ongoing care. Specifically, this measure identifies the use of primary care services and medications prior to ED visits and/or hospitalizations for children with asthma.

Numerator Statement: Evidence of connection to the primary care medical system prior to first ED visit and/or hospitalization that has a primary or secondary diagnosis of asthma among children whom our specifications identify with asthma.

Denominator Statement: All first ED visits and/or hospitalizations, in which asthma was a primary or secondary diagnosis in children age 2-21 who meet criteria for being managed for identifiable asthma

in the assessment period and have been enrolled for the 6 consecutive months prior to the ED visit/admission.

Exclusions: Children with specific concurrent or pre-existing diagnosis, as specified in S.9.

Children who have not been consecutively enrolled with the reporting entity for at least six months prior to the index reporting month.

Children who do not meet the denominator criteria.

Adjustment/Stratification: Other Stratification for reasons beyond risk adjustment

Level of Analysis: Population : Community, County or City, Population : Regional and State

Setting of Care: Clinician Office/Clinic, Emergency Department, Hospital

Type of Measure: Composite

Data Source: Claims (Only)

Measure Steward: University Hospitals Cleveland Medical Center

STANDING COMMITTEE MEETING 02/22/2017

1. Importance to Measure and Report: <u>The measure meets the Importance to Measure and Report criteria</u>

(1a. Evidence, 1b. Performance Gap; 1c. Composite)

1a. Evidence: **H-1; M-10; L-5; I-1**; 1b. Performance Gap: **H-4; M-11; L-1; I-1;** 1c. Composite Performance Measure-Quality Construct: **H-1; M-10; L-6; I-0**

<u>Rationale</u>:

- The evidence base for this composite measure is the connection to the primary care system, including use of primary care services and medications prior to an ED visit/hospitalization for children with asthma. Composite measures require that the evidence subcriteria (1a.) is met is for each component.
- The Guidelines from the National Asthma Education and Prevention Programs (NAEPP) provided graded evidence for regular follow up and the medication management approach. Specifically, evidence supporting periodic assessment and ongoing monitoring (at 1-6 month) intervals of asthma control were recommended (graded at a category B and C). Secondly, evidence (graded at a category A), was provided to support the daily use of long-term control medications on a long-term basis to achieve and maintain control of persistent asthma. Lastly, evidence that supports Short Acting Beta Agonist (SABAs) as the drug of choice for treating acute asthma symptoms and exacerbations is graded at a category A.
- The developer provided three additional studies that support the use of primary care; primary care with medication management; and asthma guidelines to improve care and reduce ED use, especially in minority children.
- The Committee discussed the strength of the evidence for each component based on the guideline-based care for asthma and concluded that the evidence is strong.
- The performance rate for the measure was 16.5% based on 2009-2011 data from New York State (NYS) Medicaid.
- The Committee agreed this demonstrated a substantial opportunity for improvement.
- Additionally, data on disparities specifically by race, urbanicity and poverty demonstrated differences in these population groups.
- The developer described the three components of this all-or-none measure as “key determinants” of connections to the primary care system that can occur prior to ED visits/hospitalizations.
- The Committee discussed whether the measure could be broader and include other elements such as the effects of the environment. Members also discussed whether these are the best

3170 Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit
components for the construct. Other Committee members commented that this measure is a "good start" and the components are available and feasible to obtain.
2. Scientific Acceptability of Measure Properties: <u>The measure does not meet the Scientific Acceptability criteria</u> (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity; 2d. Composite) 2a. Reliability: **H-0; M-2; L-1; I-14;** 2b. Validity: **H-X**; **M-X**; **L-X**; **I-X;** 2d. Composite: **H-X**; **M-X**; **L-X**; **I-X** <u>Rationale</u>: • NQF requires composite measures be tested for reliability at the measure score level. The developer indicated that testing is complete at both the county and plan level through data in New York State. However, the developer was unable to provide this testing during the in-person meeting. • The developer stated that he plans to obtain this data to present to the Committee at the post comment call. Because measure level testing was not available, the measure did not pass on reliability. • The review of the measure did not continue because reliability is must pass criteria.
3. Feasibility: H-X; M-X; L-X; I-X *(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)* <u>Rationale</u>: •
4. Usability and Use: H-X; M-X; L-X; I-X *(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)* <u>Rationale</u>: •
5. Related and Competing Measures • No related or competing measures noted.
Standing Committee Recommendation for Endorsement: **Y-X**; **N-X** <u>Rationale</u> •
6. Public and Member Comment • NQF received two comments expressing their concern with the developer's intent to present reliability testing results to the Committee at the post-comment call. The developer did not provide measure score reliability testing data as required for composite measures. The commenters recommend a second public and member commenting period if new data are presented. **Committee Response:** Thank you for your comment. During the comment period, the developer did not submit new data as stated at the in-person meeting. Due to the lack of new data, the measures will not undergo further review. Because measure level testing was unavailable, the measures as currently specified do not meet NQF's measure evaluation criteria and are not recommended for endorsement. The Committee looks forward to re-evaluating these measures in the future.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Appeals

3171 Percentage of Asthma ED visits followed by Evidence of Care Connection

Submission | Specifications

Description: This measure seeks to capture important aspects of follow up after ED visits for asthma, including prompt follow up with primary care clinicians and prescription fills for controller medications. This measure characterizes care that follows Emergency Department (ED) visits with a primary or secondary diagnosis of asthma for children ages 2-21 that occur in the Reporting Year and who are enrolled in the health plan for two consecutive months following the ED visit.

The developer stated visits were stratified into those that occurred for children who can or cannot be identified as having asthma, using the specified definitions. Identifiable asthmatic was operationalized as a child who has utilized healthcare services that suggest the healthcare system has enough information to conclude that the child has an asthma diagnosis that requires ongoing care. A 2 year look back period before the reporting year was also incorporated into the measure.

Specifically, this measure describes the connection with the primary care system (timely visits to primary care providers and filling of controller asthma medications) following ED visits for children with asthma.

Numerator Statement: Evidence of connection to the primary care medical system following ED visits that have a primary or secondary diagnosis of asthma among children, overall and stratified by whether the child had identifiable asthma at the time of the ED visit.

Denominator Statement: All ED visits in which asthma was a primary or secondary diagnosis in children who are continuously enrolled for at least the 2 months following the ED visit.

Exclusions: Children with concurrent or pre-existing diagnosis.

Children who have not been consecutively enrolled with the reporting entity for at least two months following the ED visit.

Children who do not meet the denominator criteria.

Adjustment/Stratification: Other Strtification for reasons other then risk adjustment

Level of Analysis: Population : Community, County or City, Population : Regional and State

Setting of Care: Clinician Office/Clinic, Emergency Department, Hospital

Type of Measure: Composite

Data Source: Claims (Only)

Measure Steward: University Hospitals Cleveland Medical Center

STANDING COMMITTEE MEETING 02/22/2017

1. Importance to Measure and Report: The measure does not meet the Importance to Measure and Report criteria

(1a. Evidence, 1b. Performance Gap; 1c. Composite)

1a. Evidence: **H-2; M-14; L-1; I-0**; 1b. Performance Gap: **H-0; M-8; L-2; I-6;** 1c. Composite: **H-0; M-6; L-9; I-2**

Rationale:

- This composite measure includes two components: visit(s) to a primary care provider that occurred within 14 days following the ED visit and have at least one fill of an asthma controller medication within 2 months after the ED visit (including the day of visit).
- The Guidelines from the National Asthma Education and Prevention Programs (NAEPP) provided graded evidence for regular follow up and the medication management approach. Specifically, evidence supporting periodic assessment and ongoing monitoring (at 1-6 month) intervals of asthma control was graded at a category B and C. Evidence (graded at a category A) was provided

3171 Percentage of Asthma ED visits followed by Evidence of Care Connection
to support the daily use of long-term control medications on a long-term basis to achieve and maintain control of persistent asthma. • The developer provided additional studies that support the use of primary care for asthma management. The studies focused on primary care with medication management; asthma guidelines to improve care and reduce ED use, especially in minority children; and several studies support that after an exacerbation, follow-up with a primary care physician is central for ongoing management. • During the Committee discussion, one member noted that a strength of the measure is that it assesses a subsequent event of care provided --a substantive event. • The performance rate for the measure was 16.5% based on 2009-2011 data from New York State (NYS) Medicaid. However, the Committee raised concerns about the accuracy of these data. The developer suggested that further data would clarify the information on this measure and stated that he could provide this data at the post-comment call. • Additionally, data on disparities specifically by race, urbanicity and poverty demonstrated differences in these population groups. • The developer described the two components of this all-or-none measure as "key determinants" of connections to the primary care system that can occur following ED visits for children with asthma. • The Committee discussed the components of the composite measure. One member suggested that some patients may receive medications in locations that do not bill for these prescription refills such as an ED and another member offered that some patients might not need a refill as early as two months. Other members discussed the importance of an asthma care plan and feasibility of obtaining one. Additionally, one member suggested that the measure may improve if the two components in this measure were constructed as an "Or" instead of an "And". Due to the multiple concerns by members of the Committee on the components and because the measure was an all-or-none composite, the measure failed on 1c. Composite construct. Because the measure failed on a must pass criteria, the Committee did not continue the review.
2. Scientific Acceptability of Measure Properties (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity; 2d. Composite) 2a. Reliability: **H-X**; **M-X**; **L-X**; **I-X;** 2b. Validity: **H-X**; **M-X**; **L-X**; **I-X;** 2d. Composite: **H-X**; **M-X**; **L-X**; **I-X** Rationale: •
3. Feasibility: H-X; M-X; L-X; I-X *(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)* Rationale: •
4. Usability and Use: H-X; M-X; L-X; I-X *(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)* Rationale: •
5. Related and Competing Measures • No related or competing measures noted.
Standing Committee Recommendation for Endorsement: **Y-X**; **N-X**

3171 Percentage of Asthma ED visits followed by Evidence of Care Connection
Rationale •
6. Public and Member Comment • NQF received two comments expressing their concern with the developer's intent to present reliability testing results to the Committee at the post-comment call. The developer did not provide measure score reliability testing data as required for composite measures. The commenters recommend a second public and member commenting period if new data are presented. **Committee Response:** Thank you for your comment. During the comment period, the developer did not submit new data as stated at the in-person meeting. Due to the lack of new data, the measures will not undergo further review. Because measure level testing was unavailable, The measures as currently specified do not meet NQF's measure evaluation criteria and are not recommended for endorsement. The Committee looks forward to re-evaluating these measures in the future.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Appeals