



Measure Applications Partnership Hospital Workgroup Review Meeting

The National Quality Forum (NQF) convened a public virtual meeting for the Measure Applications Partnership (MAP) Hospital Workgroup on January 11, 2021.

Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives

The MAP Hospital Workgroup convened jointly with the MAP PAC/LTC Workgroup for the morning session. Matt Pickering, NQF Senior Director, and Amy Moyer, NQF Director, welcomed participants to the virtual meeting. NQF leadership, including Interim President and CEO Chris Queram, Senior Vice President Sheri Winsper and Senior Managing Director Michael Haynie also provided a welcome to the Workgroups. MAP PAC/LTC Co-chairs, Gerri Lamb and Kurt Merkelz, then provided opening remarks. The MAP Hospital Co-chairs, Sean Morrison and Akin Demehin, followed with additional opening remarks. Dr. Pickering reviewed the meeting objectives, namely, to review and provide recommendations on quality measures under consideration for PAC/LTC, hospital, and facility programs, to discuss measurement gaps for these programs, and to provide input into the Centers for Medicare and Medicaid Services (CMS) Quality Action Plan.

CMS Opening Remarks and CMS Quality Action Plan

Michelle Schreiber, CMS Deputy Director for Quality and Value, offered opening remarks and provided a presentation on the CMS Quality Action Plan. Dr. Schreiber discussed the vision of the action plan, namely, to use impactful quality measures to improve health outcomes and deliver value by empowering patients to make informed care decisions while reducing burden to clinicians. Dr. Schreiber reviewed the impact of Meaningful Measures 1.0 and 2.0, and outlined further goals for Meaningful Measures. Dr. Schreiber discussed CMS's intentions to use the Meaningful Measure Initiative to streamline quality measurement, drive value and outcome improvement, improve quality measures through use of digital measures and analytics, empower patients to make best healthcare choices through patient-directed quality measures and public transparency, and to leverage quality measure to highlight disparities and close performance gaps.

CMS's new paradigm features Person-Centered Care at the top of six other focus areas including Patient Safety, Chronic Conditions, Seamless Communication, Affordability and Efficiency, Wellness and Prevention, and Behavioral Health and Substance Use Disorders. Discussion began on the term "patient safety", where the recommendation was made that it be transitioned to a broader term to "person safety"; this was supplemented other comments suggesting that "patient safety" may be appropriate if additional language is added to include residents and healthcare personnel to include safety for all. There were also concerns expressed related to missing health care equity language. It was also suggested that "care coordination" be used in lieu of "seamless communication"; other words for CMS to consider instead of "seamless" included "effective" or "integrated".

MAP provided feedback on "digital measures", where CMS defined digital measures to include a broad definition for both electronic clinical quality measures (eCQMs) and other measures derived from digital data sources. A concern was expressed that an emphasis on digital measures may discourage developers

from building patient reported outcome performance measures (PRO-PMs). MAP noted that there are no clear measures related to health equity such as food insecurity, income, and race. CMS notified that organizations are stratifying dual-eligible beneficiaries by social risk to address specialized needs. CMS noted that they are limited in the data that they have available but are consulting with other Department of Health and Human Services (HHS) offices on approach to incorporating social risk into measurement and stratification.

MAP also pointed out that indirect estimation presents problems in tailoring care. MAP suggested that imputation may not be the best approach and added that making the gathering of information a routine part of providing care may be more effective. It was noted that imputation introduces risk of getting the information. If personal patient data are to be used, MAP suggested that patients should be included in the dialogue around how their data are used.

Overview of Pre-Rulemaking Approach

Janaki Panchal, NQF Manager, and Udara Perera, NQF Senior Manager, provided an overview of the three-step approach to pre-rulemaking, which includes program overview, review of current measures, and evaluation of Measures Under Consideration for what they would add to the program measure set. Ms. Panchal and Dr. Perera then reviewed the four decision categories that MAP members could vote on following the discussion of each measure. Finally, Ms. Panchal and Dr. Perera briefly summarized the voting process and discussed the Rural Health Workgroup charge.

COVID-19 Measures Under Consideration

Dr. Schreiber and Alan Levitt from CMS and Dan Budnitz from the Centers for Disease Control (CDC) provided a presentation on the COVID-19 measures. Dr. Budnitz reviewed the prevalence and incidence of the disease, current vaccines under emergency use authorization (EUA) by the Food and Drug Administration (FDA), the importance of vaccinating healthcare personnel, and early precedents for vaccination measurement. Dr. Budnitz reviewed the healthcare personnel modules within the National Health Safety Network (NHSN).

Dr. Levitt provided an overview of two measures, MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel and MUC20-0048: SARS-CoV-2 Vaccination Coverage for Patients in End-Stage Renal Disease. CMS noted that the measures are being considered to go into effect in 2022. CMS noted that there is no mandate for vaccination, but that it is essential to track vaccination rates.

MAP noted potential equity differences on both the workforce and patient side. CMS suggested that this may present an opportunity for both CMS and other organizations to stratify reporting for equity purposes.

Following the presentation on the COVID-19 measures, MAP PAC/LTC and MAP Hospital reconvened separately to review their respective measures under consideration.

MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel

MAP discussed the timing for rulemaking and reporting related to this measure, namely when would this occur. CMS clarified that rulemaking would be for Spring 2021 and this measure would then be introduced into programs in 2022. MAP members also questioned whether this measure will be critical in 2023, due to the availability of vaccines. CMS noted that there are vaccines for influenza, yet we are still tracking the flu.

MAP did not support this measure for rulemaking, with potential for mitigation. The mitigation points for this measure prior to implementation are that the evidence should be well documented, and that the measure specifications should be finalized, followed by testing and NQF endorsement. MAP recognized that, the proposed measure represents a promising effort to advance measurement for an evolving national pandemic. However, the incomplete specifications require immediate mitigation and further development should continue. MAP member identified that this measure would add value to the program measure set by providing visibility into an important intervention to limit COVID-19 infections in healthcare personnel and the patients for whom they provide care.

MAP observed that collecting information on SARS-CoV-2 vaccination coverage among healthcare personnel and providing feedback will allow facilities to benchmark coverage rates and improve coverage in their facility. Reducing rates of COVID-19 in healthcare personnel may reduce transmission among patients and reduce instances of staff shortages due to illness. Prior to use, this important measure should have the supporting evidence well-documented, and be fully developed, followed by testing and receipt of NQF endorsement.

MUC20-0044 was considered for multiple programs. MAP agreed by consensus to move the voting results and recommendations forward for the Hospital Outpatient Quality Reporting Program (Hospital OQR), Hospital Inpatient Quality Reporting Program (Hospital IQR), Ambulatory Surgical Center Quality Reporting Program (ASCQR), Inpatient Psychiatric Facility Quality Reporting Program (IPFQR), PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR), and End-Stage Renal Disease Quality Improvement Program (ESRD QIP).

MUC20-0048: SARS-CoV-2 Vaccination Coverage for Patients in End-Stage Renal Disease

MAP did not support this measure for rulemaking, with potential for mitigation. The mitigation points for this measure prior to implementation are that the evidence should be well documented, and that the measure specifications should be finalized, followed by testing and NQF endorsement. MAP recognized that the proposed measure represents a promising effort to advance measurement for an evolving national pandemic. However, the incomplete specifications require immediate mitigation and further development should continue. MAP identified that this measure would add value to the program measure set by providing visibility into an important intervention to limit COVID-19 infections.

MAP observed that collecting information on SARS-CoV-2 vaccination coverage and providing feedback to outpatient dialysis facilities will facilitate benchmarking and quality improvement. Vaccination coverage will reduce transmission and associated morbidity and mortality. Prior to use in ESRD QIP, this important measure should have the supporting evidence well-documented, and be fully developed, followed by testing and receipt of NQF endorsement.

End-Stage Renal Disease Quality Incentive Program Measures

Mr. Demehin opened the web meeting to allow for public comment. No public comments were offered.

MUC20-0039: Standardized Hospitalization Ratio for Dialysis Facilities

MAP supported this measure for rulemaking. This NQF-endorsed measure is currently implemented in the ESRD QIP. The developer reported updates to the risk adjustment method of the measure, which includes a prevalent comorbidity adjustment, the addition of Medicare Advantage patients and a Medicare Advantage indicator in the model, updates to parameterization of existing adjustment factors and re-evaluation of interactions, and an indicator for patient's time spent in a skilled nursing facility. These updates have been reviewed by the NQF All-Cause Admissions and Readmissions Standing

Committee during the Spring 2020 evaluation cycle, which recommended the measure for continued endorsement. Other similar measures in the ESRD QIP program evaluate different outcomes than MUC20-0039.

MAP recognized that hospitalization rates vary across dialysis facilities, even after adjusting for patient characteristics. This suggests that hospitalizations might be influenced by dialysis facility practices. This measure seeks to improve patient outcomes by measuring hospitalization ratios among dialysis facilities. In addition, MAP observed that this measure seeks to promote communication between the dialysis facilities and other care settings to improve care transitions. MAP supported the continued use of this measure in PCHQR with the updated specifications.

Program Measure Gaps

During the discussion on measure gaps, MAP suggested that CMS identify opportunities to measuring culture obstacles to quality improvement that can further promote a commitment to doing quality improvement and a culture of knowledge sharing. MAP also suggested that CMS identify ways to make larger leaps to improving quality of care and patient safety, rather than an incremental approach.

Medicare and Medicaid Promoting Interoperability Programs for Eligible Hospitals (EHs) or Critical Access Hospitals (CAHs) Measures

Dr. Morrison opened the web meeting to allow for public comment. No public comments were offered.

MUC20-0032: Global Malnutrition Composite Score

MAP offered conditional support for rulemaking, pending NQF endorsement of this measure. This measure addresses a clinical topic area not currently addressed by the measures in the Promoting Interoperability Program (PI) set. Furthermore, this measure may be considered to address the high priority Meaningful Measure area to “Promote Effective Communication and Coordination of Care” through the electronic health record (EHR) data source and as an electronic clinical quality measure (eCQM). The measure was voted on and passed by the Scientific Methods Panel in October 2020 and will be evaluated for endorsement for the first time as part of the Fall 2020 cycle.

MAP sought clarification on the structure of the specific care plan for the patient. The developer mentioned that the care plan is structured as part of standards of care from the Academy of Nutrition and Dietetics and includes making specific recommendations based on the needs of the patient, including education and counselling needs and referrals to outside support entities. MAP observed that this measure encourages the identification and treatment of malnutrition upon hospital admission for adults age 65 years and older, leading to reduced risk of 30-day readmission, shortened length of stay, reduced risk of in-patient mortality, and lower hospital costs, as compared to malnourished patients that are not screened for risk and treated appropriately. MAP recognized that this is a prevalent clinical issue, with approximately 1 in 3 hospitalized patients at risk for malnutrition.

Hospital Inpatient Quality Reporting Program Measures

Mr. Demehin opened the web meeting to allow for public comment. No public comments were offered.

MUC20-0032: Global Malnutrition Composite Score

MAP offered conditional support for rulemaking, pending NQF endorsement of the measure. This measure addresses a clinical topic area not currently addressed by the measures in the Promoting

Interoperability Program (PI) set. Furthermore, this measure may be considered to address the high priority Meaningful Measure area to “Promote Effective Communication and Coordination of Care” through the EHR data source and as an electronic clinical quality measure. The measure was voted on and passed by the Scientific Methods Panel in October 2020 and will be evaluated for endorsement for the first time as part of the Fall 2020 cycle.

MAP sought clarification on whether CMS intends to change the reporting structure for IQR, as currently, hospitals can select from a list of eQMs available to them. CMS confirmed that hospitals will continue to have that choice and that CMS intends to publicly report eQCM data. MAP also discussed that the components of this composite had previously come to the MAP. The developer confirmed that the component measures were brought to the MAP several years ago, which, at that time, recommended that these measures be a composite.

MAP observed that this measure encourages the identification and treatment of malnutrition upon hospital admission for adults age 65 years and older, leading to reduced risk of 30-day readmission, shortened length of stay, reduced risk of in-patient mortality, and lower hospital costs, as compared to malnourished patients that are not screened for risk and treated appropriately. MAP recognized that this is a prevalent clinical issue, with approximately 1 in 3 hospitalized patients at risk for malnutrition. MAP encouraged CMS to consider using this measure in the ambulatory care setting as there is more opportunity for a broader impact.

MUC20-0003: Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)

MAP supported this measure for rulemaking. This patient-reported outcome-based performance measure (PRO-PM) aligns with the goal of patient-centered approaches to health care quality improvement and targets high variability in hospital performance. MAP recognized that this measure addresses the high priority area of functional outcomes for the Hospital IQR program. The program currently does not include a measure that assesses PROs among THA/TKA patients at the hospital level. MAP members expressed some concern regarding data collection and reporting for this measure. The developer mentioned that they have worked to mitigate burden by reducing the number of questions to a very small number. There is also an effort to create a strategic implementation plan to inform CMS’ strategy to minimize burden in data collection and reporting.

MAP observed that PROs among THA/TKA patients vary across hospitals, suggesting opportunities for improvement in quality of care. The measure seeks to improve patient outcomes following elective primary THA/TKA by providing information to patients, physicians, and hospitals about hospital-level, risk-standardized patient-reported outcomes, such as pain and functional status. This measure is risk-adjusted for patients’ comorbid conditions and the goal of the measure is to provide hospitals with performance information in order to implement focused quality improvement efforts.

Program Measure Gaps

During the measure gap discussion, MAP members encouraged CMS to be mindful of the transition of services being offered within the inpatient setting to the ambulatory setting and the relevance of these measures because of this shift. CMS commented that this was also shared during the MAP Rural Health Workgroup meeting.

Hospital Outpatient Quality Reporting Program Measures

Dr. Morrison opened the web meeting to allow for public comment. No public comments were offered.

MUC20-0004: Appropriate Treatment for ST-Segment Elevation Myocardial Infarction (STEMI) Patients in the Emergency Department (ED)

MAP offered conditional support for rulemaking, pending NQF endorsement. This measure addresses the Meaningful Measure Areas and Hospital OQR Program priorities of “Effective Prevention and Treatment” and “Promote Effective Communication and Coordination of Care”. This eCQM is a combination of two existing chart extracted measures in the Hospital OQR Program set, “Fibrinolytic Therapy Received within 30 Minutes of Emergency Department Arrival” (OP-2) and “Median Time to Transfer for Acute Coronary Intervention” (OP-3) and includes a third option to transfer patients to a percutaneous coronary intervention-capable facility. MAP recognized that the inclusion of this eCQM could reduce data collection burden from the previous chart-based measure collection. CMS added that OP-2 and OP-3 would be used in parallel to this measure and that CMS is introducing electronic measures into all programs with an intent of de-duplicating measures over time.

MAP observed that 550,000 new cases of myocardial infarction and 200,000 recurrent cases are estimated to occur in the United States annually, with approximately 38% of acute coronary syndrome presentations due to STEMI. The addition of this EHR-based quality measure can improve adherence to fibrinolytic therapy in accordance with clinical practice guideline recommendations and median time to transfer for acute coronary intervention. MAP recommended that the NQF endorsement process should evaluate the EHR feasibility, reliability, and validity testing conducted by the developer.

MUC20-0005: Breast Screening Recall Rates

MAP offered conditional support for rulemaking, pending NQF endorsement of the measure. This measure addresses the Hospital Outpatient Quality Reporting Program high-priority areas, “Making Care Safer” and “Making Care Affordable”. MAP recognized that CMS hospital programs currently do not include measures of breast screening recall rates. The measure has been fully specified and gone through initial beta testing, reliability testing, and face validity testing.

MAP observed that this claims-based measure identifies recall rates from breast screenings at the facility level. Recall rates adhering to recommended benchmarks (5%-12%) can ensure that abnormal screenings receive appropriate follow-up while avoiding over-diagnosing and causing undue anxiety and testing for patients. MAP considered if the evidence submitted by the developer includes a clear target recall rate for the accountable entity and patients using the measure to evaluate provider performance since a high or low recall rate could represent an opportunity for improvement. The developer commented that more than 40% of facilities in the analysis were in the recall range. The developer further mentioned that interpretation of the range for patients is whether a provider is in the range or outside of it. Below the range could be missing cancer, whereas, above the range leads to calling back too many people.

MAP considered that this measure is not based on a specific clinical guideline but is supported by expert clinical consensus and support in the literature. MAP raised concern whether there should be a standalone metric or within a composite. The developer commented that there is a need for a suite of measures in this area and that this measure is a first step to improve the quality of care for women. MAP recommended that this measure be submitted to NQF for endorsement consideration.

Program Measure Gaps

During the measure gaps discussion, MAP encouraged CMS to explore measures of effective use and shared decision making. MAP also recommend that there be a composite measure for breast cancer screening. MAP further emphasized that CMS be sensitive to the changes in healthcare and the migration of services to the ambulatory setting. Finally, the MAP suggested that CMS explore the major groupings of the types of services and procedures offered in the outpatient setting to identify gaps for measure development.

Public Comment

Dr. Morrison opened the web meeting to allow for public comment. No public comments were offered.

Next Steps

Chris Dawson, NQF Manager, summarized next steps. Workgroup recommendations for the eight MAP Hospital measures will be opened for public comment on January 15, 2021. The MAP Coordinating Committee will convene to finalize MAP recommendations for all measures on January 25, 2021.

Appendix A: MAP PAC/LTC Workgroup Attendance (Voting Only)

The following members of the MAP PAC/LTC Health Workgroup were in attendance during the roll call:

Co-chairs

- R. Sean Morrison, MD
- Akin Demehin, MPH

Organization Members

- America's Essential Hospitals
- American Society of Anesthesiologists
- American Society of Health-System Pharmacists
- Association of American Medical Colleges
- City of Hope
- Dialysis Patient Citizens
- Greater New York Hospital Association
- Henry Ford Health System
- Intermountain Health Care
- Medtronic
- Memphis Business Group on Health
- Molina Healthcare
- Mothers Against Medical Error
- National Association for Behavioral Healthcare
- Premier Healthcare Alliance
- Press Ganey
- Project Patient Care
- Service Employees International Union
- Society for Maternal-Fetal Medicine
- Stratis Health
- UPMC Health Plan

Individual Subject Matter Experts

- Andreea Balan-Cohen, PhD

- Lindsey Wisham, MPA

Appendix B: Full Voting Results

	<u>Measure Name</u>	<u>Program</u>	<u>Yes</u>	<u>No</u>	<u>Total</u>	<u>Percent</u>
1	MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel Measure	Hospital OQR	20	4	24	83%
2	MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel Measure	Hospital IQR	20	4	24	83%
3	MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel Measure	ASCQR	20	4	24	83%
4	MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel Measure	IPFQR	20	4	24	83%
5	MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel Measure	PCHQR	20	4	24	83%
6	MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel Measure	ESRD QIP	20	4	24	83%
7	MUC20-0048 SARS-CoV-2 Vaccination Coverage for Patients in End-Stage Renal Disease (ESRD) Facilities	ESRD QIP	20	3	23	87%
8	MUC20-0039 Standardized Hospitalization Ratio for Dialysis Facilities (SHR)	ESRD QIP	22	0	22	100%
9	MUC20-0032 Global Malnutrition Composite Score	Medicare and Medicaid Promoting Interoperability	22	1	23	96%
10	MUC20-0032 Global Malnutrition Composite Score	Hospital IQR	20	3	23	87%
11	MUC20-0003 Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)	Hospital IQR	18	4	22	82%

12	MUC20-0004 Appropriate Treatment for ST-Segment Elevation Myocardial Infarction (STEMI) Patients in the Emergency Department (ED)	Hospital OQR	19	3	22	86%
13	MUC20-0005 Breast Screening Recall Rates	Hospital OQR	15	6	21	71%

