NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Measure Applications Partnership Hospital Workgroup In-Person Meeting

The National Quality Forum (NQF) convened a public in-person meeting for the Measure Applications Partnership (MAP) Hospital Workgroup on December 4, 2019.

Welcome and Review of Web Meeting Objectives

Sam Stolpe, NQF Senior Director, welcomed participants to the in-person meeting. MAP Hospital Co-chairs, R. Sean Morrison and Cristie Upshaw Travis, then provided opening remarks. Dr. Stolpe reviewed the following meeting objectives: to review and provide input on Measures Under Consideration (MUC) applicable to federal hospital quality programs and to identify gaps in measures for federal hospital quality programs.

CMS Opening Remarks and Meaningful Measures Update

Michelle Schreiber, CMS QMVIG Group Director, offered opening remarks and provided a presentation on the Meaningful Measures Initiative. MAP provided feedback on the presentation and on proposed changes to the initiative. MAP recommended CMS consider several important priorities across programs and settings, including workforce availability, provider burnout, licensure expansions and standardization across states, staffing standards, and training. Specialty care was identified as a potential gap in the priority areas for meaningful measurement. Other gaps included changes in functional status measures, measures that improve the usability and safety of EHRs, behavioral health measures beyond concerns about opioids, and measures discouraging the provision of low-value care.

MAP highlighted the shift of services traditionally delivered in the hospital into ambulatory settings, such as surgeries and other high-risk services. MAP encouraged CMS to consider if care is being appropriately moved, and standardizing cost and quality measures across settings. MAP emphasized that the discussion of the measures should be considered as part of measure sets and systems, with each measure considered in relation to the others and the context in which they are used. MAP supported CMS's general move toward eCQMs and encouraged CMS to engage with EHR vendors early in the measure development process. MAP also applauded CMS's efforts to standardize the measures deployed across payers and across quality programs. Finally, MAP was encouraged by CMS's effort to update public facing measurement websites like Hospital Compare with a more user-friendly interface and language that resonates with consumers and patients.

Overview of Pre-Rulemaking Approach

Dr. Stolpe 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 add to the program measure set. Dr. Stolpe then reviewed the four decision categories that the Workgroup members could vote on following the discussion of each measure. Finally, Dr. Stolpe briefly summarized the voting process and discussed the Rural Health Workgroup charge.

Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program Measures

Ms. Upshaw Travis opened the web meeting to allow for public comment. No public comments were offered.

MUC2019-18 National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection Outcome Measure

MAP supported MUC2019-18 for rulemaking. A prior version of this measure is currently included in PCHQR and addresses the Meaningful Measure Area of healthcare-associated infections. The risk-adjustment model for this measure was updated, and the measure was submitted and re-endorsed by the NQF Patient Safety Standing Committee in the CDP spring 2019 cycle. The measure is otherwise identical to the existing measure in PCHQR. MAP members noted the need to monitor the use of the measure in spinal cord injuries. MAP also noted the importance of comparing cancer hospitals to like hospitals given the differences in the patient populations. The Rural Health Workgroup noted that the 11 PPS-exempt cancer hospitals in the program are in urban centers, but rural patients often use them, and the Workgroup expressed support of MUC2019-18. MAP supported the continued use of this measure in PCHQR with the updated specifications.

MUC2019-19 National Healthcare Safety Network (NHSN) Central Line Associated Bloodstream Infection Outcome Measure

MAP supported MUC2019-19 for rulemaking. MAP noted that MUC2019-19 is an updated version of the existing measure in PCHQR (NQF 0139). The risk-adjustment model for this measure was updated, and the measure was submitted and re-endorsed by the NQF Patient Safety Standing Committee in the CDP spring 2019 review cycle. MAP noted that this measure is also otherwise identical to the existing measure in PCHQR. MAP noted that CLABSIs are associated with significant morbidity, mortality, and costs. Patients in ICUs are at an increased risk for CLABSI because 48 percent of ICU patients have indwelling central venous catheters, accounting for 15 million central line days per year in United States. MAP encouraged CMS and CDC to review if there are patient-specific traits that lead to higher rates of CLABSI within cancer hospitals. The Rural Health Workgroup also noted that the 11 cancer hospitals in the program are in urban centers, but rural patients often use them, and the Workgroup expressed support of MUC2019-19.

MAP noted a gap in measures within PCHQR regarding patient-reported outcomes for functional outcomes and quality of life, access to care, and survival. It was also noted that measures are needed to ensure smooth transitions between care settings, especially hospice. MAP also noted the need to move from standardized approaches within cancer care to adopting personalized medicine and pharmacogenomic testing. MAP encouraged CMS to continue partnerships with existing cancer registries to gather data for future measurement.

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Measure

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

MUC2019-22 Follow-Up After Psychiatric Hospitalization

MAP did not support MUC2019-22 for rulemaking. MAP noted that this measure is an expansion of the existing NQF 0576 *Follow-Up After Hospitalization for Mental Illness* measure, used in the Inpatient Psychiatric Facility Quality Reporting Program. The expanded measure broadens the measure population to include patients hospitalized for drug and alcohol disorders as those patients also require

follow-up care post-discharge. MAP noted the importance of robust care transitions for this expanded population but also identified several critical concerns with the proposed measure.

MAP expressed concern that the numerator requires patient choice in pursuing follow-up care and may not reflect whether follow-up care has been arranged by the hospital being measured. MAP also noted that the Stark Law may limit the ability for hospitals and care managers to ensure necessary SUD treatment follow-up after hospitalization. MAP members were also concerned that patients may not have access to appropriate SUD outpatient follow-up care. MAP members also noted the importance of telehealth follow-up as a critical tool and the importance of including these visit types in the measure. CMS noted that telehealth is currently billable only if it is submitted with a GT modifier. MAP was generally not satisfied with the current specifications and expressed concern that the measure could lead to unintended negative consequences for patients. Finally, several members noted that evidence base provided for this measure needs to be specific to the conditions of interest. The MAP Rural Health Workgroup perspective was that this measure is appropriate as SUD and mental health issues impact many rural residents, but the Workgroup expressed concern about access to care, and it recommended telehealth follow-up as a potential solution which would harmonize with the NCQA HEDIS measure.

During the discussion on measure gaps, MAP suggested that CMS identify measurement priorities for patient populations within units for inpatient psychiatric facilities, specifically geriatric units.

End-Stage Renal Disease Quality Incentive Program (ESRD QIP) Measure

Ms. Upshaw Travis opened the web meeting to allow for public comment. No public comments were offered.

MUC2019-64 Standardized Transfusion Ratio for Dialysis Facilities

MAP offered conditional support for rulemaking of MUC2019-64, pending NQF endorsement of the revised measure. The measure is based on an endorsed measure (NQF 2979) that was implemented in ESRD QIP. There are two significant differences between the current NQF-endorsed Standardized Transfusion Ration (STrR) used on Dialysis Facility Compare and in QIP PY2021 and the proposed revision submitted.

First, for hospital inpatients, the current NQF endorsed STrR relies on a restricted transfusion identification algorithm. The measure utilizes only those reported transfusion events that include ICD procedure codes, ICD procedure codes with revenue center codes, or value codes. For the proposed revision to STrR, inpatient transfusion events are identified using a broader definition that includes revenue center codes only, ICD10 procedure codes (alone or with revenue codes), or value codes alone or in combination. The measure developer pointed out that the proposed revision results in identification of a greater number of inpatient transfusion events compared to the currently implemented STrR.

Second, the current NQF-endorsed STrR includes all Medicare patients, including those with Medicare Advantage coverage, that meet inclusion criteria based on the presence of Medicare claims activity reflected in $900 or greater dialysis paid claims in a month or recent inpatient hospitalization. The proposed STrR revision uses similar criteria but excludes all Medicare Advantage patients with time at risk from both the measure numerator and denominator. This proposed change is being made to mitigate potential bias associated with inclusion of Medicare Advantage patients. The bias derives from the absence of complete outpatient claims data for Medicare Advantage patients, severely limiting the identification of outpatient transfusion events for these individuals. MAP considered the updates to the measure to be both appropriate and necessary. MAP noted that this measure is for reporting purposes

only and is not used for payment. The developer explained that this is because the measure is now using both value codes and ICD-10 codes as indicators that blood transfusions have occurred.

In consideration of measure gaps, MAP noted that all of the ESRD patient experience measures are composites, and MAP suggested that In-Center Hemodialysis (ICH) CAHPS questions could be broken out and reported separately. MAP also called on CMS to consider how to include more specific patient safety measures beyond the generic question included in CAHPS as well as functional status and quality of life measures, especially given the slated changes in payment policy related to dialysis coverage through Medicare Advantage.

Hospital Inpatient Quality Reporting (IQR) Program and Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals (CAHs) Measures

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

MUC2019-114 Maternal Morbidity

MAP did not support MUC2019-114 *Maternal Morbidity* for rulemaking, with potential for mitigation. The potential mitigating factor identified by MAP would be to amend the question to clarify that the hospital is expected both to attest to participation in a quality improvement initiative as well as to implement patient safety practices or bundles to address complications.

MAP observed that severe maternal morbidity is increasing at an alarming rate in the U.S., nearly doubling in the last decade. There are currently no quality measures that address maternal morbidity, and MAP is encouraged by CMS' attempts to address this healthcare crisis. However, MAP expressed concern related to using attestation to participation in a quality improvement initiative rather than finding clear process and outcomes measures that address the quality issue directly, such as asking if specific bundles of care are incorporated into the services provided during maternal care. MAP members identified the language "and has implemented patient safety practices or bundles" to replace "which includes implementation of patient safety practices or bundles" as one way to add clarity that the intent of the measure is to both participate in a QI program *and* implement specific bundles known to improve outcomes. Finally, the Rural Health Workgroup noted a concern that not all rural critical access hospitals would be able to participate in a state QI collaborative. MAP noted that this is balanced by the universal availability of QI programs at the national level.

MUC2019-26 Hospital Harm – Severe Hyperglycemia

MAP offered conditional support for MUC2019-26 *Hospital Harm – Severe Hyperglycemia*, pending NQF endorsement of the measure. IQR currently does not include a measure that assesses severe hyperglycemia events that are largely avoidable through proper glycemic monitoring and intervention. MAP expressed concern and encouraged CMS to consider the unintended consequence that this measure may lead to increases in hypoglycemia, which was regarded as a more serious issue. The Rural Health Workgroup noted that diabetes rates are high in rural settings, and the measure addresses a preventable patient safety issue that is relevant for rural populations. The Rural Health Workgroup expressed concern that if glucose levels are derived from laboratory data (rather than at point of care), they may be more difficult to obtain and/or incorporate into EHR systems in rural hospitals. They also were concerned that EHR systems in rural hospitals may not be as robust or current, making it more difficult to compute the measure (e.g., using RxNORM). Finally, MAP generally agreed that the measure did not carry any significant implementation burden.

During the discussion around program measure gaps, MAP suggested the IQR program would benefit from additional care transitions measures as well as enhanced measures of preventable healthcare harm such as the *PSI 90* composite (NQF 0531). MAP encouraged the development of Medicare spending per beneficiary measures for conditions that align with CMS mortality and readmission measures. MAP also stressed that the program would benefit from additional patient safety measures as well as measures on engagement of patients and families and transfer of information across care settings.

Public Comment

Madison Jung, NQF Project Manager, opened the web meeting to allow for public comment. A single public comment was offered supporting the work of MAP and thanking the participants for an engaging discussion.

Next Steps

Jordan Hirsch, NQF Project Analyst, summarized next steps. Workgroup recommendations for the six MAP Hospital measures will be opened for public comment on December 18, 2019.