NATIONAL QUALITY FORUM

National Voluntary Consensus Standards for Patient Outcomes
Summary of the Cardiovascular Technical Advisory Panel Conference Call
March 30, 2010

TAP members participating: Edward Gibbons (chair); Irene Katzan, MD, MS; Richard Prager, MD; Anton Sidawy, MD; Sarah Spinler, PharmD. FAHA, FCCP

NQF staff participating: Reva Winkler, MD, MPH; Sarah Fanta; Hawa Camara

Measure Steward Representatives: Francois de Brantes, MBA, Bridges to Excellence

Dr. Gibbons welcomed TAP members to the last conference call for the cardiovascular TAP.

Francois de Brantes provided an introduction to the measures for discussion:

- These are measures looking at comprehensive complications of care from the patient's perspective.
- "Potentially Avoidable Conditions" (PACs) are discrete events that occur and can be counted from claims; occur after admission extending to 30 days; and are severity adjusted at the patient level.
- PACS are of three types:
  - Type 1: PACS related to the index conditions (e.g., coma for patients admitted with AMI)
  - Type 2: PACS related to co-morbid conditions (e.g., Pneumonia during a stroke hospitalization)
  - Type 3: PACS suggesting patient safety failures (e.g., skin wounds and infections during an AMI or stroke hospitalization)
- The goal is not to achieve zero PACs but to reduce the number as low as possible by creating an incentive for clinical collaboration.

Review of Measures

OT1-030-09: Proportion of AMI patients that have a potentially avoidable complication (during the index stay or in the 30-day post-discharge period)

IMPORTANCE TO MEASURE AND REPORT		
1a Impact	Completely	AMI involves a younger population but age 65 cut off will not include Medicare patients. Gap is clearly demonstrated.
1b Gap	Completely	
1c Relation to Outcomes	Completely	
SCIENTIFIC ACCEPTABILTY		
2a Specs	Completely	Includes only AMI as a presenting diagnosis, does not include AMIs that occur during a hospitalization. Does not include Medicare patients, developer states that likely it could be used on the Medicare population but they have no access to Medicare data to test the measure on that cohort; based on commercial
2b Reliability	Completely	
2c Validity	Completely	
2d Exclusions	Completely	
2e Risk Adjustment	Completely	

2f Meaningful Differences	Completely	claims, will not include uninsured or Medicaid patients; good feedback from physicians; Exclusions would be useful to explicitly state those population that are not captured in the measure; The measure does not include death as claims does not capture this data reliably; however, any care rendered associated with the death would be captured. Risk-adjustment may be revised going forward as more experience is gained; there seems to be the potential to show meaningful differences but the data does not clearly show that; TAP would like to see a histogram for the variation by state for the AMI (and stroke) populations similar to the one for diabetes that was presented; Much information from disparities is not available since the uninsured and Medicaid patients are not captured in claims data
2g Comparability	Not Applicable	
2h Disparities	Not Applicable	
USEABILITY		
3a Distinctive	Completely	Remains to be seen how information is presented for public reporting and whether it is understandable – certain concepts are challenging (e.g., "potentially avoidable" does not mean completely avoidable and some PACs are more actionable than others); the basis of PACs is cost/dollars more than clinical severity; Is a hospital that has more PACs but of less severity providing poorer quality than a hospital that have fewer, but more severe PACs? Concern that the measure might be used inappropriately before understanding what the results really mean.
3b Harmonization	Completely	
3c Added Value	Completely	
FEASIBILITY		
4a Data a Byproduct of Care	Completely	Claims data can only be calculated by those with access to the data (i.e., plans, systems, payers – not hospitals or providers). Commercial claims does not include uninsured; would need additional analysis for Medicaid and Medicare if data available; usual coding concerns for claims data – subject to coding practices
4b Electronic	Completely	
4c Exclusions	Completely	
4d Inaccuracies/ Errors	Completely	
4e Implementation	Completely	

OT1-031-09: Proportion of stroke patients that have a potentially avoidable complication (during the index stay or in the 30-day post-discharge period)

IMPORTANCE TO MEASURE AND REPORT		
1a Impact	Completely	Similar to AMI measure but overall more cautious for stroke. Age
1b Gap	Partial	

1c Relation to Outcomes	Partial	is limited to <65 years – the majority of strokes occurs in the Medicare population; Are the PACs more avoidable in the younger population? Need to understand more about the causality and relationship of process and outcomes for stroke; some PACs, such as coma, seem to be "rarely avoidable"; What is the evidence base that the PACs are improvable?
SCIENTIFIC ACCEPTABILTY		
2a Specs	Partial	Need more information on the selection of PACs: Who was involved? What were the criteria? Concerns about the face validity. Agree with exclusions – age issue as noted above, though expanding to Medicare may involve end of life issues. Risk-adjustment – concern that factors are more financial than clinical and there doesn't seem to adjustment for severity of impairment - a limitation of the model. No information on how to interpret differences among hospitals.
2b Reliability	Partial	
2c Validity	Minimal	
2d Exclusions	Complete	
2e Risk Adjustment	Partial	
2f Meaningful Differences	No Information	
2g Comparability	Not Applicable	
2h Disparities	Not Applicable	
USEABILITY		
3a Distinctive	Partial	Useful for systems. Unclear how risk-adjustment affects results. Provides useful information on care transitions. Concerns on interpretation of results. What is the significance of including PACs of low frequency? Who knows what could be actionable, developer did not want to pre-judge. Question on whether we know enough to consider this a quality measure. TAP members questioned why the intent of the measure sponsor is not to have individual hospitals examine the most common (e.g., "top 10"); Users will select for QI out of the 400-500 PACs. Concerns on the deliberate avoidance of a weighted score of PACs and the tension that will likely result from public reporting without a weighted score.
3b Harmonization	Completely	
3c Added Value	Completely	
FEASIBILITY		
4a Data a Byproduct of Care	Partial	See AMI measure
4b Electronic	Completely	
4c Exclusions	Completely	
4d Inaccuracies/ Errors	Completely	
4e Implementation	Completely	

Recommendation: TAP members strongly suggest the developer consider different language to describe the measures, particularly in public reporting. "Potentially avoidable" has an emotional charge that may be misleading in view of the fact that the developer admits that some PACs are not always avoidable.

Public comment

- Asks whether NQF has considered the health reform legislation provisions for payment around readmissions.