NATIONAL QUALITY FORUM
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Meeting Summary

Patient Safety Standing Committee Measure Evaluation Web Meeting, Fall 2020

The National Quality Forum (NQF) convened a public web meeting for the Patient Safety Standing Committee on February 10, 2021.

Welcome, Introductions, and Review of Meeting Objectives

NQF staff welcomed the Standing Committee and participants to the web meeting. NQF staff reviewed the meeting objectives and informed those on the call that the meeting was being recorded. Dr. Iona Thraen and Dr. Ed Septimus, co-chairs of the Patient Safety Standing Committee, provided welcoming remarks. The co-chairs emphasized the importance of staying focused throughout the process and confining comments to the specific measure criterion being discussed. Dr. Matthew Pickering, NQF senior director, discussed his transition off the project and introduced Terra Greene as the new director of the Patient Safety project. Terra introduced herself and welcomed everyone to the meeting. Chris Dawson, Isaac Sakyi, and Dr. Jesse Pines introduced themselves and their respective roles. Dr. Pickering reviewed the agenda and housekeeping items. Michael Haynie, NQF senior managing director, conducted roll and reviewed NQF's disclosures of interest policy. The Standing Committee members had no conflicts of interest to disclose. Quorum, which is defined as attendance of 66 percent of active Standing Committee members, and for which this would be 17 out of 25 for the Patient Safety Standing Committee, was achieved and maintained throughout the call.

Topic Area Introduction of Evaluation Process and Voting Process

NQF reviewed the Consensus Development Process (CDP) and the NQF measure evaluation criteria. Dr. Pickering reviewed housekeeping reminders and encouraged the use of video and muting oneself when not speaking. The Standing Committee was encouraged to use the chat feature, which was monitored by NQF staff. Dr. Pickering reviewed that if consensus was not reached (CNR) on a criterion during the meeting, then the Standing Committee would continue to their evaluation of the measure and would re-vote on the CNR criterion during the post-comment meeting. A Standing Committee member asked whether the related and competing measures would be addressed at the end of the meeting, to which Dr. Pickering replied that there will be time towards the end of the meeting to discuss related and competing measures.

Measure Evaluation

During the meeting, the Patient Safety Standing Committee evaluated six measures for maintenance endorsement consideration. A summary of the Standing Committee's deliberations will be compiled and provided in the draft technical report. NQF will post the draft technical report tentatively on March 24, 2021, for public comment on the NQF website. The draft technical report will be posted for 30 calendar days. Pre-Evaluation Meeting comments on the measures under review are located in Appendix A.

Rating Scale: H—High; M—Medium; L—Low; I—Insufficient; NA—Not Applicable

A measure is recommended for endorsement by the Standing Committee when the vote margin on all must-pass criteria (i.e., Importance, Scientific Acceptability, Use), and the overall suitability for endorsement, is greater than 60 percent of voting members in favor of endorsement. A measure is not recommended for endorsement when the vote margin on any must-pass criterion or the overall suitability for endorsement is less than 40 percent of voting members in favor of endorsement. The Standing Committee has not reached consensus if the vote margin on any must-pass criterion or the overall suitability for endorsement is between, and inclusive of, 40 and 60 percent in favor of endorsement. When the Standing Committee has not reached consensus, all measures for which consensus was not reached will be released for NQF member and public comment. The Standing Committee will consider the public comments received and re-vote on the CNR criteria of those measures during a webinar convened after the commenting period closes.

#0097: Medication Reconciliation Post-Discharge (National Committee for Quality Assurance)

Description: The percentage of discharges from January 1–December 1 of the measurement year for patients 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 days total).; **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Electronic Health Records, Paper Medical Records

Measure Steward/Developer Representatives at the Meeting

- National Committee for Quality Assurance (Pam Lighter)

Standing Committee Votes

- Evidence: H-0; M-8; L-4; I-11 (23 votes total)
    - The NQF staff and Standing Committee Co-chairs agreed that due to miscommunication during the voting for the Evidence criterion, which conveyed the measure had initially passed even though it had not, this specific criterion will proceed with a revote during the post comment meeting on June 4, 2021.
- Performance Gap: H-9; M-11; L-2; I-1 (23 votes total)
- Reliability: H-14; M-6; L-1; I-0 (21 votes total)
- Validity: H-0; M-13; L-8; I-2 (23 votes total)
- Feasibility: H-11; M-10; L-1; I-0 (22 votes total)
- Use: Pass-20; No Pass-1(21 votes total)
- Usability: H-8; M-14; L-1; I-0 (23 votes total)

Standing Committee Recommendation for Endorsement: Not Recommended

The Standing Committee did not pass this measure on evidence and will re-vote on this criterion, and if it passes, the Standing Committee will re-vote on the overall suitability for endorsement during the post-comment meeting on June 4, 2021. During the meeting, NQF staff made an error in calculating the votes that led to the measure receiving a CNR for evidence on the call. Therefore, the measure continued to be evaluated against the remaining NQF criteria. However, after the meeting, the correct vote totals were calculated, and the measure did not pass on evidence, a must-pass criterion. In discussing this with the Patient Standing Committee co-chairs after the meeting, it was recommended that the Standing Committee re-vote on the evidence criterion during the post-comment meeting. If the measure passes on evidence, the Standing Committee will then re-vote on the overall suitability for endorsement.

During the meeting, the measure developer provided an overview of the measure and addressed some questions from the Standing Committee. A Standing Committee member asked the measure developer

if every hospital or organization is required to calculate the measure themselves or if a central location provides the results, to which the developer responded that the measure is a health plan-level measure, meaning that it allows health plans to calculate their performance and provide it to the National Committee for Quality Assurance (NCQA). The developer also stated that NCQA audits data to ensure accuracy before it is provided to the Centers for Medicare & Medicaid Services (CMS). Another Standing Committee member asked if the measure is about discharge within 30 days, to which the measure developer confirmed and added that they are looking at a window of 30 days after discharge, for a total of 31 days.

The Standing Committee considered the evidence submitted by the developer, noting that the evidence had not been updated since the measure's most recent endorsement in 2015. The Standing Committee also recognized that a quality, quantity, and consistency analysis of the evidence submitted was not conducted. As a result, NQF staff's preliminary analysis rating was "Insufficient". Some Committee members commented that there is evidence that medication reconciliation can have an impact on outcomes. However, there were concerns that the measure itself references whether a process was done (i.e., checking a box) rather than an underlying examination of the quality of medication reconciliation.

Other Standing Committee members noted that based on the data provided, only 60 percent of providers are checking the box, so there is a need for more accountability and improvement. The developer commented, noting that there is more recent evidence that shows that medication reconciliation improves outcomes. Co-Chair Iona Thraen asked whether the more recent evidence the developer mentioned was included in the measure submission. The developer confirmed that it was not. One Standing Committee member cited a 2018 Cochrane review, showing that there was no improvement in certain outcomes with medication reconciliation, including medication adverse events. The Standing Committee noted that standardization for medication reconciliation is lacking and that more training and best practices are needed. One Standing Committee member commented that if this measure is not endorsed, the consideration of other measures in place to fulfill a gap comes into question if this measure is voted "down". Co-Chair Iona Thraen asked NQF staff to remind the Standing Committee of what would happen if the measure did not pass on evidence.

Dr. Pickering commented that the Evidence criterion is a must-pass. Dr. Pickering further stated that if the Standing Committee agreed that this measure was important, but the evidence was insufficient, the measure could be granted a rating of "Insufficient with Exception". This is achieved if more than 60 percent of the Standing Committee voted that the evidence was "Insufficient" and at least one Standing Committee member asked for an "Exception" vote. More than 60 percent of the Standing Committee must then vote to grant an exception to the evidence. The Standing Committee proceeded to vote on evidence, and NQF staff made an error in calculating the votes that led to the measure receiving a CNR for evidence on the call. Therefore, the measure continued to be evaluated against the remaining NQF criteria. However, after the meeting, the correct vote totals were calculated, and the measure did not pass on evidence, a must-pass criterion. In discussing this with the Patient Safety Standing Committee co-chairs after the meeting, it was recommended that the Standing Committee re-vote on the evidence criterion during the post-comment meeting. If the measure passes on evidence, the Standing Committee will then re-vote on the overall suitability for endorsement.

Moving to performance gap, the Standing Committee considered the data presented by the developer. A Standing Committee member asked whether the 61 percent performance gap is currently better or worse than the performance gap reported three years ago at the last review. The developer commented that this measure has since been expanded to all Medicare Advantage plans. Therefore, no trending

data could be assessed due to the expanded patient population. The Standing Committee voted to pass the measure on performance gap. Moving to scientific acceptability, the Standing Committee considered the reliability testing and did not raise any concerns, resulting in a vote to pass the measure on reliability. For validity, one Standing Committee member asked whether rehabilitation therapists and home healthcare agencies performing medication reconciliation were included as part of the measure under review. The developer confirmed that these would count within the measure. One Standing Committee member commented that this measure is one of the "poster-child measures" for the electronic health record (EHR), making it easy to check the box from a process standpoint. While this satisfies the measure, there is no connection to actual change in care. Some Standing Committee members agreed with the NQF staff's preliminary rating of "Moderate" and recommended that the developer look at other outcomes for correlation testing. The Standing Committee proceeded to vote and passed the measure on validity. The Standing Committee did not raise any questions or concerns with respect to feasibility, use, and usability and passed the measure on these criteria.

#0468: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization (Yale Center for Outcomes Research and Evaluation (Yale CORE)/Centers for Medicare & Medicaid Services)

Description: The measure estimates a hospital-level 30-day risk-standardized mortality rate (RSMR). Mortality is defined as death for any cause within 30 days after the date of admission for the index admission, discharged from the hospital with a principal discharge diagnosis of pneumonia, including aspiration pneumonia or a principal discharge diagnosis of sepsis (not severe sepsis) with a secondary diagnosis of pneumonia (including aspiration pneumonia) coded as present on admission (POA). CMS annually reports the measure for patients who are 65 years or older and are either Medicare fee-for-service (FFS) beneficiaries and hospitalized in non-federal hospitals or patients hospitalized in Veterans Health Administration (VA) facilities.; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Inpatient/Hospital; **Data Source**: Claims, Enrollment Data, Other

Measure Steward/Developer Representatives at the Meeting

- Yale CORE (Doris Peter)

Standing Committee Votes

- Evidence: Pass-25; No Pass-0 (25 votes total)
- Performance Gap: H-11; M-11; L-0; I-0 (22 votes total)
- Reliability: Does the Standing Committee accept the NQF Scientific Methods Panel's HIGH rating of Reliability? Yes-20; No-0 (20 votes total)
    - This measure was deemed as complex and was evaluated by the NQF Scientific Methods Panel.
    - The NQF Scientific Methods Panel's ratings for Reliability: H-4; M-4; L-0; I-0
- Validity: Does the Standing Committee accept the NQF Scientific Methods Panel's MODERATE rating of Validity? Yes-20; No-2 (22 votes total)
    - This measure was deemed as complex and was evaluated by the NQF Scientific Methods Panel.
    - The NQF Scientific Methods Panel's ratings for Validity: H-1; M-5; L-1; I-1
- Feasibility: H-19; M-2; L-0; I-0 (21 votes total)
- Use: Pass-21; No Pass-0 (21 votes total)
- Usability: H-9; M-10-; L-1; I- 0 (20 votes total)

Standing Committee Recommendation for Endorsement: Yes-21; No-0 (21 votes total)

The Standing Committee recommended the measure for continued endorsement. This is an outcome measure that estimates a hospital-level, 30-day risk-standardized mortality rate (RSMR). The developer defines mortality as death for any cause within 30 days after the date of admission for the index admission, discharged from the hospital with a principal discharge diagnosis of pneumonia, including aspiration pneumonia or a principal discharge diagnosis of sepsis (not severe sepsis) with a secondary diagnosis of pneumonia (including aspiration pneumonia) coded as present on admission (POA). The goal of this measure is to improve patient outcomes by providing patients, physicians, hospitals, and policymakers with information about hospital-level, risk-standardized mortality rates following hospitalization for pneumonia.

The Standing Committee noted there was good evidence to support that one or more healthcare actions could have an impact on this measure and passed the measure on the evidence criterion. The Standing Committee also agreed that there are gaps in performance that warrant a quality measure. Regarding reliability, the Standing Committee unanimously upheld the SMP's review but raised concerns in regard to the large range for reliability scores and for only utilizing a 25-case threshold. The developer responded that the split sample for reliability was based on NQF guidelines. For validity, concerns were raised by the Standing Committee about the inclusion of source of admission and social risk factor adjustments. Concerns were expressed that this measure may under adjust and fail to account for where patients are admitted from. The developer clarified that the reason the source of admission was not utilized is because historically, this field in claims was not audited. Questions were raised by the Standing Committee regarding the absence of adjustment on acute/chronic presentation and illness burden. As it pertains to the Standing Committee's concern regarding risk stratification, the developer noted that data for risk stratification were not available. The Standing Committee voted to uphold the SMP's rating and passed the measure on validity. The Standing Committee agreed the measure met NQF's feasibility criterion because the measure uses administrative claims and enrollment data. The Standing Committee acknowledged that the measure is publicly reported and used in accountability programs and did not express any concerns with usability. This measure will be available for public comment.

#1893: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (Yale Center for Outcomes Research and Evaluation (Yale CORE)/Centers for Medicare & Medicaid Services)

Description: The measure estimates a hospital-level 30-day risk-standardized mortality rate (RSMR), defined as death from any cause within 30 days after the index admission date, for patients discharged from the hospital with either a principal discharge diagnosis of COPD or a principal discharge diagnosis of respiratory failure with a secondary discharge diagnosis of acute exacerbation of COPD. CMS annually reports the measure for patients who are 65 years or older and enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals or are patients hospitalized in Veterans Health Administration (VA) facilities.; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Inpatient/Hospital; **Data Source**: Claims, Enrollment Data, Other

Measure Steward/Developer Representatives at the Meeting

- Yale CORE (Doris Peter)

Standing Committee Votes

- Evidence: Pass-23; No Pass-0 (23 votes total)
- Performance Gap: H-11; M-11; L-0; I-0 (22 votes total)

- Reliability: Does the Standing Committee accept the NQF's Scientific Methods Panel's MODERATE rating of Reliability? Yes – 22 No-0 (22 votes total)
    - This measure was deemed as complex and was evaluated by the NQF Scientific Methods Panel.
    - The NQF Scientific Methods Panel's ratings for Reliability: H-0; M-6; L-1; I-0
- Validity: Does the Standing Committee accept the NQF's Scientific Methods Panel's MODERATE rating of Validity? Yes - 22 No -0 (22 votes total)
    - This measure was deemed as complex and was evaluated by the NQF Scientific Methods Panel.
    - The NQF Scientific Methods Panel's ratings for Validity: H-2; M-5; L-0; I-0
- Feasibility: H16-; M-7; L-0; I-0 (23 votes total)
- Use: Pass-24; No Pass-0 (24 votes total)
- Usability: H-8; M-13; L-1; I-0 (22 votes total)

Standing Committee Recommendation for Endorsement: Yes-22; No-0 (22 votes total)

The Standing Committee recommended the measure for continued endorsement. The developer provided updated evidence since the previous review of the measure. Along with a logic model demonstrating how specific interventions lead to a reduced risk of COPD mortality, the developer cited multiple studies detailing the prevalence of COPD in the United States (U.S.) and the 30-day mortality rates following COPD discharge across hospitals. The Standing Committee voted unanimously to pass the measure on the evidence criterion based on the strength of the evidence in measuring differences in quality, along with literature reviews supporting the use of interventions in reducing COPD mortality. The Standing Committee did not express any concerns on the performance gap of the measure. The Standing Committee voted to accept the SMP's moderate rating for reliability. The Standing Committee also voted to uphold the SMP's review of the validity criterion with a question raised by Dr. Sood, asking what would happen to the numerator for a COPD primary diagnosis if the patient had multiple admissions with multiple diagnoses. The developer replied that one diagnosis would be chosen randomly from a period. The Standing Committee identified no concerns regarding the feasibility of this measure or the use and usability as the developer noted the measure is publicly reported in Hospital Compare and used in the Hospital Value-Based Purchasing (HVBP) Program. This measure will be available for public comment.

#0531: Patient Safety Indicator (PSI) 90: Patient Safety and Adverse Events Composite (IMPAQ International/Centers for Medicare & Medicaid Services)

Description: The PSI 90 composite measure summarizes patient safety across multiple indicators for the CMS Medicare fee-for-service population.; **Measure Type**: Composite; **Level of Analysis**: Facility; **Setting of Care**: Inpatient/Hospital; **Data Source**: Claims

Measure Steward/Developer Representatives at the Meeting

- IMPAQ International (Patrick Romano)

Standing Committee Votes

- Evidence: Pass-21; No Pass-0 (21 votes total)
- Performance Gap: H-12; M-11; L-0; I-0 (23 votes total)
- Composite Quality Construct: H-11; M-11; L-0; I-0 (22 votes total)
- Reliability: Does the Standing Committee accept the NQF's Scientific Methods Panel's MODERATE rating of Reliability? Yes –24; No- 0 measure passes (24 votes total)
    - This measure was deemed as complex and was evaluated by the NQF Scientific Methods

Panel.
    - The NQF Scientific Methods Panel's ratings for Reliability: H-2; M-5; L-0; I-1
- Validity: Does the Standing Committee accept the NQF's Scientific Methods Panel's MODERATE rating of Validity? Yes -23; No -1 (24 votes total)
    - This measure was deemed as complex and was evaluated by the NQF Scientific Methods Panel.
    - The NQF Scientific Methods Panel's ratings for Validity: H-2; M-4; L-1; I-1
- Composite Construction: Yes- 25; No-0 (25 votes total)
- Feasibility: H-18; M-5; L-0; I-0 (23 votes total)
- Use: Pass-25; No Pass-0 (25 votes total)
- Usability: H-19; M-5; L-0; I-0 (24 votes total)

Standing Committee Recommendation for Endorsement: Yes-23; No-0 (23 votes total)

The Standing Committee recommended the measure for continued endorsement. The measure developer provided an overview of the measure, noting that this is a composite measure summarizing patient safety across multiple indicators for the CMS Medicare fee-for-service population. During the discussion on evidence, the Standing Committee highlighted concerns surrounding varying socioeconomic factors, to which the developer clarified that this is an in-hospital measure and risk adjustment for illnesses occurred once the patient was hospitalized. The developer also emphasized the assessment of residual disparities due to social risk factors after clinical risk factors are considered. The Standing Committee members suggested that overall, the evidence to support the measure was appropriate. In the discussion on performance gap, the Standing Committee acknowledged that presented data satisfactorily supported the presence of disparities. The Standing Committee agreed that the quality construct of the measure was acceptable. The Standing Committee voted unanimously to accept the SMP's rating for reliability. A Standing Committee member asked how large academic hospitals compare with small academic hospitals regarding elective procedures. The developer indicated this is actively being explored along with alternative approaches to defining elective admissions, but they have yet to determine an alternative. The developer also noted that out of 10 components, only three use the term "elective" in their specifications. Overall, the Standing Committee agreed that this measure had a moderate level of reliability and met the minimum thresholds.

The Standing Committee discussed various concerns regarding the validity of the measure. A Standing Committee member asked whether the developer had considered the pros and cons involved with including medical versus surgical admissions. The developer explained that their team is working separately with CMS on the development of an electronic clinical quality measure (eCQM) that uses structured fields from the EHR. One Standing Committee member noted concerns pertaining to adjustment for patients admitted from skilled nursing facilities or other long-term care facilities. The developer confirmed that they adjust for transfer-in status in all the models, but the term "transferring in" of patients may vary across hospitals, thus leading to complexities. Another Standing Committee member shared that the measure was a convenient sample of patient safety events, but it does not drive overall improvement in hospitals. However, the Standing Committee member urged CMS to study comprehensive harm data according to the top ten events for hospitals across the U.S. The interpretation of variables was also a concern raised by the Standing Committee. Overall, the Standing Committee expressed no concerns about the composite analysis of the measure. The Committee agreed there were no challenges to the feasibility of this measure; the measure is publicly reported and in use by several accountability programs. There were no concerns regarding the measure meeting the usability criterion. This measure will be available for public comment.

#0022: Use of High-Risk Medications in Older Adults (DAE)

Description: The percentage of patients 65 years of age and older who received at least two dispensing events for the same high-risk medication. A lower rate represents better performance.; **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Outpatient Services; **Data Source**: Claims

Measure Steward/Developer Representatives at the Meeting

- National Committee for Quality Assurance (Pam Lighter, Rachel Harrington)

Standing Committee Votes

- Evidence: H-1; M-10; L-7; I-3 (21 votes total)
- Performance Gap: H-5; M-15; L-3; I-0 (23 votes total)
- Reliability: H-8; M-11; L-2; I-0 (21 votes total)
- Validity: H-2; M-10; L-5; I-0 (17 votes total)
- Feasibility: H-10; M-6; L-1; I-0 (17 votes total)
- Use: Pass-17; No Pass- 2 (19 votes total)
- Usability: H-11; M-5-; L-6; I-0 (22 votes total)

Standing Committee Recommendation for Endorsement: NA

The Standing Committee did not reach consensus for evidence in this measure and will re-vote during the post-comment call. Consensus was not reached because the Standing Committee had several concerns about the list of medications being a list of "best practice" recommendations rather than sufficient evidence to link their use directly to clinical outcomes.

The measure developer started by providing an overview of the measure, noting that the intent of this measure was to assess high-risk medication use in the older adult population. The measure is based on the American Geriatrics Society (AGS) Beers criteria, which includes drugs recommended to be avoided for older adults. The Standing Committee considered the evidence for the measure. One Standing Committee member questioned whether the medications for use within the measures included those listed in the Beers criteria (namely, Table 2 of the Beers criteria) that had low-grade evidence. The developer clarified that some medications included in the measures possess low-grade evidence. A Standing Committee member also raised concern that the Beers criteria do not consider the dose of the medication. Other Standing Committee members mentioned that the Beers criteria are endorsed by the AGS and that although there is evidence that some of these drugs are harmful, they are not widely used anymore. Another Standing Committee member commented that there are exceptions to the use of some of these medications in practice because there is truly no alternative choice for the patient. This measure should be encouraging providers to avoid these high-risk medications when there are options available. The developer stated that they do not anticipate these rates dropping down to zero completely, as there is clinical decision making and patient-level nuances that occur. Moving to the vote, the Standing Committee did not reach consensus on evidence.

For performance gap, a question was raised as to whether a change occurred in the gap since the previous endorsement. The developer responded, stating that the performance has remained the same. One Standing Committee member commented that a performance gap of 10 percent represents a great deal of Medicare patients acquiring two high-risk medications when they should not. The Standing Committee passed the measure on performance gap. The Standing Committee did not have any questions or concerns related to reliability and passed the measure on this criterion. For validity, the Standing Committee considered the testing results. A question was raised regarding the use of 90-day supply for non-benzodiazepines within the measure, as this was not reflected in the Beers criteria. The developer mentioned that in the previous Beers criteria recommendations, non-benzodiazepines were recommended to be avoided beyond 90 days. Proceeding to the 2019 update, the recommendation

stated to avoid them altogether. However, the developer mentioned that their Technical Expert Panels (TEPs) were concerned that eliminating non-benzodiazepines from the measure may then turn providers more toward benzodiazepines, which are also recommended to be avoided. The Standing Committee then voted to pass the measure on validity. The Standing Committee also acknowledged that this measure uses pharmacy claims data and passed the measure on feasibility. Moving to the use and usability criteria, the Standing Committee asked whether performance data are shared with the prescriber. The developer indicated that this is a health plan-level measure; however, some health plans implement system interventions to identify events. One Standing Committee member indicated that this measure is used to identify and push notifications to prescribers. The Standing Committee voted to pass the measure on both use and usability.

#2993: Potentially Harmful Drug-Disease Interactions in Older Adults

Description: The percentage of patients 65 years of age and older who have evidence of an underlying disease, condition, or health concern and who are dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis. Three rates are reported for this measure:

-Rate 1: The percentage of those with a history of falls who received a potentially harmful medication

-Rate 2: The percentage of those with dementia who received a potentially harmful medication

-Rate 3: The percentage of those with chronic kidney disease who received a potentially harmful medication

A lower rate represents better performance for all rates.; **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Outpatient Services; **Data Source**: Claims

Measure Steward/Developer Representatives at the Meeting

- National Committee for Quality Assurance (Pam Lighter, Rachel Harrington)

Standing Committee Votes

- Evidence: H-6; M-14; L-1; I-0 (21 votes total)
- Performance Gap: H-7; M-13; L-0; I-0 (20 votes total)
- Reliability: H-4; M-17; L-0; I-0 (21 votes total)
- Validity: H-5; M-14; L-0; I-0 (19 votes total)
- Feasibility: H-13; M-8; L-0; I-0 (21 votes total)
- Use: Pass-19; No Pass-0 (19 votes total)
- Usability: H-4; M-13; L-3; I-0 (20 votes total)

Standing Committee Recommendation for Endorsement: Yes-20; No-0 (20 votes total)

The Standing Committee recommended the measure for continued endorsement. The developer provided an overview of the measure, noting that the intent of this measure is to assess potentially harmful, drug-disease interactions in older adults with a specific disease condition or health concern. This measure is also based on the 2019 AGS Beers criteria, specifically Table 3, which outlines drug-disease or drug-syndrome interactions that may exacerbate the disease or syndrome. The Standing Committee considered the evidence and performance gap for this measure. The Standing Committee did not raise any questions or concerns and voted to pass the measure on these criteria. Moving to reliability, the Standing Committee considered the reliability testing and results and did not raise any questions or concerns; therefore, they passed the measure on reliability. For validity, one Standing Committee member asked how the history of falls was captured, specifically the lookback period. The

developer stated that the lookback period was two years and falls are identified through various value sets with a falls value set and hip fractures serving as a proxy. The Standing Committee did not have any further questions or concerns and passed the measure on validity. The Standing Committee did not have any questions or concerns related to feasibility and passed the measure on feasibility. Moving to use and usability, the Standing Committee noted that the measure is currently being used for accountability purposes. One Standing Committee member asked whether there is a threshold to consider when looking at improvement over time. NQF staff mentioned that there is no threshold to be met for improvement over time and that improvement is dependent on the context of use for the measure, namely when and how it is used, how long it is used, and any updates to the measure. The Standing Committee did not have any further questions and voted to pass the measure on usability. This measure will be available for public comment.

Related and Competing Measures

Dr. Pickering discussed the related measures for the fall 2020 measures under review and noted there were no competing measures. Dr. Pickering asked whether the Standing Committee had any concerns about harmonization of related measures for all measures, except NQF #0097 and NQF #0022, which will be re-voted on during the post-comment meeting. One Standing Committee member questioned NQF #0506's related measure and asked for clarification on whether the measure is an inpatient hospital measure. Another Standing Committee member clarified that this measure does not focus on mortality but focuses more on readmissions. The Standing Committee did not raise any further question or concerns.

Public Comment

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

Next Steps

Isaac Sakyi reviewed next steps and indicated the meeting scheduled for February 11, 2021, would be cancelled due to completing the review of all six measures during February 10, 2021. The timeline of activities was reviewed along with spring 2021 cycle updates. NQF will post the draft technical report on March 25, 2021, for public comment for 30 calendar days. The continuous public comment period with member support will close on April 23, 2021. NQF will reconvene the Standing Committee for the post-comment web meeting on June 4, 2021.

Appendix A: Pre-Evaluation Comments

Comments received as of January 15, 2021.

Topic	Commenter	Comment
NQF 1893: Hospital 30-Day, all-cause, risk-standardized mortality rate (RSMR) following chronic obstructive pulmonary disease (COPD) hospitalization	Submitted by Ms. Koryn Y. Rubin, MHA	The American Medical Association (AMA) appreciates the opportunity to comment on #468, Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following chronic obstructive pulmonary disease (COPD) hospitalization. We are disappointed to see the minimum measure score reliability results of 0.32 using a minimum case number of 25 patients and the intraclass correlation coefficients (ICC) was 0.477. We believe that measures must meet minimum acceptable thresholds of 0.7 for reliability and require higher case minimums to allow the overwhelming majority of hospitals to achieve an ICC of 0.6 or higher. In addition, the AMA is extremely concerned to see that the measure developer used the recommendation to not include social risk factors in the risk adjustment models for measures that are publicly reported as outlined in the recent report to Congress by Assistant Secretary for Planning and Evaluation (ASPE) on Social Risk Factors and Performance in Medicare's Value-based Purchasing program (ASPE, 2020). We believe that while the current testing may not have produced results that would indicate incorporation of the two social risk factors included in testing, this measure is currently used both for public reporting and value-based purchasing. A primary limitation of the ASPE report was that none of the recommendations adequately addressed whether it was or was not appropriate to adjust for social risk factors in the same measure used for more than one accountability purpose, which is the case for here. This discrepancy along with the fact that the additional analysis using the American Community Survey is not yet released must be addressed prior to any measure developer relying on the recommendations within this report. We request that the Standing Committee evaluate whether the measure meets the scientific acceptability criteria. Reference: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Second Report to Congress on Social Risk

		Factors and Performance in Medicare's Value-Based Purchasing Program.2020. https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs
NQF 0531: Patient Safety Indicator (PSI) 90: Patient Safety and Adverse Events Composite	Submitted by Ms. Koryn Y. Rubin, MHA	The American Medical Association (AMA) appreciates the opportunity to comment on #531, Patient Safety Indicator (PSI) 90: Patient Safety and Adverse Events Composite. We are disappointed to see that only 67% of all hospitals were able to achieve an intraclass correlation coefficients (ICC) of =>0.6 in the split sample testing and only 51% in the test-retest using 24 months of data. We believe that measures must require higher case minimums to allow the overwhelming majority of hospitals to achieve an ICC of 0.6 or higher. In addition, the AMA is extremely concerned to see that the measure developer used the recommendation to not include social risk factors in the risk adjustment models for measures that are publicly reported as outlined in the recent report to Congress by Assistant Secretary for Planning and Evaluation (ASPE) on Social Risk Factors and Performance in Medicare's Value-based Purchasing program (ASPE, 2020). We believe that while the current testing may not have produced results that would indicate incorporation of the two social risk factors included in testing, this measure is currently used both for public reporting and value-based purchasing. A primary limitation of the ASPE report was that none of the recommendations adequately addressed whether it was or was not appropriate to adjust for social risk factors in the same measure used for more than one accountability purpose, which is the case for here. This discrepancy along with the fact that the additional analysis using the American Community Survey is not yet released must be addressed prior to any measure developer relying on the recommendations within this report. We request that the Standing Committee evaluate whether the measure meets the scientific acceptability criteria. Reference: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Second Report to Congress on Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program.2020. https://aspe.hhs.gov/social-

		risk-factors-and-medicares-value-based-purchasing-programs
NQF 0468: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following pneumonia hospitalization	Submitted by Ms. Koryn Y. Rubin, MHA	The American Medical Association (AMA) appreciates the opportunity to comment on #468, Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following pneumonia hospitalization. We are disappointed to see the minimum measure score reliability results of 0.31 using a minimum case number of 25 patients. We believe that measures must meet minimum acceptable thresholds of 0.7 for reliability. In addition, the AMA is extremely concerned to see that the measure developer used the recommendation to not include social risk factors in the risk adjustment models for measures that are publicly reported as outlined in the recent report to Congress by Assistant Secretary for Planning and Evaluation (ASPE) on Social Risk Factors and Performance in Medicare's Value-based Purchasing program (ASPE, 2020). We believe that while the current testing may not have produced results that would indicate incorporation of the two social risk factors included in testing, this measure is currently used both for public reporting and value-based purchasing. A primary limitation of the ASPE report was that none of the recommendations adequately addressed whether it was or was not appropriate to adjust for social risk factors in the same measure used for more than one accountability purpose, which is the case for here. This discrepancy along with the fact that the additional analysis using the American Community Survey is not yet released must be addressed prior to any measure developer relying on the recommendations within this report. We request that the Standing Committee evaluate whether the measure meets the scientific acceptability criteria. Reference: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Second Report to Congress on Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program.2020. https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs
NQF 0468: Hospital 30-day, all-cause, risk-standardized mortality	Submitted by Dr. Claudia A. Salzberg, PhD	The Federation of American Hospitals (FAH) appreciates the opportunity to comment on Measure

rate (RSMR) following pneumonia hospitalization		#468, Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following pneumonia hospitalization. The FAH is concerned that even though the median reliability score was 0.78 for hospitals with at least 25 cases, reliability ranged from 0.31 to 0.98 and believes that the developer must increase the minimum sample size to a higher number to produce a minimum reliability threshold of sufficient magnitude (e.g. 0.7 or higher). In addition, the FAH is very concerned to see that the measure developer's rationale to not include social risk factors in the risk adjustment model was in part based on the recommendations from the report to Congress by Assistant Secretary for Planning and Evaluation (ASPE) on Social Risk Factors and Performance in Medicare's Value-based Purchasing program released in March of last year (ASPE, 2020). A fundament flaw within the ASPE report was the lack of any recommendation addressing how a single measure with multiple accountability uses should address inclusion of social risk factors as is the case with this measure, which is both publicly reported and included in the Hospital Value-Based Purchasing program. Regardless of whether the testing of social risk factors produced results that were sufficiently significant, the FAH believes that no developer should rely on the recommendations of this report until the question of how to handle multiple uses is addressed along with the additional analysis using the American Community Survey. As a result, the FAH requests that the Standing Committee carefully consider whether the measure as specified meets the scientific acceptability criteria. Reference: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Second Report to Congress on Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program.2020. https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs

NQF 0531: Patient Safety Indicator (PSI) 90: Patient Safety and Adverse Events Composite	Submitted by Dr. Claudia A. Salzberg, PhD	The Federation of American Hospitals (FAH) appreciates the opportunity to comment on Measure #531, Patient Safety Indicator (PSI) 90: Patient Safety and Adverse Events Composite. FAH is concerned that the majority of hospitals (67% in the split sample and 51% in the test-retest) were unable to achieve an intraclass correlation coefficients (ICC) of equal to or greater than 0.6. We believe that the developer must increase the minimum sample size to a higher number to ensure that at least 90% of the hospitals achieve an ICC of 0.6 or higher. In addition, the FAH is very concerned to see that the measure developer's rationale to not include social risk factors in the risk adjustment model was in part based on the recommendations from the report to Congress by Assistant Secretary for Planning and Evaluation (ASPE) on Social Risk Factors and Performance in Medicare's Value-based Purchasing program released in March of last year (ASPE, 2020). A fundament flaw within the ASPE report was the lack of any recommendation addressing how a single measure with multiple accountability uses should address inclusion of social risk factors as is the case with this measure, which is both publicly reported and included in the Hospital Value-Based Purchasing program. Regardless of whether the testing of social risk factors produced results that were sufficiently significant, the FAH believes that no developer should rely on the recommendations of this report until the question of how to handle multiple uses is addressed along with the additional analysis using the American Community Survey. As a result, the FAH requests that the Standing Committee carefully consider whether the measure as specified meets the scientific acceptability criteria. Reference: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Second Report to Congress on Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program.2020. https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs

NQF 1893: Hospital 30-Day, all-cause, risk-standardized mortality rate (RSMR) following chronic obstructive pulmonary disease (COPD) hospitalization	Submitted by Dr. Claudia A. Salzberg, PhD	The Federation of American Hospitals (FAH) appreciates the opportunity to comment on Measure #468, Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following chronic obstructive pulmonary disease (COPD) hospitalization. The FAH is concerned that even though the median reliability score was 0.72 for hospitals with at least 25 cases, reliability ranged from 0.32 to 0.97 and that the intraclass correlation coefficients (ICC) was 0.477. The FAH believes that the developer must increase the minimum sample size to a higher number to produce a minimum reliability threshold of sufficient magnitude (e.g. 0.7 or higher) and an ICC of 0.6 or higher. In addition, the FAH is very concerned to see that the measure developer's rationale to not include social risk factors in the risk adjustment model was in part based on the recommendations from the report to Congress by Assistant Secretary for Planning and Evaluation (ASPE) on Social Risk Factors and Performance in Medicare's Value-based Purchasing program released in March of last year (ASPE, 2020). A fundament flaw within the ASPE report was the lack of any recommendation addressing how a single measure with multiple accountability uses should address inclusion of social risk factors as is the case with this measure, which is both publicly reported and included in the Hospital Value-Based Purchasing program. Regardless of whether the testing of social risk factors produced results that were sufficiently significant, the FAH believes that no developer should rely on the recommendations of this report until the question of how to handle multiple uses is addressed along with the additional analysis using the American Community Survey. As a result, the FAH requests that the Standing Committee carefully consider whether the measure as specified meets the scientific acceptability criteria. Reference: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Second Report to Congress on Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program.2020. https://aspe.hhs.gov/social-

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