NATIONAL QUALITY FORUM

Meeting Summary

Patient Safety Standing Committee Post-Comment Call

Purpose of the Call

The Patient Safety Standing Committee met via conference call on Tuesday, October 25, 2016 from 3:00-5:00 pm ET. The purpose of this call was to:

- Review and discuss comments received during the post-evaluation public and member comment period.
- Provide input on proposed responses to the post-evaluation comments.
- Re-vote on criteria where consensus was not reached.
- Determine whether reconsideration of any measures or other courses of action is warranted.

Standing Committee Actions

1. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see Comment Table and additional documents included with the call materials).
2. Be prepared to provide feedback and input on proposed post-evaluation comment responses.
3. Be prepared to discuss voting on measure #3000: PACE-Acquired Pressure Ulcer-Injury Prevalence Rate (Econometrica, Inc./ CMS), based on the changes that were made and submitted by developers.
4. Be prepared to discuss re-voting on Reliability and Overall Suitability of measure #3025: Ambulatory Breast Procedure Surgical Site Infection (SSI) Outcome Measure (Surveillance Branch, Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention).

Due to time constraints, during this call, the Committee discussed the details of each measure criteria and changes that were submitted by developers, and submitted their votes by survey, following the call.

Background

On July 27-28, 2016, during a 2-day in-person meeting, the 25-member Patient Safety Committee evaluated 13 newly submitted measures and 2 measures undergoing maintenance review against NQF's standard evaluation criteria. A total of 10 measures were recommended for endorsement, 1 eMeasure was recommended for trial use, 2 measures were not

recommended for endorsement, 1 measure where consensus was not reached, and 1 measure that was deferred to the post-comment call. The Patient Safety Committee did re-vote on the deferred measure and the measure where consensus was not reached during the post comment call on Oct 25, 2016.

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments prior to the evaluation of the measures via an online tool located on the project webpage. Third, NQF opens a 30-day comment period to both members and the public after measures have been evaluated by the full committee and once a report of the proceedings has been drafted.

Pre-evaluation comments

The pre-evaluation comment period was open from July 11 – July 25, 2016 for 13 of the 15 measures under review. A total of 10 pre-evaluation comments were received. Some did not pertain to the measures under review in this project and instead made general recommendations related to advance care planning.

Post-evaluation comments

The 30-day post-evaluation period was open from September 7,2016 to October 7, 2016. During this commenting period, NQF received 8 comments from 3 member organizations and 3 members of the public. These included measure specific comments as well as comments about the draft report in general. The Committee discussed these comments during a post comment period conference call on October 25, 2016. Overall, the comments received on the draft report were in support of the Committee's recommendations.

In order to facilitate discussion, the majority of the post-evaluation comments have been categorized into major topic areas or themes. The focus of this call, was primarily dedicated to discussing measures with the most significant issues that arose from the comments and evaluating any additional information provided by developers that may or may not impact the evaluation of these measures, prior to re-voting.

Comments and their Disposition

Three major themes were identified in the post-evaluation comments, as follows:

1. Recommends with Continued Endorsement
2. Support of measure with recommended changes
3. Harmonization

Theme 1 – Recommends with Continued Endorsement

Measure #0022: Use of High-Risk Medications in the Elderly (DAE)
received 1 public comment from ASHP related to the Beer's Criteria that the measure is based. The commenter noted that anticoagulants and antidiabetic agents are not comprehensively captured in Beers Criteria but are the two most common high risk medication classes used in this population and warrant very close monitoring and follow up for these patients.

> **Developer Response (#0022):** The commenter is correct that anticoagulants and antidiabetic agents are not comprehensively captured in the American Geriatrics Society Beers Criteria, which are meant to address medications that should generally be avoided in older adults. While not included in the Beers Criteria, we agree that these medications should be carefully prescribed and their use should be monitored in older adults. We have current work underway at NCQA to explore development of quality measures in these areas.
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> **Committee Response:** The Committee agrees with the developer response and maintains their decision to recommend this measure for continued endorsement.

Theme 2 – Support of Measure with Recommended Changes

Measure #2940: Use of Opioids at high Dosage in Persons without Cancer
This measure received 3 comments. The commenters noted that the measure may be too inclusive and the developer should consider narrowing the measure to specific chronic conditions or diagnoses to be more meaningful.

> **Developer Response (#2940):** The recommendations in the 2015 American Geriatrics Society Beers Criteria are based on a systematic evidence review conducted by American Geriatrics Society Beers Criteria Expert Panel. The review is focused on the evidence for potential harms of medications in older adults. Medications then included in the Beers Criteria recommendations are those that the panel found evidence indicating that the medications should in general be avoided in all older adults or avoided in older adults with certain conditions or diseases, due to their associated risks for these populations. The Beers Criteria is updated regularly based on currently available literature. We believe it's important for this quality measure to be based on the systematic evidence review that is conducted by the Beers Criteria Expert Panel. The complete evidence tables for the systematic review can be accessed on the American Geriatrics Society's website here: http://geriatricscareonline.org/toc/american-geriatrics-society-updated-beers-criteria-for-potentially-inappropriate-medication-use-in-older-adults/CL001
> NCQA recognizes that some of the medications that are most attributable to adverse drug events in older adults that result in ED visits and hospitalizations are not included in the Beers Criteria as medications to be generally avoided (e.g., warfarin, antidiabetics and oral antiplatelets - although some oral antiplatelets are in fact included in the Beers Criteria and this measure: Dipyridamole, Ticlopidine). These other high-risk medications

should be addressed in separate quality measures that focus on safe prescribing and appropriate monitoring, rather than this measure which focuses on medications that should be generally avoided. We agree with the need for such quality measures to improve safe prescribing of anticoagulants, antidiabetics, and opioids and have current work underway at NCQA to explore development of measures in these areas. Of note, the Pharmacy Quality Alliance has several measures addressing opioid prescribing that are currently being considered for NQF endorsement as part of this Patient Safety project. NCQA supports the endorsement of these measures and has plans to adapt them for health plan reporting in the near future.
In terms of the way this measure is currently specified to include a number of different medications, we believe that creating separate quality measures or indicators for all the specific medications in the Beers Criteria, or for each drug-disease interaction, would be burdensome for measurement and reporting by health plans. Plans can look at medications on an individual basis to see where improvements and interventions are needed, however we do not think this level of detail would be desirable for national reporting by health plans.
As a measure of potentially inappropriate medication use, NCQA does not expect this measure's performance to ever reach 0% (i.e., no prescribing of high-risk medications). There will always be cases where the benefits of prescribing a high-risk medication may outweigh the risks for certain patients. Clinicians should take into

Committee Response: The Committee agrees with the developer response and maintains their decision to recommend this measure for continued endorsement.

Measure #2950: Use of Opioids from Multiple Providers in Persons without Cancer
The measure received 1 comment in support of the measure with a few recommendations for how the measure could be improved.

Developer Response (#2950): The recommendations in the 2015 American Geriatrics Society Beers Criteria are based on a systematic evidence review conducted by American Geriatrics Society Beers Criteria Expert Panel. The review is focused on the evidence for potential harms of medications in older adults. Medications then included in the Beers Criteria recommendations are those that the panel found evidence indicating that the medications should in general be avoided in all older adults or avoided in older adults with certain conditions or diseases, due to their associated risks for these populations. The Beers Criteria is updated regularly based on currently available literature. We believe it's important for this quality measure to be based on the systematic evidence review that is conducted by the Beers Criteria Expert Panel. The complete evidence tables for the systematic review can be accessed on the American Geriatrics Society's website here: http://geriatricscareonline.org/toc/american-geriatrics-society-updated-beers-criteria-for-potentially-inappropriate-medication-use-in-older-adults/CL001
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and oral antiplatelets - although some oral antiplatelets are in fact included in the Beers Criteria and this measure: Dipyridamole, Ticlopidine). These other high-risk medications should be addressed in separate quality measures that focus on safe prescribing and appropriate monitoring, rather than this measure which focuses on medications that should be generally avoided. We agree with the need for such quality measures to improve safe prescribing of anticoagulants, antidiabetics, and opioids and have current work underway at NCQA to explore development of measures in these areas. Of note, the Pharmacy Quality Alliance has several measures addressing opioid prescribing that are currently being considered for NQF endorsement as part of this Patient Safety project. NCQA supports the endorsement of these measures and has plans to adapt them for health plan reporting in the near future.
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As a measure of potentially inappropriate medication use, NCQA does not expect this measure's performance to ever reach 0% (i.e., no prescribing of high-risk medications). There will always be cases where the benefits of prescribing a high-risk medication may outweigh the risks for certain patients. Clinicians should take into account various factors when considering the risk-benefit ratio of prescribing a high-risk medication to an individual. A companion paper to the Beers Criteria was published by the American Geriatrics Society Workgroup on Improving Use of the Beers Criteria in 2015. The paper specifically states "the AGS 2015 Beers Criteria are reasonable to use for performance measurement across large groups of patients and providers but should not be used to judge care for any individual" (Steinman et al., 2015, JAGS). We believe measuring this concept of potentially inappropriate medication use among elderly at the health plan (i.e., population) level is an important and useful medication safety measure that health plans can use to identify high-risk medication prescribing.

Committee Response: The Committee agrees with the developer response and maintains their decision to recommend this measure for continued endorsement.

Measure #3003: PACE- Participants Falls with Injury
This measure received 1 comment. The commenter provided additional references that relevant to the measure and requested the measure include data on the urgency of the task.

Developer Response (#3003): The developer believes that this situation (i.e., urgency) is common across all care settings and this issue is not unique to the PACE setting. We sought to harmonize our measure with existing NQF-endorsed measures, which do not capture this information at this time. In addition, we are concerned that collecting this data would be challenging and therefore could negatively impact the reliability and validity of the measure if included.

Committee Response: The Committee agrees with the developer response and maintains their decision to recommend this measure for continued endorsement.

Theme 3 – Harmonization

Measure #2988: Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
This measure received 2 comments. One comment expressed that medication reconciliation as a quality measure becomes too burdensome for providers without actually demonstrating that meaningful reconciliation has taken place. Another comment noted that the measure may not be harmonized with existing measures.

Developer Response (#2988): KCQA agrees that medication reconciliation is a critical domain for patient safety and shares RPA's belief that, ideally, a systematic approach to medication management would optimize care. We note that the publication referenced in RPA's comment (Pai, 2013) suggests that the optimal model for such a systematic approach to medication management therapy (MTM) services for ESRD patients should be structured around the dialysis facility and provided by a pharmacist; the authors acknowledge that most dialysis facilities do not have ready access to a pharmacist. Recognizing this, the KCQA measure specifications permit medication reconciliation by appropriate, qualified professionals.

We disagree that NQF 2988 will be a "paper chase," and note that during testing in 5,292 facilities, approximately 4.5% of facilities scored 0 on the measure over the 6-month period for which data were examined. We believe it is a crucial first step towards improving medication management processes in the ESRD population that will improve patient safety. Going forward, we look forward to continuing to work with RPA, a KCQA member, and other members to improve medication management and this measure.

Committee Response: The Committee agrees with the developer response and maintains their decision to recommend this measure for continued endorsement.