NATIONAL QUALITY FORUM
Driving measurable health improvements together

Memo

June 3, 2021

To: Prevention and Population Health Standing Committee

From: NQF staff

Re: Post-comment web meeting to discuss public comments received and NQF member expression of support

Introduction

The National Quality Forum (NQF) closed the public commenting period for the fall 2020 draft technical report and the measure submitted for endorsement consideration in the Prevention and Population Health project on April 30, 2021. Eighteen comments were received of which the majority were supportive with two commenters requesting additional clarification and considerations outlined within this memo.

Purpose of the Call

The Prevention and Population Health Standing Committee will meet via web meeting on June 3, 2021, from 1:00-3:00PM ET. The purpose of this call is 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;
- Review and discuss NQF members' expression of support of the measure under consideration; and
- Determine whether reconsideration of the endorsement evaluation recommendation or other courses of action are warranted.

Standing Committee Actions

1. Review this briefing memo and draft report.
2. 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).
3. Review the NQF members' expressions of support of the submitted measures.
4. Be prepared to provide feedback and input on proposed post-evaluation comment responses.

Conference Call Information

Please use the following information to access the conference call line and webinar:

Speaker dial-in #: 1-844-621-3956

Web link: https://nqf.webex.com/nqf/j.php?MTID=mb844c9e35606241e384c314a2ec3e04c

Meeting number (access code): 173 715 7890

Meeting password: amPJJZUT872

Background

Population health is the collective well-being and functional ability of an identified group of people to experience their full capabilities. It has multiple environmental, behavioral, social, and biological determinants. Population health is generally understood as a systems-level concept that describes health outcomes of a group of individuals that are measured through a broad spectrum of public health, clinical care, socioeconomic, and physical environmental determinants that function interdependently and cumulatively. Population health not only focuses on disease and illness across multiple sectors, but also on health and well-being, prevention, and health promotion, as well as disparities in outcomes and improvement activities within a group and/or between groups. Identifying valid and reliable measures of performance across these multiple sectors can be challenging. Data collection, health assessments at individual and aggregate levels, payment structures, quality of patient care, public health interventions, and other components present challenges in shaping widespread, standardized implementation of population health measures. Overcoming these challenges is critical to any strategy to understand and improve the health of populations.

The Prevention and Population Health Portfolio Standing Committee (PDF) oversees NQF's portfolio of prevention and population health measures that focus on healthy lifestyle behaviors, community interventions, and social and economic conditions in healthcare and community settings that improve health and well-being.

The Standing Committee evaluates newly submitted and previously endorsed measures against NQF's measure evaluation criteria, identifies portfolio gaps, provides feedback on gaps in measurement, and conducts ad hoc reviews. On February 17-18, 2021, the 25-person Prevention and Population Health Standing Committee evaluated one new measure against NQF's standard evaluation criteria, NQF #3592e *Global Malnutrition Composite Score*, for which consensus was not reached on the performance gap criteria.

Comments Received

NQF accepts comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF accepts comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments during a 16-week comment period via an online tool on the project webpage.

Pre-evaluation Comments

NQF accepts comments prior to the evaluation of the measures via an online tool on the project webpage. For this evaluation cycle, the pre-evaluation comment period was open from December 23, 2020 to January 26, 2021, for the measures under review. No comments were received during this period.

Post-evaluation Comments

The draft report was posted on the project webpage for public and NQF member comment on April 1, 2021, for 30 calendar days. During this commenting period, NQF received three comments from three member organizations and 15 public comments from non-members, including one from the measure developer.

Member Council	# of Member Organizations Who Commented
Consumer	0
Health Plan	0
Health Professional	2
Provider Organization	0
Public/Community Health Agency	0
Purchaser	0
QMRI	0
Supplier/Industry	1

We have included all comments that we received in the comment table (excel spreadsheet) posted to the Standing Committee SharePoint site and the Prevention and Population Health webpage. This comment table contains the commenter's name, comment, associated measure, topic (if applicable), and—for the post-evaluation comments—draft responses (including measure steward/developer responses) for the Standing Committee's consideration. Please review this table in advance of the meeting and consider the individual comments received and the proposed responses to each. These comments, along with the Standing Committee's recommendations, will be reviewed by the Consensus Standards Approval Committee (CSAC) on November 30 and December 1, 2021. The CSAC will determine whether to uphold the Standing Committee's recommendation for the measure submitted for endorsement consideration. All Standing Committee members are encouraged to attend the CSAC meeting to listen to the discussion.

Although all comments are subject to discussion, the intent is not to discuss each individual comment on the June 3 post-comment call. Instead, the Standing Committee will spend most of the meeting time considering the comments summarized below and the set of comments as a whole. Please note that measure stewards/developers were asked to respond where appropriate. Where possible, NQF staff has proposed draft responses for the Standing Committee to consider.

Comments and Their Disposition

Themed Comments

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

1. Requested updates from the 2015-2017 Health & Well-being Project endorsement evaluation of the four individual measures currently resubmitted as a composite.
2. Requested clarification from developers for the 2016 Measure Applications Partnership (MAP) review of the four individual measures now currently resubmitted as a composite.

3. Requested evidence directly linking the documentation of a malnutrition diagnosis to improved patient outcomes and feedback on implementation burdens of the four component measures.
4. Requested to review a feasibility scorecard provided for each electronic health record (EHR) system assessed instead of aggregated score across all three vendors, as well as testing data elements for all elements including the denominator exclusions.

Measure-Specific Comments

NQF# 3592e Global Malnutrition Composite Score

The two comments review clarifications were received from the Federation of American Hospitals (FAH) and the American Medical Association (AMA), which were quite similar in content. Therefore, the developer responded to these comments collectively. The endorsement evaluations requests included: (1) Identifying evidence directly linking documentation of a malnutrition diagnosis to improved patient outcomes, (2) Feedback on potential implementation burdens of the four component measures, (3) Feasibility scorecard details for each electronic health record (EHR) system assessed (rather than aggregated score across all three vendors), and (4) Data elements testing for all data elements, including the denominator exclusions.

Measure Steward/Developer Response:

The Academy of Nutrition and Dietetics and Avalere Health, the respective measure steward and developer of NQF #3592 – Global Malnutrition Composite Score, appreciate the comments and feedback received from a diverse representation of healthcare stakeholders. This composite measure reflects years of multi-stakeholder input and collaboration from across the healthcare sector. In the spirit of stakeholder input and collaboration, we address the questions raised by several commenters below.

In Response to Comments on Evidence:

1. Both the previous Health and Well-being endorsement committee from the 2015-2017 cycle and the 2016-2017 Measures Application Partnership Hospital workgroup made specific recommendations to consider joining the formerly individual measures into a composite. To that end, Avalere and the Academy pursued the development of a composite measure which incorporates all the main components of the clinical malnutrition workflow beginning with screening at admission and ending with the development of a nutrition care plan for those with a diagnosis of malnutrition. Each component was evaluated, and the measure calculation was tested by assessing the influence of each component on a multi-linear model. The existing components, while similar to the individual eCQMs submitted in 2016, are significantly modified to reflect a combination of the largest quality gaps among participating hospitals and the scientific rigor of the measure. We refer commenters to the 2021 measure testing information provided that demonstrates the important contribution of each component to outcomes and the results of a hierarchical linear model with 30-day hospital readmissions and hospital length of stay as the explanatory outcomes for the analysis. The analysis was also published in the Journal of the Academy of Nutrition and Dietetics. [1]

2. Two commenters raised concerns regarding the evidence criteria for the appropriate diagnosis component of the composite score based on findings from the endorsement review of a related set of individual eCQMs submitted in 2016. The measure developer and steward would like to refer the commenting organizations to the new Global Composite Score submission which includes updated evidence and new studies that have been published since 2016. Further, testing and validation was conducted in 2016 with only 2 hospital datasets and the testing had only been conducted at the data element level. The updated testing included 56 hospitals with

over 175,000 hospital encounters and was conducted at the component and measure score levels to be able to demonstrate the contributions of each component to the overall score and the relationship with outcomes.

3. We provided several published studies on the use of the measures and the importance of each component of the workflow leading to the appropriate diagnosis of malnutrition and development of the plan of care. We refer the commenters to the evidence attachment as well as the developer/steward comments to the committee which highlight yet another set of case studies of measure implementation.

In Response to Comments on Data Element Testing:

1. One commenter suggested there was no evidence of "robust data element testing", referencing the report included for comment. We refer the commenter to the final testing attachment that was provided to the committee and reviewed as part of the committee's deliberations. In that final testing attachment, we provide both score-level AND data element-level testing results that demonstrate the role of each major component of the composite measure.

2. Another commenter suggested that testing of the exclusions was not conducted. We refer the commenter to our responses under section 2b2. Exclusions Analysis in the NQF Composite Measure Testing attachment that was submitted to the committee. There we describe our testing approach, assumptions and results indicating the rationale for retaining the exclusion criteria.

In Response to Comments on Burden of Several Requirements:

1. We appreciate the groundswell of interest on our measure having receiving at least 15 comments from stakeholder groups sharing their experiences with malnutrition care in the hospital or actual use of the measures in practice. Out of a total of approximately 20 comments, two commenters suggested that the previous committee had not endorsed the originally submitted measures from 2016 due to "burden of several of the requirements". The requirements suggested were "documenting within 24 hours of admission" and "all the components required in the plan of care". Our understanding is that what the commenters are referencing as "documenting within 24 hours of admission" is likely the original individual measure for screening being a malnutrition screening for all inpatient adults within 24 hours of admission. We refer the commenters to the specifications of the Global Composite Score which does not incorporate all adults (population was limited to adults 65 and older for evidentiary reasons) nor does it involve timing of screening upon admission as was included in the original measures submitted. Furthermore, we refer the commenters to the Joint Commission Standards that were in place for at least 15 years requiring nutrition screening for all admitted inpatients within 24 hours of admission. While this standard is no longer in effect due to high performance (indicating low burden and high feasibility), the component of nutrition screening has been rolled up into a comprehensive standard for nutritional status and care planning. Hospitals have long-been implementing these processes as part of their regulatory and certification requirements but have never been systematically measured on their compliance. [2] This measure provides an opportunity to truly understand the extent to which hospitals are complying with evidence-based nutrition care practices for those at-risk of malnutrition or already malnourished upon admission.

2. As far as the burden suggested by the two comments regarding "all the components of required in the plan of care", we respectfully disagree with this characterization of the rationale for previous malnutrition measures not being endorsed in the past. We note that the 2016 nutrition care plan measure (which is arguably different than the measure included in the composite score) was not endorsed because the measure did not pass validity at the time. The measures submitted in 2016 were individual measures and the comparable measure was a hybrid eCQM and having only been tested in 2 hospitals at the time. We took the feedback from previous review bodies, our expert collaborators and partners, and the participating hospitals themselves to redesign the measure suite into a fully electronic and feasible composite measure of optimal malnutrition care. NQF #3592 is designed as a full eCQM and all components including the nutrition care plan component were tested in 56 hospitals which follow consensus recommendations on integration of the workflow in the EHR at the time of submission. [3] This measure does not introduce new burden to practicing clinicians given that the capture of a nutrition care plan is a standard of care and the components are recommended by expert consensus as well as embedded within hospital regulatory requirements. For instance, according to the accrediting body for Registered Dietitian Nutritionists (RDNs) and other clinically qualified nutrition professionals, RDNs should develop a nutrition care plan to change a nutrition-related behavior, risk factor, environmental condition, or aspect of health status to resolve or improve the identified nutrition diagnosis(es) or nutrition problem(s). [4] Care plans are tailored to the patient needs by planning and implementing appropriate interventions. In addition, the Medicare Conditions of Participation for hospitals to qualify for CMS payment includes guidelines that request hospitals ensure individual patient nutritional needs be met in accordance with recognized dietary practices including assessing patients for their risk of nutrition deficiencies and need for therapeutic diets. [5]

In Response to Comments on Feasibility:

1. Two commenters requested additional detail on the feasibility of the composite measure given that the scorecard submitted at the time of review was aggregated across 56 hospitals reflecting 3 EHR vendors (Epic, Cerner, and Allscripts which together comprise about 60% of the hospital market). Given the request to provide additional detail, not only did we break the summary down into vendor-specific score cards, but we also added feedback from another 53 hospitals reflective of different EHR implementations. We have received feedback (and measure data) from more than 100 hospitals across the United States who have worked to implement the measures and use them in real-world to guide clinical practice improvement. In addition to overall feasibility of critical data elements, two commenters suggested that there is potential uncertainty around documenting discharge disposition (otherwise known as discharge status) of which two are included as exclusion criteria (discharge to hospice and left against medical advice). Feasibility testing according to NQF consensus development guidelines recommend qualitative feedback on critical data elements for eCQMs, particularly those that may not already be used in other measures. However, we do not share this concern regarding discharge disposition given that there are already standard term sets for discharge disposition that are requirements for EHR certification and promoting interoperability programs. To address this particular concern, we refer the commenter to Office of the National Coordinator's US Core Data for Interoperability (USCDI) which lists encounter disposition as having been used nationally at scale for many of CMS's programs. [6]

2. In addition to qualitative feasibility testing, Bonnie testing was conducted to test the appropriate design of the electronic scoring algorithm. The results of this testing demonstrated

100% coverage for all reported data elements including the exclusion criteria (see attachment). Bonnie testing works specifically with validated code sets and value sets and demonstrates the coverage of included data elements for certified EHR technology.

Proposed Committee Response:

Thank you for your comment. The Standing Committee will review this information in the upcoming post-comment meeting.

NQF Member Expression of Support

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ("support" or "do not support") for each measure submitted for endorsement consideration to inform the Committee's recommendations. Two NQF members provided their expressions of support or nonsupport: See Appendix A.

Appendix A: NQF Member Expression of Support Results

Two NQF members provided their expressions of support/nonsupport. Results are provided below.

NQF #3592e: Global Malnutrition Composite Score (Academy of Nutrition and Dietetics/Avalere Health)

Member Council	Support	Do Not Support	Total
Consumer	0	0	0
Health Plan	0	0	0
Health Professional	1	1	2
Provider Organization	0	0	0
Public/Community Health Agency	0	0	0
Purchaser	0	0	0
QMRI	0	0	0
Supplier/Industry	0	0	0