NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Primary Care and Chronic Illness Standing Committee – Measure Evaluation Web Meeting

The National Quality Forum (NQF) convened the Primary Care and Chronic Illness (PCCI) Standing Committee for a web meeting on June 23, 2022, to evaluate four measures for the spring 2022 cycle.

Welcome, Review of Meeting Objectives, Introductions, and Overview of Evaluation and Voting Process

LeeAnn White, NQF director, welcomed the Standing Committee and participants to the web meeting. Ms. White reviewed the meeting objectives. The Standing Committee members each introduced themselves and disclosed any conflicts of interest. No Standing Committee members were recused from the measures under review. Additionally, Isaac Sakyi, NQF manager, reviewed the Consensus Development Process (CDP) and the measure evaluation criteria.

Some Standing Committee members were unable to attend the entire meeting due to early departures and late arrivals. The vote totals reflect members present and eligible to vote. A quorum of 13 was met and maintained for the entirety of the meeting. Voting results are provided below.

Measure Evaluation

During the meeting, the PCCI Standing Committee evaluated four measures (i.e., three maintenance and one new) for endorsement consideration. A more detailed summary of the Standing Committee's deliberations will be compiled and provided in the draft technical report.

A measure is recommended for endorsement by the Standing Committee when greater than 60 percent of eligible voting members select a passing vote option (Pass, High and Moderate, Yes) on all must-pass criteria and overall suitability for endorsement. A measure is not recommended for endorsement when less than 40 percent of voting members select a passing vote option on any must-pass criterion or overall suitability for endorsement. If a measure does not pass a must-pass criterion, voting during the measure evaluation meeting will cease. The Standing Committee will not re-vote on the measures during the post-comment meeting unless the Standing Committee decides to reconsider the measure(s) based on submitted comments or a formal reconsideration request from the developer. The Standing Committee has not reached consensus on the measure if between 40 and 60 percent of eligible voting members select a passing vote option on any must-pass criterion or overall suitability for endorsement. The Standing Committee will re-vote on criteria that did not reach consensus and potentially on overall suitability for endorsement during the post-comment web meeting.

Voting Legend:

- *Evidence (Outcome Measures) and Use:* Pass/No Pass
- *Accepting Scientific Methods Panel (SMP) Rating and Overall Suitability for Endorsement*: Yes/No
- *All Other Criterion:* H – High; M – Medium; L – Low; I – Insufficient; NA – Not Applicable
- *Maintenance Criteria for Which Standing Committee Decided Additional Discussion/Vote Was Not Needed (Evidence, Reliability, and Validity only):* Accepted Previous Evaluation

NQF #3668 Follow-Up After Emergency Department Visits for Asthma (Albert Einstein College of Medicine/University of California, San Francisco [UCSF]): New Measure

Description: This process measure seeks to capture follow up after asthma-related emergency department (ED) visits for children with asthma after discharge from the ED, as recommended by the NHLBI 2007 guidelines. This measure assesses the percentage of asthma-related ED visits for children ages 3-21 with a follow-up visit with a primary care clinician or an asthma subspecialist within 14 days of discharge from the ED, within the reporting year, for patients who are enrolled in the health plan for two consecutive months following the ED visit; **Measure Type:** Process; **Level of Analysis**: Health Plan; **Setting of Care:** Ambulatory Care; **Data Source:** Claims

Measure Steward/Developer Representatives at the Meeting

- Naomi Bardach, MD, MAS
- Michael Cabana, MD, MPH

Standing Committee Votes

- **Evidence**: Total Votes-16; H-0; M-14; L-2; I-0 (14/16 – 88%, Pass)
- **Performance Gap**: Total Votes-16; H-4; M-12; L-0; I-0 (16/16 – 100%, Pass)
- **Reliability**: Total Votes-16; H-6; M-9; L-1; I-0 (15/16 – 94%, Pass)
- **Validity**: Total Votes-16; H-1; M-14; L-1; I-0 (15/16 – 94%, Pass)
- **Feasibility**: Total Votes-16; H-3; M-13; L-0; I-0 (16/16 – 100%, Pass)
- **Use**: Total Votes-16; Pass-15; No Pass-1 (15/16 – 94%, Pass)
- **Usability**: Total Votes-17; H-1; M-15; L-1; I-0 (16/17 – 94%, Pass)
- **Standing Committee Recommendation for Endorsement:** Total Votes-17; Yes-17; No-0 (17/17 – 100%, Pass)

The Standing Committee recommended the measure for initial endorsement. This health plan-level measure was newly submitted for endorsement. This measure is not yet publicly reported; however, the measure is currently implemented in California-, Massachusetts-, and Vermont-managed Medicaid groups.

The Standing Committee agreed that the evidence supports the measure, which showed that for children who follow up with a primary care provider (PCP) following an asthma-related emergency department (ED) visit, subsequent pediatric asthma-related ED visits are preventable. While the Standing Committee did find the evidence to be supportive, it requested clarification on several aspects of the measure during the discussion, including why the specified time frame of 14 days following an asthma-related ED visit was selected, how PCPs are incorporated into the measure, which visit types (i.e., in-person, telemedicine, and phone) are included, and the impact of documented history of an asthma diagnosis upon follow-up. The developer responded by explaining that the 14-day follow-up window was selected due to its strong association with decreased asthma-related ED utilization compared to the seven-day and 30-day windows. The developer reminded the Standing Committee that this measure is a health plan-level measure; therefore, the health plan should be helping to facilitate patients getting connected to a PCP. The developer explained that the measure specifications capture submitted claims-based Medicaid data or commercial claims data regarding the follow-up visits. Lastly, the developer responded to the concern of diagnostic accuracy by explaining that clinicians would follow up with patients following an ED visit, regardless of whether the child has an active history of asthma. The Standing Committee agreed that the measure was important and passed the measure on the evidence criterion. The Standing Committee also agreed that the data demonstrated that a performance gap exists.

The Standing Committee acknowledged that robust testing was conducted for reliability yet expressed concern regarding the validity testing and how the developer accounted for the missing data. The developer explained that the extent of missing data was minimal, ranging from 0.00044 percent to 2.3 percent, and did not warrant further analysis. The Standing Committee ultimately decided the measure was both reliable and valid.

The Standing Committee agreed that the data elements required for the measure are readily available and could be captured without undue burden. However, the Standing Committee questioned how health plans would capture various visit types (e.g., in-person, telemedicine, and phone as there may be state variability related to managed Medicaid coverage. A Standing Committee member emphasized that health plans can utilize the International Classification of Diseases, Ninth Revision (ICD-9) and 10th Revision (ICD-10) codes to differentiate between telephonic, telehealth, and telemedicine visit types. The Standing Committee acknowledged that the measure is implemented in three state-managed Medicaid programs and passed the measure on feasibility and use.

The Standing Committee acknowledged that this is a new measure; therefore, there has not been an opportunity available to demonstrate trends in data or performance improvement. Concerning unintended consequences, a Standing Committee member noted the potential risk of labeling providers as low performers if they care for patients who reside in marginalized communities and experience barriers to follow-up care (e.g., time off work, transportation). The developer noted that the measure encourages health plans to create those connections for patients with asthma with a PCP so that follow-up care can occur within the specified 14-day time frame. The developer further noted that they would continue monitoring for unintended consequences as the measure is implemented. The Standing Committee passed the measure on usability and overall suitability for endorsement.

The Standing Committee reviewed one related measure and agreed that the measure is harmonized to the extent possible.

NQF #2797 Transcranial Doppler Ultrasonography Screening Among Children With Sickle Cell Anemia (University of Michigan): Maintenance Measure

Description: The percentage of children ages 2 through 15 years old with sickle cell anemia (Hemoglobin SS) who received at least one transcranial Doppler (TCD) screening within a year. **Measure Type:** Process; **Level of Analysis:** Health Plan; **Setting of Care:** Outpatient Services; **Data Source:** Claims

Measure Steward/Developer Representatives at the Meeting

- Sarah Reeves, PhD, MPH
- Julie McCormick, MA

Standing Committee Votes

- **Evidence**: Accepted Previous Evaluation
- **Performance Gap**: Total Votes-17; H-5; M-12; L-0; I-0 (17/17 – 100%, Pass)
- **Reliability**: Accepted Previous Evaluation
- **Validity**: Total Votes-17; H-1; M-16; L-0; I-0 (17/17 – 100%, Pass)
- **Feasibility**: Total Votes-17; H-6; M-11; L-0; I-0 (17/17 – 100%, Pass)
- **Use**: Total Votes-17; Pass-17; No Pass-0 (17/17 – 100%, Pass)
- **Usability**: Total Votes-16; H-5; M-7; L-1; I-3 (12/16 – 75%, Pass)
- **Standing Committee Recommendation for Endorsement**: Total Votes-17; Yes-17; No-0 (17/17 – 100%, Pass)

The Standing Committee recommended the measure for continued endorsement. This health plan-level measure was originally endorsed in 2016 and retained endorsement in 2022. This measure is currently implemented in the Michigan Medicaid program; however, the measure is not publicly reported. The developer indicated plans for the measure to be publicly reported and used for quality improvement.

The Standing Committee questioned whether new evidence had been published since the last review in 2016. The developer attested that the evidence has not changed. Without further discussion, the Standing Committee accepted the previous evidence evaluation and passed the measure on evidence without a vote. The Standing Committee agreed that there is a performance gap sufficient to warrant measurement and noted that the developer only evaluated disparities based on age. The Standing Committee recommended that the developer provide data for gender, income, and socioeconomic status in the future and passed the measure on the performance gap criterion.

The Standing Committee acknowledged that the measure specifications have not changed since the last endorsement review in 2016 and that the developer did not conduct additional reliability testing. The Standing Committee agreed that the measure was still reliable and accepted the previous evaluation rating. Although the Standing Committee acknowledged that the measure could distinguish between good- and poor-quality care, it encouraged the developer to consider risk-adjusting the measure using socioeconomic metrics, such as the Child Opportunity Index (COI), to identify differences in resources and neighborhood conditions. Ultimately, the Standing Committee passed the measure on validity.

The Standing Committee agreed that all the data elements are in defined fields and available in electronic claims. The Standing Committee highlighted that the measure is not yet publicly reported, which is required within six years since initial endorsement. The developer explained that it was working towards public reporting and that results are provided to Michigan Medicaid Health quarterly; they also explained that this measure is being considered for inclusion in the Centers for Medicare & Medicaid Services' (CMS) core measure sets. The Standing Committee accepted this rationale. There were also concerns that progress toward achieving the goal of high quality, efficient care was not apparent from the improvement data that the developer submitted. The Standing Committee passed the measure on feasibility, use, usability, and overall suitability for endorsement.

The Standing Committee reviewed two related measures and agreed that the measures are harmonized to the extent possible.

NQF #0729 Optimal Diabetes Care (Minnesota Community Measurement [MNCM]): Maintenance Measure

Description: The percentage of patients 18-75 years of age who had a diagnosis of type 1 or type 2 diabetes and whose diabetes was optimally managed during the measurement period as defined by achieving ALL of the following: HbA1c less than 8.0 mg/dL; Blood Pressure less than 140/90 mmHg; On a statin medication, unless allowed contraindications or exceptions are present; Non-tobacco user; Patient with ischemic vascular disease is on daily aspirin or anti-platelets, unless allowed contraindications or exceptions are present. Please note that while the all-or-none composite measure is considered to be the gold standard, reflecting best patient outcomes, the individual components may be measured as well. This is particularly helpful in quality improvement efforts to better understand where opportunities exist in moving the patients toward achieving all of the desired outcomes. Please refer to the additional numerator logic provided for each component; **Measure Type:** Composite; **Level of Analysis:** Clinician: Group/Practice; **Setting of Care:** Ambulatory Care; **Data Source:** Electronic Health Records

Measure Steward/Developer Representatives at the Meeting

- Collette Cole, RN, BSN, CPQH
- Julie Sonier, MPA

Standing Committee Votes

- **Evidence**: Total Votes-16; H-0; M-13; L-2; I-1 (13/16 – 81%, Pass)
- **Performance Gap**: Total Votes-16; H-6; M-10; L-0; I-0 (16/16 – 100%, Pass)
- **Composite - Quality Construct and Rationale**: Total Votes-16; H-0; M-15; L-1; I-0 (15/16 – 94%, Pass)
- **Reliability**: Total Votes-16; H-6; M-9; L-0; I-1 (15/16 – 94%, Pass)
- **Validity**: Total Votes-16; H-2; M-12; L-1; I-1 (14/16 – 88%, Pass)
- **Composite Quality Construct - Empirical Analyses:** Total Votes-15; H-1; M-12; L-;1 I-1 (13/15 – 87%, Pass)
- **Feasibility**: Total Votes-16; H-12; M-3; L-0; I-1 (15/16 – 94%, Pass)
- **Use**: Total Votes-16; Pass-15; No Pass-1 (15/16 – 94%, Pass)
- **Usability**: Total Votes-16; H-5; M-10; L-0; I-1 (15/16 – 94%, Pass)
- **Standing Committee Recommendation for Endorsement**: Total Votes-15; Yes-13; No-2 (13/15 – 87%, Pass)

The Standing Committee recommended the measure for continued endorsement. This clinician group-level measure was originally endorsed in 2011. This composite measure is publicly reported nationally on the Minnesota (MN) HealthScores website and as part of the Minnesota Community Measurement (MNCM) Annual Health Care Quality Report.

The Standing Committee requested clarification on why the hemoglobin A1C (HbA1C), cholesterol management (i.e., statin therapy), and blood pressure values components of the composite had changed since the last review. The developer explained that three separate workgroups were convened to review new evidence for the HbA1c, statin, and blood pressure components and that the values for these components are supported by current guidelines and recommendations from the Action to Control Cardiovascular Risk in Diabetes (ACCORD) and the American College of Cardiology (ACC)/American Heart Association (AHA). The Standing Committee agreed that the measure continues to be important to measure and passed the measure on the evidence criterion. The Standing Committee also agreed that a performance gap exists, noting a decline in measure performance since the start of the coronavirus disease 2019 (COVID-19) pandemic.

The Standing Committee raised a concern with the composite construct, specifically that two of the composite components, aspirin and cholesterol statin use, are not measuring the same population. The developer explained that modifications to the aspirin and statin use components reflected changes in the evidence and guidelines to no longer include patients who do not have ischemic vascular disease. After confirming that these components provide an exception for patients for whom contraindications exist, the Standing Committee accepted the developer's response and passed the measure on the composite quality construct criterion.

The Standing Committee noted that the reliability and validity testing were strong and raised no concerns. The Standing Committee highlighted that a strong correlation exists between the overall result for Optimal Diabetes Care and four of the five components (i.e., blood pressure, hemoglobin A1C, statin use, and tobacco use). The Standing Committee passed the measure on reliability and validity, as well as composite empirical analysis.

The Standing Committee agreed that the data are captured in the routine delivery of care. The Standing Committee acknowledged that the measure is publicly reported on the MN HealthScores website and as part of the MNCM Annual Health Care Quality Report, and it passed the measure on feasibility and use.

During the discussion of usability, the Standing Committee highlighted that the measure's performance has declined slightly since 2019 and that there has been an upward trend of statewide hemoglobin A1C averages, which the developer noted could have been aggravated by the COVID-19 pandemic. The Standing Committee also raised a concern about the potential for unintended consequences, specifically adverse drug reactions to the statin use component. The Standing Committee noted the potential for severe adverse reactions among patients with a medication intolerance to statin therapy, leading to adverse drug events, decreased quality of life, and interference with other medical regimens. The Standing Committee recommended that the developer include medication therapy risk assessments or mitigation plans within the components (e.g., pharmacogenomic testing) to reduce the risk of adverse drug events. One Standing Committee member noted that the statin and aspirin components include an exception for patients with contraindications to the medication therapy. The Standing Committee recommended that the developer continue monitoring for unintended consequences and consider complimentary measures that mitigate patient harm by ensuring that providers who use these measures assess the risks of adverse drug events with their patients. The Standing Committee passed the measure on use, usability, and overall suitability for endorsement.

One related measure was identified for a component of the composite for discussion. The Standing Committee noted that other NQF-endorsed measures could also be regarded as related to other components of the composite, specifically measures focused on tobacco cessation and blood pressure control. The Standing Committee recommended that NQF review its policy on related and competing measures to ensure that the developers of those measures consider how to potentially harmonize further.

NQF #3294 STS Lobectomy for Lung Cancer Composite Score (Society of Thoracic Surgeons [STS]): Maintenance Measure

Description: The STS Lobectomy Composite Score comprises two domains: 1. Operative Mortality (death during the same hospitalization as surgery or within 30 days of the procedure) 2. Presence of at least one of these major complications: pneumonia, acute respiratory distress syndrome, bronchopleural fistula, pulmonary embolus, initial ventilator support greater than 48 hours, reintubation/respiratory failure, tracheostomy, myocardial infarction, or unexpected return to the operating room. The composite score is created by a weighted combination of the above two domains resulting in a single composite score. In addition to receiving a numeric score, participants are assigned to rating categories designated by the following: 1 star: lower-than expected performance, 2 stars: as-expected-performance, 3 start: higher-than-expected-performance; **Measure Type:** Composite; **Level of Analysis:** Facility; **Setting of Care:** Inpatient/Hospital; **Data Source:** Other, Registry Data

Measure Steward/Developer Representatives at the Meeting

- David Shahian, MD
- Jeffrey Jacobs, MD, FACS, FACC, FCCP
- Moritz Wyler von Ballmoos, MD
- Banu Yagci, MBA

Standing Committee Votes

- **Evidence**: Total Votes-15; Pass-15; No Pass-0 (15/15 – 100%, Pass)
- **Performance Gap**: Total Votes-15; H-5; M-10; L-0; I-0 (15/15 – 100%, Pass)

- **Composite - Quality Construct and Rationale**: Total Votes-15; H-6; M-9; L-0; I-0 (15/15 – 100%, Pass)
- **Reliability**: Total Votes-13; H-2; M-11; L-0; I-0 (13/13 – 100%, Pass)
- **Validity**: Total Votes-14; H-3; M-11; L-0; I-0 (14/14 – 100%, Pass)
- **Composite Quality Construct - Empirical Analyses:** Total Votes-14; H-2; M-12; L-0; I-0 (14/14 – 100%, Pass)
- **Feasibility**: Total Votes-14; H-4; M-10; L-0; I-0 (14/14 – 100%, Pass)
- **Use**: Total Votes-14; Pass-14; No Pass-0 (14/14 – 100%, Pass)
- **Usability**: Total Votes-14; H-6; M-8; L-0; I-0 (14/14 – 100%, Pass)
- **Standing Committee Recommendation for Endorsement:** Total Votes-15; Yes-15; No-0 (15/15 – 100%, Pass)

The Standing Committee recommended the measure for continued endorsement. This facility-level measure was originally endorsed in 2018. The measure results are publicly reported on the Society of Thoracic Surgeons (STS) public website for all consenting STS National Database participants.

The Standing Committee noted that the provided evidence supported the measure and that a performance gap exists for patients undergoing a lobectomy procedure. The Standing Committee further acknowledged that the quality construct of the composite is robust and passed the measure on evidence, performance gap, and composite quality construct.

The Standing Committee noted that the reliability and validity testing were strong and had no concerns. The Standing Committee discussed several topics related to the validity of the measure. Specifically, the Standing Committee questioned whether the developer plans to collect and stratify by social risk factors, specifically race and ethnicity. The developer explained that they are currently considering social risk stratification and are in the process of acquiring a geocoded deprivation index that they will eventually incorporate throughout their surgical database. Furthermore, the Standing Committee questioned how the developer handles missing data within the risk model. The developer responded by explaining that the STS recognizes the serious impact missing data have on the risk model and requires stringent data completeness from all participants. The Standing Committee also acknowledged that appropriate weighting and a high degree of validity exists to support the empirical analyses of the composite. The Standing Committee passed the measure on reliability and validity, as well as composite empirical analysis.

While the Standing Committee did agree that most of the data are readily available and can be captured without undue burden, it questioned how many of the data are available in electronic data fields and how 30-day mortality is captured once the patient is discharged from the facility. The developer explained that the data are entered on-site at the participating facility and uploaded to the data warehouse, where the data are analyzed and subsequently populated into feedback reports. Furthermore, the developer agreed that the 30-day life status has been an area of focus over the years and is working towards incorporating the National Death Index for future maintenance review. The developer reiterated that participating facilities must have a 98 percent completion rate for the 30-day status field to have their data included in the feedback reports. The Standing Committee passed the measure on feasibility.

After confirming that a high percentage of STS participants voluntarily publicly report their data, the Standing Committee agreed that facilities are using the measure for ongoing quality improvement and that the data demonstrate progress over time. Ultimately, the Standing Committee passed the measure on usability, use, and overall suitability for endorsement.

No related and competing measures were identified for this measure.

Public Comment

Ms. White opened the lines for NQF member and public comments. No public or NQF member comments were provided during the measure evaluation meeting.

Next Steps

Tristan Wind, NQF analyst, provided an overview of the remaining activities and upcoming project timelines. NQF will post the draft technical report containing the Standing Committee's discussion and recommendations on August 5, 2022, for public comment for 30 calendar days. The continuous public commenting period with member support will close on September 2, 2022. NQF will reconvene the Standing Committee for the post-comment web meeting in the fall of 2022.