NATIONAL QUALITY FORUM

Memo

September 20, 2018

To: Surgery Standing Committee

From: NQF staff

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

Purpose of the Call

The Surgery Standing Committee will meet via web meeting on September 27, 2018 from 2:00 pm to 3:00 pm 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 measures under consideration; and
- Determine whether reconsideration of any measures or other courses of action are warranted.

Standing Committee Actions

1. Review this briefing memo and the draft report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments.
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 #: 866-599-6630 (*NO CONFERENCE CODE REQUIRED)*
Web link: http://nqf.commpartners.com/se/Rd/Mt.aspx?258098
Registration link: http://nqf.commpartners.com/se/Rd/Rg.aspx?258098

Background

The measures in NQF's surgery endorsement project focus on key surgical care processes across an array of procedure types that include outcomes for general and subspecialty surgical procedures, including cardiac, orthopedic, ophthalmological, and vascular surgeries and procedures, and all phases of perioperative care. In this project, measures focused on urogynecologic and cardiac procedures. The Surgery Standing Committee reviewed two maintenance measures, and both were recommended for continued endorsement.

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 during a 16-week comment period via an online tool on the project webpage.

Pre-evaluation Comments

NQF solicits 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 opened on May 8, 2018 and closed on June 19, 2018 for the measures under review. Two comments were received. One comment was supportive of the Committee's recommendations, and another expressed concern with the measure's focus and measure validity. Both pre-evaluation comments were provided to the Committee prior to the measure evaluation meeting.

Post-evaluation Comments

The draft report was posted on the project webpage for public and NQF member comment on August 7, 2018 for 30 calendar days. During this commenting period, NQF received nine comments from five member organizations.

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

We have included all comments that we received (both pre- and post-evaluation) in the comment table (excel spreadsheet) posted to the Committee SharePoint site. 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 Committee's consideration. Please review all comments before the meeting, and consider the individual comments received and the proposed responses to each.

In order to facilitate discussion, the majority of the post-evaluation comments have been categorized into major topic areas or themes. Although all comments are subject to discussion, the intent is not to discuss each individual comment on the September 27 post-comment call. Instead, we will spend the majority of the time considering the theme discussed below, and the set of comments as a whole. Please note that the organization of the comments into major topic

areas is not an attempt to limit Committee discussion. Additionally, please note that measure stewards/developers were asked to respond where appropriate. Where possible, NQF staff has proposed draft responses for the Committee to consider.

Comments and their Deposition

Measure-Specific Comments

2063 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery

Five comments were submitted, and all were supportive of the Committee's decision to recommend this measure for continued endorsement.

Proposed Committee Response

The Committee appreciates comments from members and the public, and upholds their decision to recommend this measure for continued endorsement.

Action Item

No Committee action required.

2558 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery

Three comments were submitted for this measure, and all were supportive of the Committee's decision to recommend this measure for continued endorsement. One comment suggested that the measure should have empirical validity testing and that the developer should explore the underlying relationship between factors like poverty or neighborhood deprivation on mortality.

Measure Steward/Developer Response

We mainly assessed the validity of the CABG mortality measure (NQF #2558) using a systematic assessment of face validity. As we noted in the submission materials, we convened a Technical Expert Panel with (TEP), which included individuals with a range of perspectives including clinicians, consumers, and purchasers, as well as individuals with experience in quality improvement, performance measurement, and health care disparities.

Separate from this assessment of face validity, we also validated the CABG mortality measure against New York registry data (New York State Cardiac Surgery Reporting System [CSRS] from the New York Department of Health), which served as empiric validity testing of both the risk model and the hospital level score. Specifically, we compared the performance of the risk model and hospitals risk-standardized outcome rates calculated from the measure which is risk adjusted using claims, with the performance and hospital RSRRs calculated from the registry-based CABG mortality measure, which uses data abstracted from patients' medical records for risk adjustment. The results of these amylases [sic] show that the claims-adjusted model performs similarly and characterizes hospital performance similarly to the measure adjusted using data from patients' medical records. This analysis is not submitted as an assessment of the measure's validity. Rather, it is supplemental information presented to the committee for consideration.

For more information, see validation report is attached to the response memo [sic].

In addition, we note that mortality as an outcome allows for a broad view of quality of care that encompasses more than what can be captured by individual process-of-care measures. Specifically, mortality is the primary negative outcome associated with a surgical procedure. Many aspects of peri-operative care, intra- and peri-operative practices and several aspects of post-operative care, including prevention of and response to complications and coordinated transitions to the outpatient environment, have been shown to impact CABG mortality. A number of recent studies have demonstrated that improvements in care can reduce 30-day mortality rates (see NQF Evidence Form for more detail).

We thank the Henry Ford Health System for this thoughtful comment. We did not examine the underlying relationship between factors like poverty or neighborhood deprivation and mortality as an outcome. There are currently no national data sources that make this information available at the level of the individual beneficiary. Therefore, we are limited to the use of data mapped to census block group as a proxy for patient-level information or the use of binary variables such as the dual eligibility for Medicare and Medicaid benefits which does not lend itself to analysis of the extremes. However, CMS remains committed to examining alternative solutions that better reflect the balance of hospital- and patient-level influences on hospital outcome measures for socioeconomically disadvantaged groups and we will examine this suggestion in the future.

Proposed Committee Response

The Committee appreciates the developer's response and upholds their decision to recommend this measure for continued endorsement.

NQF Response

Thank you for your comments. NQF accepts a variety of empirical validity testing methods including demonstrating the correlation of the performance measure score on this measure and other performance measures, differences in performance scores between groups known to differ on quality, or assessing the accuracy of all critical data elements.

NQF encourages measure developers to continue exploring additional social and economic risk factors and their impact on patient health outcomes.

Action Item

No Committee action required.

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. Three NQF members provided their expressions of support: See Appendix A.

Appendix A: NQF Member Expression of Support Results

Three NQF members provided their expressions of support. Both measures under consideration received support from NQF members. Results for each measure are provided below.

2063 Performing Cystoscopy at the Time of Hysterectomy for Pelvic Organ Prolapse to Detect Lower Urinary Tract Injury (American Urogynecologic Society)

Member Council	Support	Do Not Support	Total
Consumer	1	0	1
Supplier/Industry	1	0	1

2558 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery (Centers for Medicare & Medicaid Services/Yale CORE)

Member Council	Support	Do Not Support	Total
Consumer	1	0	1