Prevention and Population Health Standing Committee—Spring 2023 Measure Evaluation Meeting Summary

Battelle, a consensus-based entity (CBE), convened the Prevention and Population Health standing committee for a web meeting on August 3, 2023, to evaluate three measures for the Spring 2023 cycle. As these Spring 2023 measures began their endorsement process with an Intent to Submit under the prior CBE, the National Quality Forum (NQF), they were reviewed using the NQF process and criteria for continuity of review.

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

Dr. Matthew Pickering, endorsement and maintenance technical lead, welcomed the standing committee and participants to the meeting. Amir Qaseem, committee chair, also provided welcoming remarks. Dr. Pickering reviewed the meeting objectives and conducted roll call. The standing committee members each introduced themselves and disclosed any conflicts of interest. One standing committee member, Arjun Venkatesh, disclosed a conflict with CBE #3751, as he served as the Director of the measure development team. This conflict led to his recusal from discussing and voting on CBE #3751. Additionally, Dr. Pickering reviewed the measure evaluation process and the measure evaluation criteria.

Some standing committee members were unable to attend the entire meeting due to early departures and late arrivals. During the meeting, the quorum required for live voting was not achieved (14 active committee members for CBE #3747 and CBE #3748; 13 active committee members for CBE #3751). Therefore, the standing committee discussed all relevant criteria and voted after the meeting using an online voting tool. Voting results are provided below.

Measure Evaluation

Dr. Pickering reviewed the measure evaluation process and the measure evaluation criteria. During the meeting, the committee evaluated three measures for initial endorsement consideration.

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, or 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 was not able to discuss related and competing measures during the meeting due to lack of voting quorum, and this discussion will occur during the post-comment meeting.

Voting Legend:

- *Evidence (Outcome Measures) and Use:* Pass/No Pass
- *Overall Suitability for Endorsement:* Yes/No
- *All Other Criteria:* H – High; M – Moderate; L – Low; I – Insufficient; NA – Not Applicable

#3747 Engagement in Community-Based Mental Health Care After a Mental Health Hospitalization (New York State Office of Mental Health)

Description: The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had at least five follow-up community-based mental health care visits in the 90 days after discharge.; **Measure Type:** Process; **Level of Analysis:** Health Plan; **Setting of Care:** Behavioral Health and Post-Acute Care; **Data Source:** Claims Data

Measure Steward/Developer Representatives at the Meeting

- Adrienne Ronsani

Standing Committee Votes

- **Evidence:** Total Votes-15; H-0; M-11; L-3; I-1 (11/15 – 73.3%, Pass)
- **Performance Gap:** Total Votes-15; H-2; M-11; L-2; I-0 (13/15 – 86.7%, Pass)
- **Reliability:** Total Votes-15; H-8; M-7; L-0; I-0 (15/15 – 100%, Pass)
- **Validity:** Total Votes-15; H-1; M-5; L-6; I-3 (6/15 – 40.0%, Consensus Not Reached)
- **Feasibility:** Total Votes-15; H-3; M-11; L-0; I-1 (14/15 – 93.3%, Pass)
- **Use:** Total Votes-15; Pass-14; No Pass-1 (14/15 – 93.3%, Pass/No Pass)
- **Usability:** Total Votes-15; H-0; M-12; L-3; I-0 (12/15 – 80.0%, Pass/No Pass)
- **Standing Committee Recommendation for Endorsement:** Not taken

The standing committee did not vote on the recommendation for endorsement as it did not reach consensus on validity—a must-pass criterion. The standing committee will re-vote on the measure during the post-comment web meeting on October 19, 2023. As this is a new measure, it is not currently publicly reported, but the developer shared plans for this measure to be implemented in one or more New York state accountability and quality improvement platforms.

Prior to this meeting, the measure received four public comments. Two comments were in support of the measure as specified, stating the measure met criteria for approval. The remaining two public comments received were not in support of the measure. Issues raised within the non-supportive comments included a concern that occupational health settings should be included in the measure, questions regarding how the measure treats dually enrolled Medicare/Medicaid patients, and a concern with this measure in rural and medically-underserved communities, where resources to outpatient behavioral health services may be unavailable.

The committee reviewed evidence provided regarding clinical guidelines for treatment of serious mental illness including schizophrenia, bipolar disorder, and major depression as well as youth

suicide risk. The committee discussed concerns around the wide age range included in the measure and the lack of clinical guidelines and other submitted evidence specifically focused on the 6-18 years age range. Additionally, committee members questioned the evidentiary support for the 42-day, 5-visit specification within the measure. The developer explained these specifications emerged from an analysis of the available data and selection of best fit, which balanced feasibility with performance. The developer reported that it looked at different time periods of three months, six months, and other time periods in between those. It also looked at the number of visits people had after discharge in those time periods, and looked at it in an association with outcomes, specifically mental health readmissions and emergency room visits. The developer ultimately found having five visits was the number of visits most associated with having fewer mental health readmissions and emergency room visits. The committee did not have any further questions and passed the measure on evidence.

Moving to the performance gap, the standing committee discussed whether data and testing for this measure across New York state could be generalizable to other states and be nationally representative. The committee also discussed potential gaps in care settings represented in the measure and suitability of the measure in settings where telehealth visits may be more common due to behavioral health access limitations. The committee also inquired about the variation across patients with socio-economic factors. The developer responded stating New York state is generalizable, as New York is the fourth most populous state in the United States with a diverse population in terms of race and ethnicity. There are also urban and rural areas, and New York has a much larger percentage of Medicaid recipients, relative to other states. Thus, the developer posited New York Medicaid data is generalizable to other Medicaid populations. The developer also shared currently, socio-economic data are not included in available health plan-level data in a reliable way. The committee did not have any further questions or concerns and passed the measure on performance gap.

Moving to scientific acceptability (reliability and validity), the committee did not have any major concerns regarding reliability. Regarding validity, the committee reviewed validity testing, which the developer conducted face validity testing of the measure score as well as conducting a correlation analysis of the measure to CBE #0576 - *Follow-Up After Hospitalization for Mental Illness (FUH)*. The developer also performed concordance testing with mental health inpatient readmissions, psychotropic medication adherence, and continued engagement. The committee recognized the face validity testing was sufficient, but some committee members noted the concordance results were weak, since the c-statistic was less than 0.7. The developer shared that it did not know why the results did not provide a stronger predictability with the mental health readmission and ER visits and shared there could be potential confounding by socio-economic indicators and concurrent substance use disorders. Ultimately, the committee did not reach consensus on validity.

For feasibility, committee members did not have any major concerns, but noted for the developer's consideration, the mental health infrastructure within New York may be more robust than other states, which may compromise feasibility in alternate settings. With no additional discussion, the committee passed the measure on feasibility.

The committee considered the planned use of this measure in New York accountability programs as shared by the developer and did not raise any concerns. Regarding usability, the committee also did not have concerns, recognizing this is new measure. Therefore, the committee passed the measure on use and usability.

A vote on overall suitability was not taken since the committee did not reach consensus on validity, a must-pass criterion.

#3748 Quality of Care Composite for Implantable Cardioverter-Defibrillator (ICD)/Cardiac Resynchronization Therapy Defibrillator (CRT-D) (American College of Cardiology)

Description: This measure is an all-or-none composite of the number of patients following an ICD/CRT-D implant procedure who received prescriptions for all medications (Angiotensin-converting enzyme inhibitors (ACE-I)/ Angiotensin receptor blockers (ARB)/ Angiotensin receptor-neprilysin inhibitors (ARNI) and beta blockers) for which they are eligible at discharge and those patients with procedures that fulfill class I, IIa, or IIb guideline indications; **Measure Type:** Composite; **Level of Analysis:** Facility; **Setting of Care:** Inpatient/Hospital; **Data Source:** Registry Data

Measure Steward/Developer Representatives at the Meeting

- Jarrott Mayfield
- Heidi Bossley

Standing Committee Votes

- **Evidence:** Total Votes-14; H-4; M-10; L-0; I-0 (14/14 – 100%, Pass)
- **Performance Gap:** Total Votes-14; H-2; M-12; L-0; I-0 (14/14 – 100%, Pass)
- **Composite Quality Construct and Rationale:** Total Votes-14; H-1; M-12; L-1; I-0 (13/14 – 92.9%, Pass)
- **Reliability:** Total Votes-13; H-0; M-14; L-0; I-0 (14/14 – 100%, Pass)
- **Validity:** Total Votes-14; H-0; M-14; L-0; I-0 (14/14 – 100%, Pass)
- **Composite Quality Construct:** Total Votes-14; H-2; M-12; L-0; I-0 (14/14 – 100%, Pass)
- **Feasibility:** Total Votes-14; H-5; M-9; 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-4; M-10; L-0; I-0 (14/14 – 100%, Pass)
- **Standing Committee Recommendation for Endorsement:** Total Votes-14; Yes-14; No-0 (14/14 – 100%, Pass)

The standing committee recommended this composite measure for initial endorsement. This facility-level measure is not currently publicly reported, but it is being implemented into the National Cardiovascular Data Registry (NCDR), specifically the Electrophysiology Device Implant (EPDI) Registry.

Prior to the meeting, one public comment was received in support of the measure, noting it meets criteria for approval. The committee considered this comment in its review of the measure.

The committee reviewed the evidence submitted in support of this measure, noting the randomized-controlled trials and clinical practice guidelines were provided. The committee had no concerns and passed the measure on evidence. Considering performance gap, the developer grouped hospitals into four-star categories and provided a distribution of hospitals across the four-star ratings. Frequency results ranged from 86 to 423 for the one-star and four-

star rankings, respectively. The committee did not have any major concerns and passed the measure on gap.

Moving to the composite rationale, the committee recognized the measure focuses on processes that are recommended for optimal care for patients following ICD/CRT-D implantation. The committee acknowledged as a composite, this measure will be used for making provider assessments of care more comprehensive, and it condenses more than one indicator of quality into one measure. The committee asked how this measure builds on previous indications and discharge medication measures. The developer emphasized that this measure will provide new and complementary information, which can be used to assess quality of care more comprehensively. With no further questions, the committee passed the measure on the composite construct and rationale.

Regarding reliability, the committee recognized that since one of the components is currently endorsed (CBE# 0965), then this component measure is deemed to be reliability and valid. The committee did not have any concerns with the testing of the second component. For the composite score itself, the committee considered the results of the test-retest analysis of the measure score, as the developer stated it was unable to perform a split-sample or signal-to-noise analysis due to the measure being reported strictly at the hospital-level. However, the test-retest results showed an intra-class correlation coefficient of 0.78. The committee did not raise any major concerns and passed the measure on reliability. For validity, the committee considered both the validity testing approach for face and empirical validity. The developer did not report component measure validity for the non-endorsed component measure, but rather summarized that the NCDR Data Quality Program (in which both components are utilized) ensures that data submitted to the NCDR are complete and validly collected. With respect to the face validity testing, the committee did not raise any concerns. For the empirical validity testing, the committee acknowledged the correlation analysis was conducted with the rate of in-hospital risk-standardized complications for ICD placement. Despite the results being low and not significant, the committee acknowledged the correlation was in the hypothesized direction, such that a higher group of patients receiving better overall quality were associated with a lower complications score. Ultimately, the committee passed the measure on validity. The committee did not have any questions or concerns related to the empirical analysis of the composite construct and passe the measure on this sub-criterion.

Moving to feasibility, use, and usability, the committee did not have any major concerns or questions about feasibility, use, or usability and passed the measure on these three criteria. Overall, the committee voted to recommend the measure for initial endorsement.

#3751 Risk Adjusted Post-Ambulance Provider Triage Emergency Department (ED) Visit Rate Measure (Centers for Medicare & Medicaid Services [CMS]/ Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation)

Description: The Risk Adjusted Post-Ambulance Provider Triage Emergency Department (ED) Visit Rate Measure (shorthand: Post-Triage ED Visit Rate Measure) assesses the quality of the triage and decision making by ambulance providers who transport low acuity patients to an alternative destination (non-ED location), or facilitate Treatment In Place (TIP), by identifying whether patients have a subsequent ED visit or death within three days.; **Measure Type:** Outcome; **Level of Analysis:** Population – ambulance service provider geography; **Setting of**

Care: Inpatient/Hospital & Population – ambulance service provider geography; **Data Source:** Claims Data

Measure Steward/Developer Representatives at the Meeting

- Nicole Voll
- David Dietz
- Arjun Venkatesh

Standing Committee Votes

- **Evidence:** Total Votes-14; Pass-13; No Pass-1 (13/14 – 92.9%, Pass)
- **Performance Gap:** Total Votes-14; H-1; M-13; L-0; I-0 (14/14 – 100%, Pass)
- **Reliability:** Total Votes-14; H-0; M-13; L-1; I-0 (13/14 – 92.9%, Pass)
- **Validity:** Total Votes-14; M-13; L-0; I-1 (13/14 – 92.9%, Pass)
- **Feasibility:** Total Votes-14; H-1; M-12; L-1; I-0 (13/14 – 92.9%, Pass)
- **Use:** Total Votes-14; Pass-13; No Pass-1 (13/14 – 92.9%, Pass)
- **Usability:** Total Votes-14; H-0; M-12; L-2; I-0 (12/14 – 85.7%, Pass)
- **Standing Committee Recommendation for Endorsement:** Total Votes-14; Yes-13; No-1 (13/14 – 92.9%, Pass)

The standing committee recommended this outcome measure for initial endorsement. This population-level measure is not currently publicly reported, but the developer noted the measure is currently in use as an accountability measure within the Emergency Triage, Treat, and Transport (ET3) Model, with the first year of measurement and payment spanning January 1, 2023, through December 31, 2023.

Prior to the meeting, one public comment was received in support of the measure, noting it meets criteria for approval. The committee considered this comment in its review of the measure.

In review of the evidence, the committee did not raise any major concerns or questions and passed the measure on this criterion. Regarding the performance gap, there were no major concerns or questions raised by the committee, which passed the measure on gap.

Moving to reliability, the committee requested clarification on the measure specifications regarding whether patients who interact with the ambulance service but refused recommended care once triaged are within the measure. The developer responded, noting how patients move through the triage process, and confirmed that those who refuse care are not captured in the measure because they are not represented in the claims data. Raising no additional questions, the committee passed the measure on reliability. With respect to validity, the committee did not raise any major concerns, recognizing only face validity testing of the measure score was conducted. As a result, the highest possible passing rating for validity is “moderate.” The committee acknowledged that nine of the 11 developer-convened workgroup members (82.0%) agreed or somewhat agreed that the measure can discern good vs. poor quality of care. The committee asked about whether initial emergency medical services (EMS) outreach was considered within the measure. The developer explained the origin of the call to EMS was excluded. The committee passed the measure on validity.

The committee next considered feasibility and passed the measure on this criterion, as it did not raise any major concerns or questions. Moving to use and usability, the committee noted the measure is currently in use by CMS within the ET3 Model, and the developer intends to seek future implementation opportunities for this measure within other accountability programs. Regarding usability, the committee recognized no unintended consequences have been identified through its current use. The committee passed the measure on use and usability.

During discussion of the measure's overall suitability for endorsement, the committee discussed the importance of measuring the drivers of health outcomes and social determinants of health in triage and encouraged more measures like this in future. The developer shared how regulatory approved protocols and clinical guidelines are used by the current triage model to address concerns around variation in care and exclusion of vulnerable populations. Following the discussion, the committee recommended the measure for endorsement.

Public Comment

Dr. Pickering opened the lines for public comments. No public comments were provided during the measure evaluation meeting.

Next Steps

Dr. Pickering provided an overview of the next steps. The project team will begin drafting the meeting summary of the standing committee deliberations and will post this to the project webpage. The meeting summary will be released for a 20-day public comment period. The post-measure evaluation public comment period will take place from August 25 to September 13. Additionally, the standing committee post-measure evaluation web meeting will take place on October 16 and the Consensus Standards Approval Committee (CSAC) review will take place on December 6. Lastly, Dr. Pickering and the committee chair thanked the committee, developers, and members of the public for their time, engagement, and participation in this work and adjourned the call.