Partnership for Quality Measurement
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Pre-Rulemaking Measure Review (PRMR) Hospital Recommendation Group Meeting

Dr. Michelle Schreiber | Centers for Medicare & Medicaid Services (CMS)

Melissa Gross | CMS

Brenna Rabel | Battelle

Dr. Meridith Eastman | Battelle

Kate Buchanan | Battelle

Dr. Lydia Stewart-Artz | Battelle

Isaac Sakyi | Battelle

January 15-16, 2025

The analyses upon which this publication is based were performed under Contract Number 75FCMC23C0010, entitled, "National Consensus Development and Strategic Planning for Health Care Quality Measurement," sponsored by the Department of Health and Human Services, Centers for Medicare & Medicaid Services.

In-Person Participation *(pt. 1)*

Please speak into the microphone to ensure we include virtual attendees in the discussion and to ensure we capture your question or comment in the meeting transcript.

If you require assistance, please raise your hand or ask a Battelle staff member.

In-Person Participation
(pt. 2)

If you need to connect to the meeting virtually at any point in the day, please use the QR code below to access the agenda, which contains a link to the meeting.*

*Computer speakers, microphone, or a headset are required to fully participate.

Virtual Participation *(pt. 1)*

We are pleased to have you join us virtually and want to create a meaningful exchange.

To participate in the discourse, type in the chat or raise your hand.

Battelle staff will serve as virtual moderators. Please unmute yourself when called on.

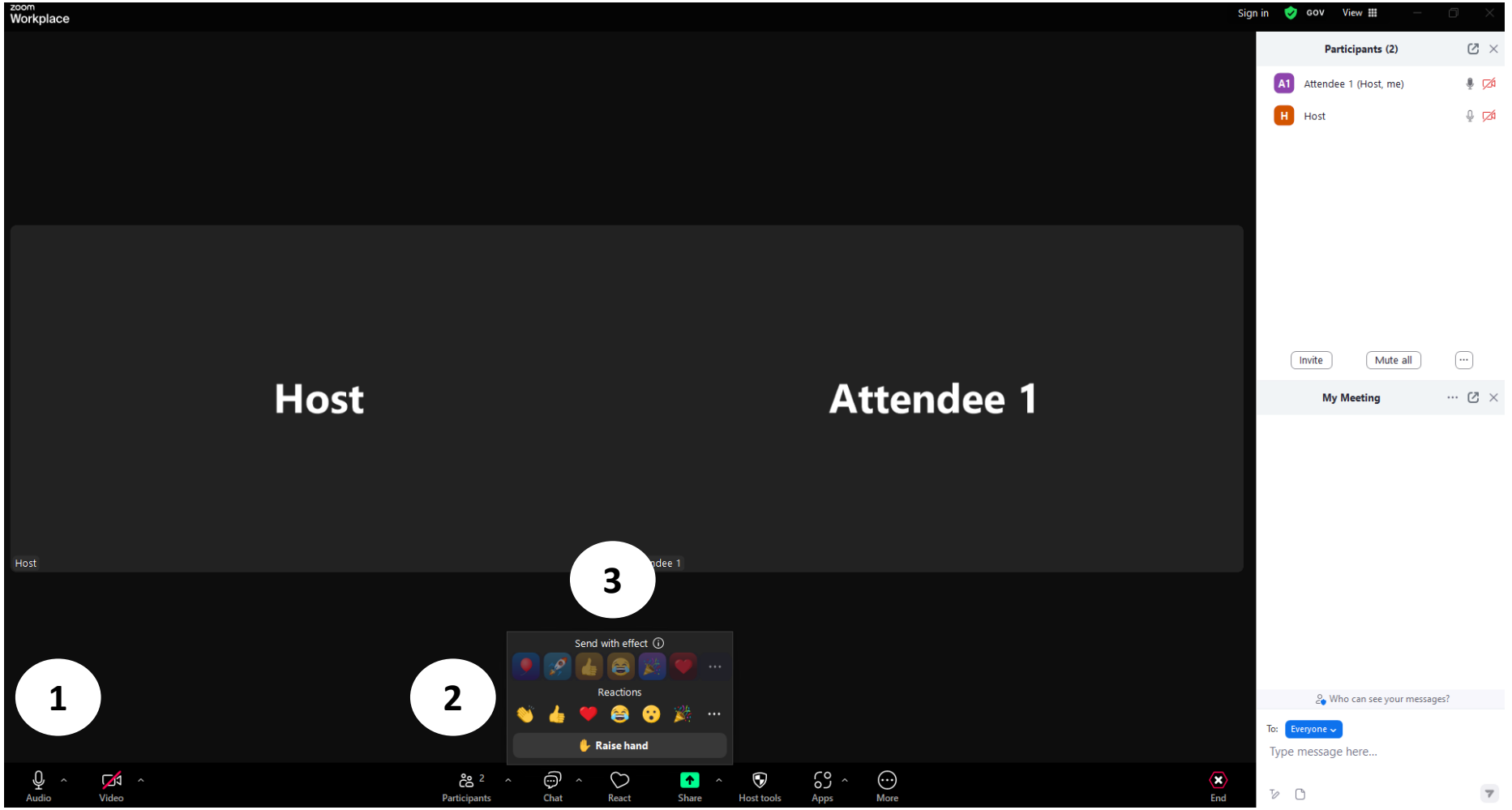
Virtual Participation *(pt. 2)*

Please lower your hand and mute yourself following your question/comment.

Please state your first and last name if you are a call-in user.

If you are experiencing technical issues, contact the project team via chat on the virtual platform or at PQMsupport@battelle.org.

Using the Zoom Platform

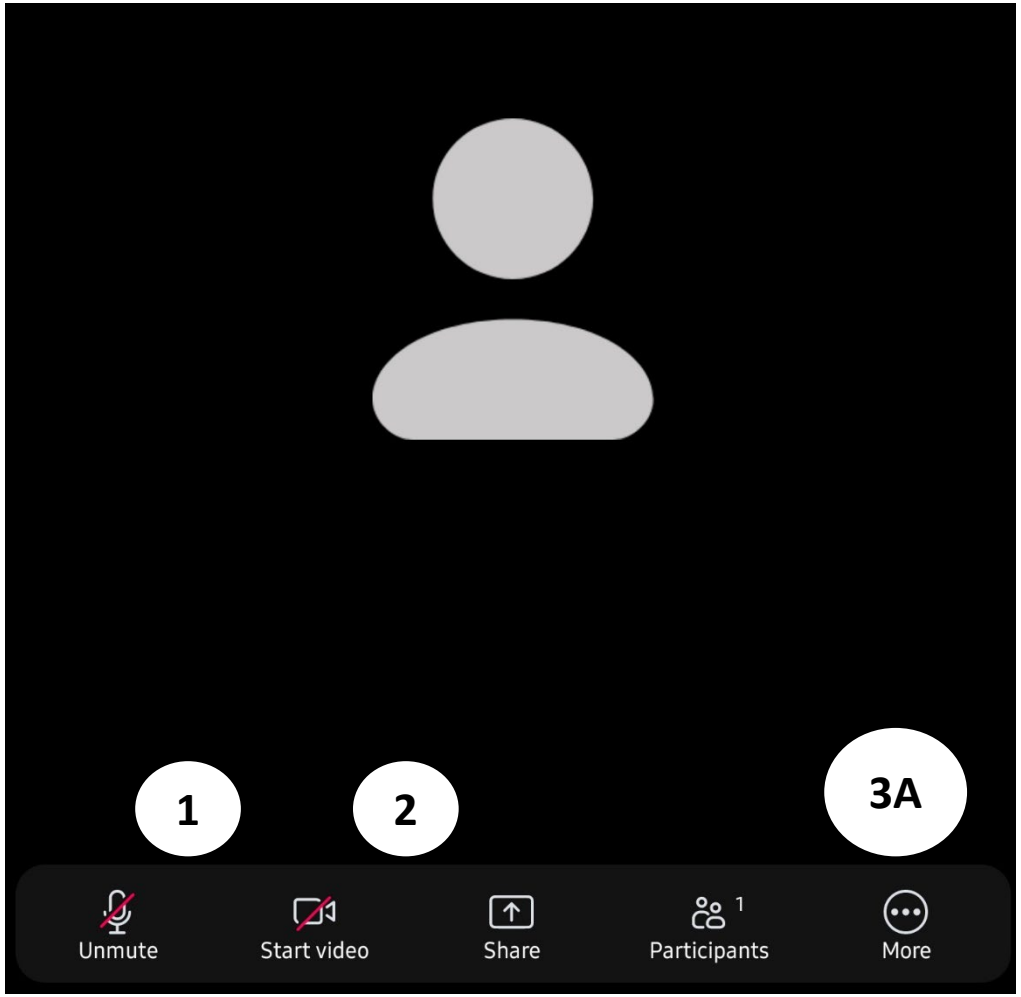


1. Click the lower part of your screen to mute/unmute, start, or pause video.

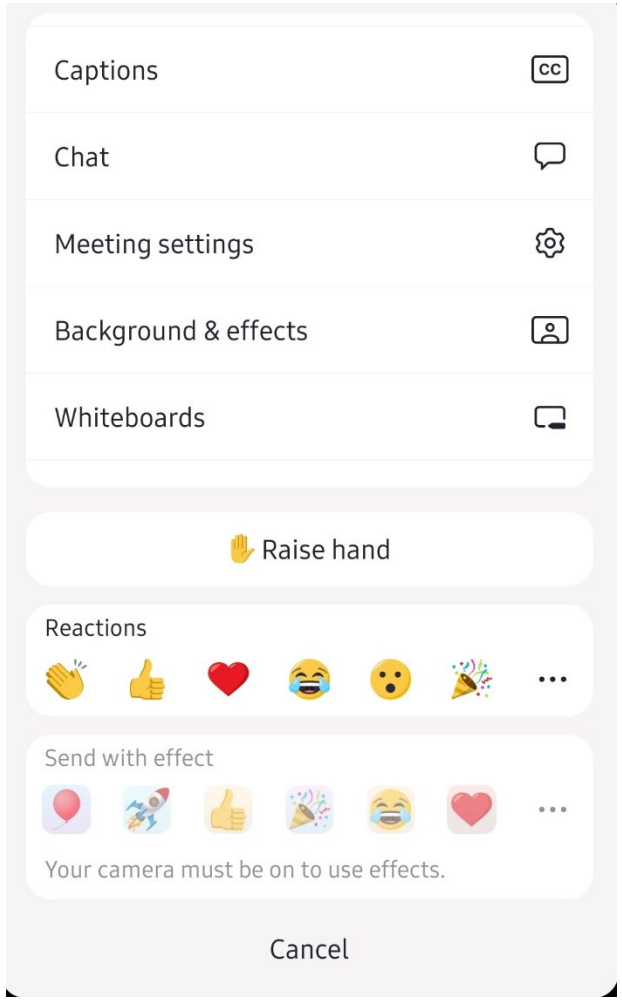
2. Click on the participant or chat button to access the full participant list or the chat box.

3. To raise your hand, select the raise hand button under the react tab.

Using the Zoom Platform (Phone View)



1. Click the lower part of your screen to mute/unmute, start, or pause video.
2. Click on the participant button to view the full participant list.
3. Click on (3A) “More” button to view the chat box, (3B) to show closed captions, or (3C) to raise your hand. To raise your hand, select the raised hand function under the reactions tab.



Community Guidance

- Respect all voices.
- Remain engaged and actively participate.
- Keep your comments concise and focused.
- Be respectful and allow others to contribute.
- Share your experiences.
- Learn from others.

Acronyms

- AG: Advisory Group
- CMS: Centers for Medicare & Medicaid Services
- MUC: Measures Under Consideration
- PA: Preliminary Assessment
- PAC/LTC: Post-Acute Care/Long-Term Care
- PIE: Pre-meeting Initial Evaluation
- PRMR: Pre-Rulemaking Measure Review
- PQM: Partnership for Quality Measurement
- RG: Recommendation Group

Welcome and Review of Meeting Objectives

Brenna Rabel, *Partnership for Quality Measurement (PQM) Technical Director, Battelle*

Welcome to the PRMR Hospital Recommendation Group Meeting

Committee members will review and discuss public comments, preliminary assessments (PAs), and Advisory Group inputs about the 2024 hospital-specific measures under consideration.

Each discussion will end with a vote about whether to recommend the measure(s) for use in the Centers for Medicare & Medicaid Services (CMS) quality program(s).

Please note, public comment is not collected during this meeting. We invite written public comments on our final recommendations from February 3-17, 2025.

Introductions

Battelle Staff

- Brenna Rabel, MPH – Technical Director
- Jeff Geppert, JD, EdM – Scientific Methods Lead
- Meridith Eastman, PhD, MSPH – Pre-Rulemaking Measure Review (PRMR)-Measure Set Review (MSR) Task Lead
- Kate Buchanan, MPH – PRMR-MSR Deputy Task Lead
- Lydia Stewart-Artz, PhD, MHS – PRMR-MSR Measure Evaluation Lead
- Isaac Sakyi, MSGH – PRMR-MSR Voting Lead

Centers for Medicare & Medicaid Services (CMS) Staff

- Michelle Schreiber, MD, Deputy Director for Quality & Value, Center for Clinical Standards and Quality (CCSQ) for Centers for Medicare & Medicaid Services (CMS)
- Melissa Gross, BSN, CMS PRMR Lead
- Kimberly Rawlings, MPP, CMS National Quality Strategy Lead
- Helen Dollar-Maples, RN, Director, Division of Program and Measurement Support (DPMS), CCSQ
- Charlayne Van, JD, CMS Contracting Officer's Representative
- CMS Medical Officers
- CMS Leads

Hospital Recommendation Group Meeting Agenda Day 1 *(pt. 1)*

10:00 AM	Welcome and Review of Meeting Objectives
10:07 AM	Roll Call and Disclosures of Interest (DOIs)
10:20 AM	Co-Chair Introductions
10:25 AM	CMS Opening Remarks, Review of Relevant Quality Programs
10:30 AM	Overview of 2024 PRMR Process and Voting
10:40 AM	Voting Test
10:50 AM	Break

* All times listed in ET

Hospital Recommendation Group Meeting Agenda Day 1 *(pt. 2)*

11:00 AM	Measure Review
12:45 PM	Lunch – Optional Networking Opportunity
2:15 PM	Measure Review
3:45 PM	Break
4:00 PM	Measure Review
4:45 PM	Meeting Adjourns

* All times listed in ET

Roll Call and Disclosures of Interest

Kate Buchanan, *PRMR-MSR Deputy Task Lead, Battelle*

Disclosures of Interest (DOIs)

- Prior to the meeting, committee members were asked to complete a “measure-specific DOI” form for each measure, or batch of measures, assigned to the committee.
- Committee members verbally disclose relevant interests during Recommendation Group (RG) meetings.
- If there is a perceived or actual conflict of interest (COI), Battelle requires affected members to recuse themselves from discussing and voting on the applicable measure(s).

Roll Call and Disclosures of Interest

Hospital Recommendation Group Members

Co-chairs: Lisa McGiffert and Edward Pollak

David Basel

Zahid Butt

Akin Demehin

Subashnie Devkaran

Michelle Doll

Wendy Fitts

Thomas Frederickson

Tejal Gandhi

Angela Ghiorso

Nadja Kadom*

Christopher Kim

David Levine

Jennifer Lundblad

Michael Lynch

Julie Marcinek

Tilithia McBride

Hal McCard

Ben McGaugh

Somaieh McMullan

Shari Michl

Jan Orton

Mark Paris

Phoebe Ramsey

Jessica Schumacher

Holly Varnell

Kathy Wilson

Beth Zimmerman

 **Denotes inactive status*

PRMR Hospital Co-Chair Introductions

Lisa McGiffert

Edward Pollak

Centers for Medicare & Medicaid Services (CMS) Opening Remarks and Review of Hospital, Ambulatory Surgical Center (ASC), and End-Stage Renal Disease (ESRD) Quality Programs

Dr. Michelle Schreiber, *Deputy Director for Quality & Value, Center for Clinical Standards and Quality (CCSQ) for Centers for Medicare & Medicaid Services (CMS)*

Overview of 2024 PRMR Process

Dr. Meridith Eastman, *PRMR-MSR Task Lead, Battelle*

PRMR Cycle

The Department of Health and Human Services (HHS) annually publishes a list of measures under consideration (MUC) for future federal rulemaking by December 1.

PRMR committees assess whether a measure is appropriate for use in a specific CMS program and for a population of Medicare beneficiaries.

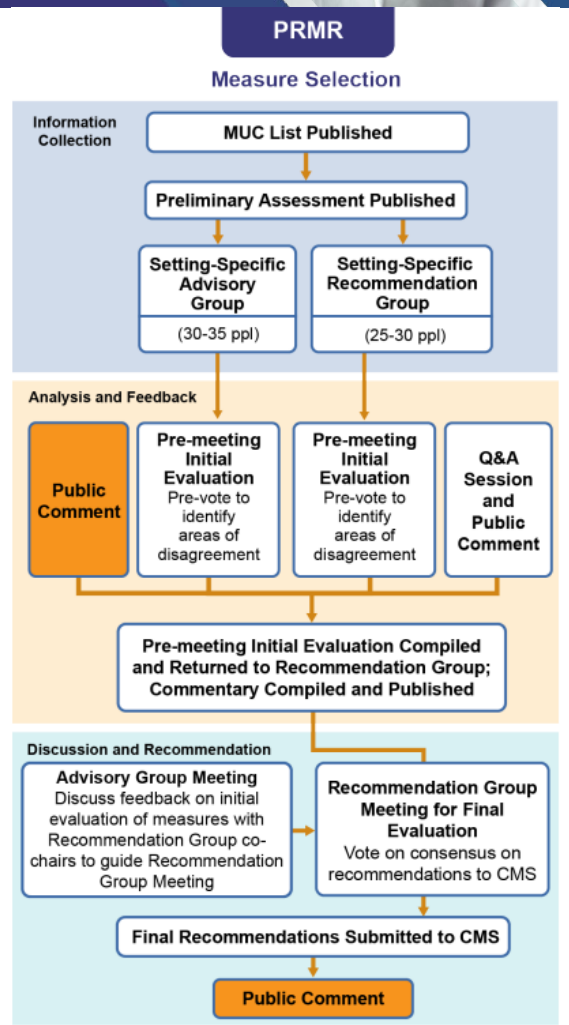
The PRMR process results in consensus-based recommendations about MUCs for CMS programs.

PRMR Process

The PRMR process builds consensus regarding MUC List measures as to whether they are appropriate for consideration for CMS quality reporting programs and value-based programs.

Three major phases:

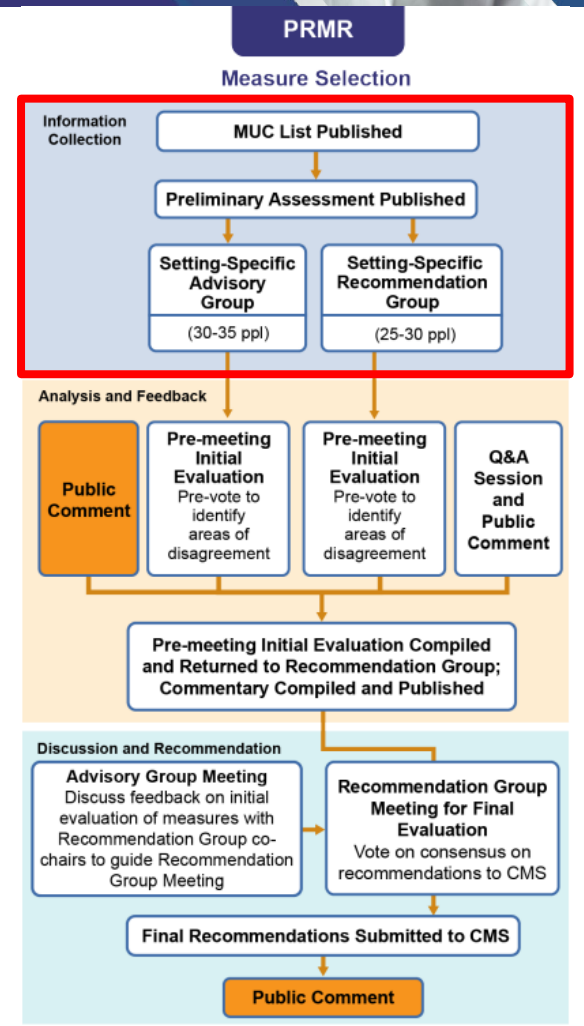
1. Information collection
2. Analysis and feedback
3. Discussion and recommendation



PRMR Process: Information Collection

Preliminary Assessment

- Battelle completes a preliminary assessment (PA) for each measure using information from the CMS MERIT* submission.
- Each PA focuses on the PRMR evaluation criteria and intentionally avoids rehashing topics better suited to Endorsement & Maintenance (E&M) discussions.
- Battelle creates PAs using information from the measure steward/developer. PAs are also reviewed by CMS leads and measure stewards/developers to ensure accuracy.
- PAs are made available to all committee members (Advisory Group and Recommendation Group) immediately following the release of the MUC List.



*CMS MERIT: The Centers for Medicare & Medicaid Services MUC Entry/Review Information Tool

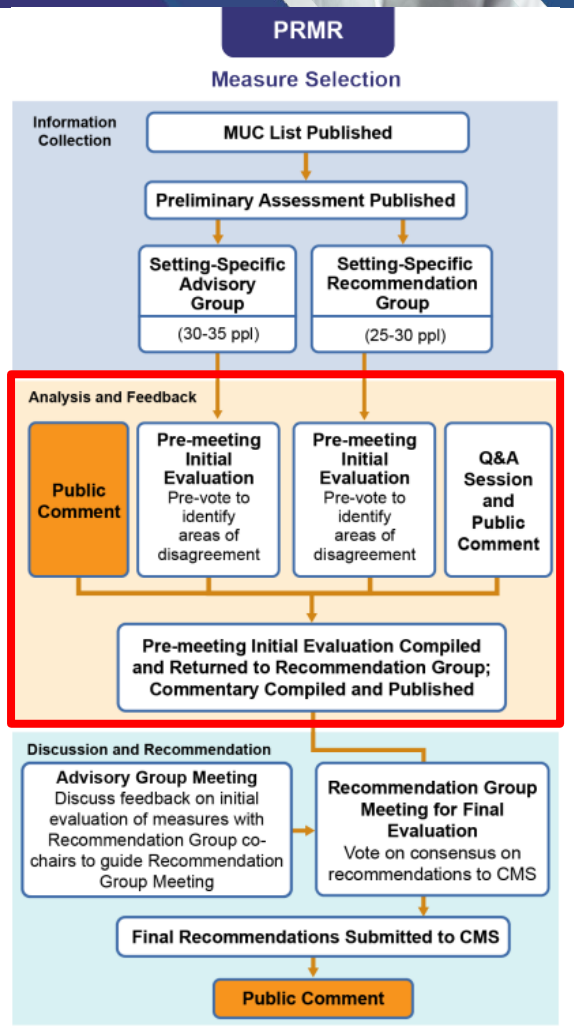
PRMR Process: Analysis and Feedback *(pt. 1)*

Pre-Meeting Initial Evaluation (PIE)

- All committee members submit evaluations on a subset of measures via the Pre-Meeting Initial Evaluation (PIE) Form.
- Along with PAs, committee members receive a PIE Form for each measure they evaluate, which includes guidance on questions to consider when evaluating the criteria.

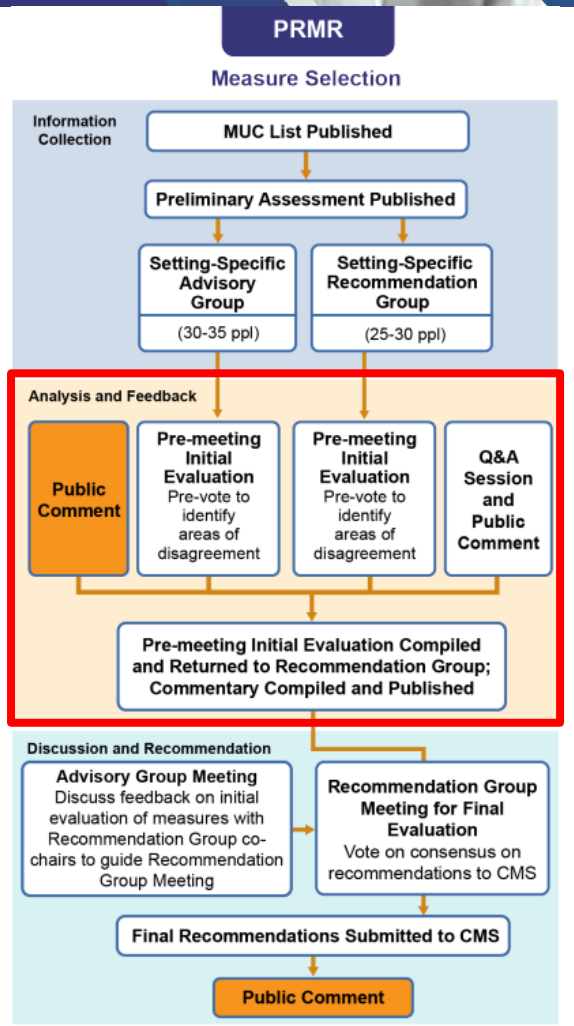
Public Comment and Listening Sessions

- Upon release, the MUC List will be posted for a 21-day public comment period.
- PQM hosts three public listening sessions, one per setting, where CMS, Battelle staff, and measure developers/stewards hear brief spoken statements on measure(s) of interest. CMS answers MUC-related questions live and/or in writing after the call. Developers may also be asked to weigh in.
- Comments received through the comment process and during listening sessions will be made publicly available on the PQM website.



PRMR Process: Analysis and Feedback *(pt. 2)*

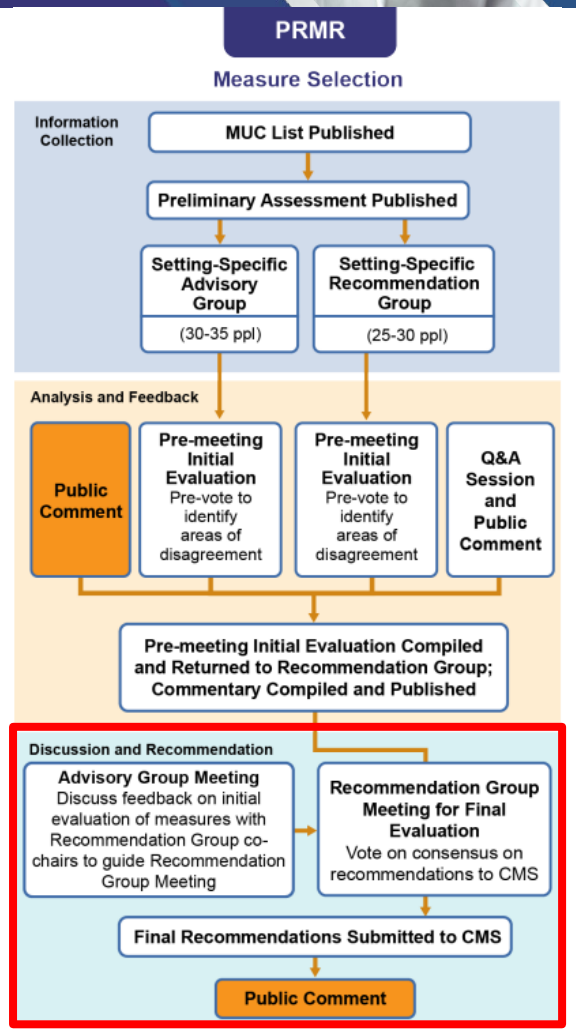
- Battelle compiles feedback from the PIE Forms, public comment, and listening sessions in advance of the RG meeting for the following purposes:
  - To help Battelle facilitators identify areas of non-consensus, so they may be discussed during the RG meetings
  - To provide to CMS leads in advance of the RG meeting to help them anticipate questions and topics where more context or clarity may be needed to inform the RG discussion



PRMR Process: Discussion and Recommendation *(pt. 1)*

AG Discussion Session*

- Prior to the RG meetings, members of the AG convene to discuss their feedback from the PIE Forms and help generate discussion questions for the RG meeting.
- The AG feedback is critical guidance for the RG discussion.
- RG co-chairs facilitate the session, and relevant Battelle staff attend.
- The co-chairs ensure that the AG perspective is represented throughout the RG meetings.

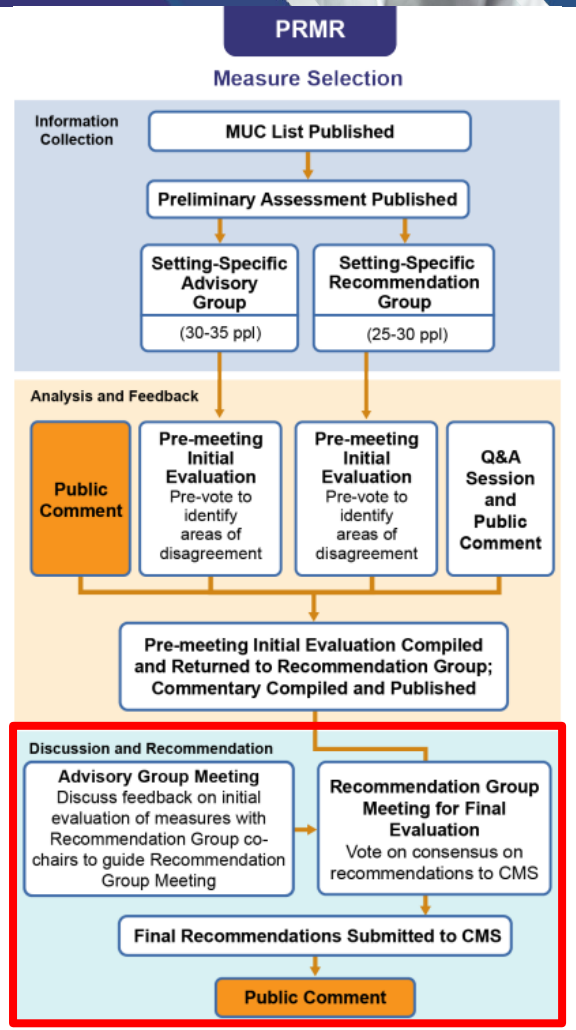


* AG members and RG co-chairs are required to attend their committee's AG meeting. Other RG members, CMS personnel, measure developers, and measure stewards can opt to attend AG meetings as members of the public in listen-only mode.

PRMR Process: Discussion and Recommendation *(pt. 2)*

Recommendation Group Meeting for Final Evaluation

- Battelle shares PIE results with the RG at least 2 weeks prior to the meeting to assist the RG in prioritizing their discussions on areas of non-consensus.
- The RG meets to discuss issues/concerns raised during the AG discussion, public comment period, and via PIE forms.



Recommendation Group Meeting

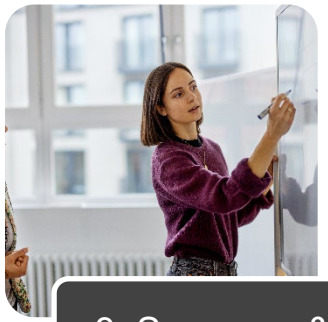
Measure Review Process

1. Measure Introduction

Battelle staff provides review of each measure.

2. CMS Overview

CMS staff provides brief overview and/or contextual background on the measure.



3. Summary & AG Feedback

Battelle staff summarizes public comments and PIE results; co-chairs present an overview of Advisory Group feedback.

4. Discussion

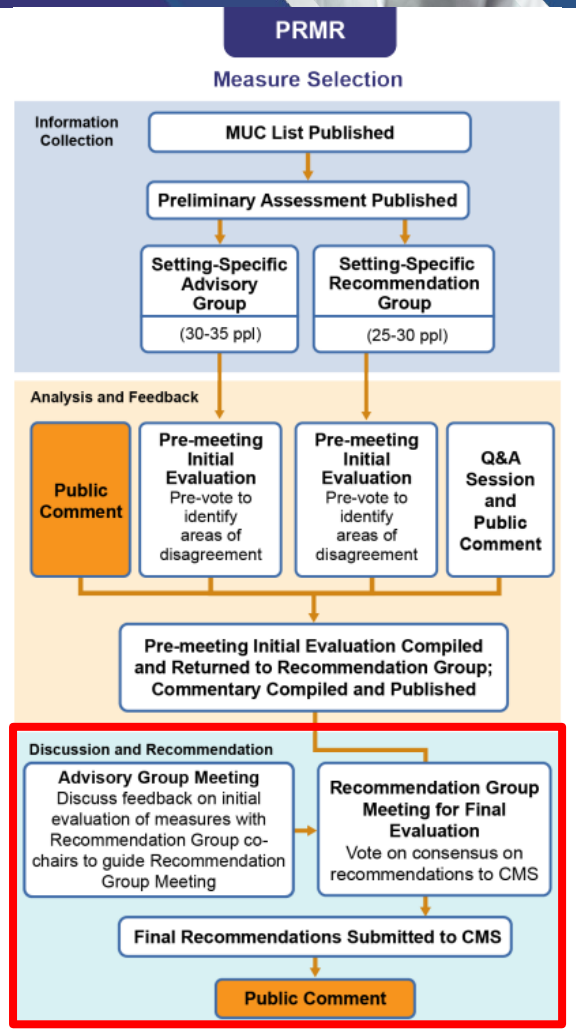
The committee discusses each measure with these considerations and context in mind.

5. Vote

The committee votes with the aim of reaching consensus about whether to recommend the measure(s) for use in the CMS quality program(s).

PRMR Process: Discussion and Recommendation *(pt. 3)*

- Recommendation Group final recommendations are delivered to CMS by February 1 and subsequently posted to the PQM website where they are open for public comment for 15 days.
- The intent of this opportunity is to provide CMS with additional feedback on MUCs and final recommendations. The public comment after February 1 does not impact the final RG recommendations.



PRMR Measure Evaluation

Dr. Lydia Stewart-Artz, *PRMR-MSR Evaluation Lead, Battelle*

PRMR Assertions *(pt. 1)*

Meaningfulness: Concept of Interest

- When evaluating meaningfulness of the concept of interest, committees evaluate whether the measure provides:
  - ✓Evidence that the measure focus is associated with a material outcome for persons and entities (Importance)
  - ✓Measure components and specifications that align with the intent of the measure focus and target population (Conformance)
  - ✓Demonstration that the tools, process, and people necessary to implement and report on the measure are reasonably available (Feasibility)

PRMR Assertions *(pt. 2)*

Meaningfulness: Context of Use

- When thinking about how meaningful a measure is, committees evaluate if the submission:
  - ✓Explains why using this measure in the quality program will bring more benefits than costs (Importance)
  - ✓Shows with data or reasoning that there are effective methods for improvement (Validity)
  - ✓Provides data showing that most differences in performance are due to those effective methods (Reliability)
  - ✓Identifies and addresses any obstacles or supports that might affect how the methods can be used (Usability)

MUC2023-219 Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio Stratified for Oncology Locations

PRMR Assertion Example: Meaningfulness

- **Evidence of Measure Meaningfulness**
  - The 2023 Hospital PRMR Recommendation Group considered the addition of this measure to the Hospital Inpatient Quality Reporting (HIQR) Program
    - The committee reviewed clinical guidelines and cited literature supporting measure relevance to the HIQR program population. (Importance-Concept of Interest & Context of Use)
    - The committee considered this measure against the existing CLABSI measure used in acute care units, specifically focusing on the practical implications of expanding use into oncology units.(Feasibility-Concept of Interest, Usability-Context of Use)
    - An oncologist committee member raised the issue of unintended consequences related to blood culture orders being cancelled or not ordered to avoid raising the CLABSI rate. (Usability-Context of Use)
    - Committee members suggested the measure account for dialysis patients with catheters in stratification, and to evaluate different types of oncology units, e.g., hematology-oncology vs. solid organ. (Validity-Context of Use)
    - Committee members commented on low reliability of the measure for some entities and requested clarification from the steward on potential causes. (Reliability-Context of Use)

PRMR Assertions *(pt. 3)*

Appropriateness of scale:

- Is the measure appropriate and tailored to the specific goals of the program and its target population?
  - ✓To evaluate this, we look at the evidence regarding how benefits and risks or harms are spread among different groups. We also need to consider how those risks or harms can be reduced.

MUC2023-219 Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio Stratified for Oncology Locations

PRMR Assertion Example: Appropriateness of Scale

- **Evidence of Measure Appropriateness of Scale**
  - The 2023 Hospital PRMR Recommendation Group considered the addition of this measure to HIQR
    - One committee member expressed concerns about the reporting period being too short for smaller or rural facilities with lower volumes to report the measure and asked whether the reporting period could be expanded.
    - The committee discussed potential implications of this reporting period on overall measure performance across different types of oncology sites.

PRMR Assertions *(pt. 4)*

Time-to-value realization:

- Does the measure include a plan for achieving positive effects in the short and long term?
  - ✓Time-to-value realization is based on the idea that measuring something over time can lead to long-term benefits or harms as the measure matures.
  - ✓To assess this, committees should look at how the benefits and harms might change over time. They should consider how to extend the benefits and prevent potential harms as the measure matures.

MUC2023-219 Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio Stratified for Oncology Locations

PRMR Assertion Example: Time-to-Value Realization

- **Evidence of Measure Time-to-Value Realization**
  - The 2023 Hospital PRMR Recommendation Group considered the addition of this measure to HIQR
    - The committee considered barriers to initial roll-out of this measure across the program, discussing implementation facilitators and barriers in rural and urban sites.
    - The committee discussed how short-term implementation barriers could impact performance and measure benefit for facilities with lower patient volumes.

Preliminary Assessments

Battelle provides committee members with measure-specific preliminary assessments (PAs).

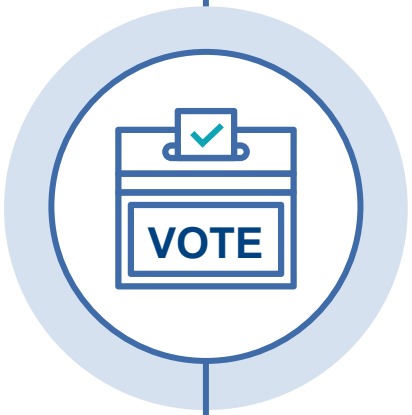
PAs include:

- Descriptive information about measure specification, endorsement, and use
- CMS-provided rationale for measure inclusion in the CMS program
- Summary of performance on PRMR criteria
- Considerations for statutorily required measure topic areas
- Reliability and validity testing results and analysis

PRMR Voting Procedures

Dr. Meridith Eastman

Voting Procedure – Quorum *(pt. 1)*



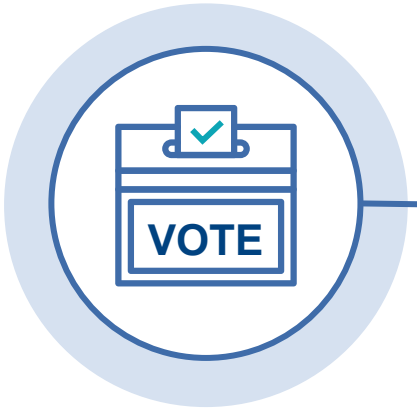
Discussion quorum: The discussion quorum requires the attendance of at least 60% of the Recommendation Group members at roll call at the beginning of the meeting.

Voting quorum: The voting quorum requires at least 80% of active Recommendation Group members who have not been recused.

Voting Procedure – Quorum *(pt. 2)*

- **It is extremely important to the process to have voting quorum, and we kindly request you stay for the entirety of discussion and voting.**
  - To ensure accurate quorum counts, please notify Battelle through the meeting chat if you need to leave the meeting for any reason.
  - If voting quorum is not met, we will collect the votes for those present and follow up with absent participants offline until a voting quorum is reached.

Voting Procedure – Consensus



Battelle staff and co-chairs will encourage committee members to follow community guidance in order to yield informed decisions.

Battelle will utilize an online voting system to capture votes by committee members.

Consensus is a minimum of 75% agreement among members.

PRMR Recommendation Voting

Committee votes on overall recommendation of the measure

- Recommend that the measure be **added** to the intended CMS program(s)
- Recommend that the measure be **added** to the intended CMS program(s) **with conditions**
- **Do not recommend** that the measure be added to the intended CMS program(s)

PRMR Recommendation

Consensus voting for final recommendations

Recommend (A)	Recommend with Conditions (B)	Do not recommend (C)	Consensus Voting Status
75% or More			A (Recommend)
	75% or More		B (Recommend with conditions)
75% or More			B (Recommend with conditions)
		75% or More	C (Do not recommend)
		Greater than 25% and less than 75%	No consensus

Recommend With Conditions *(pt. 1)*

- The RG may identify certain short-term or long-term conditions that, if met, would lead them to a vote to fully recommend the measure.
- Short-term conditions may include:
  - Stratification in reporting
  - Obtaining consensus-based entity endorsement
  - Performing additional testing to demonstrate measure meaningfulness
- Longer-term conditions might include:
  - Re-specification of the measure focus or target population
  - The addition or removal of factors in the measure's risk-adjustment model

Recommend With Conditions *(pt. 2)*

- RG members do not need to agree on the conditions that would accompany a recommend with condition status.
- Each committee member who submits a “recommend with conditions” vote provides the relevant condition(s) they believe should precede the measure’s implementation in a CMS program.
- Battelle documents the identified conditions in the PRMR Recommendations Report for CMS’s consideration.

Recommendation Report

Following the PRMR Recommendation Group review, Battelle synthesizes the results into a report for CMS.

The report includes:

- Vote counts and the rationales for recommendations
- Committee and interested parties' concerns or areas of dissent

The report is submitted to CMS and posted on the PQM website.

Voting Test

Isaac Sakyi, *PRMR-MSR Voting Lead, Battelle*

Break

Please return by 11:00 AM

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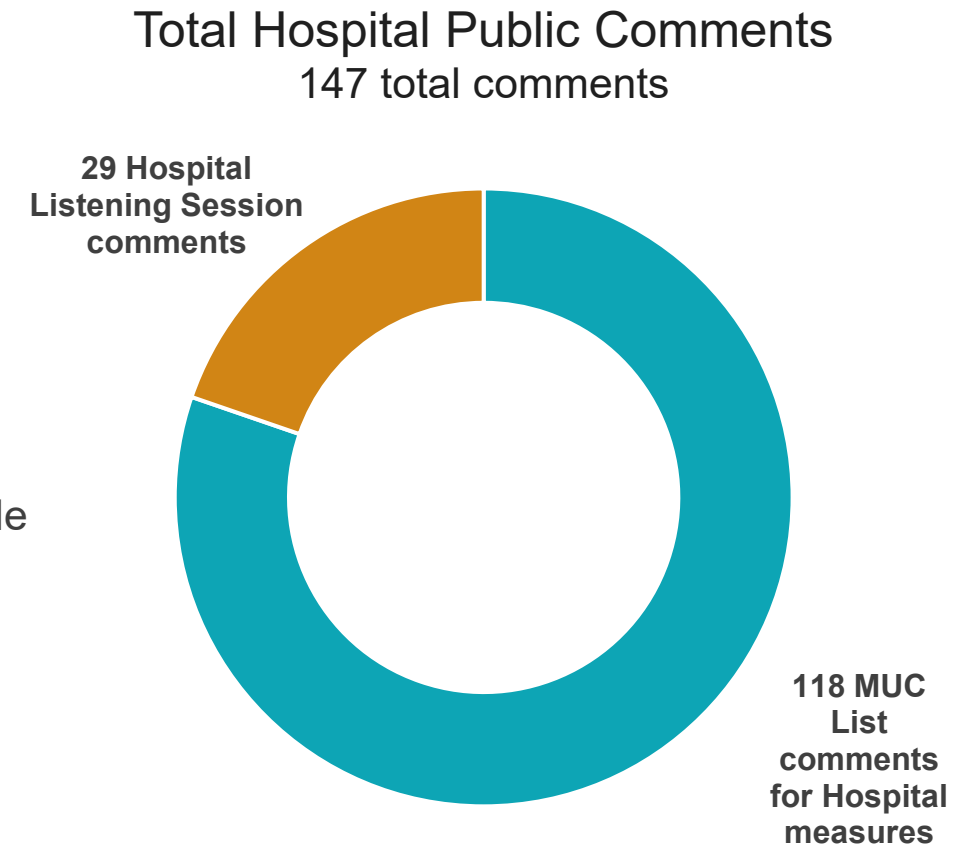
Hospital Measure Review

Public Comment Overview

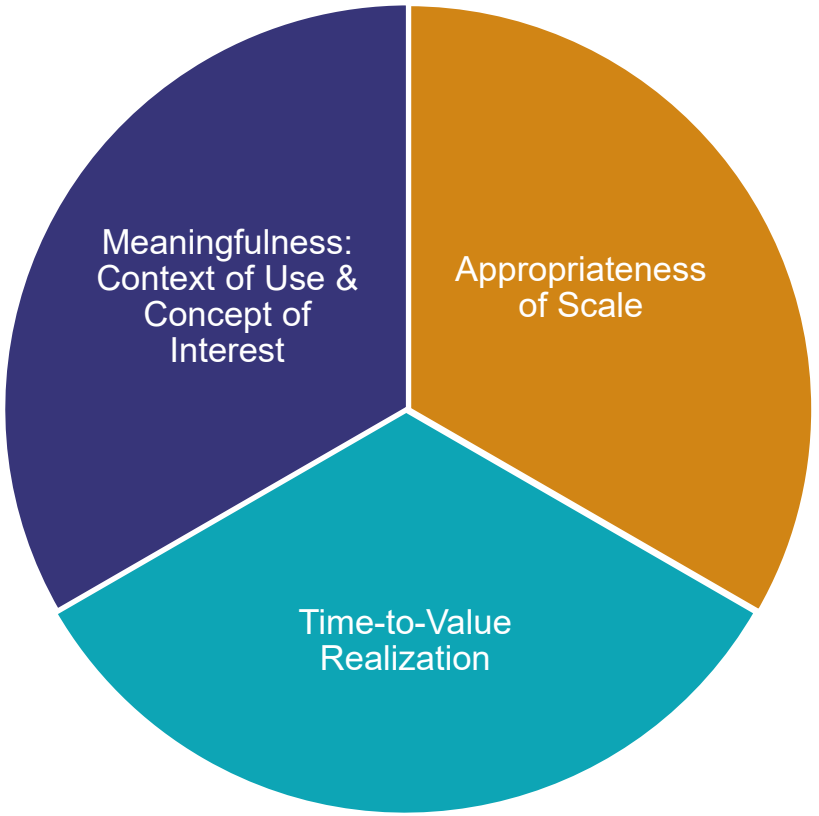
- Overall themes
  - Incorporating patient-reported outcomes and experiences critical for enhancing patient-centered care, improving satisfaction, and facilitating shared decision-making
  - Some measures may lead to unintended consequences
  - Clear definitions and guidelines are essential for effective implementation
  - Overlap with existing measures highlights need for careful integration of new measures
  - Call for measures addressing healthcare inequities to ensure equitable care
  - Timely care is crucial for improving patient outcomes and reducing complications
  - Challenges implementing measures in rural and resource-limited settings (e.g. data capture complexity, resource needs, appropriate time cutoffs)
  - Need for measures promoting comprehensive and coordinated care to improve healthcare quality and patient outcomes



Pre-Meeting Initial Evaluation (PIE) Forms

- 575 PIE Forms submitted across 41 measures
- 65% of members submitted at least one Form
- Average of 14 Forms submitted per measure (min 9, max 36)
- Questions for each criterion:
  - Based on your review of the preliminary assessment for this measure and your personal/professional experience, does it meet the criterion? (Yes/No)
  - Please discuss your rationale for your rating of the criterion for this measure. (Free-text response)
- Additional free-text comment box available for each measure to record any additional comments or concerns

PRMR Evaluation Criteria



Health Equity Assessment

- The Institute for Healthcare Improvement (IHI) conducted assessments for each measure's potential impact on health equity.
- Because equity is not a PRMR evaluation criteria, it should not factor into committee decisions.
- However, the committee can still use the IHI's assessments to inform discussion and feedback to CMS.

Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM)

MUC2024-073

MUC2024-073 Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM)

Item	Description
Considered For	Ambulatory Surgical Center Quality Reporting Program
Measure Description	The Information Transfer PRO-PM collects information from patients aged 18 years or older who had a procedure or surgery at an Ambulatory Surgical Center (ASC). Using a nine-item survey, the measure collects the average score patients rated the ASC's ability to clearly communicate personalized discharge instructions. Patients are asked to answer a brief web-based survey, comprised of three domains: applicability; medications; and daily activities. Patients would receive the survey within 2-7 days post-procedure.
Developer/Steward	Centers for Medicare & Medicaid Services (CMS)
Measure Background	Measure currently used in a Medicare program and is being submitted without substantive changes for a new or different program

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
PRO-PM or Patient Experience of Care	Endorsed for use in the hospital outpatient department setting	Hospital Outpatient Quality Reporting Program	Facility

Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM)
PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Support expressed for measure's inclusion in program, focus on patient understanding and engagement, and scientific acceptability. Viewed as important measure from patient perspective.
  - **Concerns:** Concerns about potential duplication of efforts with the upcoming mandatory CAHPS survey for ambulatory surgery centers (ASCs), which could lead to increased costs and provider burden. Concerns around web-based administration method, language options, and feasibility of measure implementation.
  - **Further consideration:** Request for more information on how measure framework aligns with existing measures, evidence base for improvement of outcomes, and plans to facilitate participation for non-English speakers and the elderly.
- **Appropriateness of Scale Themes**
  - **Support:** Several members suggested the nine-item scale is appropriate for variety of patient populations.
  - **Concerns:** Technology requirement could exclude certain patient demographics due to the necessity of a digital device, email, and understanding of how to complete survey.
- **Time-to-Value Realization Themes**
  - **Support:** Information collected through this measure may have short- and long-term positive impacts on the ASC setting and on the population served.
  - **Concerns:** Committee members requested more information from developer on long-term benefits and impacts of measure.

Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM)
Public Comment Summary

- **Received eight public comments**
  - Five support and three concerns
- **Support summary:**
  - The crucial role of delivering personalized and clear discharge instructions is vital for ensuring patient compliance and preventing unnecessary hospital readmissions.
  - Strong support for CMS's strategy to incorporate patient feedback into quality measurement and improving shared-decision making.
  - Support the use of patient-reported data to enhance patient-centered care, improve satisfaction, reduce costs, and lead to better outcomes.
- **Concern summary:**
  - Survey burden on patients could affect response rates and lead to confusion.
  - Survey administration timeline overlaps with other patient experience surveys, leading to redundancy and overlapping data collection efforts.
  - Evaluating the patient's ability to comprehend information, rather than the quality of information provided.
  - Lack of evidence supporting the implementation of the Information Transfer PRO-PM in the ASC setting.
  - Differences in size, infrastructure, and data capabilities between ASCs and hospitals pose challenges to implementing hospital-tested measures in ASCs.

Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM)
Equity Considerations

Potential Impacts to Health Equity Associated with Measure Use

Quantifying patient understanding provides insight into individualization of recovery instructions and can identify subgroups that may have lower health literacy.

Potential Impacts to Health Equity Associated with Non-Use

IHI reviewers noted that non-use of this measure may perpetuate information gaps on patients' understanding and engagement in their own recovery.

Considerations for Enhancing Health Equity

IHI reviewers suggested stratifying by geography and payor to identify differences between ASCs and patient subgroups.

Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM)
Discussion Topics

- Are there potential threats to validity for this measure at the patient or facility level?
- Are there differences between ambulatory surgical centers (ASCs) and hospital outpatient departments (where this measure was tested) that should be considered when evaluating this measure?

In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey - Quality of Dialysis Center Care and Operations (QDCCO) measure

MUC2024-060

MUC2024-060 In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey - Quality of Dialysis Center Care and Operations (QDCCO) measure

Item	Description
Considered For	End-Stage Renal Disease Quality Incentive Program
Measure Description	The ICH CAHPS Survey is designed to measure the experiences of people receiving in-center hemodialysis care from Medicare-certified dialysis centers.
Developer/Steward	Centers for Medicare & Medicaid Services (CMS) & Agency for Healthcare Research and Quality (AHRQ)
Measure Background	Measure currently used in a Medicare program, but the measure is undergoing substantive change

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
PRO-PM or Patient Experience of Care	Endorsed	End-Stage Renal Disease Quality Incentive Program	Facility

In-Center Hemodialysis Consumer Assessment of Health Care Providers and Systems (ICH CAHPS) Survey – Quality of Dialysis Center Care and Operations (QDCCO) Measure

PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Support for measure due to importance of patient experience data, the measure's ability to provide meaningful insights into patient care, and the effort to reduce the survey burden. Scientific acceptability seen as sufficient. Measure addresses topics meaningful to patients.
  - **Concerns:** One member expressed concern about lack of evidence that this measure will contribute to meaningful continuous improvement within dialysis centers.
  - **Further consideration:** Request that this version of the measure go through the endorsement (E & M) process.
- **Appropriateness of Scale Themes**
  - **Support:** Measure promotes transparency regarding patient perspectives on the quality of in-center hemodialysis care, which may lead to improvements across subpopulations. The availability of multiple languages improves the appropriateness of scale and inclusivity.
  - **Concerns:** Some concern expressed over length of survey, which may lead to some patients not completing it. Concern shared about measure's potential to exclude and/or not perform well for certain subpopulations, specifically Black patients and other underrepresented minorities. There is concern that the patient experience aspects mentioned in the measure may be prioritized over those that are not mentioned.
- **Time-to-Value Realization Themes**
  - **Support:** Updated survey can be utilized immediately and is seen as a positive due to its established nature and potential for quick-value realization.
  - **Concerns:** Several members did not feel they had adequate information to address this criteria.

In-Center Hemodialysis Consumer Assessment of Health Care Providers and Systems (ICH CAHPS) Survey – Quality of Dialysis Center Care and Operations (QDCCO) Measure

Public Comment Summary

- **Received four public comments**
  - Three support and one concern
- **Support summary:**
  - Patient experience is a valuable data source to be included in Consumer Assessment of Healthcare Providers and Systems (CAHPS), patient-reported outcome measures (PROMS) and patient-reported experience measures (PREMS).
  - Survey availability in multiple languages aligns with CMS's National Quality Strategy of fostering patient engagement to improve quality and health equity.
  - Support for refining the survey to reduce respondent burden.
  - The measure is important towards assessing patient experience related to their dialysis treatments and their interaction with nephrologists.
- **Concern summary:**
  - Urging CMS to submit the measure for endorsement, including validity and reliability testing, before its inclusion in the ESRD QIP program.
  - Low response rates and potential underrepresentation of certain patient groups, especially those with fewer socioeconomic advantages.
  - Exclusion of home dialysis patients from the survey could diminish their influence in the process.
  - Marginalizing people of color and other demographics, such as non-English speakers and those not active on the transplant list.

In-Center Hemodialysis Consumer Assessment of Health Care Providers and Systems (ICH CAHPS) Survey – Quality of Dialysis Center Care and Operations (QDCCO) Measure

Equity Considerations

Potential Impacts to Health Equity Associated with Measure Use

IHI reviewers noted this measure is particularly valuable for populations that may experience communication barriers or have limited access to health education.

Potential Impacts to Health Equity Associated with Non-Use

IHI reviewers noted that, without regular collection and reporting of patient feedback, critical gaps in understanding the patient experience and disparities in dialysis care may remain unaddressed.

Considerations for Enhancing Health Equity

IHI reviewers recommend collecting and stratifying the outcome measure data by sociodemographic variables (race, sex, ethnicity, and language, initially) to determine any differences between patient perceptions of dialysis centers.

In-Center Hemodialysis Consumer Assessment of Health Care Providers and Systems (ICH CAHPS) Survey – Quality of Dialysis Center Care and Operations (QDCCO) Measure

Discussion Topics

- Is there potential for differential benefits and burdens associated with this measure across provider and patient populations?
- Does the committee share the concern raised in PIE Forms about lack of evidence that this measure will lead to meaningful continuous improvement within dialysis centers?

Median Time to Pain Medication for Patients with a Diagnosis of Sickle Cell Disease (SCD) with Vaso-Occlusive Episode (VOE)

MUC2024-074

MUC2024-074 Median Time to Pain Medication for Patients with a Diagnosis of Sickle Cell Disease (SCD) with Vaso-Occlusive Episode (VOE)

Item	Description
Considered For	Hospital Outpatient Quality Reporting Program; Rural Emergency Hospital Quality Reporting Program
Measure Description	Median time (in minutes) from ED arrival to initial administration of pain medication for all patients, regardless of age, with a principal encounter diagnosis of SCD with VOE.
Developer/Steward	American Society of Hematology
Measure Background	New measure; never reviewed by Measure Applications Partnership (MAP) Workgroup or Pre-Rulemaking Measure Review (PRMR) or used in a Medicare program

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
Process	Not Endorsed	New Measure	Facility

Median Time to Pain Medication for Patients with a Diagnosis of Sickle Cell Disease (SCD) with Vaso-Occlusive Episode (VOE)
PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Members acknowledged the importance of addressing timely pain management for sickle cell patients, recognizing that pain is a significant cause of ED visits for this population. Support for measure's potential impact on improving hospital performance, patient satisfaction, and possibly reducing ED stay and hospital admission rates.
  - **Concerns:** Some members perceived scope as too narrow because the measure concentrates on the time to pain medication administration without assessing the broader context of treatment effectiveness or patient outcomes post-intervention. Concern expressed around the administrative burden tradeoff for benefit to "relatively small patient population" and measure implementation within context of the opioid epidemic in many communities
  - **Further consideration:** Respondents encouraged further consideration of medication types beyond the administration method stratification. Interest expressed in how this measure may improve other factors such as ED wait times for patients not included in measure.
- **Appropriateness of Scale Themes**
  - **Support:** Measure has potential to improve care for patients who traditionally may not receive appropriate pain management due to a variety of factors including implicit bias.
  - **Concerns:** Concerns expressed for unintended consequence of "disrupting continuity of care" with providers overseeing medication management and increased burden to rural hospitals.
- **Time-to-Value Realization Themes**
  - **Support:** Narrow measure focus may lead to quick improvements in care after measure implementation.
  - **Concerns:** Concerns expressed for long-term impacts on pain management in the ED and the reporting time of the measure limiting ability to improve care in timely way.

Median Time to Pain Medication for Patients with a Diagnosis of Sickle Cell Disease (SCD) with Vaso-Occlusive Episode (VOE)

Public Comment Summary

- **Received 29 public comments**
  - 25 support and four concerns
- **Support summary:**
  - The potential of the measure to significantly improve the quality and equity of care for patients with Sickle Cell Disease.
  - The measure is seen as a starting point that allows for personalized treatment plans while setting a standard for timely care.
  - The measure is seen as evidence-based, aligning with best practices and supported by guidelines from reputable organizations.
  - Implementation is believed to lead to better patient outcomes, reduced hospital stays, and improved patient satisfaction.
  - The measure enhances patient and family trust in the healthcare system and influence their decisions regarding seeking care.
  - The measure addresses the critical need for rapid pain management in patients with sickle cell disease experiencing vaso-occlusive episodes.
  - Promotes accountability and streamlines care processes in emergency departments.
  - There is support for the measure, with an emphasis on providing assistance for effective implementation and tracking.

Median Time to Pain Medication for Patients with a Diagnosis of Sickle Cell Disease (SCD) with Vaso-Occlusive Episode (VOE)

Public Comment Summary Continued

- **Concern summary:**
  - Focusing on rapid medication administration might lead to inadequate patient assessment, potentially compromising the quality of care.
  - A more holistic approach that includes rapid triage and thorough assessment is suggested rather than merely timing the administration of pain medication.
  - Concern about the use of less effective pain medications in order to meet the measure's time criteria.
  - More explicit instructions to ensure that the measure effectively guides treatment practices, particularly regarding the administration of appropriate pain medications.
  - Concerns about the need for adequate resources, including staffing and training, to support the rapid initiation of pain management, especially in under-resourced areas.

Median Time to Pain Medication for Patients with a Diagnosis of Sickle Cell Disease (SCD) with Vaso-Occlusive Episode (VOE)

Equity Considerations

Potential Impacts to Health Equity Associated with Measure Use

- Patients with SCD presenting to an ED experience longer wait times than other groups, even after accounting for assigned triage level. African American race of SCD patients, and their status as having SCD itself, appear to contribute to longer wait times for these patients. [1]
- By monitoring and striving to reduce the time to pain medication, IHI reviewers noted health care providers can ensure that all patients receive prompt and effective pain management, reducing suffering and improving overall patient experience.

Potential Impacts to Health Equity Associated with Non-Use

IHI reviewers noted that failure to track and address disparities in pain management can perpetuate existing inequities, with patients from underserved communities continuing to receive suboptimal inequitable care.

Considerations for Enhancing Health Equity

IHI reviewers suggested stratifying this measure by race, sex, ethnicity, and language as an initial step to identify and address disparities in pain management for SCD patients, particularly those from historically underserved or marginalized communities.

[1] Haywood C, Tanabe P, Naik R, Beach MC, Lanzkron S. The impact of race and disease on sickle cell patient wait times in the emergency department. *The American Journal of Emergency Medicine*. 2013;31(4):651-656. doi:https://doi.org/10.1016/j.ajem.2012.11.005

Median Time to Pain Medication for Patients with a Diagnosis of Sickle Cell Disease (SCD) with Vaso-Occlusive Episode (VOE)

Discussion Topics

- Is there potential for differential benefits and burdens associated with this measure across provider and patient populations?
- Does committee share concerns raised in PIE Forms that the measure emphasizes timeliness over effectiveness?

Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life

MUC2024-067

MUC2024-067 Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life

Item	Description
Considered For	Hospital Inpatient Quality Reporting Program
Measure Description	Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life.
Developer/Steward	American Society of Clinical Oncology (ASCO)
Measure Background	Measure currently used in a Medicare program and is being submitted without substantive changes for a new or different program

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
Intermediate Outcome	Endorsed	Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program	Facility

Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life
PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Addresses the issue of aggressive treatment near end of life, which is associated with decreased quality of life and poor use of health care resources. Meaningful from patient and family perspective. Measure “fills a gap” and aligns with the need for improved care in the final days of life.
  - **Concerns:** Concerns regarding its broader applicability, effectiveness, and lack of information on costs and feasibility of implementation.
  - **Further consideration:** Clarification was sought on the definition of “patients who died from cancer” and whether it includes only those in late stages or a broader group.
- **Appropriateness of Scale Themes**
  - **Support:** Measure may increase transparency around end-of-life care and encourage better and earlier access to hospice and palliative services.
  - **Concerns:** Barriers to use of measure cited include limited access to health care facilities other than the ICU, health care professional shortages, and socioeconomic barriers affecting patient care, such as transportation across communities with emphasis on rural settings. Concern about not aligning with patient preferences and the absence of corresponding palliative care measures.
- **Time-to-Value Realization Themes**
  - **Support:** Measure could accelerate efforts to direct patients toward hospice care, potentially stimulating investment in hospice resources in communities
  - **Concerns:** Lack of plan for oversight of long-term impacts in submission limits ability to comment on this criterion.

Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life
Public Comment Summary

- **Received five public comments**
  - Two support and three concerns
- **Support summary:**
  - Support for the expansion of cancer-specific measures to more general hospital settings, emphasizing the importance of applying proven measures to a broader range of programs that treat cancer patients.
  - The measure aligns with patient safety and quality care goals.
- **Concern summary:**
  - Concern that a claims-based measure would be unable to account for patient and family preference, highlighting a limitation in capturing the nuances of individual care decisions.
  - Concern about the measure's ability to distinguish between necessary and unnecessary services, especially in clinically appropriate situations.
  - Concern regarding the fairness and accuracy of the measure's attribution strategy, as well as how effectively the measure captures the relationship between a cancer patient and the hospital managing their end-of-life care.
  - Concern about the exclusion of patients enrolled in an HMO in the 12 months before death.
  - Concerns about the relevance and applicability of this measure to rural hospitals, suggesting it could increase the reporting burden significantly for these facilities.

Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life
Equity Considerations

Potential Impacts to Health Equity Associated with Measure Use

- Research has found that patients with metastatic cancer from racial and ethnic minority groups and those with Medicare or Medicaid coverage are more likely to receive low-value, aggressive interventions at the end of life.[1]
- IHI reviewers noted that the numerator excludes patients without any outpatient visits or inpatient stays in the last six months before death and requires at least two visits within the last six months. Given disparities in access, this could differentially impact patient groups with more barriers to outpatient access.

Potential Impacts to Health Equity Associated with Non-Use

IHI reviewers suggested non-use of this measure may prevent identification of potential disparities within the cancer patient population that can help inform improvement efforts.

Considerations for Enhancing Health Equity

IHI reviewers suggested stratification by race, sex, ethnicity, and language as an initial step to facilitate, understand, and address disparities to improve shared-decision making.

[1] 10.Deeb S, Chino FL, Diamond LC, et al. Disparities in Care Management During Terminal Hospitalization Among Adults With Metastatic Cancer From 2010 to 2017. JAMA Network Open. 2021;4(9):e2125328. doi: https://doi.org/10.1001/jamanetworkopen.2021.25328

Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life

Discussion Topics

- Are there any considerations specific to rural communities that have potential impact on burdens and benefits associated with this measure?
- Does the committee have concerns about how/whether patient preference is accounted for in this claims-based measure?

Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life

MUC2024-068

MUC2024-068 Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life

Item	Description
Considered For	Hospital Outpatient Quality Reporting Program
Measure Description	Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life.
Developer/Steward	American Society of Clinical Oncology (ASCO)
Measure Background	Measure currently used in a Medicare program and is being submitted without substantive changes for a new or different program

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
Process	Endorsed	Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program	Facility

Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life
PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Members see the value in enhancing palliative care referral and end-of-life planning, recognizing that it can improve patient comfort and potentially reduce unnecessary costs. Support 14-day window in the measure.
  - **Concerns:** Concern that measure may not be as feasible to implement in rural settings. Worry that outpatient hospitals might be penalized for honoring end-of-life patient preferences if the measure does not properly account for shared decision-making.
  - **Further consideration:** Request for more information on why the measure is being updated and how it differs from the original version.
- **Appropriateness of Scale Themes**
  - **Support:** Support from patient perspective.
  - **Concerns:** Concerns expressed around measure's relevance and utility across all settings, such as rural communities. One member expressed concern that expanding the measure could unfairly attribute care decisions to outpatient clinics. Concerns shared about the need for alternative risk stratification.
- **Time-to-Value Realization Themes**
  - **Support:** Immediate impact on end of life for individual patients if implemented.
  - **Concerns:** Encourage the development of a FHIR-based digital quality measure for long-term sustainability. Several members did not feel they had sufficient information to comment on criterion.

Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life
Public Comment Summary

- **Received four public comments**
  - Three support and one concern
- **Support summary:**
  - Strong support for expanding cancer-specific measures to general hospital settings as it aligns with patient safety and quality care goals.
  - Support for encouraging earlier palliative and hospice care for advanced cancer and illness patients, significantly improving end-of-life care quality.
- **Concern summary:**
  - Clarification needed on exclusion of HMO patients, highlighting need for transparency regarding its scope and applicability.

Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life
Equity Considerations

Potential Impacts to Health Equity Associated with Measure Use

There are health care disparities among racial and ethnic minority (including Asian, Pacific Islander, Black, and Hispanic patients) who receive more intensive treatment, including chemotherapy, in the last 14 days of life. Additionally, Medicare and Medicaid beneficiaries have a higher likelihood of more intensive treatment than patients with commercial insurance.[1]

Potential Impacts to Health Equity Associated with Non-Use

IHI reviewers noted that not implementing this measure may impact ongoing evaluation of known health care disparities associated with intensive care treatment, including chemotherapy, at the end of life, and opportunities for improvement.

Considerations for Enhancing Health Equity

IHI reviewers recommended stratification by race, sex, ethnicity, and language as an initial step to better understand health care disparities.

[1] 10.Deeb S, Chino FL, Diamond LC, et al. Disparities in Care Management During Terminal Hospitalization Among Adults With Metastatic Cancer From 2010 to 2017. JAMA Network Open. 2021;4(9):e2125328. doi: https://doi.org/10.1001/jamanetworkopen.2021.25328

Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life
Discussion Topics

- Are there any considerations specific to rural communities that have potential impact on burdens and benefits associated with this measure?
- Does the committee have concerns about how/whether shared decision-making is accounted for in this claims-based measure?
- How might this measure mature through future revisions if added to the HOQR program?

Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than 3 Days

MUC2024-078

MUC2024-078 Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than 3 Days

Item	Description
Considered For	Hospital Inpatient Quality Reporting Program; Hospital Outpatient Quality Reporting Program
Measure Description	Proportion of patients who died from cancer admitted to hospice for less than 3 days.
Developer/Steward	American Society of Clinical Oncology (ASCO)
Measure Background	Measure currently used in a Medicare program and is being submitted without substantive changes for a new or different program

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
Intermediate Outcome	Endorsed	Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program	Facility

Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than 3 Days

PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Supporters of the measure highlighted its alignment with patient-centered care and its potential to improve the quality of end-of-life care by encouraging earlier hospice referrals**.**
  - **Concerns:** Concerns centered around the feasibility and reliability of the measure, questioning whether hospitals have the necessary resources (tools, process, and people) to effectively implement it. Doubts were also expressed about the measure's attribution, given role of referring community providers.
  - **Further consideration:** Members sought clarity on the target patient population for the measure, expressing confusion over whether it included Medicare PPO-enrolled patients in addition to FFS patients and questioned why HMO patients were excluded. Clarification was requested on the statistical implications of restricting the measure to a limited set of dedicated hospitals and how that impacts the generalizability and effectiveness of the measure on broader patient populations.
- **Appropriateness of Scale Themes**
  - **Support:** Measure seen as meaningful by patients.
  - **Concerns:** Additional testing across patient groups encouraged in future to determine if differences in performance exist.
- **Time-to-Value Realization Themes**
  - **Support:** Expected to lead to rapid improvements in hospice care referral practices, with immediate benefits for patient quality of life and resource utilization at the end of life.
  - **Concerns:** Limited resources for in-depth conversation about end-of-life issues may prevent substantive improvement in the short term.

Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than 3 Days
Public Comment Summary

- **Received five public comments**
  - Four support and one concern
- **Support summary:**
  - Strong support for expanding cancer-specific measures to general hospital settings, enhancing care quality across various programs treating cancer patients.
  - Support for promoting earlier hospice referrals for advanced illness patients, improving end-of-life care practices and quality.
- **Concern summary:**
  - Clarification needed on the exclusion of HMO patients, indicating need for transparency regarding measure scope and applicability.
  - Limited resources for in-depth end-of-life discussions may prevent substantive improvement and highlights need for adequate support and training for hospital staff.

Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than 3 Days
Equity Considerations

Potential Impacts to Health Equity Associated with Measure Use

- Studies have shown that racial and ethnic minorities (such as Black, Asian, and Hispanic patients) are less likely to use hospice services compared to White patients. Additionally, patients from rural areas and those with certain types of cancer (like breast or colorectal) are also less likely to receive hospice care. Factors contributing to these disparities include socioeconomic status, geographic location, and cultural differences.[1,2]
- IHI reviewers noted the measure can impact ongoing efforts to address disparities for those in hospice and help highlight communities that need targeted improvement efforts.

Potential Impacts to Health Equity Associated with Non-Use

IHI reviewers suggested non-use of this measure may impact ongoing evaluation of the timing of hospice care cancer patients and opportunities for improvement.

Considerations for Enhancing Health Equity

IHI reviewers recommended stratification by race, sex, ethnicity, and language.

[1] Wachterman MW, Sommers BD. Dying Poor in the US-Disparities in End-of-Life Care. JAMA. 2021;325(5):423-424. doi:10.1001/jama.2020.26162

[2] Shore DD. Hospice Use in Patients With Cancer: A Comprehensive Clinical Literature Review. Clin J Oncol Nurs. 2023;27(6):629-636. doi:10.1188/23.CJON.629-636

Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than 3 Days
Discussion Topics

- What resources are needed to ensure that measured entities have systematic ways to improve their performance on this measure?
- Are there subgroups that might differentially experience benefits or burdens associated with this measure?

Lunch Break

Please return by 2:15 PM

Addressing Social Needs Assessment & Intervention

MUC2024-069

MUC2024-069 Addressing Social Needs Assessment & Intervention

Item	Description
Considered For	Hospital Inpatient Quality Reporting Program; Medicare Promoting Interoperability Program; Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program
Measure Description	Percentages of inpatient encounters for patients of all ages reflecting whether patients were assessed in four domains of social need: food, housing, transportation, and utilities; and whether the patient received a qualifying follow-up action within the visit for any positive social needs. Qualifying follow-up actions were identified from Gravity Project: adjustment, assistance/assisting, coordination, counseling, education, evaluation of eligibility, provision, and referral.
Developer/Steward	Centers for Medicare & Medicaid Services (CMS)
Measure Background	New measure; never reviewed by MAP Workgroup or PRMR Committee or used in a Medicare program

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
Process	Not Endorsed	New Measure	Facility

Addressing Social Needs Assessment & Intervention
PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Identifying and assessing social drivers of health such as transportation, housing, and food can improve care coordination and overall health. Measure seen as appropriate for target population and program.
  - **Concerns:** Concern expressed for screening for these needs in a health system that does not have the structural support to address these needs once identified. Feasibility and reliability of the measure are in question, particularly in rural or medically underserved areas where resources to follow up on social needs are limited. Concerns about the large scope of the measure overlapping with existing measures and needing to be broken into smaller, more focused measures.
  - **Further consideration:** Clarity requested on “qualifying follow-up actions.”
- **Appropriateness of Scale Themes**
  - **Support:** Measurement approach separates the numerator into categories for different social needs and allows flexibility in the type of interventions, which can be useful given the variability in intervention types and populations.
  - **Concerns:** Concerns around potential for penalization or reward due to geographic and resource variability across settings.
- **Time-to-Value Realization Themes**
  - **Support:** Immediate benefit of increasing social needs assessment and interventions that are of great importance. Allows organizations to better plan for scope of need in their community.
  - **Concerns:** Scale and complexity of the measure, which could limit long-term time-to-value realization.

Addressing Social Needs Assessment & Intervention
Public Comment Summary

- **Received seven public comments**
  - Two support and five concerns
- **Support summary:**
  - Potential to improve health outcomes by addressing social needs and reducing disparities.
  - eCQM reporting perceived to be relatively low burden.
  - Praise for the measure's comprehensive approach, with suggestions to include additional assessments such as caregiver burden.
- **Concern summary:**
  - Measure is not aligned with existing SDOH screening measures.
  - Logistical challenges may include additional data requirements, EHR field methodology, and feasibility in rural and frontier communities.
  - The measure should have an exclusion for instances in which no support services are available.
  - Reimbursement should be provided for hospital staff to conduct interventions.

Addressing Social Needs Assessment & Intervention
Equity Considerations

Potential Impacts to Health Equity Associated with Measure Use

Social needs screening is currently occurring in the inpatient setting; however, it is not happening universally with differences by community setting (e.g., urban vs. rural vs. critical access, etc.). There may be differential burden for the hospital care teams by setting and population served. IHI reviewers cited a commentary suggesting an inherent fallibility of using validated screening tools including accuracy, reliability, resource allocation, stigma, and trust.[1]

Potential Impacts to Health Equity Associated with Non-Use

- IHI reviewers asserted that even if the current process is imperfect, social needs screening is crucial to understand the current state and to set the foundation for electronic health record (EHR) optimization, screener training and implementation, and policy changes.
- IHI reviewers suggested non-use of this measure could prevent the creation of optimized processes when collecting social needs data and connecting patients to resources.

Considerations for Enhancing Health Equity

IHI recommended stratification by additional variables such as race, ethnicity, language, zip code, and insurance

1. Garg A, Sheldrick RC, Dworkin PH. The Inherent Fallibility of Validated Screening Tools for Social Determinants of Health. Academic Pediatrics. 2018;18(2):123-124. doi: https://doi.org/10.1016/j.acap.2017.12.006

Addressing Social Needs Assessment & Intervention
Discussion Topics

- Are there any considerations specific to rural communities that have potential impact on burdens and benefits associated with this measure?
- How might this measure mature through revisions in the future if added to proposed programs (Hospital Inpatient Quality Reporting Program, Medicare Promoting Interoperability, and the Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program)?

Hospital Harm – Anticoagulant-Related Major Bleeding

MUC2024-085

MUC2024-085 Hospital Harm – Anticoagulant-Related Major Bleeding

Item	Description
Considered For	Hospital Inpatient Quality Reporting Program; Hospital-Acquired Condition Reduction Program; Medicare Promoting Interoperability Program
Measure Description	The proportion of inpatient hospitalizations for patients aged 18 and older who were administered at least one anticoagulant medication within the first 24 hours of admission and had a subsequent bleeding event. Bleeding events must occur during the encounter.
Developer/Steward	Centers for Medicare & Medicaid Services (CMS)
Measure Background	New measure; never reviewed by MAP Workgroup or PRMR Committee or used in a Medicare program

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
Outcome	Not Endorsed	New Measure	Facility

Hospital Harm – Anticoagulant-Related Major Bleeding
PIE Form Feedback

- **Meaningfulness Themes**
  - **Support**: Measure is associated with important patient safety outcomes and aligns with clinical guidelines. Evidence supporting measure's use was found to be sufficient.
  - **Concerns:** Limited testing across diverse settings and questions as to the sufficiency of the face validity evidence (inputs from two experts) and feasibility. Concern for potential overlap with Agency for Healthcare Research and Quality (AHRQ) PSI-9 in which anticoagulant therapy can be an exclusion.
  - **Further consideration:** Request for clearer information regarding data element availability in electronic medical records and more robust external validation to ensure comprehensive and reliable EHR-reporting capabilities.
- **Appropriateness of Scale Themes**
  - **Support:** No differential benefit by patient subgroups based on review by one member, suggesting that benefits of the measure will be experienced equally across patient groups.
  - **Concerns:** Concern shared that the measure's use in a CMS program, especially a pay-for-performance program, may increase risk of underdosing anticoagulants and thrombolytics for individuals who are heightened risk of venous thromboembolism (VTE), a risk which may vary by race. More testing was requested across patient subgroups and facility types to better determine the potential for variation in benefits or harms.
- **Time-to-Value Realization Themes**
  - **Support:** Measure allows for clear tracking of progress and adjustments in strategies over the long term.
  - **Concerns:** Several members did not feel they had sufficient information on plans for near- and long-term measure use to comment on this criterion.

Hospital Harm – Anticoagulant-Related Major Bleeding
Public Comment Summary

- **Received seven public comments**
  - Three support and four concerns
- **Support summary:**
  - Excitement for Hospital Harm measure set, including this measure. eCQM will make patient safety reporting less burdensome.
  - Measure has received positive response from healthcare organizations.
  - Outcome measure will improve safety and quality.
  - Potential to prevent common and preventable bleeding events caused by anticoagulation medications.
- **Concern summary:**
  - Measure could discourage appropriate use of anticoagulants.
  - Structure of the measure may not effectively mitigate hospital harm, concern for partnership with the VTE measure.
  - May not accurately measure new anticoagulants (DOACs).
  - Measure should be tested in specific programs before implementation in the Hospital-Acquired Condition Reduction Program for financial reasons; guidelines and benchmarks should be provided before implementation to help facilities prioritize improvements.

Hospital Harm – Anticoagulant-Related Major Bleeding
Equity Considerations

Potential Impacts to Health Equity Associated with Measure Use

IHI reviewers noted that health equity could be positively impacted through stratified measure reporting, per the developer's recommendation.

Potential Impacts to Health Equity Associated with Non-Use

Non-use of the measure would limit understanding of existing equity gaps, including differences in major bleeding events among hospitals.

Considerations for Enhancing Health Equity

IHI reviewers recommended stratification to understand differences in types of anticoagulants used, dosing, and duration of therapy.

Hospital Harm – Anticoagulant-Related Major Bleeding
Discussion Topics

- Does the committee have any concerns about measure validity based on the testing information in the submission materials?
- Are there subgroups that might differentially experience benefits or burdens associated with this measure?

Patient Safety Structural Measure

MUC2024-027

MUC2024-027 Patient Safety Structural Measure

Item	Description
Considered For	Hospital Inpatient Quality Reporting Program; Hospital Value-Based Purchasing Program; Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program
Measure Description	The Patient Safety Structural Measure is an attestation-based measure that assesses whether hospitals demonstrate having a structure and culture that prioritizes patient safety. The Patient Safety Structural Measure comprises five domains, each containing multiple statements that aim to capture the most salient structural and cultural elements of patient safety. This measure is designed to identify hospitals that practice a systems-based approach to safety.
Developer/Steward	Centers for Medicare & Medicaid Services (CMS)
Measure Background	Measure currently used in a Medicare program, but the measure is undergoing substantive change

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
Structure	Not Endorsed	HIQR; PCHQR	Facility

Patient Safety Structural Measure
PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Support for the importance of the measure target for patient safety. Measure viewed as “a good first step” in ensuring structural components needed for reliable and effective quality programs are in place at the hospital level.
  - **Concerns:** Concerns shared about the potential administrative burden, need for clearer evidence relating directly to patient outcomes from this measure, and the adaptability of smaller or rural hospitals to the measure. Concern voiced about addition of medication questions and need for additional testing based on additions.
  - **Further consideration:** Additional insights were sought on how the measure would be tested and evaluated in real-world settings.
- **Appropriateness of Scale Themes**
  - **Support:** Support for the inclusion of patient and caregiver voices and minimal risks and burdens associated with the implementation of the measure for patients.
  - **Concerns:** Concern that there is not enough evidence on potential benefit/harm of specific groups.
- **Time-to-Value Realization Themes**
  - **Support:** Measure identifies organizational gaps and may lead to improvements in the near and long term.
  - **Concerns:** Concerns shared about long-term use of measure due to lack of standardization and no stated plan for maturation in submission materials.

Patient Safety Structural Measure
Public Comment Summary

- **Received twelve public comments**
  - Four support and eight concerns
- **Support summary:**
  - The measure is viewed as a crucial tool to establish patient safety as a key organizational goal for hospitals. It is expected to hold organizations more accountable for the care provided.
- **Concern summary:**
  - Potential increase in administrative burden due to the scope and depth of the measure are significant. The complexity of the measure and redundancy with existing hospital activities and structures are also highlighted.
  - Primarily focuses on the presence of patient safety-focused documents without a demonstrated linkage to improvement in patient outcomes.
  - Some commenters believed that structural measures are not suitable for inclusion in Value-Based Purchasing programs; measures should focus on outcomes and processes directly impacting patient care.
  - Vague language and potential implementation challenges, such as contracting provisions and policies for managing medication shortages.
  - Measure presents substantial legal challenges due to varying state laws.

Patient Safety Structural Measure
Equity Considerations

Potential Impacts to Health Equity Associated with Measure Use

- There are known racial and ethnic health care disparities related to quality and safety; for example, non-Hispanic Black women are three times more likely to die from a pregnancy-related cause than White women.[1]
- Additionally, there are disparities related to gender, limited English proficiency, culture, religion, and disabilities documented in the literature.[2,3]
- IHI reviewers noted that, in its current form, this measure does utilize risk adjustment or stratification and therefore would not address the disparities stated above.

Potential Impacts to Health Equity Associated with Non-Use

IHI reviewers suggested that not implementing this measure may impact ongoing evaluation of patient safety structural processes, which could hinder opportunities to improve cited health care disparities.

Considerations for Enhancing Health Equity

IHI reviewers recommended adding a requirement to submit data related to the patient's race, ethnicity, language, sexual orientation, and gender identification to Domain 4 of the measure, as part of the "confidential safety reporting system," to facilitate stratification.

[1] The Joint Comission, ed. Sentinel Event Alert 64: Addressing Health Care Disparities by Improving Quality and Safety. Jointcommission.org. Published November 10, 2021. Accessed November 13, 2024. https://www.jointcommission.org/resources/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-64-addressing-health-care-disparities/?form=MG0AV3

[2] Schulson LB, Thomas AD, Tsuei J, Etchegaray JM. Identifying and Understanding Ways to Address the Impact of Racism on Patient Safety in Health Care Settings. www.rand.org. Published August 8, 2022. https://www.rand.org/pubs/research_reports/RRA1945-1.html

[3] MedStar Health Research Institute. Study Shows Effects of Racism on Patient Safety, Reporting, and Equitable Outcomes—Plus Recommendations on What Health Systems Can Do. Study Shows Effects of Racism on Patient Safety, Reporting, and Equitable Outcomes—Plus Recommendations on What Health Systems Can Do. Published September 15, 2022. Accessed November 13, 2024. https://www.medstarhealth.org/blog/patient-safety-racism?form=MG0AV3

Patient Safety Structural Measure
Discussion Topics

- What threats to measure validity should be considered with regard to potential external confounders (e.g., community- or facility-level challenges to the patient safety structural domains)?
- Will benefits and burdens associated with this measure be realized within an appropriate implementation time frame?

Break

Please return by 4:00 PM

Emergency Care Capacity and Quality (ECCQ)

MUC2024-075
MUC2024-095

MUC2024-075 Emergency Care Capacity and Quality (ECCQ)

Item	Description
Considered For	Hospital Outpatient Quality Reporting Program
Measure Description	This measure captures the proportion of Emergency Department (ED) visits where patients (all ages, all payers) experienced any one of four quality gaps in access.
Developer/Steward	Centers for Medicare & Medicaid Services (CMS)
Measure Background	New measure; never reviewed by MAP Workgroup or PRMR Committee or used in a Medicare program

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
Intermediate Outcome	Not Endorsed	New Measure	Facility

Note: Developer provided correction that no data elements required review or presented feasibility challenges during eCQM testing. This is a correction from what was submitted in MERIT.

MUC2024-095 Emergency Care Capacity and Quality (ECCQ)

Item	Description
Considered For	Rural Emergency Hospital Quality Reporting Program
Measure Description	This measure captures the proportion of Emergency Department (ED) visits where patients (all ages, all payers) experienced any one of four quality gaps in access: 1. The patient waited longer than 1 hour to be placed in a treatment room or dedicated treatment area that allows for audiovisual privacy during history-taking and physical examination, or 2. The patient left the ED without being evaluated by a physician/advanced practice nurse/physician's assistant, or 3. The patient, if transferred (time from Decision to Transfer to ED departure), boarded for longer than 4 hours, or 4. The patient had an ED length of stay (LOS) (time from ED arrival to ED physical departure as defined by the ED depart timestamp) of longer than 8 hours.
Developer/Steward	Centers for Medicare & Medicaid Services (CMS)
Measure Background	New measure; never reviewed by MAP Workgroup or PRMR Committee or used in a Medicare program

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
Intermediate Outcome	Not Endorsed	New Measure	Facility

Emergency Care Capacity and Quality (ECCQ)
PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Support expressed for measure's evidence base, importance to patient outcomes, and cost and quality of care received in the ED.
  - **Concerns:** Concern shared that measure's four domains may align more with "operational factors" rather than capacity factors and that the measure is too broad. Concern that reliability values are higher than expected and may represent methodological issues in testing. Feasibility and burden of data collection also emphasized in responses.
  - **Further consideration:** Committee member would like to learn more about additional stratification factors such as substance use and race/ethnicity.
- **Appropriateness of Scale Themes**
  - **Support:** Recognition shared that the measure could lead to better triage systems and staffing improvements within hospitals serving areas of higher need and facing resource constraints.
  - **Concerns:** Concerns shared for appropriateness of attributing poor performance solely to hospitals, as external factors such as availability of beds in skilled nursing facilities significantly influence outcomes. Concern expressed for lack of adjustment or stratification by health status at arrival or triage workflows.
- **Time-to-Value Realization Themes**
  - **Support:** Measure could provide transparency on four domain areas and improve care in the near and long term.
  - **Concerns:** One member shared concern for measure's long-term impacts given administrative burden and lower performance of similar measures in past.

Emergency Care Capacity and Quality (ECCQ)
PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Support expressed for measure's evidence base, importance to patient outcomes, and cost and quality of care received in the ED.
  - **Concerns:** Concern shared that measure's four domains may align more with "operational factors" rather than capacity factors and that measure is too broad. Concern that reliability values are higher than expected and may represent methodological issues in testing. Concerns around feasibility, use in program, and burden of data collection also emphasized in responses.
  - **Further consideration:** Committee member would like to learn more about additional stratification factors such as substance use and race/ethnicity. Further information on how measure can be acted on, given the operational limitations in hospitals is requested.
- **Appropriateness of Scale Themes**
  - **Support:** Recognition shared that the measure could lead to better triage systems and staffing improvements within hospitals serving areas of higher need and facing resource constraints.
  - **Concerns:** Concerns shared for appropriateness of attributing poor performance solely to hospitals, as external factors like availability of beds in skilled nursing facilities significantly influence outcomes. Concern expressed for lack of adjustment or stratification by health status at arrival or triage workflows.
- **Time-to-Value Realization Themes**
  - **Support:** Measure could provide transparency on four domain areas in the near term.
  - **Concerns:** Concern for measure's long-term impacts given administrative burden and lower performance of similar measures in past.

Emergency Care Capacity and Quality (ECCQ)
Public Comment Summary

- **Received ten public comments**
  - Five support and five concerns
- **Support summary:**
  - Critical need to address long wait times and boarding issues in emergency departments.
  - General support for the use of eCQMs to reduce reporting burden and improve data quality.
- **Concern summary:**
  - Overlap with existing measures.
  - Measure too comprehensive and burdensome, especially for facilities with limited resources, or Rural Emergency Hospitals.
  - Four-hour recommendation for boarding may not be appropriate for patients with specific conditions requiring more urgent care.

Emergency Care Capacity and Quality (ECCQ)
Public Comment Summary

- **Received seven public comments**
  - Four support and three concerns
- **Support summary:**
  - Patient advocates supportive of the measure, standards needed to address long wait times in EDs, especially for patients with rare and chronic conditions.
  - Critical in addressing the crisis of ED overcrowding.
  - Measure is supported by key organizations (American College of Emergency Physicians, Emergency Nurses Association).
  - Voluntary reporting recommended initially to allow hospitals time to build out and test the eCQM measure, particularly in rural settings.
- **Concern summary:**
  - Four-hour recommendation from decision time to admit transfer may not be suitable for all patients, or in rural settings.
  - May be difficult for Rural Emergency Hospitals to report due to potential IT resource limitations and use of separate EHRs for emergency departments. More measure testing is needed in rural settings.
  - Median times rather than fixed timeframes to define delays may be more appropriate for this measure.

Emergency Care Capacity and Quality (ECCQ)
Equity Considerations

Potential Impacts to Health Equity Associated with Measure Use

IHI reviewers suggested this measure will quantify known disparities in ED care and treatment for patient subgroups and provide key insights into patient harm and quality of care.

Potential Impacts to Health Equity Associated with Non-Use

Per the developers, there are currently no national measures to assess the proportion of patients impacted by the quality of timely ED care. IHI reviewers noted that, without such measures and the actions they motivate, disparities in timely ED care will persist.

Considerations for Enhancing Health Equity

IHI reviewers suggested that the measure could benefit from facility-level geographic stratification to assess differences in urban and rural hospital performance within states and between states.

Emergency Care Capacity and Quality (ECCQ)
Equity Considerations

Potential Impacts to Health Equity Associated with Measure Use

IHI reviewers suggested this measure will quantify known disparities in ED care and treatment for patient subgroups and provide key insights into patient harm and quality of care.

Potential Impacts to Health Equity Associated with Non-Use

Per the developers, there are currently no national measures to assess the proportion of patients impacted by the quality of timely ED care. IHI reviewers noted that, without such measures and the actions they motivate, disparities in timely ED care will persist.

Considerations for Enhancing Health Equity

IHI reviewers suggested that the measure could benefit from facility-level geographic stratification to assess differences in urban and rural hospital performance within states and between states.

Emergency Care Capacity and Quality (ECCQ)
Discussion Topics

- Does the committee have concerns about the benefits of implementing this measure in light of potential unintended consequences (e.g., premature discharge from the ED, inappropriate reduction in admissions)?
- How will this measure mature through revisions in the future if added to the Hospital Outpatient Quality Reporting Program measure set?

Emergency Care Capacity and Quality (ECCQ)
Discussion Topics

- Does the committee have concerns about the benefits of implementing this measure in light of potential unintended consequences (e.g., premature discharge from the ED, inappropriate reduction in admissions)?
- How will this measure mature through revisions in the future if added to the Rural Emergency Hospital Quality Reporting Program measure set?

Influenza Vaccination Coverage Among Healthcare Personnel

MUC2024-034

MUC2024-034 Influenza Vaccination Coverage Among Healthcare Personnel

Item	Description
Considered For	Rural Emergency Hospital Quality Reporting Program
Measure Description	Percentage of healthcare personnel (HCP) who receive the influenza vaccination.
Developer/Steward	Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN)
Measure Background	Measure currently used in a Medicare program and is being submitted without substantive changes for a new or different program

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
Process	Endorsed	HIQR; IRF QRP; LTCH QRP; PCHQR; SNF QRP	Facility

Influenza Vaccination Coverage Among Healthcare Personnel
PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Support shared for measure's importance and evidence base for patient safety outcomes among patients at higher risk for complications from influenza. Measure's extension to rural emergency hospitals is seen as a natural progression of current use.
  - **Concerns:** Concerns were raised regarding the increased administrative burden and the practical challenges of implementing the measure, especially in rural settings.
- **Appropriateness of Scale Themes**
  - **Support:** Measure viewed as opportunity to create uniformity in reporting standards across rural and non-rural hospitals, ensuring equal focus on patient safety across different settings.
  - **Concerns:** Concern shared about potential unintended consequences on staffing and volunteer numbers in areas and populations with greater vaccine hesitancy.
- **Time-to-Value Realization Themes**
  - **Support:** Measure has potential to impact mortality and morbidity related to influenza in rural settings in the near and long term.
  - **Concerns:** Concern shared that long-term staffing shortages could increase through mandating of vaccination in areas with greater vaccine hesitancy.

Influenza Vaccination Coverage Among Healthcare Personnel
Public Comment Summary

- **Received two public comments**
  - Two support
- **Support summary:**
  - Potential to reduce flu spread and decrease morbidity and mortality related to flu infections in Rural Emergency Hospitals.
  - Feasible implementation, as hospitals are well-equipped to capture influenza vaccination information among healthcare personnel.

Influenza Vaccination Coverage Among Healthcare Personnel
Equity Considerations

Potential Impacts to Health Equity Associated with Measure Use

- There are significant differences in vaccination rates among health care personnel based on employee type, region, and health care facility type. [1]
- IHI reviewers noted that understanding influenza vaccination coverage among health care personnel impacts equity among health care workers, who could have disparate rates of influenza based on their vaccination rates. [2]
- Health care personnel vaccination rates can impact patient care equity as well.

Potential Impacts to Health Equity Associated with Non-Use

IHI reviewers noted that not implementing this measure could prevent more targeted vaccination efforts for health care personnel subgroups.

Considerations for Enhancing Health Equity

IHI reviewers recommended stratification by race, sex, ethnicity, and language as an initial step with future stratification by employee type, facility type, and region to help inform improvement efforts.

[1] Bell J, Meng L, Barbre K, et al. Influenza and Up-to-Date COVID-19 Vaccination Coverage Among Health Care Personnel — National Health care Safety Network, United States, 2022–23 Influenza Season. MMWR Morbidity and Mortality Weekly Report. 2023;72. doi: https://doi.org/10.15585/mmwr.mm7245a5

[2] CDC. Health Equity and Flu. Influenza (Flu). Published September 27, 2024. https://www.cdc.gov/flu/health-equity/index.html

Influenza Vaccination Coverage Among Healthcare Personnel
Discussion Topics

- Does the committee share concerns expressed in PIE Forms about the potential unintended consequences of widening staff shortages (esp. in populations with higher vaccine hesitancy)?
- Does the committee have share concerns expressed in PIE Forms about the potential administrative burden and implementation challenges in Rural Emergency Hospitals (REHs)?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Day 2

January 16, 2025

Hospital Recommendation Group Meeting Agenda Day 2

10:00 AM	Welcome
10:05 AM	Roll Call and Disclosures of Interest (DOIs)
10:15 AM	Voting Test
10:30 AM	Measure Review
11:15 AM	Break
11:30 AM	Measure Review
1:00 PM	Next Steps
1:15 PM	Meeting Adjourns

* All times listed in ET

Roll Call and Disclosures of Interest

Kate Buchanan

Roll Call and Disclosures of Interest

Hospital Recommendation Group Members

Co-chairs: Lisa McGiffert and Edward Pollak

David Basel

Zahid Butt

Akin Demehin

Subashnie Devkaran

Michelle Doll

Wendy Fitts

Thomas Frederickson

Tejal Gandhi

Angela Ghiorso

Nadja Kadom*

Christopher Kim

David Levine

Jennifer Lundblad

Michael Lynch

Julie Marcinek

Tilithia McBride

Hal McCard

Ben McGaugh

Somaieh McMullan

Shari Michl

Jan Orton

Mark Paris

Phoebe Ramsey

Jessica Schumacher

Holly Varnell

Kathy Wilson

Beth Zimmerman

 **Denotes inactive status*

Voting Test

Isaac Sakyi

Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

MUC2024-042

MUC2024-042 Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

Item	Description
Considered For	Hospital Inpatient Quality Reporting Program; Hospital Value-Based Purchasing Program; Hospital-Acquired Condition Reduction Program
Measure Description	The measure estimates a hospital-level risk-standardized complication rate (RSCR) associated with elective primary THA and/or TKA procedure. The outcome (complication) is defined as any one of the specified complications occurring from the date of index admission to up to 90 days post-date of the index admission (the admission included in the measure cohort). Complications are counted in the measure only if they occur during the index hospital admission or during a readmission. The complication outcome is a dichotomous (yes/no) outcome.
Developer/Steward	Centers for Medicare & Medicaid Services (CMS)
Measure Background	Measure currently used in a Medicare program, but the measure is undergoing substantive change

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
Outcome	Endorsed	HVBP; HIQR	Facility

Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Inclusion of the Medicare Advantage population was seen as making the measure more relevant for all hospitals. Support for the measure's proven track record in improving outcomes and its potential to reduce health care costs. Measured outcomes are of high clinical significance and relevance to the target population.
  - **Concerns:** Concern expressed for scope of complications covered by measure and time points selected for measurement. Potential for redundancy in data collection.
  - **Further consideration:** Additional clarity requested about risk-adjustment methodology and how to mitigate potential patient selection bias.
- **Appropriateness of Scale Themes**
  - **Support:** Support for risk-adjustment model overall for addressing equity concerns. Measure's robustness in accurately stratifying without magnifying disparities was appreciated.
  - **Concerns:** Concern that hospitals serving populations with higher burden of health disparities and risk for complications may be penalized for complications unrelated to surgery; may discourage hospitals from treating higher-risk populations. Member stated that based on their clinical experience, they see harms to patients resulting from this and similar measures.
- **Time-to-Value Realization Themes**
  - **Support:** Actionable improvements enabled by measure in near and long term, improving care and increasing cost savings.
  - **Concerns:** Potential for harm through excluding higher-risk patients in long term.

Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

Public Comment Summary

- **Received ten public comments**
  - Three support and seven concerns
- **Support summary:**
  - Inclusion of MA data has potential to enhance data reporting and improve policy and care by providing a comprehensive view of Medicare beneficiaries for better policy-making and patient care improvement.
  - Important to have outcome measures that emphasize improving safety and quality in healthcare.
- **Concern summary:**
  - Unclear implications of including MA beneficiaries warrants further analysis to ensure data accuracy and comparability with fee-for-service data.
  - Including MA beneficiaries may alter scores and penalties, affecting hospital performance metrics and requiring detailed analysis and transparency.
  - Low reliability suggests measure may not be effective in distinguishing hospital performance and driving improvements.
  - Unclear rationale for the scope of measures including MA data, questioning the selective inclusion across mortality and readmission measures.
  - Reimbursement rates may not reflect specialists' experience or procedure frequency, potentially impacting care quality.
  - Increasing number of elective procedures at ASCs may decrease the sample size in hospitals, limiting the measure's applicability and effectiveness.

Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

Equity Considerations

Potential Impacts to Health Equity Associated with Measure Use

- IHI reviewers noted this measure can help identify whether certain demographic groups, such as those based on race, ethnicity, or socioeconomic status, are experiencing higher complication rates due to inequitable care practices
- If hospitals serving historically underserved populations are found to have higher complication rates, it may catalyze improvements in care for these groups, ultimately improving health outcomes, and/or systemic factors.

Potential Impacts to Health Equity Associated with Non-Use

- IHI reviewers noted non-use of this measure could have significant negative implications for health care equity. When key outcome measures such as complication rates are not tracked or reported, disparities in care delivery and patient outcomes may go undetected, hindering efforts to reduce health inequities.
- If complications are not measured or reported at the hospital level, the larger health system remains blind to patterns that could reflect inequitable practices or care delivery.

Considerations for Enhancing Health Equity

IHI suggested the following strategies to improve the inclusivity, fairness, and utility of the measure for diverse patient populations:

1. Incorporate health-related social needs assessment into the risk adjustment.
2. Stratify by demographics for populations and sub-populations.
3. Encourage reporting across a broad array of facilities.

Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

Discussion Topics

- What are the potential near- and long-term impacts of this measure (and the addition of Medicare Advantage beneficiaries) across provider and patient populations?
- Does the committee share concerns expressed in PIE Forms about the potential unintended consequence of refusing care for higher-risk patients?

Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity

MUC2024-043

MUC2024-043 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity

Item	Description
Considered For	Hospital Inpatient Quality Reporting Program; Hospital Value-Based Purchasing Program
Measure Description	The measure estimates the hospital-level, risk-standardized mortality rate (RSMR) for patients discharged from the hospital with a principal discharge diagnosis of acute ischemic stroke. The outcome is all-cause 30-day mortality, defined as death from any cause within 30 days of the index admission date, including in-hospital death, for stroke patients. The measure includes the National Institutes of Health (NIH) Stroke Scale as an assessment of stroke severity upon admission in the risk-adjustment model.
Developer/Steward	Centers for Medicare & Medicaid Services (CMS)
Measure Background	Measure currently used in a Medicare program, but the measure is undergoing substantive change

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
Outcome	Not Endorsed	Hospital Inpatient Quality Reporting Program	Facility

Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity

PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Inclusion of the Medicare Advantage population and reducing the reporting period to 2 years was viewed positively. Scientific acceptability and past performance of measure viewed as strengths.
  - **Concerns:** Concerns shared for potential for redundancy in data collection and purpose compared to excess days in acute care (EDAC) measures. Concern that the measure's focus is only on ischemic and not hemorrhagic strokes.
  - **Further consideration:** Members sought clarity on what specific clinical actions could be taken based on the measure to change stroke mortality and how risk-adjustment methodology was determined.
- **Appropriateness of Scale Themes**
  - **Support:** Members appreciated the updates to risk stratification and the attempts to broaden the population studied through the measure and ability to perform consistently for individuals with high comorbidity burdens.
  - **Concerns:** Concern that hospitals serving populations with higher burden of health disparities and risk for complications and mortality; may discourage hospitals from treating higher-risk populations.
- **Time-to-Value Realization Themes**
  - **Support:** Actionable improvements enabled by measure in near and long term, improving care and increasing cost savings. Measure seen as "mature" based on prior use.
  - **Concerns:** One member encourages the development of a FHIR-based digital quality measure for future maturation of this measure concept within the program.

Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity

Public Comment Summary

- **Received five public comments**
  - Two support and three concerns
- **Support summary:**
  - Inclusion of MA data is a significant advancement that enhances the relevance and applicability of measures, aiding in comprehensive quality measurement and continuous improvement in patient care.
- **Concern summary:**
  - Use of outdated data with a two-year lag may not accurately reflect current outcomes.
  - Further analysis needed to ensure data to ensure the accuracy and comparability of MA and fee-for-service data.
  - Reliability using the measure's case minimum of 25 patients is below desired threshold for high reliability (0.70).
  - Use of the Predicted to Expected ratio may not accurately reflect actual performance, and the facility-level hierarchical methodology limits detailed subgroup analysis crucial for targeted quality improvement.
  - Clarification needed regarding rationale for the scope of measures including MA data, questioning the selective inclusion across mortality and readmission measures.

Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity

Equity Considerations

Potential Impacts to Health Equity Associated with Measure Use

- IHI reviewers expressed concern that risk-standardized mortality rates may mask the complex drivers (e.g., acuity and sub-optimally managed co-occurring conditions; bias) that contribute to persisting disparities in favor of making performance look better than reality. This may ultimately result in a lack of motivation to better assess, understand, and address social drivers of health and community collaboration, and therefore negatively impact the capacity for this measure to address equity.
- IHI reviewers noted concerns raised by the TEP advisors regarding data quality, especially regarding the frailty measure/construct. When there are issues with data quality, it can potentially introduce bias into a model. Poorer data quality and/or missing data are more likely to occur in historically marginalized groups.

Potential Impacts to Health Equity Associated with Non-Use

IHI reviewers did not identify any impacts to health equity associated with non-use.

Considerations for Enhancing Health Equity

- IHI reviewers recommended stratification by race, sex, ethnicity, and language as an important approach to address documented disparities in post-discharge mortality rates, as an initial step.
- IHI cited the TEP's suggestion that "hospitals with larger disparities need support to provide better outcomes rather than economic penalties".

Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity

Discussion Topics

- What are the potential near- and long-term impacts of this measure (and the addition of Medicare Advantage beneficiaries) across provider and patient populations?
- How should this measure continue to mature through revisions in the future?

Break

Please return by 11:30 AM

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Measures – MUC2024-041, -046, -030, -032, 040, and -045

Equity Considerations

Potential Impacts to Health Equity Associated with Measure Use

IHI reviewers noted measurement and tracking of 30-day readmissions is important to ensure high quality care within acute settings, as well as post-discharge. Measurement can also incentivize approaches that optimize care transitions, which is especially important for individuals with more complex cases, who may need assistance to reconnect with their medical homes, equitable access to guidelines-directed medical therapy, and complex case management.

Potential Impacts to Health Equity Associated with Non-Use

IHI reviewers suggested non-use of these measures could perpetuate disparities in care, as hospitals would lack crucial data to identify areas of inequity in readmission rates.

Considerations for Enhancing Health Equity

- IHI reviewers recommended stratification by key demographic variables, such as race/ethnicity, socioeconomic status, geographic location, and dual enrollment status to allow hospitals and regulators to understand how different groups are affected by care practices and make targeted improvements.
- IHI reviewers noted that the measure TEP did not favor adjusting for race or social risk within the risk model due to concerns about the quality of available data to account for these factors. However, they did suggest exploring other data sources for social risk and assessing frailty and social risk for other measures more broadly).

Hospital-Level, 30-Day, Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

MUC2024-041

MUC2024-041 Hospital-Level, 30-Day, Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

Item	Description
Considered For	Hospital Readmissions Reduction Program
Measure Description	The measure estimates a hospital-level risk-standardized readmission rate (RSRR) following elective primary THA and/or TKA in Medicare Fee-For-Service (FFS) and/or Medicare Advantage (MA) beneficiaries who are 65 years and older. The outcome (readmission) is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission (the admission included in the measure cohort). A specified set of planned readmissions do not count in the readmission outcome.
Developer/Steward	Centers for Medicare & Medicaid Services (CMS)
Measure Background	Measure currently used in a Medicare program, but the measure is undergoing substantive change

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
Outcome	Endorsed	Hospital Readmissions Reduction Program	Facility

Hospital-Level, 30-Day, Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Inclusion of the Medicare Advantage (MA) population. Scientific acceptability and past performance of measure viewed as strengths.
  - **Concerns:** Concerns shared for potential for redundancy in data collection and purpose compared to EDAC measures. One member suggested measure should be retired in favor of EDAC measure.
  - **Further consideration:** Member expressed interest in focusing more precisely on “preventable” readmissions, indicating a desire for more refined and effective measurement criteria.
- **Appropriateness of Scale Themes**
  - **Support:** Measure is regarded as “highly appropriate” and aligns with the goal to decrease readmissions, with emphasis on equity across populations. Use could advance better understanding of barriers to care across subpopulations.
  - **Concerns:** As more procedures move to outpatient settings, those remaining in the inpatient framework may present a higher risk of complications and readmissions. Concern that hospitals serving populations with higher burden of health disparities and risk for complications may be penalized for complications unrelated to surgery.
- **Time-to-Value Realization Themes**
  - **Support:** Actionable improvements enabled by measure in near and long term, improving care and increasing cost savings. Measure seen as “mature” based on prior use.
  - **Concerns:** Concerns were raised about possible delays and the need for additional investments due to incorporating MA in the near term.

Hospital-Level, 30-Day, Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

Public Comment Summary

- **Received six public comments**
  - One support and five concerns
- **Support summary:**
  - Inclusion of MA data has potential to enhance data reporting and improve policy and care by providing a comprehensive view of Medicare beneficiaries for better policy-making and patient care improvement
- **Concern summary:**
  - Unclear implications of including MA beneficiaries warrants further analysis to ensure data accuracy and comparability with fee-for-service data.
  - Including MA beneficiaries may alter scores and penalties, affecting hospital performance metrics and requiring detailed analysis and transparency.
  - Moderate reliability suggests measure may not be effective in distinguishing hospital performance and driving improvements.
  - Challenges in evaluating 30-day readmission rates may unfairly penalize hospitals, especially small hospitals with low patient volumes.
  - Methodology is payment-oriented, with a two-year data lag potentially misrepresenting current outcomes and affecting risk adjustment.
  - Need for adequate risk adjustment, particularly considering social determinants of health, to prevent unfair penalization of hospitals serving vulnerable populations.

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery

MUC2024-046

MUC2024-046 Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery

Item	Description
Considered For	Hospital Readmissions Reduction Program
Measure Description	This measure estimates a hospital-level, 30-day risk-standardized readmission rate (RSRR) for patients discharged from the hospital after a qualifying isolated coronary artery bypass graft (CABG) surgery. Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm.
Developer/Steward	Centers for Medicare & Medicaid Services (CMS)
Measure Background	Measure currently used in a Medicare program, but the measure is undergoing substantive change

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
Outcome	Endorsed	Hospital Readmissions Reduction Program	Facility

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery

PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Members recognized the measure's potential in bolstering postoperative care and reducing hospital readmissions.
  - **Concerns:** Concerns were raised about the measure's redundancy and feasibility of data collection. Potential for "gaming" the measure also raised.
  - **Further consideration:** Clarification about changes in the cohort and variable re-selection were requested for greater assurance of measure accuracy.
- **Appropriateness of Scale Themes**
  - **Support:** Members acknowledge the benefits and potential for use in clinical practice, highlighting the measure's inclusivity, risk-adjustment techniques, and capacity to generate actionable information for patient care for variety of patient groups.
  - **Concerns:** Concerns shared about potential for unintended consequences of the measure's use over time, including inappropriate shifting of care, and increased patient morbidity and mortality.
- **Time-to-Value Realization Themes**
  - **Support:** Measure impacts include providing actionable insights that incentivize quick improvements to patient care in both near and long term.
  - **Concerns:** Concerns were raised about possible delays and the need for additional investments due to incorporating MA in the near term, and other members did not feel they had enough information to comment on this criterion.

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery

Public Comment Summary

- **Received six public comments**
  - One support and five concerns
- **Support summary:**
  - Inclusion of MA data enhances data reporting and improves policy and care by providing a comprehensive view of Medicare beneficiaries, aiding in better policy-making and continuous improvement in patient care.
- **Concern summary:**
  - Unclear and insufficient data regarding MA beneficiaries warrants further analysis to ensure accuracy and comparability with fee-for-service data.
  - Including MA beneficiaries may alter scores and penalties, affecting hospital performance metrics and requiring detailed analysis and transparency.
  - Low reliability suggests measure by not be effective in distinguishing hospital performance and driving improvements.
  - Challenges with evaluating 30-day readmission rates may unfairly penalize hospitals, especially small hospitals with low patient volumes.
  - Methodology more suited for payment purposed than quality, with a two-year data lag potentially misrepresenting current outcomes and affecting risk adjustment.

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization

MUC2024-030

MUC2024-030 Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization

Item	Description
Considered For	Hospital Readmissions Reduction Program
Measure Description	The measure estimates a hospital-level 30-day, all-cause, risk-standardized readmission rate (RSRR) for patients aged 65 and older discharged from the hospital with a principal diagnosis of acute myocardial infarction (AMI). Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm.
Developer/Steward	Centers for Medicare & Medicaid Services (CMS)
Measure Background	Measure currently used in a Medicare program, but the measure is undergoing substantive change

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
Outcome	Endorsed	Hospital Readmissions Reduction Program	Facility

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization

PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Members support measure's alignment with clinical intent, target population of the program, and validity with addition of MA population.
  - **Concerns:** Concerns were raised about the measure's redundancy and feasibility of data collection. Potential for "gaming" the measure also raised.
  - **Further consideration:** Clarification about changes in the cohort and variable re-selection were requested for greater assurance of measure accuracy.
- **Appropriateness of Scale Themes**
  - **Support:** Inclusion of MA improves appropriateness of scale by being more representative of a greater patient population affected by this condition.
  - **Concerns:** Concerns shared about representativeness and potential bias toward specific subpopulations as well as the measure's implications on smaller and rural hospitals. Concern shared that the adjustment model is still missing the downstream social risks that result in some patients presenting to an acute care facility vs an inpatient facility.
- **Time-to-Value Realization Themes**
  - **Support:** Measure impacts include providing actionable insights that incentivize quick improvements to patient care in both near and long term. Inclusion of MA population may enable future enhancements and interoperability.
  - **Concerns:** Concerns were raised about possible delays and the need for additional investments due to incorporating MA in the near term, and other members did not feel they had enough information to comment on this criterion.

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization

Public Comment Summary

- **Received six public comments**
  - One support and five concerns
- **Support summary:**
  - Inclusion of MA data has potential to enhance quality measurement across Medicare groups, improve policy-making and patient care improvement.
- **Concern summary:**
  - Unclear and insufficient data regarding MA beneficiaries warrants further analysis to ensure data accuracy and comparability with fee-for-service data.
  - Including MA beneficiaries may alter scores and penalties affecting hospital performance metrics and necessitating detailed analysis and transparency.
  - Low reliability suggests measure may not distinguish hospital performance making it ineffective in driving improvements.
  - Challenges in evaluating 30-day readmission rates may unfairly penalize hospitals, particularly small hospitals with low patient volumes.
  - Methodology is payment-oriented, with a two-year data lag potentially misrepresenting current outcomes and affecting risk adjustment.

Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization

MUC2024-032

MUC2024-032 Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization

Item	Description
Considered For	Hospital Readmissions Reduction Program
Measure Description	This measure estimates a hospital-level, 30-day risk-standardized readmission rate (RSRR) for patients discharged from the hospital with a principal discharge diagnosis of heart failure (HF). Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm.
Developer/Steward	Centers for Medicare & Medicaid Services (CMS)
Measure Background	Measure currently used in a Medicare program, but the measure is undergoing substantive change

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
Outcome	Endorsed	Hospital Readmissions Reduction Program	Facility

Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization
PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Members support measure's alignment with clinical intent and target population of the program with addition of MA population. Scientific acceptability and feasibility also highlighted as strengths by several members.
  - **Concerns:** Concerns were raised about the measure's redundancy and feasibility of data collection. Concern that the existing EDAC measure fills the same purpose.
  - **Further consideration:** Clarification about changes in the cohort and variable re-selection were requested for greater assurance of measure accuracy.
- **Appropriateness of Scale Themes**
  - **Support:** Support for measure's capacity to analyze subpopulations, which could lead to more targeted and effective health care interventions.
  - **Concerns:** Concerns shared that measure lacks sufficient evidence base and testing in sub-populations such as rural facilities. Concern that addition of MA patients may contribute to "overlooking" of other populations such as those who are uninsured. Consideration should be given to incorporating the common condition data element (CCDE) for hybrid risk adjustment of this measure.
- **Time-to-Value Realization Themes**
  - **Support:** Measure impacts include providing actionable insights that incentivize quick improvements to patient care in both near and long term. Inclusion of MA population may enable future enhancements and interoperability.
  - **Concerns:** Several members did not feel they had enough information to comment on this criterion. Others suggested that this measure may widen performance gap.

Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization
Public Comment Summary

- **Received four public comments**
  - One support and three concerns
- **Support summary:**
  - Inclusion of MA data has potential to enhance quality measurement across Medicare groups, improving policy-making and patient care improvement.
- **Concern summary:**
  - Unclear and insufficient data regarding MA beneficiaries warrants further analysis to ensure accuracy and comparability with fee-for-service data.
  - Including MA beneficiaries may alter scores and penalties, affecting hospital performance metrics and requiring detailed analysis and transparency.
  - Low reliability suggests measure may not distinguish hospital performance, making it ineffective in driving improvements.
  - Challenges in evaluating 30-day readmission rates is may unfairly penalize hospitals unfairly, especially small hospitals with low patient volumes.
  - Methodology is payment-oriented, with a two-year data lag potentially misrepresenting current outcomes and affecting risk adjustment.

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization

MUC2024-040

MUC2024-040 Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization

Item	Description
Considered For	Hospital Readmissions Reduction Program
Measure Description	The measure estimates a hospital-level 30-day, all-cause, risk-standardized readmission rate (RSRR) for patients aged 65 and over discharged from the hospital with either a principal discharge diagnosis of COPD or a principal discharge diagnosis of respiratory failure with a secondary diagnosis of acute exacerbation of COPD. The outcome (readmission) is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission (the admission included in the measure cohort).
Developer/Steward	Centers for Medicare & Medicaid Services (CMS)
Measure Background	Measure currently used in a Medicare program, but the measure is undergoing substantive change

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
Outcome	Endorsed	Hospital Readmissions Reduction Program	Facility

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization

PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Measure has history of use within program with acceptable performance, has potential benefits of reducing readmissions in added MA population, and has acceptable validity, conformance, and usability.
  - **Concerns:** Concerns were raised about the measure's reliability in testing data and feasibility of data collection. Also concern raised about whether all readmissions or only preventable ones should be tracked. Concerns were raised about the impact of stratifying data based on dual eligibility and effect on hospital scores for those who serve a high volume of dual-eligible patients.
  - **Further consideration:** Request for additional information or clarity on how modification impacts the measure's risk-adjusted rates and overall effectiveness accuracy.
- **Appropriateness of Scale Themes**
  - **Support:** Measure closes the quality gap that now exists between beneficiaries who have FFS plans vs. those with MA plans. Extending the measure to include MA patients could improve safety for this population who may have experienced premature discharges leading to more readmissions.
  - **Concerns:** Measure lacks sufficient evidence base and testing in sub-populations such as patients at rural facilities and within the MA population nationally to avoid widening gaps.
- **Time-to-Value Realization Themes**
  - **Support:** Measure impacts include providing actionable insights that incentivize quick improvements to patient care in both near and long term.
  - **Concerns:** Long-term sustainability and effectiveness of the measure are questioned due to the lack of consistent improvement in COPD readmission rates and interventions for this measure target.

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization

Public Comment Summary

- **Received five public comments**
  - One support and four concerns
- **Support summary:**
  - Inclusion of MA data has potential to enhance quality measurement across Medicare groups, improving policy-making and patient care improvement.
- **Concern summary:**
  - Unclear and insufficient data regarding MA beneficiaries warrants further analysis to ensure accuracy and comparability with fee-for-service data
  - Including MA beneficiaries may alter scores and penalties, affecting hospital performance metrics and requiring detailed analysis and transparency.
  - Low reliability suggests measure may not distinguish hospital performance, making it ineffective in driving improvements.
  - Challenges in evaluating 30-day readmission rates is may unfairly penalize hospitals unfairly, especially small hospitals with low patient volumes.
  - Methodology is payment-oriented, with a two-year data lag potentially misrepresenting current outcomes and affecting risk adjustment.

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization

MUC2024-045

MUC2024-045 Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization

Item	Description
Considered For	Hospital Readmissions Reduction Program
Measure Description	The measure estimates a hospital-level 30-day, all-cause, risk-standardized readmission rate (RSRR) for patients aged 65 and older discharged from the hospital with either a principal discharge diagnosis of pneumonia (including aspiration pneumonia) or a principal discharge diagnosis of sepsis (not severe sepsis) with a secondary diagnosis of pneumonia (including aspiration pneumonia) coded as present on admission (POA).
Developer/Steward	Centers for Medicare & Medicaid Services (CMS)
Measure Background	Measure currently used in a Medicare program, but the measure is undergoing substantive change

Measure Type	Endorsement Status	Current Program Use	Level of Analysis
Outcome	Endorsed	Hospital Readmissions Reduction Program	Facility

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization
PIE Form Feedback

- **Meaningfulness Themes**
  - **Support:** Members support measure's alignment with clinical intent and the target population of the program with addition of MA population.
  - **Concerns:** Concerns were raised about the measure's redundancy and overlap with existing EDAC measure. One member also shared concern that measure may be too broad by calculating an all-case readmission rate versus a pneumonia-specific readmission rate.
  - **Further consideration:** Request for more specificity concerning why the measure includes all-cause readmissions instead of being condition specific to pneumonia.
- **Appropriateness of Scale Themes**
  - **Support:** Members see the inclusion of MA as beneficial for expanding the demographic coverage of the measure, potentially leading to improved care for subgroups.
  - **Concerns:** Questions raised whether risk-adjustment model coefficients would apply effectively across both traditional Medicare and MA populations and if testing was sufficient to prove effectiveness in MA population. Rural and smaller health care facilities might face challenges due to limited resources, creating potential inequities.
- **Time-to-Value Realization Themes**
  - **Support:** Implementation of the measure is perceived as straightforward, as it leverages existing data collection systems without adding additional burdens to hospital staff.
  - **Concerns:** Concerns expressed that lag in reporting across years may make this measure non-actionable by hospitals truly interested in performance improvement.

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization
Public Comment Summary

- **Received five public comments**
  - One support and four concerns
- **Support summary:**
  - Inclusion of MA data enhances data reporting and improves policy and care by providing a comprehensive view of Medicare beneficiaries, aiding in better policy-making and continuous improvement in patient care.
- **Concern summary:**
  - Unclear and insufficient data regarding MA beneficiaries warrants further analysis to ensure accuracy and comparability with fee-for-service data.
  - Including MA beneficiaries may alter scores and penalties, affecting hospital performance metrics and requiring detailed analysis and transparency.
  - Low reliability suggests measure may not be effective in distinguishing hospital performance and driving improvements.
  - Challenges in evaluating 30-day readmission rates may unfairly penalize hospitals, especially small hospitals with low patient volumes.
  - Methodology is payment-oriented, with a two-year data lag potentially misrepresenting current outcomes and affecting risk adjustment.

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization
Discussion Topics

- What are the potential near- and long-term impacts of this measure (and the addition of Medicare Advantage beneficiaries) across provider and patient populations?
- How should this measure continue to mature through revisions in the future?

Next Steps

Kate Buchanan

PRMR Recommendation Report

Following the PRMR Recommendation Group review, Battelle synthesizes the results into a report for CMS.

The report includes:

- Vote counts and the rationales for recommendations
- Committee and interested parties' concerns or areas of dissent

The report is submitted to CMS and posted on the PQM website.

2025 PRMR Events

Event	Dates
Virtual Clinician Recommendation Group Meeting	**1/21/2025** 10:00 AM-4:30PM ET **1/22/2025** 10:00 AM-3:15PM ET
Public Comment on Final Recommendations	2/3/2025-2/17/2025
2025 Call for Nominations: PQM Committees	June–July 2025

Questions or Comments?

Contact us at p4qm.org/contact
or by emailing PQMsupport@battelle.org


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