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National Consensus Development and Strategic Planning for Health Care Quality Measurement

Spring 2024 Cycle Endorsement and Maintenance (E&M) Technical Report

INITIAL RECOGNITION AND MANAGEMENT

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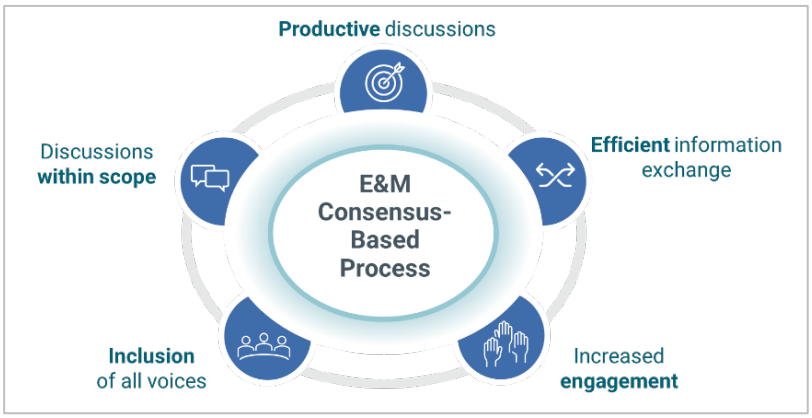
Executive Summary

For over 2 decades, the United States (U.S.) has focused on improving health care quality for Americans. One of the ways this has been done is by developing and implementing clinical quality measures to quantify the quality of care provided by health care providers and organizations. These clinical quality measures are based on standards related to the effectiveness, safety, efficiency, person-centeredness, equity, and timeliness of care.[1]

Figure 1. E&M Consensus-Based Process



At Battelle, we have a strong collective interest in ensuring that the health care system works as well as it can. Quality measures are used to support health care improvement, benchmarking, and accountability of health care services and to identify weaknesses, opportunities, and disparities in care delivery and outcomes.[1,2] Battelle is a certified consensus-based entity (CBE) funded through the Centers for Medicare & Medicaid Services (CMS) National Consensus Development and Strategic Planning for Health Care Quality Measurement Contract. As a CMS-certified CBE, we facilitate the review of quality measures for endorsement. To support our consensus-based process, we formed the Partnership for Quality Measurement (PQM), which ensures informed and thoughtful endorsement reviews of quality measures across a range of focus areas that align with a person's journey through the health care system. Battelle engages PQM members to carry out the consensus-based E&M process, which relies on robust and focused discourse, efficient information exchange, effective engagement, inclusion of diverse voices (Figure 1).

One of those focus areas is the initial recognition and management, which includes measures that focus on early signs and symptoms of diseases, emphasizing early stage management. As chronic disease rates rise in the U.S., ensuring quality care is crucial. Early detection and management of disease can lower mortality, reduce health care costs, and improve quality of life. The spring 2024 cycle measures focused on malnutrition, kidney health in diabetic patients, cardiovascular disease (CVD) assessment in pregnant and postpartum patients, and pharmacotherapy use for opioid use disorder.

Each measure focus area highlights a gap in quality care. Over 30% of hospitalized patients suffer from malnutrition, leading to worse health outcomes, increased health care costs,[3] and avoidable resource use (e.g., readmissions).[4] One in three people with diabetes have kidney disease.[5] Screening for kidney disease is crucial, as early detection can prevent or delay kidney failure, improving health outcomes. Because over 11% of the U.S. population is diabetic, such screening is vital.[6] Screening for cardiovascular disease (CVD) in pregnant and postpartum

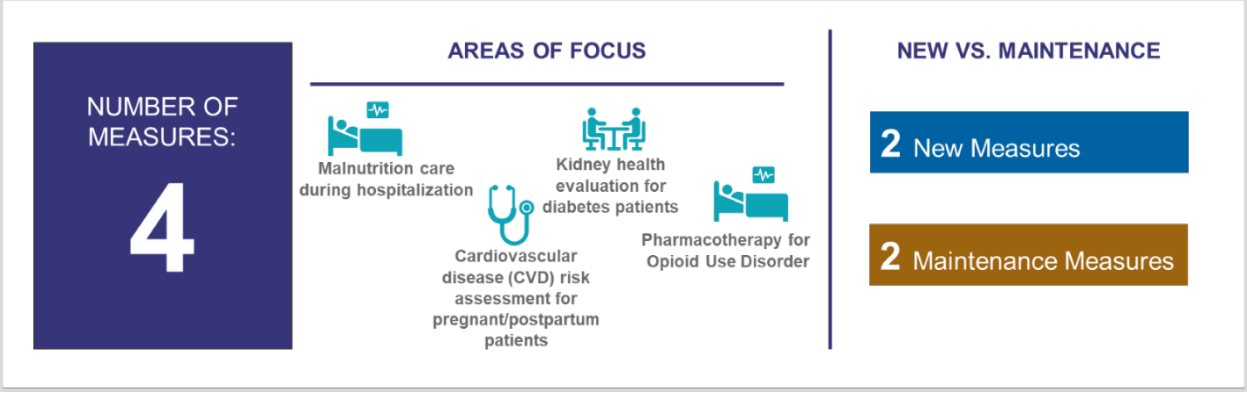
women also is essential, as CVD is a leading cause of maternal mortality, accounting for over 26% of cases.[7] Cardiovascular disease is also associated with increased maternal morbidity and preterm birth.[8] Early detection and management can reduce severe complications, improving maternal and fetal health. Lastly, with up to 7.6 million Americans experiencing opioid use disorder, appropriate treatment, such as medication assistance, is necessary.[9] Treatment can reduce opioid use, decrease overdose risk, and help retain people in treatment.[10]

For this measure review cycle, developers submitted five measures to the Initial Recognition and Management committee for endorsement consideration. A measure steward withdrew one measure that was up for maintenance endorsement review (Table 5). Of the four remaining measures reviewed by the committee (Figure 2), the committee endorsed two measures with conditions based on the PQM Measure Evaluation Rubric of version 1.2 of the E&M Guidebook. The committee did not reach consensus on the last two measures, which resulted in the measures not being endorsed (Table 1).

Table 1. Measures Reviewed by the Initial Recognition Committee

CBE Number	Measure Title	New/Maintenance	Developer/Steward	Final Endorsement Decision
3400	Use of Pharmacotherapy for Opioid Use Disorder	Maintenance	The Lewin Group/ Centers for Medicare & Medicaid Services (CMS)	Endorsed with Conditions
3592e	Global Malnutrition Composite Score	Maintenance	Commission on Dietetic Registration	Endorsed with Conditions
4315e	Kidney Health Evaluation	New	National Kidney Foundation	Not Endorsed due to No Consensus
4360	CVD Risk Assessment Measure – Proportion of Pregnant/Postpartum Patients Who Receive a CVD Risk Assessment with a Standardized Tool	New	University of California, Irvine	Not Endorsed due to No Consensus

Figure 2. Spring 2024 Measures for Committee Review

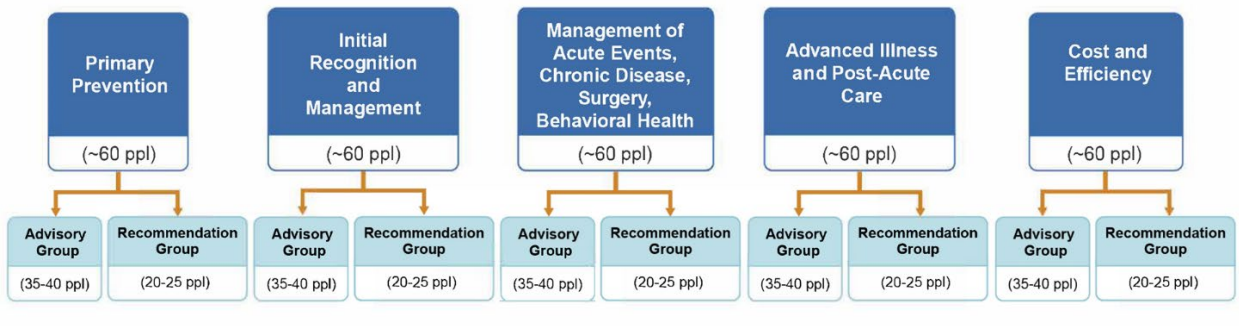


Endorsement and Maintenance (E&M) Overview

Battelle's E&M process ensures measures submitted for endorsement are evidence based, scientifically sound, and both safe and effective, meaning use of the measure will increase the likelihood of desired health outcomes; will not increase the likelihood of unintended, adverse health outcomes; and is consistent with current professional knowledge.

We organize measures for E&M by five project areas. Each project topical area has a committee that evaluates, discusses, and assigns endorsement decisions for measures under endorsement review. These E&M committees are composed of diverse PQM members, representing all facets of the health care system. Each E&M committee is divided into an Advisory Group and a Recommendation Group (Figure 3).

Figure 3. E&M Committee Structure



The goal is to create inclusive committees that balance experience, expertise, and perspectives. The E&M process convenes and engages interested parties throughout the cycle. The interested parties include those who are impacted or affected by quality and cost/resource use and represent a diverse group of people and perspectives (Figure 4).

Figure 4. E&M Interested Parties

For the Initial Recognition and Management committee, membership for the Spring 2024 cycle consisted of six patient partners (e.g., patients, caregivers, advocates) and 20 clinicians with specialties in family medicine, emergency medicine, cardiovascular

medicine, and others (Figure 5). The committee also included four experts in rural health and eight in health equity.

While a list of committee members is provided in Appendix A, full committee rosters and bios are posted on the respective project pages on the PQM website.

Figure 5. Initial Recognition Committee Members

At the beginning of each E&M cycle, committee members complete a measure-specific disclosure of interest (MS-DOI) form identifying potential conflicts with the measures under endorsement review for the respective E&M cycle. Members are recused from voting on measures potentially affected by a perceived conflict of interest (COI) based on Battelle's COI policy.

Each E&M cycle (i.e., Fall or Spring) has a designated Intent to Submit deadline, when measure developers/stewards must submit key information (e.g., measure title, type, description, specifications) about the measure. One month after the Intent to Submit deadline (Table 2), measure developers/stewards submit the full measure information by the respective Full Measure Submission deadline.

Table 2. Intent to Submit and Full Measure Submission Deadlines by Cycle

E&M Cycle	Intent to Submit*	Full Measure Submission*
Fall	October 1	November 1
Spring	April 1	May 1

**Deadlines are set at 11:59 p.m. (ET) of the day indicated. If the deadline falls on a weekend or holiday, the deadline will be the next immediate business day.*

We then publish measures to the PQM website for a 30-day public comment period, which occurs prior to the endorsement meeting and concurrently with the development of the E&M staff preliminary assessments. The intent of this comment period is to solicit both supportive and non-supportive comments with respect to the measures under endorsement review. Any interested party may submit a comment on any of the measures up for endorsement review for a given cycle (i.e., Fall or Spring). Prior to the close of the public comment period, we host Public Comment Listening Sessions to gather additional public comments on the measures; these virtual sessions are organized by project and grouped by topic/condition. Any interested party may attend to give a brief verbal statement on one or more of the measures.

All public comments received during this 30-day period, including those shared during the Public Comment Listening Sessions, are posted to the respective measure page on the PQM website.

A summary of the comments received for the measures submitted to Initial Recognition and Management for the Spring 2024 cycle is provided below.

Following the Public Comment Listening Sessions, we convene the Advisory Group of each E&M project for a public virtual meeting. The purpose of this meeting is to gather initial feedback and questions about the measures under endorsement review. We summarize the feedback and questions received from the Advisory Group members and share that information, along with all public comments received, with developers/stewards for review and written response. For Initial Recognition and Management, the Advisory Group convened on June 4, 2024, and a summary of the member feedback and developer/steward responses is published on the PQM website.

Prior to the Recommendation Group endorsement meeting, we share the full measure submission details, including all attachments, the PQM Measure Evaluation Rubric, the staff preliminary assessments, the public comments, Advisory Group feedback, and the developer/steward responses with the Recommendation Group for review. For Initial Recognition and Management, the Recommendation Group convened on July 29, 2024. Brief summaries of the Recommendation Group deliberations and voting results are provided below, while a detailed meeting summary is available on the PQM website.

During the endorsement meeting, the Recommendation Group focuses their discussions on key themes identified from the public comments, the Advisory Group meetings, the associated developer/steward responses, independent reviews, and the E&M project staff preliminary assessments. Measure developers/stewards attend endorsement meetings to provide a measure overview and answer questions. The Recommendation Group considers the various inputs and renders a final endorsement decision via a vote. Consensus is reached when there is 75% or greater agreement among all active, non-recused Recommendation Group members (Table 3). However, if no consensus is reached, the measure is not endorsed due to no consensus.

Table 33. Endorsement Decision Outcomes

Decision Outcome	Description	Maintenance Expectations
Endorsed	**Applies to new and maintenance measures.** The E&M committee agrees by 75% or more to endorse the measure.	Measures undergo maintenance of endorsement reviews every 5 years with a status report review at 3 years (*see Evaluations for Maintenance Endorsement for more details*).± Developers/stewards may request an extension of up to 1 year (two consecutive cycles), except if it has been more than 6 years since the measure's date of last endorsement.

Decision Outcome	Description	Maintenance Expectations
Endorsed with Conditions*	**Applies to new and maintenance measures**. The E&M committee agrees by 75% or greater that the measure can be endorsed, as it meets the criteria, but committee reviewers have conditions they would like addressed when the measure comes back for maintenance. If these recommendations are not addressed, the developer/steward should provide a rationale for consideration by the E&M committee review.	Measures undergo maintenance of endorsement reviews every 5 years with a status report at 3 years, unless the condition requires the measure to be reviewed earlier (*see Evaluations for Maintenance Endorsement for more details*). The E&M committee evaluates whether conditions have been met, in addition to all other maintenance endorsement minimum requirements.
Not Endorsed°	**Applies to new measures only**. The E&M committee agrees by 75% or greater to not endorse the measure.	None
Endorsement Removed°	**Applies to maintenance measures only.** Either: • The E&M committee agrees by 75% or greater to remove endorsement; or • A measure steward retires a measure (i.e., no longer pursues endorsement); or • A measure steward never submits a measure for maintenance, and the steward does not respond after targeted outreach; or • There is no longer a meaningful gap in care, or the measure has topped out (i.e., no significant change in measure results for accountable entities over time).	None

±Maintenance measures may be up for endorsement review earlier if an emergency/off-cycle review is needed (see Emergency/Off-Cycle Reviews for more details).

**Conditions are determined by the E&M committee, with the consideration as to what is feasible and appropriate for the developer/steward to execute by the time of maintenance endorsement review.*

°Measures that fail to reach the 75% consensus threshold are not endorsed.

The "Endorsed with Conditions" category serves as a means of endorsing a measure but with conditions set by the Recommendation Group. These conditions take into consideration what is feasible and appropriate for the developer/steward to execute by the time of maintenance endorsement review.

After the E&M endorsement meeting, committee endorsement decisions and associated rationales are posted to the PQM website for 3 weeks, which serves as the appeals period. During this time, any interested party may request an appeal regarding any E&M committee

endorsement decision. If a measure's endorsement, including an "Endorsed with Conditions" decision, is being appealed, the appeal must:

- Cite evidence the appellant's interests are directly and materially affected by the measure, and provide evidence that the CBE's endorsement of the measure has had, or will have, an adverse effect on those interests; and
- Cite the existence of a CBE procedural error or information that was available by the cycle's Intent to Submit deadline but was not considered by the E&M committee at the time of the endorsement decision that is reasonably likely to affect the outcome of the original endorsement decision.

In the case of a measure not being endorsed, the appeal must be based on one of two rationales:

- The CBE's measure evaluation criteria were not applied appropriately. For this rationale, the appellant must specify the evaluation criteria they believe were misapplied.
- The CBE's E&M process was not followed. The appellant must specify the process step, how it was not followed properly, and how this resulted in the measure not being endorsed.

If Battelle determines that an appeal is eligible, we convene the Appeals Committee, consisting of the co-chairs from all five E&M project committees (n=10), to review and discuss the appeal. The Appeals Committee concludes its review of an appeal by voting to uphold (i.e., overturn a committee endorsement decision) or deny (i.e., maintain the endorsement decision) the appeal. Consensus is determined to be 75% or greater agreement via a vote among members.

For the Spring 2024 cycle, the appeals period opened on August 30 and closed on September 20, 2024. No appeals were received for the measures reviewed by the Initial Recognition and Management committee.

Initial Recognition and Management Measure Evaluation

For this measure review cycle, the Initial Recognition and Management committee evaluated two new measures and two measures undergoing maintenance review against standard measure evaluation criteria. During the Recommendation Group endorsement meeting, the committee voted to endorse two measures with conditions and did not reach consensus on two measures, which resulted in the measures not being endorsed (Table 4).

Table 44. Number of Spring 2024 Initial Recognition and Management Measures

	Maintenance	New	Total
Number of measures submitted for endorsement review	3	2	5
Number of measures withdrawn from consideration*	1	0	1
Number of measures reviewed by the committee	2	2	4
Number of measures endorsed	0	0	0
Number of measures endorsed with conditions	2	0	2
Number of measures not endorsed/ endorsement removed	0	2	2

**Measure developers/stewards can withdraw a measure from measure endorsement review at any point before the committee endorsement meeting. Table 4 provides a summary of withdrawn measures.*

Table 55. Measures Withdrawn from Consideration

Measure Number	Measure Title	Developer/Steward	New/Maintenance	Reason for Withdrawal
2801	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	National Committee for Quality Assurance	Maintenance	Withdrawn by steward and deferred to future endorsement review cycle.

Public Comments Received Prior to Committee Evaluation

Battelle accepts comments on measures under endorsement review through the PQM website. For this evaluation cycle, the public comment period opened on May 16, 2024, and closed on June 14, 2024, during which time we hosted a Public Comment Listening Session on May 29, 2024. The measures received 65 public comments, and Battelle published the comments to the respective measure pages on the PQM website. If a measure received any comments, they are summarized under the measure's evaluation summary below, and developer/steward responses to public comments are available on the PQM website.

Summary of Potential High-Priority Gaps

During the committee's evaluation of the measures, committee members identified gap areas that are summarized below for future development and endorsement considerations.

Other At-Risk Populations

During the evaluation of CBE #3592e Global Malnutrition Composite Score, the committee discussed other populations that may be at risk for malnutrition but are not presently captured in the measure, such as pediatric populations and those in behavioral health settings. The developer responded that they recognize the uniqueness of these populations and will consider these groups in future iterations of the measure.

Kidney Evaluation in Persons with Hypertension

During the discussion of CBE #4315e Kidney Health Evaluation, the committee inquired why patients with hypertension were not included in the denominator, as the measure currently focuses on persons with diabetes. The developer responded that hypertension guidelines did not recommend urine albumin-to-creatinine ratio (uACR) when the measure was being developed. The developer will consider including individuals with hypertension, contingent upon updated guidelines from the American College of Cardiology and American Heart Association.

Summary of Major Concerns or Methodological Issues

The following brief summaries of the measure evaluations highlight the major concerns and/or methodological issues that the committee considered.

Outweighing Benefit vs. Cost and Burden

For CBE #4360, the Recommendation Group's major concerns revolved around the balance between the benefits of the measure and the associated costs and burdens of implementation. The Recommendation Group appreciated the developer's measure testing approach and the measure's logic model; however, they expressed concerns about the burden associated with the follow-up testing for CVD risk. This testing resulted in only a marginal increase in CVD diagnoses, which the Recommendation Group noted might have been identified by other methods, thus imposing unnecessary burdens on health care providers and patients.

The developer argued that standardized screening could improve resource use and diagnostic yields. However, the committee was skeptical about the impact of false positives and the lack of evidence that additional follow-up leads to better health outcomes or care experiences. They

also raised concerns about the emotional and financial burdens on patients receiving false positives, including emotional distress and increased health care costs. To mitigate these concerns, the Recommendation Group wanted to see evidence demonstrating clinical benefit of the measure beyond CVD diagnosis to justify additional follow-up testing burden.

Impact of Small Sample Sizes on Reliability and Validity

During the evaluation of #4315e, the Advisory and Recommendation Groups raised concerns with respect to small sample sizes skewing reliability testing results. The Recommendation Group noted that some data included providers with only one patient, which made the Recommendation Group question the measure's robustness. The developer reported minimal change in the results even after excluding clinicians with a sample size of one and expressed willingness to conduct further testing. To address these issues, the Recommendation Group suggested the developer establish a minimum sample size for analyses, as appropriate, to ensure more reliable and generalizable results. The Recommendation Group also suggested using statistical approaches, such as hierarchical or Bayesian modeling, to share information across groups or providers, improving estimates for those with smaller sample sizes by leveraging the larger dataset. Lastly, the developer may also consider increasing the sample size by combining data across similar providers, time periods, or patient groups to enhance the statistical power and reliability of the results.

With respect to validity, the Recommendation Group highlighted issues concerning the data element validity testing results, particularly at the two testing sites. The Recommendation Group pointed out that there was poor agreement for estimated glomerular filtration rate (eGFR) and urine albumin-to-creatinine ratio (uACR) due to small sample sizes, which compromised the validity of the results. In response, the developer acknowledged these concerns and explained that changes had been made to how the test's completion was verified. Instead of focusing on uACR, the new method captures urine concentration, which the developer believes could improve the validity of the testing process upon retesting. Despite this response, several Recommendation Group members remained concerned, noting that the issues extend beyond validity to include feasibility. The Recommendation Group felt that the small sample sizes also raise questions about the practical implementation of the measure and its ability to produce reliable and valid results consistently.

Measure Evaluation Summaries

CBE #3400 – Use of Pharmacotherapy for Opioid Use Disorder [The Lewin Group/ CMS] – Maintenance

Specifications | Discussion Guide

Description: The Use of Pharmacotherapy for Opioid Use Disorder measure evaluates the percentage of Medicaid or Medicare-Medicaid participants, aged 18 years and older, who have been diagnosed with an opioid use disorder (OUD) who filled a prescription for, were administered, or dispensed, a Food and Drug Administration (FDA)-approved medication to treat or manage OUD during the measurement year.

Committee Final Vote: Endorse with Conditions

Conditions: When the measure comes back for maintenance the developer should have:

- Explored the impact of patients in remission or who are on other forms of treatment on the performance results; and
- Assessed potential unintended consequences (e.g., discouraging use of other, non-pharmacological therapies) during implementation.

Vote Count: Endorse (8 votes; 44.44%), Endorse with Conditions (8 votes; 44.44%), Remove Endorsement (2 votes; 11.11%); Recusals (0).

Summary of Public Comments: The measure received one supportive public comment, which also asked if the developer had looked at Medicare Advantage, as older populations have a higher incidence of overdose. The developer noted that results from older adults dual enrolled in Medicaid and Medicare Advantage are presented within the Full Measure Submission form. Specifically, the over 65 age group and dual-eligible beneficiaries had much lower performance than their respective cohorts within the age and dual-eligibility status categories. Dual-eligible beneficiaries had a treatment rate of 8.3% versus a rate of 59.0% for non-dual-eligible beneficiaries, while those over age 64 had a treatment rate of only 3.8% versus rates ranging from 36.6% to 65.9% for younger age groups.

Summary of Measure Evaluation: This measure was last endorsed in Spring 2016 and is used in the CMS Merit-based Incentive Payment System and for quality improvement internal to the organization. The Advisory Group expressed concerns over encouraging the use of pharmacotherapy to the detriment of the patient themselves or other therapies that may already be working or be more appropriate for a certain patient. The developer noted that the goal of this measure is not to reach 100%, rather it is intended to provide information rather than penalization, as pharmacotherapy may not be appropriate for everyone. The Advisory Group also considered the broad array of care settings included in the measure and questioned who specifically would be held accountable under the measure. In addition, the Advisory Group considered why only Medicaid beneficiaries are included in the measure. The developer clarified that this is a state-level measure and does not specifically target a care setting. The developer also stated that the 2018 version of the measure focused primarily on Medicaid beneficiaries because of their contract's scope. However, this updated measure expands the population to include 18 years and older, which includes those that are dually enrolled in Medicare and

Medicaid. Lastly, the developer noted they do not have access to commercial claims data or alternative payments. The Recommendation Group also considered the potential for unintended consequences, including the diminishing of patient-provider relationships and accounting for patients who are using non-pharmacological treatment approaches. The developer stated that this measure is intended to gather information, not penalize, and the goal of the measure is not to reach 100% as pharmacotherapy may not be appropriate for all patients. Ultimately, the Recommendation Group recognized the measure's importance but expressed the need to further explore the potential for unintended consequences. The Recommendation Group therefore endorsed the measure with two conditions: to explore the impact of patients in remission or on other forms of treatment, and to assess potential unintended consequences during implementation.

Appeals: None.

Additional Recommendations for the Developer/Steward: None.

CBE #3592e – Global Malnutrition Composite Score [Commission on Dietetic Registration] – Maintenance

Specifications | Discussion Guide

Description: This composite measure assesses the percentage of hospitalizations for adults aged 18 years and older at the start of the inpatient encounter during the measurement period with a length of stay equal to or greater than 24 hours who received optimal malnutrition care during the current inpatient hospitalization where care performed was appropriate to the patient's level of malnutrition risk and severity. A version of this measure, assessing performance only for adults aged 65 years and older, is currently endorsed and active in the Hospital Inpatient Quality Reporting Program (IQR) program; this submission describes a substantive change in the measure, as the population is changed to all adults aged 18 and older.

Committee Final Vote: Endorse with Conditions

Conditions: When this measure comes back for maintenance, the committee would like to see:

- Implementation data (to include patients 18 years and older) that examines whether the measure is associated with improved nutritional status or related clinical endpoint.

Vote Count: Endorse (6 votes; 33.33%), Endorse with Conditions (10 votes; 55.55%), Remove Endorsement (2 votes; 11.11%); Recusals (1).

Summary of Public Comments: The measure received one public comment. The comment was supportive of the measure and recent changes made to the measure.

Summary of Measure Evaluation: This measure was last endorsed in Fall 2020 and is currently used for public reporting, regulatory and accreditation programs, and quality improvement. The Advisory and Recommendation Groups discussed feasibility and importance, highlighting the narrow focus, lack of coding on data element value sets, and added burden. Committee members expressed concerns that the measure does not adequately demonstrate improvement in patient outcomes. The developer responded that the measure is currently in its first year of reporting, so there is limited data on which to report. However, sites used in testing were very engaged hospitals with above-average performance, and as such the developer does not expect this measure to top out as it is implemented. The developer noted that the measure logic is continuously updated to ease burden, and, so far, the measure has been effectively built into the workflow of hospitals, including rural hospitals. The measure is intended to be a starting place to highlight malnutrition. The Recommendation Group agreed that this is an important topic to explore, and that malnutrition is closely related to social determinants of health concerns. The Recommendation Group placed a condition on the measure to see implementation data that examines whether the measure is associated with improved outcomes.

Appeals: None.

Additional Recommendations for the Developer/Steward: None.

CBE #4315e – Kidney Health Evaluation [National Kidney Foundation] – New

Specifications | Discussion Guide

Description: Percentage of patients aged 18-85 years with a diagnosis of diabetes who received a kidney health evaluation defined by an Estimated Glomerular Filtration Rate (eGFR) AND Urine Albumin-Creatinine Ratio (uACR) within the 12-month measurement period.

Committee Final Vote: Not Endorsed due to No Consensus

Vote Count: Endorse (7 votes; 38.89%), Endorse with Conditions (6 votes; 33.33%), Not Endorse (5 votes; 27.78%); Recusals (0).

Summary of Public Comments: The measure received four public comments. One comment was supportive. Two comments recommended the measure be modified by: 1) aligning with the National Committee for Quality Assurance (NCQA) Kidney Health Evaluation for Patients with Diabetes (KED) Healthcare Effectiveness Data and Information Set (HEDIS) measure, stating this will reduce provider burden; and 2) lowering the age limit to 75. One comment questioned whether the measure produces scores that are sufficiently reliable, as the minimum reliability was 0.42, which is below 0.7.

Summary of Measure Evaluation: During the evaluation of this new measure, the Advisory and Recommendation Groups discussed feasibility and expressed concerns with the numerator due to data element testing for the eGFR and uACR. Specifically, there was poor agreement for eGFR and uACR given small sample sizes. To address this, the developer noted that they changed how the test was verified as being completed, which was to capture urine concentration rather than uACR. The developer anticipates this change will improve the results of validity testing. Several Recommendation Group members remained concerned despite that reassurance, noting that the issues extend beyond validity to include feasibility. The committees also discussed reliability and exclusions. The Recommendation Group noted that the reliability testing included providers who had only one patient, which affected the results, and inquired about the exploration of minimum sample size in the analyses. The developer responded that there was no significant change when they excluded physicians with a low case count, but that they would be open to additional testing. The Recommendation Group also discussed other excluded elements, including patients with hypertension not being included in the denominator and an upper age limit of 85 years. Both choices were made by the developer to align with other industry recommendations. Ultimately, the measure was not endorsed due to no consensus. The Recommendation Group recommended the developer explore additional reliability results for small case counts as well as testing for numerator validity and feasibility.

Appeals: None.

Additional Recommendations for the Developer/Steward: Recommendation Group members requested the developer explore reliability results for clinicians with small case counts and consider implementing a minimum case count (n>1). In addition, the Recommendation Group wanted the developer to conduct additional testing to assess numerator validity (given the poor agreement for eGFR and uACR) and feasibility.

CBE #4360 – CVD Risk Assessment Measure – Proportion of Pregnant/Postpartum Patients Who Receive CVD Risk Assessment with a Standardized Tool [University of California, Irvine] – New

Specifications | Discussion Guide

Description: This measure determines the percentage of pregnant or postpartum patients at a given clinic who were assessed for cardiovascular disease (CVD) risk with a standardized tool, such as the CVD risk assessment algorithm developed by the California Maternal Quality Care Collaborative (CMQCC). The aim is to perform CVD risk assessment using a standardized tool on all (100%) eligible pregnant/postpartum patients.

Committee Final Vote: Not Endorsed due to No Consensus

Vote Count: Endorse (2 votes; 11.11%), Endorse with Conditions (6 votes; 33.33%), Not Endorse (10 votes; 55.55%); Recusals (0).

Summary of Public Comments: The measure received 61 public comments, the majority of which were from the developer organization. Fifty-nine of the comments were supportive, highlighting the potential to significantly reduce maternal mortality and improve health care quality by identifying high-risk cardiovascular conditions in pregnant and postpartum patients; that the integration of the tool into electronic health record (EHR) systems can streamline screening processes; and that early detection and management of CVD risk factors is important and can lead to timely and effective interventions. One commenter asked if the measure aligned with clinical guidelines on assessment frequency and noted a lack of clarity on performance gap and testing levels. The developer noted their commitment to ensuring the measure is based on rigorous clinical guidelines, clarifying the performance gap, and aligning testing levels with clinician analysis. The last comment said those using the measure should be allowed to modify the CMQCC risk-assessment tool with additional data or use a different tool, as the CQMCC tool includes African American race as a variable, which is a proxy for implicit bias rather than a biological variable. The developer appreciated the commenter's insights and agreed that ensuring flexibility and addressing implicit bias are invaluable.

Summary of Measure Evaluation: During the evaluation of this new measure, the Advisory and Recommendation Groups discussed cost and burden associated with the measure's use. The Advisory Group noted concerns about EHR integration, availability of paper forms, repetitive screenings, and unintended consequences. Both groups also questioned the measure's feasibility in rural settings, as the measure may not fully consider the limited resources available in maternity care deserts and rural settings. The Recommendation Group echoed concerns from the Advisory Group, including the potential cost and burden for additional follow-up testing. The developer responded that the recommendation is for a patient to be screened once, unless symptoms are present, at which time they should be screened again. A flag in the EHR system is removed once the patient is screened. The Recommendation Group noted that CVD may already be captured via other methods and that the increase in confirmed diagnoses from this measure is not currently outweighing the additional testing burden. They were also concerned that this measure incentivizes the use of a single risk-assessment tool, which is owned by the developer. The developer noted that their tool is the only tool that has been tested and validated for CVD risk assessment in pregnant and postpartum women. Although the committee recognized the importance of addressing CVD risk and maternal

mortality in the U.S., ultimately, they did not reach consensus and the measure was not endorsed.

Appeals: None.

Additional Recommendations for the Developer/Steward: Recommendation Group members expressed wanting to see information on how the measure performed in rural vs. urban settings. In addition, the Recommendation Group wanted to see evidence demonstrating clinical benefit of the measure beyond CVD diagnosis to justify additional follow-up testing burden.

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Appendix A: Initial Recognition and Management Committee Roster

Spring 2024 Cycle

Member	Affiliation/ Organization	Perspective(s)	Advisory/Recommendation Group
Patricia Merryweather-Arges *(Patient Representative Co-chair)*	Project Patient Care	Patient Partner	Recommendation
Matt Austin *(Non-Patient Representative Co-chair)*	Johns Hopkins Armstrong Institute for Patient Safety and Quality	Health Services Researcher	Recommendation
Abraham Jacob	University of Minnesota; M Health Fairview	Clinician; Facility/Institutional	Advisory
Arjun Venkatesh	Yale University School of Medicine; Yale New Haven Hospital	Health Services Researcher; Clinician; Other Interested Parties	Advisory
Ashley Comiskey	Baptist Health Paducah	Clinician; Facility/Institutional	Recommendation
Barbara Kivowitz	--	Patient Partner; Health Equity Expert	Advisory
Billy A. Caceres	Columbia University	Health Equity Expert; Clinician; Health Services Researcher	Advisory
Carol Sakala	National Partnership for Women & Families	Health Services Researcher; Other Interested Parties	Recommendation
Carole Hemmelgarn	MedStar Institute for Quality and Safety; Self and Patients for Patient Safety US	Patient Partner; Other Interested Parties	Advisory
Cecilia Purcell (Inactive)	--	Patient Partner	Recommendation
Danny Barker	Intermountain Health	Clinician; Facility/Institutional	Recommendation
Edward Bailly	Mount Sinai Health Partners	Facility/Institutional	Recommendation
Geeta Sood	Johns Hopkins Medical Center	Health Services Researcher; Clinician;	Recommendation

Member	Affiliation/ Organization	Perspective(s)	Advisory/Recommendation Group
		Facility/Institutional; Other Interested Parties	
Gregary Bocsi	Department of Pathology, University of Colorado Anschutz Medical Campus	Facility/Institutional; Clinician	Recommendation
Hannah Ingber	National Quality Forum	Other Interested Parties	Advisory
Helen Haskell	Mothers Against Medical Error	Patient Partner	Recommendation
Janet Hurley	CHRISTUS Health	Facility/Institutional; Clinician	Advisory
Janice Young	HCA Florida Ocala Health	Facility/Institutional; Clinician; Other Interested Parties	Advisory
Jean-Luc Tilly	The Leapfrog Group	Purchaser and Plan; Other Interested Parties	Recommendation
Jennifer Bailit	Case Western Reserve University	Clinician	Recommendation
Jill Blazier	Intermountain Health	Rural Health Expert; Clinician; Facility/Institutional	Recommendation
Juliet Bartsch	TNAA/INOVA Health System	Patient Partner; Clinician; Facility/Institutional	Advisory
Karen M. Fernandes	AYR Consulting Group	Patient Partner; Clinician	Recommendation
Karen Johnson	American Urological Association	Other Interested Parties; Health Services Researcher	Recommendation
Karen Joswick	Nemour's Children's Health	Facility/Institutional; Other Interested Parties	Recommendation
Kent Bream	University of Pennsylvania; Spectrum Health Services, Inc.	Clinician; Facility/Institutional; Health Equity Expert; Health Services Researcher	Advisory
Kobi Ajayi	Texas Department of State Health Services	Patient Partner; Health Equity	Advisory

Member	Affiliation/ Organization	Perspective(s)	Advisory/Recommendation Group
		Expert; Health Services Researcher; Other Interested Parties	
Kory Anderson	Intermountain Physician Advisor Services; McKay-Dee Hospital, Intermountain Health	Facility/Institutional; Clinician	Advisory
Kyle Campbell	Health Services Advisory Group, Inc.	Other Interested Parties; Clinician; Health Services Researcher	Recommendation
Lisa Leckrone	St. Mary Medical Center	Rural Health Expert; Facility/Institutional	Advisory
Marianne Kraemer	Sepsis Alliance	Health Equity Expert; Clinician	Recommendation
Mark Ellison	Elevance Health	Purchaser and Plan	Advisory
Oren Guttman	Jefferson Abington Health; Sidney Kimmel Medical College	Facility/Institutional; Clinician	Advisory
Pranali Trivedi (Inactive)	Ascension	Health Equity Expert; Facility/Institutional; Other Interested Parties	Recommendation
Raymund Dantes	Emory University School of Medicine; Centers for Disease Control and Prevention	Clinician; Facility/Institutional; Other Interested Parties	Advisory
Selena McCord	National Rural Health Resource Center	Rural Health Expert; Health Equity Expert; Other Interested Parties	Recommendation
Sheila Owens-Collins	Lexington-Fayette County Health Department	Clinician; Other Interested Parties	Advisory
Sherly Binu	RELI Group Inc	Other Interested Parties; Clinician; Facility/Institutional	Recommendation
Talia Sasson	University of Rochester School of Medicine and Dentistry	Clinician; Facility/Institutional; Other Interested	Advisory

Member	Affiliation/ Organization	Perspective(s)	Advisory/Recommendation Group
		Parties	
Tamaire Ojeda-Avila	Commission of Dietetic Registration	Other Interested Parties	Recommendation
Tammy Love	Oracle Health	Other Interested Parties; Clinician	Advisory
Thomas Spiegel	The University of Chicago Medicine	Facility/Institutional; Clinician; Other Interested Parties	Advisory
Usha Venugopal	NYC Health +Hospitals/Lincoln	Health Equity Expert; Clinician; Facility/Institutional	Advisory
Zainab Jah	Reproductive Health Impact: The Collaborative for Equity and Justice	Patient Partner; Health Equity Expert; Other Interested Parties	Advisory

Partnership for Quality Measurement Organizations

Battelle

Institute for Healthcare Improvement

Measure Stewards

Centers for Medicare & Medicaid Services

Committee on Dietetic Registration

National Kidney Foundation

University of California, Irvine

Measure Developers

The Lewin Group


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