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National Consensus Development and Strategic Planning for Health Care Quality Measurement

Final Fall 2023 Cycle Endorsement and Maintenance (E&M) Technical Report

MANAGEMENT OF ACUTE EVENTS AND CHRONIC ILLNESS

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Executive Summary

Over the past 20+ years, the United States (U.S.) has been focused on improving health care quality for Americans. Health care quality measures have increasingly been developed and used to facilitate this goal by quantifying the quality of care provided by health care providers and organizations based on various standards of care. These standards relate to the effectiveness, safety, efficiency, person-centeredness, equity, and timeliness of care.[1]

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.

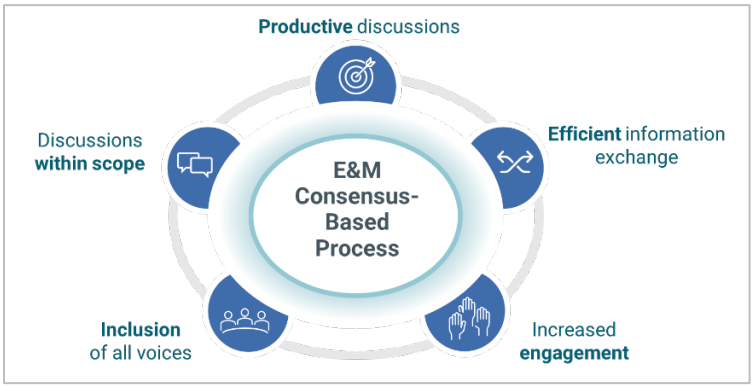

Figure ES-1. E&M Consensus-Based Process

One of those focus areas is the Management of Acute Events, Chronic Disease, Surgery, and Behavioral Health (Management of Acute Events and Chronic Illness), which includes measures that focus on the management of acute or chronic disease, including patient understanding of health care procedures and patient safety due to hospital harm and surgical complications. More than 3 million deaths occur every year due to hospital harm, and more than 50% of those instances are preventable. Not only do these events result in worse patient outcomes, but over a trillion dollars in associated costs are spent globally. Additionally, up to half of all hospital harm incidents are related to surgical care, and up to 25% of surgical patients will experience a complication related to their surgery. [4] [3]A contributing factor to improved recovery after surgery is patient understanding of post-surgical care. It has been shown that patients often misunderstand medical instructions given to them by their clinician. [5] Patient understanding is key to improving and maintaining positive health outcomes.

For this measure review cycle, 11 measures were submitted to the Management of Acute Events and Chronic Illness committee for endorsement consideration. Six measures, up for

maintenance endorsement review, were withdrawn by the measure steward prior to committee review and deferred to a future cycle (Table 4). Of the five measures reviewed by the committee (Figure ES-2), three were endorsed, one was endorsed with conditions, and endorsement was removed from one measure due to no consensus (Table ES-1).

Table ES-1. Measures Reviewed by the Committee

CBE Number	Measure Title	New/Maintenance	Developer/Steward	Final Endorsement Decision
0694	Hospital Risk-Standardized Complication Rate Following Implantation of Implantable Cardioverter-Defibrillator (ICD)	Maintenance	American College of Cardiology	Endorsement Removed due to No Consensus
4120e	Hospital Harm- Falls with Injury	New	AIR/CMS	Endorsed
4125	Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue)	New	AIR/CMS	Endorsed with Conditions
4130e	Hospital Harm- Postoperative Respiratory Failure	New	American Institutes for Research (AIR) / Centers for Medicare & Medicaid Services (CMS)	Endorsed
4210	Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measurement	New	Yale Center for Outcomes Research and Evaluation (Yale CORE) / CMS	Endorsed

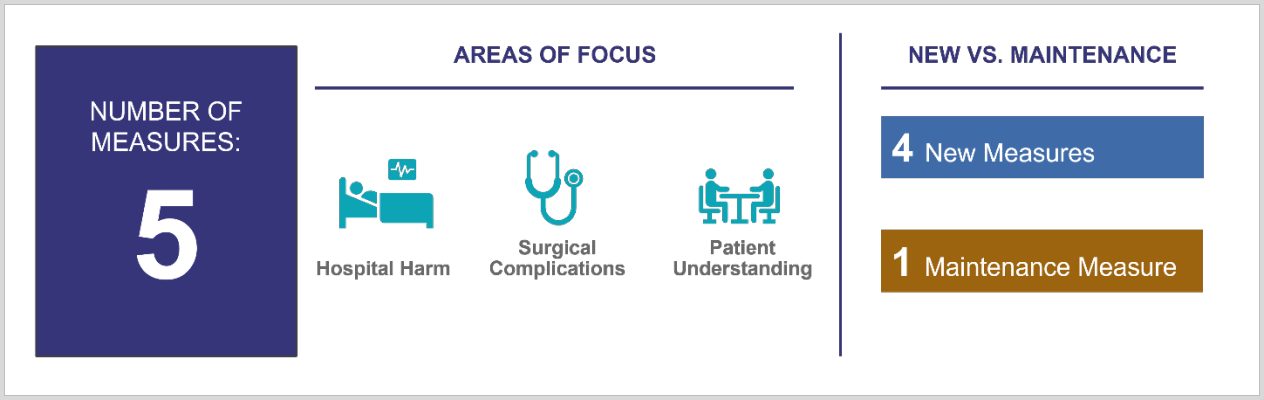

Figure ES-2. Fall 2023 Measures for Committee Review

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.

Each E&M cycle (e.g., Fall or Spring) has a designated Intent to Submit deadline, by which 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 1), measure developers/stewards submit the full measure information by the respective Full Measure Submission deadline.

The measures are then posted to the PQM website for a 30-day public comment period, which occurs prior to the endorsement meeting. The intent of this 30-day 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 (e.g., Fall or Spring). All public comments received during this 30-day period are posted to the respective measure page on the PQM website for full transparency. Summaries of the comments received for the measures submitted to the Management of Acute Events, Chronic Illness, Surgery and Behavioral Health are provided below. The committee considered all comments in its endorsement evaluation of the measures.

Table 1. 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 ends on a weekend or holiday, the deadline will be the next immediate business day.*

E&M committees are composed of diverse PQM members, representing all facets of the health care system. There are five E&M projects, each has a committee that evaluates, discusses, and assigns endorsement decisions for measures under endorsement review. Each E&M project committee is divided into an Advisory Group and a Recommendations Group (Figure 1).

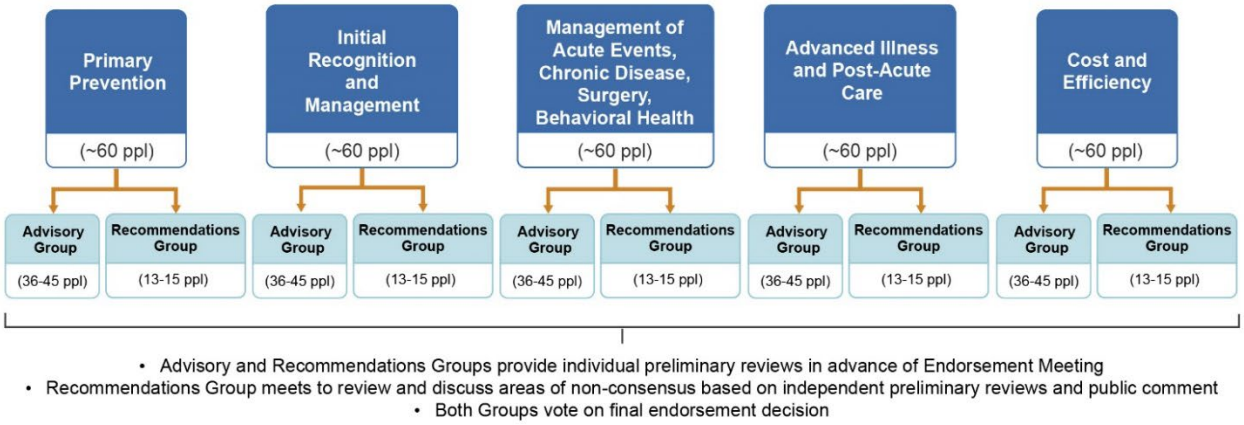

Figure 1. E&M Committee Structure

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 who come from a variety of places and represent a diverse group of people and perspectives (Figure 2 and Figure 3).

Figure 2. E&M Interested Parties

With respect to the Management of Acute Events and Chronic Illness committee, membership consisted of 10 patient partners (i.e., patients, caregivers, advocates) and 26 clinicians, with specialties in nursing, pharmacy, behavioral health, surgery, patient safety, nephrology, endocrinology, cardiology, and others (Figure 3). The committee also included four experts in rural health and 10 in health equity.

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

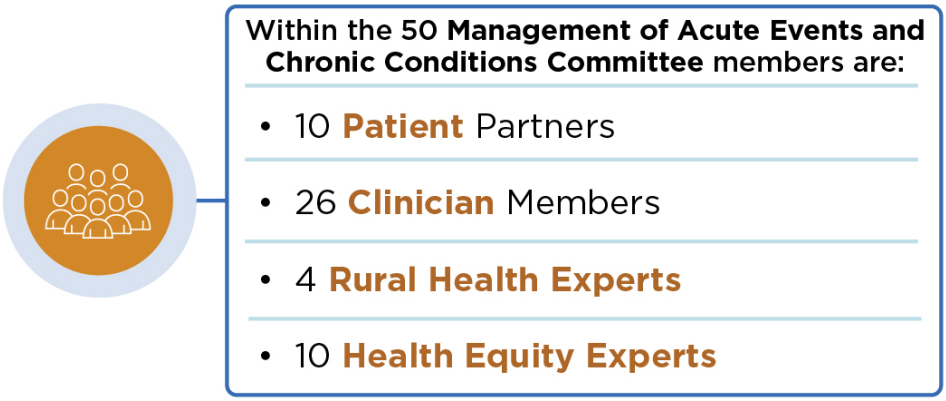

Figure 3. Management of Acute Events and Chronic Illness Committee Members

During the endorsement meeting, Advisory Group members listen to the Recommendations Group discussions before both groups cast an endorsement vote (Figure 4). This structure ensures a larger number of voices contribute to the consensus-building process.

Advisory Group	Recommendations Group
• Reviews and provides ratings and written comments on measures prior to the endorsement meeting. • Attends the endorsement meeting to **listen** to the Recommendations Group discussions. • Votes on measure endorsement decisions during the meeting.	• Reviews and provides ratings and written comments on measures prior to the endorsement meeting. • Attends the endorsement meeting to **discuss** areas of disagreement (i.e., lack of consensus) identified from the preliminary measure ratings from both groups. • Votes on measure endorsement decisions during the meeting.

Figure 4. E&M Advisory Group vs. Recommendations Group

At least three weeks prior to an E&M committee endorsement meeting, the Recommendations Group and the Advisory Group receive the full measure submission details for each measure up for review, including all attachments, the PQM Measure Evaluation Rubric, the public comments received for the measures under review, and the E&M team preliminary assessments.

Members of both groups review each measure, independently, against the PQM Measure Evaluation Rubric. Committee members assign a rating of "Met," "Not Met but Addressable," or "Not Met" for each domain of the PQM Measure Evaluation Rubric. In addition, committee members provide associated rationales for each domain rating, which were based on the rating criteria listed for each domain. Battelle staff aggregate and summarize the results and distribute them back to the committee, and to the respective measure developers, and/or stewards, for review within one week of the endorsement meeting. These independent committee member ratings are compiled and used by Battelle facilitators and committee co-chairs to guide committee discussions.

Under the Battelle process, measures reach their endpoint when an endorsement decision is rendered by the E&M project committees (Table 2).

Table 2. Endorsement Decision Outcomes

Decision Outcome	Description	Maintenance Expectations
Endorsed	**Applies to new and maintenance measures.** There is 75% or greater agreement for endorsement via a vote by the E&M committee.	Measures undergo maintenance of endorsement reviews every 5 years with a status report submission at 3 years (*see Status Report/Annual Update for more details*).[±]
Endorsed with Conditions*	**Applies to new and maintenance measures**. There is 75% or greater agreement via a vote by the E&M committee that the measure can be endorsed as it meets the criteria, but there are recommendations/areas committee reviewers would like to see when the measure comes back for maintenance. If these recommendations are not addressed, then a rationale from the developer/steward should be provided for consideration by the E&M committee review.	Measures undergo maintenance of endorsement reviews every 5 years with a status report submission at 3 years (*see Status Report/Annual Update for more details*), unless the E&M committee assigns a condition requiring the measure to be reviewed earlier.

Decision Outcome	Description	Maintenance Expectations
		At maintenance review, 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**. There is 75% or greater agreement via a vote by the E&M committee to not endorse the measure.	None
Endorsement Removed °	**Applies to maintenance measures only.** Either: • There is 75% or greater agreement for endorsement removal by the E&M committee; or • A measure steward retires a measure (i.e., no longer pursues endorsement); or • A measure steward never submits a measure for maintenance and there is no response from the steward after targeted outreach; or • There is no longer a meaningful gap in care, or the measure has plateaued (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.

** Conditions are determined by the E&M committee, with the consideration of 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 committee. 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, E&M committee endorsement decisions and associated rationales are posted to the PQM website for three weeks, which represents an appeals period, during which any interested party may request an appeal regarding any E&M committee

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

- Cite evidence of the appellant's interests are directly and materially affected by the measure, and 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, which 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 was 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 an eligible appeal is received, we convened the Appeals Committee, consisting of the co-chairs from all five E&M project committees, 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 Fall 2023 cycle, the appeals period opened on February 26 and closed on March 18, 2024. No appeals were received for the measures reviewed by the Management of Acute Events and Chronic Conditions committee.

Management of Acute Events, Chronic Illness, Surgery, and Behavioral Health Measure Evaluation

For this measure review cycle, the Management of Acute Events, Chronic Illness, Surgery, and Behavioral Health committee evaluated four new measures and one measure undergoing maintenance review against standard measure evaluation criteria. During the endorsement meeting, the committee voted to endorse three measures, to endorse one measure with conditions, and to not endorse/remove endorsement for one measure (Table 3).

Brief summaries of the committee's deliberations for each measure along with any conditions for endorsement are noted under the measure's evaluation summary below. The committee's endorsement meeting summary can be found on the respective E&M project page on the PQM website. can be found on the respective E&M project page on the PQM website.

Table 3. Number of Fall 2023 Management of Acute Events and Chronic Illness Measures Submitted and Reviewed

	Maintenance	New	Total
Number of measures submitted for endorsement review	7	4	11
Number of measures withdrawn from consideration*	6	0	6
Number of measures reviewed by the committee	1	4	5
Number of measures endorsed	0	3	3
Number of measures endorsed with conditions	0	1	1
Number of measures not endorsed/endorsement removed	1	0	1

**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 4. Measures Withdrawn from Consideration

Measure Number	Measure Title	Developer/Steward	New/Maintenance	Reason for Withdrawal*
119	Risk-Adjusted Operative Mortality for Coronary Artery Bypass Graft CABG	The Society of Thoracic Surgeons	Maintenance	Withdrawn by steward and deferred to future endorsement review cycle.
120	Risk-Adjusted Operative Mortality for Aortic Valve Replacement (AVR)	The Society of Thoracic Surgeons	Maintenance	Withdrawn by steward and deferred to future endorsement review cycle.
121	Risk-Adjusted Operative Mortality for Mitral Valve (MV) Replacement	The Society of Thoracic Surgeons	Maintenance	Withdrawn by steward and deferred to future endorsement review cycle.
122	Risk-Adjusted Operative Mortality for Mitral Valve (MV) Replacement + CABG Surgery	The Society of Thoracic Surgeons	Maintenance	Withdrawn by steward and deferred to future endorsement review cycle.
123	Risk-Adjusted Operative Mortality for Aortic Valve Replacement (AVR) + CABG Surgery	The Society of Thoracic Surgeons	Maintenance	Withdrawn by steward and deferred to future endorsement review cycle.
2789	Adolescent Assessment of Preparation for Transition (ADAPT) to Adult-Focused Healthcare	Center of Excellence for Pediatric Quality Measurement	Maintenance	Steward no longer seeks to maintain endorsement

**Endorsement was removed for maintenance measures that were retired by the measure steward.*

Public Comments Received Prior to Committee Evaluation

Battelle accepts comments on measures under endorsement review through the PQM website. For this evaluation cycle, the pre-evaluation commenting period opened on December 1, 2023 and closed on January 2, 2024. Thirty pre-evaluation comments were submitted and shared with the standing committee prior to the measure evaluation meeting on January 29, 2024. A summary of comments received is provided under the measure's evaluation summary below.

Summary of Potential High-Priority Gaps

During the committee's evaluation of the measures, no potential high-priority measurement gap areas emerged.

Summary of Major Concerns or Methodological Issues

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

Measure Feasibility

Committee discussions of several of the measures focused on the practicality and feasibility of the measures due to survey response rates, electronic health record (EHR) systems, and data availability. One measure, CBE #4210, had low survey response rates, the committee considered whether this was due to the feasibility of survey administration. The developer indicated that coronavirus disease (COVID) and Outpatient Ambulatory Surgery Consumer Assessment of Healthcare Providers & Systems (OAS CAHPS) were contributing factors to low uptake due to resource challenges. However, to mitigate this, the developer emphasized that completion of the survey online is widespread and can contribute to increased response rates. The second measure, CBE #4120e, had potential challenges with availability of EHR systems and process implementation in rural and small hospitals. These facilities may have more difficulties due to time commitment and resources. Even though many rural facilities have EHR systems, the cost of adding a new element into the workflow can be a burden. To overcome these concerns, additional guidance may be needed to support facilities with few resources. Lastly, for CBE #4130e, the committee raised concern with the measure's use of unstructured data fields and the potential impact this has on the measure's feasibility. The developer noted that this issue was appropriately addressed in testing. Information collected on intubation, extubation, and mechanical ventilation settings often had errant information included with it. The developer indicated that hospitals already capture this information, and using unstructured fields may standardize how this information is captured.

Measure Evaluation Summaries

CBE #4210 – Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure [Yale CORE/CMS] – *New*

Specifications | Committee Independent Review Summary

Description: This measure assesses how well facilities provide clear, personalized discharge instructions to patients aged 18 years or older who had a surgery or procedure at an outpatient facility. It uses a nine-item survey to obtain patient's feedback on three domains: applicability; medications; and daily activities. Facility scores are calculated by averaging the individual patient scores for each facility. Individual patient scores are calculated using a top-box approach measuring the percentage of the total number of items given the most favorable responses ("Yes" or "Very Clear") out of the total number of relevant items.

Committee Final Vote: Endorsed

Conditions: None

Vote Count: Endorse (36 votes; 81.82%), Endorse with Conditions (5 votes; 11.36%), Not Endorse (3 votes; 6.82%); recusals (1).

Summary of Public Comments: Battelle received two public comments prior to the meeting, both supporting the measure. The comments stated that personalized, clear discharge instructions are important for patient follow-through and compliance with medical recommendations. As outpatient procedures are becoming increasingly common, this measure allows for comparison between provider locations, resulting in patients being more informed.

Appeals: None

Discussion Theme	Recommendations Group Discussion
Feasibility	• The committee shared concern about the low survey response rates, which ranged from around 11 to 30%. The committee considered whether this was due to the feasibility of survey administration. The developer cited COVID and OHS CAHPS as impactors to the response rate.
Patient Engagement and Accessibility	• Committee members discussed the extent to which the patient voice was represented in the measure. • The developer stated that their Technical Expert Panel has two patient representatives, and they also held a patient and family workgroup. • The committee discussed the possibility of translating the survey into other languages besides English and Spanish. The developer confirmed the survey has only been tested in English and Spanish but expressed it could be administered in other

Discussion Theme	Recommendations Group Discussion
	languages via a translator or proxy to improve accessibility.
Use and Usability	• The committee questioned whether the survey and the measure results would be accessible to patients, noting the importance of multi-modal administration. • The committee also requested more clarity regarding how measure data would be shared with providers to improve care. • The developer responded that providers receive raw survey results, which allows them to make improvements. • The developer anticipates that the implementation of the measure will be less burdensome to providers than during testing.

Additional Recommendations for the Developer/Steward and Future Directions

No additional recommendations were made for this measure.

CBE #4130e – Hospital Harm – Postoperative Respiratory Failure [AIR/CMS] – *New*

Specifications | Committee Independent Review Summary

Description: This electronic clinical quality measure (eCQM) assesses the proportion of elective inpatient hospitalizations for patients aged 18 years and older without an obstetrical condition who have a procedure resulting in postoperative respiratory failure (PRF).

Committee Final Vote: Endorsed

Conditions: None

Vote Count: Endorse (33 votes; 75%), Endorse with Conditions (9 votes; 20.45%), Not Endorse (2 votes; 4.54%); recusals (1).

Summary of Public Comments: Six public comments were received prior to the meeting. Two comments were supportive of the measure. One of the supportive comments encouraged the developer to consider non-elective hospitalizations to improve monitoring. The second supportive comment emphasized that post-op respiratory failure is the most prevalent and serious post-op pulmonary complication. Two comments supported the measure with the condition that it should receive CBE endorsement before implementation and encouraged assessing the feasibility of collecting data from electronic health records (EHRs) and using more vendor systems and hospitals in that assessment. Two comments were received that indicated concerns relating to the measure. One comment expressed concern relating to feasibility of the measure without more information on the specification of electronic components of the

measure. Another comment noted several areas of concern that may make the measure unsuitable for use, including non-standardized data capture and sensitivity of screening technologies overshadowing performance.

Appeals: None

Discussion Theme	Recommendations Group Discussion
Feasibility and Standardization of Data Capture	• The committee considered the concern expressed through public comment regarding the measure's feasibility due to a lack of specifics about the electronic components of the measure and the lack of standardization of the data capture. • The developer responded that information about intubation, extubation, and mechanical ventilation settings often contained errant information. The developer addressed the concerns regarding unstructured fields during development and noted that the measure may contribute to more standardized data capture.
Exclusions	• The committee considered the arterial blood gas (ABG) exclusions. Specifically, for patients with severe chronic obstructive pulmonary disease (COPD), it may be challenging for them to get an ABG within 48 hours. This may cause undue burden on providers to collect an ABG the day of a procedure. The developer responded that the intent of the measure is to not create undue burden for providers caring for severe COPD patients. These patients should be included in the denominator and accounted for in the risk adjustment model. The current exclusion criteria are intended to weed out patients with severe respiratory illness and will likely not apply to patient with less severe COPD.

Additional Recommendations for the Developer/Steward and Future Directions

No additional recommendations were made for this measure.

CBE #4120e – Hospital Harm – Falls with Injury [AIR/CMS] – *New*

Specifications | Committee Independent Review Summary

Description: This ratio measure assesses the number of inpatient hospitalizations where at least one fall with a major or moderate injury occurs among the total qualifying inpatient hospital days for patients aged 18 years and older.

Committee Final Vote: Endorsed

Conditions: None

Vote Count: Endorse (44 votes; 100%), Endorse with Conditions (0 votes; 0%), Not Endorse (0 votes; 0%); recusals (1).

Summary of Public Comments: Eleven comments were received prior to the meeting. The following summary does not establish mutual exclusivity, as some comments touched on more than one issue. Three comments supported the measure and encouraged the developer to clarify the denominator exclusions language. Another comment supported the measure with the condition that it receive endorsement consideration before implementation. Four comments raised concern that this measure may lead to the reduction of mobilization for patients in order to reduce fall numbers. Four comments raised concern with the classification categories for injury used in the measure. Lastly, two comments emphasized the challenges associated with electronic clinical quality measures (eCQMs) and implementation and burden.

Appeals: None

Discussion Theme	Recommendations Group Discussion
Use in Rural Hospitals	• The committee raised concern with respect to the gaps in fall claims from small or rural hospitals. The developer informed the committee that patients who had a fall that was present on admission were removed from the denominator population to eliminate whether the injury was related to a fall or not. The developer also stated that the data are not reliant on the claim but rather on the final coding for International Classification of Diseases 10 (ICD-10). • The committee also raised concern with respect to the uptake and feasibility of this eCQM for rural facilities. Rural hospitals may have EHR systems but the addition of a new element to the workflow can be costly. The developer responded that they offer resources to help mitigate difficulties with implementation. • The committee considered the testing data, noting that testing was limited in rural settings. The developer stated that testing can be more difficult for rural facilities because of the time and resource burden. • The committee encouraged the developer to monitor measure performance in rural settings due to the concerns with

Discussion Theme	Recommendations Group Discussion
	feasibility.
Unintended Consequences	• The committee emphasized the potential for the unintended consequence of deliberate reduction of physical therapy and mobility support to reduce the probability of falls during the rehabilitation process and recommended that the developer continually monitor for this.

Additional Recommendations for the Developer/Steward and Future Directions

The committee recommended that the developer monitor how this measure performs in rural facilities due to challenges with eCQM uptake. The developer should also monitor for the unintended consequence of reduced patient mobilization, in the event that a facility takes an unnecessarily conservative approach to rehabilitation and mobility in order to reduce fall risk.

CBE #4125 – Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications [AIR/CMS] – *New*

Specifications | Committee Independent Review Summary

Description: Percentage of surgical inpatients who experienced a complication and then died within 30 days from the date of their first “operating room” procedure. Failure-to-rescue is defined as the probability of death given a postoperative complication.

Committee Final Vote: Endorsed with Conditions

Conditions: Perform additional reliability testing for endorsement review, namely conducting additional simulation analyses of minimum case volume adjustments, since about half of the facilities had reliability below 0.6.

Vote Count: Endorse (10 votes; 23.26%), Endorse with Conditions (31 votes; 72.09%), Not Endorse (2 votes; 4.65%); recusals (1).

Summary of Public Comments: Eleven comments were received prior to the meeting. One comment suggested the use of a more narrow and well-scoped list of adverse events that need close monitoring post-op. One comment also requested for further refinement of the numerator to add exclusions related to site of death, stating that a hospital should not be held accountable for traumatic accidents or other uncontrollable incidents within the 30-day window after surgery. One comment brought attention to the potential for the unintended consequence of discouraging patients from shifting their goals away from life prolonging efforts within 30 days of surgery, and suggested excluding cases where care was appropriately shifted and natural death occurred. Two comments expressed concern that the measure disregards site of death, and this can

introduce scenarios outside of a hospital's control. These same comments raised concern with the lack of risk adjustment in the outcome measure and suggested using patient population stratification. One comment recommended that testing be conducted to evaluate the measure for volume bias among facilities. The comment also promoted the use of artificial intelligence to reduce provider burden. Two comments recommended the measure with conditions, noting it should be submitted for endorsement consideration prior to use. Two comments expressed concern, one focusing on reliability and evidence for the expansion to 30 days post-discharge. The second comment raised concern regarding reliability, risk adjustment, specifications, and unsuitability for use in federal programs. Lastly, one comment stated there are excessive exclusions in the denominator.

Appeals: None

Discussion Theme	Recommendations Group Discussion
All-Cause Mortality	• The committee discussed the appropriateness of the measure's use of all-cause mortality vs. cause-specific mortality. The developer responded that all-cause is the standard consensus of the last 20 year and that any unrelated deaths that may be captured are minimal.
Reliability	• The developer responded to concerns previously submitted by the committee in the preliminary assessments, stating that the reliability testing is an improvement upon the currently used Patient Safety Indicator (PSI) 04, Death Rate Among Surgical Inpatients with Serious Treatable Complications. • The committee acknowledged that there are several approaches that the developer could apply to further improve the reliability estimates even further. These include, but are not limited to, increasing the minimum sample size. • The committee therefore placed a condition on the measure for the developer to perform additional reliability testing for endorsement review, namely conducting additional simulation analyses of minimum case volume adjustments, since about half of the facilities had reliability below 0.6.
Medicare Populations	• The committee discussed that the measure is only applicable to Medicare patients and expressed concern over the accuracy if hospitals have both Medicare Advantage and Medicare fee-for-service patients. • The developer responded that there are an increasing number of patients moving to Medicare Advantage, and both populations need to be looked at to fully evaluate the measure.

Additional Recommendations for the Developer/Steward and Future Directions

No additional recommendations were made for this measure.

CBE #0694 – Hospital Risk-Standardized Complication Rate Following Implantation of Implantable Cardioverter-Defibrillator (ICD) [American College of Cardiology] – *Maintenance*

Specifications | Committee Independent Review Summary

Description: This measure provides hospital specific risk-standardized rates of procedural complications following the implantation of an Implantable Cardioverter-Defibrillator (ICD) in patients at least 65 years of age. The measure uses clinical data available in the National Cardiovascular Data Registry (NCDR) Electrophysiology Device Implant Registry (EPDI; formerly the ICD Registry) for risk adjustment linked with administrative claims data using indirect patient identifiers to identify procedural complications.

Committee Final Vote: Endorsement Removed due to no consensus. This was due to the lack of recent data to establish whether a performance gap remains; to determine reliability and validity of the measure, namely at the accountable entity level; and to establish whether the measure has improved over time. In addition, the measure is not currently being used.

Conditions: None

Vote Count: Endorse (4 votes; 9.3%), Endorse with Conditions (24 votes; 55.81%), Remove Endorsement (15 votes; 34.88%); recusals (1).

Summary of Public Comments: No public comments were received for this measure.

Appeals: None

Discussion Theme	Recommendations Group Discussion
Measure Importance/Relevance	• The committee acknowledged the importance of the measure focus, noting that hospital readmissions remain an important area to address. • However, several committee members had concerns due to the lack of recent data to establish whether a performance gap remains and due to limited literature justifying the casual relationship between low quality of care and readmissions. • The developer acknowledged that a limitation of this measure is lack of the claims data necessary to assess performance gap and to test the measure cannot currently be accessed by the developer. The developer worked with other medical societies seeking legislative action to remove barriers to access claims data; however, Congress did not act.

Discussion Theme	Recommendations Group Discussion
Measure Specifications and Scientific Acceptability (i.e., Reliability and Validity)	• The committee expressed the same concern with the lack of recent data to support updated testing for this measure. • Some committee members considered whether conditions could be placed on this measure, such that by maintenance endorsement, if the developer obtained the necessary claims data, they would update the testing and performance data, have a plan for use and implementation, and share any trend data in measure performance over time. • Other committee members expressed that conditions may not be reasonable because it would take an act of Congress to be able to access the appropriate data.
Use and Usability	• The developer highlighted that the measure is not currently in use because the developer cannot access the necessary claims data.

Additional Recommendations for the Developer/Steward and Future Directions

No additional recommendations were made for this measure.

References

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Appendix A: Management of Acute Events, Chronic Illness, Surgery, and Behavioral Health Committee Roster

Fall 2023 Cycle

Member	Affiliation/Organization	Advisory or Recommendation Group
Whitney Bowman-Zatzkin *(Patient Representative Co-chair)*	Rare Dots Consulting	Recommendation
Marybeth Farquhar *(Non-Patient Representative Co-chair)*	American Urological Association	Recommendation
Abate Mammo	New Jersey Hospital Association	Advisory
Aileen Schast	Jefferson Einstein Hospital	Advisory
Amber Kavan	Nebraska Hospital Association	Recommendation
Anna Doubeni	Ohio State Wexner Medical Center	Advisory
Antoinette Schoenthaler	NYU Langone Health	Advisory
Ashley Pugh	National Committee for Quality Assurance	Recommendation
Ashley-Tait Dinger	Florida Alliance for Healthcare Value	Advisory
Benjamin Shirley	Pharmacy Quality Assurance	Advisory
Bianca Young	--	Advisory
Bonnie Zima	UCLA Semel Institute for Neuroscience and Human Behavior; Mental Health Informatics and Data Science	Advisory
Charles Mahan	University of New Mexico (UNM)	Advisory
Chloe Slocum	Harvard Medical School, Spaulding Rehabilitation Network at Mass General Brigham, Harvard Medical School Department of Physical Medicine and Rehabilitation	Advisory
Christopher Tignanelli	University of Minnesota Medical School	Recommendation
David Clayman	Mathematica	Advisory

Member	Affiliation/Organization	Advisory or Recommendation Group
David May	Jefferson Health	Recommendation
David Shahian	Department of Surgery and Division Cardiac Surgery, Massachusetts General Hospital; Harvard Medical School	Advisory
Eleni Theodoropoulos	URAC	Recommendation
Eric Youngstrom	University of North Carolina Chapel Hill; Helping Give Away Psychological Science	Advisory
Florence Thicklin	--	Advisory
Icilma Fergus Rowe	Icahn School of Medicine Mount Sinai	Advisory
Jamieson Wilcox	University of Southern California; Keck Medicine of USC	Advisory
Jason Wasfy	Massachusetts General Hospital; Harvard Medical School	Recommendation
Jill Nagel	Mayo Clinic	Recommendation
John Wagner	NYC Health + Hospitals/Kings County	Advisory
Joshua Ardise	Medicare – East Region, Elevance Health	Advisory
Kyle Albert Hultz	Memorial Healthcare System-Memorial Regional Hospital	Recommendation
Laurent Glance	University of Rochester Medical Center; RAND Corporation	Advisory
Lisa Albers	CalPERS	Advisory
Lisa Suter	Yale University School of Medicine; YNHHSC Center for Outcomes Research & Evaluation (CORE)	Advisory
Marisa Valdes	Baylor Scott and White Health	Recommendation
Marjorie Everson	American Association of Nurse Anesthesiology	Recommendation
Michael Hanak	Rush University Medical Center	Advisory

Member	Affiliation/Organization	Advisory or Recommendation Group
Mika Gans	Colorado Access	Advisory
Misty Votaw	FH Foundation Advocate	Advisory
Monique Sartor	Oakland Home Care	Recommendation
Nasir Khan	Loyola Medicine, Trinity Health	Recommendation
Raquel Mayne	Phelps Hospital Northwell Health	Recommendation
Rosie Bartel	--	Advisory
Samantha Tierney	American College of Physicians	Advisory
Sarah Duggan Goldstein	Phreesia	Recommendation
Sharon Ayers	--	Advisory
Tarik Yuce	Indiana University School of Medicine	Advisory
Vandolynn Tucker	--	Advisory
Vikram Shah	Cigna	Advisory
Vilma Jospeh	Alert Einstein College of Medicine/Montefiore Medical Center	Recommendation
Virna Little	Zero Overdose; Concert Health	Advisory
Wiley Jenkins	Southern Illinois University School of Medicine	Advisory
Yvonne Commodore-Mensah	American Heart Association, Johns Hopkins School of Nursing	Recommendation

Partnership for Quality Measurement Organizations

Battelle

Institute for Healthcare Improvement

Rainmakers

Measure Stewards

American College of Cardiology

Centers for Medicare & Medicaid Services (CMS)

Measure Developers

American Institutes for Research (AIR)

Yale Center for Outcomes Research and Evaluation (Yale CORE)


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