



Partnership for
Quality Measurement

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Fall 2023 Management of Acute and Chronic Events Committee Endorsement Meeting

January 29, 2024

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Welcome



Meeting Objectives



The purpose of today's meeting is to:

- Review and discuss candidate measures submitted to the Management of Acute Events, Chronic Disease, Surgery, and Behavioral Health committee for the Fall 2023 cycle;
- Review public comments received for the submitted candidate measures; and
- Render endorsement decisions for the submitted candidate measures.

Housekeeping Reminders for Recommendations Group*



- The system will allow you to mute/unmute yourself and turn your video on/off throughout the event
- Please raise your hand and unmute yourself when called on
- 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
- We encourage you to keep your video on throughout the event
- Feel free to use the chat feature to communicate with Battelle staff
- If you are experiencing technical issues, please contact the project team via chat on the virtual platform or at PQMsupport@battelle.org.

Meeting Ground Rules



- Be prepared, having reviewed the meeting materials beforehand
- Respect all voices
- Remain engaged and actively participate
- Base your evaluation and recommendations on the measure evaluation rubric
- Keep your comments concise and focused
- Be respectful and allow others to contribute
- Share your experiences
- Learn from others

Project Team



- Nicole Brennan, MPH, DrPH, Executive Director
- Brenna Rabel, MPH, Deputy Director
- Jeff Geppert, Measure Science Team Lead
- Quintella Bester, PMP, Senior Program Manager
- Matthew Pickering, PharmD, Principal Quality Measure Scientist
- Amanda Overholt, MPH, Social Scientist III
- Isaac Sakyi, MSGH, Social Scientist III
- Lydia Stewart-Artz, PhD, Social Scientist III
- Jessica Ortiz, MA, Social Scientist II
- Olivia Giles, MPH, Social Scientist I
- Elena Hughes, MS, Social Scientist I
- Sarah Rahman, Social Scientist I

Agenda



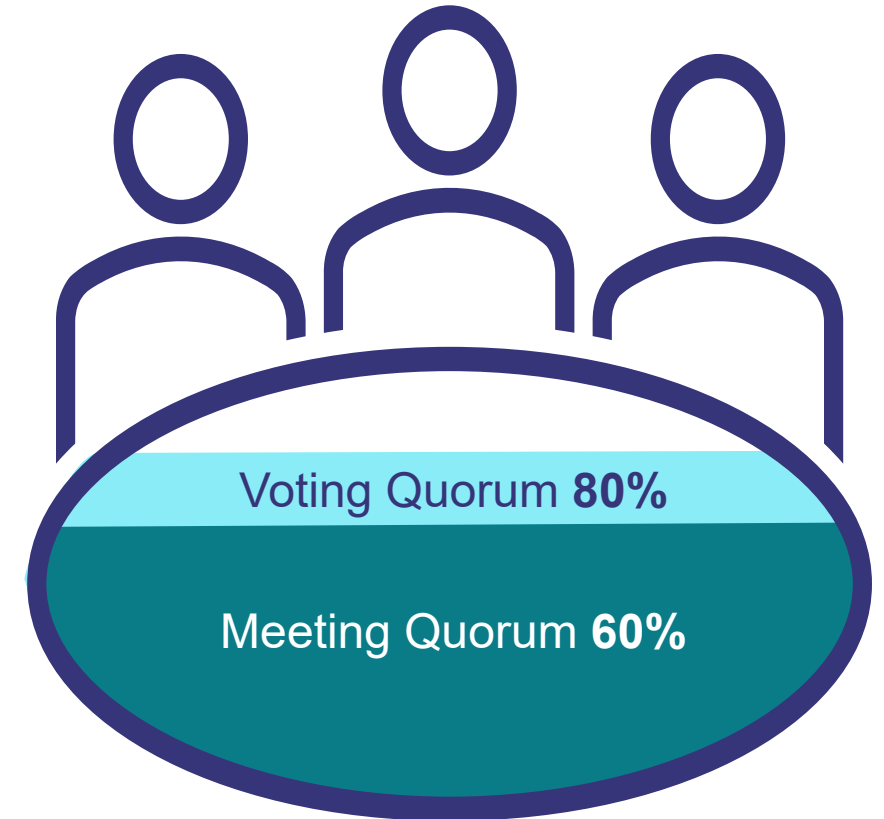
- Welcome and Review of Meeting Objectives
- Roll Call with Disclosures of Interest
- Overview of Evaluation Procedures and Measures for Endorsement Consideration
- Test Vote
- Evaluation of Candidate Measures
- Additional Measure Recommendations Discussion (if time permits)
- Opportunity for Public Comment
- Next Steps
- Adjourn

Roll Call with Disclosures of Interest



Quorum

- Meeting quorum requires that 60% of the Recommendations Group members are present during roll call at the beginning of the meeting.
- Endorsement decisions are rendered via a vote after Recommendations Group discussions. Voting quorum is at least 80% of active committee members (Recommendations Group + Advisory Group), who are not recused.



Management of Acute and Chronic Events Fall 2023 Cycle Committee – *Recommendations Group*



- Marybeth Farquhar, PhD, MSN, RN
(Non-Patient Co-Chair)
- Whitney Bowman- Zatkan, MPA, MSR **(Patient Co-Chair)**
- Amber Kavan, BSN, RN, CPHQ
- Ashley Pugh, MSHI, RN, CPHIMS
- Christopher Tignanelli, MBA, MS
- David P. May, MD, MBA, FACS, CPHQ
- David M. Shahian, MD
- Eleni Theodoropoulos, MBA, CPHIMS
- Jason H. Wasfy, MD, MPhil
- Jill Nagel, MBA
- Kyle Albert Hultz, PharmD
- Marisa Valdez, RN, MSN, CPHQ
- Marjorie Everson, PhD, CRNA, FNAP
- Monique Sartor, LPN, BA, MPH
Candidate Nasir Khan, MBBS, MPH
- Raquel Mayne, MPH, MS, RN, NEA-BC, CPHQ
- Sarah Duggan Goldstein, DrPHc, MPH
- Vilma Joseph, MD, MPH, FASA
- Yvonne Commodore- Mensah, PhD, MHS, RN

Management of Acute and Chronic Events Fall 2023 Cycle Committee – *Advisory Group*



- Abate Mammo, PhD
- Aileen P. Schast, PhD, CPHQ, CPPS
- Anna Doubeni, MD
- Antoinette Schoenthaler, EdD
- Ashley Tait- Dinger, MBA
- Benjamin Shirley, BS, CPHQ
- Bianca Young
- Bonnie T. Zima, MD, MPH
- Charles Mahan, PharmD, PhC, FASHP, FCCP
- Chloe Slocum, MD, MPH
- David Clayman, DPM, MBA
- Eric A. Youngstrom, PhD
- Florence Thicklin
- Icilma Fergus Rowe, MD, BA
- Jamieson Wilcox, MPH, OTD, OTR/L
- John Wagner, MD, MBA
- Joshua Ardise, MD, MPH
- Laurent Glance, MD
- Lisa Albers, MD
- Lisa Suter, MD
- Michael Hanak, MD, FAAFP
- Mika Gans, MS, LMFT, CPHQ
- Misty Votaw
- Rosie Bartel, MA
- Samantha Tierney, MPH
- Sharon Ayers
- Tarik Yuce, MD, MS
- Vandolynn Tucker
- Vikram (Vik) Shah, MD, MBA
- Virna Little, PsyD, LCSWR
- Wiley Jenkins, PhD, MPH, FACE

Overview of Evaluation Procedures



Roles of the Committee During the Endorsement Meeting



- **Evaluate** each measure against each domain of the Partnership for Quality Measurement Measure Evaluation Rubric
- **Indicate** the extent to which each criterion is met and the rationale for the rating
- **Review** comments submitted during the public comment period
- **Render endorsement decisions** for candidate measures



Roles of the Committee Co-Chairs During the Endorsement Meeting



Collaborate with Battelle

- | | Collaborate with Battelle |
|--|---------------------------|
| • Co-facilitate virtual endorsement meetings, along with Battelle staff | ● |
| • Participate on the committee as a full voting member for the entirety of your term | |
| • Serve on the Appeals committee <ul style="list-style-type: none">▪ Includes attending the half- to full-day virtual Appeals committee meeting at the end of every E&M cycle (contingent upon whether an appeal is received) | |
| • Work with Battelle staff to achieve the goals of the project | ● |
| • Assist Battelle staff in anticipating questions and identifying additional information that may be useful to the committee | ● |

Roles of the Committee Co-Chairs During the Endorsement Meeting, *continued 1*



Patient Representative Co-Chair

Ensure the patient community voice is considered



Non-Patient Representative Co-Chair

Ensure the Advisory group voice is considered

Evaluation and Voting Process

Non-consensus Measures



Step	Description	Interested Party
1	<p>Introduction of the measure in which consensus was lacking</p> <ul style="list-style-type: none"> • Presentation of the PQM Rubric domain rating results from the committee independent assessments and a summary of the committee's independent review, noting both strengths and limitations, and any potential conditions, as appropriate. • Summation of any public comments received prior to the endorsement meeting. 	Battelle Staff
2	<p>Floor is open for any additional public comments with respect to the measure under review</p> <ul style="list-style-type: none"> • Commenters are kindly asked to keep their comments to two (2) minutes or less. • The committee does not respond directly to commenters, rather comments are shared for the committee's endorsement discussion. 	Battelle Staff and Co-chairs
3	<p>Three-to-five (3-5) minute, high-level overview of the measure</p> <ul style="list-style-type: none"> • Presenters will kindly be asked to stop presenting if the time is over five (5) minutes. • Please refrain from using slides or screensharing of materials. • Overview may include initial Responses to committee independent reviews and/or public comments 	Developer and/or Steward

Evaluation and Voting Process

Non-consensus Measures, Continued 1



Step	Description	Interested Party
4	<p>Round-robin for clarifying questions</p> <ul style="list-style-type: none"> • Non-patient representative co-chair to confirm whether questions from A-group members (via independent assessments) have been considered. • Patient representative co-chair to confirm whether the patient partner questions have been considered. • After all questions have been collected, the developer/steward addresses measure-specific questions. 	<p>R-group discusses A-group listens</p> <p>Battelle Staff to facilitate with Co-chairs</p>
5	<p>Committee discussion of the measure elements in which consensus was lacking</p> <ul style="list-style-type: none"> • Facilitated discussion measure strengths and limitations based on PQM Measure Evaluation Rubric domain. • Determine potential resolutions that lead to committee consensus and any recommendations placed on the measure for the developer/steward to consider in the future. • The developer/steward may respond to questions posed by the committee. • Subject matter experts (SMEs) are called upon, accordingly, to address committee questions and to provide context and relevance about the measure for to the committee's consideration. 	<p>R-group discusses A-group listens</p> <p>Battelle Staff to facilitate with Co-chairs</p> <p>Developer and/or Steward</p> <p>SMEs</p>

R-group: Recommendations group; A-group: Advisory group

Evaluation and Voting Process

Non-consensus Measures, Continued 2



Step	Description	Interested Party
6	Responses to committee discussion <ul style="list-style-type: none">• After the committee discussion has concluded, prior to voting, the developer/steward is given a final opportunity to respond to the committee's discussion before the committee moves to a vote on endorsement.• Please try to keep responses brief, referring to information in the measure submission, as appropriate.• Please refrain from using slides or screensharing of materials.	Developer and/or Steward
7	Committee vote <ul style="list-style-type: none">• Any conditions or recommendations are summarized prior to voting.• If consensus is not reached, based on the 75% threshold, the measure is not endorsed.	R-group and A-group Battelle Staff and Co-chairs summarize voting conditions

Evaluation and Voting Process

Conditions for Voting Example



Step	Description	Interested Party
7	Committee vote <ul style="list-style-type: none">Any conditions or recommendations are summarized prior to voting.If consensus is not reached, based on the 75% threshold, the measure is not endorsed.	R-group and A-group Battelle Staff and Co-chairs summarize voting conditions

Example: Some committee members raised concern with the measure testing occurring in only two or three U.S. states and recommended to see additional testing across a larger, more generalizable population, then:

- A vote to **Endorse** the measure means the committee agrees that the evidence provided to support the measure fully substantiates the measure claims.
- A vote to **Endorse with Conditions**, means the committee agrees that the evidence provided to support the measure doesn't fully substantiate the measure claims due to limited testing within 2-3 states. Therefore, the committee votes to endorse the measure with the condition that additional testing across a larger, more generalizable population be conducted by the next maintenance review.
- A vote to **Not Endorse/have Endorsement Removed**, means the committee agrees that the evidence provided to support the measure does not substantiate the claims for scientific acceptability due to the limited testing in only 2-3 U.S. states. Therefore, the committee raised concern with respect to the generalizability of the testing results. In addition, there are no reasonable changes to the measure (e.g., specifications, testing, evidence) that would allow the measure to receive conditional endorsement.

Evaluation and Voting Process

Consensus Measures



Step	Description	Interested Party
1	<p>Introduction of the measure in which consensus was lacking</p> <ul style="list-style-type: none"> • Presentation of the PQM Rubric domain rating results from the committee independent assessments and a summary of the committee’s independent review, noting both strengths and limitations, and any potential conditions, as appropriate. • Summation of any public comments received prior to the endorsement meeting. 	Battelle Staff
2	<p>Floor is open for any additional public comments with respect to the measure under review</p> <ul style="list-style-type: none"> • Commenters are kindly asked to keep their comments to two (2) minutes or less. • The committee does not respond directly to commenters, rather comments are shared for the committee’s endorsement discussion. 	Battelle Staff and Co-chairs
3a	<p>Committee discussion of measures with <u>consensus to endorse</u></p> <ul style="list-style-type: none"> • Confirm the measure strengths outweigh any limitations identified • Confirm if any conditions for endorsement • Co-chairs confirm the Advisory Group and the patient community voice have been considered (via independent assessments) 	<p>R-group discusses A-group listens</p> <p>Battelle Staff to facilitate with Co-chairs</p>

Evaluation and Voting Process

Consensus Measures, Continued 1



Step	Description	Interested Party
3b	<p>Committee discussion of measures with <u>consensus to not endorse/remove endorsement</u></p> <ul style="list-style-type: none"> • Confirm the measure limitations outweigh the strengths • Identify potential recommendations for the developer to improve the limitations • Co-chairs confirm the Advisory Group and the patient community voice have been considered (via independent assessments) • After the committee discussion, the developer/steward is given the opportunity to respond to the committee's review and discussion. 	<p>R-group discusses A-group listens</p> <p>Battelle Staff to facilitate with Co-chairs</p> <p>Developer and/or Steward</p>
4	<p>Committee vote</p> <ul style="list-style-type: none"> • Any conditions or recommendations are summarized prior to voting. • If consensus is not reached, based on the 75% threshold, the measure is not endorsed. 	<p>R-group and A-group</p> <p>Battelle Staff and Co-chairs summarize voting conditions</p>

Endorsement Decision Outcomes



Decision Outcome	Description	Maintenance Expectations
Endorsed	<p>Applies to new and maintenance measures.</p> <p>There is 75% or greater agreement for endorsement by the E&M committee</p>	<p>Measures undergo maintenance of endorsement reviews every 5 years with an annual update review at 3 years.</p>
Endorsed with Conditions	<p>Applies to new and maintenance measures.</p> <p>There is 75% or greater agreement 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.</p>	<p>Measures undergo maintenance of endorsement reviews every 5 years with an annual update at 3 years, unless the condition requires the measure to be reviewed earlier. The E&M committee evaluates whether conditions have been met, in addition to all other maintenance endorsement minimum requirements.</p>
Not Endorsed	<p>Applies to new measures only. There is 75% or greater agreement to not endorse the measure by the E&M committee.</p>	<p>None</p>
Endorsement Removed	<p>Applies to maintenance measures only. Either:</p> <ul style="list-style-type: none"> • 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) 	<p>None</p>

Decision Outcomes:

Endorsed with Conditions



The types of conditions that may be placed on a measure include:

- Conducting/providing additional testing across a larger population, accountable entity-level, and/or different level of analysis
- Expanding the measure use beyond quality improvement and into an accountability application
- Providing implementation guidance or a near-term path forward for implementing the measure; providing clear system requirements for implementation of the measure

Battelle has identified several non-negotiable areas, meaning if a measure meets one or more of the following criteria, the measure cannot be endorsed, even with conditions:

- Lack of or unclear business case
- Lack of evidence supporting the business case
- Significantly poor feasibility for the measure to be implemented due to challenges, e.g., data availability or missingness
- Inappropriate methodology, calculations, formulas, or testing approach used to demonstrate reliability or validity
- Specifications, testing approach, results, or data descriptions are insufficient
- If a measure with an “Endorsed with Conditions” designation is evaluated for maintenance, but it has not met the prior conditions

What is the PQM Measure Evaluation Rubric?



The PQM Measure Evaluation Rubric (Rubric) consists of five (5) major domains:

- 1. Importance** - Extent to which the measure is evidence-based AND is important for making significant gains in health care quality or cost where there is variation in or overall, less-than-optimal performance.
- 2. Feasibility** - Extent to which the measure specifications (i.e., numerator, denominator, exclusions) require data that are readily available OR could be captured without undue burden AND can be implemented for performance measurement.
- 3. Scientific Acceptability [i.e., Reliability and Validity]** - Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.
- 4. Equity (optional)** - Extent to which the measure can identify differences in care for certain patient populations, which can be used to advance health equity and reduce disparities in care.
- 5. Use and Usability** - Extent to which potential audiences (e.g., consumers, purchasers, providers, and policymakers) are using or could use measure results for both accountability and performance improvement to achieve the goal of high quality, efficient health care for individuals or populations.

Consensus Voting for Final Determinations



Endorse (A)	Endorse with Conditions (B)	Do Not Endorse (C)	Consensus Voting Status
75% or More	0%	Less than 25%	A
75% or More		Less than 25%	B
Less than 25%		75% or More	C
26% to 74%		26% to 74%	No consensus

If no consensus is reached, based on the 75% threshold, the measure is not endorsed.

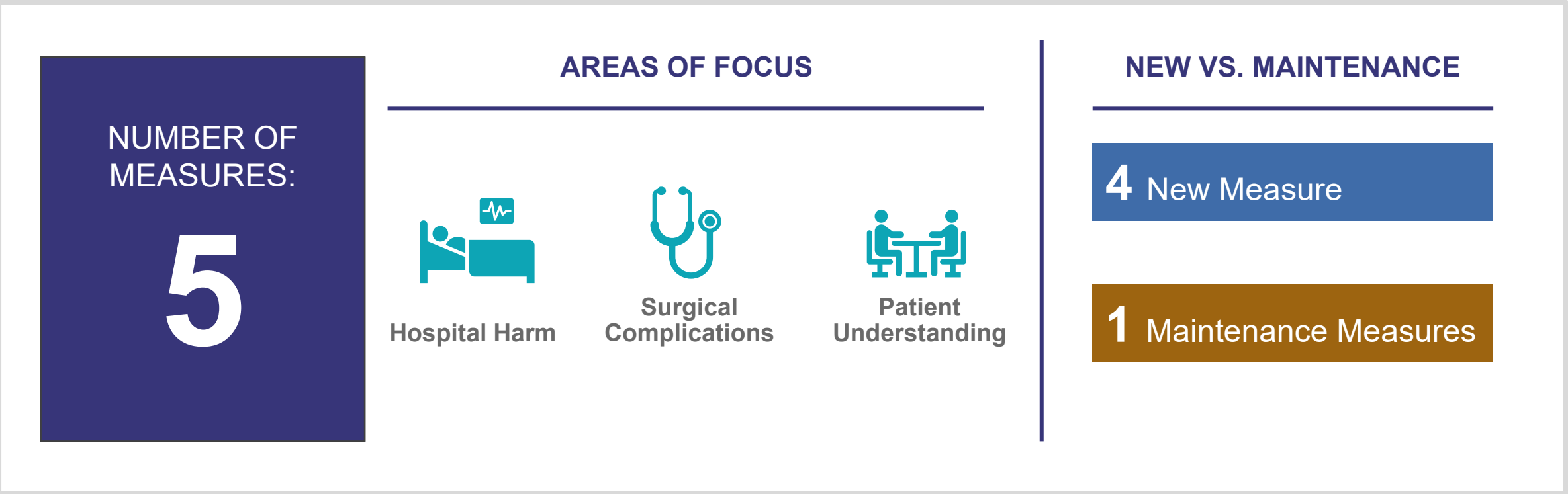
Overview of Fall 2023 Measures for Endorsement Consideration



Fall 2023 Measures for Committee Review



Five measures were submitted to the Management of Acute and Chronic Events committee for endorsement consideration.



Fall 2023 Measures for Committee Review



CBE ID	Title	Importance (n)	Feasibility (n)	Scientific Acceptability (n)	Equity (n)	Use & Usability (n)
CBE #4210	Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure	Consensus (22) 86% Met; 9% Not Met, but Addressable; 5% Not Met	Consensus (22) 82% Met; 5% Not Met, but Addressable; 14% Not Met	Consensus (22) 9% Met; 82% Not Met, but Addressable; 9% Not Met	Consensus (22) 14% Met; 9% Not Met, but Addressable; 77% Not Met	Consensus (22) 91% Met; 0% Not Met, but Addressable; 9% Not Met
CBE #4130e	Hospital Harm: Postoperative Respiratory Failure	No Consensus (18) 28% Met; 67% Not Met, but Addressable; 6% Not Met	Consensus (18) 89% Met; 6% Not Met, but Addressable; 6% Not Met	Consensus (18) 100% Met; 0% Not Met, but Addressable; 0% Not Met	Consensus (18) 100% Met; 0% Not Met, but Addressable; 0% Not Met	Consensus (18) 89% Met; 11% Not Met, but Addressable; 0% Not Met
CBE #4120e	Hospital Harm: Falls with Injury	Consensus (19) 95% Met; 5% Not Met, but Addressable; 0% Not Met	Consensus (19) 95% Met; 5% Not Met, but Addressable; 0% Not Met	Consensus (19) 89% Met; 11% Not Met, but Addressable; 0% Not Met	Consensus (19) 95% Met; 5% Not Met, but Addressable; 0% Not Met	Consensus (19) 95% Met; 5% Not Met, but Addressable; 0% Not Met

Legend:

n – number of committee independent reviews

Fall 2023 Measures for Committee Review, continued 1



CBE ID	Title	Importance (n)	Feasibility (n)	Scientific Acceptability (n)	Equity (n)	Use & Usability (n)
CBE #4125	Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue)	Consensus (18) 94% Met; 6% Not Met, but Addressable; 0% Not Met	Consensus (18) 100% Met; 0% Not Met, but Addressable; 0% Not Met	Consensus (18) 11% Met; 83% Not Met, but Addressable; 6% Not Met	Consensus (18) 100% Met; 0% Not Met, but Addressable; 0% Not Met	Consensus (18) 94% Met; 0% Not Met, but Addressable; 6% Not Met
CBE #0694	Hospital Risk-Standardized Complication Rate Following Implantation of Implantable Cardioverter-Defibrillator (ICD)	No Consensus (19) 11% Met; 16% Not Met, but Addressable; 74% Not Met	Consensus (19) 79% Met; 11% Not Met, but Addressable; 11% Not Met	Consensus (19) 0% Met; 5% Not Met, but Addressable; 95% Not Met	Consensus(19) 0% Met; 0% Not Met, but Addressable; 100% Not Met	Consensus(19) 0% Met; 0% Not Met, but Addressable; 100% Not Met

Legend:

n – number of committee independent reviews

Test Vote



Consideration of Non-Consensus Candidate Measures



CBE #4210 – Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure



Item	Description
Measure Description	<ul style="list-style-type: none"> 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 9-item survey to obtain patient’s feedback on 3 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 items given the most favorable responses ("Yes" or "Very Clear") out of the total number of relevant items.
Developer/Steward	<ul style="list-style-type: none"> Yale Center for Outcomes Research and Evaluation (CORE)/ Centers for Medicare & Medicaid Services (CMS)
New or Maintenance	<ul style="list-style-type: none"> New
Current or Planned Use	<ul style="list-style-type: none"> Public reporting; Quality improvement (internal to the specific organization); Quality improvement with benchmarking (external benchmarking to multiple organizations)

Measure Type	Target Population(s)	Care Setting	Level of Analysis
Patient-Reported Outcome Measure (PRO-PM)	Adults (Age >18)	Hospital: Outpatient	Facility

CBE #4210

Public Comments



Two comments received

- Two comments were supportive of the measure, stating that personalized, clear discharge instructions are important for patient follow through and compliance of medical recommendations and that outpatient procedures are becoming increasingly common, and this measure allows for comparison between provider locations, resulting in patients being more informed.

Supportive of the measure

2

CBE #4210 – Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure, continued 1



Importance - Extent to which the measure is evidence-based AND is important for making significant gains in health care quality or cost where there is variation in or overall, less-than-optimal performance.

Importance (n=22)	Strengths	Limitations
<p>Consensus</p> <p>86% Met</p> <p>9% Not Met, but Addressable</p> <p>5% Not Met</p>	<ul style="list-style-type: none"> • Logic model clearly connects measure performance (patient understanding of instructions) with health outcomes such as ED visits, readmissions, etc. • Committee members' own clinical experience reflects the importance of providing effective patient education to reduce poor outcomes • Measure adds value to existing portfolio and aligns with CMS's National Quality Strategy 	<ul style="list-style-type: none"> • Literature review could have been more robust; it does not clearly connect improved patient understanding with improved outcomes following outpatient surgery.

CBE #4210 – Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure, continued 2



Feasibility - Extent to which the measure specifications (i.e., numerator, denominator, exclusions) require data that are readily available OR could be captured without undue burden AND can be implemented for performance measurement.

Feasibility (n=22)	Strengths	Limitations
<p>Consensus</p> <p>82% Met</p> <p>5% Not Met, but Addressable</p> <p>14% Not Met</p>	<ul style="list-style-type: none"> Multi-modal survey administration is an advantage Fewer survey items reduce burden on patients 	<ul style="list-style-type: none"> Measure would be more effective if administered before discharge, enabling facilities to address concerns (mailed surveys would not be ideal for timing) A text survey mode might get better response rate than email Burden on facilities may be significant; e.g., Medicaid agencies may struggle to collect data and calculate the measure Testing may not have been adequate to reveal true burden on facilities Lack of clarity in how the measure is scored from survey items

CBE #4210 – Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure, continued 3



Scientific Acceptability [i.e., Reliability and Validity] - Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.

Scientific Acceptability (n=22)	Strengths	Limitations
<p>Consensus</p> <p>9% Met</p> <p>82% Not Met, but Addressable</p> <p>9% Not Met</p>	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Testing sample was too small to report reliability by decile More clarity is needed in how the denominator is defined/calculated, specifically regarding removal of incomplete surveys and the use of 'two midnights' to define episodes Face validity was assessed by TEP; additional information regarding the panel composition and voting outcomes is desired Validity test comparing measure to similar OAS CAHPS measure had limited sample size and non-significant results Not risk-adjusted

CBE #4210 – Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure, continued 4



Equity (optional) - Extent to which the measure can identify differences in care for certain patient populations, which can be used to advance health equity and reduce disparities in care.

Equity (n=22)	Strengths	Limitations
<p>Consensus</p> <p>14% Met</p> <p>9% Not Met, but Addressable</p> <p>77% Not Met</p>	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> This optional domain not addressed by the developer Unclear whether survey was validated in diverse populations, e.g., among Spanish speakers Translation quality can impact patient’s understanding of discharge instructions, if not English speaking Equity should be a focus of this measure given differences in how patient education is received as well as differences in ability to respond to the survey (e.g., literacy, language)

CBE #4210 – Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure, continued 5



Use and Usability - Extent to which potential audiences (e.g., consumers, purchasers, providers, and policymakers) are using or could use measure results for both accountability and performance improvement to achieve the goal of high quality, efficient health care for individuals or populations.

Use and Usability (n=22)	Strengths	Limitations
<p>Consensus</p> <p>91% Met</p> <p>0% Not Met, but Addressable</p> <p>9% Not Met</p>	<ul style="list-style-type: none"> Planned for use in HOQR Support for initial rollout in HOQR, though not all support the measure for public reporting 	<ul style="list-style-type: none"> Measure may not be sufficiently generalizable to patient populations to be ready for public reporting Unclear how data would be furnished to providers to help improve care

Lunch



CBE #4130e – Hospital Harm – Postoperative Respiratory Failure



Item	Description
Measure Description	<ul style="list-style-type: none">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).
Developer/Steward	<ul style="list-style-type: none">American Institutes for Research (AIR) / CMS
New or Maintenance	<ul style="list-style-type: none">New
Current or Planned Use	<ul style="list-style-type: none">Payment ProgramPublic Reporting

Measure Type	Target Population(s)	Care Setting	Level of Analysis
Outcome	Adults (Age >18)	Hospital: Inpatient	Facility

CBE #4130e

Public Comments



Six comments received

- Two comments supported the measure with the condition that it should receive CBE endorsement before implementation and also encouraged assessing the feasibility of collecting data from EHRs and using more vendor systems and hospital in that assessment.

Support the endorsement prior to use

2

- One comment supported the measure, while encouraging the developer to consider non-elective hospitalizations to improve monitoring.
- One comment was supportive of the measure, emphasizing that post-op respiratory failure is the most prevalent and serious post-op pulmonary complication.

Supportive of the measure

2

- One comment indicated concern about the feasibility of the measure without more information on the specification of electronic components in the measure.

Feasibility

1



Six comments received

- One comment noted several areas of concern that may make the measure unsuitable for its use, including non-standardized data capture and sensitivity of screening technologies overshadowing performance. The commenter indicated that there is serious potential for unintended consequences.

Suitability

1

CBE #4130e – Hospital Harm- Postoperative Respiratory Failure, continued 1



Importance - Extent to which the measure is evidence-based AND is important for making significant gains in health care quality or cost where there is variation in or overall, less-than-optimal performance.

Importance (n=18)	Strengths	Limitations
<p>No Consensus</p> <p>28% Met</p> <p>67% Not Met, but Addressable</p> <p>6% Not Met</p>	<ul style="list-style-type: none"> The definition of post-operative respiratory failure (PRF) used in the measure has been widely adopted Literature review and logic model support the business case for the measure, even if lacking consensus on PRF definition PRF is a common, serious post-operative complication and a performance gap exists 	<ul style="list-style-type: none"> Lack of a consensus on the definition of PRF Available interventions are limited and have mixed evidence

CBE #4130e – Hospital Harm- Postoperative Respiratory Failure, continued 2



Feasibility - Extent to which the measure specifications (i.e., numerator, denominator, exclusions) require data that are readily available OR could be captured without undue burden AND can be implemented for performance measurement.

Feasibility (n=18)	Strengths	Limitations
<p>Consensus</p> <p>89% Met</p> <p>6% Not Met, but Addressable</p> <p>6% Not Met</p>	<ul style="list-style-type: none"> Nearly all data elements are captured in structured fields No significant barriers were identified 	<ul style="list-style-type: none"> Documentation of mechanical ventilation is not standardized Some EHRs may require adjustment, which can be expensive and burdensome

CBE #4130e – Hospital Harm- Postoperative Respiratory Failure, continued 3



Scientific Acceptability [i.e., Reliability and Validity] - Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.

Scientific Acceptability (n=18)	Strengths	Limitations
<p>Consensus</p> <p>100% Met</p> <p>0% Not Met, but Addressable</p> <p>0% Not Met</p>	<ul style="list-style-type: none"> Approaches for testing reliability, validity and risk adjustment models are clearly described and appropriate 	<ul style="list-style-type: none"> None

CBE #4130e – Hospital Harm- Postoperative Respiratory Failure, continued 4



Equity (optional) - Extent to which the measure can identify differences in care for certain patient populations, which can be used to advance health equity and reduce disparities in care.

Equity (n=18)	Strengths	Limitations
<p>Consensus</p> <p>100% Met</p> <p>0% Not Met, but Addressable</p> <p>0% Not Met</p>	<ul style="list-style-type: none">Developers used extensive evidence base to evaluate disparities and design the risk adjustment model	<ul style="list-style-type: none">None

CBE #4130e – Hospital Harm- Postoperative Respiratory Failure, continued 5



Use and Usability - Extent to which potential audiences (e.g., consumers, purchasers, providers, and policymakers) are using or could use measure results for both accountability and performance improvement to achieve the goal of high quality, efficient health care for individuals or populations.

Use and Usability (n=18)	Strengths	Limitations
<p>Consensus</p> <p>89% Met</p> <p>11% Not Met, but Addressable</p> <p>0% Not Met</p>	<ul style="list-style-type: none"> Planned for use in IQR Agreement among patients and entities that measure is useful for decision-making 	<ul style="list-style-type: none"> Concern about the measure’s use in payment models and evidence cited showing that reduction of PRF is challenged by unclear evidence regarding risk factors and application of interventions

CBE #4120e – Hospital Harm – Falls with Injury



Item	Description
Measure Description	<ul style="list-style-type: none">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.
Developer/Steward	<ul style="list-style-type: none">AIR/CMS
New or Maintenance	<ul style="list-style-type: none">New
Current or Planned Use	<ul style="list-style-type: none">Payment programPublic reporting

Measure Type	Target Population(s)	Care Setting	Level of Analysis
Outcome	Adults (Age >18)	Hospital: Inpatient	Facility

CBE #4120e – Hospital Harm- Falls with Injury

Public Comments



11 comments received

- Three comments supported the measure. One of the comments encouraged the developer clarify the denominator exclusions language and another comment supported the measure with the condition that it receive endorsement consideration before implementation.

Supportive

3

- Four comments raised concern that this measure may lead to the reduction of mobilization for patients in order to reduce fall numbers.

Unintended consequences

4

- Four comments raised concern with the classification categories for injury used in the measure.

Concern with measure's injury classifications

4

CBE #4120e – Hospital Harm- Falls with Injury

Public Comments, continued 1

11 comments received

- Two comments emphasized the challenges associated with electronic clinical quality measures (eCQMs) and implementation and burden.

eCQM burden

2

CBE #4120e – Hospital Harm – Falls with Injury, continued 1



Importance - Extent to which the measure is evidence-based AND is important for making significant gains in health care quality or cost where there is variation in or overall, less-than-optimal performance.

Importance (n=19)	Strengths	Limitations
<p>Consensus</p> <p>95% Met</p> <p>5% Not Met, but Addressable</p> <p>0% Not Met</p>	<ul style="list-style-type: none"> • Ample, clear evidence is provided showing that falls in inpatient settings are common, preventable, and costly, and harm increases with age • Interventions are known to improve patient safety and reduce costs • A substantial performance gap has been demonstrated • The measure is supported by patients 	<ul style="list-style-type: none"> • Measure Information Form’s importance section should be updated to document screening and mitigation strategies described elsewhere in the submission

CBE #4120e – Hospital Harm – Falls with Injury, continued 2



Feasibility - Extent to which the measure specifications (i.e., numerator, denominator, exclusions) require data that are readily available OR could be captured without undue burden AND can be implemented for performance measurement.

Feasibility (n=19)	Strengths	Limitations
<p data-bbox="188 648 364 676">Consensus</p> <p data-bbox="114 739 244 768">95% Met</p> <p data-bbox="114 831 346 902">5% Not Met, but Addressable;</p> <p data-bbox="114 965 282 993">0% Not Met</p>	<ul data-bbox="479 648 1327 831" style="list-style-type: none"><li data-bbox="479 648 1327 729">• All data elements exist in structured fields in the EHR systems tested (Epic, Allscripts)<li data-bbox="479 758 1327 831">• Only one hospital required a workflow change to collect all data elements	<ul data-bbox="1406 648 2384 791" style="list-style-type: none"><li data-bbox="1406 648 2384 729">• Feasibility testing did not include hospitals using other significant EHR systems (Cerner, Meditech)<li data-bbox="1406 758 2384 791">• Information about falls may reside in text fields

CBE #4120e – Hospital Harm – Falls with Injury, continued 3



Scientific Acceptability [i.e., Reliability and Validity] - Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.

Scientific Acceptability (n=19)	Strengths	Limitations
<p>Consensus</p> <p>89% Met</p> <p>11% Not Met, but Addressable</p> <p>0% Not Met</p>	<ul style="list-style-type: none"> Reliability analysis approach is appropriate, and findings meet the threshold for reliability (>0.6) except for the two hospitals with the smallest samples The measure has strong face validity and numerator and denominator elements have excellent positive predictive value (>98%) 	<ul style="list-style-type: none"> Sample used for reliability testing is small (12 hospitals) Sample is not representative; it includes only large teaching hospitals; smaller, rural, and non-teaching hospitals are not included

CBE #4120e – Hospital Harm – Falls with Injury, continued 4



Equity (optional) - Extent to which the measure can identify differences in care for certain patient populations, which can be used to advance health equity and reduce disparities in care.

Equity (n=19)	Strengths	Limitations
<p>Consensus</p> <p>95% Met</p> <p>5% Not Met, but Addressable</p> <p>0% Not Met</p>	<ul style="list-style-type: none"> A social disparities analysis evaluated differences by race/ethnicity and insurance status to determine appropriate approach to stratification 	<ul style="list-style-type: none"> Sample included only urban hospitals, so evaluation of disparities may be limited

CBE #4120e – Hospital Harm – Falls with Injury, continued 5



Use and Usability - Extent to which potential audiences (e.g., consumers, purchasers, providers, and policymakers) are using or could use measure results for both accountability and performance improvement to achieve the goal of high quality, efficient health care for individuals or populations.

Use and Usability (n=19)	Strengths	Limitations
<p>Consensus</p> <p>95% Met</p> <p>5% Not Met, but Addressable</p> <p>0% Not Met</p>	<ul style="list-style-type: none"> Measure is planned for public reporting in IQR There exist evidence-based protocols for falls prevention hospitals can use to improve 	<ul style="list-style-type: none"> Public comments called attention to a potential unintended consequence of decreased patient mobilization

Break



CBE #4125 – Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue)



Item	Description
Measure Description	<ul style="list-style-type: none">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.
Developer/Steward	<ul style="list-style-type: none">AIR/CMS
New or Maintenance	<ul style="list-style-type: none">New
Current or Planned Use	<ul style="list-style-type: none">Public reporting

Measure Type	Target Population(s)	Care Setting	Level of Analysis
Outcome	Patients age 18-89 years	Hospital: Inpatient	Facility



11 comments received

- One comment suggested a more narrow and well-scoped list of adverse events that need close monitoring post-op.

Need more specificity

1

- One comment shared concern that the measure disregards site of death and that this can introduce scenarios outside of a hospital's control.
- One comment requested 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.

Site of death

2

- 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.

Unintended consequences

1



11 comments received

- One comment showed concern for the lack of risk adjustment in the outcome measure and suggested using patient population stratification.

Risk adjustment

1

- One comment stated that there are excessive exclusions in the denominator, the risk adjustment, and regarding missing information.

Excessive exclusions

1

- One comment recommended the measure with conditions, noting it should be submitted for endorsement consideration before implementation.
- One comment recommended the measure with conditions, noting concern about the current reliability of the measure and that it should be submitted for endorsement consideration.

Support the endorsement prior to use

2



11 comments received

- One comment recommended that testing be conducted to evaluate the measure for volume bias among facilities. They also promoted the use of artificial intelligence to reduce provider burden.

Volume bias

1

- One comment did not support the measure due to concerns with underlying evidence for the expansion to 30 days post-discharge, as well as reliability.

Evidence concern for the expansion to 30-days

1

- One comment raised a number of concerns contributing to the measure being unsuitable for federal programs. Concerns include reliability, risk adjustment, specifications, and capture of Medicare Advantage patients.

Unsuitability for use in federal programs

1

CBE #4125 – Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue), continued 1



Importance - Extent to which the measure is evidence-based AND is important for making significant gains in health care quality or cost where there is variation in or overall, less-than-optimal performance.

Importance (n=18)	Strengths	Limitations
<p>Consensus</p> <p>94% Met</p> <p>6% Not Met, but Addressable</p> <p>0% Not Met</p>	<ul style="list-style-type: none"> Strong evidence base showing multiple, facility-level interventions (e.g., nursing staffing ratios, nursing education, residency training programs) that can influence patient outcomes Failure to rescue is a key gap area for clinical quality measurement 	<ul style="list-style-type: none"> Some of the evidence related to staffing is more than 30 years old

CBE #4125 – Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue), continued 2



Feasibility - Extent to which the measure specifications (i.e., numerator, denominator, exclusions) require data that are readily available OR could be captured without undue burden AND can be implemented for performance measurement.

Feasibility (n=18)	Strengths	Limitations
<p>Consensus</p> <p>100% Met</p> <p>0% Not Met, but Addressable</p> <p>0% Not Met</p>	<ul style="list-style-type: none"> Claims-based measure with no burden on facilities or providers Measure is modeled after Patient Safety Indicator 04 (PSI 04), a highly feasible measure 	<ul style="list-style-type: none"> None

CBE #4125 – Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue), continued 3



Scientific Acceptability [i.e., Reliability and Validity] - Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.

Scientific Acceptability (n=18)	Strengths	Limitations
<p>Consensus</p> <p>11% Met</p> <p>83% Not Met, but Addressable</p> <p>6% Not Met</p>	<ul style="list-style-type: none"> The measure has strong face validity (90% agreement among the TEP) Convergent validity for the measure is stronger than for PSI 04 	<ul style="list-style-type: none"> About half of facilities have reliability below the threshold (0.6) Higher reliability may be difficult to achieve given limitations of claims data (most underlying clinical factors are not available), and raising the minimum case threshold or extending the reporting time frame may not achieve the desired outcome

CBE #4125 – Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue), continued 4



Equity (optional) - Extent to which the measure can identify differences in care for certain patient populations, which can be used to advance health equity and reduce disparities in care.

Equity (n=18)	Strengths	Limitations
<p>Consensus</p> <p>100% Met</p> <p>0% Not Met, but Addressable</p> <p>0% Not Met</p>	<ul style="list-style-type: none"> Potential disparities associated with race/ethnicity, age and sex were evaluated and reported; as none were found when adjusting for clinical risk factors, these social risk factors were not included in the risk adjustment model 	<ul style="list-style-type: none"> None

CBE #4125 – Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue), continued 5



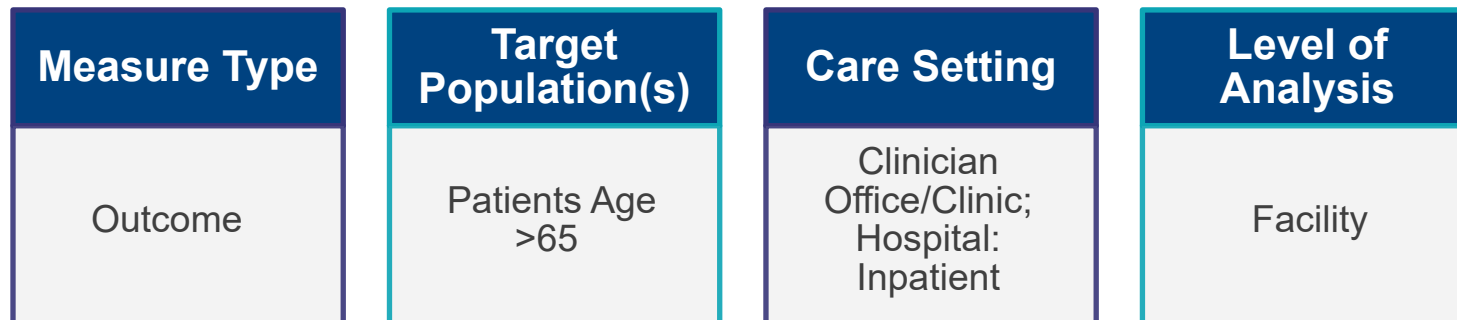
Use and Usability - Extent to which potential audiences (e.g., consumers, purchasers, providers, and policymakers) are using or could use measure results for both accountability and performance improvement to achieve the goal of high quality, efficient health care for individuals or populations.

Use and Usability (n=18)	Strengths	Limitations
<p>Consensus</p> <p>94% Met</p> <p>0% Not Met, but Addressable</p> <p>6% Not Met</p>	<ul style="list-style-type: none"> • Measure planned for use in public reporting • The literature review cites a range of facility-level interventions hospitals can use to improve performance 	<ul style="list-style-type: none"> • Concerns were expressed about public reporting before the reliability limitations are addressed • The measure might not be useful for facilities without a sizable Medicare population, and should be reworked to include all payers

CBE #0694 – Hospital Risk-Standardized Complication Rate Following Implantation of Implantable Cardioverter-Defibrillator (ICD)



Item	Description
Measure Description	<ul style="list-style-type: none"> 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
Developer/Steward	<ul style="list-style-type: none"> American College of Cardiology
New or Maintenance	<ul style="list-style-type: none"> Maintenance
Current or Planned Use	<ul style="list-style-type: none"> Not in use



CBE #0694

Public Comments



No comments received

CBE #0694 – Hospital Risk-Standardized Complication Rate Following Implantation of Implantable Cardioverter-Defibrillator (ICD), continued 1



Importance - Extent to which the measure is evidence-based AND is important for making significant gains in health care quality or cost where there is variation in or overall, less-than-optimal performance.

Importance (n=19)	Strengths	Limitations
<p>No Consensus</p> <p>11% Met</p> <p>16% Not Met, but Addressable</p> <p>74% Not Met</p>	<ul style="list-style-type: none"> This remains a meaningful quality of care measure, although there are barriers to demonstrating importance 	<ul style="list-style-type: none"> Many of the literature sources cited are older and may be outdated Performance data have not been updated in more than 15 years and continuing existence of a gap cannot be evaluated

CBE #0694 – Hospital Risk-Standardized Complication Rate Following Implantation of Implantable Cardioverter-Defibrillator (ICD), continued 2



Feasibility - Extent to which the measure specifications (i.e., numerator, denominator, exclusions) require data that are readily available OR could be captured without undue burden AND can be implemented for performance measurement.

Feasibility (n=19)	Strengths	Limitations
<p>Consensus</p> <p>79% Met</p> <p>11% Not Met, but Addressable</p> <p>11% Not Met</p>	<ul style="list-style-type: none"> All data elements are available in defined fields in claims and the registry 	<ul style="list-style-type: none"> Not all hospitals report registry data and the extent of data missingness is not provided

CBE #0694 – Hospital Risk-Standardized Complication Rate Following Implantation of Implantable Cardioverter-Defibrillator (ICD), continued 3



Scientific Acceptability [i.e., Reliability and Validity] - Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.

Scientific Acceptability (n=19)	Strengths	Limitations
<p>Consensus</p> <p>0% Met</p> <p>5% Not Met, but Addressable</p> <p>95% Not Met</p>	<ul style="list-style-type: none"> • Good data element validity – agreement between chart and other sources 	<ul style="list-style-type: none"> • Data used to test reliability is more than 10 years old • Available reliability testing results show low reliability (split-half reliability ICC = 0.1494)

CBE #0694 – Hospital Risk-Standardized Complication Rate Following Implantation of Implantable Cardioverter-Defibrillator (ICD), continued 4



Equity (optional) - Extent to which the measure can identify differences in care for certain patient populations, which can be used to advance health equity and reduce disparities in care.

Equity (n=19)	Strengths	Limitations
<p>Consensus</p> <p>0% Met</p> <p>0% Not Met, but Addressable</p> <p>100% Not Met</p>	<ul style="list-style-type: none"> This optional criterion was not addressed 	<ul style="list-style-type: none"> This optional criterion was not addressed

CBE #0694 – Hospital Risk-Standardized Complication Rate Following Implantation of Implantable Cardioverter-Defibrillator (ICD), continued 5



Use and Usability - Extent to which potential audiences (e.g., consumers, purchasers, providers, and policymakers) are using or could use measure results for both accountability and performance improvement to achieve the goal of high quality, efficient health care for individuals or populations.

Use and Usability (n=19)	Strengths	Limitations
<p>Consensus</p> <p>0% Met</p> <p>0% Not Met, but Addressable</p> <p>100% Not Met</p>	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Measure is not currently in use No recent performance data so improvement on the measure cannot be evaluated

Additional Measure Recommendations Discussion

Based on the measure discussions today, are there additional recommendations or solutions the developer can use to overcome any potential measure limitations?



Opportunity for Public Comment



Next Steps



Next Steps for Fall 2023



Meeting Summary

- Meeting summary will be posted to the E&M committee project page by February 26, 2024.



Appeals Period

- **Appeals Period:** February 26 – March 18
- Appeals committee will meet on March 27, 2024 to review eligible appeals. Please refer to the [E&M Guidebook](#) for more information about the appeals process.



Technical Report

- At the conclusion of the appeals period, a final technical report will be posted to the E&M Committee project page in April 2024.

Thank You!

Have questions? Contact us at
PQMsupport@battelle.org





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