Partnership for Quality Measurement
Powered by Battelle

Spring 2023 Cycle

PREVENTION AND POPULATION HEALTH FINAL TECHNICAL REPORT

February 2024

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Executive Summary

Prevention and population health has a central role in the mitigation of disease and the improvement of the nation's health. Prevention and population health services are often characterized by routine disease-screening practices and various methods of risk assessment as well as early disease detection and treatment.[1] The prevention-based population health approach remains a relevant practice across all domains of disease control and provides a commonly shared roadmap for clinical health professions to optimally engage their patients.

Quality measures are necessary tools for assessing improvements in prevention and population health as well as the extent to which health care stakeholders are using evidence-based strategies to advance the quality of care. To support this effort, Battelle endorses and maintains performance measures through a standardized, consensus-based process.

For this project's measure review cycle, three measures were submitted for endorsement consideration (Table 1). The committee recommended two measures for endorsement but did not recommend endorsement for one measure. The Consensus Standards Approval Committee (CSAC) upheld the committee's endorsement recommendations.

Effective March 27, 2023, the National Quality Forum (NQF) is no longer the 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. Battelle has been selected to oversee the endorsement & maintenance (E&M) of clinical quality and cost/resource use measures. Because the Spring 2023 cycle launched at NQF, measures submitted to this E&M cycle continued along the prior E&M protocols in place at time of the Spring 2023 "Intent to Submit." Battelle took over the E&M work for the Spring 2023 when developers and/or stewards submitted their full measure information. To close out this E&M cycle, Battelle published the Spring 2023 measures for pre-evaluation public commenting, convened the E&M standing committees for their measure evaluation meetings, launched the Spring 2023 post-comment period, convened the E&M committees for the post-comment meeting, convened the CSAC to render a final endorsement decision, and executed the appeals period.

Table 1. Measures Submitted for Endorsement Consideration

Measure Number	Measure Title	New/Maintenance	Developer/Steward	Final Endorsement Decision
CBE #3748	Quality of Care Composite for Implantable Cardioverter-Defibrillator (ICD)/Cardiac Resynchronization Therapy Defibrillator (CRT-D)	New	American College of Cardiology	Endorsed

Measure Number	Measure Title	New/Maintenance	Developer/Steward	Final Endorsement Decision
CBE #3751	Risk Adjusted Post-Ambulance Provider Triage Emergency Department (ED) Visit Rate Measure	New	Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation [Yale CORE]/CMS	Endorsed
CBE #3747	Engagement in Community-Based Mental Health Care After a Mental Health Hospitalization	New	New York State Office of Mental Health	Not Endorsed

Summaries of the measure evaluation meetings are linked within the body of the report. Detailed summaries of the committee's discussion and ratings of the criteria for each measure are in Appendix A.

Introduction

Prevention and population health interventions aim to prevent health and well-being problems from occurring at a root-cause level.[2] They seek to influence the structural inequities and socio-economic drivers that allow health and well-being problems to occur. Unlike public health, which focuses on larger populations such as entire cities or even a country, prevention and population health is more focused. It examines how the well-being of smaller groups of people and communities are managed.[2] The result of these activities should achieve positive health outcomes within the identified population.

Quality measures are tools to measure or quantify health care processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health. Furthermore, quality metrics can be powerful tools in helping identify substantial performance gaps in prevention and population health, affecting patient outcomes and overall cost.

As a CBE, Battelle convenes volunteer committees to evaluate and build consensus around quality measures for endorsement based on a standardized set of criteria. For the Spring 2023 cycle, the Prevention and Population Health standing committee reviewed measures focused on defibrillator quality of care, emergency department (ED) use, and community-based mental health care.

Defibrillator Quality of Care

A defibrillator is a device that sends an electric shock to the heart to restore a normal heartbeat.[3] It is used to treat and prevent cardiac arrest, thereby greatly increasing the chance of survival. Defibrillator therapies, such as implantable cardioverter-defibrillator (ICD) or cardiac resynchronization therapy defibrillator (CRT-D), can provide primary and secondary prevention of sudden cardiac death. However, these devices should only be considered in certain individuals based on clinical practice guidelines,[4] along with a patient discussion about whether the anticipated benefits outweigh the risks of device therapy.

To further improve clinical outcomes for individuals with these devices, several evidence-based medications are indicated at hospital discharge following the placement of an ICD device. These include beta-blockers and angiotensin-converting enzyme (ACE) inhibitors, angiotensin-receptor antagonists/blockers (ARBs), or angiotensin-receptor-neprilysin inhibitory (ARNI), which reduce morbidity, mortality, and hospitalizations.[4]

Emergency Department Use

Evidence shows that a substantial proportion of older adults preferred home evaluation, rather than hospital evaluation, when considering desired treatment site for acute illness or injury if both sites offered equivalent outcomes.[5] Patients seeking emergency care with low-acuity presentations value the convenience of the ED and have relayed substantial concerns with

accessing primary care clinicians in a timely fashion.[6] However, allowing ambulance providers to provide Transportation to Alternative Destination (TAD) (e.g., urgent care center, community mental health center) or Treatment In Place (TIP) intervention options for lower-acuity conditions may lead to improved patient outcomes, increased ambulance provider efficiency, lower costs to the payers, and lessen the low-acuity patient volume in EDs.[7] In cases where ambulance services are requested by a call to 911, it may be appropriate for the ambulance provider to triage lower-acuity patients to settings other than the ED.

Community-Based Mental Health Care

Follow-up care after an inpatient psychiatric discharge has been associated with reduced inpatient readmissions, increased medication utilization, increased outpatient encounters, and increased functioning.[8] People discharged from a psychiatric hospitalization are in an acute phase of their mental health condition and need to receive more than one visit for adequate treatment. Therefore, it is important to also measure engagement in community-based mental health care over a longer time period post discharge.

Prevention and Population Health Measure Evaluation

For this measure review cycle, the Prevention and Population Health standing committee (Appendix B) evaluated three new measures against standard measure evaluation criteria.

Table 2. Number of Spring 2023 Prevention and Population Health Measures Submitted and Reviewed

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

**Measure developers/stewards can withdraw a measure from measure endorsement review at any point before the CSAC meeting.*

Scientific Methods Panel Measure Evaluation

For the Spring 2023 cycle, the Scientific Methods Panel did not review any of the Prevention and Population Health measures due to the transition of the CBE.

Comments Received Prior to Standing Committee Evaluation

Battelle accepts comments on measures under endorsement review through the Partnership for Quality Measurement (PQM)™ website. For this evaluation cycle, the pre-evaluation commenting period opened on May 18, 2023, and closed on June 25, 2023. Six pre-evaluation comments were submitted and shared with the standing committee prior to the measure evaluation meeting on August 3, 2023. Four comments were received for CBE #3747, two of which were in support of the measure, stating the measure met criteria for approval. The remaining two public comments were non-supportive, expressing concern that occupational health settings should be included in the measure, raising questions regarding how the measure treats dually enrolled Medicare/Medicaid patients, and raising issues with this measure in rural and medically underserved communities where resources for outpatient behavioral health services may be unavailable.

Both CBE #3748 and CBE #3751 both received one supportive comment each, noting the measures meet criteria for approval. A summary of comments for each measure reviewed is provided in Appendix A.

Comments Received Post Standing Committee Evaluation

Following the standing committee's measure evaluation meeting, the committee endorsement recommendations were posted on the PQM website for public comment. The commenting period opened on August 25, 2023, and closed on September 13, 2023. The committee received one comment from the developer of CBE #3747 pertaining to the committee's review of the measure, as the committee did not reach consensus during the August 3 measure evaluation meeting and revoted on the measure during the post-comment meeting.

Battelle convened the committee for the Spring 2023 post-comment web meeting on October 19, 2023, to review the comment received and to discuss and revote on validity for CBE #3747, which did not achieve consensus on this must-pass criterion during the measure evaluation meeting, referred to as a "consensus not reached" (CNR) measure. A summary of the comment for is provided in Appendix A.

Summary of Potential High-Priority Gaps

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

Summary of Major Concerns or Methodological Issues

During the Prevention and Population Health committee meetings, the committee drew attention to concerns with some predictive statistics of one of the measures (CBE #3747). The developer provided face validity and criterion validity testing, which supported the validity of the measure. However, the developer also performed concordance testing to predict whether this measure can impact outcomes after the measurement period, such as mental health inpatient readmissions, psychotropic medication adherence, and continued engagement. Some

committee members noted the concordance results were weak because the C-statistic was less than 0.7, indicating the measure is not a strong predictor of mental health readmission and emergency room visits.

Committee members expressed the need for consistency in how measures are evaluated and endorsed, while other committee members expressed that the purpose of measures is to improve clinical outcomes, not to have measures for the sake of having measures, and endorsement of one measure does not guarantee endorsement of another.

Based on this measure evaluation, there was a perceived need from standing committee members for further guidance for developers regarding how to best meet the validity criterion, considering the committee's concerns with the validity testing for CBE #3747. Details of the standing committee's discussion and ratings of the criteria for each measure are included in Appendix A.

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7. Fried TR, van Dorn C, Tinetti ME, Drickamer MA. (2000). Older person's preferences for home vs hospital care in the treatment of acute illness. Arch Intern Med, 160(10), 1501-1506. https://doi.org/10.1001/archinte.160.10.1501

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Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Battelle ensures that quorum is maintained for all live voting. A quorum is 66% of active standing committee members minus any recused standing committee members. Due to the exclusion of recused standing committee members from the quorum calculation, the required quorum for live voting may vary among measures.

During the meeting, the quorum required for voting was not achieved (14 out of 20 standing committee members for CBE #3747 and CBE #3748 and 13 standing committee members for CBE #3751). Therefore, the committee discussed all criteria for each measure and voted after the meeting using an online voting tool. The committee received a recording of the meeting and a link to submit online votes. Voting closed after 48 hours with at least the number of votes required for quorum. Voting results are provided below.

A measure is recommended for endorsement by the standing committee when greater than 60% of voting members select a passing vote option (i.e., Pass, High and Moderate, or Yes) on all must-pass criteria and overall suitability for endorsement. A measure is not recommended for endorsement when less than 40% of voting members select a passing vote option on any must-pass criterion or overall suitability for endorsement.

A.1 Measures Endorsed

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

Staff Assessment | Specifications

Numerator Statement: Generator patients: Who receive all medications for which they are eligible: ACE/ARB/ARNI prescribed at discharge (if eligible for ACE/ARB/ARNI as described in denominator) AND beta blockers prescribed at discharge (if eligible for beta blockers as described in denominator), AND whose procedures fulfill class I, IIa, or IIb guideline indications.

Denominator Statement: All generator patients surviving hospitalization who meet the criteria for the individual metrics in the composite.

Exclusions: None.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility

Setting of Care: Inpatient/Hospital

Type of Measure: Composite

Data Source: Registry Data

Measure Steward: American College of Cardiology

STANDING COMMITTEE EVALUATION

Table A.1-1.1. Importance to Measure and Report (MUST PASS)

Criterion	Total Votes	Rationale
1a. Evidence	• Total Votes-14; H-4; M-10; L-0; I-0 (14/14 – 100%, Pass)	• The committee considered the logic models for each of the component measures within the composite, depicting the use of guideline-recommended medications in eligible ICD/CRT-D implant patients. • The committee recognized the importance of this measure based on the supportive evidence and passed the measure on evidence.
1b. Performance Gap	• Total Votes-14; H-2; M-12; L-0; I-0 (14/14 – 100%, Pass)	• The developer grouped hospitals into four-star categories and provided a distribution of hospitals across the four-star ratings. Frequency results ranged from 86 to 423 for the one-star and four-star rankings, respectively. • The committee did not have any major concerns and passed the measure on gap.

Criterion	Total Votes	Rationale
1c. Composite Rationale: Quality Construct and Rationale	• Total Votes-14; H-1; M-12; L-1; I-0 (13/14 – 92.9%, Pass)	• The committee recognized the measure focuses on processes that are recommended for optimal care for patients following ICD/CRT-D implantation. • The committee acknowledged as a composite, this measure will be used for making provider assessments of care more comprehensive, and it condenses more than one indicator of quality into one measure. • The committee asked how this measure builds on previous indications and discharge medication measures. The developer emphasized that this measure would provide new and complementary information, which can be used to assess quality of care more comprehensively. • With no further questions, the committee passed the measure on the composite construct and rationale.

Table A.1-1.2. Scientific Acceptability of Measure Properties (MUST PASS)

Criterion	Total Votes	Rationale
2a. Reliability	• Total Votes-14; H-0; M-14; L-0; I-0 (14/14 – 100%, Pass)	• Regarding reliability, the committee recognized that because one of the components is currently endorsed (CBE# 0965), then this component measure is deemed to be reliable and valid. • For the composite score itself, the committee considered the results of the test-retest analysis of the measure score, as the developer stated it was unable to perform a split-sample or signal-to-noise analysis due to the measure being reported strictly at the hospital level. • However, the test-retest results showed an intra-class correlation coefficient of 0.78. The committee did not raise any major concerns and passed the measure on reliability.
2b. Validity	• Total Votes-14; H-0; M-14; L-0; I-0 (14/14 – 100%, Pass)	• Regarding reliability, the committee recognized that because one of the components is currently endorsed (CBE# 0965), then this component measure is deemed to be reliable and valid. • The developer did not report component measure validity for the non-endorsed component measure, but rather summarized that the NCDR Data Quality Program (in which both components are utilized) ensures that data submitted to the NCDR are complete and validly collected. • With respect to the face validity testing, the committee did not raise any concerns. For the empirical validity testing, the committee acknowledged the correlation analysis was conducted with the rate of in-hospital risk-standardized complications for ICD placement. • Despite the results being low and not significant, the committee acknowledged the correlation was in the hypothesized direction, such that a higher group of patients receiving better overall quality were associated with a lower complications score. • Ultimately, the committee passed the measure on validity.

Criterion	Total Votes	Rationale
2c. Composite Construction	• Total Votes-14; H-2; M-12; L-0; I-0 (14/14 – 100%, Pass)	• The committee acknowledged that all data elements are in defined fields in electronic data. • The committee did not have any questions or concerns related to the empirical analysis of the composite construct and passed the measure on this sub-criterion.

Table A.1-1.3. Feasibility

Criterion	Total Votes	Rationale
3. Feasibility	• Total Votes-14; H-5; M-9; L-0; I-0 (14/14 – 100%, Pass)	• The committee did not have any questions or concerns related to the empirical analysis of the composite construct and passed the measure on this sub-criterion.

Table A.1-1.4. Use and Usability (USE IS MUST PASS FOR MAINTENANCE MEASURES)

Criterion	Total Votes	Rationale
4a. Use	• Total Votes-14; Pass-14; No Pass-0 (14/14 – 100%, Pass)	• As a new measure, the committee recognized that it is not currently in use, but the developer has a plan for use within an accountability program. • The committee therefore passed the measure on use.
4b. Usability	• Total Votes-14; H-4; M-10; L-0; I-0 (14/14 – 100%, Pass)	• Because this is a new measure, improvement results are limited. • However, the developer states that while the mean rate of performance for the individual components across participating facilities was greater than 80%, opportunities for improvement across facilities continue to exist with some facilities demonstrating low performance scores (<50% in the 5th percentile). • The committee passed the measure on usability.

Table A.1-1.5. Related and Competing Measures

Criterion	Related and/or Competing Measure(s)	Rationale
5. Related and Competing	• None	• The developer did not disclose any related and competing measures besides CBE #0965, which is one of the measure components.

Table A.1-1.6. Standing Committee Recommendation for Endorsement

Committee Endorsement Recommendation	Total Votes	Rationale
Recommended for Endorsement	• Total Votes-14; Yes-14; No-0 (14/14 – 100%, Pass)	• The committee recommended the measure for endorsement.

Table A.1-1.7. Public and Member Comment

Supportive/Non-supportive Comments	Number of Comments Received	Comment Summary
Supportive comments	• One	*Pre-evaluation* • Comment stated the measure met the criteria for approval.
Non-supportive comments	• None	N/A

CONSENSUS STANDARDS APPROVAL COMMITTEE (CSAC) EVALUATION

Table A.1-1.8. CSAC Endorsement Decision

CSAC Endorsement Decision	Total Votes	Rationale
Endorsed	• Total Votes-11; Yes-11; No-0 (11/11 – 100%, Pass)	• Unanimous approval to endorse the measure via a consent calendar.

APPEALS BOARD EVALUATION

Table A.1-1.9. Appeals

Appeal Received (Yes/No)	Appellant Organization	Summary of Appeal and Its Review
No	• N/A	• N/A

CBE #3751 Risk Adjusted Post-Ambulance Provider Triage Emergency Department (ED) Visit Rate Measure

Staff Assessment | Specifications

Numerator Statement: The outcome for this measure is an ED visit or death within three days for patients who have been triaged by an ambulance provider to an alternative non-ED destination or treated in place (TAD/TIP).

Denominator Statement: The cohort, or denominator, includes patients age 18 or older who have an encounter with an ambulance provider whose triage decision is to either transport them to an alternative non-ED destination (i.e., TAD) or to initiate and facilitate TIP.

Exclusions: The measure has no denominator exclusions.

Adjustment/Stratification: Statistical risk model

Level of Analysis: Other

Setting of Care: Inpatient/Hospital; Other

Type of Measure: Outcome

Data Source: Claims data

Measure Steward: Yale New Haven Health Services Corporation-Center for Outcomes Research and Evaluation (CORE)

STANDING COMMITTEE EVALUATION

Table A.1-2.1. Importance to Measure and Report (MUST PASS)

Criterion	Total Votes	Rationale
1a. Evidence	• Total Votes-14; Pass- 13; No Pass- 1 (13/14 – 92.9%, Pass)	• The committee considered the developer's logic model, which depicts positive connections between improved service inputs (e.g., use of innovative protocols, enhanced communication between providers), better patient selection/improved quality of TAD/TIP care, and improved patient-centered care (e.g., quality of life, reduced cost, lower ED visit rate after TAD/TIP). • The developer cited literature demonstrating that low adverse outcomes after non-transport to the ED in England support the potential benefits of non-ED alternatives such as TAD/TIP, aligning with patient preferences and offering advantages for patients, ambulance providers, and payers. • The developer cited studies noting that specific interventions similar to TAD/TIP have been shown to improve outcomes in terms of ED visits within 3 days. • The committee did not raise any major concerns or questions and passed the measure on this criterion.

Criterion	Total Votes	Rationale
1b. Performance Gap	• Total Votes-14; H-1; M-13; L-0; I-0 (14/14 – 100%, Pass)	• The developer provided summary statistics of ambulance provider-level performance scores and the risk-standardized ED visit rates (RSEDVRs) for all ambulance providers as well as ambulance providers with at least 20 encounters. Data were derived from ET3 Model Dataset January 2021 – August 2022. • For all providers (n=46), the post-triage ED visit rate ranged from 12.3% to 33.1%, with a median of 19.9% (IQR, 19.1%-22.1%). • For the ambulance providers with 20+ encounters (n=15), measure scores ranged from 12.3% to 25.7%, with a median of 21.6% (IQR 17.7%-23.0%). • No major concerns or questions were raised by the committee, which passed the measure on gap.

Table A.1-2.2. Scientific Acceptability of Measure Properties (MUST PASS)

Criterion	Total Votes	Rationale
2a. Reliability	• Total Votes-14; H-0; M-13; L-1; I-0 (13/14 – 92.9%, Pass)	• The committee considered the signal-to-noise analysis and results, which showed an average reliability (mean and median) for all providers of 0.338 and 0.210 and an average reliability (mean and median) for providers with 20 or more encounters of 0.719 and 0.665. • The committee requested clarification on the measure specifications regarding whether patients who interact with the ambulance service but refused recommended care once triaged are within the measure. • The developer responded, noting how patients move through the triage process, and confirmed that those who refuse care are not captured in the measure because they are not represented in the claims data. • Raising no additional questions, the committee passed the measure on reliability.

Criterion	Total Votes	Rationale

2b. Validity	• Total Votes-14; M-13; L-0; I-1 (13/14 – 92.9%, Pass)	• The developer conducted face validity testing by consulting with a quality workgroup composed of emergency medical services subject matter experts, medical directors, and quality assurance managers.
		• Workgroup members asked if the measure could be used to distinguish between better or worse quality of care among ambulance providers.
		  ○ 3/11 strongly agree, 6/11 somewhat agree, 2/11 somewhat disagree, 0/11 strongly disagree.
		  ○ For the two members who somewhat disagreed: One workgroup member raised concern about the need to account for ED visits related to initial triage chief complaint/ED discharge diagnosis. Another group member noted the measure captures quality of triage and not necessarily level of care provided during the intervention.
		• The measure is risk adjusted using a generalized linear model-based approach that accounts for clustering of patients within ambulance providers and variation in the patient case-mix across ambulance providers.
		• The developer included several clinical risk factors in the model, based on its conceptual model and analysis. The developer did not include social risk factors into the model due to small volume of patients with dual eligibility and low Agency for Healthcare Research and Quality socioeconomic status.
		• The C-statistic of the risk model was 0.601.
		• The committee did not raise any major concerns, recognizing only face validity testing of the measure score was conducted, and passed the measure on validity.

Table A.1-2.3. Feasibility

Criterion	Total Votes	Rationale
3. Feasibility	• Total Votes-14; H-1; M-12; L-1; I-0 (13/14 – 92.9%, Pass)	• All data elements are in defined fields in a combination of electronic sources. • The committee passed the measure on this criterion, as it did not raise any major concerns or questions.

Table A.1-2.4. Use and Usability (USE IS MUST PASS FOR MAINTENANCE MEASURES)

Criterion	Total Votes	Rationale
4a. Use	• Total Votes-14; Pass-13; No Pass-1 (13/14 – 92.9%, Pass)	• As a new measure, the committee recognized that the measure is not currently publicly reported but is being designed for use as an accountability measure within the ET3 Model, with the first year of measurement and payment spanning January 1, 2023, through December 31, 2023. • Therefore, the committee passed the measure on use.
4b. Usability	• Total Votes-14; H-0; M-12; L-2; I-0 (12/14 – 85.7%, Pass)	• Because this is a new measure, improvement results are limited. • The committee passed the measure on usability.

Table A.1-2.5. Related and Competing Measures

Criterion	Related and/or Competing Measure(s)	Rationale
5. Related and Competing	• None	• The developer did not identify any endorsed or non-endorsed related or competing measures.

Table A.1-2.6. Standing Committee Recommendation for Endorsement

Committee Endorsement Recommendation	Total Votes	Rationale
Recommended for Endorsement	• Total Votes-14; Yes-13; No-1 (13/14 – 92.9%, Pass)	• The committee recommended the measure for endorsement.

Table A.1-2.7. Public and Member Comment

Supportive/Non-supportive Comments	Number of Comments Received	Comment Summary
Supportive comments	• One	*Pre-evaluation* • Comment stated the measure met the criteria for approval.
Non-supportive comments	• None	N/A

CONSENSUS STANDARDS APPROVAL COMMITTEE (CSAC) EVALUATION

Table A.1-2.8. CSAC Endorsement Decision

CSAC Endorsement Decision	Total Votes	Rationale
Endorsed	• Total Votes-11; Yes-11; No-0 (11/11 – 100%, Pass)	• Unanimous approval to endorse the measure via a consent calendar.

APPEALS BOARD EVALUATION

Table A.1-2.9. Appeals

Appeal Received (Yes/No)	Appellant Organization	Summary of Appeal and Its Review
No	• N/A	• N/A

A.2 Measures Not Endorsed

CBE #3747 Engagement in Community-Based Mental Health Care After a Mental Health Hospitalization

Staff Assessment | Specifications

Numerator Statement: Discharges must receive five or more follow-up visits with a community-based mental health care provider within 90 days after discharge for inpatient treatment of select mental health or intentional self-harm diagnoses.

Denominator Statement: Acute inpatient discharges ages 6-64 principally hospitalized for select mental illnesses or intentional self-harm and enrolled in Medicaid on the date of discharge through 90 days after discharge.

Exclusions: In addition to the discharges with acute direct transfers, certain acute readmissions, non-acute direct transfers, and non-acute readmissions detailed above, discharges who are dually enrolled in Medicare and Medicaid and discharges in hospice or using hospice services anytime during the measurement year are excluded.

Adjustment/Stratification: Stratification by risk category/subgroup

Level of Analysis: Health Plan

Setting of Care: Behavioral Health; Post Acute Care

Type of Measure: Process

Data Source: Claims Data

Measure Steward: New York State Office of Mental Health

STANDING COMMITTEE EVALUATION

Table A.2-1.1. Importance to Measure and Report (MUST PASS)

Criterion	Total Votes	Rationale
1a. Evidence	• Total Votes-15; H-0; M-11; L-3; I-1 (11/15 – 73.3%, Pass)	• The committee considered the developer's logic model, depicting the flow from hospitalization (for mental illness or self-ham diagnosis) to short-term outcomes (e.g., discharge planning, connection to provider), to intermediate outcomes (e.g., five-plus visits to a community-based mental health care facility, symptom management, medication management), and long-term outcomes (e.g., medication adherence, continued treatment, improved functioning). • Benefits described included improvement of care via linkage to community-based mental health care services, noting need for follow-up care (beyond a single visit) after discharge for best patient results. • The committee considered the evidence provided to support the measure, which were practice guidelines and systematic reviews. • The committee discussed concerns around the wide age range included in the measure and the lack of clinical guidelines and other submitted evidence specifically focused on the 6-18 years age range. Additionally, committee members questioned the evidentiary support for the 42-day, five-visit specification within the measure. • The developer explained these specifications emerged from an analysis of the available data and selection of best fit, which balanced feasibility with performance. The developer reported that it looked at different time periods of 3 months, 6 months, and other time periods in between those. It also looked at the number of visits people had after discharge in those time periods, and looked at it in an association with outcomes, specifically mental health readmissions and emergency room visits. • The developer ultimately found having five visits was the number of visits most associated with having fewer mental health readmissions and emergency room visits. • The committee did not have any further questions and passed the measure on evidence.

Criterion	Total Votes	Rationale
1b. Performance Gap	• Total Votes-15; H-2; M-11; L-2; I-0 (13/15 – 86.7%, Pass)	• The committee recognized that the performance gap evidence provided is inclusive of several years and diagnoses, indicating variability in scores (standard deviations (SD), minimums, maximums). • The developer provided scores derived from analysis of NYS Medicaid discharge data (2018-2021). Collapsing across age, ethnicity, race, sex, and primary diagnosis. Means across years were 46.1,46.4,45.5, and 46.9 respectively. SD ranged between 12.0-13.1. Minimums were all below 20. Maximums were all above 61. • The committee discussed whether data and testing for this measure across New York state could be generalizable to other states and be nationally representative. The committee also discussed potential gaps in care settings represented in the measure and suitability of the measure in settings where telehealth visits may be more common due to behavioral health access limitations. • The committee inquired about the variation across patients with socioeconomic factors. The developer responded stating New York state is generalizable as New York is the fourth most populous state in the United States with a diverse population in terms of race and ethnicity. New York also has urban and rural areas, and has a much larger percentage of Medicaid recipients relative to other states. Thus, the developer posited New York Medicaid data is generalizable to other Medicaid populations. The developer also shared that, currently, socioeconomic data are not included in available health plan-level data in a reliable way. • The committee did not have any further questions or concerns and passed the measure on performance gap.

Table A.2-1.2. Scientific Acceptability of Measure Properties (MUST PASS)

Criterion	Total Votes	Rationale
2a. Reliability	• Total Votes-15; H-8; M-7; L-0; I-0 (15/15 – 100%, Pass)	• The committee considered the signal-to-noise reliability testing, which was at the accountable entity level. • The mean reliability for all eligible discharges was 0.946 with a 95% CI of 0.924 to 0.967, which is considered high (greater than 0.9). The second and third terciles had mean reliability of 0.969 and 0.992, respectively, which are also considered high. The first tercile had a mean reliability of 0.870, which is considered moderate. • The committee did not raise any concerns and passed the measure on reliability.

2b. Validity	• Total Votes-15; H-1; M-5; L-6; I-3 (6/15 – 40%, Consensus Not Reached)
	
	• Post-comment Validity Revote: Total Votes-13; H-0, M-7, L-5, I-1 (7/13 – 53.9%, Not Pass)
		• The committee reviewed the validity testing conducted for this measure, which included face validity and empiric validity.
		• To test construct validity, the developer calculated the Pearson correlation coefficient between Engagement in Community-Based Mental Health Care After a Mental Health Hospitalization and the NCQA HEDIS measure Follow-Up After Hospitalization for Mental Illness.
		  ○ The developer hypothesized moderate positive correlation due to overlapping eligible population and similarities in measure (62% of HEDIS overlap).
		  ○ Moderately positive correlation (r = 0.56, N = 50,234).
		• The developer calculated concordance statistics (or C-statistics) between Engagement in Community-Based Mental Health Care After a Mental Health Hospitalization and three outcomes: mental health inpatient readmissions, psychotropic medication adherence, and continued engagement in care at 6 months post discharge. The Concordance statistics between measure and the three outcomes were:
		  ○ Mental health inpatient readmissions: C = 0.53.
		  ○ Psychotropic medication adherence: C = ~0.64 for three medication types.
		  ○ Continued engagement in care at 6 months post discharge: C = 0.72, meets predictability threshold/
		• For face validity, the developer consulted a workgroup consisting of mental health clinicians and researchers. The developer highlighted the workgroup poll found 92% of respondents thought the measure had clinical benefit.
		• The measure is stratified by risk category/subgroup:
		  ○ Age stratification: 6-20 years old, 21-64 years old.
		  ○ Total (non-stratified) rate also reported.
		• The committee recognized the face validity testing was sufficient, but some committee members noted the concordance results were weak because the C-statistic was less than 0.7. The developer shared that it did not know why the results did not provide a stronger predictability with the mental health readmission and emergency room visits and shared there could be potential confounding by socioeconomic indicators and concurrent substance use disorders.
		• Ultimately, the committee did not reach consensus on validity during the evaluation meeting.
		• During post-comment, the developer submitted a comment for the committee's consideration, arguing that the committee weighed the concordance results too heavily and that a developer-conducted internal analysis of another endorsed measure showed similar results.
		• Committee members expressed the need for consistency in how measures are evaluated and endorsed. One committee member said the comparison to other measures with weak concordance statistics was a strong argument.
		• Other committee members expressed that the purpose of measures is to improve clinical outcomes, not to have measures for the sake of having measures, and endorsement of one measure does not guarantee endorsement of another.

Criterion	Total Votes	Rationale
		• Due to concerns with the concordance testing results, the committee did not pass the measure on validity, a must-pass criterion.

Table A.2-1.3. Feasibility

Criterion	Total Votes	Rationale
3. Feasibility	• N/A	• Not applicable because the measure did not pass on validity, a must-pass criterion.

Table A.2-1.4. Use and Usability (USE IS MUST PASS FOR MAINTENANCE MEASURES)

Criterion	Total Votes	Rationale
4a. Use	• N/A	• Not applicable because the measure did not pass on validity, a must-pass criterion.
4b. Usability	• N/A	• Not applicable because the measure did not pass on validity, a must-pass criterion.

Table A.2-1.5. Related and Competing Measures

Criterion	Related and/or Competing Measure(s)	Rationale
5. Related and Competing	• N/A	• Not applicable because the measure did not pass on validity, a must-pass criterion.

Table A.2-1.6. Standing Committee Recommendation for Endorsement

Committee Endorsement Recommendation	Total Votes	Rationale
Not Recommended for Endorsement	• Vote not taken	• Not applicable because the measure did not pass on validity, a must-pass criterion.

Table A.2-1.7. Public and Member Comment

Supportive/Non-supportive Comments	Number of Comments Received	Comment Summary
Supportive comments	• Three	*Pre-evaluation* • Two comments were in support of the measure, stating the measure met criteria for approval. *Post-evaluation* • One comment from the developer, which supported the measure by providing additional information and context for validity.
Non-supportive comments	• Two	*Pre-evaluation* • Two comments were non-supportive, expressing concern that occupational health settings should be included in the measure, raising questions regarding how the measure treats dually enrolled Medicare/Medicaid patients, and stating a concern about this measure in rural and medically underserved communities where resources to outpatient behavioral health services may be unavailable. *Post-evaluation* • None.

CONSENSUS STANDARDS APPROVAL COMMITTEE (CSAC) EVALUATION

Table A.2-1.8. CSAC Endorsement Decision

CSAC Endorsement Decision	Total Votes	Rationale
Not Endorsed	• Total Votes-11; Yes-8; No-3 (8/11 – 72.7%, Pass to Not Endorse)	• One CSAC member recommended that because the measure is not endorsed, the developer could choose to incorporate feedback from the current cycle and resubmit under the new process. • Another CSAC member expressed concern with the inability of the CSAC to overturn a standing committee decision to endorse or not endorse a measure and the inability to re-adjudicate aspects of the measure evaluation. The member asked if the CSAC can vote to reverse this. • Battelle staff stated that a major function of the CSAC is to consider whether criteria were applied appropriately and if the process has been followed. This type of review does require some degree of re-adjudication to understand how the committee conducted business and rendered its decision; however, this is not the rule. • In addition, the CSAC was not prepared for considering potential policy changes. • Another CSAC member believed due diligence was done for this measure. • Another member said that while she did not agree with the standing committee's decision about the concordance statistic, she recognized the nuances that went into such a decision and would be voting to uphold the decision of the standing committee. • Another CSAC member agreed to not re-adjudicate but raised concern about the lack of quorum with this committee's evaluation meetings. • Another committee member agreed with the concern about quorum but stated that if a developer decided to include the concordance testing data, the committee should review it. • Moving to a vote, the CSAC upheld the standing committee's decision to not endorse the measure.

APPEALS BOARD EVALUATION

- Based on the prior consensus-based entity's process, only endorsed measures are eligible for any appeal.

Appendix B: Prevention and Population Health Standing Committee and Battelle Staff

PREVENTION AND POPULATION HEALTH STANDING COMMITTEE

Amir Qaseem, MD, PhD, MHA, MRCP (London), FACP (Chair)
Vice President, Clinical Policy, American College of Physicians

Ron Bialek, MPP, CQIA
President, Public Health Foundation

Gigi Chawla, MD, MHA
Chief of General Pediatrics, Children's Minnesota

Favio Freyre, MD
President/CEO, Favio Freyre LLC

Barry-Lewis Harris, II, MD
Medical Director & Chief, Correctional Health Services, Parkland Health

Catherine A. Hill, DNP, APRN, GNP-BC, CMC
Chief Nursing Officer/Director of Quality and Clinical Outcomes, Texas Health Resources

Amy Nguyen Howell, MD, MBA, FAAFP
Chief of the Office for Provider Advancement, Optum Health

Julia Logan, MD, MPH
Chief Clinical Director, California Public Employees' Retirement System (CalPERS)

Lisa Nichols, MSW
Assistant Vice President, Community Health, Intermountain Healthcare

Patricia Quigley, PhD, APRN, CRRN, FAAN, FAANP, FARN
Associate Director, Nurse Consultant

Anita Ravi, MD, MPH, MSHP, FAAFP (Inactive)
Founder & Clinical Director, Purple Health Foundation; Ryan Health

Carol Siebert, OTD, OT/L, FAOTA
Founder/Solo Practitioner, The Home Remedy, PLLC

Matt Stiefel, MPA, MS
Senior Director, Center for Population Health, Care Management Institute, Kaiser Permanente

Arjun K. Venkatesh, MD, MBA, MHS
RWJF Clinical Scholar, Yale University School of Medicine

Ruth E. Wetta, PhD, MPH, MSN, RN
Lead Clinical Researcher, Oracle Health

Whitney Bowman-Zatzkin, MPA, MSR
Executive Officer, Rare Dots Consulting

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE STANDING COMMITTEE MEMBERS

Julie Goldstein Grumet, PhD
Director of Zero Suicide Institute/Senior Health Care Advisor to Suicide Prevention Resource Center Education Development Center

Bonnie Zima, MD, MPH
Professor in Residence, Child and Adolescent Psychiatry, University of California, Los Angeles (UCLA) – Semel Institute for Neuroscience and Human Behavior

CARDIOVASCULAR STANDING COMMITTEE MEMBERS

Thomas Kottke, MD, MSPH
Medical Director for Well-Being, HealthPartners

Tim Dewhurst, MD, FACC
Interventional Cardiologist, Medical Director for Clinical Value Improvement, Kaiser Permanente

Charles Mahan, PharmD, PhC, RPh
Adjunct Associate Professor of Pharmacy, University of New Mexico

BATTELLE STAFF

Nicole Brennan, MPH, DrPH
Executive Director

Brenna Rabel, MPH
Technical Director

Matthew Pickering, PharmD
Endorsement and Maintenance Task Lead

Quintella Bester, PMP
Senior Program Manager

Lydia Stewart-Artz, PhD
Social Scientist III

Isaac Sakyi, MSGH
Social Scientist III

Jessica Ortiz, MA
Social Scientist II

Elena Hughes, MSc
Social Scientist I

Sarah Rahman, BS
Social Scientist I

Olivia Giles, MPH
Social Scientist I

Catherine McBride
Tech Writer/Editor

Brittany Stojsavljevic
Tech Writer/Editor


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