Prevention and Population Health Spring 2023 Cycle: Pre-evaluation Comments

Contents

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CBE #3747 Engagement in Community-Based Mental Health Care After a Mental Health Hospitalization (New York State Office of Mental Health)

Pre-evaluation Public Comments

Public comments received for committee consideration of this measure can be found here:
https://p4qm.org/endorsements/measure/6011

Pre-evaluation Standing Committee Comments

1a. Evidence

- The evidence presented is not directly related to the process of care being measured, but is relevant. The evidence submitted also does not address all of the behavioral health conditions associated with the measure.
- Seems appropriate, the 42 days exemption seemed odd, however. Is there another measure complimenting this data point and offering coverage for extended stays beyond 42 days and the discharge requirements for follow up, medication adherence, etc.?
- No concerns

1b. Gap in Care/Opportunity for Improvement and Disparities

- There appears to be a gap in care. The data on population subgroups was based on only one state. Not clear that this can be extrapolated to other states or nationally.
- Curious why readmissions weren't checked for sp.05; Curious why inpatient/hospital was not checked for sp08 on settings; Does not eval disparities in ACCESS to care programs at discharge (though this could be an intent of the measure)
- No concerns

2a. Reliability

- Listed previously. Many hospital ERs are holding patients due to limited resources in community. Seemed inpatient/hospital wasn't considered for triggering this measure. Is it coded differently?
- No concerns
- No concerns
- No concerns

2b. Validity

- No concerns
- With all of the exclusions, what documents quality for each of those items? (ie: acute direct transfer to a mental health inpatient stay at a different facility -- does that facility then trigger this QM and the accountability moves?)
- No concerns

2b2-2b6. Potential Threats to Validity

- Exclusions
    - Concern for communities without numerator solutions obtainable in the observation period. Also for patients labeled as under the influence or other tags, not suicide ideation or qualifying labels. Even in populated areas, teens in acute suicide ideation/attempt wait in hospital ERs for transfers and then referred to waitlists for 12+ weeks for 1-hr therapy sessions. The measure would document the clinic didn't see the patient go to the 5 follow ups, but not that the patient had or didn't have follow up options -- is that enough? Then the health system would need to find more solutions for their numerators?. (State Senator Creigh Deeds' son in Virginia comes to mind.)
    - No concerns
    - No concerns
- Risk Adjustment
    - no concerns
    - Stratification by geolocation to facilities with appropriate mental health provider to population levels would be possible, perhaps?
    - No concerns
- Meaningful Difference
    - No concerns
    - No concerns. (Love that this has the age delineation at 20/21.)
    - No concerns--significant differences between top and bottom interquartiles
- Comparability of Data Sources
    - No concerns
    - No concerns
    - Not applicable, only claims
- Missing Data
    - Developer asserts significant number of missing claims would be unlikely because claims are necessary for payment. But Federally Qualified Health Cent.
    - No concerns
    - No concerns

3. Feasibility

- See earlier response about Medicaid MCO payment models which may not generate a claim for follow up behavioral health encounters.
- No concerns
- No concerns

4a. Use

- There is a credible plan in New York. Given differences in Medicaid and mental health services/systems from state to state, not clear that plan is app
- Needs to be part of the public reporting in the community health assessments.
- Not publicly reported yet

4a. Usability

- No concerns

- No concerns
- No concerns

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

Pre-evaluation Public Comments

Public comments received for committee consideration of this measure can be found here:
https://p4qm.org/endorsements/measure/6016

Pre-evaluation Standing Committee Comments

1a. Evidence

- The proposed measure is a composite measure which includes an existing endorsed measure. Most of the evidence submitted relates to the existing endorsed measure. I had to really dig in the submission to find that a significant number of patients undergoing ICD/CRT-D do not meet class I, IIa, or IIb guideline indication for device implantation, yet I found reports of this issue doing a simple google search.
- No concerns
- no concerns

1b. Gap in Care/Opportunity for Improvement and Disparities

- A simple google search produces multiple journal articles citing disparities/inequities related to ICD/CRT-D, but the data on population subgroups is not helpful as it provides data on "disparity groups" but without comparison to others (e.g. male vs female, white vs non-white, etc.). It seems like the "new" component in this composite measure, fulfillment of guideline criteria, might identify and help close such gaps.
- No concerns
- No concerns

1c. Composite – Quality Construct and Rationale

- The rationale that a single composite measure is simpler or easier is insufficient. Developer states "Combining the individual process measures into a single composite provides patients, physicians, and hospitals with a perspective of the overall quality of medical therapy provided to patients undergoing ICD/CRT-D implantation." But one component addresses whether such patients should be undergoing the procedure, while the other component is related to post-procedure care at facility discharge. Combining the two measures obscures the very different quality issues addressed by each component measure.
- No concerns
- No concerns

2a. Reliability

- No concerns
- No concerns

- No concerns

2b. Validity

- No concerns
- No concerns
- there is a typo: The devleoper does not report component measure validity. Likely limitations of data source prohibit examining association with measure's categorization of rating and patient level clinical outcomes. Thus left with face and construct validity, and data from exploration of construct validity suggests low correlation. "correlation is relatively low (-0.038)."

2b2-2b6. Potential Threats to Validity

- Exclusions
  - No concerns
  - No concerns
  - No concerns
- Risk Adjustment
  - No concerns
  - No concerns
  - The measure is not risk-adjusted or stratified.
- Meaningful Difference
  - Concerns about adequacy of subgroup analyses.
  - No concerns
  - It's not clear (to me) how the performance categories were anchored clinically? "The developer states that these star categories are set based on the recommended performance (P score) that all hospitals should achieve in their care of patients." Were these cutpoints/ratings determined by developer/"expert consensus"? Not clear from information presented what the distribution of socio's were and whether/how differences by socio's were tested. Maybe this was because the unit of analysis was the facility and not the patient??
- Comparability of Data Sources
  - No concerns
  - No concerns (None)
  - Likely not applicable because using a composite score?
- Missing Data
  - No concerns
  - No concerns (None)
  - Any hospital with missing data was excluded from the measure as it would not have passed the NCDR data quality review. Did the developer restrict to…"

2c. Composite – Empirical Analysis

- No concerns
- No concerns
- Rationale provided seems appropriate. This is an all-or-none composite, thus no empirical analyses pertinent to aggregations or weighting were conduct

3. Feasibility

- the data elements related to guideline indicators depend on what seem to be extensive chart abstraction.
- No Concerns
- No concerns, but another typo: The developer sates that measures that are aggregated by ACCF.

4a. Use

- Facilities being measured can opt to have their performance made publicly available via Cardiosmart. I realize this is a new (proposed) measure, but since one component is an already endorsed measure, I wanted to see how this process would inform the public/consumer. When I used Cardiosmart to review the three hospitals nearest to me, only one participates so I can't compare the hospitals, and would not have even known Cardiosmart existed had it not been included in the submission.
- Is the language, "on a case-by-case basis, requests for modifications to the standard export package will be available for a separate charge" standard.
- In the implementation phase of development, which includes 1 year in the registry before being implemented in the public reporting program.

4a. Usability

- It's not clear that the proposed composite measure furthers the goal of high-quality, efficient care better than these two component measures being us
- No concerns.
- Appears a large proportion of facilities are in the third and fourth quartiles. It would be useful to better understand characteristics of the programs.

CBE #3751 Risk Adjusted Post-Ambulance Provider Triage Emergency Department (ED) Visit Rate Measure (Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (CORE)/ Centers for Medicare & Medicaid Services)

Pre-evaluation Public Comments

Public comments received for committee consideration of this measure can be found here:
https://p4qm.org/endorsements/measure/6051

Pre-evaluation Standing Committee Comments

1a. Evidence

- No concerns
- No concerns
- No concerns

1b. Gap in Care/Opportunity for Improvement and Disparities

- Even with the limited data available, there is a likely gap in care related to TAP/TIP being relatively new care options.
- No concerns
- No concerns

2a. Reliability

- No concerns
- No concerns
- No concerns

2b. Validity

- No concerns
- No concerns
- Limited to only face validity

2b2-2b6. Potential Threats to Validity

- Exclusions
    - Patients who visit the ED within three days but are discharged with a primary diagnosis related to mental health or substance-use disorder are not counted as outcome events. The decision to exclude persons with primary MH dx does not appear to be justified. This likely introduces bias. It appears that ambulance drivers could take to a community mental health center but it's not clear if CMHC can handle an urgent MH crisis and it appears the specifications don't allow us to know where the person is taken to? A better approach could be to stratify by type of primary dx within the outcome. What are the findings re: variation by SES indicator if these persons were included?

    - Do the exclusions include calls the patient themselves didn't initiate (does that matter)? (perhaps a neighbor, police, etc.)
    - Two related concerns: 1) A member of quality workgroup evaluating face validity noted that this is a metric of the quality of triage, not the quality of care provided during the encounter (e.g. TIP). The submission itself indicates that this is a measure of the quality of triage. I realize that "care" is being used generically here, but given that the developer has framed this measure broadly as a way to evaluate TAD/TIP as a more patient-valued and cost effective alternative to the ED in appropriate circumstances, it is important that those measured understand that it is operationalized as a measure of the quality of triage. 2) There is no exclusion for patients who are triaged to ED and refuse transport. I realize that using claims data makes this infeasible, but a patient with capacity may have what they consider valid reasons to refuse transport to ED. For now, the data available is far too limited to explore this issue, but it may need to be considered as more experience and data become available.
- Risk Adjustment
    - No concerns
    - No concerns
    - see above concerns re: SES. The developer did not include social risk factors into the model due to small volume of patients with dual eligibility and low AHRQ SES status. What if persons with primary MH dx at repeat ED visit were included?
- Meaningful Difference
    - No concerns
    - No concerns
    - Unable to assess.
- Comparability of Data Sources
    - No concerns
    - No concerns
    - NA
- Missing Data
    - No concerns
    - No concerns
    - Unable to assess.

3. Feasibility

- No concerns
- The note that the coding happens by someone other than the original person obtaining it is important to consider.
- Relying only on claims data, feasible.

4a. Use

- No concerns
- Sharing this data with patients, particularly those using ambulance services in error, should be considered.

    - Unable to rigorously assess

4a. Usability

- No concerns
- Results are not shared with the individual patient, so it is missing a huge opportunity to make lasting change (positive change).
- Exclusion of persons with repeat ED visit for primary MH in outcome makes it challenging to use the data to identify targets to improve quality for individuals with primary MH dx.