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Re: Vizient comments to the Partnership for Quality Management (P4QM) on the 2023 Measures Under Consideration (MUC) list.

Background

Vizient, Inc. appreciates the opportunity to comment on the Partnership for Quality Measurement (P4QM) measure development process, particularly the Pre-Rulemaking Measure Review (PRMR) process. As noted by P4QM, the PRMR process makes consensus recommendations regarding the inclusion of measures being considered for CMS quality reporting and value-based programs. Vizient applauds P4QM for working with stakeholders and the public on developing these important measures, as these measures significantly impact our providers and the patients they serve.

Vizient, Inc. provides solutions and services that improve the delivery of high-value care by aligning cost, quality and market performance for more than 60% of the nation's acute care providers, which includes 97% of the nation's academic medical centers, and more than 20% of ambulatory providers. Vizient provides expertise, analytics, and advisory services, as well as a contract portfolio that represents more than $130 billion in annual purchasing volume, to improve patient outcomes and lower costs. Headquartered in Irving, Texas, Vizient has offices throughout the United States.

Comments for MUC2023-156: Screening for Social Drivers of Health
Care Setting: Hospital Committee

We commend P4QM on its efforts to prioritize health equity but have ongoing concerns regarding the Screening for Social Drivers of Health measure. Vizient and our provider members recognize the critical need to address social drivers of health for each patient to ensure equitable health outcomes and we support efforts to increase the screening of all patients for social drivers of health. However, consistent with prior comments (https://vizientinc-delivery.sitecorecontenthub.cloud/api/public/content/e46e2e8e9d704f2bbbe4250c4dd92ed9) to the Centers for Medicare and Medicaid Services (CMS), Vizient remains concerned that there is no standard definition for "screening" or "social drivers of health" as related to this measure. Whether P4QM adopts an existing standard or creates a new one, clear and consistent definitions are critical to collecting data that can be meaningfully used by the healthcare system to improve patient outcomes. Additionally, defining these terms supports identification and proper use of validated screening tools. Without consistency, it is difficult for health systems and other stakeholders to address patient needs and risks identified during screening.

Vizient is concerned that within the measure as written, the domains of Health-Related Social Needs (HRSNs) are not clearly defined. Since CMS proposed this measure, Vizient has heard from hospitals that there is confusion around how the specific domains are defined. For example, there is no standard for what constitutes “food insecurity”, so there is a range of interpretations (e.g., lack of access to any food; lack of access to healthy food; lack of access to food over a certain period of time). As a result of varying potential interpretations of the domains, hospitals are spending excessive time trying to understand and define measures, which ultimately takes time away from initiatives that would improve health equity. Vizient is concerned that failure to provide greater clarity will have the unintended consequence of negatively impacting patient and provider interactions, particularly with historically underserved populations.

We recommend that P4QM work with stakeholders to more clearly define terms and domains related to this measure. Vizient is concerned that this, as written, will limit the utility and comparability of collected data. As P4QM is aware, standardization is critical for ensuring that patient data collected by health systems and other providers can be effectively utilized to address patient needs and identify broader, community-wide needs to improve social drivers of health. Although this measure has already been approved for use in multiple CMS programs, these concerns have not been addressed. Expanding the use of this measure in other quality reporting programs without refining the measure, adapting it based on more recent learnings, or considering data from its use in the IQR program will significantly limit the utility of such data sets, as they may not be consistent across data collectors, leading to challenges in developing more refined or targeted measures in the future.

Further, the Screening for Social Drivers of Health Measure does not account for geographic variations in communities and therefore may be missing an opportunity to ask or prioritize screening for certain social needs drivers that are relevant to the community. Vizient’s analyses have shown significant variation in community need across large geographic areas as well as within local markets at the zip code and census tract level. If this measure does not account for geographic variation of social drivers impacting the population, interpretation of these data points could not only be misleading but could also take away the opportunity to prioritize asking patients about social needs that are meaningful to them (https://www.vizientinc.com/what-we-do/health-equity/vizient-vulnerability-index-public-access). Further, hospitals or providers with higher levels of community need may be further challenged to support patients and maintain relationships of trust with patients if they perform redundant, generic screenings without having the resources or capacity to better address social needs. To help address these concerns, accommodations for geographic variation could be achieved through benchmarking using an index of local obstacles to care (i.e., the Vizient Vulnerability Index™, more information available at: https://www.vizientinc.com/what-we-do/health-equity/vizient-vulnerability-index-public-access).

Comments for MUC2023-171: **Screen Positive Rate for Social Drivers of Health**
Care Setting: Hospital Committee

We commend P4QM for its efforts to prioritize health equity, however, we continue to have concerns with the measure Screen Positive Rate for Social Drivers of Health. Our primary concern with MUC2023-171 is the lack of standardization for data collection for this metric. The current measure does not include specific definitions for the denominator (i.e., patients to be screened) or the numerator (i.e., what constitutes a positive screen). Without clear definitions of who to screen or what constitutes a positive screen, it will be difficult to meaningfully interpret or benchmark the data collected.

Similar to our concerns about the Screening for Social Drivers of Health measure, the Screen Positive for Social Drivers of Health Measure does not account for geographic variations in communities and therefore may be missing an opportunity to ask or prioritize screening for certain social needs drivers that are relevant to the community. Vizient's analyses have shown significant variation in community need across large geographic areas as well as within local markets at the zip code and census tract level. If this measure does not account for geographic variation of social drivers impacting the population, interpretation of these data points could not only be misleading but could also take away the opportunity to prioritize asking patients about social needs that are meaningful to them. Further, hospitals or providers with higher levels of community need may be further challenged to support patients and maintain relationships of trust with patients if they perform redundant, generic screenings without having the resources or capacity to better address social needs. To help address these concerns, accommodations for geographic variation could be achieved through benchmarking using an index of local obstacles to care (i.e., the Vizient Vulnerability Index™, more information available at: https://www.vizientinc.com/what-we-do/health-equity/vizient-vulnerability-index-public-access).

Vizient has reviewed several state and national indices intended to help provide benchmarks for community need and found an opportunity to expand upon these indices to ensure standardization across the country and tie community need to hospital performance. Vizient welcomes the opportunity to continue to work with P4QM and CMS to leverage our analysis or conduct a similar analysis to evaluate current indices and address gaps before expanding the use of this measure.

Collectively, the aforementioned issues related to data collection standardization and geographic differences also limit the utility of the collected data for future analysis; namely, specific measures to promote addressing social drivers of health for patients. Before expanding the use of this measure, we recommend that P4QM work with stakeholders, such as hospitals and CMS, to provide clear standards for defining the target populations for screening and clarifying how a positive screen for the target population should be measured. These definitions and instructions should be grounded in currently available data and appropriate indices (e.g., fits well to life expectancy, health care focus, includes social determinants of health domains) and should be leveraged to provide a standard approach, especially for correcting for geographic variation and improving patient care. Without these changes, Vizient is concerned that

this measure will have limited use in the context of performance improvement and health equity.

Comments for MUC2023-139: **Hospital Equity Index**
Care Setting: Hospital Committee

Vizient appreciates P4QM's efforts to prioritize health equity but believes that there is a need to develop a measure that focuses on provider process measures that are within a provider's locus of control, rather than readmissions measures, which are influenced by several factors beyond the provider's control.

Regarding the Hospital Equity Index (HEI) measure, Vizient is deeply concerned that the measure, as written, continues to present a significant challenge for hospitals and other providers for several reasons. Eleven of the thirteen included measures are related to readmission rates, which can be heavily influenced by external factors outside of the provider's locus of control. Vizient suggests P4QM consider process measures that better evaluate differences in provider care and decision making, rather than readmissions measures. For example, timely administration of antibiotics for sepsis patients is an example of a measure that captures interventions within the provider's locus of control.

Also, Vizient is concerned readmissions would be double counted with this measure, as using this measure alongside condition-specific measures and the Hospital-Wide 30-Day All-Cause, Risk-Standardized Readmission Rate following Hospitalization (HWR) measure would, effectively, double-count the rates of readmissions. If readmissions rates are to be used despite our concerns, Vizient recommends, at minimum, the measure be modified to use the all-cause readmission rate to avoid compounding the rates. Alternatively, as noted above, Vizient believes differences in provider care and decision making can be better evaluated with a measure that focuses on provider processes within their control.

Vizient also cautions that combining standardized Within and Across Disparity Method results will result in patient detail being lost when the measure is reported, which makes patient-specific interventions more challenging to identify. Similarly, since the measure reports a single outcome for the combined effects of eight measures, results could be distorted by the weighting of measures and handling of measures for which volume is insufficient. The measure interpretation is then severely limited and opaque at best, but potentially misleading at worst. Additionally, since the patient perspective is an important aspect of addressing specific social drivers of heath, P4QM should not recommend this measure, as it does not give hospitals the opportunity to effectively manage a patient's HRSNs. This measure relies only on combinations of various quality measures, which does not give hospitals actionable items to pursue to address health equity in their patient populations. Vizient urges P4QM not to finalize this measure because it does not give hospitals meaningful insights regarding how to better promote health equity for their patients.

Vizient also remains concerned with CMS's continued use of the Area Deprivation Index (ADI) for assessing health disparities in a population. As expressed in prior comments,

and supported by recent literature, the ADI is heavily weighted toward income and home values, with very little contribution from other variables (see Vizient comments on the Physician Fee Schedule CY 2024 Proposed Rule https://vizientinc-delivery.sitecorecontenthub.cloud/api/public/content/f773b4354a62447b9e795f9affc48a8d and an analysis published in Health Affairs https://www.healthaffairs.org/content/forefront/aco-benchmarks-based-area-deprivation-index-mask-inequities). The ADI has been found to underestimate the vulnerability of neighborhoods where housing prices do not reflect broader trends and fails to account for other obstacles related to accessing health and healthcare. Vizient recommends CMS and P4QM explore other indices, such as the Vizient Vulnerability Index™ (https://www.vizientinc.com/what-we-do/health-equity/vizient-vulnerability-index-public-access) that more effectively identify common social risk factors related to health outcomes.

Finally, Vizient is concerned that when this measure is publicly reported, patients and caregivers may struggle to interpret the single score and may also fail to understand the detailed description of the data. In the preliminary analysis, this concern is highlighted as a potential unintended consequence of adding the measure to the IQR program where it will become publicly available, as all IQR measures are. Vizient shares the concern that the public availability of this measure may confuse patients and caregivers who do not read the detailed description of how the measure is calculated and therefore misunderstand what it represents. Vizient urges P4QM not to approve this measure, as adding it to the IQR program and making the data publicly available may have unintended consequences, especially for populations with significant community needs.

Comments for MUC2023-175: **Facility Commitment to Health Equity; MUC2023-176: Hospital Commitment to Health Equity**
Care Setting: Hospital Committee

P4QM seeks comment on the use of the Facility Commitment to Health Equity Measure to the ASCQR program, and the Hospital Commitment to Health Equity Measure to the Hospital Outpatient Quality Reporting (OQR) Program and the Rural Emergency Hospital (REHQR) Quality Reporting Program. While the Facility Commitment to Health Equity and Hospital Commitment to Health Equity measures have already been included in some CMS quality programs, we offer various suggestions for improvement that are relevant across care settings for both measures.

Many facilities and providers have implemented substantial changes to address the social risk factors in their patient populations, and we suggest P4QM work with stakeholders to better define each domain or provide more examples that would support more meaningful changes and progression.

Considering these Commitment to Equity measures, hospitals and provider activities and degree of engagement within each domain could vary drastically and such variation would not be apparent. For example, in the Quality Improvement domain, participation in quality improvement activities could be minimal or challenges could exist related to such participation in local, regional, or national quality improvement activities that may not be understood when the measure is reported. As a result, the value of these

measures to drive change appears limited unless more support or clarity is provided to support hospitals and other facilities' long-term plans. Vizient encourages P4QM to further explain the procedures for collecting data for this measure (e.g., general frequency in which certain activities should be performed, how often the domains should be reviewed and potentially modified) to inform the attestation when reported. Also, Vizient suggests P4QM work with stakeholders to better understand different approaches to health equity and whether there are opportunities to better validate actions within each domain.

Further, Vizient believes that these measures may overlook common challenges to coordinated health equity responses. For example, in working with hospitals and other providers, Vizient understands that collecting information can involve identifying various efforts and breaking down silos as an initial step to understand the range of efforts underway by a given provider. Such silos make it difficult for providers to identify the correct person within the organization to work with and may require additional effort as providers contact multiple entities to identify the correct contact. This step can take additional time and resources, but may not be easily identified as reflecting a hospital's commitment to health equity. As a result, clarity, such as better defining what these measures aim to encourage internally, would reduce this burden and allow providers to more effectively collect and act on their patient data.

Comments for MUC2023-199: **Connection to Community Service Providers**
Care Setting: Hospital Committee

Vizient appreciates the need to develop measures that encourage providers to connect with community resources to help address HRSNs, but we believe this measure will put too much burden on providers to effectively address a patient's social needs. Hospitals, providers, and community-based services providers (CSPs) do not always have the resources to support all the HRSNs in a given area. As written, this measure puts a burden on providers to both identify a range of CSPs, establish communication channels with such CSPs, and confirm that contact between the CSP and patient occurred. Further, the measure does not address what a provider should do if a patient with an HRSN is identified and unable to be connected to a CSP because there is not one readily available, or if an existing CSP is unable to serve the patient. In many areas of the country, CSPs are not available or require significant time and reliable transportation to reach. Providers should not be penalized for being unable to provide a connection to a CSP that does not exist or that would not fully meet the patient's needs. If P4QM is going to pursue recommending this measure, Vizient believes it is important that resources, education, and incentives be provided to both providers and CSPs to ensure communications are streamlined and aspects of data-sharing are clarified. In underserved areas, this could include help connecting providers with CSPs so that there is no delay if a provider doesn't have the information for a CSP immediately. As suggested by the MAP Rural Health Advisory Group in 2022, stratification of the measure could help ease the burden on rural providers who are unable to access CSPs. Further, the measure should not place the burden solely on the provider to follow-up with CSPs or patients to confirm contact was made. Vizient recommends that if this measure is recommended, further methodological considerations be deployed to

quantify the influence of the CSP rather than simply assigning full responsibility to the provider.

Also, Vizient believes several aspects of the measure are unclear, such as definitions for HRSNs. For example, the population included in the measure may reside outside of a CSP's operating area, yet the measure would still encourage the hospital to make a connection even if the patient would not benefit. Vizient believes more work is needed to better establish provider and CSP relationships and communications, and as a result, this measure is premature. Once such communications are established, we would also suggest refinements to the measure.

Comments for MUC2023-210: **Resolution of At Least One HRSN**
Care Setting: Hospital Committee

Vizient appreciates efforts to ensure that HRSNs are addressed but is deeply concerned that this measure places too much burden on providers, as resolving HRSNs can often be beyond a provider's locus of control.

While we appreciate the intent of this measure, Vizient is concerned that this measure puts a significant burden on providers. Providers are in a unique position to address and help individuals with HRSNs, but once a patient leaves the hospital it is not necessarily feasible for providers to "follow the patient" and ensure they are accessing all available services, particularly for the time period articulated. Following patients for months after a visit and ensuring that the services are provided by an outside community group is far outside the provider's locus of control and would put an untenable strain on providers who are already struggling to meet community needs. Additionally, the expectation that HRSNs may be resolved within a 12-month period does not adequately consider the drivers of HRSNs, patient complexities, or community dynamics or limitations.

Also, it is unclear how this measure could be easily reported by providers. For example, technology may not yet be implemented to easily identify patients who should be included in both the numerator and denominator. In addition, since the numerator would require the patient to report resolution of at least one HRSN, the provider would need to make additional communication to confirm this information, increasing provider burden.

As this measure is described, there is no clear definition of what constitutes a "resolution". Resolving long held social determinants of health for an individual may take years, with community development and interventions that are outside providers' control. The measure appears to rely on a subjective measure of whether the issue was resolved by asking the patient whether they feel the issue was effectively resolved within 12 months of discharge. This subjective report will create confusion and likely result in inconsistent data across providers and health systems, yielding unusable data, among other concerns. While it is important to reflect a patient's perspective when addressing health equity, patients still need information to help them identify whether the provider and community organizations followed a protocol and should not only rely on a patient's subjective interpretation of whether something feels resolved. Vizient urges P4QM not to recommend this measure.

Further, as stated in comments on other measures, Vizient remains concerned that the HRSNs are not clearly and consistently defined. If data is not clearly defined, the data collected may be unactionable, inaccurate or difficult to interpret. Vizient urges P4QM not to advance this measure, as it would be extremely challenging to implement and imposes excessive burden on providers well-beyond their locus of control.

Comments for MUC2023-188: Patient Safety Structural Measure
Care Setting: Hospital Committee

Vizient appreciates CMS's continued focus on patient safety, but has concerns about the proposed Patient Safety Structural Measure. The proposed measure is an attestation measure focused on patient safety activities that aims to help hospitals better understand priorities for improving safety and serve as a prompt for action to reduce preventable harm to patients. Patient safety is a top concern for CMS as well as for hospitals nationwide, as preventable harms were identified as a major priority for patient safety decades ago (see: https://psnet.ahrq.gov/primer/patient-safety-101). The Agency for Healthcare Research and Quality has outlined steps required to create a "systems approach" to patient safety, which many hospitals have adopted and use as they develop patient safety practices into regular care.

Vizient supports the commitment to advancing patient safety in hospitals and works closely with our members to ensure that preventable harms are being reduced (https://www.vizientinc.com/what-we-do/operations-and-quality/patient-safety-organization). Vizient's concern with this measure is that it is an attestation-based measure that will be publicly available and may provide confusing information to patients as they evaluate healthcare facilities. Attestation measures capture a yes/no answer if a hospital or facility judges that it meets the requirements as laid out in the measure, without any substantive information on what the hospital is doing that constitutes that answer. For example, under Domain 1 of the proposed measure (Leadership Commitment to Eliminating Preventable Harm), a hospital may check "yes" if its leadership signed a pledge to prevent harm, while another may check "yes" because a leader allocated funding to a particular patient safety project. Both answers may be valid, and both may represent important steps toward impacting patient safety in the facility, but without more substantive information, the measure will not give the patient actionable information about how the hospital is prioritizing patient safety at the leadership level.

Additionally, because the system's approach to patient safety has been in existence for decades, Vizient anticipates that it is unlikely any hospitals will attest "no" under any of these domains. Patient safety activities remain a priority for hospitals, but many are at a more advanced stage of addressing patient safety that is more aligned with the current, evolved landscape of patient safety work. Vizient recommends that P4QM not adopt this measure and identify better opportunities for recognizing the advanced patient safety work hospitals are doing to create a safer care environment for patients.

Conclusion

Vizient appreciates P4QM's efforts to gain additional feedback regarding these critical topics. Vizient membership includes a variety of hospitals ranging from independent, community-based hospitals to large, integrated health care systems that serve acute and non-acute care needs. In closing, on behalf of Vizient, I would like to thank P4QM for providing the opportunity to comment on the measure development process. Please feel free to contact me, or Emily Jones at Emily.Jones@vizientinc.com if you have any questions or if Vizient may provide any assistance as you consider these recommendations.

Respectfully submitted,

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Appendix 1. Vizient's comparison of different indices considered for health equity applications.

Unlike other indices, the Vizient Vulnerability Index flexes to ensure the index values are location-appropriate. Other indices have a single index algorithm for the whole country, while the Vizient Vulnerability Index adapts to the local relevance of each domain as it correlates to life expectancy. This allows for variation in the weighting of the domains across different geographic areas depending on what's important – the most relevant factors affecting health in Lincoln, Nebraska might not be the most relevant in New York City.

	Area Deprivation Index	Distressed Communities Index	Social Vulnerability Index	Intercity Hardship Index	AHRQ Socioeconomic Status Index	Vizient Vulnerability Index
Data granularity	× County × Zip Code × Census Tract ✓ Block Group	✓ County ✓ Zip Code × Census Tract × Block Group	✓ County ● Zip Code possible ✓ Census Tract ● Block Group possible	● County possible ● Zip Code possible ● Census Tract possible ● Block Group possible	× County × Zip Code × Census Tract ✓ Block Group	✓ County ✓ Zip Code ✓ Census Tract ✓ Block Group
Timeliness	Updated in 2015, 2019, and 2020	Updated annually	Updated every two years	Not provided at the national level; algorithm available	Updated in 2015 and 2019	Updated annually
Social Determinants of Health Domains	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems ✓ Transportation ✓ Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems × Transportation × Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems ✓ Transportation ✓ Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems × Transportation × Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems × Transportation × Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing ✓ Health Systems ✓ Transportation ✓ Social Environment ✓ Physical Environment ✓ Public Safety
Health Care Focus	✓ Life Expectancy / Mortality × Chronic Disease Prevalence ✓ Readmissions × ED utilization × Maternal Health	× Life Expectancy/ Mortality × Chronic Disease Prevalence × Readmissions × ED utilization × Maternal Health	× Life Expectancy / Mortality × Chronic Disease Prevalence × Readmissions × ED utilization × Maternal Health	× Life Expectancy / Mortality × Chronic Disease Prevalence × Readmissions × ED utilization × Maternal Health	✓ Life Expectancy / Mortality × Chronic Disease Prevalence ✓ Readmissions × ED utilization × Maternal Health	✓ Life Expectancy / Mortality ✓ Chronic Disease Prevalence ✓ Readmissions ✓ ED utilization ✓ Maternal Health
Measurement Focus	17 components 2 components account for almost all of the variation (income and housing) Intended to predict mortality, but only a moderate fit to life expectancy (r^2 0.40)	7 components 2 components account for almost all of the variation (income and housing) Intended to describe economic differences; poor fit to life expectancy (r^2 0.31)	14 components in 4 domains, 2 components account for almost all of the variation (income and education) Intended for disaster management planning; poor fit to life expectancy (r^2 0.20)	6 components 2 components account for almost all of the variation (income and education) Intended to describe economic differences; poor fit to life expectancy (r^2 0.14)	7 components no serious issues with partial correlations Intended to describe economic factors related to health care access; poor fit to life expectancy (r^2 = 0.30)	43 components in 9 domains. All are significant in different locations Intended to describe differences in life expectancy (r^2 0.75)
Geospatial Adjustments	Single index algorithm for the whole country	Single index algorithm for the whole country. Small zip codes excluded.	Single index algorithm for the whole country	Single index algorithm for the whole country	Single index algorithm for the whole country	Index adapts to local relevance of each domain as it correlates with life expectancy