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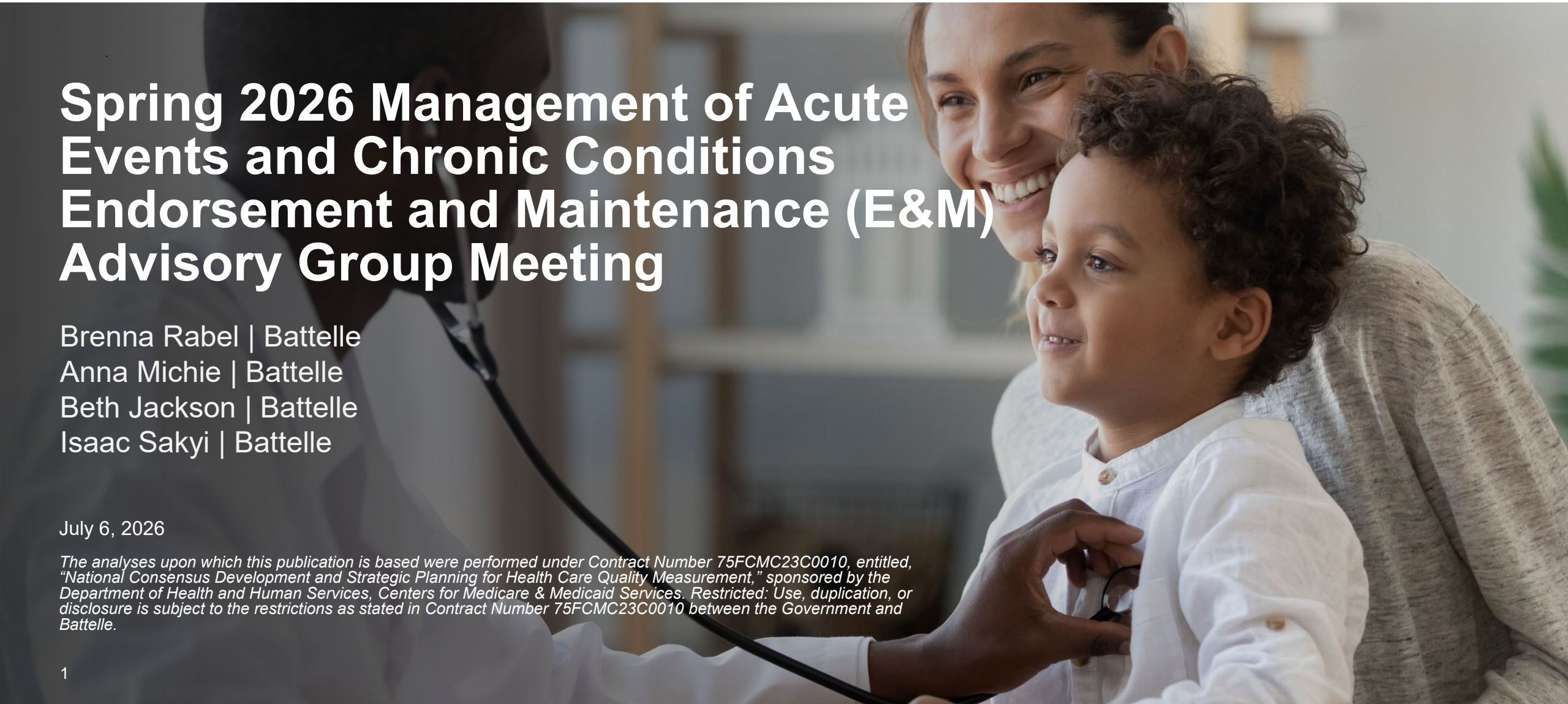

# Spring 2026 Management of Acute Events and Chronic Conditions Endorsement and Maintenance (E&M) Advisory Group Meeting

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# Agenda

- Welcome and Ground Rules
- Roll Call
- Overview of E&M Process and Advisory Group Meeting Procedures
- Public Comment
- Discussion of Spring 2026 Measures
- Next Steps
- Adjourn

# Housekeeping Reminders

- State your first and last name if you are a call-in user.
- We encourage you to keep your video on; however, the system will allow you to turn your video off/on throughout the event.
- Use the raise hand button if you have a question/comment; when called on, unmute yourself.
- Lower your hand and mute yourself following your question/comment.
- If you are experiencing technical issues, please contact the project team via the chat feature on the virtual platform or at PQMsupport@battelle.org.

# Meeting Ground Rules

- Respect all voices
- Remain engaged and actively participate
- Keep your comments concise and focused
- Allow others to contribute
- Share your experiences
- Learn from others

# Roll Call

# Management of Acute Events and Chronic Conditions Committee

## *Advisory Group Members*

- Nakia Bolden, MPH, CHES
- Carrie Bramlee, BS^
- Frankie Catalfumo, MPH, CIC, CRCST
- Maurine Cobabe, MD
- Angela Flanagan, MSN, RN, CHPIMS, FHIMSS
- Pankaj Gupta, MD, MBA
- Shawn-Marie Herring, RN, BS, MBA, CP
- Kyle Hultz, PharmD
- Jennifer Hunt, BS^
- Sarah Johnson, PhD^
- Sachie Koufalis, CCM, LMSW, MPH
- Kristen Mattingly, BS, MHA
- Chisa Nosamiefan, BS, MA^
- Adelisa Perez-Hudgins, RN
- Jennifer Plathe, MSW
- Heidi Poter, MA
- Dmitriy Poznyak, MS, PhD
- Monika Ray, BS, MS, PhD
- Rena Sackett, PharmD, BCPS
- Nagaraju Sarabu, MD, MPH
- Maureen Seckel, RN, APRN, MSN, ACNS-BC, CCNS
- David Shahian, MD
- Benjamin Shirley, BS, CPHQ
- Kenneth Shitara, BSN, RN, MBA, CPHQ
- Pavel Sinyagovskiy, MD
- Annie Slye, MS, OTR/L, CDP
- Megan Streur, PhD, RN, FNP-C
- Terra Stump, BSN, MS
- Jeff Susman, MD
- Sara Toomey, BA, Mphil, MSC, MD, MPH
- Michael Trangle, MD
- Carissa van den Berk-Clark, PhD, LCSW
- Sharronne Ward, EdD, LCPC
- Wei Ying, MS, MBA
- Bonnie Zima, MPH, MD



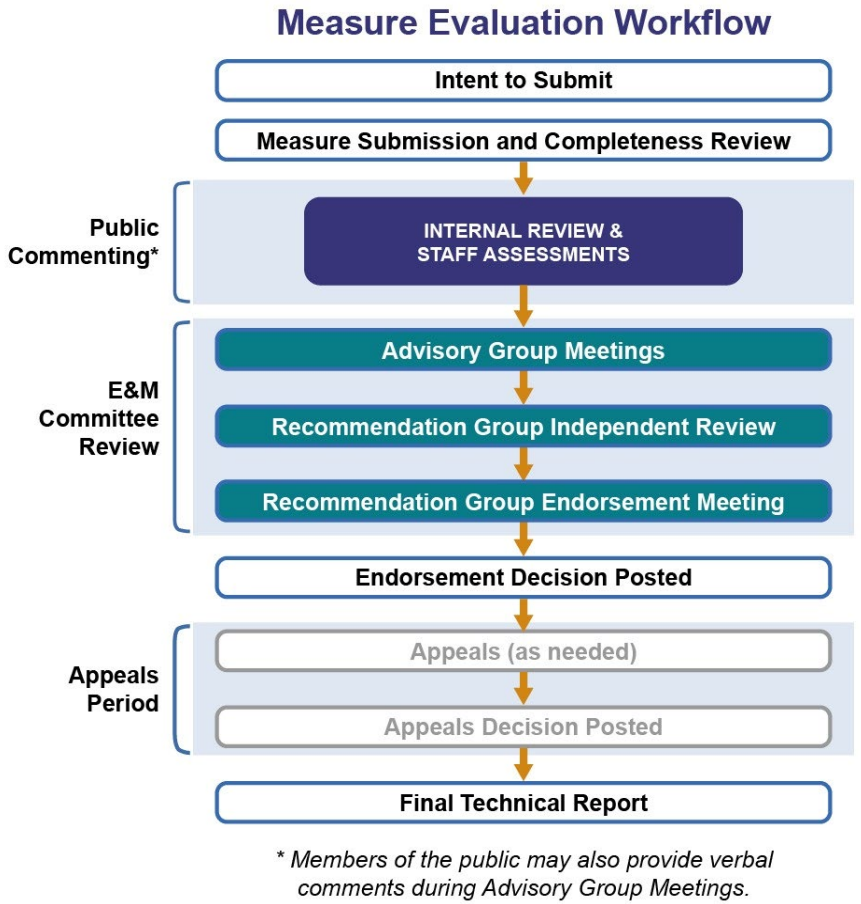
*^Denotes committee member is a patient participant.*

# Overview of E&M Process and Meeting Procedure

# E&M Process

## Six major steps:

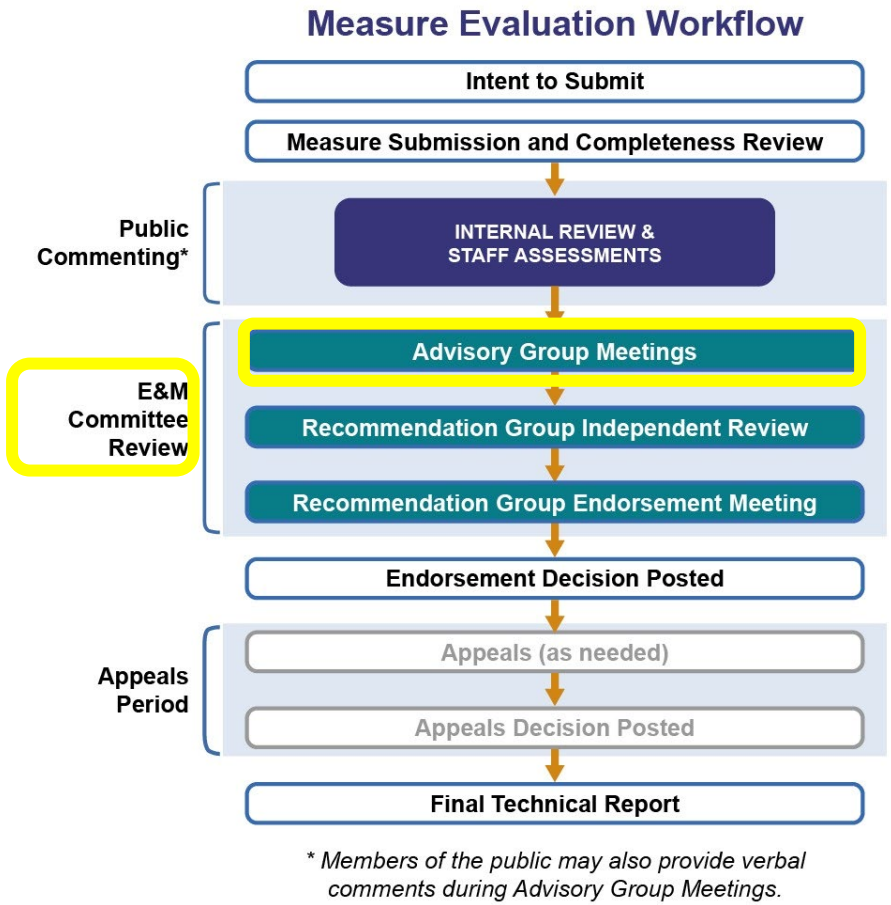
1. Intent to Submit
2. Full Measure Submission
3. Staff Internal Review and Measure Public Comment
   - Public Comment
4. E&M Committee Review
   - Advisory Group Meetings
   - Recommendation Group (RG) Independent Review
   - Recommendation Group Meetings
5. Appeals Period (as warranted)
6. Final Technical Report




** Members of the public may also provide verbal comments during Advisory Group Meetings.*

# E&M Committee Review
## *Advisory Group Meeting*

- **Steps:**
  - The Advisory Group from each E&M committee convenes to comment on strengths and limitations of submitted measure(s) and ask questions of developers.
  - We encourage developers to attend and respond to questions/feedback from the Advisory Group members.
- **Timing:**
  - Early January (Fall) and June/July (Spring)
- **Outputs:**
  - Summary of Advisory Group member feedback, questions, and developer/steward responses on the PQM website.



# PQM Measure Evaluation Rubric

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

***Closing Care Gaps (optional)*** - Extent to which the measure can distinguish differences in care for certain patient subpopulations, which can be used to close gaps in care across those identified subpopulations.

3

**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.

4

**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.

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.

# Advisory Group Meeting

## *Measure Review Procedures*

### 1. Measure introduction by Battelle

- Battelle introduces the measure, highlighting basic information about the measure (e.g., description, measure type, target population, current/planned use).

### 2. Advisory Group discusses

- Patient partners have the floor first, then members assigned the relevant measure, and then the wider AG.
- We encourage members to note risks to the measure's safety and effectiveness for the RG to consider and discuss.

### 3. Developer/steward responds to feedback and questions

- Developer/steward respond to questions by topic.
- Before moving to next measure, developer/stewards provide final response to the discussion.

# Patient Partner Feedback

- Have you had experiences related to this measure that you would like to share?
- Do you believe this measure is meaningful and can enhance patient care?
- Does this measure respect and respond to your individual preferences, needs, and values?
- Are there parts of this measure that might be hard to understand or burdensome?
- Would knowing your provider's performance on this measure be helpful to you?

# Developer Response

Throughout the course of the measure discussion, developers will have the opportunity to respond to committee feedback and questions.

Developers may also choose to provide additional clarification or detail offline after the meeting.

**If you have questions for the developer to address offline**, you may share them in the chat following the discussion so they can provide detailed responses.

# Advisory Group Meeting

*Your Feedback in Action*

**Advisory Group**

The Advisory Group raises potential major concerns about a measure.

*Example: Maintenance measure shows minimal performance improvement (0.3 increase in performance scores from 2021-2022) despite multi-year use in a national accountability program.*

**Shared Feedback**

The endorsement meeting materials flag the Advisory Group concerns.

The committee co-chairs present concerns as key discussion points to the RG.

**Outcome**

After RG discussion of major concern, if RG members agree, they may **place a condition on the measure**.

*Example: When the measure returns for maintenance in 5 years, the developer should have worked with accountable entities to identify challenges and reasons for limited improvement over time as well as strategies to address them.*

# Public Comment

# Public Comment Guidance

**Public comment is now open. To comment on any of the project's measures:**

✋ Raise hand — Use the **"raise hand"** feature to be recognized.

Please state your **name** and any **affiliation**. Please also state **the measure(s)** on which you intend to comment.

We kindly ask commenters to keep their comments to **2 minutes or less**.

**Developers/stewards:** Do not respond to commenters directly. You will have an opportunity to address feedback during the Advisory Group discussions.

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# Discussion of Spring 2026 Measures

# Spring 2026 Measures for Committee Review

The committee received seven measures for endorsement consideration.

NUMBER OF MEASURES:

**7**

## AREAS OF FOCUS

- Timely Care
- Standardized Ratios for Dialysis Patients and Facilities
- Organ Donation

## NEW VS. MAINTENANCE

- **5** New Measure
- **2** Maintenance Measures

# Spring 2026 Measures for Committee Review
*(cont., 1)*

| CBE Number | Measure Title | New/Maintenance | Developer/Steward |
|---|---|---|---|
| #1952 | Time to Intravenous Thrombolytic Therapy – 60 Minutes | Maintenance | American Heart Association |
| #3565 | Standardized Emergency Department Encounter Ratio (SEDR) for Dialysis Facilities | Maintenance | University of Michigan Kidney Epidemiology and Cost Center (UM-KECC)/Centers for Medicare & Medicaid Services (CMS) |
| #5598 | Standardized Modality Switch Ratio for Incident Dialysis Patients (SMoSR) | New | UM-KECC/CMS |
| #5601 | Rate of Hospital Referrals of Potential Organ Donors Made to the Organ Procurement Organization (OPO) from within the OPO's Donation Service Area in a Calendar Year | New | Econometrica Inc./Association of Organ Procurement Organizations (AOPO) |

# Spring 2026 Measures for Committee Review
*(cont., 2)*

| CBE Number | Measure Title | New/Maintenance | Developer/Steward |
|---|---|---|---|
| #5602 | Rate of Preferred Patients that are Approached for an Organ Donation in the Organ Procurement Organization's Donation Service Area in a Calendar Year | New | Econometrica Inc./AOPO |
| #5603 | Authorization Rate for Organ Donation Among Approached, Referred Potential Organ Donors in the Organ Procurement Organization's Donation Service Area in a Calendar Year | New | Econometrica Inc./AOPO |
| #5604 | Rate of the Number of Organ Donors to the Potential Donors in an Organ Procurement Organization's Donation Service Area in a Calendar Year | New | Econometrica Inc./AOPO |

# CBE #1952 Time to Intravenous Thrombolytic Therapy – 60 Minutes

| Item | Description |
|---|---|
| **Measure Description** | Percent of acute ischemic stroke patients receiving intravenous tissue plasminogen activator (thrombolytic) therapy during the hospital stay who have a time from hospital arrival to initiation of thrombolytic therapy administration (door-to-needle time) of 60 minutes or less. |
| **Developer/ Steward** | American Heart Association |
| **Current Use** | Professional Certification or Recognition Program |
| **Measure Specification Changes** | • Expanded measure focus from IV alteplase to IV thrombolytics, as alteplase is no longer the only IV thrombolytic used for management of acute ischemic stroke. This update impacts multiple population criteria.<br>• Specified the measure applies to patients 18 years of age and older in the initial population/denominator, rather than limiting to this age range as an exclusion.<br>• Added an exclusion for patients transferred from other hospitals. |

**Measure Type**

Process

**Target Populations**

Adults (18-64 years) and older adults (65 years and older)

**Care Setting**

Hospital: Acute Care Facility;
Hospital: Critical Access;
Hospital: Inpatient

**Level of Analysis**

Facility

**New or Maintenance**

Maintenance (Last Reviewed: Fall 2019)

**Initial Endorsement**

Fall 2012

# CBE #1952 Time to Intravenous Thrombolytic Therapy – 60 Minutes

## *Staff Assessment*

| Domain | Importance | Closing Care Gaps* | Feasibility | Scientific Acceptability | Use and Usability |
|---|---|---|---|---|---|
| *Staff Rating* | *Met* | *Not Met* | *Not Met, but Addressable* | *Met* | *Not Met, but Addressable* |
| **Strengths** | • The developer provided a clear logic model.<br>• The measure addresses a major public health issue and is supported by high-quality evidence, demonstrated performance gap, and strong patient support/relevance. | • The developer noted recommended actions entities can take to close care gaps, including timeline-based protocols and targeted strategies. | • Data elements are routinely collected and electronically available, with no major feasibility or cost concerns.<br>• The developer clearly addressed implementation burdens, mitigation strategies, and patient confidentiality. | • The developer conducted appropriate reliability and validity testing, demonstrated strong signal-to-noise reliability and a moderate positive association supporting validity. | • The measure is actively used, outlines actionable strategies for improvement, and demonstrated performance improvement over time with no unexpected findings. |
| **Limitations** | • The minimum and maximum number of entities and number of person/ encounters/episodes are missing from the performance gap table.<br>• The developer did not provide the timeframe from patient input on the measure. | • The developer did not explain the methodology or approach used for empirical testing or interpret performance across groups. | • The developer did not fully discuss implementation costs and did not clearly explain or justify potential fees, licensing, or other use requirements. | • Reliability testing used two-year data; therefore, reliability may be lower for shorter periods.<br>• The timeframe of reporting for the STK measure is not clearly specified. | • The approach to collecting/responding to feedback from interested parties and/or entities is not clear.<br>• Staff education and training may require ongoing financial and administrative commitment. |



*Currently optional.

# CBE #3565 Standardized Emergency Department Encounter Ratio (SEDR) for Dialysis Facilities

| Item | Description |
|---|---|
| **Measure Description** | The Standardized Emergency Department Encounter Ratio is the ratio of the observed number of emergency department (ED) encounters that occur for adult Medicare ESRD dialysis patients treated at a particular facility to the number of ED encounters that would be expected given the characteristics of the dialysis facility's patients and the national event rate for dialysis facilities. Medicare patients include those with traditional Fee for Service Medicare and those with Medicare Advantage. The time period for the measure calculation is one calendar year. |
| **Developer/ Steward** | UM-KECC/CMS |
| **Current Use** | Public Reporting |
| **Measure Specification Changes** | • The denominator now includes Medicare Advantage (MA) patients who were previously excluded due to lack of outpatient claims data.<br>• The measure includes MA as a covariate in the risk adjustment model. |

| Measure Type |
|---|
| Outcome |
| **Target Populations** |
| Adults (18-64 years) and older adults (64 years and older) |
| **Care Setting** |
| Other: Dialysis Facility |
| **Level of Analysis** |
| Facility |
| **New or Maintenance** |
| Maintenance (Last Reviewed: Spring 2020) |
| **Initial Endorsement** |
| Fall 2011 |

# CBE #3565 Standardized Emergency Department Encounter Ratio (SEDR) for Dialysis Facilities

## *Staff Assessment*

| Domain | Importance | Closing Care Gaps* | Feasibility | Scientific Acceptability | Use and Usability |
|---|---|---|---|---|---|
| *Staff Rating* | *Met* | *Not Met* | *Met* | *Reliability: Not Met, but Addressable*<br>*Validity: Met* | *Not Met, but Addressable* |
| **Strengths** | • The developer provided a clear logic model.<br>• The measure addresses a major public health issue and demonstrated performance gap. | • The developer did not address this optional domain. | • This measure has a well-documented feasibility assessment, clear and implementable data collection strategy, and transparent handling of patient confidentiality, burden, licensing, and fees. | • The developer used appropriate, large-scale data for testing, demonstrated validity through expected relationships with related measures, and applied a well-conceptualized risk adjustment model with acceptable calibration. | • The measure is actively used, outlines actionable strategies for improvement, include s a mechanism for questions/feedback from interested parties, and reports no unexpected findings. |
| **Limitations** | • Literature and patient input presented are dated. | • The developer did not address this optional domain. | • None identified. | • Accountable entity-level reliability is limited, with only about half meeting the desired threshold and some below acceptable levels, due to small sample sizes.<br>• The concordance index of 0.61 indicates moderate discrimination. | • There was no improvement in the measure score, and the developer did not provide a sufficient rationale. |

*Currently optional.

# CBE #5598 Standardized Modality Switch Ratio for Incident Dialysis Patients (SMoSR)

| Item | Description |
|---|---|
| **Measure Description** | The standardized modality switch ratio (SMoSR) is defined as the ratio of modality switches from in-center hemodialysis to home dialysis (peritoneal dialysis or home hemodialysis) among all adult incident ESRD dialysis patients treated at a particular facility, to the expected number of such switches given the characteristics of the dialysis facility's patients and the national average of modality switches for dialysis facilities. The measure includes only the first durable switch that is defined as lasting 30 continuous days or longer and is limited to the first 12 months of in-center hemodialysis. This measure is calculated as a ratio, but can also be expressed as a rate. |
| **Developer/ Steward** | UM-KECC/CMS |
| **Current Use** | Public Reporting |
| **Measure Specification Changes** | N/A |

| Measure Type |
|---|
| Outcome |
| **Target Populations** |
| Adults (18-64 years) and older adults (64 years and older) |
| **Care Setting** |
| Other: Dialysis Facility |
| **Level of Analysis** |
| Facility |
| **New or Maintenance** |
| New |
| **Initial Endorsement** |
| N/A |

# CBE #5598 Standardized Modality Switch Ratio for Incident Dialysis Patients (SMoSR)

## *Staff Assessment*

| Domain | Importance | Closing Care Gaps* | Feasibility | Scientific Acceptability | Use and Usability |
|---|---|---|---|---|---|
| *Staff Rating* | *Not Met, but Addressable* | *Not Met* | *Met* | *Reliability: Met*<br>*Validity: Not Met, but Addressable* | *Met* |
| **Strengths** | • The developer provided a clear logic model.<br>• The measure demonstrated a performance gap and is supported by strong patient meaningfulness. | • The developer did not address this optional domain. | • This measure has a well-documented feasibility assessment, clear and implementable data collection strategy, and transparent handling of patient confidentiality, burden, licensing, and fees. | • The developer demonstrated strong data element reliability and validity using well-described data sources with consistently low error rates. | • This measure is actively used in at least one accountability application, with a systematic feedback approach that allows for continuous updates based on stakeholder feedback. The developer reported no unexpected findings. |
| **Limitations** | • The evidence detailing the measure's anticipated impact is limited.<br>• No discussion of other potential existing/ competing measures or programs. | • The developer did not address this optional domain. | • None identified. | • It is unclear whether all numerator, denominator, and exclusion data elements, particularly those from Medicare claims and the Medical Evidence Form, underwent validity testing.<br>• The c-statistic of 0.611 indicates moderate discrimination. | • None identified. |



*Currently optional.

# Break

Meeting Resumes at 12:45 PM ET

# CBE #5601 Rate of Hospital Referrals of Potential Organ Donors Made to the Organ Procurement Organization (OPO) from within the OPO's Donation Service Area in a Calendar Year

| Item | Description |
|---|---|
| **Measure Description** | This measure is the rate per 100 deaths of ventilated hospital referrals to the OPO of potential donor population in the OPO's Donation Service Area (DSA) within a calendar year. |
| **Developer/ Steward** | Econometrica Inc./AOPO |
| **Planned Use** | Public Reporting; Regulatory and Accreditation Programs; Quality Improvement with Benchmarking (External Benchmarking to Multiple Organizations); Quality Improvement (Internal to the Specific Organization) |
| **Measure Specification Changes** | N/A |

**Measure Type**

Process

**Target Populations**

Patients who are 0 to 80 years of age

**Care Setting**

Other: Organ Procurement Organization (OPO)

**Level of Analysis**

Other: OPO

**New or Maintenance**

New

**Initial Endorsement**

N/A

# CBE #5601 Rate of Hospital Referrals of Potential Organ Donors Made to the Organ Procurement Organization (OPO) from within the OPO's Donation Service Area in a Calendar Year

*Staff Assessment*

| Domain | Importance | Closing Care Gaps* | Feasibility | Scientific Acceptability | Use and Usability |
|---|---|---|---|---|---|
| *Staff Rating* | *Met* | *Not Met* | *Met* | *Reliability: Met*<br>*Validity: Not Met, but Addressable* | *Met* |
| **Strengths** | • The developer provided a clear logic model.<br>• The measure's anticipated impact on important outcomes would be positive and is supported by high-quality evidence, with justifiable advantages over existing measures. | • The developer did not address this optional domain. | • This measure has a well-documented feasibility assessment, clear and implementable data collection strategy, and transparent handling of patient confidentiality, burden, licensing, and fees. | • The developer provided the required evidence for this measure to demonstrate sufficient reliability at the data-element level.<br>• The developer supports validity through retrospective mortality reviews and reported low error rates. | • This measure outlines intended use in an accountability program, includes plans for implementation, and provides actionable performance information to support quality improvement. |
| **Limitations** | • While performance gap data are optional for new measures, the committee may seek clarification, as Exhibit 3 shows referral rates over 100% across OPOs, suggesting the numerator and denominator may be reversed. | • The developer did not address this optional domain. | • Test sites utilized two different Electronic Donor Resources (EDRs). The application could be strengthened with discussion about the feasibility of calculating the measure in additional EDRs. | • The developer described OPO processes as sufficient but not standardized, with limited and potentially outdated validity evidence and concerns about MCOD data accuracy. | • Potential unintended consequences were not fully considered, particularly around over-referral from the perspectives of hospitals, providers, and donor/next of kin. |

*Currently optional.

# CBE #5602 Rate of Preferred Patients that are Approached for an Organ Donation in the Organ Procurement Organization's Donation Service Area in a Calendar Year

| Item | Description |
|---|---|
| **Measure Description** | This measure identifies the rate of approaches per 100 referrals by the Organ Procurement Organization (OPO) to referred potential donors or their next of kin in the OPO's donation service area (DSA) in a calendar year. |
| **Developer/ Steward** | Econometrica Inc./AOPO |
| **Planned Use** | Public Reporting; Regulatory and Accreditation Programs; Quality Improvement with Benchmarking (External Benchmarking to Multiple Organizations); Quality Improvement (Internal to the Specific Organization) |
| **Measure Specification Changes** | N/A |

| Measure Type |
|---|
| Process |
| **Target Populations** |
| Patients who are 0 to 80 years of age |
| **Care Setting** |
| Other: OPO |
| **Level of Analysis** |
| Other: OPO |
| **New or Maintenance** |
| New |
| **Initial Endorsement** |
| N/A |

# CBE #5602 Rate of Preferred Patients that are Approached for an Organ Donation in the Organ Procurement Organization's Donation Service Area in a Calendar Year

*Staff Assessment*

| Domain | Importance | Closing Care Gaps* | Feasibility | Scientific Acceptability | Use and Usability |
|---|---|---|---|---|---|
| *Staff Rating* | *Met* | *Not Met* | *Met* | *Not Met, but Addressable* | *Met* |
| **Strengths** | • The developer provided a clear logic model.<br>• The measure's anticipated impact on important outcomes would be positive and is supported by high-quality evidence, with justifiable advantages over existing measures. | • The developer did not address this optional domain. | • This measure has a well-documented feasibility assessment, clear and implementable data collection strategy, and transparent handling of patient confidentiality, burden, licensing, and fees. | • Data for reliability testing were sources from six OPOs across 2021-2024, with one OPO contributing data from 2022-2024.<br>• The developer provided evidence from one OPO showing high documentation completeness and a structured data collection process. | • This measure has a clear plan for use in at least one accountability application and provides actionable information for improvement.<br>• Entities can address potential unintended consequences through educating OPO staff. |
| **Limitations** | • The committee should seek clarification on what an appropriate Approach Rate should be and whether any empirical evidence exists which ties higher approach rates to more successful transplants. | • The developer did not address this optional domain. | • The committee may consider potential burdens of implementing this measure for hospitals, health care providers, and potential donors or next of kin.<br>• The application could be strengthened with discussion about the feasibility of calculating the measure in additional EDRs. | • The developer did not conduct required reliability testing or sufficiently demonstrate reliability for person- or encounter-level reliability.<br>• Validity is limited by non-standardized OPO processes, reliance on unstructured data, limited evidence from one OPO, and shared denominator limitations from a related measure. Data element validity issues outlined in 5601 are applicable here. | • None identified. |



*Currently optional.

# Break

Meeting Resumes at 2:00 PM ET

# CBE #5603 Authorization Rate for Organ Donation Among Approached, Referred Potential Organ Donors in the Organ Procurement Organization's Donation Service Area in a Calendar Year

| Item | Description |
|---|---|
| **Measure Description** | This measure calculates the authorization rate for organ donation (defined as authorizations per 100 approaches) among referred potential organ donors or their next of kin within the Organ Procurement Organization's (OPO's) donation service area (DSA) in a calendar year. |
| **Developer/ Steward** | Econometrica Inc./AOPO |
| **Planned Use** | Public Reporting; Regulatory and Accreditation Programs; Quality Improvement with Benchmarking (External Benchmarking to Multiple Organizations); Quality Improvement (Internal to the Specific Organization) |
| **Measure Specification Changes** | N/A |

| Measure Type |
|---|
| Intermediate Outcome |
| **Target Populations** |
| Patients who are 0 to 80 years of age |
| **Care Setting** |
| Other: OPO |
| **Level of Analysis** |
| Other: OPO |
| **New or Maintenance** |
| New |
| **Initial Endorsement** |
| N/A |

# CBE #5603 Authorization Rate for Organ Donation Among Approached, Referred Potential Organ Donors in the Organ Procurement Organization's Donation Service Area in a Calendar Year

## *Staff Assessment*

| Domain | Importance | Closing Care Gaps* | Feasibility | Scientific Acceptability | Use and Usability |
|---|---|---|---|---|---|
| *Staff Rating* | *Met* | *Not Met* | *Met* | *Reliability: Met*<br>*Validity: Not Met, but Addressable* | *Met* |
| **Strengths** | • The developer provided a clear logic model.<br>• The measure's anticipated impact on important outcomes would be positive and is supported by high-quality evidence, with justifiable advantages over existing measures. | • The developer did not address this optional domain. | • This measure has a well-documented feasibility assessment, clear and implementable data collection strategy, and transparent handling of patient confidentiality, burden, licensing, and fees. | • The developer provided the required evidence for this measure to demonstrate sufficient reliability at the data-element level.<br>• The developer reported 100% completion of authorization across OPOs, supported by double-documentation processes. | • This measure has a clear plan for use in at least one accountability application and provides actionable information for improvement.<br>• Entities can address potential unintended consequences through educating OPO staff. |
| **Limitations** | • The committee should consider whether the stratification scheme described in section 1.19 allows OPOs to make meaningful and appropriate comparisons. | • The developer did not address this optional domain. | • The application could be strengthened with discussion about the feasibility of calculating the measure in additional EDRs. | • Validity is limited by the lack of a gold standard, non-standardized OPO processes, and use of unstructured data, with a need for clearer examples of data entry tools. Data element validity issues outlined in 5602 are applicable here. | • None identified. |

*Currently optional.

# CBE #5604 Rate of the Number of Organ Donors to the Potential Donors in an Organ Procurement Organization's Donation Service Area in a Calendar Year

| Item | Description |
|---|---|
| **Measure Description** | This measure is the rate of donors out of the potential donor population in an Organ Procurement Organization's (OPO's) donation service area (DSA) in a calendar year. |
| **Developer/ Steward** | Econometrica Inc./AOPO |
| **Planned Use** | Public Reporting; Regulatory and Accreditation Programs; Quality Improvement with Benchmarking (External Benchmarking to Multiple Organizations); Quality Improvement (Internal to the Specific Organization) |
| **Measure Specification Changes** | N/A |

| Measure Type |
|---|
| Outcome |
| **Target Populations** |
| Patients who are 0 to 80 years of age |
| **Care Setting** |
| Other: OPO |
| **Level of Analysis** |
| Other: OPO |
| **New or Maintenance** |
| New |
| **Initial Endorsement** |
| N/A |

# CBE #5604 Rate of the Number of Organ Donors to the Potential Donors in an Organ Procurement Organization's Donation Service Area in a Calendar Year

*Staff Assessment*

| Domain | Importance | Closing Care Gaps* | Feasibility | Scientific Acceptability | Use and Usability |
|---|---|---|---|---|---|
| *Staff Rating* | *Met* | *Not Met* | *Met* | *Reliability: Met*<br>*Validity: Not Met, but Addressable* | *Not Met, but Addressable* |
| **Strengths** | • The developer provided a clear logic model.<br>• The measure's anticipated impact on important outcomes would be positive and is supported by high-quality evidence, with justifiable advantages over existing measures. | • The developer did not address this optional domain. | • This measure has a well-documented feasibility assessment, clear and implementable data collection strategy, and transparent handling of patient confidentiality, burden, licensing, and fees. | • The developer provided the required evidence for this measure to demonstrate sufficient reliability at the data-element level.<br>• The numerator, denominator, and exclusions use well-established national data sources that are structured, widely used, and present no feasibility concerns. | • The developer provided a summary of how accountable entities could sue the measure results to improve performance.<br>• The developer described potential unintended consequences and plausibly argued that the measure's benefits outweigh the potential unintended consequences. |
| **Limitations** | • None identified. | • The developer did not address this optional domain. | • None identified. | • While SRTA and MCOD data are generally considered valid, concerns about data completeness and coding accuracy remain. | • The measure developer did not address the current use and disposition of the existing measure that is active in CMS programs. |

*Currently optional.

# Next Steps

# Next Steps for Spring 2026 E&M Cycle

## Compiled Comments

- We will post all comments from today to the respective measure pages on the PQM website.
- We will share all public comments, Advisory Group feedback and questions, along with developer/steward clarifications, publicly and with the Recommendation Group in advance of the endorsement meetings.

## Upcoming Meetings

- **Endorsement Meeting:** August 12-13, 2026
- **Appeals Committee Meeting (if needed):** September 30, 2026

## Upcoming Webinars

- **Enhancements to the Endorsement and Maintenance (E&M) Guidebook and Processes:** July 2026

# Questions:

Contact us at p4qm.org/contact
or by emailing PQMsupport@battelle.org

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