NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
August 6, 2014
2:00 p.m. ET

Taroon Amin: Good afternoon, everyone. Thank you for joining this All-Cause Admissions and Readmission Measure Endorsement Project Standing Committee conference call to discuss the Post-Draft Report Comment.

My name is Taroon Amin and I'm joined here by NQF staff and our Co-Chair Sherrie Kaplan. We want to welcome you to the call.

Sherrie, if you want to just extend your welcome to the committee.

Sherrie Kaplan: I would also like to extend my welcome to the committee. And Taroon will be speaking shortly about the agenda. We have really a packed agenda. So in advance, we're kind of asking for your help in making this a very concise and full throughout the discussion. On the other hand, I would underscore it concisely because we have a fair amount to get through.

So if we could have some help and when you make remarks, making sure that they are pithy. That would be very much appreciated.

So welcome and go for it Taroon. Thank you.

Taroon Amin: Great. Great. Thank you very much.

Again, I just want to welcome the committee and thank you all for all of your hard work reviewing these measures and the comments that we received from the NQF membership, public, and in some cases, additional material by the measure developers.

Judging by the number and the breadth of the comments that we received during this project, this was an area of high interest of NQF members and the public. I just want to remind everyone that this call is recorded, transcribe and publicly available after the call. And I would encourage you to please mute your lines if you're not speaking during the call.

If you have any trouble speaking on the call, if you are potentially on a separate line and you're not able to speak, please send us a note through the webinar chat and we'll be sure to make sure that you get called on.

Again, as Sherrie describe today, because of the strong interest that we received on this project during the comment period, we are challenge by the agenda today. And I'll ask Zehra to move us just quickly to the agenda. And I just want to point out that we have comments to review on 11. Separate measures that require a committee discussion and five different themes that span across all of the comments in the measures.

This translates to about three to five minutes of conversation by the panel per measure and about 8 to 10 minutes per theme. So we will ask the lead discussant of each of the measures to be concise in their review of the comments but hopefully thorough and thoroughly considering the comments that we received from the membership and the public.

Again, we'll ask you to use the survey link on the webinar platform to submit final votes on the measures where a consensus was not reached. We will also send out an email following this call with a link for anyone who may be having difficulty accessing it now or following the meeting. We would highly recommend voting on these measures as they're being discussed during today's call. That will limit the amount of follow-up required after the call.

Again, for – we're also joined by a number of other members, members of measure developers and members of the public and commenters. So I'd like to point out that this is primarily a call for the committee to consider the written material received by the public and members along with additional written material from the developers.

If the committee has any clarifying questions for the measure developers, please feel free to ask them. However, we will ask you to primarily rely on the written material provided by the developer and we're also limited with the number of presentations by developers considering the amount of time that we have for each of the measures.

We invite developers, commenters and any other members of the public to provide any comments during the public and member comment period at 4:40 Eastern Time which we'll try to stick to in the agenda.

Again, we have assigned each of the lead discussants to review the comments and each of the themes. And I'll just point out, as the agenda – I'll just point out, for the agenda, what we're trying to achieve, we have a discussion – we'll begin with a discussion of the measure-specific comments received focusing primarily on – or first I should say, on the measures where a consensus was not reached. And the goal of this discussion will be to have the lead discussants review the measure-specific comments and highlight areas where any new information has been presented to the committee again, focusing on the measures where a consensus has not been reached. The action that we'll ask the committee members to take is to provide a final recommendation on each of these measures via the SurveyMonkey.

The second section of the agenda will be focused on reviewing the comments for the measures that were recommended for endorsement. The goal will be to have the lead discussants review measure-specific comments and highlight areas where new information has been presented to the committee.

Again, we're not asking for rehashing of each of these measures, many of the commenters focus on some of the elements that were already discussed during the in-person meeting. So again, I would strongly ask the lead discussants to review the measure-specific comments and highlight areas where new information has been presented to the committee.

The action that we're asking in the section for measures recommended for endorsement is to consider whether the committee should accept any of the

proposed – should accept the proposed committee responses provided in the comment table or overturn initial recommendation.

And finally, we will have a discussion of the cost cutting themes and we've also assigned lead discussants for these sections of the discussion and the goal here would be to have the lead discussants review the cost cutting themes as identified in the briefing memo and provide – and also, review the proposed committee responses. The actions here would be to determine if the proposed committee response is acceptable.

For harmonization, there have been a number of comments related to harmonization and the committee's action here is to determine whether its initial recommendation on harmonization needs to be reconsidered. The initial recommendation by the panel was to move multiple pairs of measures forward considering that they were sufficiently different to move for endorsement on multiple measures.

Again, we'll conclude with the public and member comments where we'll invite members of the public developers if there are other additional information that you would like for the committee to consider and other members of the public to provide public and member comments. Adeela will summarize or not summarize, just provide next step discussions at the end of the call.

So as I just described, we do have a packed agenda for today. Again, we thank you all for taking the time to review all the comments and the additional material received by the developers. I'll just quickly stop there and then see if there are any questions from the committee about today's agenda. And if not, I'll turn it over to Sherrie to begin the conversation around the measures where a consensus was not reached with measure 2496, standardized readmission ratio for dialysis facilities.

And I would just actually point out one additional element as far as the agenda goes, we will be postponing the conversation on measure 2503 so this is for committee members Leslie Hall and Tom Smith. I just want to point out for

that measure and then for 2504 for – with (Karen Joynt) and (Paul) and (Inaudible).

Those two measures on the hospitalization and rehospitalization per 1,000, we'll postpone that until after 4:00 p.m. since we just received a word from the developer that they won't be available until after 4:00 p.m.

Sherrie Kaplan: OK.

Taroon Amin: So let me just stop there and see if there are any questions from the committee members on the agenda and then I'll turn it over to Sherrie to take us off with 2496.

OK, Sherrie, it sounds like there are no questions on the agenda. I'll turn it over to you to lead off the discussion.

Sherrie Kaplan: Well first, first on the point as ordered, how do we – should people push the raise hand icon on the website to ask a question or should they just chime in? How do you want to handle that Taroon?

Taroon Amin: Let's try to use the raise hand feature on the webinar. If anyone has any trouble getting called on, please – any committee members having trouble getting recognized, please feel free to chime in.

Sherrie Kaplan: OK. So measure 2496 with the standardized readmission ratio for dialysis facilities and in the way the comments came back, I'm going to attempt to summarize but anybody else is reviewing this – who also was a primary reviewer including Dr. (Fishbane), (Inaudible) and Jencks are welcome to amplify.

So the first issue I believe was the attribution of care provided by the dialysis unit versus the care that was provided by the discharging hospital making – potentially compromising this measure as a reflection of the care provider that the dialysis unit versus the discharging hospital and was further noted that the discharging hospital really doesn't have an incentive of communicating discharge information to the dialysis unit.

The response was that actually, and it was further noted that there isn't very much evidence supporting the link with outcome care provided or processes provided by the dialysis unit to indicate that this would be a useful outcome measure that's in that link.

So having said that, it is true that the developers commented that it is true that there is limited evidence of the link between – from – that care provided in the outpatient setting can reduce the risk of readmission for this population but they based it on the evidence in other populations in chronic disease that care provided outpatient setting can reduce readmissions.

And right now, NQF guidance doesn't require a kind of evidence for outcome measures. So that was the response from the reviewers.

It was further noted that 16 percent of readmissions occur prior to first post-discharge visit to the dialysis unit. It was also noted that by – comments show that there was no minimum for admission or readmissions. And the developer responded that they eliminate those with less than 11 hospital discharges per year. It was further noted that disease statistic is less than 65 and therefore low.

However, it was also noted that this is absolutely – and that is true across the readmissions measure so this is a not on a typical statistic for these measures. Planned admissions including AV fistula and graph interventions and other access procedures are planned. The developer responded that the procedures that are planned are much more likely to be performed in an outpatient setting rather than as a planned readmission.

And their sample and data showed that only 1.9 percent of unplanned readmissions included a placement of the (variety) that was of concern and therefore, there would be no disincentives introduced for most planned access procedures.

And finally – and somebody else can comment better on this that knows this piece of the story better than I do. There was a concern about the 90-day rule. And the developer responded that for readmissions, that 90-day rule doesn't

very much sense. So, I will ask the others to add – the other people who were the lead discussants on this measure to further comment.

Steven Fishbane: Yes. Sure. It's Steve Fishbane. You know, that's why I'm not sure where you're reading from. I'm read – looking at the document which was the July 28th, 2014 memo to the committee which lists the comments on this. So I see things in a very different order and a number of other issues that were raised that haven't been addressed. Is there a different document that you're looking at?

Andrew Lyzenga: Dr. Fishbane, this is Andrew from NQF. Sherrie is actually looking at the spreadsheet, the Excel Spreadsheet that contains the full comments and developer responses. You should have gotten a link to that and a number of the emails that were sent out. And we can just shoot, you know, another copy to that to you again, if you – oh, it's also on the webinar.

Steven Fishbane: Yes. All right. Because, you know, I used to link – that was in – but I guess there were two separate links that looks like that that were in the original email. You know, I think we should take real care because there are a lot of comments for this measure.

In addition to that, this is a measure that the technical evaluation panel generally was quite negative about and we have pretty extensive discussion on that. It's very important that we'd be sensitive to the comments that were received.

So I think that the developer's responses there generally make sense. There is a couple of other issues that were raised. So one of them, you know, which really got very strong comment was on the denominator specification. And this was in a letter from the American Society of Nephrology. It's something that we hadn't discussed at the previous meeting.

And I guess Steve Jencks who had shared the TEP was with the American Society of Nephrology on their response. And the concern that they had here was that the decision – and I'm going to quote a little bit here, made with access infections where the number of catheters does not determine their denominator but rather, the number of patients determines the denominator.

ASN believes that the number of discharges should not be the determinant, but rather that the number of readmissions should be based on the total number of patients treated in the facility.

They felt very strongly about it. Dr. Jencks felt that it was a fatally flawed measure because of this. And, you know, their concern here is obvious that if it's not based on the number of patients in the facility, you have the risk that a couple of patients in the facility might excessively lever what the results turned out to be. So I don't have access to the developer's response on that, but I think that needs some discussion by us because I think it was a very strong response by the ASN and I do think that at least, that phase value, it's the response that makes sense that probably, that's (inaudible) here should be at the number of patients for the unit.

Did the developer comment on this?

Sherrie Kaplan: Yes. If you look at the comment table, the developer did provide a response. It would be under the tab that says consensus not reached. There is a response there from the developer. And we can actually screenshot that for you. We're opening that up right now.

Is there anyone from the University of Michigan who wanted to just kind of respond back and summarize what they provided as a response? I think it's now up on the screen as well for everybody to see.

Steven Fishbane: You know what, might I ask that, you know, as one of the primary reviewers for this because I haven't seen the developer's responses, can we go on perhaps to some of the other measures? I will go back to the Excel Spreadsheet. You know, I think that would be very helpful to me but I'll go with whatever the chairs prefer.

Taroon Amin: Sherrie, I'm fine with that. Is that OK with you?

Sherrie Kaplan: Yes. That's fine. We should probably bring that at some point during the, you know, during the consensus, not reach discussion. However, not let it drift too far beyond that. Is that OK with you?

Taroon Amin: Yes. That's fine. Let's, you know, so we have – like I said at the beginning, 2503 and 2504, we have to delay. So I'm going to ask – we can move on to the measure 0327, the risk adjusted average length of stay for inpatient hospitalization. So I'll turn it over to (Alison) if you want to get us started with this as a lead discussant.

(Alison Shippy): Sure. I hope you can hear me. Great. So 0327 is our risk adjusted average length of stay measure. The steward was premier. In keeping with the suggestion that we only focus on kind of new information, a couple of commenters had noted that the measure should really exclude inpatient rehab facilities from the specifications based on large variation. And the developer has responded with that saying that it is appropriately accommodated for in the risk adjustment strategy.

Other commenters – and I think we may have touched on this a bit but maybe not, that there were some questioning on whether this was really a true quality measure. I have a couple of comments noted that for a length of stay measure, there really is no kind of true norms as far as what's an appropriate benchmark or what should hospitals be aiming for as far as length of stay.

The developer did respond in agreement there saying, you know, there certainly is no kind of predetermined length of stay that any facility should be aiming for but should be kind of looked at independently and should be – a facility should think about it in reference to previous benchmarks.

Some other comments that were noted was the inclusion of sociodemographic status or certain variables in the risk adjustment strategy from the developer. The developer did – so the comments were noting that this is not in alignment with the current guidance from NQF and I may not comment that much on that just because I know that is one of our themes that we will be digging into a little bit deeper later on in this call.

The measure developer did respond saying that they had some evidence that would suggest that it's appropriate but would defer to the committee and understands that there is a large discussion being undertaken by NQF and the

board, et cetera, et cetera. So the measure developer did respect that that kind of national discussion on risk adjustment was occurring.

I would close that there was a last kind of comment about lack of a dissemination plan as far as more widespread execution of this measure, any sort of plan for public reporting, anything of that nature outside of the premier kind of family was a kind of a negative remark from commenters and I do not see any sort of follow-up there from the measure developer indicating any sort of more widespread dissemination.

So I think I'll stop there. I don't know if (Ron) is on the call but I'll pause.

(Ron Stettler): I am, (Alison). I think you did a great job summarizing it. Yes. I think the stratified nature of the model is what the developer is basing the rehab variation on and I think that basically makes sense.

And I think the drill down, the capability of actually getting to more detailed information without actually I guess procuring the premier model or actually gyrating it yourself I think is what they are concerned about on the dissemination. So – yes. Other than that, it's completely – well, everything you said.

Taroon Amin: Yes. Are there any other comments from the committee members or are we generally OK with the proposed committee response?

Sherrie Kaplan: Taroon, can you remind voting and how that's supposed to go so it would – this would be an appropriate time?

Taroon Amin: OK.

Sherrie Kaplan: People are interested in either making notes for votes after the fact or loading now on these measures. Can you kind of just give us …

Taroon Amin: Yes.

Sherrie Kaplan: … a summary about what that does?

Taroon Amin: OK. So first, we'll go through just as the lead discussants had on this measure, just go through a quick summary of the comments and then review the committee response to ensure that that adequately reflects the committee's consensus. If there's elements with the committee's proposed response that folks would like to clarify or add to, please raise those.

And then on the links section of your webinar, you'll see item number 4 which is your consensus not reached SurveyMonkey six. Sorry, I don't know what I said, but six. You'll see SurveyMonkey. There, you'll be able to enter your final votes on these measures. So we would encourage you to follow along there or just make some notes for yourself about how you would like to vote on these measures and enter them at the end of the call.

(Off-mike)

Taroon Amin: So if you're looking at the webinar, you'll see a link section. There's meeting information and then there's links. And if you scroll down on the links on item number six, you'll see that it says consensus not reached, SurveyMonkey vote. If you click on that, it will bring you to the SurveyMonkey.

Sherrie Kaplan: OK.

Taroon Amin: We'll also send out a separate link at the end of the call just to make sure everybody has got it.

Andrew Lyzenga: And the vote will be open until tomorrow, close of business.

Taroon Amin: OK. (Paula), you had a question or a comment?

(Paula Minton-Foltz): Yes. Thank you. I notice that a lot of the proposed committee responses included statements that we would suggest that the project be closely monitored. And can we – can you elaborate on what closely monitored actually mean?

Taroon Amin: So this is – we can clarify this in the proposed response. Well actually, in this case, it would be just sort of a general recommendation to measure

implementers as you're using this measure to closely monitor for any other unintended consequences.

In other cases, we may note to CMS in terms of using them in programs. But either way, it's really a recommendation to program implementers as they're using this measure. So, you know, those are generally the folks that are picking up these measures and using them. So these are the recommendations to program implementers.

(Paula): OK. And so, we're not suggesting how they monitor nor are we suggesting that they report back to us their findings.

Taroon Amin: We are not making those specific recommendations but if you feel like there needs to be a specific recommendation, then we can certainly entertain that.

(Crosstalk)

(Paula): … to the groups thinks but I think it would be nice to hear back what their finding as they implement these.

Taroon Amin: OK. We'll make them note of that in the committee response.

(Alison): Taroon, this is (Alison). I raised my hand on the webinar.

Taroon Amin: Yes.

(Alison): If I could make an addition. Just to add in our committee response, something a little bit more specific to this measure. I know that we kind of repackage a lot of the same language throughout our committee responses. And I don't know if there's something that we could add especially about the unintended consequences related to pairing measures with other quality measures.

So pairing this measure specific to – with other quality measures to have a truer picture, I think this lack of context that some users may have if you look at the length of stay measure kind of in isolation. The kind of assumptions or inferences that you're going to make if you look at that on its own is not something that I don't think that a measure developer is intending. And I know that we as committee members, you know, have raised some concerns

about as well as commenters. So I don't know if we could just add a quick sentence in there about – specific to this measure being paired with something to create a fuller picture.

Taroon Amin: Yes.

(Alison): Thanks. Oh, and also the rationale or will that –.when we as committee members put our voting rationale in the SurveyMonkey, is that reflected anywhere publicly?

Taroon Amin: Yes. Well, that will be in the final report I believe. Yes.

(Alison): The final report? OK.

Taroon Amin: And that also will help – if you had specific recommendation, if you ask specific rationale, that will also help us in developing the final committee responses.

(Alison): Right.

Taroon Amin: So if you have a specific language, you would like to consider, please add it there as well.

(Alison): OK. Very helpful. Thanks so much.

Taroon Amin: OK. I'm not seeing any other hands on the webinar. And so if the committee is OK with moving on, we'll move on to 2512. And I'll ask (Anthony Gugenis) to get us started if you don't mind.

(Anthony Grigonis): Not at all. Thanks. The readmission measure for long-term acute care hospitals generated several different types of comments. And let me just review quickly RTI's response to one of the issues that was raised concerning the rationale for including readmission not only back to short-term acute care hospitals, but back to the – to an LTAC in the measure. And their supplemental material that they came back with demonstrated that the actual readmission back to an LTAC is – has a minimal impact to the actual readmission measure that less than 4 percent of all the readmissions are

actually readmitted back to LTAC as opposed to the readmissions back to the acute care hospital.

So as far as sort of a negative way to support continuing to include readmission back to LTAC in the measure by showing that its impact is low. So it's sort of – it supports keeping it in sort of statically because that has a little impact but it didn't really address the real rationale for why include it in the first place. But they did a good job I think with retesting and at least reexamining that question.

As far as the comments, there are about six or seven comments that we received. Most of them were sort of general comments regarding – many people agree that potentially, more work should be done to really determine what this measure is doing and how it's working. And although most of the comments did support – ultimately support the – for NQF to approve the actual measure.

I think one of the main issues that was brought out both in the previous comment and also in the RTI response and a few of the other comments that came in is that the question related to, is the use and usability issue, does that really have an impact on our NQF endorsement because if it does, there are other issues that RTI did not address concerning even issues that were brought in the initial work, if you will, that RTI put in to this measure regarding they have not determined how this measure could be used to let's say, compare hospitals or to compare hospitals over time.

There are several sort of fundamental usability issues that came up that were not specifically readdressed. But if it's the committee sort of tasked not to use that information in their final approval of the measure which appears to be scientifically sound, I think all those issues had been addressed. Then I think that could be the sort of one of the determining factors in whether or not a consensus would be reached on this measure.

Any other of my committee – subcommittee would like to add anything to that? (Helen) or (Carol) or (Laurent)? Anything to add?

OK. So I would just provide from the NQF perspective on the question of use, you know, the NQF process, the endorsement process is purely looking at whether it meets the four criteria. One of the criteria does look at use and usability. The intent of that criteria is to ensure that measures that are endorsed have – either are in use or there is a credible plan for use. However, the particular question around, is it appropriate for different applications is outside the scoop of this evaluation. So hopefully, that clarification helps in your final decisions on this measure.

Are there any other comments from the committee members related to this measure or the proposed response? If not, we'll move back again to measure 2496.

Sherrie Kaplan: Well, let me just ask. Steve, are your ready?

Steven Fishbane: Yes. I guess so. So this issue in terms of the denominator, again, I thought that this was particularly important. Sherrie, I'm not sure how you felt about it but this issue that was raised by Dr. Jencks about the American Society of Nephrology has to do with the denominator here and whether it should be based on discharges from a dialysis facility or whether it should be based on a number of patients in the facility.

I'll be honest. You know, I didn't really think about this in a lot of detail the first time through. I don't think we had much discussion on this, what's relatively new issue. ASN takes a pretty strong position here that they believe that it should be based on the size of the facility to get rid of the issue of individual patient characteristic. Dialysis units tend to have a few patients who are very big outliers in this regard.

I read the developer's response which really speaks for the most part to harmonization between the standardized hospitalization rate and this new measure. So that already exists and there's a new measure, the standardized readmission rate. And, you know, there certainly should be some use of both – together, that make sense.

Dr. Jencks in the ASN response letter commented that in his research which is published, it shows a very high level of redundancy between the two. So they,

you know, strongly asked the developer and I don't really think that there's a direct response from the developer on this to switch to using a denominator of the total number of patients in a facility.

I am fairly sympathetic to that view but I kind of like to hear people's opinions on it.

Sherrie Kaplan: Let me understand because the – I pulled the article and we're going to have I think, Taroon, correct me if I'm wrong, we're going to have a discussion about the issue on the generic level about a population-based versus a discharge-based denominator because of the findings that were publish in (inaudible) in 2013 that showed that in fact, the admissions, if you use a denominator as the number of Medicare beneficiaries for example versus the number of discharges, what's happening is people – there is a reduction in admissions which is actually shifting towards a sicker population.

And if you look at the ratio of readmissions to discharges versus readmission to beneficiary, you actually get a difference looking that it looks like people are in one case, not reducing the readmission rates when in the other case, it does look like a reduction because of this business that shift in the number of admissions and hospital admitting more sick people.

So I think, unless I'm wrong Taroon, are we going to have a generic discussion about that issue or are we going to make that unique to this particular measure?

Taroon Amin: We will have an overall discussion about that because obviously, the implication of that type of conversation would apply to multiple different measures. However, there's a bit uniquely specific to this measure in some way. I mean, not necessarily seeing how that particular issue (inaudible) for this measure but, you know, I don't want to completely stifle discussion here. That's something that Steve feels very strong about.

Steven Fishbane: No. I don't feel very strongly about it. I think it would be a good subject for general discussion. I think the one way – and ASN gives an example here that it's important is that there is a lot of variability in the size of dialysis units. So you have a number of units that are greater than 200 patients. You have a lot

of smaller units as well that are 40 or 50 units and by doing it at a discharge level for the denominator, that would have an effect of putting a lot of emphasis on an individual patient who is admitted more frequently.

But I suspect that this could probably go under the general discussion that we're going to have on the subject of denominator bases. So, I mean, unless anybody else has comments on that, I'll just go to a couple of the other public comments that were received.

Sherrie Kaplan: Go ahead.

(Off-mike)

Steven Fishbane: OK. I'm not hearing anything else so we go forward. There was a fair amount of the comments that we discussed. I think in a lot of depth, attribution was a really big issue among commenters. There certainly were a number of commenters that got to this basic argument that we had about whether a dialysis unit is really structured in terms of regulatory or practical function to be able to affect readmissions.

You know, as the committee knows, my bias here is that there is very little ability with current regulatory structure to move things. However, I do think we had a very full discussion on this subject before a vote was initially taken. So I think we simply saw more support among – or a lack of support I should say for the ability to truly attribute from comments that were received.

There was also comments on resources that dialysis units have. It's kind of unique financing for dialysis units, wanted to be responsive to this commenter's note that in the current reimbursement framework that's present that there are specific individuals who are in the dialysis unit. What would really be tremendously helpful would be to have somebody like a case manager so that there is a number of other types of facilities who are part of these types of measures where they have case managers or people who are available to coordinate care.

And that's really not true at the dialysis unit level. There were some specific, very technical questions that were raised. I'm not particularly comfortable

with this one. So Sherrie, I'm not sure if you had a chance to consider this which was the validity of the two stage random effects risk adjustment model. So there was, you know, a request for some clarification on that. Did you have a chance to take a look at that one?

Sherrie Kaplan: I did. But again because it followed the sort of more generic problems with that kind of risk adjustment model, I was not as disturbed about that and it does, you know, again, we can have a discussion about that later on. But if the developer wants – is the developer on the line, Taroon?

Female: Yes. They are.

Sherrie Kaplan: I want to quickly comment about that.

Female: Sure. Go ahead. Anyone from the University of Michigan?

Taroon Amin: Operator, can you make sure that our colleagues from the University of Michigan have an open line?

Female: That's UMKECC.

Operator: Their lines are open.

Sherrie Kaplan: OK.

Steven Fishbane: Well, I'll go forward until they're able to get back on. In terms of reliability and validity, I think we had a pretty robust discussion about this at the in-person meeting. Commenters did note about reliability. I think we have come to an agreement as a committee that generally, the statistics don't give us a very high correlation but that's what's expected for most of these measures.

I think there is a fair, you know, comment that's made about validity that the approach to validity here was primarily looking for our correlations between existing quality measures and the fact that, you know, they really isn't a great definition of validity here other than some relatively weak correlations which I think is a fair comment.

I think, you know, the greatest – overall, I'll stop after this, again, as I think I argued pretty strongly at the initial meeting is that there is pretty widespread comments from most of the commenters and there were 10 separate commenters here.

I think, I think one comment – one of the commenters was generally supportive, the rest were, you know, generally fairly critical as the TEP was. But the issue of attribution, the ability of really being able to affect any of this with the regulatory and practical structures that are present in dialysis units.

And at our meeting in-person, we had some discussion – well, for congestive heart failure, hospital stuff that they wouldn't be able to move that. But I think that that analogy might be a little bit weak because there's a lot of things in life that we could apply that to, things that we didn't believe and then turned out to be true. I think given a priority, what we understand about the structure of dialysis units, it's very hard to imagine what the ability to move this measure would be. And a lot of commenters certainly spoke to that attribution issue. So I think that's most of what we're seeing.

In addition, there's a lot of quality measures that are already publicly reported in part of the pay for performance quality incentive program. Most of them have very little evidence behind them but dialysis facilities are at least able to move most of them like anemia measures, like some of the other measures that are there for catheter use. We accept those because those are things that we truly know that we can affect. And I think what most of the commenters and the TEP spoke to was really this issue that, you know, first, define a structure then have the quality measure to be able to show how you performed based on it. And I'll stop with that.

Taroon Amin: OK. Great.

Sherrie Kaplan: Excellent.

University of Michigan: Hi. This is (Inaudible). Can you hear us?

Female: Yes.

Taroon Amin: Yes.

Sherrie Kaplan: We can hear you.

University of Michigan: Well we can. OK. So would we have a chance to comment on some of this since there's been a lot of discussion?

Taroon Amin: Were there specific questions, Sherrie that you had for the developers? I just want to make sure we're specific to addressing the question to the committee.

Sherrie Kaplan: Yes because I do think all those feeds – we acknowledge that dialysis facilities, that's a unique problems. I think the attribution issue, you know, for many – in fact, the majority of these readmission measures has been problematic right along and people have raised that issue. And despite those concerns, we've managed to figure out ways to reduce readmissions in the facilities that have been, you know, innovative and yada-yada-yada.

And the – I think they expressed from people like the CMS and others, they expressed issue is if you begin to kind of monitor these things, then people use that information to try and make those kinds of improvement. So the question is, is this so problematic that you would not want it to go (fluid) at all or is this one of those learning environments where in a learning healthcare environment, you would actually put this out there as a way to stimulate those kinds of innovation?

So that – I just like to sort of frame that it's not unique to dialysis facilities in some ways. I – concerns but it may be more generic in general with these readmission measures. So the concern for the developer was, can you tell us more about and defend, if you will, the Tuesday analytic process?

Steven Fishbane: OK. I guess – just one comment about the one positive comment we got which I think should be noted was from patient groups. So that was from a patient group that there were a large number of comments from large corporate entities and fellow providers I guess that it tended to be more negative. And I think many of the criticisms and comments apply more generally to readmission measures. So I think not just Jencks comment or the denominator comment but many of them apply to the readmission measures.

And so there is an issue of consistency here. I think it's important for the committee to keep in mind.

I think it's just on the Jencks issue. I did read the discussion on Theme 3 and the committee's response to that which seemed to be very close to our view that a general measure of readmissions or admissions combined with a measure of readmissions that those two together is very useful. But the readmissions measure is a useful one on its own right and I think we gave a fairly thorough answer to that.

Two stage model. It's a model – so the random effects in a logistic model is something that's used quite extensively. I think it's in most of the measures perhaps in a different way than we've done it but it's a – there are kind of effects included in most of those measures. The issue here is that there was a claim and certainly, a lot of concern that there's attribution both to the hospitals as well as the dialysis facilities that should be accounted for in a readmission measure. And so the aim was to make some adjustment for hospitals in the (inaudible) measure.

One can't adjust for the hospitals. As a fixed effect, it wouldn't work. And so the (inaudible) hospitals and there's a random effect, there's a way basically of making an adjustment so that it would take account of a hospital. It has a very poor record with respect to readmissions of dialysis patients. And so there would be some recognition of that in the estimate that applies to the dialysis facility.

And the technical aspects of a random effects model, of course, one gets estimates basically for hospital effects that would be shrunk in toward the overall mean. And so it's – and so there are some conservatism basically in the adjustments that's made for hospitals but nonetheless, it does account to some degree for that attribution of cost to the hospital as well as the dialysis facility.

There have been a few technical questions about whether it would work if you had just a single dialysis facility in a single hospital. We did respond to that in the written comments. They're certainly with the random effect model and

the kind of assumptions there that are in that model, then it does handle that situation without difficulty and basically, that hospital is assumed to come from the population of hospitals and it makes an adjustment mainly to the standard error in that case.

And so I think it's based on well-understood methods with I think as was mentioned, for a random effects logistic model and allows some adjustment basically for the direct responsible of hospitals and dialysis facilities.

Sherrie Kaplan: Thank you. And, you know, again, (inaudible) destination has been part of the bane of our existence for low volume hospitals and that's part of different discussion I think. Taroon, is that true or are we not going to bring that issue up again?

Taroon Amin: Yes. So we're going to discuss the issue of the relationship between the admission and readmission near the close of the call. So if we can postpone that part of the discussion as the developers described and as Dr. Fishbane described as well, that's an issue that crosses multiple measures. So, you know, and then we actually have – I believed (Steve) and (Joan) are actually on the call as well. And I'd like to invite them to have a discussion about this at that time not as it relates to this individual measure.

So if it's OK, I'd like to kind of wrap this up and, you know, move on to some of the other measures that still had consensus not reached if that's OK with members of the committee and the lead discussants. OK. So if we can move on to – I believe, we know the developers online for 2503 and 2504. So I'm going to ask Leslie Kelly Hall to lead the discussion on 2503. And then (Paula Milton) (Inaudible). If you have – we'd like you to try to take these two measures together.

So (Paula), if you have any other thoughts because the comments very much mirrored one another for these two measures, let's see if we could take these two measures together. So Leslie, if you can take us off and then (Paula), maybe you can take, you know, just add to this as it relates to 2504. Leslie are you there? (Paula) are you there?

(Paula): Yes. I'm here.

Taroon Amin: OK. So maybe you can start us off with 2504? And (Tom Smith) if you're on the line too, we can go to 2503.

(Tom Smith): I am here.

Taroon Amin: OK. Great. So (Paula), maybe you can take us off then.

(Paula): OK. I think the comments that we saw were very much mirrored in our discussion at the committee about the – really whether this is just an actual quality measure or a raw utilization statistics. And I think the developer answered the question and that they don't really see a difference between the two things and that it's not really meant to do anything except for to measures the community's improvement over time.

One thing that was commented on was that these were useful tools for the (inaudible) CMS (inaudible) care transitions work and saw that the use of this could be valuable for some of this community work.

There was recommendation that we look at a minimum presented claims that are available but that seemed to be not a very big recommendation. So I think that kind of summarizes what I saw that was new material.

(Tom Smith): I agree. It's (Tom). Yes. It was noted that claims lag can impact the measure in that. I think (Paula) mentioned that there might be a time on it – a suggestion to handle that. A number of people did comment on the usefulness of these measures for community-based interventions and community health studies quality and cost studies. So there's of no significant interest in that.

I also notice, you know, elsewhere, there were comments about the unintended consequences of using readmission rates as metrics when, you know, if in fact hospitals are doing good things, they're lowering not only – I don't know.

Taroon Amin: Operator, can you mute that line please? Thank you. Sorry about that.

(Tom Smith): You know, there is this parallel discussion which I will get to later about, you know, hospitals that actually do good things and lower their admission rates

can in fact show a steady or even increasing readmission rates. So that the notion that we should also have reports of overall geographic-based or population-based admission rates to accompany those analogies.

I thought that's an interesting parallel discussion. I think, you know – and again, the arguments again are basically that it's a utilization statistic and not a measure and then it's not risk adjusted. The developers did suggest that they would be interested in doing age standardized adjustment to address the issues of Medicare populations changing over time. You know, that was another point that was made up. Medicare population is not a stable population but age adjustment could account for that.

And then again, that's as (Paula) said. And I'll end with this. We as developer noted that this is really in arbitrary distinction between a statistic and a performance measure that they're both metrics that should be, you know, can be used to guide interventions and quality initiatives and that developers should not be responsible for potential misuse of a measure. That kind of stuff happens all the time is the right response to not endorse the measure. And I think that's an important question for us to wrestle with.

Taroon Amin: OK. Great. Operator …

Leslie Kelly Hall: Leslie Kelly Hall. Can you hear me?

Taroon Amin: Yes.

Sherrie Kaplan: Yes we can.

Taroon Amin: Yes we can.

Leslie Kelly Hall: OK. Thank you. I just would like to reiterate in the original comments about this is a measure for community use to determine community need around any specific geography. And it's not – it's meant to be a baseline to help determine whether communities are being served and not to determine whether or not the certain risk of population is being served. I think the developers felt quite eloquently about this need and I doubt that – so I would just like to reiterate that. sorry.

Taroon Amin: OK. Great. Are there any other comments on 2503 or 2504? OK. Seeing none, I believe we've addressed the five measures that were within the consensus not reached. For a quick time check, we're at 4:05. We have a little less than 40 minutes before public comments.

The main question that is at hand for the committee to consider for the recommended measures is whether there was any information or any comments that were submitted that would justify overturning the committee's initial recommended status or their initial recommendation to recommend these measures going forward. So ultimately, what I'd like to ask is for the lead discussants to essentially raise their hand if there was something in their comments that they believe that the initial recommendation of moving forward with recommending these measures was present in the comments.

If there was, we would go into a deeper discussion on any one of these measures. If not, we will move forward on to the schematic issues that span the measures. So I'll specifically ask any of the lead discussants, (Kathy), Sherrie, (Paula), (Paulette Ross) if there are any particular comments that you believe on these measures for which you are the lead discussants need to be raised to the committee's attention that would overturn the original recommendation that was made by the panel. So we'll consider these measures as a cohort.

Sherrie Kaplan: It looks like – (Kathy), you've got your hand raised. So we can talk about your measure.

Taroon Amin: Go ahead, (Kathy).

(Kathy): Sure. Sure. So the – I was looking at both the pediatric measures and the comments addressing them were really discussed both of the measures together. There was really two things that I don't think we talked a lot about at the meeting that was raised. And one was the issue raised by (3M) and their comment is about these measures. And it's probably not just applicable to the pediatric measures but whether or not we're talking about potentially preventable readmissions versus unplanned readmissions.

And I think that this measure – the measure developers took the care to do some chart review to ensure that they really are measuring unplanned readmissions. But the comments that we received were more about whether or not that's really the right thing to be measured and whether or not it could have unintended consequences if we're looking at – if we're not looking at potentially preventable readmission.

Having said that, it's a little challenging because there's not – there isn't – we don't have a measure to look at potentially preventable or a way to try to assess that. So I think we have what we have and we have to – it kind of gets into use a little bit but whether or not just looking at unplanned is the right thing to do. So that was one thing that came up.

And then the other comment that came up and a couple of them were unintended consequences. And I think because these are the first pediatric, all condition on the respiratory tract measures are the first pediatric readmission measures. I think it's worth at least thinking about. I know earlier on the call, we talked about can people report back any potential unintended consequences.

I think the one that is most – probably, most worthy of thinking about is length of stay because things like (low) respiratory tract infection have such an incredibly short length of stay like the median length of stay for bronchial (inaudible) is only two days.

So if it turns out that people are trying to prevent readmission and then keeping these kids for a week instead of two days, and that might be something that would be worth knowing. So whether or not we need – there needs to be some other measure or some other monitoring in terms of unintended consequences.

Sherrie Kaplan: Thanks, (Kathy). (Paula), I see that your hand is up. Did you have a comment related to the two pediatric measures?

(Paula): No. Not the pediatric ones, just the 2504.

Sherrie Kaplan: Oh, OK. Well, OK. We'll get back to you then.

(Paula): OK.

Sherrie Kaplan: Were there any other committee members who have any comments about the two pediatric measures?

Taroon Amin: (Paula), go ahead on the measure that you wanted to discuss.

(Paula): Well, if I recall correctly, the reason we had a difficulty reaching consensus in 2503 and 4 was, you know, much like the comment is we didn't know that they needed our endorsement to just do a statistical number. And I think it was really helpful for me to hear how valuable this was for community transition work. And so I think that's weighed my thought on these particular measures.

Taroon Amin: OK. Thanks, (Paula). I'll invite – does the committee have any other comments particularly, the lead discussants? Are there any other comments that would compel the committee to overturn the initial recommendation to recommend the measures 2502, 2505, 2513, 2539? Are there any other compelling comments that would require reconsideration of the initial endorsement recommendation? If not, I'd like to move on to the discussion of the themes.

(Ross), if you want to go ahead. Operator, can you make sure (Ross) has an open line?

(Ross): Can you hear me OK?

Taroon Amin: Yes.

Male: Yes we can. Thank you.

(Ross): OK. Great. On 2539, the colonoscopy ED utilization seven days following, I think there was a significant comment. I know this is an area that we have discussed before. I believe it came up in our conversation but a very good discussion and question concerned about the low outcome rates and the usefulness and the usability.

So there are a couple concerns that were brought up. One was the inclusion of high risk – what was high risk and I think the developer made a very good comment. Actually, there was one concern about risk adjustment factors that were not caught on – included in the initial risk adjustment recorded at the time of colonoscopy would adversely impact the results. And the example given was, for instance, ESRD being picked up not as an additional risk factor.

So the developer responded by that they'll review their list of potential complications and update that list, and I think that was fine. But on the usability, very, very – it's a frequent procedure, very low rates of numbers were returned to the emergency room, a very long timeframe because low numbers have to go to two to three years, so there's a significant time lag. It's not otherwise stratified into what happens to these patients for quality improvement.

And so the comment that was made was with the number of – that the very, very small number of facilities that would come out as higher than expected would be miniscule. And then as a practical matter, the risk standardization results would indicate little room for any opportunity for quality improvements. IE, is this an important – it gets back to the, is this an important measure or is it something that is significant for us to endorse if we can't make timely quality-related decisions on it?

So I bring that up for discussion for the group but it's kind of an issue that is not only on this particular procedure but probably any procedure that we do in the future – now and into the future for outpatient procedures.

Taroon Amin: Thanks, (Ross). Are there any other comments related to this measure or any of the other recommended measures? OK.

Sherrie: Taroon, this is (Inaudible). If we wouldn't change our original vote, what do we do with these when we're using SurveyMonkey?

Taroon Amin: They're not in SurveyMonkey. So you don't do anything with them basically.

Male: We'll only add them in if somebody says that reconsideration is warranted, somebody on the committee, and it doesn't sound like we've heard anybody suggested that's necessary at this point.

Sherrie: Thanks.

Taroon Amin: OK. All right. So we will move on now to spend the next 30 minutes talking about the five main comment themes that arose across multiple measures and across multiple comments. Those five included adjustments for sociodemographic status, questions around our harmonization decision, the relationship between admission and readmission, provider attribution, and NQF evidence requirement for outcomes.

So I will begin actually and I will invite Sherrie, if you have any other thoughts to add around adjustments for sociodemographic status. We received a number of comments focused on the risk adjustment using sociodemographic status particularly related to the NQF guidelines, factors associated with disparities of care should not be included in risk adjustment.

Many of the commenters raised strong concern about moving forward with endorsement of outcome readmission measures noting that NQF currently has an expert panel focused on this exact issue on whether (SES) adjustment should be included and we should not – essentially making the recommendations that this panel should not finalize this recommendation until developers have had a chance to update and test their measures on finalizing the expert panel recommendation.

And a number of commenters noted that the standing committee should limit the endorsement for one year with the required ad hoc review on the measures in this project noting that the expert panel recommendations are occurring concurrently to this project.

So I just wanted to note that many of you may be aware that the NQF Board of Directors met on July 23rd and approved the implementation of a trial period for adjusting for performance measures where sociodemographic factors may be appropriate. The trial period has not yet started and NQF is currently developing an implementation plan and timeline for this trial period.

For projects that are already in progress such as this panel's discussion for the admission-readmission project, NQF will continue to guide committees to operate under the preexisting criteria, guidance and policy that was in place when this project started, that factors related to disparities in care should not be included in statistical risk adjustment model, and if relevant, performance measures should be stratified for (SES) factors.

With that being said, we recognize that it may be difficult for the committee members and for NQF members to operate in this way knowing the impending changes to our policy. Therefore, in planning for the trial period will also address the potential for an ad hoc review for measures that we're endorse prior to start of the trial period and that would meet the conditions for SDS adjustment. So in summary, you know, we hear the concern by the commenters related to the expert panel recommendations on SDS and risk adjustment which were just finalize last week. However, this project is currently underway and essentially, at the end of its process and that would be unfair to expect that measure developers have incorporated guidance at this point in the project. So again, we're instructing committees to operate under the current preexisting criteria.

We'll be sure to send a more – We'll be sure to send the expert panel recommendation paper to the committee members for your review and likely in our future discussions with the standing committee will make sure to review in a much more detail.

So, I'll stop there Sherrie, is there anything else that you would like to add on the topic of adjustment of socio demographic status? And then, I would open it to members of the panels if there's, you know, the committee if there's any other questions related to that.

Sherrie Kaplan: No. I think that it's going to be very difficult for many of us who have strong feeling that though whether or not its fair, you know, fair comparisons are being made for people who are serving the poor and undeserved. And that just a matter of I guess time. And the policy that's going to come down and as you point out Taroon, I think to ask with the measure's developers to go back

and re-modify the measures now wouldn't be fair to them neither. So, it's kind of between the rock and a hard place here but I would advice others who want to chime in or anyone you choose to give us thoughts.

Female: Yes. Two hands up – three hands up at least that I can see Taroon.

Taroon Amin: OK, yes. I'm sorry, I moved away from the Webinar for a second. So, I wasn't able to see. Cristie Travis, if want to start.

Cristie Travis: Sure. Thank you very much. I wanted to appreciate the proposed committee response that was written here and just suggest that, including that last sentence I think would be very important that we would encourage CMS to strongly consider retesting the measure specifications and resubmitting the measures that readmission. The one thing that I would recommended that we change because I think actually this may have been a hold over in the language prior to the board meeting that we say. You know, once the trial period begins, in other words, I think it would be really important to encourage CMS to consider submitting during that trial period. And that, perhaps, we awarded that way versus the way its currently wording which kind of presuppose as what the board may chose to do it the end of that trial period.

Taroon Amin: That's helpful Cristie. Thank you. (Wes)?

(Wes): Yes. I just think that that has implications for 2504 as emerge to position. I consider myself a community based provider. And I'm really sensitive to the local goals, they're trying to achieve in terms of demonstrating how you make a difference with the case management.

One of the things I'm pretty passion about. But I think that it maybe that until this trial period has been establish and implemented that we probably have a pretty good reasons to hold off on changing or review of 2504. Because I think it's going to have a lot of impact on them. You know, my criticism humbly offered is that assuming that you're going to have a stable static view of what admission rates mean for a local community without a risk adjustment.

I think that there's a structural problem there because, the population in the community are changing underneath your feet while you're trying to make these interventions.

So, you know, we may not agree about this but I'm think of a long run community based case management and innovation's probably going to be better serve by risk adjustment as well, at least in terms of socioeconomic status. So, speaking in favor of sort of keeping our position as it is on 2504 until we see what SDS adjustment looks like in order domains of measures. Thank you very much.

Taroon Amin: OK, great, and (Frank)?

(Frank): Yes, and leading in the working in West Virginia. We see this all the time with the socioeconomic and factor influencing readmission rates whether it's the distance from the hospital's ability to seek care in their local setting and such to the point that according to our government affairs up here at the university. Our senator is expected to interview legislation, probably not this session but perhaps in next session in favor of requiring CMS to adjust based on socio demographic factors from a legal standpoint.

Taroon Amin: Thanks, (Frank). We certainly heard that is part of some of the congressional conversation. So, is there any other comments related to the sociodemographic factors. Otherwise, we'll move on to our next topic around harmonization.

OK. We'll move on to harmonization and the main – we have two different questions being asked here. I just remind the committee that we went through and had a robust conversation around the multiple measure was the multiple cares f measures that – And we had a follow up call from the in person meeting to consider this pairs of measures and whether or not it was appropriate to continue moving forward with endorsement of both.

2375 and 2510 SNF readmission measures, we voted in this project and the committee voted to move both measures forward. And so, I'll ask (Helen) to start this off in that conversation in 2515 and the 2514 are the two CABG readmission measure. And we – these are also both measures in the project.

The second two pairs of measures 2380 and 171, I believe 171 was not in this project, and 2505 and 173 was not in this project as well. So, really the two second set of measures, the decision to be made is whether or not we should continue moving forward with the endorsement of the one measure that's in our project.

So anyway, we'll start with that, we'll start with (Helen), if you can take us off on harmonization conversation. (Helen), let us know if you're having trouble accessing on line by sending us a note on the Webinar otherwise, (Frank) if you are able to kick us off on this conversation.

(Helen). Hi. Hello.

Taroon Amin: OK, great. Thanks.

(Helen Chen): Hello.

Taroon Amin: Yes, we can hear you now.

(Helen Chen): I'm sorry. Can you hear me now?

Taroon Amin: Yes.

(Helen Chen): Oh, sorry. I wasn't – I must have been on mute. There's really not much new ground here. Basically, the material that we discuss at the meeting and also the additional materials Back-End CMS is pretty much what we've already talked about. Essentially, they used two different data sources. They have slightly different data definition that the one measure 2375 is all cause admission. All readmission is not, excluding planned readmissions. And there were some public comment about that in terms of watching to take those up. We also talk about that at the meeting. So really, I don't think there's anything new to discuss here. I would still in favor putting forth vote unless other people have an objection.

Taroon Amin: Are there any other objections of the committee members? OK, great. (Paul), you can kick us off on the conversation, 2515 and 2514.

(Paul): Sure. I think it's a similar situation, the things that were brought up were what we had discuss earlier there was a request that there are only one be use. But I don't think there's anything new that came up as a summary one is primarily based of administrative data, the other is based of registry data. They already has – have been a lot of work going in to harmonize them. And, I think we do a better service by having both measures available since they – have different ability to implement and potentially different benefit. So, I would not in favor changing anything at this point.

Taroon Amin: Thanks, (Paul). (Frank), I apologize on the prior of pair measures on the SNF readmission. Do you have a comment?

(Frank): Yes. I just go into to (inaudible) and those two measures on the harmonization. Many of the comments that were submitted after the meeting really did suggest more harmonization or the promotion of a single measure over the idea to having two competing measures in the same basket if you will. I think there are some validity to the discussion on there around confusion of the public trying to differentiate between the two and if the two became publically reported or used in different means where the public be able to figure out the differences to the degree of the that exist, with the main different team, the data source and then the second difference being around planned readmissions.

Taroon Amin: Thanks, (Franks). So, for 2375 and 2510, I'm generally hearing from the lead discussants that continue to move forward on the two measures as recommended for endorsement. If there are any other committee members who feel differently, please raise your hands on the webinar and make sure to, you know, we calling you. And (Paul) walk us through the 2515 and 2514 recommending a similar moving both measures for based on the different sources. But also (John) did you have anything to add for the conversation on 2515 or 2514?

(John): But just one update that I think 2514, the developer did see that on the question of planned readmissions that they do. It is – possibly add that on 2514 and further harmonize that.

Taroon Amin: OK, great. OK. So, we move on to the next two pairs. And again, I'll reminding the committee that the question being asked here because one of the measures and the pair was not in this project, the question is whether to continue to move forward on endorsement of the measure that was in this project. So, the question is for 2380, rehospitalization within the first 30 days of home health. And I'll turn it over to Pam Roberts to lead us in that discussion and share if you had anything to ask.

Pam Roberts: Sorry. This is Pam. So, looking at the two different measures, one of the big different is and there was some comments from the developer is that, the 2380, the time window is public reporting of the most recent three years worth of data and 0171 was the timeframe and 60 days filing, they started the home health. But more importantly, the 2380 is the rehospitalization measure that evaluates the hospitals – evaluate readmission to hospital in 30 days after starting home health care for patient have recently been discharge to the inpatient setting. And it assesses the efficacy of care coordination doing the patient's transition of care from the inpatient to home health.

Where-as, 0171 looks at patient admission to the kid care hospital doing 60 days following home health stay. And it accesses the efficacy at clinical care provided to all patients as indicated by rates of hospitalization after entering to home health services. So, the developers comments on this whether there are two different measures with two different focuses and the newer measure is really focusing on the transition of care. And so, for that reason, I would suggest that we move forward with it. Anybody else want to comment?

Taroon Amin: OK, great. Are there any other comments about 2380 and 0171? (Pam), you might want to just take us through the last one here on 2505 and 173. And (Wes), if you have anything else to add on this pair of measures as well, we welcome that.

(Pam): Just one second, let me get my notes out here.

Taroon Amin: Great.

(Pam): OK. So, 2505 again is – for the developer, those are some differences on the focus of this. 2505 which was the current measure that was up for endorsement looks at the percentage of home health stay inpatient whose had an acute inpatient hospitalization and five days before they started the home health. And the use of the ED that they were readmitted to the ED within 30 days following the start of home health services where 0173 looks at home health stay inpatients with ED were not admitted to hospital within 60 days. So, there's a difference in that time window. Also, in 2505, it's based on three most recent years of data were 0173 is 60 days following the home health stay

Very similar issues in this one to compare to the other one. And again, I would move forward because the focus is again, on the transition. At the current measures of 2505.

(Wes): Yes. I do. I agree with the – what Pam just said about the apple and oranges aspect to this. I don't think there's a fundamental problem at 0173 harmonization. I do think that's a different care process and a different category of patient being serves. So, at least at the conceptual level, understands what trying to be accomplished with 2505 for the immediate post discharge patient from the hospital.

The one thing I did see in the comments or any responses from the developers that you heard me say before. But I want to underline for the sake of the implementation period if it moves forward. And that is that as some comments suggested, one on intent a consequences here might be delays on care in the emergency department that might actually result in a readmission to inpatient status. The thing which is more fundamental to that which I think CMS needs to be accountable for in terms of the data that is responsible for is that – the whole concept of observation services that could last up to two midnights is a moving target. It's a separate problem.

But as it stands, I don't believe there's anything in 2505 is going to just allow any home health agency or any emergency department to distinguish between a patient bouncing back for revision of skin care addressing. And one bouncing back after stated mission for sepsis where the patient becomes

acutely elegant and may require pretty aggressive hospital treatment that may or may not result in an admission.

So, I just pointing out to you that there's parallel problem with claims data and with some of the definition that surround care and that – it's possible for emergency department visit under 2505 to be trivial, if you will, are very, very significant. And I think if nothing else that this is meant to be a measure of the effectiveness of the home health service, you're not going to be able to discern that from claims data if you're not able to distinguish between a very significant subset of patients require observation services or short stay that may last more than two midnights or up to two midnight. And one that has a very minor reason to return to the emergency department. Thanks.

Taroon Amin: Thanks, (Wes). To summarize, it sounds like for the pairs of measures that are in front of us. There is the committee continue to move forward with recommending the measures, pairs of measures. And so, the second queue set continues to recommend measures going forward. Is there any additional comments related to that? Please, raise your hand. Otherwise, we're going to move to the 3rd team which is around evidence for outcome. And I'll turn it over to Andrew to summarize the comments and provides the committee – based of the committee response. And Sherrie, if you have anything to add, please do.

Sherrie Kaplan: Well, the only thing I have to add immediately is where are we for time Taroon?

Taroon Amin: We're moving along very nicely. I think we have about 20 or we have about 10 more minute to get to the scene. I would imagine that we will be able to do that.

Andrew Lyzenga: So, on that note. I'll just jump in here. I'm addressing this because it is in many ways kind of an NQF policy issue. A number of commenters raised concerns about the evidence standard the NQF has for outcome measures raising concern that the requirement only that there be a possible rationale that – a process or structure of care influences the outcome, not necessarily at

sufficient level of rigor for the measure that maybe publically reported or use for payment for purposes.

We do still have the current guidance as NQF policy. And I know that some of the committee members have express a bit of discomfort about this as well. Similar to the sociodemographic status issue, it wouldn't really be fair at this point to hold our developers to a different standard that we had provided them at the outset of the project.

So, we kind of have to stick by the guidance that is existing at this point. And say that, you know, the responsible rationale is efficient to support an outcome measure, though, we can I think consider adding a note or some sort of, some language in the report as well as the memo to the CSAC, just noting that some of our committee members do share that concern as well. And that, they have recommended thinking about this issue at the policy level for NQF and considering whether this policy should be modified but at this point, we recommend that we move forward as with according to our current values.

So, let's just ask if Sherrie or anybody else has any additional comments on that or objection to the proposed committee response.

Sherrie Kaplan: This is Sherrie. The only thing that maybe it was just me that brought this up. But I think NQF – what NQF to consider as a potential revision in policy could include something about where in the phase of development outcome measures are in terms of gathering of evidence before measures are held to or (to be used) for accountability. Because, for example, if this is a very new measure and some of pediatric measures are, you know, if it clear the whole developer accountable for evidence when there is no evidence yet.

On the other hand, if – it's been out there for some time, then there should be a fair amount of evidence to suggest either it is or it is not effective in terms and could be – for example, for accountability. So, yet, if we could just – yes, I don't know if that's going to be part of subsequent discussion or not but I'm just thinking a phase and kind of where in the phase is development, a measure is might be helpful to kind of guide further discussion.

Taroon Amin: And that's a good Sherrie. And we – I know we are doing some work around considering things like endorsement fit for purpose or to sort appeared endorsement at least potentially and we can certainly bring that up as a part of that discussion and sort of have that flow into our considerations for that as we move forward.

Steven, I see you have your hand raised. We welcome your comments.

Steven Fishbane: Yes. Thanks. So, you know, I appreciate the thoughtful comments on this as I express that the in person meeting. I don't agree with the NQF policy of this. But I understand that it is policy. I guess the one thing that concerns me here is that throughout the NQF documents that speak to how we evaluate a measure. It speaks for the fact the evidence is part of the evaluation. And in our voting, we are asked to vote and part of it was in relationship to evidence.

And I'm concerned about what the final report would say and what I'm particularly sensitive too hear is that, there is a very conventional definition that the scientific and medical community uses for evidence. And I wonder if we could attach some statement whether it's in our committee response or in our final report on these measures that speaks to the fact that the evaluation here is not specifically endorsing the fact that there is scientific evidence to support linkage. But rather, it's based simply on possibility. Because if we use the work evidence in our response without giving such of a question or statement. I think we risk a certain laws of credibility.

Andrew Lyzenga: I think that's reasonable. And we will explore a ways that we can make the sense of the committee known on that. Maybe changing the wording a bit to say that the committee is reported the rationale rather than finding that there was sufficient evidence supporting the measure. And we'll have to explore that a little bit and as we suggested may have bit a possibly a some sort of attachment to the reporters something statement of some sort, or again, this sort of rephrasing the language to make clear that the committee did think that they were endorsing the measure based on a rationale rather than a sort of systematic body of evidence. Would that be acceptable?

Steven Fishbane: It seems very reasonable, yes.

Taroon Amin: OK. OK, great. (Alison), we'll take this as the last comment on this topic. We want to quickly move on to the provider attribution. And so, we'll ask (Wes) if you can be teed up for that conversation. Go ahead, (Alison).

(Alison): Sure. So, I just wanted to come on a point that Andrew had made. I'm not hearing consensus from the committee that they would like to have a comment included in the response about a potential exploration of a policy change. I think Andrew's response to Dr. Fishbane is very reasonable as far as kind of massaging language to say rationale versus evidence. I'm fine with that.

But I do have some issues with putting any language in the committee response that would denote that the committee had a consensus around the needs for further exploration around this evidence outcome threshold. Because I think it is well stated about the current thresholds does stimulate, you know, identification of, you know, new processes and, you know, stimulate innovation. So, I like that and would support that, so just wanted some clarification there.

Taroon Amin: Thanks, (Alison). I think maybe the safest ground to be honest to clarify that we're referring to rationale rather than an evidence threshold. But we may stay silent on the committee's recommendation that in every threshold be reconsidered or elevated.

(Alison): That's great.

Taroon Amin: OK. So, with that, let's move on to the provider attribution conversation (Wes) or Pam Roberts if you want to lead us – Sorry. You're not Pam, you're not on that. I …

Pam Roberts: (Inaudible) – wait a minute.

Taroon Amin: I'm sorry. I'm sorry to do that to you on the last part of the call here. (Wes), if you have any – if you want to lead us on the conversation with the provider attribution.

(Wes): Well, I think I may have expressed most of my concerns about this. And if there's something else specifically, you want me to response to maybe you can

give me some guidance. But I think that, you know, my folks are concerns about this, of being expressed on the meeting. And I think a lot of them were supported in the comments from the public on the documents. I'll leave that interest of time, there is something else that I'm missing.

Taroon Amin: OK. No, I think we're good with that. And then, finally, and there are other – any other comments from the committee members. I don't want to cut the story because I know what did bring this up as an earlier part of the call. So, I don't want to be repetitive.

OK. I'm not hearing any or not seeing any raise hand. I want to move to the relationship between admission and readmission. And I'm going to turn this over to Cristie. And I'll also point that if the operator, you can get that queue started was a public or member comments. I know that we have a number of folks who are interested in providing public or member comments on this particular topic. We want to make sure that they're recognized during this part of the conversation. So, Cristie, actually operator, if you can tell the members of the audience how they can be queued up and then, we'll turn it over to Cristie to start on this topic.

Operator: Yes. If you would like to ask a question or make a comment, please, press star one. Again, ladies and gentlemen that is star one.

Taroon Amin: OK, great. Cristie, if you could start us off on this, and then we will queue the public comments and then we will go up in there.

Cristie Travis: Sure Taroon, thank you. This theme is really focusing in on the fact that as people pay more attention to readmissions and quite frankly probably to other quality and resource use measures that admission themselves may begin to go down especially at a community level. And that if we're looking at readmissions as the numerator and admission as the denominator. We may begin to see, you know, essentially a higher percentage if you will of readmissions because there may be fewer admission actually occurring.

And so, the concern is that, you know, as readmissions in--may not go down or may go down but not as fast as admissions are going down, that we could

perhaps not be really looking at the underlying issue which is that the admissions are decreasing.

And so, I think, you know, the proposed committee response was something that I felt pretty comfortable about although, Taroon, I do have a couple of question myself to be sure I understand the issue is that, we probably need to actually consider pairing readmissions measures with measures for admission rates or other (cultivating) factors, to be sure that we're really understanding how readmissions are acting, if you will, in relationship to admissions and other factors that maybe going on.

One question I had Taroon is, is this specifically – they seems specifically apply to the community measurements that we were considering? Or, also looking at facility based measures?

Taroon Amin: Cristie, I think the commenters – and again, I'll note that the commenters are on the public line. Also, I think they would argue that it would apply to all readmission measures, not just those that are at the community level. So, let's leave it with that. So, there was probably a (inaudible).

Cristie Travis: Yes. And to be honest with you, that's how I've read it the first time myself. But when I was re-reading it, it seemed to talk about community-oriented focus areas. But I understand that better now. I guess my thoughts on these are that I think it would be important to look at these relationships as time progresses, to be sure that we do understand how readmissions and admissions are working together, and that considering the pairing of the readmission measures with admission rates would be a proper thing to do just so that we understand the readmission issue in the light of the broader context within which it's happening. So, I'll just throw that out and see if there are any comments or if there's another lead discussant.

Taroon Amin: (Helen), if you have anything to add? Otherwise, we'll get started with the public comments.

(Helen): I think I agree with what was already said. She – I think this is really tremendous that we're proposing to add this on here, although I did want to

say that there is some literature that says that admissions and readmissions do tract, but, you know, people can argue with me about that.

Taroon Amin: OK, great. Operator, if you can open the line for public and member comments.

Operator: Yes, Sir. Your first comment or question is from (Steve Jencks).

(Steve Jencks): Yes. Thanks for the opportunity. I think that the general idea would be certainly that when you haven't assigned communities, it makes a lot more sense to use that community as the denominator than to use the number of discharges as the denominator. You do have a design community and a number of experiments like the community care transitions. You have a defined community in ESRD. You have a defined community in health plans. But we have a problem of how to balance the seer value of these measures against the form that they can do. This is (versus) where the defined community is not yet available.

And what I think we ought to consider, what I think you want to consider, is that a way of doing this is to say that if the number of admissions that are averted is more than some multiple of the number of readmissions that are averted, that this should not be considered a trackable measure because the denominators change too fast. And exactly where you might set that multiple, I would suggest if the decrease in admissions is more than twice the decrease in readmissions, but that's clearly arbitrary, you expect the decrease that is equal to the number that decreased readmissions. Thanks.

Operator: You have another question or comment from (Joanne Lin).

(Joanne Lynn): Hi. Can you hear me? Am I live?

Taroon Amin: Yes, we can. Go ahead.

(Joanne Lynn): OK. I think that the response of the committee, well, it's a good start, does not in fact respond to the seriousness of this issue and that this is a time – rare time in which NQF really have the responsibility to step out and call out this measure and really push for substantial work on how to do the corrections that

are needed. (Steve) made an ad hoc suggestion, but it's not data driven. And it could be data driven because we have hundreds of communities that have been working as the QIOs and data is available.

So, I think that NQF can't in this case rely on the plausible rationale. You were just talking about it clearly did not work. And the committee response that says, "We should be also tracking admission rates," that's just the question, that there aren't admission rates if there's not a population from which you can based it. So, if you're in a dense community with multiple hospitals, it's overlapping population penetration. There's no way to attribute a population to any one hospital.

So, we really have a serious problem here. And I think the kind of (gentile) response that the committee has proposed is really inadequate to the seriousness of the issue. There are real hospitals being penalized a substantial amount of money for a metric that is not functioning. There are real CCTP programs that are coming up against evaluations that are finding them to be inadequate when in fact they're the paradigm case that we all should be emulating.

So, you know, I think that instead the committee should really have a strong call to CMS and others to begin really working on how to resurrect adequate measures for what has been a wonderful set of initiative regarding care transitions and has gotten many communities rallied, has been the first thing that's really turned around utilization. And the metric that has been guiding it is now demonstrably inadequate for a substantial number of uses, and we really need to buckle down and evolve to a better set of measures. Again, I urge you not to endorse any more of the form. I would encourage you to really call on CMS to develop the measures we need, that we can evolve too and to do so quickly, and to figure out how not to penalize the very best communities and hospital in the country because of a malfunctioning metric. You got a malfunctioning metric that billions of dollars of public money now turns on. And it is inadequate to say, "Gee, we have to think more about it."

Female: Thank you. Is there another – any other comment?

Operator: No, there are none at this time.

Taroon Amin: Are there any responses from the committee members to the comments that were raised?

Female: (Tracy), you can go ahead and speak if you'd like.

(Tracy): Thank you. I'm just representing CMS from the perspective of 2503 and 2504. And I just wanted to comment on the discussion the committee had around the socioeconomic factors and risk adjusting. We've made an argument that risk adjusting for those factors for the purposes of the measures that are showing improvement overtime will likely risk adjust out challenges that need to be addressed specifically by the community that is working on improvement. So, I just wanted to make that comment.

And with respect to those two measures, we are looking to pair those, both readmission and admission per thousand measures and look at those simultaneously as others had mentioned. Thank you.

Sherrie Kaplan: Taroon, this is Sherrie – all right. Sorry. Go ahead.

Taroon Amin: Go ahead, Sherrie.

Sherrie Kaplan: Well, I see there's other hand from the …

Taroon Amin: OK. All right, Allen, please go ahead. Operator, can you be sure that Allen Nissenson's – that his line is open.

Operator: His line is open.

Allen Nissenson: Yes. Hello. Can you hear me?

Taroon Amin: Yes.

Allen Nissenson: Yes. Hi. Thank you. This is Allen Nissenson. I'm Chief Medical Officer for DaVita Healthcare Partners and I'm also on the NQF MAP post-acute care LTAC workgroup. And first, I just want to endorse everything that (Joanne) said, but I have two specific comments about the 2496 measures, the SRR for

dialysis facilities. First, I hope that the committee will discount what I took is negative implications by the developer about the one positive comment on the recommendations coming from consumer group, and the rest coming from the industry. So, without their saying what they meant by that, I think we can all interpret it.

And I just want to say that members of the provider community have spent decades working closely with CMS to help drive improve quality in this program. In addition, the provider groups have extensive experience with development of measures, implementation of measures, and being held accountable for measures. So, I just wanted first to make that comment.

Secondly, a couple of specific comments, the Reno community – and I can speak for DaVita, but I think I'm reflecting the thoughts of the majority, if not all of the rest of the provider community, has embraced the idea of being accountable for outcomes, so there's no issue there.

The issue, as you were discussing, has to do with attribution in this particular example. And the developer as well as extensive literature has shown that a third or fewer of readmissions in this population are due to conditions that could even plausibly be considered under the control of the dialysis facility. And facilities would be more than willing to be accountable for those, but not for all readmissions.

Secondly, I like to apply the Richard Feynmen yardstick of common sense to these sorts of metrics in addition to just looking at a lot of statistical analysis. And think about whether it make sense that if a patient is discharged from the hospital but doesn't – 17 percent of the time is readmitted within three days without having ever being seen again in the unit, the dialysis unit. How is it reasonable to hold the unit accountable for that readmission when there's been absolutely no contact? And one could wish that that gap could be closed by the dialysis facility, but that really isn't practical. So, I appreciate having some time. Thanks.

Taroon Amin: Thank you, Allen. (Melvin)?

(Melvin): Yes. Am I on?

Taroon Amin: Yes.

(Melvin): OK. I'm calling on behalf of RTI and the measure 2512 which is the readmissions post discharge from LTACs. We weren't quite called upon during the discussion of that, so I just want to clarify a few things. The issue of usability per se, it seemed we were not clear on what the issue was in terms of usability because it seems that all the inpatient facility readmission measures worked the same way and have the same usability. So, that was one of the points we just couldn't quite understand what was wrong with that part.

With respect to the issues about readmissions to LTACs, the intent of these measures is generally to detect an admission to an acute level of care, to a high level of care, from the post discharge when they're going to a lower level of care and then going back up. And LTAC certainly considered that their patients need a high level of care. So, in some sense, LTAC readmissions, or going to the short-term acute, both represent the same kind of problem for the patient.

We've also found – and this wasn't in the note – that the time – this was brought up during – I think during the in-person meeting, that there might be something different about these readmissions in the time before the readmission occurred. And we found that there really was no difference. It was mean number of days to readmission, it's about 13 for going to a short-term acute or an LTAC, so we couldn't find any difference there.

And so, we're not really stressing so much that the scores won't change that much. But one more issue is about incentives created by eliminating from accountable admission and readmission back to an LTAC which would be all of a sudden we would be aided incentive for an (inaudible) admit people because that would prevent them from going to a short-term acute which would be countered against from number one, and they would get paid another (DRG) payment which wouldn't hurt any.

So, I just wanted to clarify a few points which we didn't get to mention directly or discuss in (inaudible).

Taroon Amin: Operator, can you please mute the other line here from North Shore? And could you also open (Joel's) line please.

Female: (Joel Andres)?

(Joel Andres): Good afternoon. This is (Joel Andres) from CMS. First, I'd like to thank all of the committee members for their time and effort in this project. My comment has, as with (Mel's), to do with the LTAC readmission measure. I think there are two points that are important to make (inaudible) I think in a more perspective (inaudible). The first, that's – is the concern that we did not address the rationale for …

Taroon Amin: (Joel), I'm sorry. One second here. Operator, can you please mute the line with the feedback, please. Thank you, (Joel) – or sorry, (Joel), for that.

(Joel Andres): No problem. So, I think that the core issue here is that it is a measure of care coordination. And that as we are seeing a patient discharge from an LTAC that we are measuring the extent to which the care has been coordinated as the patient leaves that setting of care. If we leave out the returns to LTACs, that we are essentially saying that coordination of care for patients who eventually have to turn to an LTAC after being discharge from one is not a matter of concern for the population. And I think that it would be difficult to justify that particular rationale.

I think the other issue that was raised was that of usability. And I would point out first of all that I don't think the usability of this measure can be called into question anymore so than any of the other readmission measures that we've submitted – that CMS has submitted here of this type. But I'll also point out that this measure has been proposed through rule making, underwent public scrutiny through public comment period, and will finalize inequality reporting programs. So, I think the question of whether or not the measure is useful is usable for, "All needs, all purposes, at all times," is not the issue. It clearly has utility inequality reporting program in which it is currently operating. Thank you.

Taroon Amin: Thanks. (Joe Messana)?

Joe Messana: Joe Messana. Thank you. I'm a faculty member at the University of Michigan. I worked at University of Michigan Tech. And therefore my contractor with the (inaudible) team related that measure 2496. And I have a brief comment in response to Dr. Nissenson, his last point related to the fractional percentage of patients who are readmitted prior to first touch in a dialysis unit.

And my concern relates to the fact that in the earlier discussion of 2496 it seemed as if not all committee members were familiar with all of our responses. And I wanted to make sure that they have an opportunity to review our response to the public comment relating to this similar nature. I think we addressed it reasonably well. I hope the committee agrees. Thank you.

Taroon Amin: Thank you, Joe. Are there any other comments from the committee related to any of the other themes, any other public comments we just heard, or any individual comment in the measure – in the comment table that we haven't had a chance to address during this call?

Sherrie Kaplan: No. Taroon, this is Sherrie. In terms of some subsequent response, I think a greater thought by NQF could be given to (Joanne's) point and it's actually (inaudible) several of our discussions about the responsiveness of measures to – and the cause of relationship between efforts to improve quality and then demonstrable improvement that's reflected in the measures of quality around the performance issue at hand. So, it might be worthwhile. This can't be done online. But this is to consider maybe in the tiering (inaudible), we've talked about from the early phases of the measure development to the later phases went in the course of the mature measure. It's appropriate to actually include measures or some assessment of responsiveness to efforts to improve quality.

Taroon Amin: OK. OK, that's helpful. I think we might consider that in terms of how we frame our next in-person meeting as another thought of how to maybe address this in a little more detail.

Operator: We do have a follow-up public comment from (Steve Jencks).

Taroon Amin: (Steve)?

Operator: Mr. (Jencks), your line is open.

Taroon Amin: Are you there, (Steve)? You may be on mute.

Operator: Please unmute your line and pick up your handset.

(Steve Jencks): OK. Yes, you're right. So, I just wanted to endorse everything that (Joanne) said, that includes the semicolons, commas, and periods. And to really emphasize that if we haven't addressed this, if we leave it so that it seems that it is reasonable to use these measures, we are sending a terrible message to the most successful hospitals. And ...

Taroon Amin: Thanks, (Steve). I don't know if you're done. We can't hear any more. I think you're done. (Gene) …

(Crosstalk)

OK, great. Thanks, (Steve). (Gene), do you have a comment? Are you on? Is your line muted? Operator, can you ensure that (Gene's) line is open?

Operator: Sir, all lines are open currently.

Taroon Amin: OK. (Gene), we see your hand raised on the webinar. I'm not sure – we can't hear you if you're trying to speak.

OK. All right, well, are there any other comments from the committee members related any other themes, individual comments? I know we're a few minutes over so we appreciate your time. Adeela is just going to walk through next steps and talk through where we are in terms of the committee timeline.

Adeela Khan: Thanks everybody for your hard work. I just wanted to note that the SurveyMonkey will be available until tomorrow, so we'll actually send a follow-up email right after this meeting with the link. And so, if you haven't responded yet, please do so. And just to note that we've actually moved our

NQF member vote. It'll be September 10th through September 24th. And we'll be sending out an alert as well on our project listserv, just to keep everyone informed.

What we'll be doing now after this call is just updating the draft report based on what we heard today and we'll be finalizing the comment table, and both will be available at the time of member vote.

That's all I had in terms of next step. So, again thank you everyone and big thanks to Sherrie for leading the call and everyone out (inaudible) lead discussant. Well, we will follow up with you in the next – we'll be following up with you right after this call for the Survey Monkey's link. Thank you.

Taroon Amin: Thanks everybody.

Female: Thank you all. Bye.

Operator: Thank you. This does conclude today's conference call. You may now disconnect your lines.

END