NATIONAL QUALITY FORUM

Moderator: Zehra Shahab
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Operator: This is Conference #: 41547413

Welcome to the conference. Please note today's call is being recorded. Please standby.

Zehra Shahab: So, good morning everyone. Good afternoon everyone. I know it's morning for some of you. My name is Zehra Shahab and I'm the project manager for the admissions and readmission project.

This is the first of three SDS trial period webinars for the All-Cause Admissions and Readmissions Committee.

Before we get started, I wanted to introduce my team. On my team is Taroon Amin who is our consultant, Erin O'Rourke, the senior project manager and Severa Chavez, who's the project analyst.

I also want to introduce Bruce Hall, one of the co-chairs and ask if Bruce would like to say a few words and then go over the agenda and committee action slide.

Bruce Hall: Hi, good morning, everybody. Sorry we're getting started a couple minutes late and that's my fault because I am – was dealing with some clinical issues that may pull me away, but I re-appreciate as does the NQF everyone taking time and making the effort to join this call, very important topic as all of you are well aware. And we look forward to getting some viable input and feedback on some of these measures and some of the responses this morning.

Zehra Shahab: Thanks, Bruce. Did you want to go over the agenda?

Bruce Hall: You know, I am – my computer is still not pulling it up. I'm hoping it's ...

Zehra Shahab: OK.

Bruce Hall: ...coming soon. Why don't you run it?

Zehra Shahab: Yes, I can go through it.

So, first, we wanted to discuss the SDS trial period measures. Next, we wanted to see if we can get some committee feedback on the draft empirical analysis that's provided for 2502, 2510 and 2512. And these are the measures that we will discuss after the initial ones.

We will also talk about – we will also have time for the NQF member and public comment. And then we will go through some next steps.

So, on the next slide, you see the committee action. So, we just wanted to kind of give you an overview of what we're expecting. The lead discussants are assigned to each measure and they will have about three minutes to present on their measure. And then, we will have a committee discussion.

So, the presentation of the lead discussants should focus on the following questions. How well did the SDS variables represent the conceptual relationships? Number two, should the measure developer move forward with empirical analysis testing the variable? And number three, do you believe this requires a full committee discussion?

So, on the next slide, as we discuss each of these measures, please provide feedback via the SurveyMonkey and the link is there and it's also available on the link section. This will be due next week, Monday, September 21st by 6:00 p.m. So, while this is not a formal vote, it's the time for the developers to get committee feedback on the conceptual analysis and their variables in advance of conducting the empirical analysis.

So, before we get started and before we start on the discussion on these measures, I wanted to point out a few things for the committee members.

On the webinar, you can see the link section. It has all the materials that are needed for this call. There's the agenda, the developer responses, the draft empirical analysis plan, and lastly, the SurveyMonkey link, where the committee can provide the feedback.

So, as you can see on the agenda, the measures are going to discussed according to groupings, whether there are condition or procedure specifics that include (specific) pediatric or population model measures.

However, the PDF, so you can see that the developer responses are organized according to numerical order and there's both a table of contents and tab on the left hand side which will take you to each measure. So that way, you can follow along in the PDF as we discuss each of the measures that will be listed on the slides.

Does anyone on the committee have any questions before we get started with the discussion?

Male: Can you just show us the first slide again, please?

Zehra Shahab: Sure, (go back there). You're talking about the committee action slide?

Male: This slide over here, thank you.

Zehra Shahab: OK.

Male: Thank you.

Taroon Amin: So, Zehra, this is Taroon. One other thing I would just point out to the committee, as you're looking at the questions and as you're sort of thinking through your comments for lead discussant. Obviously, we have a significant number of measures to get through during today's call. And so when Bruce takes over, we'll sort of take it sort of topic by topic, the condition specific and then, you know, the pediatric measures and whatnot.

The main question, really, that we're asking for from the lead discussants is after your thorough review of the information provided by the measure developer, can you sort of accept the proposal that the variables that have been presented by the developers and whether or not you believe that, you know, you can move onto the next page which is really the empirical analysis stage.

And if you – you know, if so, then that's fine and you can just say that to the committee and just sort of accept the findings of the developer. And if not, if you do believe that requires a full committee discussion, we'd certainly welcome that given the time that we have. But the goal is to really focus the conversation on those measures that require full committee discussion based on the information that's provided by the developers at this sort of intermediate tollgate.

Zehra Shahab: Thank you, Taroon.

Paul Heidenreich: This is Paul Heidenreich. I just wanted to make a comment that I think a lot – (brings) to a lot of the developers came up with a conceptual models of readmission in general and all that relates to socioeconomic status unrelated to their particular condition. And I am concerned that we could go into detail in all of these different versions of that conceptual model, and the one thing to consider is that we focus the discussion on the particular – how that particular setting would vary from the standard.

Taroon Amin: Agreed. The conversation around the conceptual model, you know, is – has been focused around the concept of readmissions but certainly we have various difference (inaudible) which would interact with, you know, that care continuum in many different ways. So certainly, that would be an appropriate way to have the discussion.

Again, we – just to remind the committee, we've had the discussion around the conceptual model which is what brought many – all of these measures into the trial period to begin with. And the question that's really in front of us at this point is whether the variables that have been presented by the developers given the data sets that they have access to, how well they represent the

underlying conceptual relationship and then sort of moving onto the next stage of the empirical work.

Again, this is not necessarily – this is not a major – I mean, this is a step in the process for the SDS trial, but the decision really here for the committee is whether if the, you know, given the information that we've been given by the developers, if their race are moved onto the next stage of empirical testing. So it is very much intended to be sort of intermediate tollgate to, you know, the ultimate question which is continue the endorsement based on the empirical analysis and the final measure as specified with or without SDS variables which we'll look at later on next year.

Thanks to that comment, Paul.

Zehra Shahab: OK. If there's no other questions, Bruce, are you ready to facilitate the discussion?

Bruce Hall: Sure. So, let's kick off with the measure 2513, All-Cause Risk-Standardized Readmission Rate following Vascular Procedures.

I think this was mine and Paulette's, and I'm hoping Paulette is on as well to add some color to this conversation.

As we've noted, we have very short times to hit all these. These developers provided very nice information about the conceptual background, but focusing on exactly the relevant statements about their measure. Can – their response can be found in the answer to question three, which is that they proposed that race dual-eligible status and then potentially some neighborhood socioeconomic factors might be available for them to investigate.

So that was how I understood their proposal of what they might pursue. Paulette, is that how you read it or – is Paulette with us?

Paulette Niewczyk: I am. I'm on the line.

Bruce Hall: Oh, great, OK.

Paulette Niewczyk: Yes, I agree.

Bruce Hall: Please add anything you'd like.

Paulette Niewczyk: I agree. I do just want to add and I think that this might be reflected in some of the other measures that are, you know, put forth to us today. That some of the variables are actually quite limited, especially using race as a proxy. Race is very much a social construct. So, I – it's not many other additional socioeconomic variables, just kind of a standalone race with, you know, eligibility status, Medicare, Medicaid or dual, and then census data, I think, is quite limited.

Bruce Hall: Agree, agree.

So, again, in the context and in the spirit of agreeing with you, our job on the call today, though, is to say, yes, we approve with this developer investigating these factors. Is that how you see it, Paulette?

Paulette Niewczyk: Yes.

Bruce Hall: OK. All right, so, sounds like that's pretty much our brief take from me and Paulette. Would anyone else like to chime in at this point?

And Zehra, or Taroon, or anyone, if you feel like we're not driving this conversation that are actually you wanted to go, please let us know.

(Crosstalk)

Katherine Auger: This is Kathy Auger. I just had a quick question about, what is the NQF feel – how do they feel about using race as an SDS, because I just noticed in question one, race wasn't one of the things specifically listed as a possible SDS risk factor.

And so, I noticed this is going to come out throughout the call, because many developers do.

Bruce Hall: That's a question to our NQF colleagues.

Taroon Amin: So this is Taroon. That's a relatively complicated question, I mean, I think Paulette just described some of the challenges with using races as a variable. So, the sociodemographic expert panel that looked at this question which led to the start of this trial period cautioned strongly on using race in risk adjustment model for the basic factors that Paulette pointed out which is that, it's difficult to understand it points what the underlying construct is that race is measuring.

However, you know, it is the burden of the measure developers to explain the conceptual pathway from which – and how race, first of all, is a precise variable for inclusion and how it interacts with the outcome of interest.

To the extent that it is, you know, does provide a strong conceptual rationale and there is evidence to support the use, it's not that it's completely off the table, it's just that the burden of using that variable in particular because of its imprecision of what it represents in terms of an underlying conceptual construct and how it relates to the conceptual pathway readmission as a measure would be difficult (to buy).

However, you know, I guess at this stage, we can continue to suggest that the developers continue testing it, but we'll have to see when we get to the empirical stage (what is an) appropriate.

And, obviously, the developers will have to consider whether it's appropriate measure – variable for inclusion. So it's not off the table in summary, but the burden is pretty high to demonstrate what it actually represents in the causal pathway.

Bruce Hall: Great, thank you, Taroon.

So, Zehra, Taroon, other than us saying at this point, does anyone else on the call want to add any comments? Are you looking to us to have any further or deeper discussion, or is this how you want things to transpire?

Taroon Amin: Absolutely, you've asked a critical question which is, you know, are we comfortable with what the developers have provided and then you can feel

free to just move on if there's no other comments from the committee members. I recommend ...

Bruce Hall: And really it's – I'm sorry, Taroon, and really it's, are we comfortable with the developers investigating these things?

Taroon Amin: Correct.

Bruce Hall: Correct. OK.

Zehra Shahab: Yes. And I would also ask Bruce and Taroon for the committee members to fill out this survey, for each of the measures as you go along. They're on the left – down the left hand side in the link section. It is number four.

Bruce Hall: OK, then are you comfortable with us moving forward and we'll go for measure 2514, Risk-Adjusted Coronary Artery Bypass Graft Readmission Rate?

Zehra Shahab: Yes, sounds good.

Paul Heindenreich: So, this is Paul Heidenreich. And I guess like in the first of the three, I'll just briefly say, in terms of CABG specific data, they didn't provide at the very end that in the multivariable analyses that both race, African American race and an insurance status are independently associated with 30-day readmission and they proposed though to just look at Medicaid and dual eligibility as their risk adjustment.

And I think that's reasonable, although given their empiric data, I thought it would have been interesting to see how also adjusting for race would have impacted their results.

But I don't object to them, I'm only looking at that because I think they did provide some data to say that may be something useful in examining both.

Bruce Hall: Thank you, Paul. Anyone else?

And is your take that they – that their material submitted states that they will emphasize looking further into payer and insurance variables as well as the

dual eligibility status? Is that what you took us kind of their concluding statement?

They had said in their remarks that they felt that various geography or an address-based proxies were a problem.

Paul Heidenreich: Yes. Well, my understanding was it was (only kind) that they were primarily going to look at insurance status and by that, primarily, on Medicaid dual – and dual eligibility.

Bruce Hall: Great, thank you.

Anyone else, any other of three reviewers or anyone else want to throw any additional comments? So the question in front of us really is, are we comfortable with them pursuing what they have stated they will pursue.

NQF colleagues, is there a role for us to say that's not enough or do we not go there? I'm not saying it is a (recent) in this case, but I'm just asking.

Taroon Amin: Well, so let's think about it so, to certain extent, the basic question is based on the conceptual model and the – based on the conceptual model, are the variables that they're presenting sufficient, you know, proxies, if you will, the underlying conceptual model that the developers have suggested.

You know, I think we could suggest others to look at, but really the principle question is, which is in front of us, is given what they've – what the developers have provided, you know, is this sufficient to move forward. We don't necessarily want to go into a whole laundry list of (inaudible), but to the extent that there are other questions that the committee would want first to consider, we would certainly welcome that, and particularly through the survey as well.

Bruce Hall: OK, OK.

Taroon Amin: And so, some of the – you know, to all that's out there.

Bruce Hall: Well, I'm just – I'm – hopefully I'm clarifying something that some others worry about as well, but I'm just worried that, let's say, the SDS in the end

decided all they could really handle robustly was dual eligible status. No other payer information, no other geographic information. And then they resubmit their measure with dual eligible status and then that version of the committee decides to not pass it because isn't happy that dual eligible status was adequate. You know, I'm just wondering, so are we in a position now, or we try to avoid some of those scenarios, or is that not what we're to worry about today.

Taroon Amin: That is exactly the purpose of today's call, Bruce, which is to give the developers confidence as they move to the next stage that they have the small number of variables that the committee agrees to and they're testing that, and the testing result is brought to the next meeting of this committee.

So, there should not be the discussion about, you know, well, it wasn't sufficient at the next stage. That is the purpose of today's call. And the committee does believe that it's not sufficient, then they should state that and then suggest to the developers additional variables for examination during the empirical portion of the – of their analytic work.

So, you know, the purpose of today's call really is to give developers confidence as they move into the empirical analysis portion of their evaluation that they have defined scope and so, we don't, you know, we shouldn't have that level of conversation at the next meeting which is, you know, this was not a sufficient variable for examination. That's the purpose of today's call and (inaudible).

Bruce Hall: OK, so then let me embellish, we would like that to be the purpose of today's call. But in this case, you know, the SDS developers of whom, I'm a fan, are basically saying, we know we can use dual eligible status, we don't know whether any other payer information will come in, and we will look at geographic things but we're really worried about missing data there.

And so, really it's a bit of a gray zone right there saying they'll look at a couple of things, but in the end, if they came back with only dual eligible status, would everybody on the committee be satisfied, and that's a tough – that's kind of a tougher thing for us to get our heads around.

So, if anyone else wants to stop me from talking, please chime in.

Laurent Glance: Hey Bruce, I have a comment. This is Larry Glance.

Bruce Hall: Yes, Larry.

Laurent Glance: Couple of things, the first thing is reading through the developer, measure developer responses, it wasn't clear to me that they are telling us which SDS measures they're going to investigate. I think they're telling us which SDS measures or variables are present in the data set.

For example, for the CathPCI measure, they listed gender, race, ethnicity, age, zip code, insurance status, as SDS variables. They didn't say which one of those they were going to investigate. So that's the first comment.

And it wasn't clear from the questions that were presented to the developers that they would have known how to answer the question that the committee is interested in, specifically which variables, which SDS variables are they going to investigate?

The second comment that I have is that as important as it is to identify which SDS variables to investigate, the second piece is, do the developers or the measure developers know what our expectations are for the investigation, what their plan is going to be?

Bruce Hall: Larry, I echo and second your concerns. And, that's why I'm trying to make sure we have enough of a conceptual developed discussion today to try to get our hands around this.

Obviously, they have limited time, but I think your questions are right on the mark. The developers might not have felt that that's what they were proposing to us today. And yet, as Taroon said, we don't want to get into the situation where they rework, resubmit and then end up being told it's insufficient.

So, NQF colleagues, I'm not sure what can we – what clarification can we accomplish here on this or how do we keep moving forward?

Taroon Amin: So, Bruce this is Taroon. And Larry, those are sort of good points. I mean, I guess the way that this was – or proposed was, you know, a discussion around the conceptual rationale, the question of what variables do they have available in their data set and then how well did those variables represent the underlying conceptual rationale.

You know, the decision about whether or not – or, you know, which variables you're including in your empirical analysis should represent the underlying conceptual rationales, how you believe those patient demographic variables represent, you know, how they lie in the concept – you know, in the causal pathway here, if you will.

So that was the intent of the questions that we were asking, but I see (inaudible) that you're raising, which is it was not, you know, we may not have asked this precisely which is, you know, which variables are you using for your empirical work. I mean, I would suggest that the committee sort of look at the patient level, demographic variable that were available that the developers presented and provide guidance through the survey about which variables you believe the (developers) investigate.

You know, we're really trying to avoid a situation where we come to this conversation again in early part of next year and sort of have some questions about whether or not the variables were sufficient enough.

So to the extent, especially the lead discussants or the lead reviewers, if you can narrow down and we can focus this conversation as we are with this first measure to say, you know, they're proposing moving forward with dual eligibility status that's sufficient, we would recommend, you know, examination about X, Y and Z variable. If we can get to that level of (inaudible), that would be the best outcome from today's call.

Female: Hi, hi.

Laurent Glance: (But Taroon), the point that I was making is I don't believe that they're actually proposing – at least for the two measures that I reviewed, it's not clear that they're proposing to review those particular variables. They are just listing them.

Taroon Amin: So Larry, I guess the question I would ask is if we can have a conversation as we get to those around which you would recommend that they examine further. And that might be the best we can get to (drink).

Laurent Glance: OK.

Taroon Amin: Was there another question from the committee member?

Paulette Niewczyk: Hi, this is Paulette Niewczyk.

I just wanted to add that – I mean, I think it came to a point where it was said if there were only, you know, payer (stores) or dual eligibility, would be we OK with that.

And I just wanted to speak to on that and with the vascular measure, there was really only three included in the measure developer's response to us. And when I said I believe it was quite limited, I just feel that, you know, (pushing the) CABG where there was more variables, at least (that offered upper) that they could potentially access for sociodemographic. I would say that the more, the better.

Bruce Hall: Yes, it's Bruce. I would agree that the more that they can at least investigate and give us information on, the better, but obviously, there's going to be a finite burden that they can take on.

And Taroon, there, obviously, also has to be a reservation of judgment in some sense, right? That even a resubmitted measure can be later reviewed by a committee as inadequate. I mean, that judgment has to be reserved. So, you know, there can be gray zones here.

Taroon Amin: You're correct, Bruce.

I would just point out that, you know, the next question that the standing committee is going to be faced with, is that the developer has to make a final decision on the risk adjustment model including the variables that they feel are appropriate.

And the next question of the standing committee is, you know, whether to continue endorsement of the measure as specified. But the developer is ultimately the one that's going to have to make the decision and justify that decision to the standing committee about which SDS factor they've decided to select based on (conceptual) and empirical results.

So, again ...

Bruce Hall: Taroon, Zehra, a question on that though, when those resubmissions come back to us, will we be asked the question, is this better than it was before, or we would be asked the question, are you totally happy with this?

Taroon Amin: We will be at – I mean, well, the basic jurisdiction of the standing committee is to make up or down endorsement decision to this point. And so ...

Bruce Hall: But these are endorsed. So the question is, on a resubmission, is it – it's already endorsed, right? It's ...

Taroon Amin: It's to continue endorsement, Bruce.

Bruce Hall: To continue, OK. So you could actually reverse course.

Taroon Amin: Correct.

Bruce Hall: OK.

Laurent Glance: So, I don't want to monopolize this, but the second comment that I had made was that we have not told them, I believe, what empiric approach to use in their analysis. And I think that the approach is actually quite important. And I wonder if that's something that this committee would want to consider.

And the reason I make this point is that, if you decided to include or not include the SDS variable and then you use, for example, hierarchical modeling to construct your performance measure and then your empiric approach is to compare the results of hierarchical modeling with or without the SDS variable, almost always, you'll find that there's virtually no difference in the outlier status, high, low and average quality.

On the other hand, if you look at the point estimate for the – what is – could be viewed as an O/E ratio based on the hierarchical model, you will see differences in rank ordering. And the reason that's important is because as currently constructed, the Medicare Hospital Readmission Program – Reduction Program looks at whether or not your (absorbed) is at anything greater than your expected.

So, you will be penalized as long as the O to E is greater than one. It's actually a little more complicated than that. But the point being that, if you include SDS, you will get a different result and if you don't include SDS when you're just looking at point estimates for the O to E ratio.

So, depending on whether – depending – in other words, depending on what your empiric approach is going to be to look at the effective SDS, you're going to find very different results. And I think it's going to be important for us as a committee to provide some guidance to the developers in terms of how to approach what we're asking them to do.

Taroon Amin: So Larry, this is Taroon. I have two comments, regarding that and then, you know.

First is, we're sort of in a difficult position here because, you know, NQF has traditionally stayed away from guidance or direction in terms of empirical analysis approaches for (inaudible) developers. Mainly, because, you know, we basically that we believe that as sort of (worth) the measure developer and trying to stay away from overly prescriptive of the approaches that measure developers can take in the empirical work.

However, your point is very well taken which is that guidance on our empirical strategies that developers should be taking to test SDS variables is absolutely something that (inaudible) taken and actually has convened a group of statistical experts based on the first expert panel that reviews this material to provide guidance to the developers on how to undertake the empirical work.

It doesn't get to the level of whether or not to use, you know, hierarchal modeling and comparing results in that way. However, it does get to the level

of looking at differences of ranks, you know, the measure score, if you will, in addition to just the empirical significance of the individual variable.

So, what we can do as a follow up to this call is that guidance that we provided to developers, that is a result of various conversations with a group of statistical consultants. And if you have additional (inaudible), we would (inaudible). But if we can table that portion of it because that certainly is what we're (doing), you know, early next year and we have some time to work (inaudible). However, I can – we can definitely share with you at the end of this call to give you a sense of the guidance that we've shared with them and if there's additional feedback that you have, we would certainly welcome that.

Laurent Glance: OK, thank you.

Bruce Hall: All right. I'm going to exert privilege of moving us along, I guess, and just say let's go to measure 2515. I think many of the issues that we're raising are of concern to all of us in a very general fashion. So, you know, that is what it is. So let's go on to 2515 and ask for some specific comments from our discussants on 2515.

(Jane Han): My apologies, this is (Jane Han) from STS. I'm sorry to interrupt, but was there a decision made regarding 2514 at all? I didn't quite catch.

Bruce Hall: I thought the decisions would be communicated after the surveys are filled out, NQF ...

(Jane Han): Oh, OK.

Bruce Hall: ...colleagues, is that correct?

Zehra Shahab: Yes, Bruce, correct.

Taroon Amin: That is correct.

Zehra Shahab: So, the committee has about a week to finish the survey, especially for those who are unable to attend and then we'll follow up with the developers.

(Jane Han): OK, thank you.

Jane Han: And public comment and next steps.

(Jane Han): Just so you know, we – SDS does have the ability to look at insurance status and other insurance variables as well. So, we just wanted to make sure that you were aware.

Bruce Hall: Thank you very much.

OK, our discussants for 2515, any additional specific comments relevant to this measure?

Do we have any discussants on 2515?

Cristie Travis: This is Cristie Travis, I was just waiting to see if anybody else jump in first. But really, it's the same issues that we discussed for 2513 in terms of race, dual eligibility and neighborhood SDS factors.

And those were the three that they discussed, presuming they go into more detail around race and the complicated nature of thinking through as Taroon was saying earlier, what the underlying structure that race would really be reflecting. And, I think the dilemma about, you know, what that would really be showing us.

So – and actually did state that if it was – if race was really reflecting a bias that was broadly throughout institutions, including hospitals and providers, then it probably would not be something that should be adjusted for because it would be giving hospitals credit for disparate and discriminatory care. But the other issues, I think, are very similar for 2513.

Bruce Hall: Thank you, Cristie. Anyone else?

Well, as I said, I'm not sure we've resolved all of our more general concerns. But, let's go ahead and keep moving and we'll move onto 0505 readmissions following AMI.

Laurent Glance: So, I can take the lead on that.

Basically, they've already done some preliminary analysis using either race or dual eligibility status as the variables of interest. And I think it's reasonable for them to proceed and do more detailed analysis using those two variables.

Those are the only two variables that they've said they have access to for SDS.

Paul Heidenreich: And this is Paul Heidenreich. I know they said they think they may be able to get the neighborhood zip code (a little bit), but I don't think that's part of their – this year's proposal.

And I think they did – in regarding their inclusion of race, I think they did say in all of their work, they found race to be, even after adjustment for other factor, even more powerful than the other typical SDS adjustments and for whatever it's measuring, whatever the underlying (conceptual it does seem). And I agree with their approach.

Bruce Hall: Thank you, both. Anyone else on the call on the committee with any additional concerns there?

Thomas Smith: This is Tom Smith. You know, with this measure and the prior measure, I didn't see any mention of age and gender or sex. Should we consider those to be sort of basic minimum measures that ought to be in all these analyses?

Bruce Hall: I think, commonly, they are already, but good question. But I don't have specifications in front of me.

Taroon, Zehra, are they generally – am I correct in recalling that generally, we are dealing with those age, gender.

Taroon Amin: Yes. Yes, generally, we are. Those are a lot less controversial so, you know, we don't necessarily need to focus (inaudible) from those.

Paul Heidenreich: But then I thought they were already – my understanding was they already were included in the risk adjustment models.

Taroon Amin: I mean, age ...

Bruce Hall: Right, I believe that's the case in most of them, and go ahead, Taroon.

Taroon Amin: No, yes, it's OK. They generally are. The one that I'm hesitating on is gender. I don't want to make that as (broad stay), I'm not completely sure about all of them.

But, you know, as it relates to this question, you know, I think they're – you know, age definitely is, you know, mostly always included. Gender may not always across all of the measures in front of us.

Thomas Smith: So, if they had a blanket recommendation, we want to get to all developers that they're now should all consider age and gender if they have not already?

Bruce Hall: Yes, Taroon or colleagues, is there a mechanism in the synthesis function after you received all the surveys that you can express that?

Taroon Amin: Absolutely.

Bruce Hall: OK. So I think as long as we make that comment in some of the survey responses, then that can be captured in that way.

OK, if there are no other immediate concerns on 0505, let's go to 0695, readmission following PCI, 0695.

Laurent Glance: So again, in this particular, the measure developers did do some preliminary analysis looking at race and looking at dual eligibility, and it seems that that is going to be the way they're going to proceed.

They have some other variables on SDS, including ethnicity and zip code insurance status at the group level, but I think I would encourage them to continue with the analysis that they've already done in greater detail.

I would avoid using zip code SDS variables just because they may not be very specific to the individuals necessarily to patient level data.

Bruce Hall: Great. Thank you, Larry. Anyone else with additional comments?

I don't want to push people too fast, but those that even know me know that I'll just keep talking if nobody else talks, so.

OK, 2375, 2375, SNF rehospitalizations, skilled nursing facility.

Helen Chen: Right, it's Helen Chen.

So, this is one of the paired measures, I think it goes along with 2510, which we'll get to later. The main difference being the data set that's available to them and their ability to actually pull up more features that are not available through Medicare claims data which, if you recall, when we originally discussed, this was appealing to most of us.

And, I think like the people who reviewed 2510, they struggled a bit with existing data regarding the conceptual model and what's out there in terms of literature for the primarily racial and ethnic disparities to a lesser degree, the SDS related factors.

And, I think for me, again, similar to what people had discussed before, there's a huge laundry list of things that they potentially, because they have that in their MDS data set, would be looking at putting into their empirical model and I'm not clear that all of these need to be there. That would be a question for them moving forward.

And then the sort of bigger conceptual question is to whether we're talking about within facility disparities versus across facility disparities, and whether we need to be careful to – as in the hospital work to not penalize facilities that are situated in low SDS regions.

I did like their ability to look at other payer classes, which again, in the other measure, it's all Medicare claims data, and including commercial plans Medicare Advantage, and trying to find some more county-based or regional-based characteristic for empirical testing.

I thought they did a nice job with what they had. There isn't that much data out there in terms of literature.

Bruce Hall: Great. Thank you, very insightful comments.

I was impressed that they were at least bringing into the discussion seems like more potential issues to examine.

Thank you. Anyone else?

Cristie Travis: This is Cristie. And I think this is kind of a broader question as well. You know, I think this is kind of the first measure where they're looking at facility characteristics. At least they've suggested that they may be looking at some facility characteristics as well as, for the first time, like county level characteristics.

And I guess, you know, I'm struggling with when is the discussion on – when do we have the discussion around whether those are appropriate, is it during the individual measure review once we get the empirical testing back, or are there broader issues that at some point we, as the committee, need to address around whether or not these types of potential adjustments are what we're thinking really are appropriate for this activity.

And that's probably a question for NQF or anybody else who wants to suggest an answer.

Taroon Amin: Cristie, this would be – this is Taroon. This would be the time to discuss whether you believe if you believe that these – those following variables are appropriate proxies for individual level data.

There has been a lot of conversation by the risk adjustment expert panel on the appropriateness of adjusting for a facility level characteristics. And clearly, that's not limited to just facility – inpatient acute facilities. Obviously, that would apply to other facilities as well. So if you do have concerns related to the variables that have been presented here by the developers, this would be the time to weigh in.

Cristie Travis: Thank you, Taroon.

I think I will share a concern that I do have specifically around county level characteristics. And that I think it's brought up in several of the other measures as well.

And I think I'm having a difficult time wrapping my head around how a county's median or average for different characteristics, or even in this case percent characteristics can be used as a proxy for individual patient characteristics.

And I guess, the way that I'm thinking about it and I certainly can be educated on this is that if I live in a county and if I'm a patient and I'm from a county and I'm in a facility that I'm going to be considered to be the average, or I'm going to be considered to be the percent. I just (inaudible), I can't even figure out how this would actually be done from a math perspective.

And I don't – I mean, I am who I am, not necessarily what my average or what the statistics for my county are. And I just don't see how you apply county level. I can get the zip code and especially the non-zip code, you know, at least there's something that I think is worth investigating. But, when you get down to total county, it seems like everybody is going to look the same based on the county's characteristics. And I just don't really see how that is getting us where we want to go in terms of the particular patients that are in their outcomes.

I have similar concerns about the facility characteristics, too. I mean, they are descriptive at least of what's going on in that particular facility. I'd have to think a little bit deeper on that one. But for the county, I'm just not sure I get the conceptual link between how that really reflects what's going on in that particular facility.

Paulette Niewczyk: Hi. This is Paulette. And I would agree with your take.

If they're going to use census data, they could certainly refine that. I'm assuming they're just going to use the patient's address. But they could refine that for the census tract or the (schemes) of census blocker which would give, you know, significantly less variability in, you know, a range of income or, you know, highest education and some of the other markers with it.

Bruce Hall: I agree. And ...

Wesley Fields: Yes, this Wes Fields.

Bruce Hall: Yes, go ahead.

Wesley Fields: Oh, I'm sorry. I just – this was fascinating to me. And I think it's (perked) into 2380 and 2505, the ones that relate to the interaction between home health and the emergency department that are coming up.

But, speaking from myself and thinking about problems with small samples and the care of individuals in a small sample versus something closer to the current debate, I'm actually pretty comfortable with the context that most of these measures are really looking at the interaction between communities and the facilities or provider groups, you know, that are treating populations within the community.

So in many ways, I think some of these SDS challenges are going to be better understood and possibly better defined if we allow the best possible perspective that includes the interaction between community and facility. I think it's very true about home health. I think it's very true about who's in the emergency department especially those returning. I think it has many pertinent influences on chronic conditions and how stable it can remain in the community.

So, speaking in favor of variables that allow us to get closer to understand the interaction between communities and facilities and feeling not so terribly uncomfortable about outcomes that are patient specific, and therefore, part of potentially samples that are too small could be truly meaningful.

Female: And along those lines, I actually really like what the RTI developers did in there supplemental materials regarding looking at the addition of HIPAA, and I know HIPAA is typically driven by the codes but, you know, our health profession shortage areas and, you know, thinking about how that impacts, what level of care is actually provided in the various communities as you're saying.

Bruce Hall: Great comments, thank you. Thank you, both. Thank you all.

Any additional thoughts or concerns? Cristie, thank you very for opening up that discussion, those topics, expanding those topics, I should say.

Frank Briggs: This is Frank Briggs. I'll just going to agree, I think as you get to less acute areas of care or locations of care, it does become more regional or dependent upon what the valuable in your immediate community. So I think looking at, at least, some of these regional characteristics as described in 2375, at least we can begin to look at what is the true impact of the surrounding community, think of what – certainly have less impact when you're looking at acute care probably (LTACs) and things of that nature.

But when you look at where the patients are from in these (nests), they're going to be closer to home and certainly more regional. So I think the impact is potentially there for these two measures.

Bruce Hall: Thanks, Frank.

Taroon Amin: Bruce, this is Taroon. Before we move on from this topic, I just wanted to – I know we had a rich discussion around there regional characteristics and obviously that supplies to other measures as well.

I think Cristie also raised the question of appropriateness of the characteristics on how well they are proxies for individual data.

I would just welcome one – a few – just one or two comments from the committee about that topic as well since they'll be across a few measures.

Bruce Hall: Well, let me state and then Cristie, I may be – I may offend you by saying something you already know. But let me just state at the grade school level, the mathematic principle here behind, you know, having hierarchical adjustment where you might have a factor that applies to an entire region, and then to a community, and then to a hospital, and then to a person.

And at each level, what you're doing is you're sort of resetting the baseline. So, you're not saying that necessarily, you can fully characterize each patient inside of that level just because of this community characteristic. But what you are saying is that on average, this community tends to skew here or skew

there and let's adjust that baseline and then let's continue working toward adjusting all the way down to the patient level.

And so, in that sense, mathematically – it's usually fruitful to pursue kind of multiple levels of adjustment that you might see reflected in something like a community level metric.

Cristie Travis: No, that's helpful. Thank you.

Bruce Hall: Sure. Any other comments from the committee?

Katherine Auger: This is Kathy Auger. I know and so many of (inaudible) works, they've done sort of analysis to try to look at how – what is a sort of a better reflection of individual characteristics, whether you're looking at census tract versus zip code.

And my understanding of that work is that the census tract is typically a little bit better looking at the – like, better approximation of the individuals that live there. I'm not as familiar with looking at county level, and I think as what other people have said, the county level feels very heterogeneous to me and not representative of any particular necessarily individual level.

So, I'm struggling a little bit with this conversation as, you know, are the developers trying to put in some sort of large community and that's what they're trying to adjust for, or are they trying to approximate patient level variables using county level because they feel very different from my perspective.

Paul Heidenreich: This is Paul Heidenreich. I'd say – for me, the question is, is this an improvement, are we – or is this actually confusing the issue.

Katherine Auger: Right.

Paul Heidenreich: And, so that's how I'm interpreting it and even though it may not be as ideal as having individual patient level SDS data income, it seems that the community level data will be (inaudible).

Bruce Hall: And this is Bruce again. I want to point out that, of course, just because we talk about a county level metric doesn't mean it would fall out as a statistical driver, right? And so, in many cases, if that's a really heterogeneous approach to something, it's not going to end up carrying statistical significance because there won't be clean, you know, unidirectional aligned signal coming out of it.

On the other hand, if you use some county level metric and it's showing up as having a substantial effect, then at a minimum, we, as researchers, should say, "Wait a minute, what are we seeing there?" We may not be able to explain it and detach it all the way down the patient level characteristics, but if we see at county level metric carrying huge significance, that should force us to ask questions about it.

Katherine Auger: Sure.

Cristie Travis: And this is Cristie again. I guess the other broader question I had is that so many of the developers were – are planning to look at the neighborhood level data. And the zip plus, you know, the five plus four, the nine level.

So there's part of me that wonders why isn't everybody then looking at that level of data, and this kind of comes back to the question of the burden when the – well, the burden on the developer is to look at it but also whether or not if that data is available, why the decision not to use that and to use something like county level data instead.

And I guess, I'm trying to get my head wrapped around that issue too, that if that information is out there for some developers, is it not out there for all? And is that kind of more where, you know, we would lean towards saying, "Why not use that data if it is available?"

(Off-Mic)

Zehra Shahab: Hi, Bruce. This is Zehra.

We have the developer for measure 2375 on the line. Did you all want to ask him a question, or did you want to let him speak regarding the measure? This is a question for the committee.

Bruce Hall: I don't think we need a lengthy commentary. If there's something specific that was raised that they would like to make a particular comment about, I'm sure we're open to that.

Zehra Shahab: OK. Operator, can you please let (James Miller) have an open line, please?

Operator: His line is open.

Zehra Shahab: Great ...

(James Miller): All right, this is (James Miller) (at ACA). Just a very quick comment. We agree with all of your concerns and all of your – the custom benefit of adding this community level variables in, and really the purposes of including them in our large list of candidate, risk adjusters is to explore exactly the relationships that you're talking about here. I'm just as curious as you as sort of seeing that. The relationship and the conceptual link further as we explore this.

Bruce Hall: Thank you, (James).

OK, Zehra, how are we doing on time?

Zehra Shahab: We're OK, Bruce. Let's just – if everyone is ready, we can move onto 2380.

Bruce Hall: OK, 2380 after home health, our discussants.

Pamela Roberts: So this is the Pam. So 2380 is also the developers combined 2380 and 2505 in their response. So can we just talk about them together? And, you know, we can separate out as needed. But their response was the same for both.

Zehra Shahab: Yes, Pam, we can do that.

Pamela Roberts: OK. So, the developers talked about some of the literature and in the home health world, there is some socioeconomic status with people using the E.D. more for primary care and that was supported in the literature.

They currently, on both of these measures, have five categories of risk adjustments that they use, which is looking at the prior setting, age and sex

interactions, health status as measured by the HCCs, Medicare enrollment as well as some additional interactions.

They also did talk about the eight categories in medical – or Medicare enrollment that they also identified beneficiaries who are disabled and discussed some about that may have some impact on sociodemographic status with the correlation of income or employment.

They also did mention that they have additional areas that they have the data available too that they're going to explore, and as we've talked about race, ethnicity, Medicaid status, rural location, neighborhood characteristics as we've just talked about.

So it seems like that they are trying to include the data that is available and the discussions that we've already had, I'm not going to repeat on some of the issues.

Wesley Fields: This is Wes. Just a couple of things I want to sort of underline without repeating the prior discussion which I think has been useful.

I think in many measures, the concepts at rural locations, in some ways, act like an independent variable. I think that's important.

And I am also very intrigued by the concept that the ability to look at health status by HCC and looking at – I think that becomes a great proxy for comorbidity and complexity of a community level care and all the intermediate phases of care.

And, again, I just want to support the concept that there probably is a hierarchical approach to take to looking at communities and facilities and programs.

And I'm wondering why – since the vast majority of measures are based on claims data, why if the developers of these two measures don't see lots of things which are potentially meaningful that they can look at, I'm just curious that it's not something that technically we would expect the developers across, you know, all measures. And the sort of hypothesis that's sort of raised last

five minutes ago, which is to have the technical guidance be sort of favor complexity or diversity of data, and then to ask developers why they chose not to include some of the variables. That makes sense to me.

Otherwise, Bruce, I support the measures developers' responses on both of these.

Bruce Hall: Well, Pam and Wes, those are great comments, and it leads me to ask a question of our NQF colleagues.

Would a more – would a more developed product coming out of this conversation be that we share with all the developers, "Look, here are all the unique things we've seen proposed. And we are, you know, starting to get a sense of a best practice out of everything that's been proposed", and we would ask every developer to look over that list and push themselves to consider anything on that list that they didn't already propose.

Is there a role for us to sort of have a little a bit more developed product back to the developers along those lines?

Taroon Amin: Bruce, this is Taroon. I think there's absolutely (thing) that we can do that reflects that sort of goal.

The only thing that I would – so I would say yes and we (look) to do that to consolidate the information that's been provided by the developers across to understand the data source that they're using in the proposed variables.

I would just offer to the committee that, again, one of the things that we continue to balance, and I understand that all of you respect is just not to – you know, different developers are coming at this with different data availability and resources and given the time – the limited time that we've given them to turn this around for the committee and obviously their process, there might be some variation there.

But there's, obviously, work that we can do on our end to help facilitate a thoughtful conversation among the developers about approaches and creative

ideas that they can use across themselves between now and the next days of the empirical evaluation.

Bruce Halls: Yes, and Taroon, absolutely, obviously, everyone on the call understands that not every developer would be able to react to every item because data sources themselves and resources available are going to differ, so we get that.

Pamela Roberts: But at least that would help for the next conversation, we know that they at least, you know, were aware of that item and not be shocked when it comes back or something.

Bruce Halls: Yes, absolutely.

I mean, it does sort of feel that even through this conversation today that sort of as Wes just said, our tendency would be to start with a little more complexity and reduce from there. And, you know, even starting to establish that as a best practice for the developers might be helpful to them.

So I think next in line is 2496.

Helen Chen: Hi, it's Helen Chen.

So, this was not one of the measures I've reviewed originally. But, basically, this was interesting, they spent a fair amount of time talking about the racial issues around dialysis. And then the measures they (select), and then a bit about area deprivation and the interest in doing more with zip codes and community-based analysis.

But what they came up with in terms of what they would like to focus on was in addition to race, this interesting other measures of income and specifically unemployment status prior to the – which I thought was fascinating and also like other developers, dual eligibility and Medicare status at discharge.

So, that was different. I'm not entirely clear that has necessarily possibility for me. But, the short list and I think it's based on what they have to offer. But I'd like to hear other people feelings about that particular addition in terms of looking at SDS for the measure.

Bruce Hall: Thank you, Helen.

Additional comments?

Karen Joynt: So, hi, this is Karen Joynt, I was one of the other reviewers for this measure.

I agree, I hadn't seen that the unemployment variable previously either, so that was very interesting.

I will say that this, in addition to the other ones I reviewed and the other ones I've just, you know, read through overall, the area-level variables sometimes represented as being in the area deprivation index, there's also an AHRQ indexes. There's usually a lot of ways that one could view this, and I sort of like to add to the list of potential guidance that could be provided, a little bit of input perhaps on whether or not a consistent approach there makes sense. There are so many variables available at the area level and if every measure looks at them in a bunch of different ways, it's going to be pretty difficult to compare results. So I would add that to the list of things that developers might learn from each other if there were variables or indexes that were particularly useful.

Few other thoughts I had about this and the other measures, everyone seems to use the dual status and this one (made) through in the – an indicator of high income that was Medicare as a secondary payer as index discharge, because I didn't see in the other measures, but again, could theoretically be something that might be available in other Medicare data.

Similarly, any indication of partial versus full dual or disability that were brought up in other settings, I think that'd be particularly applicable to the dialysis setting. So those were my additional thoughts on this measure.

Bruce Hall: Thank you.

Any other thoughts?

OK. Next in line is 2502.

Pam, are you ready to talk about 2502?

Pamela Roberts: Sure.

Bruce Halls: OK, fire away.

Pamela Roberts: So this one – oh, wait, (let me get this in) here.

They – this was – the developers talked about different issues with race and they talked about depending on how they modeled it, sometimes the race fell out. They did talk about some conceptual rationale using neighborhood and community characteristics and the influence and we've already talked about that.

So, the data set is a little bit more limited on this one, they did talk about using county sociodemographic status, as well as sex, race and dual eligibility.

They also talked about Medicaid Buy-In as an indicator. And I think that was about it on as well.

But anybody else has anything else to say?

Bruce Halls: Great, thank you. I reviewed this one as well. I agree with you that seemed to be as much as any of the other sort of a reasonable set of issues to check.

Anyone else have specific thoughts?

OK, 2505, (we hit). 2510, skilled nursing facility.

Frank Briggs: This is Frank.

So, the response actually has a – the separate attachment that was sent out, included with all those other – the measures 2502, 2512 and 2510.

Very similar to 2375 that from county level adjustments potentially in there, I think the one difference here that actually makes me wonder in regards to all of these different potential adjustments is in 2510. They actually have a frequency of updates, so I'm wondering if that isn't something that we need to

consider in regards, especially to anytime that we're going to look at zip code, what our zip code or zip code plus four or any other county level.

Is how often is that data source can be updated, is that based on a annual survey and it's updated once a year, is it based on census data and potentially 10 years apart. But other than those, they had very similar adjustments potentially but had slightly different thresholds in regards to how they're going to capture their data and to begin to put it into their equations.

Bruce Hall: Great, thank you. I think that the question about frequency of updates is a good one note that probably lives better in a more general best practice guidance document than with respect to anyone measure because that should apply to all measures.

Any other thoughts on 2510? OK, 2512.

Antony Grigonis: Hi, this Tony Grigonis.

For the long-term care hospitals, RTI had already conducted some logistic regression studies and they found that the Black race category had the highest rate admission rate compared to Whites.

And – but they did not find any significant difference between beneficiaries in the other race group compared to Whites.

They also used the Medicare Buy-In indicator, and they found an actual higher difference between patients with the Buy-In compared to patients that did not. And for long-term acute hospitals, there's a pretty high rate of the Medicare Buy-Ins, I think around 40 percent.

So I think it's definitely appropriate to take these measures into consideration in trying to use them to – for the risk adjust, the measure – readmission measure for LTACs.

I did want to mention that as far as using zip codes, that RTI did state that the – they feel Medicare county code is more reliable in terms of a geographical

indicator, but they feel the zip code can also represent just a mailing address which could be a representative or a trustee.

And also, I worked with the – at least one set of a Medicare data, you know, they may have another. But the set I worked with rarely uses the – a nine-digit code. So I just wanted to throw that out as a consideration of another rationale for using the county code.

Bruce Hall: Great comment, Tony. Thank you.

Any other thoughts?

I examined this measure as well myself and I agree with Tony's comments.

Not hearing any other additional comments, we'll go to 2399, pediatric.

Katherine Auger: Yes. Hi, this is Kathy.

I think the measure developers had a really a nice job outlining the importance of considering these markers in pediatrics given the high rates of child poverty in this country.

They primarily focused on Medicaid insurance as their primary marker, and I think part of that was what they had access to in this development data set.

And I – they did do some preliminary analysis showing that kids with Medicaid were – had higher odds of readmission compared to kids with private insurance. So, I think that was a reasonable first step.

They also comment, though, that they will take the steps to look at using a separate data source to look at census tract data to look for determinants of neighborhood level influences, including income and education. And I think those are also important to at least examine in pediatrics. Especially given the fact that sometimes in pediatrics, we only have single-payer databases, so we can – we may only have Medicaid databases, in which case, you couldn't use Medicaid as sort of sociodemographic adjustment, so I think looking at some of this neighborhood level stuff is reasonable.

The one variable that they didn't mention that other developers do look at is race. And, while I don't know the right answer or whether or not it's appropriate to adjust this for race, I think it might be something that they may want to consider at least.

Bruce Hall: Great. Thank you, Kathy.

Anyone else, additional comments? Those are very insightful?

Karen Joynt: Hi, this is Karen Joynt, I reviewed this one, too.

My only additional comment is that, just to concur that it's a little tricky in the pediatric phase because the applicability of things like employment, education, income, really don't work for kids.

And so I wondered if in this state, there was maybe more of a (role) for enhanced sort of medical or sociodemographic things, things like mental illness or complex (ownist) or disability or something like that that might give us the kind of complexity beyond just a single variable given that we don't have a lot of their indicators in kids, that are direct measures, but that's sort of just a difference between this and the adult measures, I think.

Bruce Hall: Karen, I don't want to put you on a spot, but how much access do we have to big numbers around what you just suggested, mental illness, complex (ownist) and disability as a ...

Karen Joynt: I'm not sure actually.

Bruce Hall: ...that I get the – I'm odd by thinking we would need to get those and grab those.

Karen Joynt: Yes, I'm actually not sure in the Medicaid data. You know, in Medicare, there is certainly a lot of emerging ways to get to good evidence around things like disability, royalty, functional status. But, I actually have no idea in Medicaid type data set, I've not worked with kids only data set, I don't know what's collected in them. I think this is an area where ped's experts probably know a lot more about the (penalties) just because it is so different.

Bruce Hall: Yes. Great, thank you, both. Outstanding comments.

Any additional comments? 2393? OK, 2414?

Jo Ann Brooks: Hi, this is Jo Ann Brooks. In 2414, it's really a subset population of 2393. It's looking at pediatric lower respiratory infection readmission measures, and actually the developers looked at these two in tandem.

The SDS variables represented, they did a very nice job as previously had in the conceptual relationship, looking at insurance status which they do have and then income and education through the census tract data.

I don't have any additional comments, I think they should move forward. And, I'm fine with what they have presented to us.

Bruce Hall: Great, thank you. Any additional comments?

Not hearing any, 2503.

Thomas Smith: Yes, hi, Tom Smith is on. I guess I can go ahead and start.

These are – in the developers group to 2503 and 2504 together, these are those geographic-based measures of admissions per 1000 Medicare beneficiaries in 30-day readmissions, again, for 1000 Medicare beneficiaries. So, because they are the geographic-based measures, it really does make it an interesting discussion in terms of risk adjustment.

I'm hearing music. Can people still hear me?

Bruce Hall: I think someone must have gone on hold.

Thomas Smith: OK, I'll keep going.

And, you know, they make the point which we discussed at length earlier that, you know, these are measures intended to track changes in that particular geographic region overtime, and these are not measures meant to be used to compare different regions to each other. They go on to note that, you know, the sociodemographic composition of a particular region tends to be fairly

static and stable overtime, and so therefore, when they originally developed and tested the measure, they did not adjust for sociodemographic status.

If in time, they do go on appropriately and note that it is an important question to study whether, you know, certain neighborhood characteristics might have an impact. They do describe a study that they did where they use the area deprivation index, which is a nice combination of a number of educational and income and employment, you know, variables. And showed that the deprivation index did have an impact on the readmission rates for certain conditions at one end of the tail, it was in the most deprived subgroups where they saw a clear association. So that was interesting.

And they go on to make the point that this neighborhood label variables, in their opinion, are probably as good as if not better than personal sociodemographic status variables and they advocate the approach.

Now, when they go on to talk about the variables that are in their data set, they really only mentioned three, they mentioned sex, race, and age group. So it's not clear to me whether they are proposing that they will do analysis of their existing data looking at new neighborhood level variables.

I would strongly recommend that they do include a similar analysis looking at the area deprivation index or whatever, you know, is determined to be the best measure or measures.

I'd also would think it might be interesting to look at homelessness if there is the opportunity to get data on homelessness housing stability. Other studies or other developers had mentioned the Medicaid dual eligibility status and at the same time, the high-earner, you know, Medicare secondary status, those should be considered as well.

And then lastly, I'm interested in other people's opinions, but again, given that these are geographic-based measures, I think analysis looking at facility characteristics in those regions, which again, might not change overtime but, of course, they may, I do think that would be important. So, if they could give some consideration to facility characteristics, I would support that. Those are my thoughts.

Bruce Hall: Great, thank you. I will admit to the group as well that I still have a hard time processing this too mentally because of the described structure of having a geographic measure not intended to use to compare to other geographies, but rather intended as an internal mark.

And then if that's that case, then how does that change what we might or might not expect from SDS type adjustments. I'm eager to hear other people's thoughts.

But I'm not hearing any.

Taroon Amin: Well, certainly, any analysis looking at change overtime in a particular geographic region is going to have to control for such factors. And I think a measure like this, if it's going to be looked at overtime, it's going to be looked at in the context of interventions likely to – or interventions aimed at addressing particular sociodemographic factors like neighborhood stability or what have you, so.

Certainly, analyses and studies and outcome studies should – will have to control for these variables. So, conceptually, it's gets messy, that's a different question from whether you risk adjust, but in some ways, there is a lot of overlap.

Bruce Hall: Oh, I think there is, because agree with you that, in fact, I would not call it risk adjustment if you were truly looking at the changes of a region overtime.

I think you would probably portray those changes and maybe stratify the changes that have occurred, but you're actually not trying to risk adjust some metric internally to that region. So that's one issue. And I agree with you strongly.

But a second issue is, you know, how comfortable are we as a committee saying that since this was proposed to be used as an internal benchmark, we're more or less concern about the SDS adjustments here. Do we have any real underlying sense that that is the only way this will be used, because if you're going to compare cross-regions overtime, then all of these risk adjustment

issues that this group race is even inside of the area deprivation index really become key factors.

Paul Heidenreich: This is Paul Heidenreich. I mean, I was thought that the (burden) NQF performance measure was for public reporting. And I think that you're going to be publicly reporting across for all different regions there will – but, you know, people will use that to compare regions. And so, it seems that in the end, even though maybe that wasn't the intention, if that's going to be a (clerical) performance measure, one needs to be to able to compare across regions.

Bruce Hall: Yes, Paul. And I think that's exactly what we have expressed in past conversations. It's almost an issue of whether we buy the proposed intended use or whether we're supposed to be concerned about the intended used, and again, our NQF colleagues, I know, can comment on that.

Karen Joynt: I'd add – I'm sorry, this is Karen Joynt and I had a comment there, which is – for example, things like the prevention quality indicators which are essentially unplanned, the admission per population. Those are only adjusted for age and gender, they're not typically risk adjusted in the way that we think about them, but those are increasingly used in paper performance where fundamentally, you are being compared to other people and those are made public. So I think there are some precedents for these measures even if they aren't risk adjusted being used, you can, agree or disagree with either one. But those measures are another example of something that's out there currently.

Bruce Hall: Yes, great comment. Thank you.

Taroon Amin: This is Taroon.

This is a very thoughtful (inaudible). You know, we struggle with this as a committee a bit during the – you know, during our initial evaluation of this measure. Developer made it very clear, the intent of this measure or the use of this measure was for public reporting but not for use in comparing across regions. You know, and that was, you know, something that the committee grappled with during our in-person meeting and the evaluation of this measure, and obviously, evaluated the validity of the measure with no risk

adjustment at that point under that context. And, you know, that was (inaudible) that point.

I mean, I think the members of the committee that are uncomfortable with that given, you know, just, you know, uncomfortable with that at that point, and then obviously, continuing with this conversation about (additional) SDS factors.

But I think, you know, given that that was sort of the proposal and the nature of the conversation on what the developer put forward, and what the committee evaluated during the first round of this measure evaluation, I think we should (inaudible) again that we're operating under that construct that it is for public reporting and it is not intended to be compared across regions, but intended to compare a region across time and look at this question of SDS adjustment in that context.

You know, and I still think the question that Bruce is raising is the conversation about SDS more or less relevant given that context, I think, is still appropriate question for the committee to consider.

Bruce Hall: But Taroon, there is a little bit of a disconnect in that in the past, we've been told not to pay so much attention about – regarding comments about intended use.

We've sort of tried to be agnostic. I know those times may be changing, but we've tried to be agnostic. And in this case, we were actually considering the proposed intended use as an element of this proposal, right?

Taroon Amin: Yes, no, you're right.

So – and I think Paul mentioned this earlier as well, which is that we do have a use and usability criteria in which we do (inaudible) evaluate the appropriateness of the measure for quality improvement and public reporting, or accountability applications which include reporting.

The developer at the initial evaluation of this measure did describe that this measure is available on publicly available website that should look at an

individual or region's performance, but was not necessarily for the purposes of comparing regions. That was a narrative that we, you know, generally accepted as a committee and evaluated the scientific properties.

You know, the question of whether it's appropriate for specific application is definitely something that we have guided the committee against evaluating for the appropriateness for a particular program or a particular use. And obviously, you know, that is something that is currently under discussion and debate at NQF broadly. And, you know, as potentially in the process of changing.

But, for the purposes of this conversation, I think we should assume that this measure is appropriate for public reporting and stability application – or quality improvement and accountability applications which means public reporting in the context that which it was described by the developer during our initial evaluation.

You know, again, I know there are members of the committee that feel strongly that it's still not conceptually appropriate to not have any risk adjustment. But, you know, that was something that was discussed at length and generally was accepted.

Bruce Hall: Right. So I guess where we're settling down a little bit on these two measures is, you know, we've at least heard an initial desire that maybe they do focus on the deprivation index so where the components thereof, it's not clear that they're actually offering to do that versus just commenting about it, so. Those of us on the committee who are inclined might want to include some remark about that in our survey comments.

Are there any other additional thoughts on 2503 or 04, or anything specific to 04 that we have not touched on?

If not, I will turn it back over to our colleagues.

Zehra Shahab: Thanks, Bruce. We can just see if the committee members have any feedback on the draft empirical analysis that was provided for these three measures.

I know we provided this to you pretty late, so we wanted to see if any of the lead discussants for any of these measures wanted to start, and then see if the committee wanted – any other committee members wanted to add anything if they got a chance to review this.

Taroon Amin: So this is Taroon also. I just wanted to point out that at this point at this sort of intermediate tollgate, we had asked for the measure developers to provide information about the variables that were available to them that represented the underlying conceptual construct. And if they had a draft empirical analysis plan for the committee to evaluate, they could provide it.

The measure developers from RTI, I believe, did provide a draft empirical analysis late last week, and we did want to send that to the committee in the spirit of transparency. I'm not sure – we, obviously, didn't give the committee very much time to look at this, but if there are any comments from the lead discussants about the draft empirical analysis plan, again, and you'll find that as link number three on the side of the webinar, we would certainly welcome any comments about the empirical analysis plan for these three measures.

Bruce Hall: Well, this is Bruce. I'll say I looked it over because I was commenting on two other, the three measures inside of this. And they, to me, seems like a very earnest proposal with very relevant points and some very specific logistical questions that I think should be addressed.

So, I thought it was a very earnest proposal. I think most of the individual items that are in play that they've proposed to have in play, we've probably already touched on today as individual items across these measures. But, I also welcome anyone else on the committee who looked it over to throw in additional comments.

Antony Grigonis: Yes, hi. This is Tony Grigonis again.

I just have two comments that sort of stood out. I think the first one is, it appears that they are actually going to be undertaking a two-phased approach as far as the county measure goes and they are actually trying to develop a specific measure based on the county factors.

And, I think it should be clear that that's, in a sense, could be considered separate. It's obviously important because we've all agreed that some sort of community measure should be examined. But, I think the danger in that is that, if they are coming up with a new measure that that should be thoroughly tested also, so in addition to its impact on some of the readmission measures. So I just wanted to bring that up.

And the second comment had to do with – they included the comment that they will stratify by condition, severity, comorbidities as appropriate. They've sort of already determined that at least in the long-term acute care hospital setting, if they were not going to stratify because of the sample size.

So I just wanted to make those two points that sort of stood out to me making sure that there's no, you know, inconsistencies between what they've already presented and what they plan to do.

Bruce Hall: Yes, thank you, Tony and I agree, great comments, great insights.

Anyone else, any additional thoughts?

Karen Joynt: This is Karen Joynt. This is – I'm sorry, one sec. This is what spurred my comment earlier about the different entities.

I'm not sure what the pros and cons are of creating an index of community factors that's not previously been validated or the additional sort of time or effort that requires from the NQF standpoint. But, there are some valid entities out there.

And so, I think it's just worth bringing (outset). I also found creation of a new set of measures to be a pretty big step beyond what some of the other groups have proposed.

Bruce Hall: Great, thank you, Karen.

Yes, it will raise the question, I was – I, in my thinking of it, was a little bit agnostic about the end result but it does raise the question of, you know, whether the components analyses that they would do would be tuned to, again,

a particular outcome that could be different model by model. So, there's some very interesting challenging aspects to even what they've proposed to do.

Additional thoughts, anyone?

OK, Zehra and Taroon, I think it's still with you.

Zehra Shahab: Yes, Bruce, this is Zehra. I was just going to ask if RTI wanted to make a comment or ask any other clarifying questions for the committee members for this draft empirical plan.

And if so, operator, can you open the line if anyone on RTI is on the line?

Operator: The RTI International lines are open.

Zehra Shahab: OK, great. Thank you.

Taroon Amin: Any comments from our colleagues at RTI?

If not, before we move to public and member comment, I just wanted to thank the committee again for a very thoughtful and rich conversation as it relates to this intermediate step of looking at proposed variables and the underlying conceptual construct that has been presented by these measure developers and the myriad of measures that we've looked at and discussed today.

Again, just to remind you, please fill out the survey. And any additional (inaudible) have as it relates to any of the measures that we've evaluated today, the best approach is, obviously, to get through that during the webinar today. So, we don't have to follow up with you after the call.

But again, we appreciate of your time that you've taken to provide very thoughtful comments (set) for this call and, obviously, your comments during today's call.

So, Zehra, (over) to you to lead the next section of the agenda.

Female: Can I ask a quick question about the SurveyMonkey?

Zehra Shahab: Yes.

Female: The question that's up there is, are the variables recommended by the measure developers for the empirical analysis appropriate. So there were several times where people suggested other things. So, if I say no, and then put in the things that I heard other people suggest that I thought were good ideas, am I in a (sense voting) that this doesn't move forward though, or is that a separate ...

Taroon Amin: I think the way to interpret that is that, do you believe that what they have proposed are just not sufficient at all, then I would say no. If you believe that they're sufficient but you would ask them to consider others, put yes. But then also include the others that you think are appropriate for them to consider.

Female: In the box, OK, thank you ...

Taroon Amin: In the box, if you can, yes.

Bruce Hall: I like to throw out another question there, Taroon.

With respect to the RTI plan that we just were talking about, are you soliciting any sort of separate independent opinion from us based on the fact that RTI as a developer actually provided, you know, more detail at the last minute than others. Or, you just wanting the same general comments or the same orientation of our comments by a SurveyMonkey as you do for all the other measures?

Taroon Amin: So Zehra, you can correct if I'm wrong or maybe you wanted just jump in here.

Zehra Shahab: We have an additional question for those three measures for their empirical analysis plan and you can provide more feedback on the empirical analysis plan just specifically for 2502, 2510, and 2512.

Bruce Hall: Oh, OK, thank you.

Zehra Shahab: Yes, so that's how we differentiated those measures and those questions. Does that help, Bruce?

Bruce Hall: Yes, thanks.

Zehra Shahab: OK, you're welcome.

Are there any other questions from the committee members before we move onto public comment and next step?

OK, hearing none, operator, can you open up the lines for public comment please?

Operator: Thank you. At this time, if you have a comment, please press star then the number one on your telephone keypad.

We'll pause for just a moment.

You do have a comment from John Shaw.

John Shaw: Hi, this is John Shaw from Next Wave in Albany.

First, I wanted to agree with Karen Joynt and also suggest a possible NQF for all. She spoke to the need to really look at the SDS variables available and it might prove useful for NQF to do an inventory from what various developers have indicated and possibly facilitate a standard data set of those community SDS variables at the county and zip level, and anything else like the HPSAs that might be somewhat different.

Secondly, the conceptual framework of looking at the drivers of readmissions, the individual patient characteristics, the capabilities of the person themselves really are OK to use alone, only if the patient is totally self-sufficient post-discharge. And that's seldom true and that's why there's a need for the community level variables for the frail elderly, the pediatric population, those that require some form of formal or informal post-discharge supports, and the availability and effectiveness of those supports is a big part of what we saw as the goal and role of the SDS adjustments.

And, subset within that would be looking at it as a workforce issue and that's some of where the community comes in if the presumption is everyone has an

informal caregiver and the resources to manage that may not be true in the poor communities.

Likewise, in looking at the analysis we've done, there's differences between regions and there's relative differences within regions.

So, it's a mechanism where are the poorest of the poor and are those resources predictive of what some of the outcomes are.

Thank you.

Operator: Your next comment comes from the line of (Nancy Foster).

(Nancy Foster): Good afternoon, and thank you for undertaking this work. It's very, very important and we're very excited that it is now underway.

I just wanted to point out that in today's JAMA, just a couple of hours ago released online, there's a critically important study (design). I can't imagine anybody has read it yet, but it's from three researchers at Harvard, (Barnett), (Sue), and (McWilliams), in which they have identified 22 factors that affect the propensity for a patient to be readmitted to a hospital. Some of them, the more traditional sociodemographic factor, some of them really related to the patients on health.

I think important for this group to take a look at that study and to incorporate some of that in their thinking about what factors they would expect the developers to look at, and whether just one or two factors would be enough to appropriately adjust for what is a very complex sociodemographic interplay as we think about how to prevent readmissions for patients.

So, I urge you to take a look at that before and, in fact, before voting on these measures, and whether or not these are – what the measure developers have proposed is sufficient.

Zehra Shahab: Thank you, (Nancy).

Operator, are there any other comments?

Operator: There are no further comments at this time.

Zehra Shahab: OK. Well, if there's no other comments, we can move onto the next step.

And, before I review some of the next steps, I wanted to echo Taroon's comments earlier. Thank you everyone for this rich discussion, and especially thank you for the developers for providing all their responses for the committee to review in advance and also for the committee members that provide this rich discussion for us.

OK. So, as we mentioned earlier, the developer – we have the committees to review the developer responses and vote via the SurveyMonkey and this will be due for the committee on Monday, September 21st. And once we get a chance to look at all the committee responses, then we will send next steps to both the committee members and the developers.

So that's for this webinar.

After this webinar, we will have the second and third webinars, which the measures are going to split up into two groups, but the topic of the call is going to be the same.

And during these two calls, the committee will review and discuss the empirical analysis of the risk adjustment approach specifically in terms of the validity criteria. And, they will also review and discuss the developer's decision to include or not include SDS adjustment in the measure based on the empirical analysis. And finally, they will either make a recommendation to either (conceive) endorsement or to remove endorsement of the measures on these two webinars.

And these two webinars are already scheduled. The second one is scheduled for March 8th from 2:00 to 4:00, and the third one is scheduled for May 13th, 12:00 to 2:00. So this is in 2016. So we have a few months for the developers to include their empirical analysis and provide it back to the committee.

And I also wanted to mention an additional resource that we are providing for the committee. We wanted to have a library/discussion board for committee

members in case they want to share articles with each other and any other information. And so you can just e-mail it to us, any of us on the project team or the readmission's project mailbox and we will add it to the committee SharePoint site so you can use these resources and read the articles.

So, those are the next steps. Do any of the committee members have any questions?

Female: What were the dates on those meetings again? I'm sorry.

Zehra Shahab: So, the dates are March 8th. We should have Outlook calendar invites, but I can also send them out afterwards. It's March 8th, 2016 from 2:00 to 4:00 and May 13th, 2016 from 12:00 to 2:00. And these are the time for (Eastern).

Female: Thank you.

Zehra Shahab: Are there any other questions?

OK, well, hearing none, we can finish out a few minutes early. Thank you everyone for your time again. And we really enjoyed the conversation.

Taroon, did you want to add anything, or Bruce?

Taroon Amir: No, thanks again and thanks for – thanks to Bruce for facilitating that conversation. Thank you all.

Female: Thank you.

Operator: Ladies and gentlemen, that does conclude today's conference call. You may now disconnect.

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