National Quality Forum

Moderator: Readmissions Standing Committee
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Operator: This is conference #: 60370416

Operator: Welcome, everyone. The webcast is about to begin. Please note, today's call is being recorded. Please standby.

Erin O'Rourke: Good afternoon, everyone. This is Erin O'Rourke, I am a Senior Director here at the National Quality Forum, supporting the work of the All-Cause Admissions and Readmissions Standing Committee.

Welcome to the All-Cause Admissions and Readmissions Standing Committee Measure Evaluation Web Meeting. First, thank you to all of our committee members, developers and members of the public for all of the time you spent up to this point on these two complex measures. We really appreciate your continued dedication to the NQF process and thank you for your time.

We do have a full agenda today and we did jot down a two-hour Web meeting rather than an all-day interesting meeting given that we only had the two measures. So, we have a lot to cover, you know, a limited amount of time, so we'd appreciate everyone keeping your comments focused and helping us to keep the conversation moving along.

Just a reminder that this call is, as all of our meetings are, open to the public. So if you're dialing in, please remember to mute your line and your computer speakers to help with the noise and the interference.

All of the committee materials are available via your SharePoint site. You can pull those down at any time if you need to. We'll also be screen sharing today, so if you're having any trouble connecting to the webinar, please let the project team know.

Next slide. So I'd like to begin by introducing the NQF team to you. As I said, I'm Erin O'Rourke, the Senior Director supporting the project. I'm joined by Donna Logan, our Project Manager, (Brenda Quiajar), our Project Analyst, and Taroon Amin, our Consultant.

So with that, I'd like to introduce the NQF leadership staff. I'm joined by Dr. Shantanu Agrawal, our new President and CEO, Dr. Helen Burstin, our Chief Scientific Officer, Marcia Wilson, our Senior Vice President, and Elisa Munthali, our Vice President.

So with that, I'd also like to introduce Cristie Travis and John Bulger, our Co-Chairs, to say a few welcoming remarks to everyone. Cristie?

Cristie Travis: Hi, this is Cristie Travis and thank you -- I want to thank all of you for your commitment to NQF and to the admissions and readmissions committee. We're very pleased to be able to look at these measures today. I know that you, all, have put quite a bit of homework into preparing your thoughts about how to move forward with these measures.

I do want to welcome two new members to our committee, Mat Reidhead and Susan Craft. We'll be hearing more from them as we go around and make our disclosures in a few minutes, but it's always nice to have some new participants in the committee as I have always found it, it really helps broaden and strengthen our consideration of the measures. So thank you, all, for making this commitment and agreeing to serve on the committee. And I'll turn it over to John.

John Bulger: Thanks, Cristie. And I'll just echo the thanks, as Cristie said, a lot of work goes into reviewing these measures. Those of you who have been following

along will get a little bit of background on some of the measures we reviewed the last time and how we got to where we are now.

But, you know, I think the committee should be commended as well, there was a lot of discussion at the other committees which this group reports to about the measures we went through the last time and I think a lot of public discussion in the space, so it's -- you know, the work that gets put into this and I think the depth of our deliberations I think has been very important to make that work going forward.

I'd like to welcome Mat and Susan as well and I'm going to turn it over to Shan Agrawal, the new President and CEO of the NQF who is going to make some introductory comments.

Shantanu Agrawal: Sure, thank you very much. First, I just want to thank John and Cristie for their leadership of this committee and for all the committee members including the new ones that are part of this work.

I am an E.R. doc by training, so definitely, the whole admission/readmission kind of picture resonates with me personally. And I know this committee has been very active for a while. I believe this is your third day now. This is clearly a really challenging issue but I think extremely critical certainly from a patient standpoint but also it's just a matter of a great national importance I believe right now. And we'll continue to be especially as we layer in other considerations like sociodemographic status and other aspects of the work.

I think we are very aligned at reducing unnecessary readmissions and admissions to begin with is extremely important, I am sure that is what keeps everybody coming back to this committee. And if you are keeping track at home, that was a slightly bad and weak pun about readmissions. I have more and I will try to make them better. Thank you.

Erin O'Rourke: Great. Thank you, Shantanu. And with that, I think we're going to turn it over to Marcia Wilson who will be taking you through your annual disclosure of interest process and committee introductions.

Marcia Wilson: Thank you so much, Erin. And those of you who have been on the committee for a while and for Mat and Susan, our new members, annually, we do disclosures of interest, verbal disclosures of interest here at National Quality Forum. And as Erin said, we're going to combine this with introductions and the disclosure of interest.

So, you should have received the disclosure of interest form when you were first named to the committee. We asked you a lot of questions in that form. But today, we're going to ask you to orally disclose any information that might be relevant to the subject matter before the committee.

So, when you do your introductions, we'll ask you for your name and your organization but you don't need to go over your whole resume. We're really interested in a disclosure of information directly relevant to the committee today, and that includes both funded work, it could be grants, research or consulting, but also any unpaid work, for example, you might sit on a board that's relevant.

Just a few reminders, that you sit on this group as an individual, you do not represent the interest of your employer or anyone who might have nominated you for this committee. And just because you disclosed doesn't mean you have a conflict of interest. We do this verbal disclosure of interest in the spirit of openness and transparency.

So I'm going to start with the two co-chairs and then just go through the list of committee members alphabetically by last name. So please, John, we'll start with you, if you could tell us your name, who you're with and if you have anything to disclose.

John Bulger: Hi, John Bulger. I am with Geisinger Health System in Danville, Pennsylvania. I'm a general internist, hospitalist and now, the Chief Medical Officer of Geisinger's health plan.

I do work as a consultant for the ABIM Foundation on the Choosing Wisely Campaign. I don't think it's anything directly involved with the work of this committee, but there are some -- certainly some tangential realities with that, and otherwise, I have nothing else to disclose.

Marcia Wilson: Cristie?

Cristie Travis: Hi, I'm Cristie Upshaw Travis. I'm the CEO of the Memphis Business Group on Health which works with employers on both the health and health care for their employees in the West Tennessee, North Mississippi and Eastern Arkansas area.

I am involved on several national boards. One of which is the National Quality Forum, so I do serve on the NQF Board of Directors, also on The Leapfrog Group and the NBCH which represents employer coalitions across the country. But I don't think that there are any particular issues relative to my service on those boards. So that's it.

Marcia Wilson: Thank you, Cristie. Katherine Auger?

Katherine Auger: Hi, I'm Kathy Auger, I am pediatric hospitalist at Cincinnati Children's Hospital and I will disclose that I have grant funding from (Pacori) to look at a randomized control trial of the effectiveness of a single home health care visit after routine pediatric discharge on readmission. And that's the only thing I have to disclose.

Marcia Wilson: Thank you. Frank Briggs?

Frank Briggs: Good afternoon. Frank Briggs, I'm a Chief Quality Officer of WVU Medicine in Morgantown, West Virginia. I also serve on the Board of Directors for a local HealthSouth Rehabilitation Hospital. Other than that, I have nothing to disclose.

Marcia Wilson: Thank you. Jo Ann Brooks?

Jo Ann Brooks: Hi, my name is Jo Ann Brooks, I'm the System Vice President for Safety and Quality at Indiana University Health based in Indianapolis, Indiana. I would just disclose that I am an unbranded speaker for Janssen Pharmaceuticals where I talk on CMS pay-for-performance and the three programs of which readmission is one of those.

Marcia Wilson: Thank you. And I believe that Mae Centeno will not be joining us today. So Helen Chen?

Helen Chen: Hello, I'm Helen Chen, I'm the Chief Medical Officer of Hebrew SeniorLife, which is an integrated senior care company that primarily focuses on post-acute care. I'm a geriatrician by training. Like John Bulger, I serve for the -- serve on the American Board of Internal Medicine but I don't think it's really relevant and I don't believe I have any relevant disclosures.

Marcia Wilson: Thank you. Susan Craft?

Susan Craft: Hi, this is Susan Craft, I'm the System Director for Care Coordination at the Henry Ford Health System. And I have nothing to disclose.

Marcia Wilson: Thank you. William Fields?

William Fields: This is Wes Fields. Nice to be back with you. My day job is Core Faculty in Emergency Medicine on behalf of the University of California Irvine. And I have no disclosures, no conflicts to disclose.

Marcia Wilson: Thank you. Steven Fishbane? Steven, are you with us and possibly on-mute? OK. Paula Minton-Foltz?

Paula Minton-Foltz: Hi, good morning. This is Paula Minton-Foltz, and I am an Administrator for Clinical Integration and Quality for UW Medicine. And I serve -- I'm a nurse by training and I do serve on the Washington State's Hospital Association value-based purchasing committee which includes readmission work. The efforts are to standardize (efforts) around Washington states and I do not feel it's a conflict.

Marcia Wilson: Thank you. Brian Foy?

Brian Foy: Hello, my name is Brian Foy, I'm a Vice President of Product Development with Q-Centrix. Q-Centrix is a firm that helps hospitals manage and submit quality data to third parties including CMS. I don't have anything to disclose.

Marcia Wilson: Thank you. Laurent Glance?

Laurent Glance: Hi, my name is Laurent Glance, I am a cardiac anesthesiologist and Vice-Chair for Research at the University of Rochester Department of Anesthesia. I have two disclosures. One of them is I am on the committee for performance and outcomes measures at the American Society of Anesthesiologists. The other is I am on several committees at the Anesthesia Quality Institute. None of these represent conflicts of interest however. Thank you.

Marcia Wilson: Thank you. And I think Steven Fishbane, have you joined us on the phone? Are you on-mute, Steve? OK, we'll keep moving forward. Anthony Grigonis?

Anthony Grigonis: Hi, this is Tony Grigonis, I am a Vice President for Quality and Healthcare Analytics at Select Medical which is basically long-term acute-care hospitalist and rehab hospitalist in post-acute care. And I have nothing to disclose.

Marcia Wilson: Thank you. Bruce Hall?

Bruce Hall: Hi, good morning. Bruce Hall, I am a Surgical Faculty for Washington University in Saint Louis. And I'm also Vice President and Chief Quality Officer for our hospital system, BJC Healthcare, 15 hospitals across this region.

I'm a Director for the American College of Surgeons. We've been a measure developer in the past. We don't have any conflicts of anything being discussed today. And I also serve NQF and CMS on the measures application partnership. I don't identify any conflicts in any of these items. Thank you.

Marcia Wilson: Thank you. Leslie Kelly Hall?

Leslie Kelly Hall: Hi, I'm Leslie Kelly Hall, and I'm with Healthwise and the Informed Medical Decision-Making Foundation. We're a 40-year-old nonprofit committed to helping people make better health decisions. And I do not have any conflicts.

Marcia Wilson: Thank you. Paul Heidenreich?

Paul Heidenreich: Hi, this is Paul Heidenreich, I am a cardiologist at Stanford University and the VA Palo Alto Health Care System. And I recently served as Chair of the American College of Cardiology and American Heart Association's Task Force on performance measures but we have not addressed readmission.

Marcia Wilson: Thank you. Karen Joynt?

Karen Joynt: Hi, everyone, this is Karen Joynt. Sorry, I did not get to see you, all, in person. I am a faculty at Harvard Medical School and Harvard School of Public Health and also Brigham and Women's Hospital.

Until about six months ago, I was on a two-year appointment with Health and Human Services which has since ended and I do continue to do some contract-based work with (Ashlie) at HSS.

Marcia Wilson: Thank you. Sherrie Kaplan?

Sherrie Kaplan: Hi, can you hear me?

Marcia Wilson: Sure can, Sherrie.

Sherrie Kaplan: OK. I am a -- I'm Sherrie Kaplan, I'm a psychometrician by training. I'm the Assistant Vice Chancellor for Healthcare Measurement and Evaluation in UC Irvine. I only see and interact with Wes Fields on these calls or in these meetings.

On the Technical Advisory Panel for a Physician Compare and actually served on another committee for NQF, the patient and family-centered care committee, but I don't see any conflicts.

Marcia Wilson: Thanks. Keith Lind?

Keith Lind: Good morning. Keith Lind, I'm a Senior Policy Advisor with AARP. I was on a CMS Technical Advisory Panel on hospital days away from acute care which I understand is a conflict with that measure, that particular measure, not the measures we're considering today.

Marcia Wilson: So you have no other disclosures, Keith?

Keith Lind: No other disclosures.

Marcia Wilson: Thank you. Paulette Niewczyk, and forgive me if I'm not -- I'm not pronouncing that correctly? Paulette, are you with us on the phone today?

Operator: We do not have Paulette.

Marcia Wilson: Thank you, operator. Carol Raphael?

Carol Raphael: This is Carol Raphael, I'm a Senior Advisor with Manatt Health Solutions, and before that was the CEO of the Visiting Nurse Service of New York. I'm chairing the Technical Expert Panel for CMS on measures with dual eligibles and from Medicaid long-term care health plans but I don't think there are any conflicts with the measures under consideration.

Marcia Wilson: Thank you, Carol. Mat Reidhead?

Mat Reidhead: Hi, this is Mat Reidhead, and thanks so much for the warm introduction…

(Off-Mic)

Mat Reidhead: With this committee. I'm Vice President of Research and Analytics at Missouri Hospital Association. As far as disclosures go, we have been fairly vocal proponents of the inclusion of social determinants and particularly the readmission reduction in program measures. I'm also the President of the board of a local critical access hospital which is unfortunately (shielded from HRRP), so no disclosures other than that.

Marcia Wilson: Thank you. Pamela Roberts?

Pamela Roberts: Hi, I'm the Director of Physical Medicine and Rehabilitation Academic and Physician Informatics for Cedars-Sinai Health System. I do serve on the post-acute care, long-term care taskforce for NQF as well as I have had a grant from the center from rehabilitation research using large datasets to study readmissions in stroke patients. And I have worked in the past in advisory (class right before that), but nothing that has -- with anything to current measures.

Marcia Wilson: Thank you. Derek Robinson. Derek, are you with us on the phone today? Thomas Smith?

Operator: We do not have Derek.

Marcia Wilson: Thank you, operator. Thomas Smith?

Thomas Smith: Hi, this is Tom Smith, hi, everybody. I am a psychiatrist and the Associate Medical Director for the New York State Office of Mental Health. And I'm also on the faculty of the Columbia University Department of Psychiatry.

I have two disclosures. One, I've been a member of the Physician Compare Technical Expert Panel for the past two years. And the other is that I'm a Principal Investigator on (an RO1) from the National Institute of Mental Health that's examining a Medicaid database, the statewide Medicaid database looking at discharge planning practices for inpatient behavioral health units and their impact on care transitions and readmissions, but I don't believe there's any conflicts there.

Marcia Wilson: Thank you so much. And let me just ask, is there anyone who did not provide a disclosure of interest who has now joined us? OK. Let me just say that thank you, all, for those -- the introductions and disclosures.

At any time during this webinar you think that you or someone else might have a conflict of interest, we would encourage you to speak up and you can do so either literally verbally or by typing a message in the chat box and notifying the NQF staff and we will be able to discuss that. What we don't want you to do is perceived that there is a conflict and not say anything. We do encourage you to speak up.

So based on the information that you heard today or what I said to you, do you have any questions for us? All right. Thank you very much. And I'm going to turn it back at this point in time to Erin.

Erin O'Rourke: OK, thank you, Marcia. So I am just going to quickly run through the admissions and readmissions portfolio of measures. As you know, in this

project, we will be evaluating two measures related to readmissions that can be used for accountability and public reporting.

However, we'd like you to also keep in mind the portfolio of measures that NQF currently has endorsed related to admissions and readmissions as a whole. We look through our standing committees to be the steward of their portfolio and to help us identify measurement gaps and provide feedback on how the portfolio should evolve over time.

So right now, we have about 48 endorsed measures that are related to admissions, readmissions or length of stay. I did want to note that some related measures with specific concerns have been evaluated by other relevant standing committees, for example, the perinatal committee review, the measure of NICU readmission.

The admissions and readmissions portfolio includes both all-cause and condition-specific measures. We also have measures addressing a wide variety of care sites including hospitals, inpatient rehabilitation facilities, children care hospitals, skilled nursing facilities and Accountable Care Organizations.

So in today's project, we'll be reviewing two measures. The first is Number 25-15. I did want to explain to the committee why you are looking at this measure today. This is a measure that you may remember reviewing in Phase 1 of this project in 2015 and it was endorsed with conditions.

When the committee reviewed the measure again, to see if there was a potential need for adjustment for (XCF) factors, the committee recommended the measure -- for endorsement without conditions.

The feedback agreed with this recommendation. However, the executive committee voted not to recommend or not to ratify the decision by the CSAC. The measure has not changed since the committee recommended for endorsement. However, given the results of the vote by the executive committee, we need the standing committee to review again and make a recommendation about endorsing it again.

The second measure addresses a 30-day unplanned readmissions for cancer patients. This was a measure that the committee reviewed during your meeting last year. There was a lot of support for it conceptually, however, the committee raised some concerns about the measure and ultimately, it did not pass the reliabilities of the criterion. However, the developers have addressed the committee's concerns and suggestions and has submitted an updated version for consideration.

So with that, I'm going to turn it over to Donna to run through the evaluation process that we will be using today.

Donna Logan: Thanks, Erin. So now, I'm going to do a quick overview of the evaluation process today. So, as Erin briefly described earlier, the standing committee's responsibilities, and overall, it includes knowing which measures are included in the portfolio, understanding their importance and considering issues of measure parsimony.

As standing committee members, we ask you to take ownership of this portfolio which means not only participating any evaluation today but also using your knowledge and work in the field to advance the portfolio.

So a brief overview of the measure discussion and the voting that's going to happen on the call today, we would like to thank the measure developers for participating in this meeting. We will be asking them to briefly introduce their measures as they come up for discussion.

During the measure evaluation today, committee members will often offer suggestions for improvement to the measures. These suggestions can be considered by the developer for future improvement, however, the committee is expected to evaluate and make recommendations on the measure as submitted.

Committee members act as a proxy for NQF membership, as such, this multi-stakeholder group brings various perspectives, values and priorities to the -- to the discussion.

Respect for differences of opinion and collegial interaction among all participants is expected on the call.

As I stated, we'll begin with the measure developers. They will do a brief introduction of their measure then we'll move to the lead discussants on each measure, the committee members, and they can talk about each criteria fully and then we will vote and then move on to the next criteria.

So this is a brief overview on the structure of the voting that's going to happen. The voting is by criterion in the order presented on the measure worksheet that you should have in your possession.

If you are missing any of the documents for the meeting today, you can find it in the Links section, it should be on the left side of your screen, and there's the agenda, the measure discussion scripts and both measure worksheets there as well.

If you have any questions at all during the meeting, please feel free to verbally ask any of the staff here or send us a message through the chat box and we're more than happy to address any questions that you might have.

So, for voting during today's meeting, we will be voting directly through this CommPartners site. Your voting will happen in real-time and you'll be able to vote right through the presentation today.

So I'm going to turn it over to (Shan Vitori) at CommPartners. She's just going to give you a little bit of an explanation of how that's going to go.

(Shan Vitori): Thank you so much. And if you'll notice, the slides does recommend that if you did not log in today using the personalized linkage you were sent that you would need to log out.

We've actually made allowances for you to be able to vote utilizing your current connections so there's no need for you to log out and log back in. You did receive a personalized link ahead of time and that sets up your voting right for you automatically. For those of you that just logged in to the meeting, a different way, we did make allowances for you.

When a voting slide appears, you will be able to click in the box next to the answers of your choice. Now, prior to the live voting slide, you will see a slide that will show you the options but the boxes will not be live on that slide.

Once the NQF team advances to the next slide, you'll have the option to click in the box next to the answer of your choice and it will register your vote for voting members only. We will be counting those votes and they will populate in real-time as you just heard a moment ago. Back to you.

Donna Logan: Thank you, (Shan). So then finally, to achieve consensus on the call today, we will need a quorum which is 66 percent of the committee which we currently have, and we will need you, all, to submit votes to make the decisions moving forward. If you're having -- as I said before, if you're having any trouble voting, please alert us as soon as possible so that we know that.

If the standing committee has not reached consensus on a vote of any of the must-pass criteria that we went over on the previous slide, we will continue to vote on the measure and then we will put the measure up for comment and then the committee will revisit that discussion at a later time.

If we are voting and the votes are below 40 percent then there is no further evaluation of that measure if it's on the must-pass criteria such as evidence or any of the scientific acceptability, and we'll be as clear about that as possible as we're going through.

So with that, I'll ask the committee if they have any questions about what I just talked about, and if not then we can move into the measure evaluation. OK, so then I'll…

Mat Reidhead: This is Mat. I guess just a little bit of context, you know, having not been involved last go-around, why was -- and briefly why was 25-15 not endorsed the last time and was there a reason why -- whatever, you know, concerns were brought up were not addressed but I hear that it was resubmitted as is?

Erin O'Rourke: Hi, Mat. So unfortunately, we didn't have a lot of context around the executive committee's vote for that. There was no discussion, it was rather just the vote was taken and we did not have enough to get us over the consensus threshold to maintain the endorsement of the measure.

John Bulger: So, Mat, yes, this is John Bulger, so I was on the phone for it. There was no discussion, and what essentially happened was, and I don't know remember the exact numbers of how many members of the executive committee were on the call, but one of the members in the executive committee voted against all of the measures.

And in this particular measure, one of the members of the executive committee recused themselves because they were related to the measure. And because of that, you ended up not having -- you didn't have a majority on this measure because one person recused themselves. There was no comment as to the -- specifically why this measure was any different than the other ones. The only difference in this measure was there was a recusal of one member of the executive committee which caused the vote to not move forward.

Mat Reidhead: Fair enough. Thanks, John. Thanks, Erin.

John Bulger: Yes.

Donna Logan: OK, then with that, does anyone else have any questions before we move on? OK, well, then Cristie, we're going to turn it over to you to facilitate the discussion for Measure 3188.

Cristie Travis: OK. Thank you very much. This is Measure 3188, 30-day unplanned readmissions for cancer patients. And I would like to see if the developers that are on the line, I think Tracy and Barb, if they would like to give us a brief overview, trying to keep it to, you know, under 5 minutes, and then we will begin our criteria by criteria discussion in both on this measure. So Tracy or Barb, with the Alliance of Dedicated Cancer Centers.

Barbara Jagels: Hi there. This is Barb Jagels. In my day job, I am Vice President of Quality Safety and Value at the Seattle Cancer Care Alliance. But I'm with you today representing the Alliance of Dedicated Cancer Centers and the quality

committee that has undertaken the substantial excursion into measure development. So I'll start with a brief overview this morning and ask Tracy to elaborate.

A few years ago, and I'd like to give a shout out to (Denise Moores) who's dialed in today, our 11 PPS-exempt cancer centers asked ourselves the question, if we could identify an opportunity to reduce the variation in the care that we deliver to cancer patients. Specifically toward reducing the consumption of acute care resources, how would we explore that opportunity and what would we do to address those concerns?

So at the time we were using UHC-based data, now known as Vizient, all 11 of our centers are now participating and submitting data to Vizient, and we identified that the all-cause readmission measure wasn't serving us well for cancer patients for the following reasons.

We intentionally readmit cancer patients to the hospital, this will be self-evident to most of you, for very appropriate reasons, think radiation, chemotherapy and the surgery. Instead, what we were finding is that we could actually use the claims-based data to sensitize our understanding to those clinical conditions which we think actually are foreseeable and avoidable, think clinical conditions such as chemotherapy-induced nausea and vomiting, neutropenic fever and pain.

Toward that end then we started the measure development excursion with consolidating our data, understanding the opportunities for improvement and actually putting our desired goals in writing.

So using this measure, we have successfully at five of our centers very effectively started to report internally and with one another the contributing factors to patients being readmitted to the hospital for what we believed are foreseeable and avoidable conditions and we're just beginning then to reduce those rates of readmission, happy to tell you that story another time.

The description of our measure is as follows. We're measuring patients admitted to an acute care hospital with a cancer diagnosis. The measure captures unplanned readmissions within 30 days of discharge.

Unplanned readmissions are defined as an admission that has an "urgent" or "emergency" type of admission on the claim. We exclude readmissions for patients who have a principal diagnosis of metastatic cancer as a proxy admission due to disease progression, that's important. We also exclude readmissions for patients who have a principal diagnosis of chemotherapy or radiation encounter which is often part of the treatment plan for some patients.

So, once again, we're a group of spirited, collaborative hospitals seeking to improve the care that we deliver to our patients. Toward that end, we brought a draft of this measure before you in June of 2016 and we appreciate the (TAP)'s input, our measure was not successfully endorsed at that time.

Please hear me say, we took your input to heart, we readjusted and revised our approach to the measure, we expanded the dataset which we are actually taking a look at the patterns of care that we're delivering to our patients and we've addressed we believe sufficiently the following concerns. We've definitely improved the transparency around where our patients are readmitted inside our hospitals and outside of our hospitals.

This is a source of great discussion last time. We were given the Vizient, the limitations of our Vizient datasets. We were only seeing readmissions to our in-depth hospitals. Subsequently, we've expanded our dataset and can now see readmissions to other hospitals in our regions as well.

Secondly, we're testing in a broader population generating national comparative rates.

Thirdly, we have adopted a more rigorous reliability testing with that much larger dataset, which, as you can imagine, was a rather significant undertaking.

Fourth, and I'm most proud of this because it's definitely I think we definitely started to gain substantially in this area, we've refined our risk adjustment within the larger dataset and we'll explain in more detail what that does for us.

And then thirdly, we are very proud of ourselves for continuing to sponsor this measure through the NQF endorsement process. One again, we could just use this claims-based measure to characterize and approve the quality within our centers but we're so proud of this work, we really believe the stamp of approval would be through NQF. So we're back for a second round.

Tracy, can you, please, walk us through more specifically the (TAP)'s concerns and how we've addressed them?

Tracy Spinks: Absolutely. And just real quickly, so my day job is working at MD Anderson. I'm the ?Program Director for Cancer Care Delivery where I'm focused on outcomes and alternative payment models. And then my other job is working with the ADCC as their program director for their quality committee. So you'll see a little bit of background there. So…

Cristie Travis: And Tracy?

Tracy Spinks: Yes.

Cristie Travis: Tracy, we have just a couple of minutes left, so just be sure that you have the opportunity to hit the most important pieces that you want to share with us.

Tracy Spinks: Absolutely, I'll be very brief. So Barb already talked to you about the changes that we made in the measure definition, so we feel like we do have greater transparency around where patients are being readmitted specifically to any acute care hospital.

Our testing in a broader population, we use the Medicare 100 percent standard analytic file for -- with 3-1/2 years of data. So fourth quarter 2012 through first quarter of 2016, we looked at over 3 million admissions during that time period for cancer patients.

This testing generated right for nearly 5,000 acute care hospitals. And also through our revised reliability testing, we used the standard approaches of tests in test/retest, and looked at a number of different statistics there.

We observed fair to strong reliability depending on the test in larger site size. We also noticed that the measure was pretty stable over time, and so that was important in looking at this larger dataset.

And then as Barb talked about our risk adjustment model, we certainly refined that. It's a logistic model, but it was applied to the larger dataset. We found that it was adequate. We gave a considerable consideration to inclusion of sociodemographic status within our risk model and we are utilizing dual eligible status for that purpose. So that -- those are really the high points that I wanted to hit.

Cristie Travis: OK. Well, thank you, and we appreciate that and thank you for highlighting the work that you had done since the last time we reviewed the measure and we appreciate all the work that you have put in to this revised measure.

I'm going to turn it over now to our lead discussants. We're going to start by looking at the first criteria which is importance to measure and report, and there are kind of two sub-criteria here, evidence and then gap in care or opportunity for improvement.

We will be voting on both of those sub-criteria. And I want to thank our lead discussant on this, Bruce Hall, Leslie Kelly Hall and Jo Ann Brooks. And I'm going to turn it over to the three of you, all, to talk about your thoughts relative to evidence first and then we'll move to improvement opportunity.

Jo Ann Brooks: This is Jo Ann Brooks, and I'll go ahead and get started. Regarding the evidence, there is evidence for this importance to measure, it's been supported through the literature and initial references have been added since the last -- when it came in to us as 3188 in '15. It reflects the very unique critical aspects of the cancer patients and there are numerous clinical actions that can be taken to impact this outcome measure. So using the first two criterion, I would say it's a pass.

Cristie Travis: Thank you. Bruce or Leslie?

Bruce Hall: I agree with Jo Ann. I think the evidence remained strong. And are we doing gap as well and disparity or just evidence first?

Cristie Travis: Just evidence first.

Bruce Hall: OK. I agree with Jo Ann.

Leslie Kelly Hall: And this is Leslie. I also agree. I do want to -- I did have some questions on the overall numerator and denominator, but I think we will get to that later I believe.

(Crosstalk)

Cristie Travis: Thank you.

Leslie Kelly Hall: Yes, thanks.

Sherrie Kaplan: This is Sherrie.

Cristie Travis: Are there any -- are they any comments or questions from the committee relative to evidence?

Sherrie Kaplan: It's not exactly with respect to evidence, but Donna asked me to -- this is Sherrie Kaplan, asked me to also participate in this. It was actually probably supposed to lead the discussion on it. But…

Cristie Travis: Oh, OK, thank you.

Sherrie Kaplan: No, no, no. I'm happy to not do that. It's just that in the -- this kind of definition, the exclusions in the denominator need to -- I need -- we -- I feel we need a little more clarification. So, if we're going to discuss that, that's great. If we're going to discuss it here then please let me know.

Bruce Hall: No, Sherrie, you're out of line. I'm censoring you. It's Bruce, your former co-chair. We're just on evidence and we'll get to the modeling and…

Sherrie Kaplan: Got it.

Bruce Hall: Yes.

Cristie Travis: Thank you, Bruce. I appreciate that. You're an old hand at this, so thank you. Any other comments or questions from the committee relative to evidence? OK, hearing none, I'm going to ask the staff, are we to vote at this point on evidence or when we'll we vote on that?

Donna Logan: Yes, we're going to go ahead and vote on evidence now.

Cristie Travis: OK.

Donna Logan: Give us just one second so I queue up your special voting slide.

Cristie Travis: OK, thank you.

Donna Logan: So moving forward, standing committee members will be able to view their selection options on the first of two identical slides. On the second slide, that members may make their selection to officially cast their votes.

For the -- for evaluation criterion, importance to measure and report, sub-criterion 1A evidence, if the rationale supports the relationship of the measured health outcome to at least one healthcare structure, process, intervention or service plus one pass, it's not reflect to do not pass. Standing committee members, please make your selection now.

Female: I'm sorry. Do we just type into our keyboard? How do -- how does this work?

Male: Yes.

Cristie Travis: OK, thank you.

Donna Logan: Oh, you should be able to…

(Crosstalk)

Donna Logan: Sorry, this is Donna at NQF. You should be able to just click directly on your screen. There is a little checkbox next to A and another checkbox next to B. Do you have that option?

Female: My -- you may just see but my webinar has like a PDF over the slide and it's definitely not -- it's in my browser, it's not on my desktop.

Male: But have you tried to refresh your session by pressing F5 on your keyboard or refresh on your browser line and see if it appears clearly to you then.

Female: Thank you.

Male: Excuse me. When I checked my selection, there is no Submit or a Proceed button. Is that OK, you get it just by the checkmark?

Female: That is correct, just simply click in the box and once the checkmark appears, you have registered your vote.

Male: Thank you.

Female: And thank you, refreshing words for me.

Female: Excellent. NQF team, we're 21 -- according to our numbers, we should have 23 voting members online?

John Bulger: Yes, this is John Bulger. I tried to refresh, I still don't have a voting…

(Crosstalk)

John Bulger: Go ahead.

(Off-Mic)

Cristie Travis: I can't get it either.

Donna Logan: OK, if you're comfortable, you could give us your vote verbally.

Cristie Travis: OK, I say pass.

Donna Logan: OK. John?

John Bulger: Yes, pass. And I have it now but -- so.

Donna Logan: OK, alrighty. Twenty three for pass, zero for do not pass.

Cristie Travis: OK, well, thank you, all. That was our first voting opportunity and hopefully, we've all figured out how to make it work on our end, and thank you for the guidance that we just received. We may need some more as we move along.

And the second sub-criterion under importance is performance gap. Here, what we're looking for is that the performance gap requirements include demonstrating quality problems that there is actually an opportunity for improvement.

So I'll turn it over to our lead discussants to kick off with some of their thoughts around performance gap.

Jo Ann Brooks: This is Jo Ann again, I'll lead off. The investigators looked at -- to look at the performance. They looked at 4,975 acute care hospitals and evaluated their potential performance gap.

They found that this was looked at over three years. And the mean readmission rate was 16.54 for the hospitals. The 25th percentile was 12.5, 50th percentile was 17.32, and the 75th percentile was 20.80, and these data represent a range of performance among the hospitals and there is an opportunity for improvement there.

They also -- oh, go ahead, oh. In evaluating disparities, they used dual eligibility and for the cancer rate patients, it was 22.49 percent as compared to others at 18.32 percent of all the other patients. Thus, there is a very strong and a high opportunity for improvement with this measure.

Cristie Travis: OK, thank you.

Bruce Hall: It's Bruce, and I agree. It's Bruce, I agree.

Leslie Kelly Hall: I agree. And this is Leslie, I also agree.

Sherrie Kaplan: This is Sherrie. There was a disparity by race. Blacks had a 4 percent to 5 percent higher readmission rate and it was subsequently excluded in the -- in

the risk adjustment, so I was just making a note here that there are some disparities, noted also a gap by race.

Cristie Travis: Thank you, Sherrie. OK.

Leslie Kelly Hall: This is Leslie. I just -- I just want to add to that a little bit, and that in the original discussions, we did talk a lot about local versus regional versus (distant) disease. And the group did review that but it was well-defined in the claims data, so they couldn't provide any sort of adjustment for that, but it was part of our original discussions.

Cristie Travis: Thank you, Leslie. Any comments or questions from the committee relative to opportunities for improvement?

Thomas Smith: Can somebody say more, a little bit more about the decision to adjust for dual eligibility but not to adjust for race given that there were similar disparities?

Bruce Hall: This is Bruce. So normally, we would do that back in -- under scientific acceptability. Right now, we're just asking whether there is a gap in performance.

Thomas Smith: It's clear.

Bruce Hall: I did not mean to (sculpt) your question in any way.

Cristie Travis: You know what, just be sure and re-ask it in a moment. OK, hearing no other comments or questions, I think we're ready to vote on the gap in care opportunity for improvement and disparity, sub-criterion 1B.

Donna Logan: Great. So the extent to what the data demonstrated considerable variation are overall less than optimal performance across providers and/or population group. Please make your selection -- or your selection options are as follows: one, high, two, moderate, three, low and four, insufficient. You may make your selection now.

So we have two missing votes. If you are having computer issues, would you mind casting your votes verbally? John, are you still having trouble casting your vote via the Web?

John Bulger: I refreshed and just put it in. You're not getting it?

Donna Logan: Let's see. We have two people who have not voted yet. We have 21 votes.

John Bulger: Because I did vote, but I assume I'm going to have to refresh every time I need to vote. It seems like that way.

Donna Logan: OK.

Female: Carol, did you cast your vote or would you mind telling us verbally?

John Bulger: I said high if mine is not on the vote but…

Donna Logan: OK.

(Off-Mic)

Female: OK, OK. So for 1B performance gap, 10 selected high, 11 selected moderate.

Donna Logan: Thank you. And now, we can move on to scientific acceptability.

Cristie Travis: OK. And this will be -- and Bruce, you can -- you can let me know if I'm correct here, but this will be our opportunity to look at the specifics relative to the measure itself. And we're going to be looking at scientific acceptability.

There are two sub-criterion and we will be voting on each one. One is reliability and the second one is validity. And under reliability, we will be looking at reliability testing, and obviously, under validity, we are also looking at validity testing.

So we're going to start with reliability and I will turn it over to our lead discussant to share with us their thoughts.

Bruce Hall: Jo Ann, do you want to jump in again and…

Jo Ann Brooks: Oh, OK, I'd be happy to.

Bruce Hall: All right. We'll build on you.

Jo Ann Brooks: OK. So starting -- with respect to this, it's an outcome measure using Medicare administrative claims. It's specified from the facilities level of analysis in the hospital setting.

The risk-adjustment model includes 11 risk-factors and 15 values and they used logistic regression to estimate the probability of an unplanned admission and the risk-adjusted rate is obviously observed over expected rate. All the specifications are clear as are the data elements. And the algorithm as a logic, the algorithm is clear and it's consistently implemented.

To test reliability, they were obtained from about 3,500 hospitals between that three-year period of 2013 through 2015. They used test/retest analysis. They used the intraclass correlation and the Spearman-Brown prophecy formula.

Reliability test for the three-year period produced an intraclass correlation of 0.570 for unadjusted and 0.482 for risk-adjusted values, and they noted that was fair reliability. And for the same period of time, the Spearman-Brown was 0.726 for unadjusted rates and 0.650 for the risk-adjusted. Both of these indicate a larger (text) size of P less than 0.001.

I didn't have any concerns regarding the specification, definitions or coding of this data and Vizient reliability was demonstrated.

Bruce Hall: This is Bruce, I'll just build on those remarks. I think the numerator importantly was specified using emergency, urgent codes and the patients classified as having progression of disease or planned admissions, as the developers mentioned earlier on, were excluded.

There were a number of seven total exclusions from the denominator and those are listed for everyone. And there are a couple that might warrant some additional thoughts such as the transfer patients, the missing data patients and the patients not admitted. So I'll invite committee colleagues to chime in on whether anyone else has concerns about those.

The numerator exclusions, as mentioned, are specified and as long as we have confidence in the planned/unplanned distinctions then -- and those feel appropriate and those feel like a major improvement to the prior version of the measure, it is a facility level specification as Jo Ann mentioned.

And the risk adjustment is done on a logistic regression fashion, so it's probably not the most advanced method available to us. It doesn't appear to cluster but it has been unused and the centers have found that the measure still works for them in practice in terms of reliability and validity, so I think that's worth considering.

The reliability numbers, I think it's important to remember that the numbers that the developers present are for three years of data, and so with the -- with the reliability being judged fair, it's important to note that there should be some caution against over generalization because it's certainly not known that everyone in the future would use three years of data in terms of assessing performance.

In fact, there are reasons to not use three years of data in terms of assessing performance. So I think that's an issue that raised some concern in my head, and if that's not clear, again, the measure is being derived with three years of data, are we only saying that we would use three years of data in assessment, if so, then that becomes a fairly slow-moving assessment vehicle.

In addition, the S.B. metric approached a good number or yielded a good number for three years but year by year, it fell down substantially and did not appear to perform too well in 2015, so again, it raises concerns about the metric if it were to be used in the future on less than three years of data. So with that -- with those additional comments on reliability, I will let additional colleagues to chime in.

Leslie Kelly Hall: This is Leslie, and I -- my -- I felt that the concerns that were mentioned in the earlier review were addressed largely in this new measure specifically in the reliability specification.

I would urge that the specifications that are -- that note the actual unplanned readmission to any short-term acute care hospital defined in the measure,

more clearly communicates that in the brief measure information worksheet, I felt that there were not -- was not clarity for that. It was just an advice around communication and definition of communication.

And then I did have concerns about the claims -- or the coding discrepancies given the range of hospitals like a critical access hospital all the way through to specialty, cancer specialty hospital, but it looked like these were largely addressed through having a minimum patient set of 50. So I think there would be an expertise around that given that volume and that we shouldn't see disparities in coding. So I thought that was largely addressed.

So those were my comments, more on the definition all along being consistent in the communication and the measure worksheet and in the specification, and other than that, thank you.

Cristie Travis: Sherrie, any thoughts?

Sherrie Kaplan: Yes, a few. One relates to what I was going after earlier which is some of the exclusions here -- the exclusions are written at the -- in the numerator about 20 percent of the data is lost.

And the question then is those are patients-level exclusions. They -- in the reliability testing, they are actually looking at hospitals with more than 50 readmissions per hospital, so -- or that's another thing I didn't get, 50 admissions or readmissions for hospitals.

So the question then is if these are patient-level exclusions, the question that I would have is what is that due to the hospital-level, are we pulling hospital, specific hospitals especially low volume hospitals out with those exclusions.

So that was question one, and it wasn't any -- and again, I, as Leslie did, would note that this is a substantial improvement in the -- in the data provided by the measure developer from the last admission.

So following on that then I would really like to have seen some sensitivity that the analysis for excluded data especially at the hospital level since that's the end of comparison.

Regarding reliability, what's really being done is split-half, not test/retest reliability because they're randomly sampling. And again, I got a little confused in the actual procedures being done, maybe the measure developer can clarify.

It said they went after 100 re-samples, and I wasn't sure how that was done, but they split the sample in half and then -- and random set of equal numbers of patients per hospital for hospital s with more than 50 admissions per hospital.

And they compared the intraclass correlation three consecutive years. That's not test/retest reliability. What test/retest reliability usually does is they look at the same subjects over a short period of time versus averaging these intraclass correlations over three consecutive years.

But it's not as relevant because that split-half reliability testing is a form of reliability testing and under NQF, it's currently sort of what their standards are. Some of those adjusted and unadjusted intraclass correlations are moderate so they're not real -- they're not a real homerun. And the Spearman-Brown values actually suggested that the full sample would have improved the reliability. So I'm less concerned than Bruce is, but something happened in 2015 that probably warrants additional scrutiny.

And then the question would be, are you actually making the case that if you average over a longer period of time, you get greater reliability or greater precision. And given that there was more within -- there are more patients, those are different patients, I would actually say that's pretty good, those reliability coefficients are not bad except in 2015.

Cristie Travis: Thank you, Sherrie. Do the developers want to try to address Sherrie's concern as briefly as possible?

Female: Sure, we'd be glad to. And I just wanted to clarify, there were a couple of questions that I think -- that Sherrie had specifically related to why -- and I want to make sure I understand this, why we establish a minimum case count

50, then also questions about what might have happened in 2015 that was a little bit different, is there anything that I'm missing there?

Sherrie Kaplan: What was the -- there was something about re-sampling of the whole bunch of -- it was the 100 patients re-sampling a bunch of different, was that a patient or hospital where you -- it looked like you went into do good strapping and tried to figure out where the threshold was that gave you the greatest precision and you arrived at 50, but I wasn't sure how that was done.

Cristie Travis: Sure, OK, thank you.

Female: So we wanted to include as many hospitals as possible in our reliability testing and yet, we know that smaller volume hospitals are going -- we're going to see I think greater sensitivity to outliers, one we're dealing with hospitals that have smaller volumes of claims and Susan White who's on the phone can certainly speak to this in greater regard.

So after we looked at different thresholds, we found that 50 seemed to be the right point at which we still are able to generate what we thought -- what we thought were fair to strong validities for reliability scores depending on the statistical test that we were using while maintaining as many of the claims and as many of the hospitals as possible in the dataset.

And we also looked at it for the three-year period in total but also independently for each calendar year, again, just to understand, you know, what the variation might be with the larger dataset obviously looking at the full three-year period. This measure is intended to be an annual measure.

So with that, I'll let Susan see if there's anything she wants to ask from a statistical perspective.

Susan White: Sure, I can. And we -- I totally agree that this is a split path methodology and I think that the Spearman-Brown prophecy formula really gives us a better read on the reliability.

Now, I can -- I can make some guesses as to what we think is happening in 2015. That is the beginning of ICD-10, obviously. And so we may have

some learning curve of hospitals for some of our inclusion/exclusion criteria for the numerator, you know, looking at whether it's disease progression or not.

As you know, the cancer portion of the codes, like most of the codes had a pretty robust revision. Now, we do have ICD-10 codes in our methodologies. But like any measure -- I think all of the measures are going to see some wiggling when that happens. So, that would be my guess, nonstatistical guess.

Was there also a question about why exclude from the numerator? Was that your question or was that a previous question?

(Miranda): Yes. I was just looking for -- if you're losing 20 percent of the data and you're doing patient level exclusions, what was happening with the hospitals? Did you drag hospitals out of the analysis differently as a function of patient level exclusions?

Susan White: No, mostly -- so the numerator exclusions are really the meat of the -- of the measure. So, we -- if we don't exclude planned readmissions for chemo and rad onc and disease progression and then -- and only include urgent/emergent, then it -- this pretty much looks like the same methodology as the all-cause readmission but only for cancer patients. So that numerator -- those numerator exclusions really do differentiate that.

And we did want to remove hospitals with a very small volume. Honestly, we don't think this measure is appropriate for every hospital in the country. We think it's appropriate for hospitals that treat a significant level of cancer patient, so we're not seeing noise. I don't know if that helps or hurts. I just…

Female: Yes. No, I was just asking whether excluding certain patients, are you excluding with those exclusions at the patient level, are you taking hospitals, especially low-volume hospitals or, you know, let more than 50 but, you know, smaller hospitals out of with those exclusions, are you taking hospitals out of the analysis, probably doesn't matter since you have, you know, 5,000 hospitals. But I was just curious if you've done any sensitivity or specificity analysis for your exclusions on…

Susan White: Yes. So we did -- we did sensitivity analysis around three cut points, 50, 75 and 100. But our exclusion is based on the denominator so I'm a little confused when you talk about numerator exclusion or denominator exclusion.

So, numerator exclusion is really critical to what we're trying to measure, right, unplanned readmissions after cancer treatment. The exclusion in the denominator are more, sort of, practical and, you know, missing data, that kind of thing. There weren't very many of those and we actually have an appendix to kind of outline those.

So, yes, hospitals would be excluded but I think there'd be -- the hospitals that we would like to be excluded from this measure where there, you know, giving us, you know, a 100 percent readmission rate and had two cases. I mean, that's just not something we want to measure, that sort of noise.

Cristie Travis: OK. Well, thank you -- thank you for that. I know -- we're going to go to the committee now. I know that Larry, I think, you got your hand raised. If you'd like to make a comment or ask a question.

Laurent Glance: Yes. So I had a comment with regards to the interclass correlation coefficient. I think part of the reason that we may be seeing a slightly smaller ICC that, I mean, we may be used to, so the fact that they're use hierarchal as opposed to hierarchal modeling. And so, what happens is with hierarchal modeling, with the use of shrinkage estimators, the lower volume hospitals got shrunk to the mean.

And so then, if you have a bunch of lower volume hospitals and you're comparing them in the different samples, they're going to look very similar and thereby yielding a higher interclass correlation coefficient.

So in part, this question about maybe slightly lower reliability than we're used to seeing, maybe a function of the approach to regression modeling that was used by the measure developers and just wanted to sort of throw that in as maybe an insight. Thanks.

Cristie Travis: Thanks, Larry. Wes, did you have a comment or a question?

William Fields: Yes. I've got -- I've got three things that relate to the specifications and the exclusion criteria and I'll try to go quickly to each of them and then I'm sure we'll have a broader discussion. I was probably most concerned by number seven under the exclusion criteria or the measures, the denominator, which is that we're only looking at admissions and patient status, just about all the common causes for patients to return in this category that were mentioned at the top of the discussion or things that are likely to flow through the emergency department and it's increasingly true that those wouldn't necessarily result in readmission to inpatient status.

So I just feel like that's in the -- that's a very narrow measure of quality in terms of utilization resources and the process focus of this. So I think as it's true with a lot of other measures we look at, in the future, at least, it would make sense to me that observation stays and even longer emergency department stays probably are worth counting.

To go back to the top, I'm kind of troubled by some of the exclusion criteria. The one about dropping patient improvement because of progression of disease, I think we all know that -- especially for neurological cancers and some of the hematologic cancers, they're not metastatic by nature. And so I'm confused because it seems like solid tumors and other categories that are more likely to be metastatic in terms of their behavior, I see a big difference between how you treat those by diagnostic categories and I'm troubled by that.

And then the last one I have for you is I'm a little bit bothered by the presumption that all scheduled care is high quality by definition. I'd like to know what the evidence is for that. I understand that there's protocols or especially for many of these high-volume categories that you see in tertiary and quaternary centers, so that's kind of not my criticism or concern. But I'm not clear about how you looked at claims data because I know that there's lots and lots, sort of, readmissions that are scheduled that aren't patient-centered or protocol-driven but they're about other timing issues with specialty providers and things like that.

So I'm just troubled by every readmission that's scheduled automatically being deemed to be of high quality and I'll leave it with those three.

Cristie Travis: OK. Thank you, Wes.

I'm going to go on and go to Katherine. I think you have your hand-raised and then maybe we'll be able to have -- and let's see who else might want to have some comments and then maybe we'll give the developers a brief opportunity to respond to some of what they've heard.

So, Katherine?

Katherine Auger: Great. Thanks, Cristie.

I have three questions, I think, somewhat a followup on the previous discussion. The first is the designation of emergent/urgent to identify unplanned readmissions. Conceptually, it seems really great. I guess, just trying to figure out how reliable and valid that is and wondered if it -- if it varied across institutions. And I saw in the measure developers language that I thought that they had done some medical review and different institutions to try to validate that but then and then this may have been my inability to find the proper document. But I could not find the appendix for this measure so it's possible that I just missed it and I apologize if that's the case. But, so, just trying to figure out -- how -- how reliable is that flag of emergency urgent when they did the medical record review.

And then, my two other questions, again, about this concept of progression of disease, I was wondering about how -- if they had done any medical record to say this really is using this metastatic codes or is it really good way of getting at that but I was also not sure conceptually that that would always capture it but then, again, I'm not an oncologist so I could be wrong on that as well.

And then my third question was how mortality plays into this and how 30-day mortality rates would be, perhaps, balanced with this because I noted that the patient population of 85 years and older actually have the lowest readmission rates which made me think that perhaps there's some out of hospital deaths that are occurring. And so, just trying to figure out how -- how do you balance 30-day mortality with 30-day readmission and conceptually, how would these potentially been used? Thank you.

Cristie Travis: OK. Just so that we kind of don't lose track of where some of the committee's comments have gone to date and giving the opportunity for the developers to respond, we'll ask the developers if you want to briefly add any additional information or try to address any of the concerns that have been raised so far.

Tracy Spinks: Sure. So, I'll jump in. This is Tracy. And then I'll ask Barb to jump in because I think there's a couple of areas where she can certainly ask some perspective. So, trying to go through quickly the questions or concerns that I heard.

One was whether we should expand the measure, not just look at inpatient admissions but to look at emergency visits and observations stays and I think that's something that we can certainly take back to our workgroup to see if there's opportunity to include that.

That feels like a substantively different measure but I agree those are important -- important outcomes of care as well as an important, just fast, sort of care, that we should looking at.

I wanted to address the question about using emergency -- the type of admission, urgent and emergency, to identify unplanned readmissions in this case and this is something that we talk a lot about because, again, looking at sort of the gold standard, the Yale measure, they felt that they are -- in their testing that they are approached -- this was not a good approach for cancer outside of surgical cancer admissions.

And so because of that, we felt like we had to look for a different approach which is why after working with -- talking with our workgroup and completing the literature, we felt like using that admission type was the best proxy we could find to identify unplanned readmissions.

Now, when we did manual chart review and sensitivity and specificity testing back in 2015, we found global scores of 0.879 sensitivity and 0.8976 specificity. So we felt like that was -- that generated good information.

We also found a study out of California from 2011 that found almost 95 percent agreement between type of admission and external validations. So because of that, we felt like this was a pretty -- a pretty -- we had a strong basis for using this as the -- to determine those unplanned readmissions. We discussed in our -- as we were revising our testing this year, we talked about, well, should we do additional chart review? But because we're now looking -- we're using such a broad dataset and we're not just looking at what happens at the exempt cancer centers, revisiting that would have -- well, it might have been enlightening. It wouldn't have gotten at the broader population, certainly, and since we don't comprise the majority of claims in the dataset.

So because of that, we felt that we would rely on the pieces of information we had to move forward with that. I think the point about mortality is important. We did find and looking at our denominator that about 6 percent of patients and the denominator were excluded because they expired during the index admission. And so, we also looked at patients, we look to see -- looks at some sort of proxy to try to see where we're losing patients due to mortality even in the readmitted population.

And so, I think we found that -- the data that we looked at, we found that we were able to retain a good proportion of the claim set and so we felt like we were -- we were going to move forward there but I think looking at the interplay between mortality and readmission is going to be important as we move forward.

And then the last question that I heard was around excluding readmissions for disease progression and I think Barb may be able to best address that question.

Barbara Jagels: Thank you, Tracy. So this is Barb again. I'll keep it pretty high level and very brief.

First of all, we were really interested in exploring the data related to foreseeable and avoidable readmission. So, not all cancer admissions necessarily are high quality but our goal was not to measure how many times patients are being admitted within that 30-day range for surgery or inpatient radiation, as you know, hyper fractionation is changing that dynamic rapidly.

Secondly, our patients are absolutely cycling through the ED and through obs admissions. We actually do measure those -- that care variation in our centers but, once again, that doesn't fit neatly within the confines of this particular measure which was cancer-specific readmissions related to these patterns of care we think are foreseeable and avoidable so that's why -- that would be a distinct set of work.

And then thirdly, patients who are metastatic necessarily create a risk adjustment opportunity that we believed offered additional validity. And to your point, heme malignancy patients aren't necessarily metastatic but they definitely emerge in our scrutiny of the data to show different patterns of variation that we can use that risk adjustment methodology to identify -- Susan are you there? Are you on mute?

Susan White: Yes. I'm sorry.

Barbara Jagels: Metastatic.

Susan White: Right. So we have a -- we have a risk adjuster for metastatic and solid tumor that we hope will, you know, obviously, the -- well, not obviously. In our Center, the James, we have a pretty good percentage of heme onc. And so, we were concerned about that adjustment also. And so, the solid -- we have a risk adjuster for solid tumor without mets and then a separate mets adjuster.

So we -- as opposed to including/excluding and the numerator rate, we hope to adjust for those or chose that path, I guess.

Cristie Travis: OK. Well, thank you for those clarifications and additional information. We're going to get ready to vote on reliability. But before we do, are there any other committee members that want to make a comment?

Frank Briggs: This is Frank. I had my hand raised but it was generally around…

Cristie Travis: I'm sorry, Frank.

Frank Briggs: Similar comments in the use of elective and urgent and not being well defined. We've done a lot of work across our hospital system and we find a lot of

variation there. It's generally coded or not coded but inserted into our record by registration clerks so it isn't to the same level as our coders. And if we have exclusion criteria included for planned readmission is that not sufficient to capture those patients. I think the res was asked previously.

Cristie Travis: OK. Do you -- do you need anything from the developers on that, Frank?

Frank Briggs: I don't think so. I think it's similar comments and theme with the urgent and emergent.

Cristie Travis: OK. Great. Thank you. Any other comments from committee members? OK. Well, we'll go and go to voting on reliability.

(Miranda): All right. For evaluation criterion, scientific accessibility of measure properties, subcriterion 2A, reliability, including 2A1, precise specifications, and 2A2, testing, your options are as follows, one, high; two, moderate; three, low; and four, insufficient. Standing committee members may now make their selection.

For 2A, reliability, 17 members selected moderate and five members selected low.

Cristie Travis: OK. It's time now to move to validity. And under validity, we will be looking at the specification, the validity testing, as well as threats to validity. And for those who had some questions about the risk adjustment, this would be the opportunity for us to be sure we understand the risk models and share any feedback or comments or concerns regarding that as well. So I will turn it over to our lead discussants to share with us their thoughts around validity.

Not sure who wants to go first. Someone want to give Jo Ann give a break and go first?

Sherrie Kaplan: This is Sherrie, I'll jump in. The equation actually between something that is all-cause readmissions at 1789 and this -- this measure, you'd expect some degree of overlap, you know, again you'd expect it to be quite deluded but the correlation coefficient, even though it's quite low, it's only about -- it's 0.328, 0.28. It's significant and I think substantial enough, with this so they actually

is good evidence to validity and then they did some sensitivity and specificity analysis that actually, we're very -- we're very reassuring as well. So I thought that that was adequate validity testing.

Cristie Travis: Thank you, Sherrie. Bruce or Jo Ann?

Jo Ann Brooks: I agree.

Cristie Travis: Or Leslie?

Bruce Hall: Yes. This is Bruce. I think the correlation between the two measures was not an issue because you don't want them to be perfectly correlated. You have redundancy somewhere. So I didn't quite understand the full impact of examining the inpatient admission type code. But apart from that, I was OK with the other statement about validity. As Larry said earlier, there's some -- there some expectations from the way they model this that would lead what they've given us to think about validity to be considered appropriate.

They did include dual status in the modeling. We can see that that had an impact. They did also include race in their initial investigation but they said that it was removed for fear of (medicine effects) and there wasn't a lot more discussion around that I could identify myself.

The risk death file plots that they provided actually showed pretty reasonably plots compared to most other measures we see, a little bit of overestimation high and low and the reverse in the middle and that's not unusual. So, I did not have any additional concerns about validity other than what's kind of already been described in terms of reliability and validity combined.

Leslie Kelly Hall: And this is Leslie. And I am -- my only concerns here were the or not concerns, I guess, compliment is the review and the consideration that was done and some of the risks that the group had identified early on. So I felt that the address to concerns that we had.

Sherrie Kaplan: This is Sherrie one more time on risk adjustment. I thought they actually did do a nice job of why they include variables including multiple, you know, one single comorbidities, admission via the emergency room and bone marrow

transplant to kind of avoid multicollinearity and the impacts that would have on the -- on the modeling process.

My question is, if (resection) was specified on page 43 as excluded because they didn't have a causal hypothesis and even though, you know, I'm not sure what the effect of things like including dual eligibility and race once one thing is in the model and might have resulted in insignificance but I wondered if they had actually tested rates in and out of the model and found anything or just excluded it because of this lack of conceptual or causal attribution.

Bruce Hall: Yes. It was stated also, Sherrie, as for your masking but that was the extent of the discussion.

Cristie Travis: Would the developers like to address the race issue and the rationale for your decision to exclude it?

Erin O'Rourke: Hi, Cristie. This is Erin and Helen at NQF. We just wanted to chime in a little bit about some guidance that we gave the developers. Really, what we've heard from our disparity standing committee is that we should be approached with extreme caution and perhaps include it if there's a strong reason to do so, obviously, don't use it as a proxy for income or SES, anything like that. Really, the disparities committee came down more around -- include if there's, perhaps, like a genetic basis but to really be cautious with including race.

Helen, did I miss anything there?

Cristie Travis: Thank you, Erin. That may really be sufficient.

OK. Any other comments from the committee around the validity? Any questions or comments?

William Fields: This is Wes. I've got one more thing here.

Cristie Travis: Yes?

William Fields: I'm sorry. I couldn't tell if I muted myself. It's a -- it's neither a numerator/denominator question. It's a little bit about what goes inside the

bracket in terms of which kind of claims gets studied. I'm looking at the risk adjustment summary and I just see that the -- one of the things which is more predictive in terms of point estimates is multiple comorbidities, the MCC effect, if you will, and I guess, one of the things which I would like to know more to know more about is the interaction between referral of Medicare beneficiaries to quaternary centers and the degree to which, you know, that affects some of the intensity of service.

Another way of saying that at the other end of the spectrum is that it's interesting to me that there was no attempt to look at age less than 65 as a predictor of risk adjustment and the reason I mentioned it is that it's -- it's highly likely to be treated, that, you know, the beneficiaries less than 65 are also likely to be (medi-medi) and there's lots of other data, some of which I've shared with you that suggest that cohort of beneficiaries that are less than 65 are, in fact, actually, you know, have higher MCC profiles, you know, higher levels of comorbidity and that -- that's actually the place you're most likely to see or one of the places you're most likely to see an FDS effect.

So, I'm just troubled by it and it's something which is not unique to this measure but I think it's part of our ongoing dialect about STS. So, two comments here. One about -- one about people are very fragile, very sick and patient selection at cancer centers about people that are either very old, very fragile or have lots of MCC and how appropriate some of the aggressive care is. And another that's less about age and fragility and more about (medi medi) status. So, my apologies but I never feel like we get this one right.

Susan White: This is Susan. May I -- may I get clarification. Sorry…

(Crosstalk)

Susan White: OK. So we didn't exclude less than 75 out of our -- or less than 65 out of our model and the logistic model, that's the reference age.

William Fields: OK.

Susan White: So all the other ages are sort of with respect to those. So you're correct. And then all of the other ages sort of has a protective factor when we compare them to people under 65.

So your hypothesis is exactly right. But we did include them in. So I just wanted to make that point, sorry, if it was out of turn.

(Crosstalk)

William Fields: …it's kind of thing which I've been reaching for as a nonexpert on the technical structure, some of the measures, is that I, you know, I guess a simple way for me to express this is that readmission is viewed as an outcome in this measure and I think for the population with cancer, obviously, there's really one outcome that matters. And so, I just -- I just feel like the -- especially, to the extent that this is an alliance that's taking care of the sickest folks in the system or in the population, I just -- I just feel like sometimes we focus on measures which may be very important in terms of say, payment rules in 2018 but which kind of missed the point of patient selection, patient referral and the degree to which patients and their families can actually, you know, figure out what the most appropriate care plan is.

Leslie Kelly Hall: This is Leslie. I just would like to build on that from a patient point of view and maybe not on this measure but subsequent measures that could follow this and that is unnecessary admissions, in general in cancer patient especially where there's a high degree of (pulse mults) against directives in place. I'd love that see that investigated in another measure.

Cristie Travis: Thank you all. I know that, Bruce, you're going to drop off in a moment. I didn't know if you had any additional comments or thoughts you'd like to leave with us before you drop off the call?

Bruce Hall: You may already be off or on mute. OK. Larry, I think you have your hand raised?

Laurent Glance: Yes. Thanks. I had a concern about the fact that the adjustment for comorbidities was essentially collapsed into one single indicator variable for whether or not a patient had multiple comorbidities or not. I think the gist of

risk adjustment is to adjustment four comorbidities. Most of the models that we have looked at have separate indicator variables for important comorbidities. I think reducing adjustment to comorbidities to just account of comorbidities is perhaps an oversimplification. This particular model is based on, I believe, the Elixhauser Comorbidity Algorithms and, again, this is just a count of the comorbidities, one or more.

And I don't think there's a lot of evidence to suggest that all of the comorbidities within that algorithm have equal impact on readmissions. So I kind of question the scientific validity of this particular model because of the way the adjust provider that they don't really adjust for comorbidities.

Cristie Travis: Would the developers like to address that?

Susan White: This is Susan White again. And on the status issue on our side so I can help with this a little bit. One of the issues that we had with the individual comorbidities is we had a -- we kept introducing a good bit of multicollinearity and part of that's due to our large sample size looking at the multiple years of data. You know, we're kind of overpowered and I agree that all comorbidities are not created equal. Going forward, I'm actually part of a group that's developing a score based on the Elixhauser comorbidities that is to be used for readmission adjustment. So we hope to be able to integrate that going forward but it wasn't available at this time.

Sherrie Kaplan: This is Sherrie. I agree with the developer, the multicollinearity, Larry, that we've been looking at with -- specially things like cardiovascular disease and diabetes and other things that are in single -- single comorbidities when you introduce them one at a time, really over specifies the models that we're looking at and I'm -- my concern would be that this is probably anything, if anything, it underrepresents the impact of multiple complex patients on a readmission rate. But at the same time, that multicollinearity accepting huge samples gets to be really problematic.

One thing I am concerned about was the hospitalization on page 46 of this material I was sent. Hospitalization in the prior 60 days, the readmission rate present gives at impact of about 26.2 percent versus readmission rate absent.

It's 10 percent lower. So, the readmission rate is 10 percent for folks who have been hospitalized in the prior 10 days that caused me to worry about who's getting left out of this analysis.

Can the developers comment a little bit on what the impact would be of -- or is there a concern there we should be worried about why those hospitals with more hospitalizations in the prior 60 days got affected?

Susan White: So they weren't -- they weren't excluded from the measure. It's sort of -- it's Susan again, sorry. It's sort of a proxy for frequent admitter. We call him frequent flyer, just not politically correct, so people who are admitted often to the hospital. So, it's meant to be a proxy for that. It doesn't cause any body to be excluded or included.

Sherrie Kaplan: So what is the -- what does that table represent? Present versus absent. So, it's readmission rate present and absent?

Susan White: Yes. So the rate is higher when they've had that indicator. So it takes -- you know, imagine setting up an indicator variable for -- did you have a readmission or a hospitalization prior six days -- 60 days prior to the index admission and it's a yes, no and then we say OK, let me take those guys and then say did you get another 30-day?

Sherrie Kaplan: Thanks for that.

Susan White: Sure.

Mat Reidhead: This is Mat. I'd like to build on that really quickly. I mean, if you think about it, including hospitalization, the prior 60 days for risk adjustment, for a covariant and that's a function of what you're trying to measure in a lot of cases, right? So it's, you know, it's -- it seems like that, you know, that can be mediated by hospital quality. So, I mean, isn't it a appropriate adjuster?

And then back to the numerator exclusions, you know, confused about why it's appropriate to exclude metastatic patients from the numerator and not the denominator, you know, particularly, you know, given my assumption that the distribution of metastatic patient isn't equal across hospitals. Isn't that going

to artificially influence, you know, hospitals that treat a lot of metastatic patients and give them better assessments?

Cristie Travis: Developers?

Tracy Spinks: Sure. I'll speak to that briefly and then see if Barb wants to address that.

So, anyone that's an expert in coding roles which I'm not, by the way, but I think I could probably speak to the difference here. What we're looking at is we didn't want to exclude patients with metastatic cancer from the measure itself but where patients have a principle guidance of metastatic disease on the readmission claim based on our expert input we felt was different and that we felt that in that case, that really meant the patient was being readmitted for progression of disease and not just happen to be a patient with metastatic disease that was being readmitted.

And so we are really trying to tease out those ones where -- was not due to quality of care but rather due to patients disease status. But Barb or Susan, would you add anything?

Barbara Jagles: I wouldn't add anything. This is Barb. Susan?

Susan White: I don't think so. I don't have anything to add.

Laurent Glance: This is Larry glance. I'm going to push back a little bit in terms of the comorbidities. I think it's -- certainly, some people do feel it's reasonable to use a single scaler measure of comorbidities like the Charlson Index when you have a relatively small patient sample. But in this case, where you have a really, really large patient sample, I think, virtually all measure developers and if you look back on other measures that we have looked at in this committee, we'll have a much more granular approach to coding for comorbidities.

And the real risk is not really multicollinearity or overfitting. You're not going to have problems with overfitting when you have such a large sample. The real problem is going to be omitted to variable bias. And I think a single -- a simple count of comorbidities is a very, very primitive way to adjust for

the comorbidity burden and I think really affects the scientific validity of this measure and of the risk adjustment process.

I think if you think back on maybe a slightly more concrete example, say that you were risk-adjusting for the risk of mortality after cardiac surgery, would you really just simply count the number of risk factors like ejection fraction, history of heart failure, diabetes, et cetera, and use that to adjust for case mix and severity of disease or would you instead quote for each one of those different risk factors separately? And I think you really got to think about that. Because at the heart of scientific validity is the risk adjustment and I think just saying whether or not you have one or more comorbidities, really does not adjust in any way for comorbidity burden. Thanks.

Cristie Travis: Thank you, Larry. OK. It's about time for us to vote on validity. One last call for any committee members that have any comments they'd like to make before we vote? OK.

(Miranda): Thank you, Cristie. For evaluation criterion scientific accessibility of measure properties, subcriterion 2B, validity, including 2B1, specifications consistent with evidence; 2B2, testing and threats addressed; 2B3, exclusion; 2B4, risk adjustment (gravitation); 2B5, meaningful differences; and 2B6, comparability, multiple specifications. Your options are as follows, one, high; two, moderate; three, low; and four, insufficient. Please make your selection now.

(Off-Mic)

Female: For 2B, validity, 10 standing committee members have selected moderate and 11 have selected low. So at this time, the measure does not pass validity which is a must passed criteria. So we will…

(Off-Mic)

Female: I'm so sorry. I'm so sorry. It is consensus not reached so it means we will continue voting and then we will discuss this on the post-comment call. This measure will still go out for comment and then we will be able to discuss the comments with the committee on the post-comment call and then you can

revisit these criteria and vote then. And at this time, we will move to feasibility. Sorry, about the confusion.

Cristie Travis: It's k. We got it -- we got it right. So that's important.

The next criterion is feasibility. And basically, this is the extent of which specification including the logic -- logic required data that are readily available or could be captured without undue burden and can be implemented for performance measurement. So with any of our lead discussants like to share with us their thoughts…

Jo Ann Brooks: Yes, this is…

Cristie Travis: …on feasibility.

Jo Ann Brooks: Yes. This is Jo Ann. I would say the feasibility is high as all data are available through the administrative claims.

Leslie Kelly Hall: This is Leslie. I agree.

Sherrie Kaplan: This is Sherrie. I agree.

Cristie Travis: Any comments or questions from the committee around feasibility? OK. I think we can go on and vote then on feasibility.

(Miranda): Thanks, Cristie. I'm pulling up the slides now. All right. For evaluation criterion feasibility, subcritera 3A, data generated during care; 3B, electronic sources; and 3C, data collection can be implemented. Your selection options are as follows, one, high; two, moderate; three, low; and four, insufficient. Please cast your votes now.

Nineteen standing members have selected high and two standing committee members have selected moderate for…

Cristie Travis: Great. Thank you.

Let's move on to criterion four which is usability and use. And here, we're looking at the extent of which the audiences, those who would be using this

information either use it already or could use the performance results for accountability and performance improvement activities. So any comments from our lead discussants?

Jo Ann Brooks: Well, this is Jo Ann -- go ahead.

Leslie Kelly Hall: Go ahead, Jo Ann.

Jo Ann Brooks: I was just going to say, it's presently used in both QI and accountability applications at several centers that are listed here. And also, it was noted that, let's see, this measure has been looked at in measures under consideration that would be in the 2015 data or the 2015 report, I would say, and it was a possibility that it'd be included in the future rulemaking as soon as FY 2018. So, overall, I'd say the usability is high. Its presently being used in both QI and accountability around the United States.

Leslie Kelly Hall: I agree. This is Leslie.

Sherrie Kaplan: This is Sherrie. I agree.

Cristie Travis: Any other comments or questions from the committee members around usability and use?

Mat Reidhead: Yes, this is Mat again. I'm sorry. So, in order for this to be usable in terms of, you know, for performers taking corrective action, it has to be specified properly and I don't think this was addressed in my -- the last time I commented on it. But including covariant which has the second largest effect in your model around, you know, a number of hospitalizations in the previous 60 days, I mean, in a lot of cases, those -- you know, I realized that the risk variable with that one is going to be a readmission that occurred earlier in the study period. So you're codifying for performance in some instances, I think.

Cristie Travis: Any comments from the developers around that question or comment?

Tracy Spinks: Well, I just wanted to clarify. So the risk factor hospitalization prior 60-days only applies to the index admission. So, so that's not capturing -- that's not

being counted both in the numerator and the denominator, if that helps. I hope I understood your question correctly.

Cristie Travis: Mat, does that help?

Mat Reidhead: No, I don't think so. So, OK, I guess the point is, you know, you've mentioned super utilizers, right? So super utilizers is a -- is an adverse health outcome that can be impacted by the quality of the healthcare system surrounding the individual. So, by risk adjusting four patients that are super utilizers and patients that have had, you know, have had poor outcomes in the previous 60 days of an index admission, you might be excusing a way for quality for the very hospital you're assessing, if that makes sense.

I'm sorry, I don't feel like I'm articulating it well. But, you know, typically with risk adjustment you should not control for factors that can be mediated by the inherent quality of the (input) that you're assessing, right? Does that make sense?

Tracy Spinks: I understand what you're saying. I've seen it used as a patient-level risk factor or identified as a patient-level risk factor in at least one study. And I know Susan's done a lot more work around this. Susan, do you want to speak how you're using it?

Susan White: Yes. I think we've implemented a very similar model here at the James Cancer Center and actually integrated it into Epic. So we're actually basing our discharge planning on it. And, actually, we have another an ED visit within the last 30 days. So, ours is slightly different than the one we've submitted. It seems to work really well for our patients and we've -- we have made a significant reduction in our readmission rate using it.

So, you know, I think what it is, really, is we're using it as a proxy for -- a lot of the risk adjusters, you know, are a proxy for severity of illness, obviously. And I see your point. The heard thing is, I don't have another good proxy for patients that just aren't doing well and there's nothing we could do about it. Very nonclinical explanation but…

Mat Reidhead: I appreciate it. Yes. I mean, in predictive applications, it's absolutely, you know, appropriate to use indicators (that have brought) utilization as, you know, as a predictor but I think in quality evaluations, I'm not so sure.

Female: Just a question from a -- for maybe Cristie or John. This issue that we're talking about, I think, is really important. Where does that go in our assessment of this? Is this in use or is it backend in validity or…

Cristie Travis: You know, this is just my thought on it probably under the validity issue. You know, that's part of where I would think about it. But I certainly am open, John, to your thoughts or to anybody from the staff in terms of where this particular issue rests.

Taroon Amin: Cristie, this is Taroon, and it's probably best in the validity section in our risk adjustment conversation as well. But the important points to take a note here in usability but really, they probably spent it mostly in validity.

Cristie Travis: Thank you, Taroon.

Sherrie Kaplan: This is Sherrie. Just with a followup on that. The likelihood is that some of those people hospitalized multiple times in the last 60 days are also going to have more comorbidities. So, you know, then the question is how you sort out the attribution. So, we're back to Larry and I agreeing to disagree on this issue.

Cristie Travis: Thank you, Sherrie. OK. Are we ready to vote on usability and use? I think so.

(Miranda): Because consensus was not reached for validity, this will be the last evaluation criterion we will vote on. This is usability and use, subcriteria 4A, accountability and transparency; 4B, improvement, progress demonstrated; 4C, benefits outweigh evidence of unintended negative consequences; 4D, setting up the measure by those measured and others.

Your selection options are as follows. One, high; two, moderate; three, low; four, insufficient information. You may now cast your votes.

For usability and use, 4 standing committee members selected high, 15 standing committee members selected moderate, and 3 members selected low.

Cristie Travis: OK. So are we now through with this measure for today? Did I understand that…

(Miranda): You are correct. We are through with this measure for today. So we could go ahead and turn to public and member comments.

Cristie Travis: OK.

Operator: At this time, if you'd like to make a comment, please press star then the number one on your telephone keypad. And there are no public comments at this time.

Female: And there are no public comments via the chat either.

(Miranda): So the next time the standing committee will convene will be for the post comments, follow-up call -- I'm sorry -- post meeting follow-up call next week on March 6th and we will discuss 2515 during that time. The public and member comment window will be open from April 5th to May 4th. The standing committee will convene again for a post comment call on May 16th. NQF members will then have a time to vote on the measures of (each day) between June 5th and 19th. The CSAC will meet in Washington, D.C., July 11th and 12th to ratify these measures and one month -- the one month appeal window will be open from July 14th to August 14th.

And finally, the final report will be published by September 26th. At which time, our projects will come to a close.

Donna Logan: So this is Donna. Real quick, just so as (Miranda) just said. On our post meeting follow-up call, so we're going to be discussing measure 2515, we do apologize for people on the phone that we weren't able to discuss it today. But we will be engaging in voting next week. And if you're unable to make that call, please e-mail the project staff at readmissions@qualityforum.org so that we are able to know if you're not able to attend.

Erin O'Rourke: Great. So I think -- this is Erin. I just want to thank everyone for your attendance and the great discussion today. John, Cristie, do you have any remarks before we close for the day?

John Bulger: Nope. Just thank the members for their diligence.

Cristie Travis: Yes. Same here. Thank you very much.

Erin O'Rourke: Good. And thank you to you both for you leadership and we'll talk to everyone again on March 6th and discuss 2515. Thanks, everyone.

John Bulger: Thank you.

Cristie Travis: Thank you.

John Bulger: Bye-bye.

Female: Bye.

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

END