National Quality Forum

Moderator: Readmissions Standing Committee
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Operator: This is Conference #: 84068328.

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'm the senior director supporting the All-Cause Admissions and Readmissions 2015 to – or 2015 to 217 project. I'd like to first welcome our standing committee members, our measure developers and the public for our second measure evaluation web meeting. Thank you so much for bearing with us today and your patience in joining us again.

We didn't get through everything we needed to cover last Monday. We greatly appreciate you joining us for the second measure that we need to review today. So with that, I'd like to welcome Cristie Travis, our committee co-chair. Cristie, can you have a few words for us?

Cristie Travis: Well, I just want to thank everybody for our call last week as well as coming back today for measure 2515 and I think we got the process down (pat) last time, so I hope everything will work smoothly. If not, be sure and speak up and let us know if you have any trouble, especially during the voting phase, so thank you for being us with us again today.

Erin O'Rourke: Thanks so much Cristie. So next slide, so again I think we're all familiar, to you by now, I'm Erin O'Rourke, senior director as I said. I'm joined by

(Donna Logan), our project manager; (Miranda Kuwahara), our project analyst; Taroon Amin, our consultant for the project. Also joined by the NQF quality measurement leaders and staff, Helen Burstin, our chief scientific officer; Marcia Wilson, our senior vice president and Elisa Munthali, our vice president.

Next slide. So with that, I just want to do a quick roll call, so we know who is on the phone, starting with John Bulger, our co-chair, John is not attending. Cristie Travis?

Cristie Travis: Here.

Erin O'Rourke: Katherine Auger?

Katherine Auger: Here.

Erin O'Rourke: Frank Briggs? Jo Ann Brooks?

Jo Ann Brooks: Here.

Erin O'Rourke: Mae Centeno? Helen Chen?

Helen Chen: Here.

Erin O'Rourke: (Susan Kraft)?

(Susan Kraft): Here.

Erin O'Rourke: Wes Fields?

William Wesley Fields: Here.

Erin O'Rourke: Steve Fishbane? Paula Minton Foltz?

Paula Minton Foltz: Here.

Erin O'Rourke: Brian Foy? Larry Glance?

Laurent Glance: Here.

Erin O'Rourke: Tony Grigonis?

Anthony Grigonis: Here.

Erin O'Rourke: Bruce Hall?

Bruce Hall: Here.

Erin O'Rourke: Leslie Kelly Hall?

Leslie Kelly Hall: Here.

Erin O'Rourke: Paul Heidenreich?

Paul Heidenreich: Here.

Erin O'Rourke: Karen Joynt?

Karen Joynt: Here.

Erin O'Rourke: Sherrie Kaplan?

Sherrie Kaplan: Here.

Erin O'Rourke: Keith Lind?

Keith Lind: Here.

Erin O'Rourke: Paulette Niewczyk? Carol Raphael?

Carol Raphael: Here.

Erin O'Rourke: (Matthew Readhead)?

(Matthew Readhead): I'm on.

Erin O'Rourke: Pam Roberts?

Pamela Roberts: Here.

Erin O'Rourke: Derek Robinson? Thomas Smith? And did I miss anyone or did anyone joined in since I called your name?

So moving on, we just want to briefly re-orient everyone to what we'll be doing today. As Cristie said, we're here to review measure 2515, hospital 30-day, all-cause, unplanned, risk-standardized readmission rate following coronary artery bypass graft surgery. So just to give the committee a little bit of background about why this measure is in front of you, this is a measure that the committee reviewed in phase one of this project back 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 SDS factors, the committee recommended the measure for endorsement without condition. The CSAC agreed with this recommendation; however, the executive committee voted not to ratify the decision by the CSAC.

The measure has not change since the committee recommend it for endorsement. However, given the results of the vote by the executive committee, we do need the committee to review this measure and make an endorsement of recommendation about endorsing it again of – so I think with that, I would like to turn it over to Donna, to just give you a quick refresh on the evaluation process we'll be using today.

(Donna Logan): Thank you Erin. Hi everyone, I just wanted to go over some information about discussing the measure today and the voting process. This is the same as we did last Monday but just to be clear with everyone about what we're going to be doing today, we'll start the discussion with the brief introduction by the developer.

And then the (lead) discussions for the measures will lead the committee inner discussion. They will provide a brief summary of the measure before moving into the individual criteria. We will vote on each criterion and then discuss the next. So for instance, we'll discuss importance measure report, vote on that before we move into performance gap and so on and so forth.

And we have the developers on the line today and they will be available to respond any questions that the committee has during their discussion. And as I said, we'll vote on each of the criteria which you can see on the next slide. If the measure falls into consensus not reach on any of the must pass criteria, we will continue voting on the measure and then we will revote on the consensus not reach criteria on the post comment call which is on May 16th.

If we fail on any of the must pass criteria, we will halt voting and the measure will not proceed from there. So today, you were sent a link from (com) partners that you could you have used to log in to the webinar today. If anyone is on the phone and not on the webinar, we do ask that you please join us on the web, so that you're able to vote on the call today. We actually do have exactly 18 people on the call which means that we have quorum for now.

But if any does have to drop off, please let us know at any point because that means we will lose quorum and we'll have to resume voting via a SurveyMonkey if we drop below 18 people participating today. So, the same as we did last …

(Multiple Speakers)

Bruce Hall: Hi, this is – hi, this is Bruce Hall, sorry interrupt, I did let you guys know by earlier message that I could only be present for about the first 30 minutes.

Erin O'Rourke: Right.

(Multiple Speakers)

Katherine Auger: Same for me, Kathy Auger.

Erin O'Rourke: Okay. And Wes Fields anything from you? I see your hand is up.

William Wesley Fields: Just a quick process (thing) for folks like Bruce. Based on the reason this came back to us from the board, is it not possible for us to uphold or affirm by acclamation our previous action on the measure rather than having to revote everything?

Erin O'Rourke: I'm sorry, Elisa and I are conferring on the – the process, I'll defer to her as our process expert.

Elisa Munthali: Yes, I think since it was so recent, that the measure was looked at even though that it wasn't recommended by the board, I think if there's agreement we'll just kind of get a feel from everyone on the call to see if there's a motion put forth to accept the previous evaluation, we could do that.

Male: I'll second that.

Katherine Auger: Kate will to.

Female: Yes.

Female: Any objections to that motion?

(Matthew Readhead): Yes, this is (Matt), you know, being a new member and not having been through the deliberation last time, I definitely had some questions and comments. I hate to – I hate to throw a monkey wrench into the mix but I would – I would – at least if we could, you know, have a little bit of Q&A prior to going with that motion, that would be great.

Elisa Munthali: Yes and I think (Matt), thank you for that, I think what we'll do is we'll key up at the end of the discussion ask, if anyone opposes or objects to us just carrying over the votes from the last time. If there's one objection, then we will go ahead and vote. Would that help?

(Matthew Readhead): I think so and it could unpopular on the – on the committee, I apologize to everybody.

(Multiple Speakers)

Elisa Munthali: No, that's totally fine.

(Matthew Readhead): It could be – it could be a – the extra burden.

Cristie Travis: This is Cristie, I guess it's a matter of trying to think through the format we're going to be using. You know, I guess to a certain extent, I heard a motion in a

second, I guess – are we going to have discussion in general or are we going to try to go through each of the criterion which, you know, then kind of – probably doesn't get us where Wes was trying to – to get us with – with the motion.

William Wesley Fields: I think it might be an order for any member to ask questions as a point of personal privilege, so that the Q&A could be discussion on the motion. I don't think there will be a lot from folks that were part of the original vote.

(Multiple Speakers)

Cristie Travis: Right.

William Wesley Fields: So you know unless there's a parliamentarian that disagrees, I think we could leave the motion open since there was no opposition (deal) with the Q&A. And then without objection, conclude the action and the – and the motion.

Cristie Travis: Thank you Wes. I guess that's what, you know, my thinking was very similar to that and I just look to NQF staff to let us know if that – if you all feel comfortable with moving forward that way as well.

Female: Yes, we're shaking our heads, thank you.

Cristie Travis: So – so, just to reiterate we have a motion that we accept our previous recommendations by acclamation. We have a second to that motion. Now it's time for discussion relative to the motion and we will take questions and comments during this time period relative to any aspect of the – of the measure, so that we will be able to move to vote on the motion that is before us with everybody feeling comfortable that they're ready to do so.

So do I hear any questions or comments from the committee?

(Matthew Readhead): Yes, this is (Matt) again, I might be only one – so first I try to move through these quickly before we lose quorum but first I was a bit confused on which measure with – the CABG measure for which cohort we're endorsing.

So is this the (HRP) measure? There was – there was a lot of mention of it, all-payer 18 and older cohort of Californians, so it seems like if we're endorsing both, you know, an individual process for each might be in order?

Erin O'Rourke: CMS (L), would you mind explaining to (Matt) the population …

(Multiple Speakers)

Karen Dorsey: Sure.

Erin O'Rourke: … for this measure?

Karen Dorsey: Sure, this is Karen Dorsey from the (L) CORE. So this measure was developed in – and tested in both of the populations that are listed in the endorsement forms in the Medicare fee-for-service 65-year and older population but also in a dataset that included all payer 18-year and older adults from California claims.

And both of those populations, the measure is currently only in public reporting for the 65-year and older Medicare fee-for-service population and included for that population only in the hospital IQR program and the hospital readmission reduction program. So to our knowledge the all payer version is not in – is not in public use.

(Matthew Readhead): Okay, so we're just focusing on the Medicare fee-for-service 65 and older. I mean I was curious I know you guys, you know, I know you guys scrutinized which risk adjusters to include with some – some, you know, elegant method. I was just curious if, you know, the clinical (caveats) that you include that were tuned on the Medicare 65 and older crowd, if those are, you know, extendable to the – to the all-payer cohort.

Karen Dorsey: Yes, I can say a word just briefly about our process when we – when we test the measure for the all payer cohort, we do that after we fully developed the measure for the 65-year and older Medicare fee-for-service cohort. We looked through the – the risk variables once again to – with clinical experts to think through whether we left something critical out or include something that shouldn't be included given the cohort change.

And in the instance of this measure, we did not make any changes to the risk variables that we had already selected and identified for the 65-year and older population but we did rerun the risk model, so that those risk variables have coefficients that are specific to the 18-year and older population. It was tested in the California database. So, those coefficients are allowed to vary and we test the model performance with the same methods that you see presented in the testing attachment here.

(Matthew Readhead): Next question is about the study period that you guys used. I know it seems that older data that, you know, don't subscribe to the typical 36 months study period that you use for HRP, you know, in the performance gap, you know, you worked for distribution. But in looking at the latest data on hospital compare from their download database site, which is about four-years newer, there's been a substantial reduction in variation. Just any comments on why the older data were used to justify this re-endorsement.

Karen Dorsey: Right. So, you're seeing all the materials from the original submission when we first developed the measure because the committee voted twice to endorse the measure and that vote was ratified by the (CSAC). We provided the same materials that we provided in that initial submission. We do have more recent information on the measure from the measurement periods from last year. And actually, I'm looking at the data from this year as we're speaking.

It's true that we've seen over the years a reduction in the readmission rate for this cohort as we've seen from many of the cohorts for the other readmission measures. And despite a site, you know, change and the variation among measured entities, we still see about the same magnitude in the inter-quartile range in this most recent reporting period as we did in the earliest years where we used the three-year measurement period.

(Matthew Readhead): OK. Thanks. I got just a process comment for NQS staff. I mean it seems as if, you know, one of the main criteria for justification of re-endorsement is the remaining performance gap, you know, theoretically that performance gap could evaporate over time and there wouldn't be a need, you know, per se to continue to monitor and follow beyond some of these fronts.

It seems like, you know, a requisite should be using the most recent data available.

(Multiple Speakers)

(Sue Krafton): Sorry. This is (Sue Krafton).

Paul Heidenreich: Paul Heidenreich. I'd also say that just because there's -- as one of the re-interviewers, just because there's a variation it doesn't mean there's a performance gap. I know there are some people that argue that readmission rates would be 2 percent or less and I'm not sure I agree with that, but -- because if there's a variation among hospitals it doesn't mean they've all gotten improved.

(Sue Krafton): And this is (Sue Krafton). As a new member as well, I would just echo the comments of Matt regarding the data and the time led.

Erin O'Rourke: Hi. This is (Erin) from NQS. And (Helen) and (Alyssa), please jump in if there's anything to add. I think Matt raises a great point and we do normally ask for updated data when developers bring their measures in for their about every three-year maintenance review. This is a little outside the norm since we did not have the votes to maintain endorsement at the executive committee after the review for -- after it was endorsed with conditions and we did the additional work to review it for SPS …

(Multiple Speakers)

Karen Dorsey: So, Erin, also I just -- I just want to point -- this is Karen Dorsey again from (Yale). This is the initial endorsement of the measure and will be -- submit for initial measure endorsement. We submit the development data. When we bring measures back that have already been endorsed for endorsement maintenance, we bring back the most up-to-date performance data. So, that's the difference here. It's just that this initial endorsement process has taken two years and -- so your -- that's what -- you know, that's the unusual feeling of seeing the older data.

Erin O'Rourke: (Thanks, Karen).

Karen Dorsey: Yes.

Erin O'Rourke: This is a little outside our norm here with this process.

(Helen): Right. And (Erin), this is (Helen). I just want to say I completely agree. I think this is an unusual circumstance. And you may want to remind the committee when the measure will be up for full maintenance review when we would expect to see the updated performance data.

Erin O'Rourke: Also, I think we'll be conferring with (Alyssa) and the maintenance team. We can follow up with the committee.

(Helen): Yes.

Karen Dorsey: OK. Great.

Male: Sue, thanks for entertaining the comment. And then, you know, if I only -- I mean just some overall comments on the treatment of, you know, the interaction with CABG and readmissions and (STS), so -- I mean overall I'm pretty sure (race) is a questionable construct of (Italy's) from socioeconomic status that can actually be confounding.

At one point, you mentioned that, you know, the measurement of dual eligibility is without variants from state to state, but that's absolutely not the case, you know, risk adjustor rates of the percentage of population 65 and older that are -- that are dual eligible ranges from, you know, 5 to 26 percent after control and from factors that you would expect to drive that. So, there's the thought about -- of variation there.

You know, I'm encouraged by the inclusion of the area level deprivation and that's fantastic. However, you know, I noticed that in certain measures you have tested those relationships down to the block level. And you know, as you know, the zip codes (were) extremely large and subject to ecological (fallacy).

Also, I assumed linearity there in other work like of (Amy Kind) and (Steven Jenks). They've noticed that the effects really manifest towards the (tails) of

the distribution. So, I'm just wondering if you guys tested (DFM), you know, and (debt files) or some other categorical comparison to look at what's going on, you know, (advent of tails). I noticed that the (debt file) tables were included for (race) and for dual eligibility but not for the -- for ADI that you used from HRQ.

Male: (I'm asking myself) 516, 652, 5113?

Female: So, I'm not sure if there was a question embedded in that for me, but I'll say that the -- there was some discrepancy between some of the measures in terms of the level that we use the, as you call it, the deprivation index or the arc SCS index score, and that again was sort of a process issue of going through the SCS trial. So, the trial sort of -- we had to develop a code to be able to map the (application) survey data down the census block group that we did that process of developing that code and then applying it to the measures happened in real time while the SCS trial was going on.

So, for those people who were on the committee last year right at the in-person meeting, they saw the level -- the census block group level analysis for several measures but not all. And based on the, you know, sort of the consistent direction and implication of that evidence, you know, voted on all of the measures.

So, I think that was a little bit of our process issue of just how the trial rolled out, and yes, take your suggestions about looking at (tails) seriously. I will just reiterate for the committee that, again, when we add SCS variables into the risk model with the other comorbidities. We greatly mitigate the independent association between the SCS variables and the readmission outcomes. That remaining association is -- it is still there but the impact of it when we include those variables in the risk model is incredibly small in terms of the change at the hospital level and (RSRR).

And then the decomposition analysis showed that for these SCS variables in particular, there's a dominant hospital level effect suggesting that there's more of an issue of patients clustering in low quality hospitals as compared to the patient level effect. So, it was really on the basis of the totality of that. I think

that we brought it back to without adjustment in it. The committee had voted to endorse.

And I'll just say again for the new members of the committee that didn't hear this whole conversation last year that we do not include race as a proxy for SCS. We in no way mean for it to be considered a proxy for SCS and our analysis. We included it because we think it's a useful comparator since some of the mechanisms by which SCS is related to quality also true of the relationship between race and quality. And so, it serves as a useful comparator. We try to understand the directions and mechanisms behind some of the relationship.

(Wesley Fields): Now, this is (Wes), and I'm kind of getting in my own way here in terms of trying to be helpful with the process in our timeframe, but I really think your question is good -- very good, but it's kind of a separate thread that we won't be able to resolve today. But my thesis is that a lot of the variation you've believed to be there between states is not as obvious in the data because they cut off the (medi-medis) at age 65 even though more than 20 percent of new Medicare beneficiaries are less than 65 and have permanent disability.

And I think the other component that's very dynamic these days is that you still have enough variation between states about Medicaid status for below income adults that I think it's another confounder. So, you know, we all had been delving deeply into this. We all care about it deeply on behalf of our patients and our hospitals, but I actually think this, especially since this an older measure, reflects, you know, our best efforts and our highest levels of agreement at the time.

Male: Sure. That makes sense. (Thanks a lot).

Female: OK. Matt, thank you for your questions. We really do appreciate it and wanted to be sure that we had an opportunity to review them. I haven't heard anybody else chime in and I know we're getting close to the time when we're going to lose our quorum. But if there's anybody who wants to say something before we move to a vote?

OK. I'm going to turn it over to NQS staff to tell us what the way for us to vote on this current motion, which is to reaffirm our original recommendation by acclimation.

Erin O'Rourke: OK. So, we were just conferring about how we want to do that. Perhaps, we should go through criteria by criteria so we can get a vote on the record. But rather than asking you to vote, again, for each criterion we'll put it in the terms of Wes' proposal to accept the committee's previous recommendations for that criterion.

Female: OK.

Erin O'Rourke: So, maybe -- does anyone on the committee to just doing a vocal vote and if you have an objection to say it?

Female: No.

Female: No.

Erin O'Rourke: That might be easier than going through the slide because they won't match up to what does the new proposition to the committee would be.

Female: OK. So, Erin, the effect of that would be silence is acclimation and only folks that need to speak up would be those opposed. Is that your intent?

Erin O'Rourke: That was my intent. If you are -- if you have -- if you are opposed to the (report) with the previous recommendation, voice your concerns.

Female: OK.

(Matthew Readhead): Sorry. This is Matt again. I'm with the information that I have -- and the concerns that I have I can't endorse. I'm a nay.

Erin O'Rourke: OK. So, given Matt's concern, why don't we just go back to our standard process and we'll go through each criterion. Christie, do you want us to turn this to the (yellow) core team to see if they have any opening remarks and definitely how we would get started?

Christie Travis: Yes, that would be fine. Thank you.

Erin O'Rourke: Karen, was there anything else you and your team wanted to say to introduce the measure?

(Multiple Speakers)

Female: And if we could just -- I apologize -- if we can just remind those folks that are joining by phone to keep their computer speakers turned all the way down so we don't have feedback and echo. That would be lovely.

Karen Dorsey: I think -- I don't want to take a lot of time going through the measure that folks already know and understand pretty well. I'll just way that the one issue that we saw raised in the committee comments most consistently was about the ICC test values and just to make sure that everybody is aware that we provided additional materials because the way that we did this tests did not apply to Spearman Brown prophecy formula which is just for the load case volume in the split sample versus the entire measurement sample. So, we provided that to you and the ICC when we used the prophecy formula does correct up to 0.5 which is by the convention that we provided in a moderate range.

So, I just wanted to make sure that everybody's attention has been drawn to that, and I'll just stop there.

Cristie Travis: OK. Thank you for that. So, I just want to be sure, Erin, that I'm doing what, what I need to do understand in this and we're now going to go through each of the criterion like we did on the first call last week. We'll hear from our lead discussant and then we'll have committee discussion and comments and then we'll vote on each of the criterion. Is that correct?

Erin O'Rourke: That's correct and we'll use the – as long as we maintain quorum, we'll use the web platform votes with the question that you'll see in front of you rather than the voice objection and if we will require, we're going to (jump) to a survey that we'll send out immediately after the call.

Cristie Travis: OK. So, the first criterion is evident and I'll ask Paul and sorry, yes, I had already kind of switched up. I'll ask Paul and Karen just the – if they have any opening comments they'd like to make about evidence.

Paul Heidenreich: (Now), I'll go first then as the outcome measure, I think all that's required is they rushed now and it could improve readmission – that measuring this could improve readmission. I know the last time the group thought there was potential rationale. I don't we actually have significant evidence on (CABG) directly, but it definitely passes the criteria for a rationale.

Cristie Travis: Karen?

Karen Dorsey: I agree. I found this whole process a little odd given that we were reviewing old evidence and I know we've discussed right out was the case. One – there's certainly have been publications since this measure was initially submitted examining things like the relationship between quality improvement readmission incentive that was brought up but I think given the criteria of the test to be that there is a rationale. I think that -- even with no additional evidence still passes this criterion.

Cristie Travis: Thank you, Karen. Any comments from the committee about evidence? OK. Will we be voting now on evidence?

(Miranda Kuwahara): Yes, yes, we will. This is (Miranda) …

Cristie Travis: OK.

(Miranda Kuwahara): … from NQF. (Good – pleasure) to everyone, standing committee members will be able to view their selection options on the first of two items on (that) slide. On the second slide, members may make their selection directly on the slide to officially tap their vote. So, for evaluation criterion, important to measuring reports sub-criterion 1a evidence. Your options:

One pass, two do not pass.

We have major selection now.

We do still have 18 on the webinar. I believe and only 16 have voted. If you have not yet made your selection, please do so now.

Is anyone having difficulty voting? I think we …

(Multiple Speakers)

Cristie Travis: We could potentially have a member that was logged in that is – has left and maybe not shut their web down.

(Miranda Kuwahara): OK. We also just got a message from the operator that we now only have 17. So, I think what we're going to do is just – we'll do the survey. So, Cristie, as we continue to go forward, we'll just (so hear you) and then the committee will have the opportunity to vote via survey after the call today.

Cristie Travis: OK. That sounds good. All right. So, we will now move to performance gap and Paul and Karen, any comments that you'd like to start our discussion up with on performance gap.

Paul Heidenreich: I'm Paul. I'll just say, the original data provided that show about 1-1/2 percent readmission rate difference in the interquartile range and even if that did having your own substantially, and I think one could argue that it's still should be lowered. So, I would say that there still is a performance gap based on that data.

Cristie Travis: Karen?

Karen Dorsey: I agree.

Cristie Travis: Are there any comments or questions from the committee members about performance gap?

OK. We will now move to criteria two which Scientific Acceptability of Measure Properties and -- focuses on the liability. We're looking at the reliability specifications and testing as part of the reliability consideration. So, Paul or Karen, any comments to kick off the discussion of reliability?

Paul Heidenreich: I'll just briefly say that you'd measured both of the variable and score level. For variable, they looked at the frequency then odds, ratios and saw that they have a relatively stable over time for individual variables and then they did a test-retest reliability for the overall score which a predictive readmission rate divided by the expected readmission rate and got a value 0.331 which some might say it is low. They called it moderate reliability.

I think (inside of rates) are the questions to me about, you know, it's reliable for what. It's telling that that very reliable for showing stability and scores over time that you could say, "Well, maybe readmission rate does vary," and so we're just picking up that change over time, but I think my conclusion would be that that to have the acceptable reliability.

Cristie Travis: Karen?

Karen Dorsey: I agree. I mean, I think I've brought up a few concerns about the exclusion of the under 65 CMS population and sort of a general question for measures. I understand that group may be different but across many measures they are systematically not included and so I routinely bring that up as a question for why those decisions are made but I agree with Paul that certainly given both this reliability and then the updated though I will not pretend to understand the additional adjustment made to the new reliability testing, I think given sample size limitations. This is it -- is a reasonable place to be.

Cristie Travis: And thus the developer wants to just take a moment since - it is where the new information you shared with us kind set. Would you like to just kind of once again, kind of remind the committee of the additional information you provided us about reliability?

Karen Dorsey: This is Karen Dorsey, again, and I have one of the analysts from our team, (Jack Herren) who's on the line. I don't know of he has an unmuted line or not.

(Jack Herren): I don't know. Can you hear me?

Karen Dorsey: Yes. I can hear you, (Jack).

Cristie Travis: Yes.

(Jack Herren): OK.

Cristie Travis: Yes.

(Jack Herren): Yes. When we do the split sample with calculation or the test-retest reliability calculation, we used half of the patients from each hospital to make a measurement and then another -- the other half and then we compare the results. Because we do that, we're reducing the sample size substantially, you know, by half and so the reliability calculation we got this based upon half the patient.

So, what – as Karen mentioned ealier, what we typically do for our measures then but we had not done previously for this one is to apply a formula, it's called the called the Spearman Prophecy formula which is a way of correcting for (financially) -- or predicting what (reliability) going to be – would be for a larger number of measured patients – measured about this patient, so. So, we applied this formula the ICC increase from, you know, 2.3 to 2.5 which would be the number we usually report for our measures.

Cristie Travis: OK. Thank you for that. Sherrie, and so you have you written copy?

(Multiple Speakers)

Sherrie Kaplan. Yes. It – technically, what's being done here is split half reliability and when you do that is -- which is just said, you reduce the sample size and you increase within hospital variability. So, that's exactly what you would expect, and when you -- when you get that kind of agreement between two halves of a whole there, it's a – that's pretty – that's really considered moderate reliability.

So, just to endorse what (Yale team) actually did, it is really split half reliability and they got the ding that you would expect to get when they would have included the whole sample. It would have been moderate reliability. What you really ultimately want to see is between hospital variations. So, you'd want this ICC that isn't what – NQF request at the time, but you'd want

to see between visits within hospital variations. But just to reiterate that, you know, (Yale team) did was what you'd expect to see in split half reliability.

Cristie Travis: Thank you, Sherrie. Any other comments or questions from the committee members about reliability?

(Helen): Cristie, just one comment. This is (Helen) from the committee but I just want to return to (Karen Joynt's) comment because I think it's a really important one. I don't want to lose. For a long time, we were asking that CMS in fact test the measures for the (full) population not just for that 65 and up populations so that may just be something -- I just want the committee to realize that we did hear that and we'll go back and make sure that that's something we can work with CMS ongoing forward, again.

Cristie Travis: Thank you, (Helen).

Karen Dorsey: This is – this is Karen Dorsey from Yale. I just – I also want to say, you know, this is one of the reasons that we do the California all payer data testing so that we can give the committee – and NQF some information about how the measure performs in a broader population of adult patient.

Cristie Travis: Great. Thank you.

Karen Dorsey: I think that was – that that was included. Great.

Cristie Travis: OK. Any other final comments or questions around reliability? They will now move to validity which deals both with the specifications and the testing -- validity testing and threats to validity as well and includes the risk adjustment. Paul and Karen, any opening comments?

Paul Heidenreich: This is Paul. (Bill) first thing, they started to agree with some (phased) validity for we're using a technical expert panel of all National Experts and other stakeholder organizations and I think we had about 71 percent agree overall measure that the measure was useful and worthwhile.

In terms of the risk adjustment, they've done a claim's risk adjustment versus registry which had a lot more clinical data, overall limit that can first thing

829 hospitals, and I had relatively few differences between those. I think they said about 8 percent hospitals had a change of 1 percent -- greater than 1 percent in their risk-adjusted readmission rate. And the overall statistics for was about 0.62, which as well we often see for readmission models and the calibration overall was good.

And then they also – this is then they also were able to test it in a – in the population (ATN) and not using California data again had a statistic model of 0.66 and then as was mentioned before including or excluding aids interaction had very little from the model.

They also give their data on including or not including race issue – race or socio-economic status and I think primarily for a philosophical reason to say that in the end decided not to include those to avoid, you know, covering up potential disparities and processes of care. So, overall, I'd say nothing – it pass – would pass for validity.

Cristie Travis: Thank you, Paul. (Karen), any thoughts – additional thoughts?

(Karen Joynt): Yes, you know, I think validity is a bit of a tough construct because there's not exactly, you know, what are we judging against to say to what degree does this represent a failure of the hospital versus, you know, patient characteristics or unmeasured things that went together in hospitals about patient.

And so I think – I certainly agree with Paul that it meet sort of the reasonable validity construct but I do find a sort of phase validity testing to be – I don't know that totally convinces me that we've separated out the degree to which some of these measures really represent hospital versus community versus – versus patient effects.

And I would say for the socio-economic status that I think we as the committee have discussed before and I think we have to be very clear that deciding that we don't – deciding that we want to endorse the measure without a socio-demographic factor included in it is not the same as saying we don't think that these things are very important contributors to the outcome and you can decide that they shouldn't be included in the measure itself while at the

same time validating that there is in fact the powerful effect seen within the data.

And I think that's a subtlety that we as the committee need to be sure that we are pretty consistent about so that we don't inadvertently say this stuff is an important. At the same time as we have, it seems collectively decided to say that we will endorse measures without the inclusion of an element. That maybe a longer discussion for another time but I think it's worth bringing that in the SCS.

I think there are two other issues that come up in many of these measures, again that I don't think interfere with endorsements but may bear repeating the issues competing risk comes up often and these readmission measures you have to survive the 30 days in order to be eligible for readmission and their particular concern among the surgical community that those two outcomes of debt and readmission true in the medical community too but in surgical measures, that those two outcomes are not actually independent.

And then finally the issue of the shrinkage methodology particular when there may be a volume outcome relationship and when volumes are dropping overtime for the surgery I think this bear keeping in our discussion as we think forward to how are we going to continue to evaluate these measures and how that might improve in the coming years.

Cristie Travis: Thank you, (Karen) and thank you for reminding us some of the deep discussions we've had around those issues in the past. Any comments or thoughts from the committee around validity issues?

(Bruce Salt): Hi, this is (Bruce Salt). Can you hear me?

Cristie Travis: Yes.

(Bruce Salt): OK. Thanks and I had to switch phones and I'm in transit so I'm not in front of the computer. I want to build on what (Karen) said and I just want to point out one thing that made me a little bit uncomfortable. I thought in some prior work this group had descriptive developer group that kind of acknowledge, you know, the role that some of these risk factors had play but had sort of

taken the stance that that was a policy issue to fix and not a model issue to fix and in this case saying that they've chosen not to include a factor because they don't want to cause a difference that's actually counter to what the NQF directions now are, right?

The NQF directions around these factors now are to show whether they make a difference and then to present results stratified by the (mystic duo) rather than to have the developer say we don't think this should be in me because it might cover something up. So, I was a little puzzled by that, I don't know that it changes the overall evaluation but it seemed to be slightly countered to some of the prior stance from the developer and the guidance – the most current guidance from the NQF.

(Multiple Speakers)

(Helen): Yes, (Bruce) this is (Helen). I think – I think your assessment is correct. I think (Karen) was making – (Karen Joynt) was making an assumption about the developers, I don't know if you want to say anything further (Karen) but from our perspective what you just stated is exactly (appalled).

Paul Heindenreich: Well, and this is Paul I was sort of making the assumption based on yes that groups approach to all of their readmission measures and the view which, you know, and I also would say it seems sort of – it really shouldn't in my opinion be – it shouldn't be our committee's view about what are these sort of policy issues should – should are relevant or not.

I think there is a separate socio – CS committee and I think that should make the decision that yes maybe each developer has to produce both and then both will be available for anyone to use or not but I don't like to see us making some decision that will say the mortality committee make the opposite decision.

(Helen): Yes, (Paul) this is (Helen) again I just wanted – I think what – what (Bruce) was really making the point of it is that it actually is established through the NQF trial period and the disparity committee will ultimately make their recommendation by the summertime as to whether or not we make this a part of our permanent policy but that as part of the trial period if a measure is

endorsed with SCS adjustment, there is an expectation that there will also be specifications to the measure to allow stratification of the measure so that there was in fact no masking of disparity.

Cristie Travis: The people feel comfortable that I mean I guess I'm not feeling really comfortable now (Helen) and I apologize…

(Off-Mike)

(Helen): OK, I'm sorry.

Cristie Travis: I think part of and this may really be for (Bruce) I think I am got a little lost in (Bruce) your rational for why we would look differently today on this SDS measure than we did historically when we took it through the trial period, so helping me understand that I would really appreciate that (Bruce).

(Bruce Salt): Yes, I apologize I'm not in front of a computer so I can't relate to the exact words on the paper. My concern was just that I think a developer and they expected to say we've looked at these factors and we feel that the impact of these factors is negligible or insignificant or runs counter to some other aspect of the model. What we don't want is the developer saying, "Oh, yes we show that rates have an impact but we decided not to include it because we don't want to mess something. That decision is made by NQF", that's what I was hinting at and again I don't have – I'm not at the computer, so I can't…

Cristie Travis: No, that's helpful.

(Bruce Salt): …the exact handling of each factor but that was my concern because of the earlier conversation sort of relaying that for that reason the factors weren't concluded. It may not have been for that reason alone, it may have been for reasons that we would allow a developer to say for these reasons, we have excluded the SDS factors but we would not allow a developer to say because we don't think we want to cover them up, we've excluded them.

Cristie Travis: Thank you, that's very helpful to me and I guess I am going to ask the developers if you could please clarify for us the rational for why you did not include the SDS or SDS variables in the risk adjustments?

Karen Dorsey: Right, so yes I've heard a couple of committee member say that it was a philosophical argument that was made. That certainly was not the intent of how we presented the materials. Again, you know, we took a stepwise approach as was recommended or the guides that we receive by the committee and NQF through the process which was to first look at the – (bivariant) relationship between the SDS variables and the outcome to establish both a conceptual relationship and that empirical relationship with the (bivariant) level.

We then added the rest of our risk adjustors and found that there was a small residual effect after we adjust for the differences in comorbidities among patients who maybe – have an SDS indicator as compared to those who do not. That small residual effect we were sort of further directed to look into that more deeply. When we calculated the risk standardized readmission rate, we looked at the impact of including those variables both individually and in combination in the risk models and found that the inclusion of them had a very, very small again not philosophically small but quantitatively small impact on the re-standardized readmission rate to the 0.1 percent level.

Despite the fact that that was incredibly negligible and so inclusion of those variables would not really change hospitals re-standardized readmission rate, we still were directed and further analyzed the decomposition of the breakdown of the degree to which the effect that we were seeing in the model that residual effect was related to hospital quality versus patients intrinsic risk of readmission and when they come in with one of these SDS indicators.

And in that analysis we found that the hospital level effects dominates meaning that the effect that we were seeing in the model was due to the tendency for patients with low SDS indicators to cluster at low-quality hospitals. Again, right this is based on the strength of that evidence, we suggested that the gain of including these variables in the risk model was negligible and the risk is that we would do something that we don't typically do which is adjust for hospital level issue which should be a signal of quality.

The – so, this was really an empirical argument I just want to restate and, you know, to say also that we take no issue with the broader guidance that we are hearing from this committee and that we agree with which is that, you know, we want to continue to explore relationships between SDS and this outcome as we get better data as we get more granular information as thinking (invisibles) and as the NQF guide (visible) on how we might bring these measures back in the future with additional analysis.

(Bruce Salt): Right and so this is (Bruce), so I entirely agree and I think that's the right way to present it, right? The developers are saying they did examine this. The developers are saying first of all the effect was small and then second of all they think the effect rides on a locust of the model where it's appropriate to not include those factors in the model and that's a different statement than saying these have an effect and we didn't want to cover it up and so I agree with exactly what was presented and with that I will – I'll take my comments back to silence. Thank you.

Cristie Travis: Thank you (Bruce). I appreciate that and thank you (Karen). Sherrie I know you had your hand up, do you have any additional thoughts or comments?

Sherrie Kaplan: Well I - I think I was one of the culprits in asking for the decomposition analysis and I didn't think the developers were going to get to that, but - but because we want to discriminate between who people attract as hospitals and what they do to them in the hospital is was the rationale behind that, but I think they did an excellent job of saying no, no, no, no, it's, you know, the attribution is in this case, there's a substantial effect of the hospital rather than who those hospitals attract and that's - that's kind of a short-hand way of saying I think I really - I think the developers did a nice job of explaining that.

Cristie Travis: Thank you Sherrie. Paul?

Paul Heidenreich: Yes, I guess I have not - I have not seen the harm stated in doing the adjustment. I see that they feel it as a small adjustment, although I would have felt more comfortable if they could have shown the impact on dollars to the hospital with and without risk adjustment to the Readmission Reduction Program and to show that that would not change at all.

Karen Dorsey: And so …

Paul Heidenreich: But - So but anyway so I have to say I don't - I don't see why one would not included in all models even, you know, assuming the data is available even though the small improvements might not improve the model.

Karen Dorsey: So I …

Paul Heidenreich: And I (would just) - I'll just finish by saying I actually agree with the prior reasoning that this might then trigger up hospital-level effect that we don't - that we want to see, but if the - but if that is no longer to be considered, I don't know why we wouldn't just try to maximize the predictive value of the model.

Karen Dorsey: So just in …

Cristie Travis: Is that - Is that you (Karen) from the developers?

Karen Dorsey: It is - It is and I think the responder is you want to …

Cristie Travis: Please. Please do.

Karen Dorsey: So the purpose of the decomposition analysis I think it's what you were suggesting, which is, you know, that sort of last piece of the rationale showing that the residual effect of the (STS) variables in the model was (due) in greater part to the tendency for patients with low (STS) indicators to cluster hospitals that are low quality and so that was the risk of including the variable that we would actually be adjusting for a signal of quality that we want to measure, we want to capture in the - in the restandardized rate and all this ad that, you know, we think very carefully about that issue as we construct the risk model right because one of the reasons why we don't include information that's garnered during the course of the hospital stay right because we want to leave out (inaudible) in the hospitals and only adjust for things that patients bring sort of before care is initiated and you know, we again right there is a significant patient-level impact and that residual (inaudible) of (STS), but it is smaller than a hospital-level effect so the - the impact of adjusting would be to more so adjust for the hospital-level effect of the signal of quality so I think - I think it's a - it's a yes both to (Bruce's) point and to your point about the two

pieces of the argument that were - that are supported by the evidence we presented.

Female: So this is - (Karen) is right. Can I ask a quick followup question? Is there no way to so if you have random effects models in which there's already a hospital effect in them and the effects we're seeing of - of dual status or race or you know, whatever it is is essentially comparing within the same hospital and if you additionally (exert good) control for hospital-level confounding with the term for effects of first with the proportion of X at a hospital is the assertion that that remaining effects that we see of dual status or black race or whatever it is that we look at is still largely a hospital rather than patient effect and I just - and I'm not sure I totally understand that.

Karen Dorsey: Right yes, it is a larger hospital-level effect than patient-level effect. I'll say, you know, I hear in the substance of your comment the desire to think about the ability to within the model, the residual patient-level effect is a very complicated (prospect) to think about how to do that and you know we are thinking about testing ways to address this issue, but it was a little bit beyond the scope of what we were asked to do in the (STS) trial, but we are still pursuing sort of answers to this more complex questions about how we can incorporate new information and deal with the information we have in this already very complicated risk model.

Cristie Travis: OK. Any other comments or questions from the committee relative to validity?

OK. I think we will now then move on to feasibility, which is the extent to which the specifications including measure logic card data that are readily available. It could be captured without undue burden and could be implemented for performance measurement. So Paul or (Karen) any opening thoughts about feasibility?

Paul Heidenreich: Yes, it's already being used so it's (currently) feasible.

Karen Dorsey: I agree.

Cristie Travis: Any other comments from the committee around feasibility?

OK. We'll move on to usability and use, the extent to which the audiences use or could use performance result for both accountability and performance improvement. Paul and (Karen)?

Paul Heidenreich: I don't think anything has changed. You could argue how useful these readmission letters are to improving quality, but I think - I think there has really been no change in the last several years.

Cristie Travis: (Karen)?

Karen Dorsey: I think the readmission measures are pretty interesting in that they have two distinct uses that have two very different approaches to statistics so in public reporting in order to be considered an outlier you have to be statistically different. In the Hospital Readmissions Reduction Program, you just get what you get with no consideration of uncertainty.

My understanding of the Risk Standardized Measures was that they were - they were intended to be used with uncertainty that they are not intended to be used to compare two hospitals to one another, but rather to give the best estimate if we have the ability to see a bazillion times that was going to happen to the range of performance that a hospital might experience and so it seems to me unless I'm misunderstanding that the use - the current use in two different programs (fits) more or less well with the way that the measure is - the measure is presented. That said, they are obviously highly usable in that they are being used for multiple purposes and at least initially we're associated with some improvement in readmission rate for this condition.

Cristie Travis: Thank you. Any comments or questions from the committee around use and usability?

OK. Well that - I think that brings us to the end of the criteria, am I correct Erin?

Erin O'Rourke: Correct. I think that's, you know, if there's not any other overall comments, I think that covers what the - the committee needed to discuss today.

Cristie Travis: Great. So is it time to move to member and public comment?

Erin O'Rourke: Yes. Let's open for comment.

Cristie Travis: So operator …

Operator: Thank you at this time …

Cristie Travis: Yes, go ahead.

Operator: Thanks - Thank you. At this time if you would like to make a comment, please press star then the number one on your telephone keypad. We'll pause for just a moment.

And there are no public comments at this time.

Cristie Travis: Thank you operator. Well I want to thank everybody on the committee today. I appreciate the flexibility in terms of working through the process that we needed to get through today.

I'm going to turn it over to (Miranda) for next steps, which will include some discussion about the SurveyMonkey Survey, which will go out hopefully right after this meeting so that we can start our voting process on the criteria so (Miranda)?

(Donna Logan): And actually we're going to turn it over to (Donna).

Cristie Travis: OK.

(Donna Logan): I'll just talk quickly about the SurveyMonkey Cristie. So we're going to send out the SurveyMonkey right after this call concludes. It will have a - a recording of the call today and it will also have the measure worksheet so that you can refer to that easily as you're going through your voting.

We will be asking for your votes by next Monday, March 13th. If you're not able to provide your votes before then, please let us know as soon as possible. We will also be sending out a transcript of the call today. That will not be available until tomorrow, but you will have it in your inbox first thing

tomorrow morning, which can also assist you in your voting. So with that, I'm going to turn it back to (Miranda) to walk through our next steps.

Cristie Travis: Thanks (Donna).

(Miranda Kuwahara): So up next public and member comment window will be opened from April 5th to May 4th. The standing committee will then convene again for a post-clinical on May 16th.

Next, NQF members will vote on measures 2515 and 3188 between June 5th and 19th. The CSAC will meet in Washington, D.C. July 11th and 12th to ratify these measures. The one-month (field) window will be opened from July 14th to August 14th and finally the final report will be published by September 26th at which time all projects will come (pretty close).

As always, please reach out to project team with any questions or concerns. (You can quickly reach us by e-mailing) readmissions@qualityforum.org. Please also remember that all of our process documents are saved to the SharePoint site and that meeting materials can be found on the project web page as well. I will turn it back over to Cristie for our closing remark.

Cristie Travis: Well I want to thank the staff as usual for preparing us for both of these measures that we have reviewed as part of this project and for being flexible in helping us think through the process that works to (basket) these measures, their - their due consideration.

I want to thank the developers for both of these measures and for your patience and for your willingness to help us understand in more detail and really be able to come to good conclusions regarding these measures and I want to thank the public as well for participating in this process so thank you all very much and we look forward to the next steps and everyone getting their (buzz in) by - by Monday. Thank you.

Erin O'Rourke: Thank you everyone and thank you again for joining us today and we look forward to talking to you again soon.

(Multiple Speakers)

Female: Thank you everyone.

Female: Thank you.

Female: Thank you.

Female: Bye.

Female: Bye.

Male: Bye.

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

END