NATIONAL QUALITY FORUM

Moderator: Readmissions Standing Committee
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Operator: This is Conference # 92793018

Welcome everyone, the webcast is about to begin. Please note today's call is being recorded. Please stand by.

(Erin): Hello everyone and welcome to today's call. This is the All-Cause Readmission and Admissions Measures Post Comment Web Meeting. Thank you all for joining us this afternoon.

We'll quickly review our call agenda first. We'll begin with welcome introduction and overview of today's call and roll call. Next, we will review and discuss the comments that we receive during the post-comment period or during the comment period.

Next, we will have an opportunity for public comment where the line will be opened and we'll be taking calls from the public. And then finally, we'll do a quick review of our next steps for the Committee.

So, we'll go ahead and begin with roll call for the standing Committee. Do -- we have John and Cristie both on the line.

Cristie Travis: Here

(Erin): Is Katherine Auger here? Susan Craft?

Susan Craft: Here.

(Erin): Thank you. Frank Briggs?

Frank Briggs: I am here.

(Erin): Excellent. Mae Centeno? Helen Chen?

Helen Chen: Here.

(Erin): Thank you. William Wesley Fields?

William Wesley Fields: Here.

(Erin): Thank you. Brian Foy?

Brian Foy: Here.

(Erin): Thank you. Laurent Glance?

Laurent Glance: Here.

(Erin): Excellent. Sherrie Kaplan? Keith Lind? Paulette Niewczyk? Mathew Reidhead?

Mathew Reidhead: Here.

(Erin): Great. Thank you. Pamela Roberts?

Pamela Roberts: Here.

(Erin): Great. Thank you. Derek Robinson?

Derek Robinson: Here.

(Erin): Thank you. Thomas Smith?

Thomas Smith: Here.

(Erin): Great. Thank you. Is there anyone on the line whose name I do not call?

Keith Lind: Keith Lind.

Kathy Auger: Kathy Auger. Sorry, I was late.

(Erin): No problem. Great. Thanks so much. Is there anyone else?

Paul Heidenreich: Paul Heidenreich's here.

(Erin): Excellent. All right.

So, a quick overview of what we'll be discussing today. This Committee is going to be reviewing comments (submitted on key measures). The first was the recommended Measure 2515. And then the second measure where consensus was not reached is 3188 which we will be discussing first because that measure will require voting.

During the comment period, we received 35 comments from 14 organizations. We have (themed) them and we'll be discussing them alongside the measure discussion. The first overall theme was support for the validity of measure 3188 and then we recognize two themes relating to Measure 2515, one was a discussion of adjustment for social risk factors and then another theme around acceptable levels of reliability.

Just to note, it appears that we have not reached quorum on the call, so we'll be going ahead and sending out a survey right now so that those on the call can complete their voting during the call. And then we'll follow up with those who are unable to attend as a follow up with the transcript and notes from the meeting. So, be on the lookout for that in your inbox in just a moment.

So, we'll go ahead and pass it over to the chair for discussion of Measure 3188.

Cristie Travis: OK. Well, this is Cristie Travis and I welcome all of you to the call. Thank you for being here today. As was indicated earlier, we did not reach consensus on the validity component of our review so that will be the focus of our conversation today. And you should be getting an e-mail around voting on the validity measure as well as the total standing Committee recommendation for endorsement.

The way that we're going to work this today is that we will have an overview from the developer's kind of giving us their response. Then we will have a lead discuss it and Wes is going to lead us in our discussion today of this measure. And then we will have Committee discussion and so that you will be prepared to vote.

So, let's get started and I will turn it over to the developers for their comments. I think we have Tracy and (Barb) on the line.

Tracy Spinks: Hi. This is Tracy Spinks from MD Anderson. My colleague, (Barb Jagles), is on but actually out on PTO so I think she's going to let me do most of the talking here.

So, we're genuinely appreciative of the committee's feedback. Obviously, we've provided some comments, some more detailed comments on writing but I'll just kind of summarize where we -- where we aim with this. We gave careful consideration to all the committee's feedback. We brought together our clinical and quality experts to discuss the committee's recommendations.

We did not make any changes to the measure after careful consideration and some additional statistical testing and list search because we found that when we went through our list search and went through our statistical testing and the sensitivity we run, we still felt like we had approached this in a correct way. But that said, we do a appreciate the recommendations to consider other events that happen post discharge, for example, emergency visits, those are conceptually different but we intend to consider those for future measure development because we agree they're very important.

We consider the comments about plan readmissions and the question of whether they reflect high quality care. Our experts told us that, in general, that's true, but we understand there's opportunity for improvement and to ensure that those are patient-centered admissions.

But for now, we wanted to focus on those readmissions where we have the best opportunity to improve patient care which we felt was unplanned readmissions or potentially avoidable readmissions and this approach harmonizes with other readmission measures that are currently endorsed.

We also gave additional consideration to ensure that we weren't excluding too many cases from our numerator or denominator. After revisiting those exclusions, for example, patients with a principal diagnosis of metastatic disease, we felt like that was still a very appropriate exclusion because it's a narrowly defined population. And yet we have a broad code list that we think fairly inadequately applies that exclusion across cancer sites. And we think metastatic patients, in particular, are such an important population that can still benefit from an improvement in care. They represent about 35 percent of the population in this measure so we didn't want to exclude them.

We also revisited our risk adjustment. We gave careful consideration to the feedback and the question of whether hospitalization in the prior 60 days might be more of a hospital level factor or be related to quality of care. We found more than 25 peer review studies that characterize this -- these are similar factors as patient level of factors as things that couldn't be modified and several studies also noted that this was a proxy for higher patient acuity that just isn't accounted for in other risk factors such as comorbidity.

And so, on that basis, we found -- we felt that it was appropriate to keep it in and particularly because it improved the model -- the discrimination of a risk adjustment model.

And then finally, we also spend a good deal of time looking at modeling individual comorbidities versus a single comorbidity indicator. And again, we brought -- we talked with our clinicians as well as our statistician and other quality experts. We modeled different approaches.

And when we looked at individual indicators, what we found was that it created clinical inconsistencies within our model. So, some variables that are known risk factors for readmission appear to be protective factors at some time -- in some cases. And we also found that there was some money of the water there because some of these risk factors are actually risk factors for the cancer itself.

And so, like that created just some overall methodological inconsistencies if we were to look at -- if we were to include individual comorbidities as

separate indicators. We also found -- and this came up in our -- during the initial call on February 27th that about a third of our models would be removed due to multicollinearity and so we felt like that was -- that would create an issue within the model as well and would limit the risk adjustment for comorbidities.

We also found that a number of peer review studies did utilize count-based comorbidity indicators and found that to be statistically valid. So, again, we probably spent the most time on this one but we found that when we -- that in order to balance the need for conceptual validity and statistical validity, we felt like that the current approach of these single multicomorbidity indicator was the best approach.

But we do recognize that we want to continue refining this approach. And so we're going to look at, for example, we mentioned this on the last call that there is an Elixhauser Comorbidity Index variable that's actually in press right now that could potentially be applied first. So we're going to take a look at that in the future.

But considering all of the committee's feedback, we felt, again, at the time that we weren't going to make any changes to the measure, like, it's appropriately risk adjusted and it -- and the way its defined right now, it meets the intent of the measure which is really to capture those readmissions where evidence-based practices can be most readily applied to improve quality of care and to reduce readmission.

So, that's all I had to share. But I'll see -- I'm going to get (Barb) isn't going to chime in here but I'll just ask her if she wants to add anything.

(Barb Jagles): Hi, Tracy. This is (Barb Jagles) calling in. I just wanted to reiterate Tracy's remarks that while we recognize this measure is imperfect and requires further consideration and improvement, we are actively using this in our clinical settings to identify patient's at greatest risk for readmission and prospectively trying to understand the clinical risk factors that we can better manage outside the hospital. So, I hope our supportive comments reflect the fact that we

believe the measurement of current configuration warrant endorsement for validity. Thank you.

Cristie Travis: Well, thank you both, very much. I'm going to turn it over to Wes as our lead discussant. Do you have some comments, Wes?

William Wesley Fields: I do. I just took myself off mute. My apologies in advance, I've got some folks building the fence outside my home, so I hope that doesn't become an issue but I'll see what I can do about it. I'm going to work mostly from the appendix that responses from the alliance and I want to thank them for their diligence around this. And I'm more or less going to work from top to bottom.

The thing which I think you understand, first of all, about ED visits and observations space that I think is something which is -- something we look at across a variety of health conditions is that it's a sort of a moving target, you know.

I want to try to be somewhat fair about this because I was looking back at my notes and some of our -- some of our prior project data and then realizing that we asked the alliance-included missions to community hospitals and they have strived to do that. And yet that means we now have to struggle with administrated data around coding and clinical assessments that will be by definition, quite heterogeneous.

So, let's just say that we all understand that there's really sort of a gray scale in terms of severity of treatment and duration of treatment around ED visits that may include transfusion of blood products, for example, or a short stay for patient having been in life facility that is admitted or observed because of fever where cultures proved to be negative and they're discharged home before, you know, they're put in inpatient status. So, look forward to their future workaround that as well spend the other measures.

The next thing I wanted to kind of touch on going through this, let's see here. I had a bit to say about this whole issue of cancer type metastatic disease and I actually feel like I learn quite a bit from their discussion and some of their additional analysis. My confusion around this or my concern around it is that

my best understanding is that patients with metastatic disease make up something like 35 percent of the denominator and we all want patients with advanced disease to have the benefit of advanced treatment.

But I find it curious that within our own testing population, readmission rate for people with metastatic disease was 19 percent and nearly 18 percent, quote-unquote, for people without metastatic disease. And I think that paragraph also speaks to the risk adjustment showing it as a risk factor as being nonsignificant.

So, I just find it a little bit curious as an English major that their own analysis shows that it -- as you would expect, metastatic diseases, very prevalent in the population, appropriately part of the denominator. And I just remain a little bit mystified that even though the readmission rate is very similar and apparently nonsignificant in terms of the respect to risk adjusted that is left of the numerator. So, I'll leave it at that. It's probably something that others will want to -- we'll discuss a bit further.

The issue of multiple comorbidities, I think has been well discussed. I think one of the things I would step back from this measure and point out is that most other measures that we deal with these providers, you know, as the peer review panel, are really about frequent -- frequently seeing chronic conditions like congestive heart failure, better seen in virtually in the acute care hospital where we're looking for measures and outcomes that are a bit more like apples to apples.

I think one of the things that continues to be sort of a structural or conceptual challenge with this measure is that we're looking at one condition which, in fact, is many, many diseases as we understand cancer to be. But we're looking at the impact of treatment and have displaced protocols at a handful of quaternary facilities that are part of the alliance. Yet, we see ripple effects as those patients of that population returns to homes and communities and is subject to readmission in the following 30 days.

So, I really do think one of the structural problems for this, the more I think about it is that it's-- the measure is really unlike most of the measures that this

Committee deals with and I -- and I think that that makes harmonization or problem.

Let me just look at my notes here really quickly. I think -- I think the last thing I want to say about the use of administrative data here relates back a little bit to the question of metastatic disease is that the first reference goal had been -- was cited as a way of feeling comfortable with the likelihood that the administrative data from hospital claims is reliable about metastatic disease.

I had a chance to peek at that that's based on California patient data. OSHPD data is pretty good compared to many states in that regard. I just want to point out that that was something like 91 percent accuracy when Goldman and his co-author studied it. But the purpose of that article was actually about trying to confirm DNR status at the time of admission which, to me, is quite different.

So, there was a nuance statement. I won't try to quote that this part of the alliances response to us but my best understanding of it is that they were trying to parse from administrative claims data the difference between progression of metastatic disease and something more kind of specific to the treatment at the index submission for patients with metastatic disease.

And I guess my concern about the limits of administrative data is that if a lot of the -- if the vast majority of the readmissions are going to occur at community hospitals with many, many providers that aren't part of the care teams of the quaternary facilities in the alliance, I just remain skeptical about the accuracy of hospital coding and discharge at the time of readmission reflecting accurately whether the admission -- the readmission is because of progression of disease or something that would be more pertinent to the care they received.

So, I just want to conclude by saying that I want to thank the alliance for their comments and also for the measure developers. We all see how important it is for this to be addressed. Going forward, I hope that, you know, all resources and services for this very sick population can be part of this evaluation about the quality of their outcomes.

But I think that there is a bit more to discuss here. Give me -- give me one half of the second here. I guess my other concern about the structure of the measure is that it still feels like any patient regardless of the degree of comorbidity can either refer to themselves or be referred by any provider to a quaternary facility for any cancer condition including 35 percent to 38 percent time patients who present with metastatic disease.

And that the measure as its structured really probably does not adequately, in my opinion, reflect all significant outcomes, if readmission is an outcome, for those populations. And so, to me, there is still a matter of accountability and attribution here. And the final, final thing I just want to point out from their response is that kind of speaks to this is unless I misunderstood it, unless I'm mixing up their prior measure with today, 3188, it's possible for one patient to be readmitted more than once from the 30 days quality index and it would only be counted once under this measure.

So, you know, forgive me if I'm wrong about that but that's my best understanding of what I read last night and this morning. And I just think it sort of speaks to the struggles that, you know, we're trying to find a way to resolve this morning. So, thanks very much.

Cristie Travis: Well, thank you, Wes. I appreciate your thoughtful comment. I do want to give the developers an opportunity to address any of the points that Wes brought up either through clarification or through, you know, your thoughts about why it's important to keep the measure the way that it is now.

And while I assume Tracy will do that -- and while they're getting ready for that, the rest of the Committee, please start thinking about if you have any questions or comments.

But I'll ask Tracy if she would like to respond to some of the points Wes has raised.

Tracy Spinks: Sure. I'd be happy to and I'm hoping I can cover all of them because I appreciate that you went in order of trying to take notes as we were talking.

And I wanted to just clarify a couple of points just to make sure that we're all on the same page here. So, this measure started as a measure that really focused on academic medical centers and in particular the 11 centers within the alliance. But as we approach retesting, we -- again, we took the committee's feedback from 2016 really to heart.

And so, we said, well, it makes sense that this measure be validate not just for our small group of hospital but really for all hospitals where -- all acute care hospitals, rather, where patients receive care for cancer.

So, I just wanted to make sure -- to make that clarification that we are looking at a very broad population here when we did our testing, almost 5,000 hospitals were included in the dataset that we used. So, I wanted to touch on the comments about the metastatic population because I agree, I that was one that we really spent a lot of time thinking about how do we appropriately measure readmissions in this population?

You know, I mean, this is the population that is very much at risk as I said and it's what's reiterated. You know, it's about a third of the population within the measure. So, we didn't want to say, OK, well, they're just overly complex. We're going to exclude them all together but we wanted to make sure that there were adequately reflected in the measure while at the same time we did exclude any readmission that we really felt were not tied to quality of care but rather, those readmissions were due to progression of disease itself.

So, I say leading up to the February 27th meeting and, in particular, in the ensuing period as we did our research and as I spoke with several coders and coding experts from across our centers, what I learned is that the approach that we've used is a good one and that it is very narrowly focused. So, it's not that a patient has neutropenic fever and they're coming back in and we're excluding that readmission. It is truly that we're excluding readmissions for those patients with a principal diagnosis of metastatic disease which is only used when patients are being evaluated or treated for the metastasis itself.

So, for example, if patient presents with final compression and they, you know, they find themselves suddenly paralyzed or they find themselves with,

you know, tremendous pain and that's due to the progression of the disease and the development of the final metastasis and it's not related to what we get and do a get a good job of managing the pain of the, you know, pain related to treatment or things like that.

So, we chose a very narrow definition so that we wouldn't overly exclude readmissions in that population. So, just to take you have a sense of this, in the current -- from our testing about one -- a little over a million patients with metastatic disease were in the denominator population and about 200,000 or a little over were included in the numerator. This is after we applied the exclusion for principal diagnosis of metastatic disease which is about -- which is a little less than 31,000 patients.

So, just to give you a sense, we really were trying to include as many as we could by limiting the exclusion to a principal diagnosis of metastatic disease.

So, I think -- I hope that helps with that or helps with the explanation and a couple more points that I wanted to bring out. The more I think about this, the more I think, I agree, that there's so much heterogeneity within cancer that, you know, I even thought to myself, well, goodness, should there be multiple measures?

But I think the complexity of doing that -- it doesn't lead us in the right direction which is trying to broadly measure readmissions in this population even though we understand that the risk for readmission and the risk for the cancer itself are going to be different within patients with different types of tumors both, even within solid and within hematologic cancers.

So, I agree that it's an extraordinarily complex disease in which to measure readmissions but we feel like it's such an important population, again, in terms of volume and it felt like this was a good place to start and trying to find the different approach since others had been acknowledged that they didn't work well in the cancer population.

And so, because of that, I think, again, we'll continue seeing are there ways that we can refined this but we feel like the current measure does a good job of being a starting point that we can all use to start, again, directing

performance improvement or continuing performance improvement, activities in this population.

And there is one final point, I'm sorry, I'm just looking at my notes but I want to make sure that I wanted to make sure that I made here and now, of course, I'm drawing a blank on what that was. But we will continue -- we are going to continue looking at other outcomes because I agree there are ones that are important.

And I just wanted to loop back on the comment about the goal because, yes, I agree. That was not -- that was not focused on the admission type. We were just excited to see external validation beyond our own validation that there was actually a good degree of accuracy in the -- in the way that we are approaching this.

But we do agree that claims, you know, it's hard to utilize claims, you know, really for any of these measures because it doesn't provide the rich clinical context that we'd like to have to better understand this. But since it's the broadest dataset that we have and it's the one that, you know, most that's used because it's readily available, we feel like, again, it's the best approach for now.

But we agree that there's opportunity, you know, again, in the future to think about were there -- are there other clinical data elements that we might be able to introduce as electronic health records, for example, become more robust in their collection of structured data. So, I'll pause there. Let (Barb) respond if there's anything she wants to add. But otherwise, we'd really love to hear from the rest of the Committee as well if there's any other question.

(Barb Jagles): Thanks, Tracy. This is (Barb). I don't have anything to add except once again, measuring readmissions and cancer will always be a challenge when using claims-based clinical data.

I want to reiterate that we believe this measure's validity is established because we're using the results of the measure to better understand which populations, to your point, goes with metastatic or hematologic disease are at risk for readmission.

So, this is how, I believe, we can contribute to the literature and the better understanding of using claims data to at least point us in the right direction. Thank you.

Cristie Travis: Well, thank you both. I'm going to open it up to the Committee. Are there any Committee members that have any comments or questions? And if you will, please state your name. I can't see your faces today.

Laurent Glance: I'm going to jump in since -- this is Larry Glance. So, I had -- I brought up the issue at our previous conference call about the comorbidity adjustment. I appreciate the work that the measure developers have done to reexamine this issue. I'm still pretty concerned about what I would consider to be the lack of granularity in this model. I think -- I think this readmission model really stands out compared to many of the other risk adjustment models that we've looked at in terms of the -- what I would consider to be fairly sparse number of covariants in the model.

Specifically, when it comes to comorbidities, I think that if you look at the -- at risk adjustment models that are out there for readmissions and for mortality and morbidity, it's very, very uncommon to see models nowadays that just count the number of comorbidities.

Most models that we have used specific comorbidities. There are a number of different comorbidity algorithms that are available for administrative data, the HRQ, Elixhauser algorithm is one. The CMS HCC algorithm is another.

I think simply counting the number of comorbidities really is, in my mind, is not adequate. And that's really the main comment that I have. Thank you.

Cristie Travis: Thank you for that, Larry. Would you like to make a response? From the developer?

Tracy Spinks: Sure. Absolutely. Again, we understand that this is not the most technically sophisticated approach. And, again, that's why we really revisited it over the past couple of months to see, well, is there a way that we could maybe amp up the sophistication of the model and the approach that we used.

And so, you know, again, we found when we looked at individual comorbidity indicators that it just wasn't the right approach and it created some real methodological inconsistencies in the model. But that said, I'm disappointed that my colleague, (Susan White) can't be on the phone with us today because she's traveling. But she's been working with I'm almost positive it's (Arken) and Dr. Elixhauser and others to actually validate an Elixhauser-based index for use with readmissions. Now, that wasn't specific to cancer but that's something that we're going to look at in the future.

But again, we -- you know, as we looked at the indices that are out there, none of them, to our knowledge, really had been validated for readmissions, specifically in cancer, and we did quite a bit of researching and couldn't find that. And so, because of that, you know, for example, a lot of the indices actually include cancer as one of the comorbidities. So, you know, that was something that, obviously, wouldn't make a lot of sense in this model.

And so, because of that, we felt like our approach was the best one when we considered the other options but we agree that there is an opportunity to refine that in the future as validated indices are produced for readmissions as well as, you know, are tested in cancer.

Cristie Travis: Thank you, Tracy. Any other Committee members have comments or questions?

William Wesley Fields: Cristie, this is -- I'm sorry. I have one more thing to say but I don't want to step on any other Committee members.

Cristie Travis: Sure.

William Wesley Fields: Because if you just come back the -- before we wrap this, so there's one thing I meant to throw out there that I forgot.

Cristie Travis: OK. OK. I'll be glad to Wes. Any other Committee members before we go back to Wes? OK. Wes, back to you.

William Wesley Fields: Yes. It's really just an analogy and it doesn't sound like there'd be a lot more discussion about this but for your consideration, I've spent some time this morning looking at some other measures that we've looked at and thinking about analogs for metastatic disease or Stage 4 disease, the congestive heart failure, the all cause of readmission measure for congestive heart failure came to mind.

And the question I asked myself is if most of our measures include readmissions for Stage 4 disease in other categories for things like congestive heart failure, and then the instance of that one -- that even readmissions in people that have Stage 5 kidney disease and are on dialysis are still included in the measure, I just -- I'm still struggling with the notion that there are people who are -- who's disease is so advanced that somehow, they don't deserve to be included in the numerator.

But honestly, the more we talk about this, I think for future measures, perhaps, the thing we're really all struggling with is that this not one disease entity. And it's -- and I think it's most obvious when we start to think about the interaction between cancer diagnosis and comorbidities, multiple comorbidities.

So, you know, in the long run, I'm not so sure that the -- the approach that this measure takes is going to be the one that's either the most predictive or the most -- the most useful for providers or payers or patients and their families.

But I want to be the first person as an emergency physician to say that the perfect is the enemy of the good and that's why we're looking for a favorable outcome for everybody this morning.

Cristie Travis: Thank you, Wes. OK. Well, I think that -- I'm sorry.

Helen Chen: Cristie, it's Helen. I just want to thank everybody for those -- for those great comments. I just want to also point out, though, that there are a fair number of comments that we got about this measure and I just don't want that to slip since it's your post comment call and most of those were overwhelmingly positive from cancer hospitals who are being measured by the measures. So, I just want to throw that in there.

Cristie Travis: No, thank you, Helen. We appreciate that. Any other comments before I summarize what our next steps are?

(Barb Jagles): This is (Barb Jagles). Just, once again, from a measure development and measure developer point of view, I want to echo what Helen said. I certainly do respect and appreciate the committee's comments this morning. But I'd really like to end on the note, the perfect is the enemy of the good. We've invested significant time and resources in developing something we think is at least a good start and recognizing the limitations of administrative claims, recognizing limitation of trying to measure cancer as a whole entity.

I want to reiterate that we're really proud of our accomplishment in helping our cancer hospitals think holistically about better keeping patients out of the hospital where we can. So, I'd really like to leave the Committee on the note that we're using this measure for exactly what the National Quality Forum would wish us to use it for and concerns about validity aside, I hope you'll consider the fact that our supporters are joining us in improving the care of patients. Thank you.

Cristie Travis: Well, thank you very much and thank you for all of your work and especially responding to the concerns that were raised on our last call. So, thank you for those concluding comments. You all should -- you all do have the SurveyMonkey in your inbox for voting. If you could vote now, that would be great.

And that way, it's just one last thing you have to think about for later. So, just remember that we're voting on validity and then the overall recommendation for endorsement.

So, thank you. With that -- and now I'll turn it back over to the NQF team.

(Erin): Great. Thank you. And just a reminder, we'll ask that everyone complete their survey by next Tuesday, the 23rd.

All right. And now, we'll actually…

Frank Briggs: This is Frank. When did you send the survey? I'm looking in my inbox, trying to find it.

(Erin): At 1:08 but I can resend. Who is speaking?

Frank Briggs: It's Frank Briggs.

(Erin): All right. I'll resend right now. Thank you. OK. And now we'll move on to the discussion of 2515.

John Bulger: Thank you. So, welcome everybody. John Bulger. The 2515 is the hospital 30-day readmission for CABG. As we discussed the last -- the last time we met this came back to us because of an issue around voting and (inaudible). So, it's just (for us) again but it's noted by the staff in the beginning, the comments we received were really around two different areas. One, is the area around validity; and two was around (SGS). And just a reminder, this measure did reach consensus as part of the voting process so we're trying to commenting on the comments today on this (specific) measure. So, I'll open it up first to the developers to put their comments (on the topic).

Susannah Bernheim: Hi. This is Susannah Bernheim from the Yale CORE team. We received a number of comments that we sent responses in that I think the Committee has seen and then some additional ones after the commentary had closed. Do you want me to speak to both sets of comments at this point?

John Bulger: I think that'd be great.

Susannah Bernheim: OK. I'm going to try to be very brief because I think you've seen a lot of it already and I'm happy to answer further questions that come up from the Committee.

So, as you noted, the initial set of comments expressed -- raised some questions about SDS adjustment and I will remind the Committee that we looked at a number of different SDS variables. We also looked at (race) and we reiterated in our response that we were not considering (race) to be a proxy for SDS, we were looking at it as a variable to sometimes shed some light on the patterns that you see with SDS but not as a proxy so we reiterated that.

We found when we look at SDS that as an individual covariant, it does have a significant relationship with the outcome but that when it is put in to the risk model, it has minimal effect on hospital scores. And then we -- I will remind you that we also had done this decomposition analysis which helps us to understand the extent of which the variable behaved -- sort of as a patient level variable or more is reflective of a hospital factor and that suggested that there was a substantial hospital effect of SDS.

So combined, we did not recommend endorsement. And as you noted, we've kind of gone through this with this Committee, the first time that this measure came through although we brought additional work this time.

The other issues that came up were around the approach to validity testing and reliability testing. I'll remind you that we use a somewhat unique approach to looking at measure and reliability which can cause some confusion because it doesn't -- the standard for our analytical approach are different than what are used for a number of them. But we cite a convention which shows our CABG measure to have moderate reliability using the standard that's appropriate for the measurement approach we take.

And then there were questions about the validity testing, I think, two key points to make here. One is that we bid for measure validity rely on phase validity at the time that this measure was developed. The one of the commenter's raised questions about the comparison that we did with our measure in a harmonized measure that comes out of the STS registry, the Society for Thoracic Surgeons that uses registry data which we compared to show the Committee that there's very high agreement in the results from our measure, in the STS measure despite using different data sources.

But that- that's not used as a standard measure of validity. It gives more to show that the risk adjustment using the claims does an adequate job of mirroring the risk adjustment that you would get with the more granular data that you get in a registry.

I think those were the major comments that came free during the measurement period. I know -- there's one additional -- one from Johns Hopkins just

requesting that we look at the measure results stratified by different kinds of hospitals and we point out a place where you can see that on the CMS website.

I'm going to pause because I'm moving pretty quickly but I'm happy to now move to the key things that came through after the comment period closed. Do you want me to keep moving?

John Bulger: Yes. Keep moving. Thank you.

Susannah Bernheim: OK. OK. So, the -- we got a letter from the Cleveland Clinic after the measure period closed. I think you all have access to that letter but we have not yet had time to provide a written response so I will go a little lower with their letters. And again, I'm happy to get into more depth anywhere that you would like.

This letter was concerned about -- about six different issues. The first was that you -- if you see procedures where their CABG is following by another CABG or PCI, does that might be a stage procedure and is not currently counted as planned in our algorithm. We spent a lot of time with this measure thinking about how to think about planned readmissions.

And I will say that the STS measure count nothing as planned, they feel like it's almost never scheduled for a patient to come back within 30 days of their CABG. We actually do have a handful of readmissions that are considered as planned and therefore don't count as planned procedures but the feeling of the experts that we consulted with was that most of readmissions for CABG or PTCA within 30 days although initial CABG were probably unplanned.

So, we do not -- I can't say the word exclude because it's not the cohort of the outcome but we don't -- we count those as readmissions, that's the way to say it. They had a request to, again, review the SDS analysis we did. I think you all have seen that so I won't spend time on that now.

They ask about excluding places that we're emergent or urgent CABGs. We did not do this with this measure nor those SDS, as far as I know. In the case of our measure, it is -- the claims data is not good at differentiating those and -

- so we don't think we could accurately differentiate those and also that would mean that we might have sort of an imbalance of cases across hospitals that were not consistently identifying the emergent procedures.

But for now, they are in the model. We think, again, the correlation with the STS measure helps us in the state as well because we're sort of capturing similar signal from hospital. Their fourth question has to do with transfer the patient. So, this, we just clarified, again, that this measure -- if a patient is transferred, it is the hospital that discharges to the nonacute setting, not the hospital when the patient is initially admitted. So, it's the -- the final hospitalization in a transfer bundle that is held accountable for the readmission.

And the final question from that group asked about patients on preoperative mechanical circulatory support including balloon pump or ECMO and a concern that they were at increased risk. And we point out to the extent that we can -- we account for this measure. Most of these patients would probably be closer to having shock and we -- I'm getting we do adjust as best we can for patients who have need for circulatory support.

I want to go back to an earlier question because I actually made a mistake. Almost all of our readmission measures, it is a hospital that discharges to the allocation setting but, in fact, the cath insertions felt strongly but if the patient was readmitted after a CABG regardless of where that hospitalization occurred and the series of CABGs, it should be attributed to the hospital where the CABG procedure was done. So, this measure actually differs from other one.

So, my initial response was -- was a mistake. I have covered everything as fast as I can. I'm happy to answer more questions.

John Bulger: Great. Thank you. Why don't we go to Paul? You're the lead discussant. Paul, you're ready to…

Paul Heidenreich: Sure. So, Paul Heidenreich here. So, right, I agree that, you know, we -- the comment, there weren't a lot of comments but they were from, I think, some

big major organizations including the AMA and the American Hospital Association/

I think -- and there were all -- seemed to be fairly synchronized in their -- in their comments and I say they all did want more socioeconomic adjustment. And personally, I think it's -- it should really be taken out of our hands and the developers hand. They pushed, you know, I think some of the findings by that the -- they mentioned the report to Congress from December 2016 from the assistant secretary for planning and evaluation.

I think saying, you know, we should be taking adjustment should include community variables, so not just the patient level variables but a lot of more things about that community probably impacts whether or not they're going -- you know, their outcomes, I'm sure, it impacts the readmissions.

And so the uniform -- this comment was we need more and not less and we should be spending -- even if it cost a little money, we should probably be spending that to get -- to do better socioeconomic demographic adjustments.

My own personal view is developer should report both and let the users decide which ones they want to use. And not try to make some value judgment about whether the improvement in the mortality is enough and whether it is worth the cost of collecting the data.

I think -- so that -- again, I'm not sure we've gone around this a lot with -- on the Committee, the socioeconomic response. I think -- but I also have the concern on reliability which I think that we acknowledge reliability was only fair, let's say, and that shouldn't be good enough and that should fail on that reliability and I think the Committee recognize that but felt it should, you know, with good enough to go forward.

And I think -- although it's not in our NQF summary, I think there was another scheme and that was that do we know for sure that readmissions have not bottomed out in terms of, say, preventability. And at some -- I think they're saying, at some point, that will probably occur and we should really -- it'd be good for everyone -- the developers to demonstrate that we, you know, to the extent that we can that there is not -- that there still is a significant amount of

preventable readmission for which we can improve care and I think that applies to, you know, to all the readmission measures.

So, again, I think -- I think they were relatively fair comment. I think -- I think there are things that the Committee has considered. And, you know, other than that, I think the potentially going -- putting a new community variables into socioeconomics demographics, I'm not sure -- there'd be any action our Committee would recommend.

So, I'll stop there and see if there are any questions.

John Bulger: Yes. That's great, Paul. Thank you. And I'll just say, I think you've stated it very well. We had a fair amount of discussion with this, you know, we've had it for some time and we had it on our -- our prep call as well that committees -- a little bit in a -- in a situation where we look at the measures which are brought to us and I think it's, as you noted, the measures that brought or brought to us are finite, meaning we are able necessarily to decide what we'd like brought to us. We get -- we see what's brought to us.

And, you know, in our last live meeting which we had a year ago, as you said, there are viewpoints that are held by the measure developers which affect what's brought to us. So then, you know, downstream from that, the Committee then looks at what's brought to us and the charts that the Committee has decided to (does that meet) reliability, (does that meet) validity and, you know, is it able to used from that standpoint?

I think many of the comments that we received, you know, I think are very well written and raise a lot of points, it's just the reality is to the -- to the decision that the Committee has in front of it, some of them aren't germane but they are germane to the, I think, greater issue around these measures. And, again, I think you stated very well.

And I would like just to reiterate, I mean, we, as a Committee, have made that statement many number of times to say that while we may be commenting on SDS as it relates to what, I think, Paul mentioned and I mentioned is the measure in front of us and the rules of how we need to look at the measure in front of us, the Committee, has not -- as a group opined to say, you know, yes,

we -- we definitely think SDS should be included or no we don't think SDS should be included because we're already -- we've just been looking at the measures in front of us.

Do other people have comments or questions for developers or on the -- on the comments that we received? OK. Going once? All right.

(Erin)? I think you're up next.

(Erin): Great. Thank you, John. So, we just wanted to take a little bit of time with you all today to debrief a bit on our trial period for risk adjustment for sociodemographic factors. This committee's been one of the most active.

So, given that we are in the process of evaluating the trial period, we wanted to just have a touch base with you to get your input and see if there's anything you would like to highlight for the Disparities Standing Committee as they really helping us think through some of the strategic issues around risk adjustment for these factors.

Next slide. So, just to bring everyone up to speed, we began the trial period two years ago in April 2015. Since that time, we've asked the standing committees to consider the potential role of sociodemographic factors and their evaluation of all submitted outcome measures.

We've also asked your Committee as well as the cost and resource use Committee to go back and do some work on measures that were endorsed with the condition that additional analysis be performed to determine if there was a need for the inclusion of SDS factors. Those were measures that were endorsed prior to the start of the trial period, so it was not really in that committee's purview at that time to have those conversations.

Next slide. So, we have learned quite a bit from our trial period, in particular, a lot about the challenges to doing some of these risk adjustments. We've seen a significant number of outcome measures come through with the conceptual basis for SDS adjustment. However, as this Committee has -- particularly struggled with when the empirical analysis don't always -- don't

always need the inclusion of those factors. So, there's a bit of a mismatch between the conceptual basis and then what is found in the empirical analysis.

To support the trial period, it's a monitor progress in the field, working closely with folks from (SBNM) and other organizations that are doing work in this space and bringing that back to groups like the Disparity Standing Committee as well as the CSAC and the board to keep everyone informed.

Next slide. So, we are getting the end of our trial period. It officially ended in April of 2017. The feedback has approved an initial evaluation plan. NQF staff are currently in the process of gathering information to assess the number of key questions about the trial period. We're taking a look at measures that were submitted with SDS adjustment, measures where there was the conceptual basis but the empirical analysis didn't support inclusion of those factors. How often this was raised as a concern during the Committee evaluation.

We're working to -- with the measure developers to explore things from their perspective, what was the cost from the burden on them to do some of this work, how you (work them) at the resources NQF provided. We've also reached out to standing Committee members to get your input a number of you probably saw a survey come through a few weeks ago asking for your thoughts. So we're often surveying you to see how effective you thought the trial was, how supportive what NQF put together was for you and I think we could do better in the future. So, just a little sales pitch, if you could, take a moment to fill that out.

We are planning to explore some general key questions to see what we've learned here. In particular, could we see SDS factor having a significant effect on the outcomes being measured. If there was a strong conceptual basis, the analysis with specific variables demonstrate an empirical relationship, what SDS factors were available and analyzed and what critical data gaps were (I guide) in the availability of SDS factors.

Next slide. So, just to keep you up to date on some of our next steps, in June, the Disparities Standing Committee will be meeting to review the results of a

trial period and offer further input to NQF. We'll also be bringing the results as well as the -- from the disparity standing Committee to the CSAC during their July meeting and they'll take that input and offer further guidance to the NQF board of directors. When they finally -- during their July meeting, the board will review the guidance from the disparities committees from the CSAC and NQF leadership and consider a teacher policy directions.

Next slide. So we did want to take a little bit of time with you all today to review some of the committee's guidance on social risk over the past two years and see if there's any additional points you'd like to highlight for the Disparities Standing Committee as we move forward.

So we've summarized them a bit, key things of your discussions and would welcome your input to see if this summary reflects your thinking and if there's anything else you'd like the highlight. The committee's really stressed that readmissions are influenced by a number of factors including the various patient and hospital quality as well as the availability of Committee resources. The readmissions reflect, health system and community health quality as well as well as hospital quality.

And additional work as we did to explore the impact of community level variables. The Committee is highlighted that data is the limitation to examining the impact of social risk factors on readmission measures, limited information and claims data as well as the underlying data element should be improved. We need to raise assess factors such as homelessness, community resources, available home supports and other social risk factors.

Geographic proxy data should represent the actual SDS characteristics of the patient as accurately as possible. And at this time, attributes as a nine-digit zip code, maybe the closest data available. The Committee stressed that five-digit zip code (for account fee) is too heterogeneous.

Next slide. The Committee's warned that there is a high risk of unintended consequences related to adjusting or not adjusting for social risk, emphasis on the provider serving the vulnerable should not be unfairly penalized. However, we ask them to (queue) to balance it, that was not worsening

healthcare disparity. The committee's noted it can be challenging to disentangle clinical and social risk once methodological point has been raised is that adding social risk factors after all the clinical risk factors into the model could mean that the majority of the impact reloading on the clinical factors and that could be a reason we're seeing some limited impacts from the social risk factor.

The Committee's highlighted this could be particularly challenges for -- challenging for issues like functional status and behavioral health And the Committee has emphasized the need to reevaluate measures as new -- new data becomes available.

Next slide. So, I think with that, I did want to open it up for discussion and, John, I know this is something we've discussed on our prep calls. I was hoping we could put you on the spot to, maybe, kick off the discussion and share some of your reflections as the co-chair over this in the past two years.

John Bulger: Sure. You know, some of them I just shared. So, I mean, I think it goes in with that but I think that's, you know, this whole notion of -- and there's obviously given the comments on the last measure, there's a lot of, say, angst in the Committee about, you know, what's happening with SDS.

And I think there's a -- you know, over the years, we've had a fair amount of frustration from the Committee standpoint about where we stood with that, again, feeling like, as I've said, you're in a -- you know, less than a Catch-22, it's kind of a no-win situation.

I think, you know, as I said Paul laid that out, I think pretty well his comments on 25, on the CABG, Measure 2515, the -- you know, and I do think there needs to be a call from a -- and this is a really, an NQF -- a community standpoint to begin to look at some of these measures differently because as long as you get a fine item out of measures that are coming through, you allow for, you know, biases from developers and biases from other places to sit within those what see.

And again, once it comes to us, we have a -- we have a very narrow window of what we look at -- of what's sitting in front of us. So, I think, you know,

increasing that pipeline of what we're able to see from a Committee standpoint, I think would go a long way to getting us done the road of being where we need to be.

But as we see in the comments, you know, the comments are, you know, around what should be -- we should be we'd like to see this, we'd like to see that and I think -- again, many times this Committee has said, you know, we'd like to see them too and, you know, then we could -- we could look at that them and review them when they come to us and then comment on them just as commented on the two measures we've looked at today.

But without them sitting in front of us, I think there's a general frustration that we've had as a Committee and that, you know, different people, I think, vocalize it louder than others but with that the pipeline that we actually see coming to us.

And clearly, there's a -- there's a concern now in the Committee of what that looks like and what it should look like. You know, and then as you said, (Erin), I think many of the measures we look at are probably the ones that are on the forefront of most people's minds when they're talking about adjustment.

(Erin): Great. Thank you, John.

So, I think with that, we'd love any input the rest of the Committee might have that you'd wish to pass along to the Disparities Committee as they evaluate the trial?

William Wesley Fields: This is Wes. I think this is an important discussion. I appreciate the chance to be updated on it. This is the area of which I actually have done some work, surprise, surprise. You know, has some impact on emergency departments around the country.

And I just was speaking in favor of, actually, maybe looking at a course correction or some additional parallel activity because, you know, there's a lot of literature in and around acute care that suggest that the single largest predictor of return to the emergency department, for example, of readmission is not a host of chronic conditions we all are familiar with but alcoholism.

I'm thinking about a specific study that was done by the folks of UC San Francisco about frequent visitors to their department and that over in it -- over and above that kind of midlevel tier of frequent visits by people with (MCC) status who typically also had SDS sort of challenges but the real driver of the most frequent utilization of resources not just in the ED.

But elsewhere in the Committee is are things like alcoholism, there's some obvious corollaries with other types of substance abuse and the sort of dual diagnosis acute care patient who's also got an underlying mental health disorder that's untreated or unstable. That's a huge thing.

The reason I mentioned this is that the most important thing I've learned from our prior look at the data and some of the empirical analysis is that for better or worse, the majority of STS impact is reflected in the severity of patient's health status and the extent of comorbidity which can be documented in, say, a problem -- a set of discharge diagnosis from a hospital. You know, to me, that's somewhat tragic but I think, you know, it's something which has been shown to be true.

So, I think it may well be that the future of this in terms of our ability trying to tackle what the real problem is not just SDS status but the -- you know, the true catalyst for what makes people struggle to comply with care plans in the community as we'll as to be, you know, sort of further -- that they made it even more vulnerable by some of the lack of social supports and resources and community setting.

So, in the end, I think that, you know, a big chunk of the future of this debate probably needs to morph into a discussion about how you -- how you measure the severity of problems with substance abuse and the behavioral health disorders and what kind of interventions are most likely to have a positive impact in those subpopulations and whether, in fact, it's reasonable and appropriate for hospital-based providers to be the one that, you know, wind up with the most accountability for that.

Susan Craft: This is Sue Craft from Henry Ford Health System in Detroit and I would echo those comments. We live that pretty much every day with our -- our main

hospital being right in the city of Detroit. And I don't think that there's really a good understand of the impact of the social conditions in the city on our patient's help.

And, you know, we -- we look at things even like having food in the refrigerator and patients aren't, you know, and I -- when I -- when I think about claims data and trying to pull a lot of these information out of administrative data, it's really difficult because so many patients don't even want to tell you their circumstances.

And, you know, it really -- if you look at the multitude of measures and things that we need to comply with and the impact from penalties and value-based purchasing, to not consider the community situation is really different for those of us that are -- that are trying to take care of an incredibly vulnerable population that doesn't have access to transportation, sometimes food, certainly follow-up appointments, medications, all those kind of things. And I think that they really is just not a good appreciation of how challenging it is to care for these patients.

And from a hospital perspective, how we help them to help maintain their health without things occurring actually within the community. It's very hard for the hospital to own all of the accountability for patients being readmitted and a lot of these other metrics that we are very responsible for.

So, I would just echo that looking at the SDS factors, it's incredibly important and not only applying to readmissions but really looking at the broader scope of all of the metrics to see which ones because for the most part, I would say most of those SDS has an impact on those.

John Bulger: Other thoughts from the Committee?

Paul Heidenreich: Well, this is Paul. I'll just reiterate that, I think, over these last several years of reviewing this, the develop -- the developers comes from this with all different views, angles and I'm not sure looking at that but in the end, we want, you know, that we should be doing it on a case by cases basis.

Ideally, we would have enough research to say, OK, these variables through these publicly available datasets sort of talk about the community or other patient level data are going to be available to everyone. We should use these in an SDS adjustment and then report that alongside and unadjusted.

Because there is potential harm in doing adjustment if we -- if we then obscure real disparities and care. So, I don't think we can handle these on case by case basis. That would be my recommendation.

Katherine Auger: This is Kathy Auger. I feel Paul's comments as well in the sense that it's -- I found, as part of these discussion, it's really challenging to reconcile, like, one developer might argue for one way and then another developer, another way. And they're both potentially reasonable thought processes yet it felt very inconsistent that sometimes we would incorporate it -- incorporate patient (inaudible) measure, but not the other.

And clearly, I think I would -- I was struggling with and hoping, of course, for a more harmonious way of approaching this so that there is a sort of more standardized way of approaching this.

And but then the other thing that I think is important too, is the ability to continue to incorporate new findings and new evidence that's out there. I mean, since we've had these discussions, there's been several publications in the pediatric world about pediatric readmissions and adjusting (precision) determinants and how it changes hospital ranking, et cetera, which is not surprising information.

But, you know, again, it probably -- this information that what actually (to) the conversation probably had that information back when we were discussing those measures. So a way of sort of updating the inclusion, exclusion, I think is important as well.

John Bulger: Great. Other thoughts? OK. (Erin), go.

(Erin): OK. Well, thank you all so much for taking the time to work through some of these issues with us. We'll bring your input to the Disparities Committee in

June and we'll keep this Committee in the loop on some of the findings as we go forward with the evaluation of this, the trial period.

I think before we open for comments, Helen and Taroon, was there anything you wanted to add before we move on?

Helen Chen: This is Helen. No, I thought that was a great discussion. Thank you. That's all really useful information as well as the survey we have sent you on the SDS trial. So we really welcome your thoughts on paper even if you didn't chime in on the call today.

And again, I think this whole question raised by the commenter's and several people in the Committee about, you know, what does it mean to explore those community factors issue further, I think, is something we'll be certainly talking with the Disparities Committee by June. So, thanks for all of your efforts here, I realized that's an incredible amount of work for the last couple of years. So, thank you to you and particularly to Cristie and John.

Taroon Amin: Yes, (Erin), I don't really have anything else to add beyond that. Besides just reflect on the fact that it's been, you know, a challenging two years with this trial period to try to understand how to incorporate these factors. Obviously, there's been a lot of conversation in the field regarding them. So, clearly, we look forward to hearing what the Disparities Standing Committee recommends in terms to the next steps.

(Erin): OK. Thank you. So, I think with that, we can move to the next slide. And I believe we are going to open for public and member comments. Operator, if you could put the two together?

Operator: Thank you. At this time, if you'd 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.

(Erin): OK. Thank you.

(Crosstalk)

(Erin): Sorry, (Miranda), you go.

(Miranda): That's OK. I can handle the next steps. So, moving forward, measures number 3188 and 2515 will open for member vote between June 5th and June 19th followed by CSAC review, July 11th and 12th. And then we will open for appeals July 14th and close on August 14th.

And always, please feel free to reach out to the readmissions team at readmission.qualityforum.org. Please also note that all meeting materials are available on our projects web page. And as a final reminder, we ask that all Committee members submit their votes no later than 6 p.m. Eastern time next Tuesday, May 23rd.

And with that, I'll turn it back over to our chairs for any closing remarks.

Cristie Travis: No, I just want to thank everybody for your thoughtful consideration and participation in the Committee as well as the developers who were in measure stewards for their hard work and answering all of our questions and participating in the process as well.

John Bulger: Yes. And I just echo those comments and appreciate everybody's hard work and dedication.

(Erin): All right. Wonderful. Well, thanks everyone. Have a good afternoon. This is the end of the call.

Female: Bye.

(Erin): Bye.

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

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