National Quality Forum

Moderator: Ashley Wilbon
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Operator: Welcome to the conference. Please note, today's call is being recorded. Please stand by.

Ashley Wilbon: Hi, everyone. Welcome to the call.

This is Ashley Wilbon from the National Quality Forum. I'm one of the team members on the Resource Use project team here at NQF and I just wanted to welcome everyone and thank you all for coming.

This call is the Cardiovascular Technical Expert Panel Call. We have convened a subset of the standing committee members from the Cardiovascular Consensus Development Process standing committee to help us gather input – clinical input on the measures that are going to be under review by the Resource Use standing committee that have been submitted by a couple developers within the cardiovascular topic area.

So those of you that are on the call, we're going to do a roll call in just a second. I just wanted to just give a brief overview of what we're looking to do today and kind of how we expect the call to go. There maybe a couple housekeeping items – housekeeping items as well.

If – because we open all the lines, if you're not speaking, just to kind of cut down on any echoes or anything that may happen, if you could just mute your phone when you're not speaking, I think that will cut down on a lot of background noise.

And also, we are going to be using pretty much the format for the call, in terms of the questions that you were asked to respond to in the survey for each of the measures and we'll have up on the screen in the Webinar, if you're logged into the Webinar, you'll be – you should be able to see documents. We'll screen-share and bring up documents for easy reference, in case you're not able to view them on your computer otherwise.

And so we'll try not to switch screens too frequently, because we know that sometimes there's a lag (in going), but we'll try to bring up any relevant documents that come up in the discussion. Right now, we don't have any flags, per se, on the screen, so you probably don't see anything of significance; maybe just the ...

Female: (Should be the technical expert panel) (inaudible). (Can we see) ...

Ashley Wilbon: The measure evaluations, so if you're logged into the Webinar, can you see the screen with – OK.

Male: I can.

Ashley Wilbon: OK, great. Great.

So just a quick overview of what we're looking to accomplish today; we have scheduled two two-hour calls for this group of experts to convene and discuss the three measures that we asked you guys to review. We are hopeful that we'll be able to get through the review of all three measures in this call.

If for some reason we aren't able to and we need to continue the discussion on any of the measures, we will use that two-hour slot that we reserved next week, but our hope is that we'll be able to get through everything today, so we'll be as efficient as we can to not have to use that call, but hopefully we can also get what we need.

The input from this technical expert panel will be used and filtered to our – or passed on to our Resource Use standing committee. They also have the measures and they are reviewing them as well, but many of the people on that Resource Use standing committee are not clinical experts and really the sole

purpose of this group as being experts in cardiovascular disease and cardiology and so forth is to provide that specific clinical expertise (and) the review of the components of the measure that are very specifically clinically related.

There is a member from the Resource Use standing committee who is a cardiologist and we've asked him to chair this panel, so he'll be helping us to guide the discussion today. That's Bill Weintraub. Are you on the phone, Bill?

OK, hopefully he'll be joining us. But ...

Bill Weintraub: I'm here.

Ashley Wilbon: Oh.

William Weintraub: I had it on mute, like you told me to do.

Ashley Wilbon: Oh, OK, great. Thanks; I'm glad you're there.

But we'll be doing roll call and introductions briefly, but just wanted to let you know that, as we go through getting input, Bill will be helping to guide the discussion for the group and also, because he's also on the standing committee, it – when they meet and have discussions about these measures, if there's any input from the (TEP) that you know the committee has questions about, we'll be looking to Bill to kind of help bridge that gap for those on the committee who don't have the clinical expertise and are looking to try to get that input that they may not have within themselves.

So thank you again, all, for joining and I'm going to hand it over to Ann Phillips, who's a – team of – member of our team to do a quick roll call and then we'll go ahead and jump in.

Well, actually, as she calls the names, we'll ask you to do just a brief introduction on yourself, so you guys can get an idea for who's on the phone and we'll go from there.

Ann Phillips: William Weintraub.

William Weintraub: Oh, yes; I'm Bill Weintraub. I'm here; I'm chair of cardiology, Christiana Care in Delaware. My scientific background is as cardiovascular epidemiologist and I've worked with large data sets, clinical trials and I worked in cost-effective analysis for decades.

Ann Phillips: Sana Al-Khatib. And you can correct me; please. Sana?

No; OK. Leslie Cho.

Leslie Cho: Hi, I'm Leslie Cho. I'm the section head for preventive cardiology at the Cleveland Clinic. I'm also an interventional cardiologist. I've served on NQF in the past on the Cardiovascular Steering Committee and this is my first time serving on a Technical Expert Panel.

Ann Phillips: Thank you.

Ted Gibbons.

Ted Gibbons: Hi; Ted Gibbons, University of Washington, Harborview Medical School – Medical Center, which is the public health hospital for Seattle, home of the Seahawks I want to point out. The – I – most of my interests have been in heart failure and also quality improvement. I have been, before I joined the University of Washington faculty, at the Virginia Mason Medical Center, which is a large practice here in Seattle.

I've been on the Cardiovascular Steering Committee in the past, 2010-2011, and am very interested in participating in the technical evaluations that have been put forth.

Ann Phillips: Thank you, Ted.

Judd Hollander?

Judd Hollander: Yes, hi; I'm Judd Hollander. I am at the University of Pennsylvania as an emergency physician and clinical researcher. I mostly cardiovascular diagnostics research, but also have some familiarity with the therapeutics area; largely see myself as a clinical trialist and I'm excited to be taking part in this.

And I will congratulate you, Ted, even though I was rooting for Peyton, because (inaudible).

Ted Gibbons: Well, I originally was too, but I changed my mind at the first quarter.

Didn't even have to wait the first quarter; just the first play.

Judd Hollander: Right. It was impressive; I just got to say that.

(Ted Gibbons): It was great.

Ann Phillips: Thomas Kottke?

Thomas Kottke: Hi; Tom Kottke. I'm a cardiologist out here in – at HealthPartners in the Twin Cities. I'm medical director for Population Health for the health plan and most interest has been in both population-based intervention and also in organization of practice to improve outcomes.

Ann Phillips: Great, thank you.

(Ashley Wilbon): Sana, just in case she might have joined during introductions? Sana Al-Khatib.

OK, hopefully she'll join us during the course of the call.

So I think we'll go ahead and get started. And everybody can see the Technical Expert Panel Measure Evaluations; the overall?

Yes. So I think where we'd like to start is just kind of going through each of the questions that were asked of the panel to discuss and kind of getting a summary of what the responses were and let Bill kind of take the discussion from there.

(Sherone): Ashley, real quick; this is (Sherone). I just wanted ...

Ashley Wilbon: Sure.

(Sherone): ... (inaudible) help if there are any questions from the group on what we are trying to achieve today, before we jump into the actual evaluation.

Ashley Wilbon: Great; thanks, (Sherone).

Male: Yes, so I guess – so I'll ask the question. Are we supposed to be giving general recommendations that the larger group is supposed to take into account in evaluation the specific points they evaluate for the measures? Is that the concept?

(Sherone): Well (inaudible) I think we have specific questions that we were asked. But I don't think we should feel entirely bound by that either.

Ashley Wilbon: Right.

(Sherone): So I think that, as we have interesting and important things to say, we should feel free to say it. But we (inaudible) specific questions we should address.

Female: OK.

Ted Gibbons: Are we – are we going – this is Ted. Are we going to have some interaction with the measure developer before we give some kind of feedback to the standing committee?

Ashley Wilbon: That's actually a good question. Are any of the developers on the line?

(Nancy Kim): (Hey, Nancy Kim); I'm a general internist from Yale CORE and we developed the AMI heart failure 30-day AMI pain measure and heart failure measures. I'm on the line.

Ashley Wilbon: OK, great. That's a great question because I forgot to prompt them to see if they were there, so thank you for that question.

So to the extent that you guys do have questions, you're welcome to direct them to the developers on the phone.

Male: There's no (inaudible)...

Male: (Is there) ...

Male: ... have the developers make a presentation; right?

Ashley Wilbon: We can certainly do that and provide them some time to give a brief overview. We hadn't prepared them to do that, but to the extent that they ...

Male: Had not – had not prepared them.

Ashley Wilbon: We had not; I don't believe that we'd asked them to do that, but we can.

Male: (So we'll) have to ask people on the – off the cuff to do that. We could (ask and see).

Ashley Wilbon: Yes.

Male: Would the committee prefer to hear a five-minute introduction of the measures? Now we have the other one from ...

Ashley Wilbon: (Inaudible)

Male: ... (inaudible). Is there a – is a developer available for that one as well; (1558)?

So there's no one from NCQA; we could not have a presentation from them, of course.

Male: I think we'll have to get feedback from them, because I think that AMI and heart failure ones are extension of the 30-day episode of care ...

Male: Right.

Male: ... measures that were passed a couple of years – several years ago. The (NCQA) is a little bit – a little bit more opaque, so I think we'll probably need to get some feedback from them or answers to some of these questions.

Male: (Having sat) on NQF panels previously, it is a good idea, I've found, to have a – have a presentation of the measure. But this is a little different; this is a TEP as opposed to a committee.

Male: (Inaudible), can you hear me?

Male: So ...

Male: Hello?

Ashley Wilbon: Hi. Yes, go ahead.

Ben Hamlin: Hi, Ashley. It's Ben Hamlin from NCQA. I can't seem to be – I'm having trouble getting heard I guess.

Ashley Wilbon: Oh, OK; great.

Male: (Inaudible). Maybe you were on mute; yes. Oh, that's great; then you're here.

Ben Hamlin: Yes, I'm here.

Male: Well so I think what I'm hearing, Ashley, is that the committee would – if the – if the developers do not mind, the committee would like to hear presentations – brief presentations before we start the discussion.

Ashley Wilbon: That would be great; that would be great. If the developers are comfortable doing that, we'd welcome them to do so.

Ben Hamlin: Sure; fine with me.

Nancy Kim: Hi, it's Nancy Kim.

(Ben Hamlin): Do you want me ...

Nancy Kim: Totally fine with me, but I will say that the guidance was that we should only speak if we're spoken to; that we received (inaudible).

Male: (Inaudible). So the question will be (we're) asking for a brief presentation, so (inaudible).

Nancy Kim: (Fine). Happy to provide.

(William Weintraub): OK, great.

OK. What I would advise people to do is you'll – you're going to find it a lot easier to look at the Word document rather than the Webinar, which (inaudible) – I have both open right now, but the Word document is much, much easier to read.

So if everybody has that, you might prefer that to the Webinar.

All right, so, Ashley, are we ready to go ahead?

Ashley Wilbon: Sure. Whichever developer you'd like to go first; we can (inaudible) ...

(William Weintraub): Well why don't we take them in order as we see it in the – in the document?

Now we have a lot of questions and only two hours and so there's a lot of work to be – to be done here and to try to move through. But let's go ahead and have a presentation on (1558), relative resource use, people with cardiovascular conditions from NCQA: about five minutes or so?

Ben Hamlin: OK. This is Ben Hamlin from NCQA. Can you all hear me?

(William Weintraub): Yes.

Ben Hamlin: OK, great. (I said) I think I was on a muted line or something earlier.

So the five-minute elevator speech on RRU for cardiovascular conditions is that we looked at a general population with cardiovascular conditions, or more broadly, as we've defined in the past as IVD, ischemic vascular disease; a long list of things.

We have use the HEDIS definitions for the (elderly) population, which I think some of your questions may address as far as you know some procedures in the year prior versus a diagnosis in either year.

The measure itself looks at all resource use for – during the measurement period for patients who have been identified with these conditions, so

basically it's a total resource use measure. You know we don't try and attribute the resources used to the condition itself, which we just looked at, sort of broadly, all resources used for these patients who've been identified.

It is broken down into a number of subcategories, as you've all seen, I think, in the measure specification. And I think I'm actually just going to leave it at that.

(William Weintraub): Oh, OK. So I think that we will have additional questions for you as we begin to move through, but why don't – why don't we begin from the very top then, with the clinical logic? And I'm going to ask the committee to go ahead and speak up.

So based on the stated intent of the measure, to what extent is the measure population clinically appropriate?

Judd Hollander: Can I go back one minute, just to ask you?

(William Weintraub): Absolutely.

Judd Hollander: It's Judd. I'm guessing from your comments that this is available to us on the SharePoint site rather than looking at the Webinar?

(William Weintraub): So I don't know if everybody's got it.

Judd Hollander: Yes, because I can't find it.

(William Weintraub): (Inaudible) or not. Ashley, do you know?

Ashley Wilbon: It is. If you go to – are you speaking about the actual measure or the summary of the TEP – the TEP evaluations?

Judd Hollander: Summary of the TEP.

Ashley Wilbon: OK. If you go to the main page; I'm not sure exactly where you are, but if you – if you click on Committee Home in the left kind of blue bar ...

Judd Hollander: Got it.

Ashley Wilbon: And if you scroll down to the meeting and call documents for today, under 2/3/14, you should see a word document that's titled Technical Expert Panel Measure Evaluations.

Judd Hollander: Got it; perfect.

Ashley Wilbon: OK, great.

Female: Great; can you say that one more time?

Ashley Wilbon: Sure. Are you on the SharePoint home page for the committee?

Female: (Inaudible)

Ashley Wilbon: (Yes, the) Committee Home and the left side blue bar on the side; scroll down to meeting and call documents, under the call for today, 2/3/14. There'll be a Word document for Technical – OK.

Female: (Thank you).

Ashley Wilbon: Yes, sure.

(William Weintraub): OK, is everybody ready, or close to ready?

Male: Yes.

(William Weintraub): So let's go ahead; all right? And again, based on stated intent of the measure, to what extent is the measure population clinically appropriate?

Ted Gibbons: I had – I had a comment; this is Ted Gibbons. (It) seems to be fairly well consigned to the patients with coronary disease, but doesn't include other manifestations of vascular disease. Is that – is that intent of the – of the developer?

(William Weintraub): Can the developer comment, please?

(Ben Hamlin): I don't think it was necessarily intentional limitation, but I think because it's a claims-based measure, we have been continuously refining the value (FETs) we used the codes to identify the population. And you know it has to pass a

pretty high standard of reliability and so I think that you know for the identification protocols, we try and use the ones that fairly reliably identify the population.

And I've been looking at some of the specific comments and questions in here and trying to map those to our value (FETs) to see if they're buried somewhere in the list of codes or not at this – at this point in time, but unfortunately it's about 100 pages, so I'm taking – it's taking me a few minutes.

(Ted Gibbons): Sure. But specifically peripheral vascular disease, abdominal aneurism and nonsurgical carotid disease, as well as ischemic cardiomyopathy would be one that would lead to consumption of cardiovascular resources, but they're not listed in the – in the measure that I can see.

(Ben Hamlin): I'm not sure and I would – I would agree that those probably should be you know critical diagnoses that would be included, but they probably would be listed in the value set and not in the – in the short list of E.G. diagnoses. It would be included in the IVD characterization. That's a – includes, but not limited to.

Male: You know so I – so I understand the idea here is not to try and cover everything, even within a disease area, but really to have – to have things that can be evaluated across institutions, reasonably reliably. Is that correct?

(Ben Hamlin): For plan-to-plan comparisons; yes. That is – that's exactly right.

Male: But (it's) so that some things are left out; it's not necessarily a problem.

(Ben Hamlin): No, it's not, but again, we want to – we want to be as inclusive as possible for the appropriate population. And as you know as the coding has been – become more and more reliable, we do try and revise these as much as possible.

If you have access to the clinical logic PDF that was submitted alongside the measure, you can see the comprehensive list of IVD diagnoses that are included, starting around page 90 of that – of that piece of paper. It really

does cover a fairly broad range of you know anginas, cardio vascular conditions, including arthrosclerosis and native artery arthrosclerosis. Sorry; my tongue is not working very well today. And various occlusions of carotid arteries within (that, infarct) and et cetera, et cetera.

So it's a – it's a fairly comprehensive list, but it's all buried in the coding. It – we just – to do that as a list in the measure would just – would really kind of overwhelm, I think, the elderly population criteria.

(William Weintraub): So then ...

Male: Thank you.

(William Weintraub): ... (within) that construct, recognizing certain limitation, are we reasonably confident then that this is a clinically appropriate population?

All of said so, basically, in the – in the comment I'm looking at.

Male: Right. I just want to add the caveat is, as I went through these, there appeared to me to be – and this was probably just because it's my time through it; I wasn't exactly sure where to put what comments. It seems like something that could have gone in one of these questions could have also gone in another, so I restricted it.

So my feelings were that, broadly, the clinical logic made sense. I had some issues with some of the exclusions that will come up later.

(William Weintraub): All right; fair enough.

Leslie Cho: It's Leslie Cho. I just have a – like a overview question. You know my sense is is I'm – this measure has been adopted by the steering committee in 2012; correct?

Ashley Wilbon: Yes, it is. It was (inaudible).

Leslie Cho: So is the – knowing the resource utilization, is there any data on outcomes; like do you have – does the measure developers, now that the measure has

been – or they've been working on these measures for a long time; is there any outcomes that they can – they're willing to share?

(William Weintraub): You mean besides what was in – what was provided to us?

Leslie Cho: Right. I mean I – the question is is here's the – I understand the resources and I understand you know the cost or whatever. But all of these measures, I think my philosophical sort of issues are that I understand one hospital uses $30,000, another hospital uses $10,000, but if the outcome of the patient is different between hospital A and hospital B, I'm not sure I care about how much money they use. Do you know what I mean?

Male: (Yes, well we actually) ...

Leslie Cho: (Inaudible)

Male: Yes. So you're – I mean you're right, if you don't look at clinical – if you don't look at clinical outcomes too.

Leslie Cho: Right.

Male: (We need) – you really need to look at both. Sort of you know the goal is the best outcomes at the lowest cost.

Leslie Cho: Correct.

Male: (Inaudible) really like to be.

Leslie Cho: Right. So I guess the question is is I mean you know I – now that the measure has been adopted you know for the last two years, are there any clinical outcomes associated with these measures?

Ben Hamlin: So this is Ben. I have two things that I wanted to point out I think that I forgot to mention. First of all, we use standardized prices to define resource use for this, so we don't actually have exact dollar amounts between hospitals for these health plan measures.

And the second is we don't actually get patient-level information for these measures. Despite the fact that there's about 75,000 data elements that come in you know for each of these measures from each plan every year to report this, none of that is patient level. It's all aggregate by the plan. And so the only entity that would be able to actually look at the actual outcomes for specific patient populations would be the plan itself.

We only report these measures with the HEDIS quality measures, so we have what we call a value equation, so it's quality against the resource use so we can try and map, at least at the aggregate level of the plan, the plan comparison, the you know the value offered for that plan at the – at the level of quality.

Now of course that's firmly dependent upon the quality measures that are available and right now we don't have any outcome measures that are currently available for these – for this level of measurement. I hope in the future that will change; however, those are – that's why we do not have outcome data.

We do look at the correlations between specific service categories of the data submitted every year and various quality elements to try and, again, create some fairly high-level associations to certain plans that have certain high-resource use in certain areas and why those might be and if that you know we don't –we don't judge. We don't say high-resource use is bad. We just say it is, because we calculate that every year.

So I hope – I hope that answers your question.

Leslie Cho: No, that was very helpful. Thank you.

Ashley Wilbon: Hi, this Ashley. I just wanted to clarify too; for our resource use measure evaluation efforts, it's something that we're working towards, but we don't yet require developers who submit resource use measures to link them with quality or outcome measures at this point in time.

We do have another effort going on that's really exploring how best to do that from a technical aspect, in terms of how you actually make you know those

two signals you know how those two signals can be correlated into a measure of some sort, either through reporting or a composite or somewhat, but we don't yet have that guidance, so the – that requirement hasn't yet been implemented.

So for the purposes of work – the work we're doing now, we're really just kind of looking at the individual resource use measure on its own merits as it's submitted and we just kind of do our best to – with what the developers have and for what we're asking for at this point, so hopefully that helps.

William Weintraub: OK. So philosophically, it certainly helps, but – and we recognize it as a limitation, but meanwhile we will plow ahead.

So are we ready to move beyond question 1? And we have 27 questions we're going to consider, team, underneath – on each measure.

Male: Fire away.

William Weintraub: OK, so next. To what extent are the definitions you used to identify and measure population clinically consistent with the intent of the measure?

So did they do what they say they're going to do? We're going to look at resource use for these particular populations; have they – (can) they – (have) they actually done it?

Thomas Kottke: Yes, Tom Kottke here. I think they can. I think the questions that came up were whether the – every single diagnosis was listed in the measure or in the background material. And I think that's where the issue showed (up here).

Female: Yes.

William Weintraub: So the question (that) is (are) the definitions too narrow and are we actually prepared to tell a developer to go back and widen their definitions? It's a lot of work we'd be asking them to do if we ask them to do that.

Male: Well my understanding is those codes may be actually part of the measure, even though they're not listed here. And so I guess the people who raised the question; you could say yay or nay.

William Weintraub: All right, so let's ask the developer to reflect on what you're hearing here. There's a worry that, again, we're hearing that the definitions may not be inclusive enough.

Ben Hamlin: Yes. And we, like I said – I mentioned earlier, we annually update our value sets for inclusion in the measure population. And as we convert to (ICD-10) this year, we've given them additional scrutiny because of the increased specificity.

So we will be looking back from these suggestions to test whether these are in fact – they should in fact be included in what the code – what the appropriate coding would be. It's part of the value set process. We always appreciate the feedback and we can certainly expand that population if deemed appropriate and the coding is tested to be consistent enough.

(William Weintraub): OK.

Ben Hamlin: It's difficult with such a broad category like cardiovascular conditions and ischemic vascular disease, because obviously there could be – sort of like cancer; there can be thousands and thousands of codes. We just have to make sure that the ones we include in the measure are the ones that are actually being used by the plans you know in such a way that we can actually map to them and we can assign standard prices to them for their resource use as well. (Inaudible) ...

William Weintraub: So that may be as much as we can realistically ask; that rather than go back and say start over, we don't like it, we can say please consider, going forward, to be more inclusive if you realistically can be. Does that sound reasonable?

Thomas Kottke: Yes, Tom here. I (inaudible) ...

Ben Hamlin: We're very happy to do that.

William Weintraub: OK?

Thomas Kottke: Yes.

William Weintraub: We ready to go forward?

Male: Yes.

Female: Yes.

William Weintraub: Was that a yes?

Male: Yes.

Female: Yes.

William Weintraub: OK, all right. Evidence to support clinical logic described in (F8.2); to what extent doe the submission adequately describe the evidence that supports the decision logic for grouping claims to measure clinical condition for the episode?

Thomas Kottke: Tom here. I think you know this issue about active in cancer and HIV is that they're outliers. They're fairly rare and they're exceptional and so, I mean I'm satisfied that those are out of there and otherwise I think they do a nice job; an adequate job. Plus we have their attention about the other codes and they're going to go to ICD-10 and take another look at what's appropriate.

William Weintraub: Other comments?

Judd Hollander: Yes, I – this is Judd. I had the comments about the active cancer and HIV in a subsequent question. You know to me, most patients with active cancer have you know a reasonable life expectancy. It's obviously different (in people with) metastatic cancer. And HIV, in this day and age, is a little bit like diabetes, in that it's a really chronic disease people do quite well with.

So that didn't give me a really good reason for excluding those people in 2014, but it's probably a small piece of the set and it probably doesn't change the reliability or validity, but I don't see a particular reason to exclude them.

William Weintraub: All right. So I think we could ask the developer (inaudible) ...

Male: (Inaudible) ...

William Weintraub: ... as they refine it again for the next time, to reconsider that.

(Inaudible)

Ben Hamlin: Yes, I mean just for your own information, the principal reasons for our exclusions in these measures is primarily around the amount of resources used for those conditions are disproportionate to the others you know for a – for a patient who does not have either active cancer and a cardiovascular condition and/or HIV and a cardiovascular condition.

We cap out the resource use on a per-patient level at $100,000 and obviously active cancer treatments can go well above that quite quickly. And so what you might see is a number of – if a plan has a large number of active cancer patients, their results will be capped out for that versus another plan who might not have that same population or have a different population.

So it's more about the cost and not about the clinical component of whether active cancer is appropriate to (include) in the measure, (or HIV) ...

Male: So the worry here is that you could have some clustering within institutions of high – of high-resource use measures, which could distort the ability to create a level playing field. Is that the idea?

Ben Hamlin: Exactly.

Male: Then I think I makes (inaudible) ...

Male: (Inaudible) that's a very good answer.

Male: Yes, I think that's great.

William Weintraub: OK, so then are we happy to – with this – with this?

Male: Very happy.

William Weintraub: Point?

Female: Yes.

Male: Yes.

William Weintraub: (All) right, good. OK, next. Given the condition being measured and the (intent of the measure described), the alignment of the length of the episode, including what triggers the start and end with the clinical course of the condition.

Male: (Yes) ...

William Weintraub: So remember that this is basically an annual resource use.

Male: Yes.

William Weintraub: Is this appropriate?

Male: Yes, I think if it's (an annual resource) ...

Female: Yes.

Male: ... use, (yes); it makes sense.

Male: I think that makes sense. I think this is an easy one.

William Weintraub: OK, next. (Discuss) the clinical relevancy of the exclusions (inaudible) the target population of the episode, condition (course) or co-current condition and measuring 10. So here we – and this was sort of a little bit repetitive of what we discussed before; and comments, please.

Female: I think we addressed a lot of this issue you know initially, when we started (inaudible) (8.1)

Male: Yes.

Female: I think it's appropriate you know that I've heard the whole background from the measure developers

Male: I agree.

Male: Agree.

Male: I think there's only one area, and I don't remember whether this was the section that I discussed it; I don't see the comments here. But I think there was a little concern, when I looked at it, that if you had you know step A, for example, you had a PCI, but then you ended up with a CABG, presumably during the same year, it only counted as a CABG.

And I just wonder whether that – maybe I misunderstood it, but it seems to me that that wouldn't accurately capture the resources used, unless it captured all the (resources that were) used.

Ben Hamlin: So – right. So the measure will – for a patient who has a – has a PCI and a CABG during the measurement period, both of those would be included in the measurement, in the – in the aggregation of the resources used.

That would also – they would also be listed independently under the frequency section for this measure, where we actually look at the number of PCIs, the number of CABG, number of carotids that the plan you know members had on a per member per year basis. So it would be – it would be included in both, I guess, (as I – as long) ...

Male: (So someone) ...

Male: (OK), maybe I misunderstood that then. That makes (inaudible) ...

Male: So if someone has a complicated PCI and then goes on to have a CABG, they're still included in both measures? In both categories?

Ben Hamlin: Both of those two – both of those two ...

Male: (But is there) ...

Ben Hamlin: ... (separate) procedures ...

Male: Is there a risk of double-counting?

Ben Hamlin: Not for the individual patient; no, because basically the plan (has, I know), identified the patient in the eligible population if they have either of those in the year prior to the measurement periods, but if they've had both of those in the year prior to the measurement period, they would not be included.

Those procedures would not be priced as resources used during the actual measurement period itself. That's why during the measurement period itself, we only rely on the – on the diagnosis criteria. But if it – if that person did have a CABG and a PCI during the measurement period; maybe they had one you know in the previous year – poor patient; and the measurement period you know then those would be included in the resources used.

Male: OK.

William Weintraub: More comments? We really sort of discussed this in some detail now.

OK, do the exclusions represent a large number of patients?

I personally had trouble following whether this did or didn't and maybe the developer should comment.

Ben Hamlin: They currently do not represent the proportion of the – of the plan populations, at least at our last analysis, when you look at the plan-by-plan reporting.

Male: So what ...

Ben Hamlin: So as I mentioned earlier, they do – they do account for a disproportionate amount of resources used by a plan; the actual number of patients on a (PMPN) basis is actually quite low, overall.

Male: And what percentage?

Ben Hamlin: I don't have (it at tip) of my finger know, because it – because it varies by plan and we have you know over a thousand plans reporting this measure; at least we did last year, so.

I could probably dig up that data and present it, but I'd have to go back and ask (here in the) office group to (inaudible) ...

William Weintraub: Yes, it would be interesting to know the distribution of that.

Other comments?

Female: No.

William Weintraub: Does everyone agree with my suggestion?

Male: Yes.

William Weintraub: That we ask them to look at the distribution of (the number or who the patients)?

Female: Yes.

Male: Yes; I think we're supposed to evaluate it.

Male: Yes.

Male: (Then) evaluate it.

William Weintraub: Yes. Yes, we're asked to evaluate that and we really can't.

OK, so there's a (task for you), but not – Ben, but not a difficult one, after all. We're not asking you to do a reanalysis; OK?

All right, (we're) going back to exclusions now. To what extent is the rationale for clinical exclusions adequately described and clinically relevant?

We really discussed this in some detail.

Male: Yes.

William Weintraub: Do we need more discussion on this or are we (inaudible) appropriate?

Male: Yes, so only added in one thing to this, because we're supposed to look at resource utilization within the plans and as an emergency physician who often takes care of patients that aren't paying, I noticed that if the plan opts not to pay for the service, it doesn't count, but yet it's still a plan member using a resource.

And so without knowing how often plans or what percent of their payments or what percent of their resources they deny, it's really hard to see everybody (has) a level playing field. So my concern is that a plan could look better by refusing to pay for resources, based on this measure, if I understand it correctly that if you're just excluding all denials; I see that as a little bit of an issue.

Male: But it seems to me that's a different issue (inaudible) ...

Male: Yes, (inaudible) ...

Male: ... than what's being asked here, which is really clinical exclusions.

But I do – I do see your point that you could have other reasons for a measure not being (inaudible) distorted.

Ben Hamlin: So that – actually that issue is actually handled in a different arena. That's handled under our accreditation standards for each health plan you know the services that are paid or denied (and their) processes for that.

We don't actually address that in this specific measure though.

Male: OK. I think if that's OK to the big group you know just highlight that here and I'm fine with moving on.

William Weintraub: Yes, I think it's probably just – you know I think it's a very important point but a little bit beyond our scope.

All right, next is to what extent are the relevant conditions represented in the codes listed in the submission for clinical inclusions and exclusions? So we keep (coming) you know these are questions are very much overlapping and I think there was concern here that we may not have all relevant conditions.

But I think what our decision was that rather than ask them to start over again, that we ask them to reevaluate this on an ongoing basis. Other comments, please.

Male: Yes, I agree.

Male: Very good.

Male: All good.

William Weintraub: All right, so now we get into something a little more complicated here, on our final one. To what extent are the co-variants factors, including the risk adjustment model clinically relevant and consistent with the measure intent?

And here we ask the developer to discuss with us their risk adjustment methodology a little bit.

Ben Hamlin: OK.

Male: Ben?

Ben Hamlin: Well, so we used the risk groups from the CMS-HCC (hierarchical) two-condition category risk adjustment process that we've basically taken a good proportion of that, because that is a resource-driven risk adjustment method.

We assign – I'm trying to – I don't know if I can give you the reference page on the materials provided, where it gives a brief description of the risk adjustment, but effectively what happens is all the diagnoses that appear on the – on the patient's record during the measurement process, give it a clinical category, then a hierarchical clinical category and then it's – then additional weights are applied for age and gender.

And that then assigns them to a specific risk group; a risk cohort. And we have 13 separate risk cohorts that are assigned for these measurements based on that analysis that we did in the early days in the (OPTIM) research database to determine what the appropriate divisions of the risk cohorts are for a plan-by-plan comparison.

And so every person who ends up with multiple co-morbids at a certain age and gender will end up in a risk group that's being compared to that same person – or that same risk group in another plan. It's fairly extensive; like I did mention there's about – it requires us to you know get about 75,000 data elements from each plan in order for us to be able to do both the expected calculations, but also to assign the risk cohorts for each of the patients.

Male: (So then it's based on) age, sex and co-morbidity and what else is in the – in the – in the model?

Ben Hamlin: It's actually – it's a lot more than age, sex and co-morbidity. It's actually – it's a hierarchical condition, so it takes each diagnosis that is – that is apparent in the patient in the record and assigns it a risk weight. And then it creates a hierarchy of those risk weights, dependent upon the condition and the severity of the condition, which then assigns it into a category.

And like I said, I'm not having a good time trying to find the risk adjustment summary. So basically, you go through and you assign a patient a specific category, based on all of their co-morbidities, so it's not just yes or no, but it's actually every co-morbidity that is apparent in the patient record is a factor in that – what risk group they end up in, because again, the HCC is a – is a – is a utilization-based risk adjustment, so it's a – it takes diagnoses that are predictors of drivers of healthcare utilization, so that's what the – what it's oriented around.

And we use the majority of the CMS-HCCs in our risk adjustment. I don't know why we don't use all of them, but I think there's a specific reason.

Female: So if a patient ...

Ben Hamlin: (So) it's a very – it's very sensitive and very specific.

Female: Oh; sorry. So if a patient comes in with redo bypass surgery, so it's their second bypass surgery they – that – those patients are clearly at a higher risk, much more complex surgery than people going for a first-time bypass surgery.

So how is that – how are you guys able to risk adjust for that, because there is no code for that; for redo bypass?

Ben Hamlin: Right. So again, this is where the you know one of the limitations is is that it's based in the – it's based in the – in the claims. So it uses a claims code as a predictor for utilization and severity. And by taking everything over the entire measurement period to assign that patient to a risk group, so it would you know the other factors; the procedure itself, additional diagnoses you know if there is some you know a previous – if the previous procedure is during the measurement period, that will actually be captured and included as part of the risk adjustment stratification and hierarchy.

But again you know the limitations are that as a – it's a claims-based risk adjustment approach and so it really is beholden a bit to the sensitivity of the – of the claims codes available, but we do use the entire measurement period; the entire 12-month period in assigning people to risk cohorts.

Male: Well I understand this much better now that if you – after you explained it than I did after reading about the measure. So and claims are what they – what they are. They're always going to have their limitations. If buy at all into the use of claims, we've got those limitations; they're just built in.

What are – what are the metrics that you're using to look at how good the – at how good the measure is? (Inaudible) ...

Ben Hamlin: We do an annual analysis. We actually do an annual analysis of all data submitted to NCQA you know all the – all the RCA data that's been at NCQA every year. Initially that was to look at the number of outliers that might have been present due to calculation errors. But again you know given the complexity of the – of the data that's actually pushed into us from the plans, we look for specific variation and we look for correlations between different service categories.

We look at the – at the RRU by risk cohort, because the – not only when we – when we report out, we actually unwind some of the risk adjustment by – we actually report out by age and gender and risk cohort, so that one NCQA (calculation has been – puts) back to the plans, gives the males 44 to 56, or I

don't remember what the cohort numbers are – in risk category 7 is what's compared to the other plan data from one of the other cohorts.

So it's really very – it's a very discreet way to do it. We you know we – again, we do a comprehensive analysis of any correlations we can see, between either risk cohorts or certain service utilization categories, the quality measures, et cetera, et cetera. And we do this every year and every year we find something slightly different.

There's you know there are some medium correlations, there are some weak correlations, but really what we're trying to look for is consistency and reliability of the data submitted to us, principally.

William Weintraub: So here, let me – let me narrow the question here a little bit. If – of your – of your risk adjustment methodology, what statistical methods have you – have you used to look – to show us how good the measure is; how good the risk adjustment is?

Ben Hamlin: Well that's one of the reasons we use the CMS model, because CMS was the one who actually validated the risk adjustment approach for this type of reporting, so again, for resource use-based risk adjustment, the HCC system is the one that you know CMS developed, CMS recommends and CMS maintains.

And there's a number (inaudible) ...

William Weintraub: All right, well fair enough. I understand; I understand what you did, but still (inaudible) the question of what your own metrics where.

Ben Hamlin: You mean why the decision to use HCC? (Inaudible) ...

William Weintraub: (Inaudible), I mean did you use (R-squared) or what measures of how good a risk adjustment this is? How much of the variability ...

Ben Hamlin: (We didn't – we did) – we didn't – we don't revalidate – we don't revalidate the risk adjustment itself. You know we do do analysis, like I said, on the data coming in for reliability and you can – I think you can probably find that ...

William Weintraub: Yes. I mean it's not – you know it's not actually the job of the – this TEP is a clinical TEP as opposed to a statistical evaluation, which will go on for this measure as well. I'm still a little bit worried that you're applying the measure and you're not revalidating it yourself.

(I know) (inaudible) here. I'd like to hear what the other members of the committee think.

Male: Well I – so I agree with you. I mean I had trouble and quite frankly it wasn't clear to me that we were really a clinical TEP and so I was looking for some you know reliability and validation, particularly for a measure that's already been in use, and couldn't find it terribly well.

Male: I couldn't find it either and I was looking and looking and looking and I was saying like am I completely lost here?

Male: Right. And so that was my biggest criticism of this particular measure. If it's just how's the clinical stuff, well then I have a very different opinion, but I think the issues you raised, I thought you know the answers to the statistical modeling were generously, I considered superficially addressed. I mean it just (isn't) clear exactly what was happening.

William Weintraub: So you know when NQF asked me to chair this panel, they knew that I wasn't going to stick to the questions. I was going to ask people to speak broadly, so here's our opportunity.

If we feel that they haven't done that, we should ask them – we should – we should voice that.

Male: So I'm comfortable voicing that. I guess I'm not sure that it's in our domain to review it, but I think certainly the larger committee's going to need it if that's one of the things they're going to be judged on, so (inaudible) ...

William Weintraub: Well you know I will – I mean I'm representing the – I'll be representing the TEP at the steering committee and on the clinical side they pass pretty well here, but I'm a little concerned about this. (I mean it's) addressable

without them having to do reanalysis and you know start over from scratch and redefine things; just doing statistical validation is much easier.

I'm prepared to say that at the steering committee if TEP – if the TEP feels that way.

Judd Hollander: I would support that. This is Judd.

Male: Yes, I think it would be reasonable to ask for this validation and an explanation or a demonstration that his does in fact risk-adjust and the extent to which it risk-adjusts.

Ted Gibbons: This is Ted. I guess I would go back to a more qualitative question rather than a statistical one, saying if the – if the measure developers just have to have – give another elevator talk, what do they hope to accomplish by reporting these data and what's their impression about the impact of these data, without actually quantifying things in a – in a more specific way?

Do they feel that they're – that the institutions of the plans that have excess resource use; are you using it one direction or another? Is it a geographic distribution or is it – is it a (inaudible) ...

Male: Wow.

Male: Everybody still there?

Female: Hello?

Male: Yes.

Male: Did everybody hear that?

Female: Yes.

Female: Yes.

Ted Gibbons: Yes, I don't know what that was.

Is it an excess of (PCI; is it an) excess of bypass surgery and so forth? So it would be nice to have a paragraph summary of what – where we're headed with this measure. Is it really accomplishing what it set out to do?

Male: Yes. So I think those are two really great thoughts. You know that on the (narrowness) of the questions, I think that the develop – we support the developers, but we do ask them both, what are you trying to accomplish here.

And I felt that also when I – when I read this and there was this long list of the items, but I didn't feel like I came away with an overview of it.

Male: Right. That's what I had the sense of.

Male: Yes.

Male: Could I ask another question? Having looked at a number of hyperlinks, I was wondering about the resource utilization in tables – the data elements in table RCA123, where it lists gender and age groups and the metric specification name. But it's not clear to me, and I'm asking the measure developer; why are inpatient-outpatient (E&Ms) included in the younger age groups, but based on the table, they don't seem to be in the Medicare age group, or the over 65 age group.

Is that – is that just a misreading or why is it ...

Ben Hamlin: That's a – that's a misreading of the table. The table actually – this is a – it's not supposed to be a table that uses the rows. It actually just lists in columns the different data elements that are required for the measure, so you have to report both male-female, the age cohorts, the 13 risk groups, as I mentioned, the type, whether it's a cost resource use or a frequency count, and the you know specific component to which that falls under.

It's not a great table, but.

Male: That's why I asked the question. Great; thank you.

William Weintraub: All right. More comments on our first measure.

Do people need a brief break before we go on to the second measure?

Male: No.

Male: Let's (inaudible) ...

William Weintraub: Onward; OK. So the next – the next measure is – Ashley, are you – are you comfortable with where the discussion went on the – on the first measure?

Ashley Wilbon: Yes. I think – I think – yes; I do. (Inaudible) any questions or comments (inaudible) at this point?

Male: I (really) – I know it might be challenging for some of the committee members to be focused just on the clinical logic, but as Bill sort of pointed out, it would be you know if there are other pressing issues that are more broad, feel free to note them and we'll carry those forward for the larger committee deliberation.

William Weintraub: OK, very good. So no more comments on the measure, we'll go onto the second one. We thank the developer very much.

The second measure is (2431), the (hospital) level (for) risk standardized payment associated with 30-day episode of care for acute myocardial infarction. This was developed by CMS with a contract to Yale. And we'll ask the developer for an overview up to five minutes.

Nancy Kim: Hi. It's Nancy Kim from Yale CORE. Excuse me. So as you mentioned, this is a hospital level risk standardized payment for a 30-day episode of care for AMI and also heart failure. And it measures payments made on behalf of Medicare beneficiaries.

We'd like to point out that it's condition-specific, so we have one for AMI and one for heart failure. And I think to address the broader comment from the group about what this is really about; although it is a payment measure and it stands alone because it reveals transparency on the costs of care associated with both AMI and heart failure; the two separate measures, it's really intended to be paired with our quality metrics and in that vein, it's harmonized

with the specification of our 30-day (of the) CMS publicly-reported AMI 30-day mortality measure, as well as the CMS publicly-reported 30-day heart failure mortality measure.

Do you – would you like some more? (Inaudible) ...

William Weintraub: (Inaudible) feel they need more detail or should we go onto the discussion? We'll be coming back to you with questions, (I'm sure).

Nancy Kim: Sure, of course.

Male: Could I ask one question about that? Is it – is it part of the intent in harmonizing it with the other 30-day AMI and heart failure measures to actually get some data about the sequence of use? For instance, we had quite a bit of discussion three years ago about bundling readmissions with E.D. visits and outpatient visits.

Are we able to learn anything from the data you're acquiring here regarding cost as it relates to sequence and appropriateness of chronic care management?

Nancy Kim: The intention is actually to expose value and illuminate value by pairing both payments with quality. We do learn something about sequence, because it is a 30-day episode of care, so you follow patient from admission through discharge through their post-discharge services for up to 30 days post-admission. But the intention was really to try to illuminate value.

Does that answer your question?

Male: Sort of; I – but do you – do you have to gain some insight about quality of chronic – or quality of care within 30 days, based on early follow-up and avoiding E.D. visits and so forth?

Nancy Kim: We do hope to gain insights into the use of post-acute care settings; not necessarily specifically E.D. and observation, but all of that; SNF use, home healthcare use, readmissions, all of that that falls within that 30-day episode.

So we do hope to gain some insights into post-acute care, but not specifically intended to focus on E.D. or observation.

Male: I see. Since it's – it's not patient level data; you'll just be able to see the broad picture within a plan.

Nancy Kim: Correct. This is hospital – it's a hospital level.

Male: Hospital level; it's not (plan level).

Nancy Kim: (Inaudible)

Male: Yes, it's not patient level; it's an administrative database; right.

Male: OK, thank you.

William Weintraub: OK, are we ready to go to the specific questions then?

So most of these are also pretty straightforward and then I think there's going to be some overview at the – at the end. Based on the stated intent of the measure, to what extent is the measure clinic – population clinically appropriate?

Male: I'm good here.

William Weintraub: Yes, I would think so. This one looks pretty straightforward.

Male: Yes.

William Weintraub: Any problems with (this)?

Male: (Inaudible) straightforward.

Female: No.

Male: All right; none at all.

William Weintraub: OK, good.

To what extent are the definitions used to identify the measure clinically consistent with the intent of the measure? (Inaudible) ...

Female: I think it's consistent.

William Weintraub: I agree; I don't see any problems here. Any problems?

Male: Yes, no; I sort of raised the (deaf) and AMA thing in the text, but after going through the last measure, I think that's probably a small amount of patients and I think it's fine.

Male: What's the problem – the reason's (deaf's) out is that they're cheap.

Male: Yes, no; I understand that and I guess if it's just hospital level data, it's not useful in the – (they) – you know the AMAs are sort of a real quality measure, potentially, and maybe the people who (roll) through the door or maybe something you're doing to drive them away, but again, I think in the big picture it's probably fine to leave them out.

Male: OK.

William Weintraub: And that comes up here again, also; to what extent does the submission adequately describe the evidence that supports the decision's logic for grouping claims, identifying the measure population exclusions to measure clinically – the clinical condition for the episode?

Male: I thought it was (inaudible) ...

Male: So the only thing that I had as a real issue; I you know in the absence of a better explanation, I found it unusual that costs were distributed the way they were. As I see it, for a 30-day measure, the majority of costs will probably be at the second hospital; not the first hospital, unless I'm wrong.

You know I live in the E.D. but my world is, if someone gets transferred, it's often out of the E.D. to the secondary to the receiving hospital and then the receiving hospital does all the expensive things and makes the 30-day plan for care.

It would seem to me that if you want to charge costs to the transferring hospital, we probably should see a sensitivity analysis to say the that's the right place for cost to be, but (it's) my guess that people spend a day or less at the hospital that ships the patient out and then the remaining 30 days of their care are driven by the hospital that they get transferred to.

Male: All right, (so this is) (inaudible) ...

Female: (Inaudible) ...

Male: (Inaudible) ask the developer to discuss the problems of patients that are sent from one hospital to the other and the decisions that have been made.

Nancy Kim: Sure; no. Thank you so much. It is a great question. It came up a lot with our TEP.

So just to clarify, these transfers are from hospital A inpatient, so not from the E.R. – straight from the E.R. to the second hospital. It's really (you're) an inpatient to an inpatient. So you were admitted at that first hospital so I hope that clarifies the E.R. issues.

Male: OK.

Nancy Kim: Secondly, when (we view) the transfers, there's no – really only three ways to go. You can exclude them; we didn't want to do that with AMI, because about eight percent of our cohort involved a transfer, which you can attribute to the first hospital, as we are doing, or you can attribute to the second hospital, as you suggested also would be valid.
We actually did a lot of sensitivity analyses and it works out that you know you think that the second hospital's the expensive hospital, because they're doing PCIs, but they – it doesn't really change the nature of the hospital grade. I don't want to call it a grade; the hospital profile.

So we didn't want to exclude because there's too many and we felt this is fair because hospital A initiates the decision to transfer. There are obviously some you know there are problems with attributing to A, but there are also problems attributing to B and we thought, on par, this would harmonize with the way

that our mortality measure does (it when) we did sensitivity analyses; A, does it come out looking more expensive because they transferred?

Male: OK. I'm perfectly good with that.

Male: Everybody comfortable with this?

Male: Yes.

Male: Yes.

Male: All right.

Male: This has come up with other measures and it makes sense.

Male: (Right).

William Weintraub: Next is given the condition being measured and the intent of the measure, describe the alignment of the length of the episode with the clinical course of (this – this) – the condition. So this is a 30-day measure that includes the initial hospitalization up to 30 days. Is this appropriate?

Male: Yes. There's – in the literature there's been plenty of complaining about that 30-day period, but I just don't think it's appropriate.

Male: So would people prefer that we – that (they use) something else; a 60-day, 90-day?

Female: No.

Male: We don't have anything better. We don't have anything better, so I think 30 days is fine. It just ...

Female: Yes.

Male: You got to make it – the thing is you got to make a decision.

Male: Yes.

Male: So I think 30 days is fine.

Male: Yes.

Female: Yes.

William Weintraub: Everybody comfortable?

Male: Yes.

Female: Yes.

Male: It harmonizes, (though), so people are used to it. It's what (they have their eyes on) (inaudible) ...

William Weintraub: Right. If people are used to it, it goes along with the clinical measure; indeed.

OK, (inaudible) including exclusion criteria detail. Describe the clinical relevancy of the exclusions to narrowing the target population for the episode, condition, clinical course of co-occurring conditions and measure intent.

Maybe we can ask the developer to discuss inclusion/exclusions a little bit; their thoughts.

Nancy Kim: Sure. I think you all had our technical report materials. We included basically any discharge that was an ICD-9 code for AMI or heart failure; I know we're discussing AMI right now.

Male: Right.

Nancy Kim: And the excluded, basically if we couldn't measure you through the episode of care, so I'm just going to turn to that section, or if you have it in front of you. So we excluded populations for patients who had at least 30 days of post-admission enrollment in fee-for-service Medicare, because we couldn't calculate the payment outcome.

We excluded hospitalizations for patients admitted and discharged on the same day, because we didn't really believe they suffered a significantly clinical AMI. We – it says transfers; it's just (the way we) – we don't exclude transfers. They're already bundled into one inpatient episode, as we discussed regarding the payment, so we don't really exclude transfers. In written that way in the technical report, but I think that's really confusion and we've since changed our language about that.

We exclude for patients with claims that contain inconsistent or unknown vital status, so date of death precedes date of admission just because we think they're erroneous. We exclude hospitalizations for patients with claims that contain unreliable data; similarly, if your age is greater than 115. We don't believe that that's true.

We exclude hospitalizations for patients discharged against medical advice, because we don't believe that hospitals had a full opportunity to implement high-quality care. And so I've just lost my page again.

And we exclude patients who are transferred to federal hospitals, because we don't have the data for these hospitals. We exclude patient with hospice enrollment within one year prior to or on the date of (an indexed) admission. This is done for our 30-day – (the standards) (inaudible) for AMI and also allows – you may treat folks with a hospice enrollment differently than you would others.

We exclude patients without a diagnosis-related group or (DOG) waiting for their (indexed) hospitalization, because we are not able to calculate a payment because we heavily rely on the (DOG) weight to calculate our inpatient payment.

We exclude hospitalizations for patients with an (indexed admission) within days of a previous (indexed) admission. It's really only for the one – this is really specific to admissions per patient per years, so if you cross years, 2009 to 20010 or 2008 to 2009, this would apply.

And lastly, for heart failure, we exclude those folks who have had an LVAD on the (indexed) admission or during their episode of care. And we exclude –

for heart failure, we exclude patients who received a heart transplant during their episode of care. And do those in those two sub-cohorts, because we think they're really, really expensive and happen only in a – in a few hospitals. And for AMI, we don't exclude either LVADs or transplants.

William Weintraub: All right, so that was a very good explanation. Any comments?

Anybody troubled by that?

Male: No trouble.

William Weintraub: It all sounded very reasonable to me.

Male: Yes.

Male: All good to me.

William Weintraub: OK. So do the exclusions represent a large number of patients? And let's ask the developer again to comment on that.

Nancy Kim: No, they don't represent a large group of patients.

William Weintraub: So how many?

Nancy Kim: I can look on the technical reports. So I'm looking for heart failure. Did you want to look for AMI or heart failure? Is it OK if I give you (inaudible)?

William Weintraub: (Inaudible) do those together, just to make it more (rapid).

Nancy Kim: For heart failure, I will just say it's – (incomplete) administrative data is 1.29 percent of the cohort. And these are – these are done at the same time, so these are not hierarchical. It's not 1.29 and then another percent. This is anybody who meets any of these criteria.

Same or next-day discharge, in patient did not die or get transferred is 7.7 percent. Transfers into the hospital, again, are less than one percent. Inconsistent or (inaudible) vital status is 0.01 percent. Unreliable data is zero percent. AMI discharges are 0.4 percent. And these are all really small.

Hospice is one percent. Transfers to federal hospitals is 0.03 percent. Missing (DOG rates) are 0.1 percent. I'm sorry; am I still there?

William Weintraub: Yes.

Nancy Kim: Heart transplants are – for – this is, again, for heart failure. Heart transplants are 0.05 percent. LVADs are 0.04 percent, so it's very, very small. It's very similar for AMI. Also we don't exclude (inaudible) ...

Male: (So one of them that was) larger. There was one of them that was seven percent (inaudible).

Nancy Kim: Same or next-day discharges in patient did not die or get transferred is what's seven percent, for heart failure.

William Weintraub: All right. Is everybody comfortable with that?

Male: Yes.

Male: Yes.

William Weintraub: OK.

So to what extent are (the) rationale for clinical exclusions adequately described and clinically relevant? We just heard all about that. Anybody troubled by what we've heard?

Male: No.

Male: (Inaudible) – Tom here. Just going to back to that next-day discharge. You know we see a fair number of patients who genuinely do have heart failure who are brought in for diuresis and have a pretty brisk diuresis and are able to go home the next day. We even have some who – in the E.R. where we diurese them in the E.R. and they go home.

I mean I'm – I don't want to sort of kick the tires too hard here, but I'm not – I'm not positive that those aren't you know true heart failure patients. They're (inaudible) heart failure.

Female: Good. I agree with you.

Male: (Inaudible) so there's not at Yale? What's your response?

Nancy Kim: Yale is considering that in the next round. So for measure – evolution for measure maintenance; what we call maintenance for measure reevaluation, we are look at that, both for AMI and heart failure, because even AMIs now, (inaudible), you're kind of going home within one day, sometimes two, so it's a very, very good clinical point. (Inaudible) ...

Male: (I'd say frequently) these days, with (STEMIs) they go home the next day; amazing.

Female: That's right; that's right.

Male: (Inaudible)

Nancy Kim: I will – I will – oh, go ahead; I'm sorry.

Male: I just said, we're sending home (STEMIs with only) four-hour stay; (abnormal L.E.) foundation and then got a stent in and you know (inaudible) ...

Nancy Kim: I know. It's totally – it's very, very true. I will say we developed these data in 2008 and 2009. I don't think it was happening as frequently then, but your point is a good one and we are considering that for measure maintenance (inaudible) ...

Male: Yes, I think it's (inaudible) I had that down for the heart failure comments. I think it's really important for that, because the landscape has changed since the time you evaluated this to (inaudible) ...

Nancy Kim: Yes.

Male: (Right; very true).

Male: Basically (you have to) be what used to get in the unit to even get in the hospital these days.

Nancy Kim: It's very, very true. I will say that (inaudible) ...

William Weintraub: I think we have (inaudible), whether we can recommend going ahead with the measure or we – do we feel that this sufficiently – a problem that I should go back in and review the measure now or is it OK to say consider this in your next revision?

Male: Yes, let's do plan B there. Go ahead with ...

William Weintraub: It would seem to me that's too much to ask of (inaudible) go and start over for this round. Does that sound reasonable?

Male: Yes.

Female: Yes.

Male: I'm OK with it.

Male: (Inaudible). I think it's heterogeneous too. I think that heart failure centers are more – and primary TCI centers are more likely to have a short length of stay and other centers may have – may be catching up, so it's probably the next round.

William Weintraub: Yes. So you – so that actually suggests that there – that there may be a systematic bias here with some institutions systematically sending people home earlier. And so those are going to be probably lower cost and so you can (bias against) the institutions that send home a lot of people earlier.

So there is a –there is a potential for something here that really throws off the measure.

Male: (Wouldn't it be) a good way? It would decrease overall cost and presumably have the same quality.

Male: Sending people home decreases overall costs. That's not the point. The point is if you don't include them because they go home early, you throw off the measure and you may be biasing against hospitals that are – that are working to send their patients home early.

Male: Right. That's fair enough.

Male: (Inaudible) patients.

Male: Yes. So I think that that one's worth bringing forward; (let the) full steering committee know that, but know that the plan is to look at that in the future.

Male: Right. I also would like to just draw a distinction between the AMI measure and the heart failure measure. I mean you know I don't live upstairs in the unit, so in the (OBS) unit, we're not yet seeing you know (STEMIs), but we are seeing the majority of the heart failure admissions and many of them are going home relatively fast.

So that may be something that's different now; more commonly than the short AMI visits, but (inaudible) ...

Male: Actually I think shorter AMI visits for (NSTEMI); not (STEMI), for (NSTEMI), short – the short visits are common.

Male: Right.

Female: Actually, as an interventionist, I just want to say that for (STEMIs), it's very common. If you have an uncomplicated (STEMI), at the Cleveland Clinic, we get you out of here in 48 hours or less, depending on how you know where the location of the (STEMI) was, because now we do radio PCIs for 50 percent of our you know (STEMI) PCIs. It makes a big difference.

Male: All right. (But) the measure, is it 48 or 24 hours; the exclusion?

(Nancy Kim): Forty-eight; no?

Male: Forty-eight. Yes, 48's pretty long, actually.

Female: (Inaudible)

Male: (Inaudible) 24. Yes, 48's pretty long, both for (STEMIs) and heart failure today. I'm surprised its only seven percent.

Male: (It's older).

Female: (I think) – excuse (me); data are older.

Male: Yes.

Female: Two-thousand-eight, 2009.

Male: So I guess maybe, actually problematical going forward.

Nancy Kim: It is something we're going to reevaluate. I really appreciate your comments.

Male: What's the timeframe for that?

Nancy Kim: For the measure?

Male: To reevaluate this.

Nancy Kim: Over the next year.

Male: Over the next year. So I mean that may be the most that we can ask of them; that we see a problem here, that it actually create a bias, (work) against (sort) of sending a lot of – lot of patients home earlier and that the data are a little bit historical and may have – may have changed considerably in the last few years.

Male: Yes.

William Weintraub: OK, are we ready to move on?

Male: Yes.

William Weintraub: OK. So we're up to – they're all sort of the same here. To what extent is the rationale for clinical exclusions adequately described and clinically relevant?

So I think we've really been over this and we see the one particular problem.

Male: Right.

William Weintraub: OK, next. To what extent are the relevant conditions represented in the codes listed in submission for clinical inclusions and exclusions?

All right, so we've already heard about this. Do we want more discussion about this?

Male: No, I'm fine.

William Weintraub: (Fine). I think we're good.

All right. Now again, we move on to something a little more complicated here in the last one. To what extent do the co-variance factors included in the risk adjustment model clinically relevant and consistent with the measure intent?

And here the variables used in the model were spelled out in very great detail. Maybe we could ask our developer to discuss their thoughts about risk adjustment here a little bit for us.

Nancy Kim: Sure. So we risk adjust – the way we risk adjust is the NQF-publicly endorsed measures. We – it's a patient-level risk adjustment, so we take all the (inaudible) for the days that any patient with an AMI – let's just talk about AMI right now; (time) in the 12-months preceding their indexed submission or on their indexed submission and run by varied analysis to see which ones are frequent and clinically significant with the outcome, which is our total payment.

Because there are 15,000 ICD-9 codes, it becomes unwieldy, so we try to shrink these down with a clinical team of experts into about 189, what we call condition categories. So we run them by variance. We choose the ones that seem reasonable. We exclude ones that don't matter, like pregnancy and things like that; not appropriate for Medicate populations, or (AED) or something like that.

And then we run them through half of our development samples, so a random 50 percent split of our samples. We'll run through, see what's frequent and

clinically significant and we'll validate with the other random half of our sample and then we do temporal validation of the model as well.

William Weintraub: (Comments)?

Nancy Kim: (And that) ...

William Weintraub: Go ahead. Go ahead; I'm sorry. I didn't ...

So, OK, so comments please?

Thomas Kottke: Yes, Tom Kottke here. Looks good to me and I have a 2:20 patient, so I've got to sign off. I'll see you guys.

William Weintraub: OK, thank you for coming.

So my problem with this is the – looks like the methods of risk adjustment are very good, but the validation of it is really worrisome for AMI, if I've got it right, your (R-square) was 0.05 and for heart failure, it (was putting out a) three, so (you) explained very little of the variability by your risk adjustment.

Is that correct?

Nancy Kim: That is correct.

It is also on part with the level of risk adjustment we saw in the paper published a few years ago by Medicare, using HCC as their hierarchical condition category. And their risk adjustment only counted – it was a longer term; it wasn't a 30-day window – for about 8 to 12 percent, depending on the way they risk-adjusted, of the variation they saw around payments.

It doesn't work as well as for mortality and readmission and we think that may be because of clinical decisions we make that affect payment may not be related to co-morbidities. They might be related to physician behavior or other structural qualities at the hospital in which we practice. (Inaudible) ...

Female: I have a quick question. You know like acute renal failure and whatnot have been predictors over and over again, besides just dialysis – being on dialysis,

of poor outcomes in AMI you know as well as all the mechanical complication of a (STEMI) and arrhythmia and cardiogenic shock.

Am I – am I just stupid, because I can't seem to find that in the risk modeling?

Nancy Kim: Are you talking about AMI or heart failure?

Female: For AMI.

Nancy Kim: It should be there. (Inaudible) ...

Female: (Because I) ...

Nancy Kim: Go ahead.

Female: So if you look at, for this – so I went through the statistical and I looked through all the stuff and like dialysis status is there, but you know having acute renal failure during the (STEMI); that's not there. And things like you know just major mechanical complication of a (STEMI), like you know V.T. you know it – also, like other things like A Fib, but also mechanical complication, like (severe M.R., VSC), all of these sort of complications are not there.

Nancy Kim: Great. That's a great point. It's because our risk adjustment is based on claims data, so they're not based on clinical data or clinical question in the submission, unless that clinical course is reflected in claims data.

So for example, any – some complications that happen during index admission can increase your (GRG) weight, so that would make your indexed admission look more expensive, so if you have an ICU stay or had some complication that was included in the claims, we would see that.

But we wouldn't get down to the level that you're talking about; hypotension or, as you're saying, A Fib; unless that were coded and bumped you up in the (GRG). So similarly, the you know the (inaudible) of (1.4) wouldn't get coded unless somebody ticked it off. Does that answer your question?

Female: I guess my thing is is when your – when your – these statistics or whatever is 0.5 or 0.3 in heart failure cases, it makes me think that it's such a poor measure of risk adjustment that it might be unreliable.

Male: Yes, so here's the point. If you're only expecting – explaining five percent of variation with one measure and three percent with the other measure and you're sort of attributing every – (a lot) – the rest of the hospital, how much is it realistic?

What kind of risk adjustment would you say; were you doing a good enough job that a lot of what's left is (inaudible) to the hospital? After all, you want to judge hospitals by this, but your risk adjustment; I mean it sort of seems to me like a long climb for a short slide.

Nancy Kim: Yes. It's – you guys are making a great point. There are other things that we do believe could (inaudible) the risk adjustment. We haven't included them by design, because we don't think that they are – such as coming from a SNF or something like that. So it's sort of related to your co-morbidity, sort of not; it sort of depends on where you live and all the resources around you.

We haven't done that in the past, because we believe it's sort of a structural quality of the – it's a health structure quality, rather than a hospital – something we should adjust away from the hospital. But you guys are – you're raising a good point. (There are other) ...

Male: So ...

Nancy Kim: Go ahead.

Male: In my experience, with cost models using clinical databases, you get your big bump-ups for length of stay and for – and for complications. But co-morbidities generally don't add very much.

Nancy Kim: I think ...

Male: Yes, and I would say I'm not surprised that you can't explain a lot of the variation, because we're looking at clinical parameters that we know are important, but don't necessarily drive changes in reimbursement.

And so, hence, there should be a lot less variability than we would naturally expect; right? Because if you're not going to double the cost because somebody has capillary muscle rupture, then you're not going to see – then you're not going to be able to explain that variation, even if they have capillary muscle rupture.

Nancy Kim: I agree with you. That's sort of the way (I) interpret this. This is – because the (DRG) takes into account things like length of stay – this is a (DRG) payment system, so the indexed admissions are heavily based – they're completely based on the (DRG ways). So unless that complication is going to bump you up in the (DRG) weight, you won't see that.

I will also say it's a 30-day episode of care measure. It's not just the indexed admission, but we do know that the indexed admission is a high proportion of that 30-day episode of care total payment.

Male: Right.

William Weintraub: So I just wanted to add, and you raised the SNF thing on your own and I had missed, but I'd written it somewhere earlier; I think taking into account where a patient comes from is actually very important and I think the socioeconomic status (into) the hospital and not a patient-level measure is probably important too.

I think it's kind of unreasonable to expect an inner-city hospital with no resources and no public support to have the same quality measures as a private hospital of you know where everybody is insured and has a job. We can't get educational level you know for the patients, but we can actually get zip code, (SES) of the hospital to give it a proxy measure.

And I think that if you have a high percentage of people coming in from long-term care facilities, you're going to have entirely different outcomes, because

they're all going back to long-term care facilities and that's going to drive up the post-discharge costs phenomenally.

Nancy Kim: Thank you for that comment. We don't routinely adjust for (SES), gender, race or ethnicity in our measures; mostly because we don't think that hospitals should be held to different standards based on the demographics of their patients. They shouldn't be making choices, necessarily, based on the (SES).

I will say we've also done some sub-analyses, looking at hospitals at higher and lesser proportions of low (SES) patients by using dual eligibility as a proxy for the (SES) and we really haven't found a substantial difference based on that.

William Weintraub: OK, all right. So NQF also has policies on using socioeconomics in risk adjustment. Ashley, do you want to comment on that?

Ashley Wilbon: Maybe actually (Sherone) might be a better ...

William Weintraub: (Sherone), could you comment?

(Sherone): Absolutely. So NQF's current position, there's a – there's actually an expert steering committee panel that is looking at this precise issue and it just met a few weeks ago, but as far as NQF's current criteria goes, adjusting for a factor; we look for adjustments of factors that happen at the present – that are present at start of care.

And particularly, we're not looking for measure developers to make adjustments for socio-demographic and socioeconomic factors in the risk model, even though they may be predictive – and increased predictive nature of the – of the risk adjustment model.

However, the issue is certainly under evaluation at this point, but as NQF's current guidance stands, we don't look for those types of adjustments in order to facilitate understanding of differences (of) performance across groups and to ensure that we're not masking disparities of care.

Again, this issue is under evaluation from an expert panel that's looking at this precise issue at this moment in time, but as far as the committee is concerned, we should sort of operate under the current NQF endorsement guidance on this particular issue.

Male: So, now the (other) thing about this is this modeling does not include complications or length of stay; right? It only includes co-morbidities and things present at baseline, as you—as a risk adjustment.

Nancy Kim: Correct. We don't – we don't include complications occurring during the hospitalization, because they're not really ...

Male: So ...

Nancy Kim: Go ahead

Male: So it's a problem, because one of the things that drive cost and will drive up a – give you a much better R-square, but on the other – on the other hand, it doesn't tell you anything about the hospital (performance).

Nancy Kim: Correct.

Male: If you include ...

Nancy Kim: We're trying to illuminate. Exactly.

Male: So what you'd like to do is you'd like to start out at baseline and level the playing field. But the problem is that you don't know – when your – when your R-squares are this poor, you don't that you've leveled the playing field or not.

And how would you know?

Nancy Kim: By providing case risk adjustment, we feel like we take it into account to the extent that we can, based on claims data; the hospital's case mix.

Male: Yes, but to the extent ...

Nancy Kim: (And we don't want) ...

Male: .. that you can, but is it – is it good enough? Is it meaningful?

Nancy Kim: It is (inaudible) ...

Male: (And it's) the best you can. I'm not saying (do this and do this) and you've done a great job in developing and I think we'd all say that.

But maybe it's an impossible task.

Nancy Kim: I will say it's on par with other folks who try to risk adjust cost and payments.

Male: Yes. So I agree; I've been there and done that. But I know that if you don't begin to include things in the – during the hospitalization, you don't get very far and so I think that's what you're seeing. But the problem is that it may be in a par with what others have done, but I'm not sure that that gives you – that gives you a pass that we can say, OK, fine.

Nancy Kim: But we don't want to adjust for complications, because (inaudible) ...

Male: I understand – I understand that. I understand; I understand sort of the dilemma before you.

Male: So can I suggest that maybe when this resource use measure is actually combined with the quality measure, the kinds of adjustments we're talking about will become more relevant?

Female: I think it would be harder to do an outcome measure when the – when the risk adjustment is so poor. And I think that you know for me, one of the things I worry about in measures like this is that you know these things will be you know that people will know or whatnot. And you have poor risk adjustment, so you have information without – no one's going to look at the R-square besides us.

After we're done, that's it; maybe.

Male: That's true.

Female: And so I ...

Male: (Inaudible)

Female: Huh? (Inaudible)

Male: (I'm on the steering) committee beyond us. We'll discuss this as well, you can be sure.

Female: But, OK, also on the steering committee, but when these things get disseminated and people have the – this information without sort of the subtlety and the nuances of it, I fear that you know there'll be repercussions (at) – you know what I mean? Based on (these) ...

Male: That's exactly right. There's danger in applying this if it – if it can't be done well.

Female: Yes, exactly; exactly.

Female: And I'm not saying that the Yale (inaudible) ...

Male: This is not the fault of the developers. They've done the best job they could with this I believe. I think they're ...

Female: Exactly. I mean I think the Yale Group does a phenomenal job with all the measures that they come up with. Maybe it's an impossible task, but at the same time, when something like this gets disseminated and people get sort of you know they get their hands on this and then without understanding all the subtleties then bad things can happen you know.

Male: (Inaudible) I (guess the name here).

Male: Can I try (inaudible)

Male: (Well) that's the basic idea. I mean I think that, on both of these measures, we can – we can carry it forward that technically they've done a great job. They've done as well as they possibly could. But the problem with the

measures is, as we've just discussed; that there's this inherent limitation that you – that you don't get very far in the risk adjustment on costs based on co-morbidities.

Male: Right, but I don't know that that's a problem, so I want to be the sort of contradictory view here. You know it makes sense to me that if your costs are not directly aligned with your co-morbidities, and they're not, that using the co-morbidities to adjust for costs may not work.

Female: (No).

Male: And I think it's a little you know apples and oranges.

Male: (They're all true).

Male: They're not directly related to each other. If every (CBC) I ordered was an extra $30 and then I was trying to look at who needs a (CBC) and who gets an extra $30, it would be different. But if I'm looking at what your co-morbidities are, but you're still getting the same (DRG), whether you have them or not, you're going to explain very little of the variability based on your co-morbidities.

Male: (Absolute) – absolutely true.

Male: So I (don't think) – so I'm not sure (inaudible) ...

Male: (Inaudible) admit you're right. It may not be a problem, but it's hard – it's hard to know.

Male: Right.

Male: And maybe you know (20) percent of the variability in cost is due to the hospital, so you'd like – (you) like the R-square that was really pretty strong. Or maybe 80 percent of the variability is (variable in the) hospital, so the R-square based on this – what we see here should be very weak. I don't know.

Male: (Yes).

Male: Nobody knows.

Male: Right.

Male: (Inaudible) ...

Male: And I (you know since we've started) going back and forth ...

Male: (Inaudible) (fully) independent way of getting at that.

Male: And since we've gone back and forth between the two measures, I'll just say that on my 10,000-foot view, when I looked at the spread in costs on the graph that was provided for the AMI measure, there was a pretty big spread. I actually was surprised at how narrow it was for the heart failure measure.

So I think part of the difference is explaining the variability is maybe there's just way less variability.

Male: Yes, I think you could see (how) that would happen, given the way resources are used for heart failure versus AMI.

Male: Right. So you know I know that when you get to the committee, the first thing you look at is what's the importance of it and if you're not seeing a big spread then maybe it doesn't get past question number 1, even though it's a high-yield area.

I don't know; it's my first time through this.

Male: Well that an – that's an interesting point.

William Weintraub: Well you know I think that, in terms of what our real charge – our core charge, I think that we can be very supportive of (they've) done at Yale in both of these measures. But I do think – (I'm quite) sure that will come up about the – limitations of risk adjustment will come up at the committee meeting. And if it isn't brought up by others, I will – I will bring it up, but I'm about 100 percent sure that there's going to be a – quite a discussion about this.

And I think the point is maybe we shouldn't worry about that so much also needs to be brought up. But I'm not you know I don't – I don't – I don't know. I find it troubling.

Female: Me too.

Male: Because what you'd like to know is that you're reliably leveling the playing field. That's what you'd like to know. And we don't.

Female: Yes.

Male: (Well) any measure like this also to have a – it has a – has to have a message about how to interpret the data and how to improve. And if people aren't clear about what the message is then it's difficult to create change.

William Weintraub: Right. So you know I think that the developer probably – you probably could have done a better job in explaining some of those limitations. I mean I knew to go right for it, but I think you know it would be a good idea to really try and bring that forward; what your own limitations are, in greater detail.

Anything else?

I think we've sort of covered heart failure and AMI together. I don't know if there's a reason to go – to go through heart failure again, now that we've gone through AMI, unless people want to.

Female: I don't think we have to.

Male: Ashley and (Sherone), anything else from NQF's point of view that you would like us to cover today?

Ashley Wilbon: This is Ashley. It sounds like you guys have done a really thorough job. I'm just kind of looking through; is there – just trying to make sure there wasn't anything – I know you guys kind of flipped between the AMI and the heart failure measure, but just wanted to make sure, earlier on in the – any questions or concerns about the heart failure; the length of the heart failure episode. I think that's also 30 days.

Some of the earlier questions, because I feel like you kind of – you guys were going back forth in the AMI – between the AMI and the heart failure measure a little bit later on in the questions, so I think as long as everyone feels like either the – your discussion would have been mutually relevant to the heart failure measure, I agree, there was no need go back and you guys were extremely efficient with that, so thank you.

Male: I'm looking over my notes ...

Male: So I think the same issue about the 48 hours applies equally for heart failure and AMI.

Judd Hollander: Yes, this is Judd. I have one more issue with the heart failure one in that you know the question about whether – are there a lot of patients excluded. I believe the repeat visit exclusion was more than 20 percent of heart failure patients. And so that's a – that's a really large number.

William Weintraub: All right. So can we ask the developer to comment on that please?

Nancy Kim: I'm sorry. I didn't – the – repeat (inaudible) ...

William Weintraub: (It's more – you have) 20 percent exclusions in – maybe you could go over the exclusions for the heart failure. You went over that for AMI; may (we) ask you to over that for heart failure as well?

Nancy Kim: Sure. I just have to pull that up so bear with me.

Maybe can the commenter point me to the place where they saw that? I'm sorry. I don't want to waste everybody's time. I'm on the heart failure measure methodology exclusions, so we took all the total discharges for heart failure, based on our ICD-9 classifications for 2008 and 2009, in the calendar year. We had about (986,000). We lost 1.23 percent for incomplete administrative data in the 30 days following indexed admission.

We lost about seven percent, as mentioned, on the same or next-day discharge. We included about less than one percent for transfer bundles. We lost 0.01 percent on inconsistent or unknown vital status. We lost zero

percent on unreliable data. We lost 0.4 percent on AMI discharges. We lost 1.3 percent on hospice characterization on the indexed year or the year prior.

We lost 0.03 percent to transfers to federal hospitals. We lost 0.2 percent on missing (DRG or DRG) rates and we excluded 0.05 percent on heart transplant and we excluded 0.04 percent on LVAD. And both heart transplant and LVAD are on the indexed admission or during that episode of care.

Is there ...

Male: So again, I thought the most troubling thing; the 48 hours, which again, you're going to – you're going to go back and reevaluate in your next go-round.

Male: Right. And I may have just missed it when you were reading the list, but did you comment again on the number that were excluded because they were readmitted?

Nancy Kim: Oh, oh; I see what you're saying. You're saying – OK, this is, I think your point. We ran – if somebody has more than one heart failure admission in the year, we randomly selected one hospitalization per patient per years. So we did (leave out) ...

Male: (So they didn't) – yes.

Nancy Kim: Is that what you were talking – the 20 – the 20 percent?

Male: I guess so.

Nancy Kim: Yes.

Male: Yes.

Nancy Kim: So that's where – because obviously most heart failure patients come back, we (know) 20 percent aren't readmitted within 30 days. We randomly select one per patient per year.

Male: Yes, I think that's a justifiable method.

Male: OK.

Male: And that's (considered) ...

Male: Otherwise (inaudible) ...

Male: (Inaudible) you could use both of them and you have to do an interclass correlation; makes you – makes it pretty statistically a little bit trickier.

Male: OK.

Male: So you know I'm not troubled by that.

So that's a little different; OK.

So again, I you know I think our big – our big problems are the 48 hours and the limitations of the risk modeling.

Any other comments on anything, please, everybody.

Male: (Inaudible)

Ted Gibbons: This is Tom Gibbons again. Oh, go ahead.

Male: No, go ahead; all yours, Ted.

Ted Gibbons: I was going to say that as a – running the heart failure clinic in our public health hospital in Seattle, I would say that socioeconomic status plays such a huge role in managing these patients that it's something that needs to be addressed, but it may not be easy to do so.

Certainly avoiding – having avoidable readmissions in our patients is based on frequent visits and giving social support and paying attention to a whole lot of other things that have very little to do with the pathophysiology of their heart failure. But certainly underserved populations tend to have very high readmission rates for heart failure and that is not addressed and it's probably as important for heart failure as any other issue that we're – that we're looking at.

Male: I'm sure you're absolutely right. Again, that needs to be taken up at the level of NQF policy. You know I think they're going to come around on this.

Ted Gibbons: Yes.

Male: So my question is did Bill just do such a good job that we have two hours free next Wednesday?

Ashley Wilbon: I think so, actually.

I was just looking at the calendar because I wanted to make sure I have the exact date of that call. (Was that) next Tuesday; to give you – to let you guys know – I think it's on the – it was supposed to be on the 10th? No, no, no, no, sorry; on the ...

Male: The 12th at 11:00, I believe.

Ashley Wilbon: Oh yes; you're right, the 12th at 11:00. Thank you.

Yes, I believe we are all set. If you guys think of anything, as long as everyone feels like they got every – all their issues out on the call today, we're going to take the next few days to summarize your comments on the measures and we'll be forwarding that on to the committee to kind of include in their preliminary evaluations of the measures.

So I wanted to thank the developers for being on the call and for being so engaged and responding to the many questions that the – that the TEP had, as well as each of the TEP members for you know doing such a thorough review. We really appreciate that and I'm sure our standing committee; our Resource Use standing committee will find your input very helpful as well.

And thanks to Bill for doing such a great job in getting us through in one call; appreciate that.

William Weintraub: Well (every call's) better; we – these comments were just wonderful. The – I'd like to thank the fact the developers in particular, for their really hard, really excellent work, NQF for organizing this so well and facilitating

everything as they – as they always do, and really great, very important comments by everybody on the TEP.

Ashley Wilbon: Thank you.

If you guys think of anything along the way, you can always e-mail you know anyone from the team and just kind of send your you know pop your comments in an e-mail and we'll be sure to pass that forward. Otherwise, I think for the – with the exception of Bill who's on our Resource Use standing committee, I think the rest of you guys will plowing forward on the review of the cardiovascular quality measures that is – that are coming up over the next few weeks.

So good luck in your efforts there and thanks again for your participation. We really appreciate it.

I do actually need to take one second before I forget to open up the public comment period. Operator, if there's anyone on the phone who would like to provide a comment to the TEP, can you prompt them now?

Operator: At this time, if you would like to ask a question or have a comment, please press star 1 on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

And there are no (further) comments or questions.

Ashley Wilbon: OK, great; thank you.

So I think that's everything. Thanks, folks, and you have two hours of your life back next Wednesday. We'll send a follow-up e-mail just to confirm that.

Male: All right; thanks. Have a good day.

Male: Terrific, everybody. Thanks for everything.

Ashley Wilbon: Thank you.

Male: Thank you.

Female: Thank you. Thank you.

END

END