

## **NATIONAL QUALITY FORUM**

**Moderator: Alexis Morgan**  
**January 31, 2012**  
**1:00 pm CT**

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

Female: Good afternoon everyone and thank you for joining. Today the readmission steering committee will review the submitted comments. I'd now like to turn this call over to Helen Burstin.

Helen Burstin: Hi everybody. We thought it would be helpful to go over a bit of process and expectations for the call today and then I will turn it over to Eliot and Sherrie to run the duration of the call.

But first what I'm going to do is lay out a bit of an overview of where we are on the project and talk about the path before the committee and how we're going to handle it today.

I think as you will see as you reviewed the submitted comments that a number of comments specifically address the issue of whether this endorsement project should have been expedited.

And just want to share with you that that is more of a process issue, that will be dealt with by the NQF consensus ((inaudible)) approval committee and likely the NQF board of directors.

So with perspective today of your work before you that should not enter into your deliberation for the measures before you.

Today we're really talking about what you view as the issue - remaining issues or acceptability of the measures based on the NQF endorsement criteria.

So the process for today is first after I go through this brief introduction we'll turn it back over to Eliot and Sherrie, we'll review the submitted comments, we'll actually review them by theme since they are heavily grouped into several themes just to make it easier.

You will of course have an opportunity to pull any specific comments that you'd like further discussion on -- as you can see in your materials we have provided both the measure developer responses as well as the proposed responses based on the ((inaudible)).

We'll also have an opportunity for the developers to provide any additional clarification. You'll also have a chance to discuss measures separately. You will also have an opportunity to discuss the measure from UHC as well and Dr. Sam Ho will be having a brief opportunity to talk to the committee.

And then lastly, certainly not least, we'll have an opportunity for public comments. One of the things that will likely happen through the course of this call since there were a number of substantive comments is you will be asked by the chair if you would like to reconsider the decision to recommend the measures.

And that is certainly within the purview of the steering committee. That decision should be grounded in the NQF criteria for endorsement. And so for example one of the issues that has come up is the issue around adjustments for SES.

And just want to point out that we still have to hold to what our criteria say that really are the basis of which the developers develop their measures.

So for example we do currently have as part of our NQF criteria factors related to disparities in care should not be included in risk.

So we would ask you to really think through and follow this guidance that we've already given to developers. There may be policy issues here that are broader that will need to be dealt with prospectively but at least for now the measures have been developed under this set of criteria.

We will ask you to really consider those criteria as you reconsider the measures. So briefly if you do decide that you would like to reconsider your decision to recommend we will have a process not on the call today but an offline opportunity for you to revote on the measures via SurveyMonkey.

You'll have an opportunity to revote on the overall decision to recommend each of the measures. We will ask you to ground your decision in the evaluation criteria in a comment box.

And again consider the fact that it has to be specifically on the merits of the measure as developed rather than any of the implementation issues that may be really outside of our endorsement process.

If you revote and the measure is recommended the measure will be put out for member voting. If you revote and the measures are not recommended, keep in mind that the CSAC, the consensus standards approval committee has the prerogative to conduct a detailed review of any project, particularly ones where measures do not emerge.

And the developers also have an opportunity to request reconsideration from the CSAC so our assumption is that would likely occur for this project. But certainly don't have any assurances of that at this time.

So we thought that would be helpful just as a backdrop before we get into the specifics to have that opportunity to lay out what we expect the process to be.

And again keep in mind you don't have to deal with the issue of whether the project should have been expedited. We will have a CSAC call February 13 in which that issue will be dealt with.

With that, I'll turn it back to Eliot and Sherrie.

Sherrie Kaplan: Helen, this is Sherrie, before you - we start if we decide that - what is the process through which we'll decide how to reach consensus on whether to revote?

Helen Burstin: Yes, so that's excellent question, we would not - I don't think there's any requirement that you vote for example on the decision to revote but I think it should be a general consensus of the committee.

And you know in general I think if there's enough of a groundswell the committee to revote I think you know the default will be we'll just go ahead and do that.

Eliot Lazard: And maybe - this is Eliot maybe I'll turn it over to Sherrie to start going through the comments in just a moment. But just to underscore what Helen said, we obviously have the ability to you know reconsider the prior vote.

And you know we ought to do it on the basis of the criteria and obviously again as Helen said that we're not going to do it in terms of process or whether this should be expedited or not.

What we could do is at the end of the conversation after we have you know considered all the comments, you know had the various measure developers make their comments and how in particular is interested in speaking before you.

And then of course any public comment which we would be very interested in we'll just take a bit of an informal straw poll as to whether there needs to be a formal vote on one or all of the measures.

And as Helen said if that happens then you know in the affirmative then we would do it by a proxy, kind of an online process but not during this meeting.

So are there any questions at this point about what our agenda is for today before I turn it over to Sherrie?

Jeff Greenwald: This is Jeff; I have one question. Sorry, I know Alexis sent around a UHC letter as well, I assume on this call we are not reconsidering the measure that did not pass in our original meeting, is that correct?

Helen Burstin: We will actually - this is Helen again Jeff it's a good question, we shared the letter that came from UHC with all of you, UHC also made comments that are part of the comment table and you know one consideration might be after the discussion of the measure do you want to also consider revoting on scientific acceptability if you think additional information was provided that would lead you in that direction.

And you'll have an opportunity to hear from Dr. Ho as well.

Eliot Lazard: Okay, any other questions? All right Sherrie would you want to start to guide us through the comments?

Sherrie Kaplan: Well let's just kind of go over the agenda. The agenda right now is supposed to be starting on review of the comments received and proposed actions including some discussion and it was my understanding Helen that the UHC team would be given five minutes to discuss their submission under that discussion of the measure that was not recommended in the period between 2:05 and 3:50.

And then by 3:50 we're allowing some time for NQF and public member comments and then by then we'll wrap up with some next steps that will be summarized by Alexis and we're trying to adjourn by 4:00 pm Eastern.

Helen Burstin: That's correct Sherrie and the only thing I'll qualify is we think it might be easier if you'd like rather than going comment by comment if you'd like to go by theme and then have a discussion by theme.

Taroon would be happy to lead that discussion unless you would like to review the memo which is organized by theme as well.

Sherrie Kaplan: No, I think the theme level discussion is one that probably will help us organize our comments.

Taroon Amin: Okay so we received 117 comments on the draft report from the public and NQF members. The themes fell into five major buckets however again as we - after we finished the review of the themes, any committee member that wants to raise any particular comment is free and welcome to do so.

This is not meant to limit the discussion but more or less organize the discussion in the most useful time of the committee.

So the first theme raised the concern of the justification of the expedited review and actually this was what Helen just noted that this would be really moved to the CSAC to evaluate and essentially up to the board.

So actually I'll move directly to theme two which actually raises the concern of commenters who suggested that SES variables while they should not be included in process measures recommended that they should be included in this particular measure, particular CMS hospital measure.

Arguing that literature supported the relationship between and a patient's SES and the likelihood of a readmission. And further some commenters believe that at the very least the measure should be stratified to avoid differences in disparities of care.

So I'll turn that over to Sherrie, Eliot and the committee for discussion.

Eliot Lazard: Sure, I - Sherrie do you think it would be a good idea to perhaps Taroon you could do this, just to remind everybody since the discussion was you know a while ago on where we came down on SES you know during our two day session and then the subsequent phone call.

Sherrie Kaplan: Maybe that would be a good jumping off point for consideration of these comments. Especially Taroon commenting on NQF's position on patient versus community level socioeconomic status variables.

Taroon Amin: Sure. Helen ((inaudible)).

Helen Burstin: So what that's doing is pulling some documents from the in person meeting for reference, I did specifically pull up the element of the NQF criteria that relates to the issue of risk adjustments.

And it says specifically safe for outcome measures and other measures when indicated and evidence based risk adjustment strategy as specified is based on factors that influence the measured outcomes but not factors related to disparities in care or the quality of care are present at the start of care as demonstrated adequate discrimination and calibration.

It is not specific really as to whether it is individual or not but usually individual patient outcomes are included individual level patient risk factors.

So we would assume that would be applicable here. We also have Karen Pace with us here today, our lead methodologists if there's any specific questions related to the criteria.

Taroon Amin: Okay. So, the committee's discussion although it was very varied on this topic generally landed on the fact that the committee recognized that socioeconomic that it does drive the likelihood of readmission, although - and is clearly linked to the availability of community level support.

And recognize also that it's a measure of community health quality, not just hospital level quality - however raised two different points, one that FDS is a difficult construct to measure in a reliable and valid way using administrative claims data.

And secondly relying on the NQF endorsement criteria or sorry the - yes the NQF endorsement criteria that patient level SES variables are inappropriate for use in a risk adjusted model.

However, recommended that the measure developer consider community level SES variables or potentially hospital level SES variables for future measure development.

And so I'll turn that back to...

Sherrie Kaplan: That's very helpful, thank you Taroon. So we probably should for the people that raised the issues to begin with and remain very concerned about the impact of socioeconomic status on readmission measures, right now we are considering a readmission as an outcome, is that correct?

Taroon Amin: Yes.

Sherrie Kaplan: Yes, so it falls under the category of being risk adjusted. So - as opposed to process, just for example. So I'd like to if Eliot concurs open it up for committee discussion now about the comments that we just heard and the comments that we made during the meeting in December, the face to face meeting in December about using adjustments for SES and in risk adjustment models.

Helen Burstin: Yes and Sherrie there's just one more process point, this is Helen again since we also had as part of the comment table detailed responses from the developers you should also feel free to ask the developers if there's any clarification they need to provide, any questions raised by the committee, they're all on the speaker line as well.

Sherrie Kaplan: Great.

Eliot Lazard: Okay, comments from the group?

Brent Asplin: Yes this is Brent Asplin as I mentioned in our two day meeting while I would generally stick with NQF's general approach which is to not risk adjust for socioeconomic status because then your ability to see differences along SES lines disappears.

I had mentioned that this field is unique given the community level resources. We went back and forth on this and I guess my comment today is wondering if the cohort approach would be a middle ground on this.

In other words don't put it into the model and risk adjust directly but have some sort of stratification scheme that hospitals that are serving similar populations even though you can see differences, rather would be compared as a cohort.

Sherrie Kaplan: This is Sherrie, Brent can you be a little more specific about how you would envision that or is that a use, when I was cautioned sort of in thinking - rethinking this I remember the approval that we - the endorsement of these measures is really kind of independent of the use.

So Helen you want to help us a little bit about what the parameters are capped around use of these measures?

Helen Burstin: Yes that's a good point. Certainly we would not be specific to the reporting format but I do think at times there have been measures for which there was a clear recommendation to stratify based on known disparities.

I'm actually going to defer to Karen Pace here our methodologist.

Karen Pace: Right, so we often talk about stratification and you know then we realize there's confusion about whether you're talking about stratifying the results within hospitals so that you would have a result for your patients however you would try to classify them, where lower socioeconomic status

versus your patients that are higher economic status versus as was just mentioned in terms of hospital comparisons that you would compare like hospitals.

However, you would determine to classify hospitals that are serving economically disadvantaged groups versus not. So I guess you know those two approaches, one is kind of a measure specification of how you would identify those patients, aggregate their data and then be reporting different strata.

And the other falls more into the reporting and implementation so that you know how you would display the information, how you would identify comparison groups tends to cross over into the reporting and then even implementation in - when you're using that comparison group say for identifying differences in performance or payment incentives etcetera.

So I think you know that's where the line is typically NQF endorses the performance measure versus how it is reported and implemented. So you know that's always been an area of discussion and certainly can be a recommendation and you know you can pose that question to CMS as well.

Brent Asplin: Yes now that you've gone through this we did get to this area during our discussion back in early December, I just had forgotten how in depth we had gotten into it.

And I was leaning more towards an implementation issues so it would be really more of a CMS cohort or stratification implementation question, not something that would be part of the measure itself.

Paula Minton-Foltz: This is Paula Minton folks from Harborview and I think we just can't be naïve all payers are going to use this information. Again we're a public hospital.

Public hospitals are going to look lower if they're not going to get the risk adjustment to explain why. I just think that you know we have to take a step...

Helen Burstin: I think we may have lost her. Hello? I think we may have lost her.

Male: Did we lose NQF or did we lose the speaker?

Helen Burstin: I think we just lost the speaker.

Male: Just checking.

Helen Burstin: Thank you though.

Eliot Lazard: I was going to say, I think we got the gist of the comment, how do others on the call feel about it?

Female: Was that Eliot?

Eliot Lazard: Yes it was.

Female: Thank you. If we could just identify yourself, because not all of us have really keen voice recognition still so please identify yourself when you're making a comment.

Male: This is ((inaudible)) in St. Louis and I actually made this comment in person when we were all together and in this case I think that some kind of stratified reporting recommendation is critical to the measure.

We've seen implications along these lines here in St. Louis and I realize - I understand the distinction between measure and implementation.

But I mean I would imagine we still have some prerogative to say that we think that measure like this used without stratification you know could pose a threat or could pose dangers.

I mean I would imagine that in some fashion we have the authority to make some kind of statement that we don't think you know an implementation without stratification or something like that would be wise. And maybe NQF can correct me if that's not the case.

Helen Burstin: This is Helen, that's most definitely the case, the steering committee could recommend - make a recommendation that as part of implementation the measure should be stratified. Again it's not in the measure itself but it's a reasonable recommendation.

Male: And Helen just to clarify a little bit further thinking about the eventual decision we have to make about re - you know revoting or revisiting, I'm assuming if we have implementation concerns there would not really be criteria about the measure.

And therefore really should not factor into a decision as to whether a revote should happen, is that right?

Helen Burstin: Yes, I think so unless I mean if your driving force is that the measure shouldn't be used in any reporting. I mean that would - I think it's going to affect some people's voting but they are a separate issue in terms of you know was the measure constructed using appropriate methods and according to our criteria versus how you see the measure reported and implemented.

Frank Ghinassi: Right, Frank Ghinassi here again I made similar comments during the initial meeting and feel the same way if not even more strongly now.

I think to roll out a measure that has potential implications that this one does and I mean that in the most positive sense.

I think this is a - you know it is a good thing to look at. I think it's important to devise a benchmarking capacity nationwide that allows institutions to push toward excellence and to improve quality.

And I think that to do that in using a tool that does not allow organizations to stand on equal footing with respect to the acuity that they face and the environmental circumstances and resources that are available to them, sets up a model where not only might certain places be seen negatively, inappropriately.

But I'm equally concerned that some places might be seen positively inappropriately and I know that nobody on the committee wants that to happen.

And yet I think if we ignore that we're going to charge down a corridor that's going to potentially lead us there and I think it will undermine the effectiveness of what we're trying to accomplish.

So I think stratification, something that's going to allow for the capacity for places to compare from equal footing and to jointly move toward quality that takes into account all the variables that have impact upon their ability to prevent and reduce readmissions.

And I don't think we have that yet.

Sherrie Kaplan: This is Sherrie Frank, could - if - so your - this measure, this issue really applies to one of the measures but may not apply to both because the unit in one case is the hospital or the institution and in another case it's the health plan.

So is your recommendation risk stratification for the hospital base or the institution base measure or for both?

Male: We may have lost - go ahead.

Jeff Greenwald: This is Jeff Greenwald, while I guess maybe he's thinking about that question I actually was thinking about it as well and I think that's an interesting question.

I mean the reason to level the playing field for hospitals in many ways is because they don't have as much control over things that happen beyond their walls perhaps and that's one of the attractions to having a plan level measure as well.

And in some ways you know having it at the plan level may obviate the SES question partly because the field of SES sort of data identification for the purpose of modeling is so poor.

So I'm wondering whether or not it really does apply or more cleanly and clearly at the hospital level because we're going to use community based SES, or we're going to hopefully be able to use community based SES measures most patient level ones.

But less so at a plan level, I suppose I could be swayed on that one but it seems to me that this is really more germane to the hospital measure than the plan level one.

Helen Burstin: Sherrie it might be appropriate to see if Yale or CMS or anybody would like to respond since it's about their measure in particular.

Sherrie Kaplan: Thank you, we will invite them so to do.

Michael Rapp: This is Mike Rapp, I think the Yale team is on so I'd like them to talk about the measure itself first and then I'd like to address some of the implementation issues.

Leora Horwitz: Hi, this is Leora Horwitz from Yale, thank you Mike. This is an interesting a question and we've thought about this pretty hard as well. We - there was actually one public comment related to this comment, number 1943 so we did write down some thoughts about stratification.

As was mentioned earlier there's two ways to stratify a measure, you could stratify it at the patient level or at the hospital level.

And practically speaking there are some challenges with doing this either way and I just want you to make sure that the committee understands that there's a feasibility challenges with this approach.

So in either approach, hospital level or patient level we would have to set some kind of arbitrate cutoff right, stratification means you create a group.

So we'd have to make some kind of relatively arbitrary cut points of SES which might be disputed by people.

This does formalize different standards of performance when caring for low SES patients any way you look at it, whether it's at the hospital or the patient level.

And our main concern is that the results might be hard to interpret. SO let's suppose we stratify by hospital right? So we take a group of hospitals that care for perhaps disadvantaged patients and compare them to each other.

And then we take hospitals that don't and compare them to each other so then what we have is two totally different risks, standardized readmission rates each with their own norm and so what this means is that we may well have a hospital for example with many low SES patients that we would report as better than expected.

Even if actually it's risk adjusted, readmission rate is higher than hospitals with low proportion of low SES patients and that's just slightly peculiar to report to consumers. I think it would be a little hard to understand.

And it also lumps the high SES patients for those hospitals in at the same time so we're holding them to a lower standard even for their highest SES patients which is less appealing to us.

We could do this at the patient level which is more appealing in that you're holding each hospital responsible to the same standard for its different types of patients.

So all hospitals would be held to the same standard for their high SES patients and all hospitals would be held to the same standard for their low SES patients.

So that's sort of a little more philosophically appealing. But practically speaking we're concerned that it would lower the power of our panel substantially because the samples are smaller.

So we may not be able to have results for hospitals with few low SES patients or conversely hospitals with few high SES patients.

So volume is a challenge with that approach. So we find this approach appealing conceptually as a committee does but we're concerned that practically speaking it's a little more complicated than I think you might at first suppose.

Sherrie Kaplan: Thank you Leora, this is Sherrie again, can you - I mean CMS obviously has ((inaudible)) the disproportionate share hospitals in their database and talk to us a little bit about if there is anything that - this gets in a little bit beyond our charge which is gets into the sort of implementation and use zone.

But there are obviously data you have access to that might be a little bit easier to stratify. The other issue I would worry a little bit about is power gets to be a curious commodity when you've got a database as large as yours.

There are two big attempts that you're doing regionalization things or other things that we're not quite understanding. Help us out a little bit when you're talking about power and precision and its impact for the group.

Leora Horwitz: So I'm going to leave that to Sam to talk about disproportionate share. We certainly could use that as a metric for stratification, that would be one of many possible ways to cut hospitals.

But in terms of power remember that our median hospital has 100 beds. So although we certainly have enough power to make our models and you know taking all of our patients from the hospital once we cut them to fractions we have more difficulty.

And remember also that when we divide our hospitals into quartiles based on proportion of Medicare patients they take care of.

We're basing that based on sort of less than 10%, 10 to 20 to 30%, so we actually - there are relatively few patients in the sort of low SES group per hospital so if we're trying to do this on a patient level we do run into volume problems even taking all the patients at a hospital.

And so that's part of the issue.

Sherrie Kaplan: Thank you.

Michael Rapp: So this is Mike Rapp, I'd like to just address a few things with regard to implementation and try to separate the measure issue itself from implementation.

The measure is - ends up with a ratio that is not exactly observed over expected but that's basically that's a ratio with those - the first performers, a number above one and those better performers less than one.

So then we implement the measure and I think the part about the SES if you incorporate into the model you would end up in effect, insofar as there were disparities you would end up hiding those in effect.

If you think about in - how it works for our other measures, we have AMI heart failure, pneumonia readmission measures and mortality measures, none of those have SES status in there or race or factors like that.

But conceivably if you put them in there you would not - you would to the extent that there are disparities you would in effect eliminate those.

Now the practical impact on that, I know there's different concerns about how we might implement these in terms of what we've indicated this is an outcome measure and we're required to develop certain outcome measures by a certain date according to the affordable care act.

And secondly we did indicate that we have interest in implementing this in the in patient quality reporting program and presented that to the measures application partnership which I believe at least tentatively did recommend this measure.

So with regard to some of the other provisions in the affordable care act, actually there's community based care transitions programs that provides \$500 million for - to assist hospitals with high readmission rates through this community based care.

So let's say one sort of distorted the measure in effect, then and possibly would result in higher rates than we looked at this, the - the additional money as a way of addressing or seeking to address and help hospitals that might I think we have heard the point about some hospitals may have additional challenges and so forth.

So this would actually - this money is intended to help address that. So that's a factor, I think it is important to separate the measure itself and what results you get and then what are you going to do about the results when you get them.

And as I say we do have this \$500 million that goes directly to hospitals in that area. With - in terms of display and so forth, that is certainly an open question as how one deals with that, these display issues and we would be happy to take input on that either from the committee if they desire to give that or from the public when we get around - get to the point of displaying them.

I know that there's concern about well would this be in a measure that would be applied for the readmission adjustment that's part of the affordable care act.

We have not indicated anything about that, and that would depend completely on first of all would this measure be appropriate, meeting the statutory requirements and so forth, that would have to be decided first of all.

And second of all one would have to go through the process of actually using the measure in that way. But as far as the measures that we're using for that purpose we did finalize those last year

which were the AMI, heart failure, pneumonia readmission measures, none of which as I say have readmission - SES adjustments in the model itself.

And so in that respect this measure is exactly like that. There aren't - we did hear also concerns about just the implementation process and how we go about that and I want to make - just make sure you're aware that we have a policy of approaching implementation which includes a dry run.

In other words we of course went through - Yale went through calculations to develop the model and measure and so forth.

But we wouldn't take it that this assuming NQF goes ahead and endorses it, we would not then immediately crank it out and put it up on a website.

The first thing we do in implementing in the in patient quality reporting system assuming we went forward and did that, it was finalized and all that sort of thing, and there's plenty of opportunity for comment even through that.

But assuming we went through all that process we would do a dry run which would mean that we calculated it and we give the hospitals a chance to see how the data looks, comment at that point.

Understand the model exactly and at that point we expect possibly to hear comments on display as well. So those things all take place. Another point that I think people have made is about improvement and particularly rapid cycle improvement.

And while this is a measure that's based upon a certain amount of data, it's based upon a year's worth of data.

And actually in terms of our other measures, the conditions specific to get sufficient discrimination among hospitals we need to use three years' worth of data.

And so that's what we do and so in other words it takes a while for a hospital to work through that even if there is improvement.

With this one year's worth of data would be sufficient so in terms of that it's better if you will. But additionally we don't really regard the measure results per se especially risk adjusted measure results as one that you can immediately act upon.

And to help hospitals deal with that, we have some plans in terms of sharing data and specifically the agency has developed the ability to get much more timely runs on data and we've looked into what we can share with hospitals.

And we understand that we can first of all share information on patients who are readmitted and not just the hospital of course but to other hospitals which they would need to do.

So we're looking into what kind of schedule we can send - provide hospitals with that information on a regular basis, perhaps quarterly and so that they could go through the information which is going to provide them with the raw information about who was readmitted and they can - because I think for quality improvement for this sort of thing one needs to actually look at the particular patient.

And with respect to the co morbidity factors that do affect the risk adjustment that is another factor that probably hospitals would be interested in having, in other words what co morbidities that relate to this measure would the patients that are readmitted have.

And we have determined that we have the ability to share that information too. So those are our plans and I think again this is all implementation, it's not about the measure per se. I think we feel fairly strongly, I think measure itself should stick with the basic risk adjusters that are in there in keeping with the NQF policy on this, our policy on it.

And also the way other measures that use this basic approach are constructed. But nevertheless again in terms of how hospitals are identified assuming this were used for that purpose, hospitals that are in the lower performing category would benefit from the affordable care act, additional money.

We would look to make sure that we provide hospitals with data that helps them improve on these measures and finally that we would for sure have a dry run on this and walk through all the issues and explore any - if there are any that would be related to this and at that point think in terms of how the data would report and be reported.

And take into account any suggestions that the committee might make in that regard.

Sherrie Kaplan: Thank you, I'd like to - you obviously touched on theme number three which is the sort of usability and I'd like to sort of move us back a little bit to make sure we give others on the committee a chance to address the SES issue.

Specifically if there are those that have issues, talk about the hospital and about the health plan that haven't addressed here action on.

Richard Bankowitz: Hello, it's Richard Bankowitz with Premier and I'd like to speak specifically about the hospital measure.

And it does really touch upon usability. I'm somewhat perplexed because I really would like to support this measure, we need a measure of readmission rate.

We need desperately to improve this and so - and I think this particular measure is thoughtfully and scientifically done in many, many ways.

I think it is certainly useful as Mike just said and perhaps in uncovering disparities. So I think if we're saying we're going to use this measure as a measure of coordination of care between hospital and community and also as perhaps revealing disparities, that's fine.

My concern comes when we start to use the measure to distribute resources in terms of payments to hospitals. I'm gratified to hear that there's going to be help available for the local ((inaudible)) hospitals and that's very reassuring.

You know my concern from the beginning has been if we use this as a method of allocating resources then we have hospitals who are already at risk and serving disadvantaged populations are even becoming more depleted in resources.

So I would like some sort of statement that would say if the measure is to be used for the purpose of a payment, it should be coupled with some type of mechanism to place hospitals on an equal playing field specifically in stratifying by some method, I don't know which method, SES.

So that would be my ideal view.

Sherrie Kaplan: Helen, do you want to comment on that?

Helen Burstin: Yes we were actually just talking about it internally here. I mean certainly the issue of stratification for comparison could be a recommendation of the committee.

But we would need to stay fairly out of the issues of the payment issues as being outside of the endorsement process.

Richard Bankowitz: Well I understand Helen and I think if we make the comment about comparison that would be fine.

Sherrie Kaplan: The recommendation is, would go something like for the purpose of fair and appropriate comparison for the hospital measure, some either type of stratification or adjustment procedure that address the issue that disproportionate distribution of economic status in the population being cared for is appropriate.

Richard Bankowitz: I think that would be ideal.

Helen Burstin: Sherrie you just said adjust or stratify.

Sherrie Kaplan: Well I didn't hear a strong consensus one way or the other about a stratification process other than we do the payments, apparently does have data on disproportionate share hospitals so that would be an option.

But - so do you - is the consensus of the committee adjustment or stratify?

Frank Ghinassi: Sherrie Frank Ghinassi here again, I apologize, the call dropped on me before, I'm not sure why.

Could you say a little more about how you perceive the difference between adjustment and stratification?

Sherrie Kaplan: Stratification takes ((inaudible)) the way I was understanding, hospitals that cared for  
((inaudible)) folks who...

Female: You're breaking up.

Frank Ghinassi: Yes there's a lot of static on the line now.

Female: If you're not speaking could you try to mute your line please, that helps a lot. Usually. Operator,  
are you with us?

Operator: I am, it's actually Eliot's line.

Female: Thank you.

Female: All right, Sherrie? You've got to love technology.

Sherrie Kaplan: Okay so one is to compare groups of hospitals who look more similar in terms of their  
disproportionate share of people with lower socioeconomic status and another is just to pool the  
resources and do a risk adjustment procedure for the purposes of presenting the data.

But again I was assuming that that is more of a presentation display issue Helen and not an  
approach that you want to kind of go down that road.

The recommendation would then be either for one or the other but not address either one of  
those. Or is that the consensus of the group that that should be part of the risk adjustment  
procedure?

Female: Well I think as Helen pointed out at the beginning our general criteria and recommendations regarding risk models is not to include SES. And I think the suggestions that have been made have been more towards comparison groups at the hospital level versus within hospitals comparing low and high SES patients.

But let's hear more from the rest of the steering committee.

Richard Bankowitz: So it's Richard Bankowitz and my opinion would be don't adjust, leave it out, let the disparities be seen. I think that's a good thing done now with disparities.

But if we're going to use it for comparison purposes, we have to have people on equal playing fields, so we need to stratify and compare like communities to like communities, that would be my opinion.

Female: Others?

Sherrie Kaplan: I agree.

Cristie Travis: This is Cristie Travis, Richard can you explain to me your use of the term communities? Are you talking about communities of similar hospitals or communities as geographic regions?

Richard Bankowitz: Well I guess I could have used the word hospital but - because we're measuring hospitals but I use the word community only because I believe this is a - this measure is something that measures both the performance of hospital and community together because both have a role here.

Cristie Travis: Thank you.

Jeff Greenwald: So this is Jeff Greenwald again, I think we're back to some degree where we started but

I also think that Leora's comments about the pragmatic aspects of this needs to be sort of reevaluated. We haven't heard from the NCQA folks as clearly on this one.

But I suspect the issues are the same, how do - I wonder how folks think about this as a hospital versus plan level issue number one, and number two you know doing sort of a post hoc grouping of like hospitals at the hospital level one, has an intrinsic appeal to me.

But gets to Leora's point of taking patients who are higher SES and lumping them in with lower SES if we're going to do it at the hospital level.

So I'm still a little bit up in the air on that one.

Sherrie Kaplan: So this is Sherrie, so NCQA people want to address the issue of SES and of - how it applies to health - all country admission at the health plan level?

Michael Rapp: Sure, so I think in one respect we have certain stratification already built in in that our measure focuses on the commercial and Medicare populations separately and when we eventually develop the measure and are waiting process for Medicaid population that we would treat those plans separately.

So there is a form of stratification already built in based upon the populations of patients served. I think we agree with Yale in terms of the complexity of implementing what is you know - what is the right way to adjust for SES and these things.

WE think that it's less of a problem on the health plan level that we're already sort of a population based measure, population based perspective and so we think that the comparisons between hospitals are more sensitive to this than difference - comparisons between health plans.

Sherrie Kaplan: So this is Sherrie, Eliot are you there? Did we lose Eliot on mute?

Eliot Lazard: No, I'm - I've been on mute the whole time, I'm not quite sure why it sounded staticky but no  
I am absolutely here.

Sherrie Kaplan: Okay, do we want to sort of try and wrap up the issue of the theme number two of  
socioeconomic things so we can move on to the usability issues?

Or we've kind of woven those two themes together right now in this discussion.

I'm still not hearing a clean and clear cut - I hear a profound message from the group about fair  
and appropriate comparisons that there is the sense that the hospitals that take care of a  
disproportion of lower socioeconomic status patients are going to be at higher risk for having  
higher all cause readmission rates.

And something about fair and appropriate comparisons leveling the playing field needs to be  
done to address that concern.

I'm not hearing a clear cut approach to that. Is that the consensus of the group and Eliot do you  
have anything you can add to that, sort of help the group kind of clarify its position on this as we  
move forward?

Eliot Lazard: I think you've assessed it you know and summarized it quite well. I mean if I'm reading the  
comments correctly there seems to be a little more weight on the side of you know sort of a you  
know sort of post measure stratification rather than an inter measure risk adjustment.

That's probably the first thing we ought to try and make sure that everybody agrees with. Is that the consensus of the group?

Male: Yes.

Female: Yes.

Male: That's what I'm hearing.

Frank Ghinassi: I think we're closer to that. Frank Ghinassi here, just one thought as I heard this, gentleman spoke before about part of the methodology is to have this field reviewed and shadowed before it's posted on a public forum and my only concern about not devising a strategy for fair and equal comparisons, equal playing field comparisons, whether it's intra measure.

And I realize all of the political implications of that and concerns about doing that, or whether it is the stratification process that's put in place post measure to make sure that like hospitals, to the extent like could be defined.

And is available by the data sets that you guys have, my only concern about waiting till it's all done before you address that is once you roll this out into the field, if there are inherent inequalities about the way people perform or hospitals performed based on the challenges that they face both in terms of their environment and the particular patient population that they're devoted to.

You're going to get very few comments from people who look good whether it's a reflection of their quality or it's a reflection of these other mediating variables.

And you'll get lots of comments from folks who look bad and it sets the stage for it looking like only the places that did bad complained and I'm trying to proactively avoid that if it's at all possible.

Sherrie Kaplan: And again I'm a little - I'm concerned about us straying - we've already kind of strayed into the how the use of these measures issues, how far afield are we of NQF recommendations?

Female: We're not far afield on the stratification piece, the recommendations of stratify.

Sherrie Kaplan: So stratification recommendation would be something I heard from the group that sounded like there was a fair amount of consensus on some interest in some kind of - in the interest of fair and appropriate comparison, some kind of stratification post hope, is that an accurate reflection right now of the consensus of the broader group?

Female: Right, and I think it will help us all if we kind of use the terminology of comparison groups of hospitals, you know the discussion about comparing like hospitals and of course the challenge is to identify that but one suggestion was disproportionate share hospitals.

For example as a like hospital group versus if we just say stratification it leaves the question in our mind are we talking about stratifying in the measure or stratifying the comparison group.

So I think let's just be clear when you're saying stratification that which we're talking about and I think most have been talking about the hospital comparison group, who you would be compared to. Thank you.

Brent Asplin: Sherrie it's Brent Asplin again, on the comparison groups approach just real quick question for the Yale group is that my mental model of how that would work is you just run one analysis, so there's only one normative score for everybody.

But then you do the reporting out in implementation using the comparison groups and on the list of practical concerns that were alluded to earlier by the measure developer, they seemed to imply that each comparison group would have its own normative score.

And you'd run the analysis separately for each comparison group and I don't see the reason or the need to do that. And in fact this might be the best of both worlds over time is if you just report out by comparison groups but run one analysis, we're going to see that some of the members of the low SES comparison group are going to outperform some member of the high SES comparison group.

Sherrie Kaplan: Does the Yale team want to respond to that?

Female: So I think we would have to think about this internally more , the way that we imagine you would stratify at the hospital level would be to run two separate models.

So if we ran one model then we would have one national norm, you know sort of an average to compare to and it's hard for me to see how we would then take out of the hospitals and compare them to each other given that their result is based on one national norm.

So our impression is that we would have to do it running two separate models having two different norms, but we could think about it more internally as to whether it's possible to do it the way that Brent is suggesting.

Bruce Pomeranz: So this is Bruce Pomeranz, I actually agree with the suggestion, I think you just need one model and you could report whatever sub groups you want according to that one model.

And then I support everything else that Brent just said so I think that's worth thinking of, that's certainly what I had in mind when I made my original comment.

Sherrie Kaplan: Yes, so we certainly could do that, that's pure reporting issue, that has nothing to do with the measure at all, that would just be totally a reporting issue and we were thinking about it as a measure issue, it would be ((inaudible)).

Brent Asplin: No you're exactly right, this is Brent, that's what I'm thinking too, it's all reporting not how you do the model.

Male: Does this have implications then for the NCQA methodology in terms of its use of a stratification within the model of Medicare versus private pay or rather private insurance?

Sherrie Kaplan: We can ask NCQA to respond but my understanding is that it's also comparison group. Well no I guess, NCQA would you respond to that, are you giving each hospital a different score for their - or yes the plan level.

So it's plan level at the Medicare commercial, is that correct?

Michael Rapp: That's correct it's at the plan level, Medicare plan level commercial.

Male: To which each plan gets two scores.

Michael Rapp: Right. Well so we think of a plan as defined benefits or defined population so there might a divided health plan operating in the mid-Atlantic region. They all have one product that they offer to their Medicare beneficiaries and another product where they offer to their commercial beneficiaries.

So even though it's United and operating in the same region, they're treated as different entities.

So United would see two different scores but it's one score for one population, one score for another.

Sherrie Kaplan: Okay, I think that ((inaudible)).

Eliot Lazard: So Sherrie just to summarize what I hear from the committee's recommendation that there's a strong recommendation for implementation to CMS that they create a like comparison groups for reporting purposes of this measure.

So that's what we're hearing, I just want to make sure that that's good, otherwise we can start to move on.

Sherrie Kaplan: Yes I think and please anyone that holds a different opinion please speak up now, because I think that's what I'm hearing from the consensus of opinion.

Eliot Lazard: Agreed.

Michael Langberg: Hi this is Michael Langberg, I just wanted to be clear, so if it's a recommendation as it was just stated then the - what happens to the creation of the stratification of hospital, whatever that methodology is, how that's created or whether or not it's done at all in the reporting be a CMS decision and would not be a recommendation of ours, but it wouldn't necessarily be binding.

Sherrie Kaplan: Helen?

Helen Burstin: Yes, correct.

Michael Langberg: And the methodology by which CMS if it were to choose to accept the recommendation at it's hospitals, whatever that methodology would be would be beyond the purview of our review.

Sherrie Kaplan: Helen?

Helen Burstin: Believe so although again I don't know whether CMS wants to speak to that, if that's something that they would share with the broader community for comments.

Male: Well with regard to input on display we're always happy to receive that. As far as - I'm not sure all what's implied by this but there's a lot of other policy factors that weigh in there.

Female: You know and also the steering committee can make a recommendation of you know it sounds like you're talking about like hospitals based on socioeconomic issues are caring for patients that are economically disadvantaged.

You know it's hard for you to specify a specific methodology that's something that would have to be explored but you can put a little more descriptive around that recommendation.

Sherrie Kaplan: I'm a little concerned that we're kind of now that that could devolve into a much detailed and probably beyond this scope of this discussion, especially since there are a lot of variables that could be considered.

In the spirit I think the recommendation was that the disproportionate share hospitals share a burden in caring for poorer people that their hospitals may not. And that's the spirit of the recommendation.

Male: Okay.

Sherrie Kaplan: Okay so kind of usability we've spread a little bit into the issue as we heard of you know the - if your condition specific readmissions need three years worth of data to get precision of estimates.

And we still cause readmission rates only need a year, that may not be so useful in sort of the rapid cycle improvement issue. Do we - does the group want to discuss the issues of how useful all cause readmission is and maybe for the two endorsers so far sort of discuss hospital and health plan readmission, all cause readmission measures for their utilities, improving quality of care.

So we're kind of open for that discussion now. Comments? This group isn't usually shy; I'm kind of surprised by the silence. There were issues obviously that came up about being able to use these data in the short term for rapid cycle improvement because of that lag.

Because of it at least in the Yale measures there was a year's worth of data that people were being relied on. So while maybe reliable and accurate for quality assessment purposes, quality improvement purposes, this data may not ((inaudible)).

Jim Bellows: This is Jim Bellows from Kaiser Permanente, maybe I'll try to reinsert the comment I made before. It's not only about rapid cycle but it's about being able to chart the measures during the course of the year as the data accumulates.

And it's - I think what's of more concern to me is not the use of a year's worth of data. Of course it's always true that if the ascertainment period is longer the measure will be more stable.

It's actually the fact that there's - because of the hierarchical modeling there's no way of even if you got all the data from the payer, there's no way of estimating the coefficients and applying the

risk adjustment model on an individual basis to be able to produce the measure on whatever basis a person wants to do it or on whatever scale or unit or floor or provider, whatever.

So it's the ability to not - it's the inability to choose how to do the drill down of the measure and be able to execute it by a decentralized unit or hospital or health plan that I think is the problematic piece.

And I think that could be addressed by the measure developer providing even if they do a hierarchical modeling to provide a logistic model that very closely estimates what the final hierarchical model will be.

But some way of working around so that a person can get something other than what's provided from the national government would be hopeful.

Sherrie Kaplan: Yale team and then the NCQA want to respond to that because I want to give the NCQA a chance to respond to that for the health plan.

Helen Burstin: And also CMS certainly since their the developer on that measure as well.

Sherrie Kaplan: Absolutely.

Male: ((inaudible)) so I think on the NCQA side I think our plan based measure has regression ways available and so I think health plans are in a position where they could real time if they wanted to look at any incremental time they don't have to necessarily wait for their regular HEDA submissions to do a year's worth of data.

They could be doing this on an ongoing basis. So we think that those ways are available and don't have to - because we're not doing the hierarchical model and we don't have the similar limitations that Jim just described.

Jim Bellows: Yes that's correct and it's helpful.

Helen Burstin: Yale, you want to respond?

Female: Yes, this is something that's come up often in terms of being practically useful for hospitals and we've been thinking ourselves about what's a good way to help hospitals real time estimate where they might fall.

And obviously there's no way for us to help hospitals understand where everybody else is at that moment, this is a measure that's comparing your performance real time to other hospitals real time, that's how we develop the co efficiencies in a full year data.

But there may be a way to help hospitals figure out where they would be if nothing had changed from the previous year, so at least to help people estimate where they would be based on the risk adjustment from the previous year.

And we'd have to think a little bit about how best to provide that kind of data, but that in principle that's possible.

Sherrie Kaplan: Thank you, CMS want to add comments?

Michael Rapp: No I think only - this is Mike Rapp, the only thing I would add is just to reiterate what I said before which a real key ingredient here is providing raw information when you have a readmission measure, hospital doesn't necessarily know all the patients who were hospitalized elsewhere.

And that's what we're exploring as to providing this raw data on a very frequent basis, not yearly. But more often than that. So that permits one to look more real time at what's going on with the patients.

And as far as the risk adjustment and comparing the other hospitals ((inaudible)). But in the end you would I think looking to see how you can improve one looks at the actual patients and the situations with them to try to figure things out.

Sherrie Kaplan: Thank you. Helen in the interest of time because I want to give us a chance to get to theme four and theme five, could the sort of spirit of that concern that there be some exploration into better or more improved strategies for feedback to hospitals that could help in use for quality improvement purposes.

Is there any precedent for giving that kind of recommendation up the line?

Helen Burstin: Absolutely.

Sherrie Kaplan: So we can incorporate that then from the steering committee as a recommendation, would that be the view of the group that that should be done?

Male: I agree.

Male: Thank you.

Male: Would that be part of the measure or again after the measure or implementation question?

Sherrie Kaplan: My assumption is that the - any usability issue gets to the latter, not incorporated as part of the measure but in its potential uses. Is that accurate Helen?

Helen Burstin: Yes.

Michael Rapp: And the other use that the measure was intended to be used for in addition to performance improvement was accountability.

And the - I think we heard at the in person meeting that for the Yale measure the report would be about 18 to 24 months after the last discharge. Did I recall that correctly?

Sherrie Kaplan: Yale you want to respond to that?

(Leanne Hyme): Hi, this is (Leanne Hyme) from CMS. It's not 18 months. Currently the condition specific measure is about one year less. But as Mike explained we are exploring ways to provide hospital with more timely data.

And we'll cut the - we'll provide timing that more frequently and I think we don't want committed but Mike mentioned maybe quarterly raw data so hospital can use the data.

Michael Rapp: But they're asking about the timeliness of the data with respect to the calculation of the measure and I think what (Leanne)'s saying that we have within CMS now a way to get the claims data itself more frequently.

In other words I think on in fact a weekly basis so that the database is updated more frequently and that would allow us - we can't say exactly what but it will - we won't have as much lag time in terms of producing measure results.

Sherrie Kaplan: Thank you. So - I'm sorry; go ahead.

Brent Asplin: Sherrie, it's Brent, but I'm wondering if we're trying to ask too much of the measure. I understand that this measure is not going to adequately support real time rapid cycle performance improvement within a given hospital.

But for reasons we discussed back in December using raw readmission rates is probably more useful for that internal real time focus anyway.

And this is more of a longer term measure used to compare performance across hospitals over time and I think by trying to be all things to all purposes, we're asking too much from the measure.

Sherrie Kaplan: Thank you for saying that. I think that once again this gets at a recommendation that strikes me that CMS is receptive to for a use issue that goes a bit beyond what the normal NQF parameters of our task are. But in the spirit of making that recommendation and in the spirit of receiving that recommendation on CMS's part I think that it's part of a more frequent or more ((inaudible)) of information will be more helpful.

How it's used and how it's done again is probably beyond the purview and you're right, I think probably not part of the measure itself but at least in the spirit of making that recommendation I think the committee unless I heard otherwise the consensus of opinion was more timely feedback would be helpful to end users of these data for quality improvement purposes, is that accurate?

Michael Rapp: Yes.

Brent Asplin: Yes, definitely.

Male: And additionally if I could add since - I want to add the accountability component as well as the performance improvement component, those were both described as the purposes of the measure.

So the - I think the same quest or adjustment ought to be made for the accountability piece as well as for the performance improvement piece, otherwise hospitals would be held accountable for their performance a year and a half to two years old as compared to what they might be doing in the current year.

Sherrie Kaplan: Thank you, there are obviously issues and there are tensions between precision and rapidity of feedback that have to be addressed as well but I think we have the spirit of the recommendation for usability and because we've got two more things to get to in about 45 minutes left I don't want to short trip the conversation about work for harmonization and inclusion and exclusion criteria.

So is everybody okay with the usability concern the way it is now or does anybody have any final thoughts?

Eliot Lazard: Sherrie quick process check, I just wanted to let you know I know that these two - these last two themes are probably not as robust as the first ones that we've gone through so I wouldn't worry too much there.

However I would say that we probably should try to move to public comments around 3:30 rather than what the agenda says because there are a number of members of the committee and also there are some other - there's Sam Ho as well from - that wanted to address the committee.

So just to put those on the docket for you.

Sherrie Kaplan: Thank you very much, thanks for the reminder. Okay so support for harmonization, the committee the last round and once again Bruce you might want to chime in here.

Because neither Eliot - well Eliot was on the phone, I wasn't able to attend that piece of the discussion.

But the committee, the face to face session agreed that the two measures are related and not competing. And so there should be despite the challenges and effort made to harmonize the hospital and same level measures.

Is that accurate?

Bruce Pomeranz: Yes, I think that's pretty much accurate, I think most of - you know were viewed all the responses from the developers. Most of the responses could be characterized as you know within a shorter period of time we will do our best to address this further with that shorter period of time being one year.

And the committee in general accepted that under the provisions that developers would recommend on these issues within a year, that most everything we saw was acceptable.

Sherrie Kaplan: Somebody else trying to say something?

Taroon Amin: Sherrie this is Taroon, I just wanted to say the majority of the comments here were actually very strongly supportive of the committee's recommendation.

So I'm not sure that there's that much more to discuss here, it's just more strongly recommending that the committee move forward and the measure developers move forward with harmonization.

Sherrie Kaplan: Okay. So we can move on to inclusion/exclusion criteria unless somebody has any final thoughts?

Jeff Greenwald: Can I make just one quick point, this is Jeff Greenwald. And I know we're not talking about the extradited review question here but I think it does sort of reflect on that question as to whether or not we're going to ask for a much more formal review at one year as opposed to sort of an interim review.

And I know we had discussed this at the meeting so - and I think our formal committee recommendation was to ask for a more formal review at one year as opposed to an interim review.

Helen Burstin: Yes Jeff, this is Helen I'll just clarify that we would plan to review any changes to the measure at the annual review which is in one year. Thank you.

Laurent Glance: Hi, this is Larry Glance; I would just like to make a dissenting comment. I still feel very strongly that these are in fact competing measures.

Hospitals are clustered within healthcare plans and I think we're looking essentially at more or less the same outcome, readmission.

And we're doing it using a different set of risk adjusters and using a different risk adjustment methodology, hierarchical versus non-hierarchical and I still think that there is a significant risk of sending two different quality signals to the same institution, the same healthcare groups.

And although I understand that the ship has probably sailed in this case I think it's something that it's probably not a good thing to do and I just wanted to make sure that I put that out there.

There's a lot of evidence out there in the literature that when you use two different risk adjustment models to look at quality across a group of hospitals that you will come up with very different answers for a large group of those hospitals.

And I think that if you're going to use this readmission measure as a way of making healthcare either hospitals or healthcare plans accountable, if you want to make things more transparent it's very important that you use a single metric which you can report at different levels as opposed to two different metrics that are very different.

And I think that no matter how much we encourage the measure developers to harmonize I think the reality is that if we come back here a year from now or two years from now these are still going to be very different models with probably different approaches and different sets of predictors.

Sherrie Kaplan: Thanks Larry, Helen in the course of this year if the harmonization process quote fails and the harmonizers were not able to homogenize these variables sufficiently and Larry's prediction comes true is that in the purview of the committee to sort of reevaluate after one year?

Karen Pace: This is Karen, I'm not sure it would be appropriate after one year because I think the recommendations were kind of a graduated approach.

But I think you know when these are back up for endorsement maintenance, you know the goal of NQF is to have measures with the broadest applicability so if a measure - one of these measures could be expanded so that it can accommodate both levels of analysis, that would be the preferred approach.

And that would certainly be looked very favorably at the time of endorsement maintenance when these measures were back up for review.

Sherrie Kaplan: So where does that leave us?

Eliot Lazard: Yes exactly, this is Eliot; my question is what are our options in terms of Larry's concerns?

Helen Burstin: I think Larry - I think the concerns there are two-fold. The first is you know I think this is more Sherrie's issue, what happens if within a year there's not progress being made on harmonization and will it come back to the committee?

I think Larry's getting to the broader issue, should there in fact be one measure that accomplishes both. That certainly seems like - and Karen just spoke to that, the longer term vision that certainly won't happen in the short term period.

But I think the committee has clearly gone on record saying they would like to see these measures harmonized within a one year period of time.

Whether we bring it back to this committee or not I couldn't say for sure at this point but I will tell you that we will do a re-review at the time of the annual updates to see if harmonization's been satisfied.

Sherrie Kaplan: And if not why not?

Helen Burstin: Yes.

Sherrie Kaplan: Larry, does that...

Laurent Glance: Helen is there any mechanism by which NQF can keep an eye on this in the interim between now and one year? In other words are there any you know sort of mile posts, you know

to ascertain some progress, some you know process going on that you know will get us to where this committee would like to go?

Helen Burstin: Yes it's an excellent question, NQF does frequently play a role between developers working at harmonization as this group all knows well from the recent efforts we did between ACS and CDC.

So we'd be delighted to stay engaged with the two developers and you know continue to work with them because that's their progress and see if we can in fact help in any way, so we'd be happy to do that.

Michael Langberg: It's Michael Langberg, in this one year period both of the measures would be produced and released in the wild so to speak?

Sherrie Kaplan: I think - Mike let me see if I can frame that differently, this is a one year period for opportunistic empiricism so that these groups get a chance to actually work on some of the issues that have been raised by the committee and use that empirical experience to address some of these concerns, is that what you're asking?

Michael Langberg: I think maybe I am. While they're working on the concerns, of course we're urging that they be done within a year, the measures in that year period would be produced and published publicly, is that correct?

Sherrie Kaplan: I don't know the answer to those, CMS?

Helen Burstin: Well Michael this is Helen, I just want to point out that in some ways NQF certainly has no control over the use of the measure. If the measure is endorsed it can be used by the developer.

But you know CMS might want to speak further to at least their plan to use for the readmission measure.

Michael Rapp: well this is mike Rapp again as I indicated our plans are determined for something like this to rule making we did indicate that this measure is under consideration for inclusion in the 2012 rule making cycle for the inpatient quality report program.

The map tentatively support that, I guess I'll have a final recommendation tomorrow but that's - so we can't say we're going to use it or not going to use it, we just indicated it was under consideration and after we get feedback from the map then the development of our proposal for the inpatient prospective payment system rule that who are we treat the inpatient quality reporting program will be taken under advisement.

Sherrie Kaplan: Thank you. We have like four minutes before we're supposed to go to public commentary but I don't want to again short shift the inclusion exclusion criteria issue. Eliot we have some issues here, but some of them we've actually already discussed.

Eliot Lazard: Yes no I agree, I guess you know perhaps the most expeditious thing to do is just to open it up to the group in terms of any extra issues around inclusion/exclusion criteria. Comments from the group?

Taroon Amin: Also maybe this is a good time to open it up for any other specific comments, any of the other 117 comments, if there was any of the responses that the committee didn't feel comfortable with or wanted to address further.

Sherrie Kaplan: And Taroon, we're now going to allow - I want to give Dr. Ho and the UHC team a chance to address their responses as well to their measure.

Taroon Amin: That's fine, I would say maybe we can see if the committee has any other questions about any of the other comments and then we can ask Dr. Sam Ho to present to the committee briefly for five minutes.

And then I would ask the chairs to straw poll the committee to see if any of the newly submitted comments changed the committee's existing recommendations.

And if they would like to move to a vote, if not that would be fine as well.

Leslie Kelly-Hall: This is Leslie, I just had a question if the theme review was meant to be inclusive of the HA letter specifically as well? Will we be doing any other discussion about that?

Taroon Amin: The HA letter was - are we talking about the slides or the actual letter that was submitted?

Leslie Kelly-Hall: The letter that was submitted.

Taroon Amin: Yes so if there's any particular comments that anybody wants to raise about the HA letter that's - this is the time to do it as well.

Helen Burstin: Right and a good portion of that letter was focused on the expedited review which we won't talk about today and the rest of it was on SES.

So if there's any additional issues you'd like to raise as a result of that we'd be happy to discuss that as well.

Leslie Kelly-Hall: I think timeliness was also reviewed and I think we've covered that. Thank you.

Sherrie Kaplan: So Taroon, where did we leave it last?

Taroon Amin: So I think there's no additional comments, I mean no additional conversation around the additional comments, so if you would like to move to a response from Dr. Sam Ho that would be fine.

Sherrie Kaplan: Eliot I think that's where we should go next.

Eliot Lazard: Yes absolutely.

Sherrie Kaplan: Dr. Ho?

Helen Burstin: Sarah can you make sure Dr. Sam Ho's line is unmuted?

Operator: Yes just one moment, okay, open line now.

Helen Burstin: Thank you, hi Sam.

Dr. Sam Ho: Hello, hi. Thanks a lot and I'll make my comments brief. I just want to highlight and thank you for circulating both the letter as well as the comments we made on the web link and the letter we wrote last Friday.

I just want to highlight three features to provide context to the committee and I'll summarize them right now.

The first feature, of course this is not the old readmission measure, 0329 previously endorsed a few years ago by NQF. This is basically a revision and an enhancement of that measure which includes basically developing a readjustment, a readmission adjustment factor for each of 175 discreet diagnoses or procedures.

And that readjustment factor is based on what the readmission rate for each of these discreet conditions or diagnoses are and compared to the total number of readmission in a population, whether it's under 64 or over 65.

This provides a significant degree of discrimination and case mix adjustment to be able to understand better the readmission rates at a particular unit of analysis. And I'll give you an example.

And this is - we think this discrimination is really important in terms of getting accuracy of measurement but also in terms of discrimination and working toward quality improvement efforts as well.

I'll give you one example to make it pretty clear. Within the 175 discreet conditions there are 15 cardiac related conditions that range from non-specific chest pain all the way to congestive heart failure.

And their readmission adjustment factor for each in those examples, non-specific chest pain in the 0.65 versus the congestive heart failure measures, readjustment factor is 2.57.

So we think this is a very good tool and by the way and I'll get to point three in a second but it also can be used for virtually every unit analysis including hospitals, health plans, medical groups, geography, regions, cities, and the nation.

And it offers a lot more discrimination than the five general domains say for example promoted by the Yale and CMS measure.

The second key point is that we have deliberately paired this measure on readmission rates within 30 days with the adjusted average length of stay measure which was the NQF measure 0328.

And we deliberately paired it because we wanted to make sure there was an effective counterbalance to - in terms of measuring appropriate in patient utilization, for example the hospital or any entity could actually mitigate increased readmission rates by just keeping people in the hospital longer for the index admission.

And the third point which is something the committee has grappled with obviously today and extensively previously is that entire usability of our measure for - that goes beyond a measure issue but really focuses on what we'll call measurement.

And its ability to be useful from a QI perspective, again it deals with the index submission and the condition, 175 discreet conditions. It doesn't require a 12 month history of continuous enrollment and it's completely transparent in its measure so that hospitals or medical groups or health plans can measure themselves in a timely way that would be useful for implementation and for quality improvement.

And this actually has been commented on to us by various hospitals with whom that we're contracted. And by the way one of the things that's also been useful for is in the value based contracting or the payment reform that we've instituted over the last year and a half it kind of underscores the importance of transparency and timeliness of data.

That this can be relatively real time in the calculation by hospitals, accountable care organizations, medical groups and so forth.

So I kind of just wanted to summarize the discussion there and then ask respectfully to have the committee reconsider our measure for recommended status.

I also offer that we be happy to provide - one more comment. I want to make sure that everyone understood the comparison with the C statistic which I know the committee is extremely familiar with.

When we read the C statistic for the UHC measure, it compares quite favorably with the NCQA and the CMS measure for the Medicare population at 0.753 and for - I'm sorry, for the Medicare population it's 0.609 and for the commercial population with NCQA of 0.753.

So want to just basically request a humble reconsideration for recommended status form measure, its usability, its transparency, its correlation in predicting readmissions and also offer at the end in closing to provide the coefficients and the method itself to CMS and Yale so that they can do a correlation analysis across all of the claims database, not just the 30 million covered lives that we've applied it within United Healthcare. I'd be happy to answer any questions you have for clarification or other purposes.

Eliot Lazard: Great, comments or questions by the group on Dr. Ho's remarks? Any comments or questions for Dr. Ho? Okay. Taroon is the next step Sherrie and Taroon is the next step public comments?

Taroon Amin: Actually before you move there Eliot, I would ask that for potentially each of the three measures if any of the conversation or any of the comments just by a straw poll of the committee if you could leave that.

If there's actually been - if any of the members would like to revote and we can provide a SurveyMonkey post discussion. So ((inaudible)).

Sherrie Kaplan: Taroon can I qualify that, this is Sherrie, the issue for - the issue I heard was would there be consensus on revoting the measures versus making the recommendations that were suggested by the committee by topic.

Reconsideration of the measure as a revote versus making recommendations that were suggested in each of the categories by topic.

Eliot Lazard: Right, Sherrie if I understand this and again we return to NQF guidance but we're at the point where we need to consensus as to whether we need to or would like to revote on the specific measure, so this really is independent of those recommendations. Is that correct?

Taroon Amin: That's correct.

Jeff Greenwald: This is Jeff, I guess my other question is, is that something we want to do now or do we want to do it after any additional public comment that may be forthcoming?

Eliot Lazard: I would prefer hearing the public comments before deciding on the ((inaudible)).

Jeff Greenwald: Before we get to that though, this is Jeff Greenwald, you know I - Dr. Ho made a very compelling argument about the quality of the measure that they provided.

I think it would be premature of us to think about whether we want to vote on the passage of that again given that the other two measures had hours and hours of group discussion in a round robin way.

I think that we would be doing unjust assessment to sort of not have some further discussion given the fact that that initially did not get voted up. So I'm concerned that we'd be moving too expeditiously if we were to decide to vote on that one without further discussion.

Eliot Lazard: Well I think we'd be happy to entertain further discussion, you know it's so far none has been forthcoming but let's ask again.

Jeff Greenwald: I hear what you're saying and you know not so much discussion in response to the comments that were provided but again we went through each of the other two measures that were voted in great detail over many hours.

And I'm concerned that we would be doing a ((inaudible)) just to jump to a vote at this point. I'm not sure that's something that we're going to be able to accomplish today in my opinion.

Eliot Lazard: Well Helen and Taroon would you like to provide some guidance on this.

Helen Burstin: Essentially the measure was evaluated through scientific acceptability and then stopped because there was ((inaudible)) that didn't pass that. So I think the question would really be before we even proceed is you know one question is whether the committee would like to based on the additional information provided by Sam and UHC entertain revoting on just scientific acceptability.

We would then need to reconvene the committee virtually of course to reconsider the full measure. I just think before we even proceed I think the question is, is the additional information provided such that - compelling enough to want you to revote on the scientific acceptability which stopped the evaluation of the measure.

Eliot Lazard: Yes my only concern about that is if the spirit of you know the comment was that you know with Dr. Ho's additional remarks we really ought to give it a more robust discussion whether we vote on scientific acceptability or whether we decide to you know develop - to you know ask for consensus around revoting.

We're not solving that problem. And I guess I'm hearing that we've got to make some more time for you know a deeper discussion about it and I guess the question is how best do we do that?

Helen Burstin: Okay we can just focus on those - you know the first two issues, the first two measures today. We'd be happy to again provide a separate email with just the documentation, the initial submission form, the evaluation done by the committee and then the additional information provided by Sam.

And if we need to schedule a follow up call we'd be happy to do that. But why don't we just for the sake of today go through public comment and at least make a decision about the first two measures, so that would be fine.

Eliot Lazard: Does that satisfy everybody?

Male: Yes.

Male: If we were to change our minds about the UHC measure then we would also have to have a conversation about competing versus harmonizing, is that true?

Helen Burstin: Yes.

Eliot Lazard: Okay, so it sounds like we're to be able to you know answer the question on the first two as to whether we need a revote or not.

But we'd like to do that after hearing any additional public comment that may be forthcoming, is that where we are now?

Female: Yes.

Female: Yes.

Male: Yes.

Eliot Lazard: Okay, so how best do we see if there's any additional public comments?

Taroon Amin: Sarah, can you please open the line for public comment?

Operator: Certainly; ladies and gentlemen, if you would like to ask a question at this time, star 1 on your phone please. Once again, star 1. And we will go first to Nancy.

Nancy Foster: Hi, can you hear me all right?

Female: Yes.

Nancy Foster: Great, this is Nancy Foster from the American Hospitals Association. First of all thank you all for the hard work today and in the past and I want to thank the NQF staff for generously sharing the analysis that we had conducted in conjunction with the AAMC.

We know it was completed and sent after the end of the comment period and know they weren't obligated to that. We were very glad that when we shared it with them they were able to share it with you.

We as you know from our comment letter have had significant interest in the socioeconomic issue and continue to be concerned that hospitals will not be fairly compared.

We understand the comments that were made about when this goes up and is used for payment purposes that in fact you want apples to apples comparison and that may best be achieved through stratification. But in fact hospitals are equally concerned about how they appear to the public they serve when the data are shared publicly.

So I would urge the committee to think about both the use in public accountability as in public display as well as in payment and the need for stratification in both regards as accountability measures.

I would also point out to the committee because we recently had reason to go back and take a look that this issue came up in the previous steering committee reports around the heart attack, heart failure, pneumonia measures.

In fact there the steering committees robustly recommended and the NQF adopted their recommendations that going forward those measures should be adjusted for socioeconomic status, for disparities in care.

And they have not been as yet, it's the same Yale CMS team as measure developers and so consistency here would be good but certainly this whole question of what is the appropriate role of socioeconomics in reviewing the admission measures is an ongoing concern.

And while I appreciate the current NQF policy around not adjusting for socioeconomic status.

I think in fairness it may be time for the CSAC to revisit this issue, they hear the robust kind of conversation that you all heard and participated in around this particular issue.

And to think again about whether there is a role for adjustments for socioeconomic status for outcome measures going forward at the NQF.

And so I would ask you to consider recommending that as things go forward. And that would be all of my comments at this point. Thank you for the opportunity.

Helen Burstin: Great, thanks Nancy, this is Helen, that's something that CSAC will clearly deal with as they discuss this measure.

It has been something also addressed as part of a commission paper done by (Joel Vett) and (Joe Weisman) for the disparities committee which we'd be happy to share broadly with folks that actually went through this issue once again.

But we agree it's a policy issue, certainly raised by this project and others and we'll make sure it gets brought up to the higher level.

To date NQF has not supported any measures with adjustment for SES, any outcome measures so we'll continue to bring this through our process, so thank you.

Nancy Foster: Thank you Helen.

Eliot Lazard: Are there further comments from the public?

Operator: There are no further questions, but once again star 1 please. And there are no questions.

Eliot Lazard: Okay, Sherrie?

Sherrie Kaplan: So where we are as we understand it, that we are going to run a straw poll on whether or not to reconsider our original vote and therefore revote using SurveyMonkey, the two measures that we recommended for NQF endorsement after the conclusion of our December meeting.

So do we - Helen, does Taroan want to go through the exercise, should we go around and get a straw poll? How should we do this?

Helen Burstin: I don't know that we need a straw poll Sherrie, it really is more just a sense for you of whether you think there is consensus. You could talk - you know just have the committee indicate if people would like to revote in general we'd be happy to do that.

And you know we can certainly clarify in any of the follow up materials the discussion that resulted today that will add those recommendations.

Taroan Amin: And there's a further clarification as part of the SurveyMonkey we'll you know if the committee does decide to go through another revote based on the comments, we would ask - it would be a recommendation on the overall recommendation for the measure and we would ask that there would be justification based on the endorsement criteria, so...

Sherrie Kaplan: So Taroan, just to follow up, if the committee decides to revote their position they can get from you their original position?

Taroan Amin: Yes, we can share that with them, yes.

Sherrie Kaplan: Okay so if reconsidering means you're not going to have to reevaluate the whole thing again but you could look at your previous position on the various scientific criteria and decide whether or not you want to change your position.

Female: Although again the only thing we would potentially have the committee revote on if they would like to is the overall decision to recommend.

Sherrie Kaplan: Okay, so that's...

Female: Not individual criteria.

Sherrie Kaplan: Thank you. So basically this is to the committee the charge is did you really - did you hear from today's discussion enough information that would suggest that you might want to reconsider your ((inaudible)) recommending versus not recommending to measure that were originally recommended.

Bruce Hall: This is Bruce Hall; I would just move that we revote them by SurveyMonkey. I don't see a big downside on that and gives everyone a chance to consider what they heard.

Sherrie Kaplan: Others?

Michael Langberg: Michael Langberg, I agree with Bruce's comment.

Sherrie Kaplan: Others? Different dissenting opinion? Okay so now Helen the committee thinks that we are going to need a SurveyMonkey on the single question of would you recommend this measure, yes or no.

Helen Burstin: Correct and we will also include in there obviously the recommendations that emerged from the call today that will flow forward with the measure going forward.

Taroon Amin: And Helen obviously we're going to set up the SurveyMonkey such that each measure is voted on individually and independently.

Helen Burstin: Yes.

Sherrie Kaplan: Okay and so then the question is do we - as part of that exercise do we now want to go through the - and we would have to then go through the scientific review process for the UHC measure.

So as a result of - I know we heard one person's opinion in the committee, does the rest of the committee like to reevaluate its position on the UHC measure.

Taroon Amin: Well Sherrie count the question you just asked the SurveyMonkey and then if the answer is yes then we know that has to proceed and if the answer is no then we know where we are.

Sherrie Kaplan: Helen?

Helen Burstin: We'd be happy to do that and we'll share the materials as well just to make sure everybody has it at the top of their email box.

Sherrie Kaplan: Okay, thank you. So good suggestion, I think that would clarify things and help people decide. So are we at a position where we are actually finishing up any last - is that - anybody have any last remaining thoughts that they want to share with the group?

Eliot Lazard: Helen, Sherrie, just one question, this is Eliot; I think I just got a little confused. I thought that the earlier comment and again I apologize, I didn't - I don't recognize who's voice it was this was before the public comments was that on the UHC measure we did not give it sufficient or as much discussion as we did the other two.

By simply querying on SurveyMonkey are we you know perpetuating that? I thought what we agreed was you know as much of an imposition as it might be that we you know needed some additional sort of group think about this.

Perhaps we ought to just clarify that with the committee if we don't need to then of course we won't, but I do remember the comment being fairly strident.

Sherrie Kaplan: I think though that you can do - signal that we can do the SurveyMonkey question of whether the steering committee wants to have a more in depth discussion. I think you need to remind yourself what information had been submitted because that short-cuttled the discussion based on what information was submitted.

And then you need to look at what additional information and then you know the question could just be do you want to have further discussion, you know do you need to have further discussion on that measure with ((inaudible)) Eliot?

Eliot Lazard: Yes, I understand that clarifies things for me and I just want to make sure the rest of the committee is okay with it, but it certainly deals with the issues that I think were raised.

Jeff Greenwald: So this is Jeff Greenwald, I was the strident voice and I'm comfortable with that plan as well.

Eliot Lazard: Good, excellent, Jeff, thanks for coming forward.

Cristie Travis: This is Cristie Travis, I guess I had a procedural question, if after the SurveyMonkey if for some reason the vote comes back differently than what our original vote was on any - either of the two measures I guess I have a concern that that would go forward without discussion, the ability for committee members to have an understanding for why votes ((inaudible)).

Because the other times we've voted we've had the opportunity for discussion.

Sherrie Kaplan: Helen?

Helen Burstin: We'd be - you know we will share the results of the vote on email and if the committee would like to have a follow up discussion we'd be happy to arrange it.

Cristie Travis: Thank you.

Helen Burstin: Sure.

Eliot Lazard: Okay, Sherrie would you like to make some closing comments? It sounds like work is done for the day.

Sherrie Kaplan: I agree, I think the group has worked extremely hard to get a very complex problem to have what we call full throated discussion about very complex issues and I for one am very grateful for people's attention for two hours, I know it's a long call and it's difficult to do in such a large group.

So I'm very appreciative of everybody's time, effort and energy.

Eliot Lazard: Yes let me echo Sherrie's comments, I am as well and you know obviously we want to thank Taroon and Helen and Alexis and you know the NQF staff for you know engineering this and obviously you know putting the appropriate materials together and getting a lot of things to us in very short order. So thank you all.

Taroon Amin: Thank you, I just wanted to just jump in here real quick with some closing comments on some logistics. So we'll send out the survey ideally today with some updates and we'll ask for those submitted responses by Thursday February 2. So that's a quick turn around, by 12:00 noon on Thursday February 2.

We'll also update the draft report and the committee responses based on today's call which will include the recommendations regarding SES and usability. And NQF member voting will open on the 17th depending on again conditionally on what the SurveyMonkey results are and close on March 1.

Also we'll also send along the UHC original measure submission along with the steering committee's deliberation on the measure, along with Dr. Sam Ho's response to assess whether or not additional conversation needs to occur on this measure.

So again we thank you all for a very complex task today and also for your continued involvement in this very exciting and complex topic.

Male: Before we hang up for ((inaudible)), I wanted to ask a question.

Sherrie Kaplan: who is this?

Male: Regarding Nancy Foster's comment about the recommendation for the stratification I was under the impression the language we adopted was not around payment but rather around comparison.

And I was under the impression that language would be broad enough to include the public reporting. So am I correct in that?

Taroon Amin: Yes.

Male: very good, thank you.

Eliot Lazard: And we will send around that language to the committee to ensure that it captures the essence of your conversation today.

Female: Thank you.

Male: Thank you.

Sherrie Kaplan: All right everybody, thank you much.

Eliot Lazard: Thank you.

Female: Thanks, bye.

END