

NATIONAL QUALITY FORUM

Moderator: Alexis Forman
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12:30 pm CT

Operator: Welcome everyone. The conference is about to begin. Please note, today's call is being recorded. Please stand by.

Female: Good afternoon everyone and welcome to the patient outcomes all cause readmissions expedited review pre-voting Webinar. And now, I'd like to turn the Webinar over to Adeela Khan.

Adeela Khan: So here are the goals for our Webinar. During this Webinar, we want to provide an opportunity for clarification prior to our member voting. We're going to go over the project scope, the measures recommended for endorsement, overarching issues and comments and actions taken.

The goals of this project are twofold. The first was identification and endorsement of additional cost cutting non-condition specific measures for accountability and quality improvement that address all cause readmissions to hospitals.

And the second is all cause hospital readmissions related consensus standards that were endorsed by NQF before June 2009 will be evaluated under the maintenance process.

This project was our first expedited review project. There are three criteria that must be met for a project to be expedited. The first - the extent to which the measure is under consideration have been sufficiently tested and/or in widespread use.

The second, the scope of the project or measure set is relatively narrow. And three, there is a time sensitive legislative regulatory mandate for the measures. Even though the project was expedited, all submitted measures were evaluated using the four NQF evaluation criteria of (influence) to measure, scientific respectability, usability and feasibility.

This slide provides an overview of where we are currently in the project. Our public and member comment periods closed on January 20th and all comments were addressed by the committees. The developers were also given a chance to respond to comments made on their participant measures.

Right now we're going through member voting on the two measures that were recommended by the steering committee and our draft report and comment table are available on our project page.

The committee recommended the following two measures for endorsement - 1789 hospital wide all cause unplanned readmission measure, HRW by CMS scale and 1768, plan all cause preadmissions by NCQA.

Measure number 0329, risk adjustment, 30 day all cause readmission rate developed by UAC was not recommended with a final vote of 7 for yes and 12 for no.

Several overarching issues that we saw in this project were a modeling approach - approaches, specifically statistical modeling and the use of HLMs. All three measures used logistic regression modeling. The CMS yield measure used hierarchical modeling to estimate the hospital risk adjusted readmission rate.

Some steering committee members expressed concern that with hierarchical modeling the risk adjusted rates for low volume hospitals would be no different than from the average rate. But the committee agreed that the methodological concerns for hospitals with lower volumes would not - would be less of a concern because this would be an all-cause readmission.

For the selection of (Covariates), the committee was interested in the rationale for the inclusion or exclusion of hospital volume and socioeconomic status of (Covariates) in the model. Both CMS, Yale and MCQA chose to use (Covariates) to help the level of - to create a level playing field across the hospitals and adjust for patient clinical condition at the time of admissions.

For example, the CMS Yale measure used five clinical cohorts to account for the variation in service mix across hospitals. And the NCQA model used as an indicator for major surgery.

On hospital volume, shrinkage issues, the committee members felt that including volume as a (Covariates) might improve the statistical performance of the risk adjustment model. But the developer argued that there's limited evidence to support any justification, that difference in readmission performance between hospitals on the basis of volume are acceptable.

And lastly, adjusting for socioeconomic status, some steering committee members expressed concern that in the case of a hospital readmission, SES influences resource available after a hospitalization that can affect the readmission.

For usability for quality improvement, several members view the plan level NCQA measure as a way to hold plans accountable for readmissions and the committee expressed concern that the measure results for the CMS yield measure would not be available in a timely fashion.

The committee also discussed related and competing measures. These include issues relating to the hierarchal condition category versus condition categories. Specified NCQA users, the HCCs and CMSCL user CCs, the committee suggested both developers need to harmonize and use a single approach.

I just wanted to clarify, MCQA users, CCs and CMS CL users HCCs. So logistical or hierarchal modeling, the committee preferred that the developers harmonize their risk models. For the inclusion of structured cohorts, members of the committee requested that NCQA harmonized their denominator to include the five (clinical) cohorts used by CMSCL.

The exclusion of plan readmissions - it was suggested that NCQA exclude plan readmissions from their measure as including plan readmissions is not a signal of poor quality of care.

The exclusion of cancer patients with planned readmissions, the committee suggested NCQA exclude plan readmissions but retain the cancer patients that were not planned readmissions.

Inclusion of patients with psychiatric conditions - CMSCO was asked to incorporate patients who received primary psychiatric treatment at acute care hospitals into their measure because of possible implications of the readmission rates for patients with co-morbid psychiatric conditions.

And lastly, counting readmissions as (invest) admissions. And then the committee requested that NCQA harmonize with CMSCO to count readmissions as index admissions.

Our comment period closed January 20th and we receive 117 comments from 43 organizations and individuals. The major themes of the comments included the justification of an expedited review, socioeconomic status, variables in the risk adjustment model, usability concerns, support for harmonization and inclusion and exclusion criteria.

All comments and responses from the MQF staff, measure developers and steering committees can be found on the voting draft report which is available on our Web site.

Female: So at this time, we'd now like to open the floor for any questions. We do have with us Dr. Lazar who is one of the steering committee co-chairs ((inaudible)) project. And we also have Dr. (Timothy Affairs) who is the chair of the consistent standards approval committee here on the call with us to answer any (questions). (Danielle), can you please open the lines for questions?

(Danielle): Absolutely. Ladies and gentlemen, if you'd like to ask a question, please press star 1 on your telephone keypad. If you're joining us using a Speakerphone, please ensure your mute function is turned off to allow your signal to reach our equipment.

Once again, for your questions at this time, please press star 1. And again, that is star 1 for your questions. We'll hear from Nancy Foster with AMA.

Nancy Foster: Hi. It's Nancy Foster with the American Hospital Association and good afternoon. Let me just understand, because this is somewhat different from the agenda. You're throwing the door open now for any kind of questions or comments. Is that correct?

Male: That is correct Nancy.

Nancy Foster: ((inaudible)).

Male: Hi. Yes.

Nancy Foster: So could I ask just a simple question about process which is that I know that the questions that we had raised in our letter and that others had raised in their letters, with regard to the

expedited review process, and whether or not it was appropriate for this particular set of measures is still an open question, and that the board will be reviewing it at a later date.

How exactly does that influence the voting process and the fact that we're all being asked to vote now without some sense of whether that - how that question might be resolved?

Heidi Bossley: ((inaudible)), this is Heidi. Do you want - I don't know...

Male: Sure, go ahead.

Heidi Bossley: Is my line open? I can't tell.

Male: Yes, we can hear you Heidi.

Heidi Bossley: Okay good. Hi Nancy. So I know others have wondered this as well. The feeling was the board will discuss it on the call on Friday. And if, at that time, the board decides that they want to reverse any actions that we're taking at the moment, any that we will go ahead and work on that, we're actually figuring out if they do decide that they'd like us to - I don't know what the request could be.

It could be more - additional comments or whatever it would be, we would, at that point, circle back and stop where we are in the process. But not knowing where we were and knowing that we still have an obligation and then a timeline and we notified the public that this will go out for votes, we thought we needed to move forward.

So that's how - where we are. We will step back if we need to. But at this point, felt that we needed to keep moving forward as planned.

Nancy Foster: Thanks.

Heidi Bossley: Does that answer your question?

Nancy Foster: Yes, it does. Thank you. And if I might take advantage of having the floor to ask a somewhat different question about the recommendation that the measure be stratified and displayed separating out the (dish) hospitals from the non-(dish) hospitals, which is as I understand it, where the steering committee landed, vis-a-vis the question of the socioeconomic factor and its implication for readmission rates. First of all, do I have that right?

Male: Let me clarify that actually Nancy. It's a little more - a little nuanced in the sense that the committee agreed to move forward with the measure as specified with a supporting recommendation to CMS that in order to support fair and appropriate comparison that hospital's performance should be repaired - should be reported within like comparison groups.

And one example could be disproportion in (share) hospitals. So it was not necessarily a stratification recommendation but rather that like hospitals should be compared when reported, when this measure's reported.

Nancy Foster: So thanks, (Chewin). That's a helpful clarification, so if CMS were to decide that like hospitals meant a division by size or ownership or anything else, that would be satisfactory to the steering committee and meet with the intent of the steering committee's recommendation? Is that your understanding or, (Tim), yours?

Male: Well, I mean, the question was really for vulnerable populations so I'm not sure that just the comparison of hospital size would adequately address this recommendation by the steering committee. Eliot, if there's something else that you'd like to add there as well, but that is my interpretation.

Eliot Lazar: No, I think you captured it.

Male: Okay.

Nancy Foster: Well, I stand corrected then. It really is about an adjustment that reflects the differences in circumstances of the patient.

Male: Right.

Nancy Foster: A reporting methodology that reflects the differences in the circumstances that of patients as sort of a nod towards this whole question of socioeconomic status and the research that has really outlined out how important the impact it can have on readmission rate.

Male: Right.

Nancy Foster: Let me turn the floor over to others.

Operator: And once again, ladies and gentlemen, for your questions, please press star 1.

Male: Okay, if there are no additional questions, I...

Operator: And I apologize. We did just have two participants dial in. And our first question will come from Carol Mullin with Virtua.

Carol Mullin: Hi. Thank you. I just had a question about the inclusion of the psychiatric - patients with psychiatric conditions.

Male: Right.

Carol Mullin: The way it reads, you know, have there been in the metric originally or were the excluded and now they're being added.

Male: Patients who were - patients who had a primary diagnosis of psychiatric condition were excluded from the CMSCO measure.

Carol Mullin: And will they then continue to be in the maintenance?

Male: There was a recommendation by the steering committee that patients with a primary psychiatric treatment at acute care hospitals should be included. But that is the recommendations for the measure going forward. That doesn't mean - that is not the way the measure is currently specified.

Carol Mullin: But it does say in the draft report there that it does suggest coming up with a sixth cohort but it looks like there'll be a whole year to allow that to happen. So I'm not clear when we vote, we're voting on that they were excluded before or they're now in but a year from now they will be added as a cohort. If you could just clarify that for me.

Male: So - yes, sorry for the confusion on that. So the measures as currently specified do not include stations with a primary psychiatric diagnosis. There was a recommendation by the steering committee moving forward at annual update that the measures harmonized with each other and one of the components would be to include patients with psychiatric conditions.

Obviously this would require a certain degree of testing by the measure developers and at that year - at the annual update, we will evaluate the updated measure and at that point it'll be open to public and (member) comment again.

And so the way to assess the current voting is that you would vote on the measure as currently specified which would mean that.

Carol Mullin: Okay, thank you.

Male: Okay.

Operator: And next we'll hear from Don Casey with Atlantic Health Systems.

Don Casey: Hi. Thank you. Can you hear me?

Male: Yes.

Don Casey: Thank you for the chance to speak. I certainly wanted to echo our colleague's comments - Nancy Foster - and appreciate the fact that she's representing a large number of hospitals even though she only gets one vote. My question - the first question is quickly, my understanding is that if this measure is the endorsed by NQS, it will be able to be used by CMS for two purposes.

One is public reporting. And the second is potentially adjustment to reimbursement for certain hospitals that have high levels of readmission. So I just wanted to validate that those two possibilities for this measure were in play.

Male: We - actually I believe CMS is on the call, but the measures endorsed for national use, so it could be used for public reporting, a public accountability program or a quality improvement. The specific uses for CMS, we can't really speak for. CMS, are you on the call?

Don Casey: And I understand that. I'm just trying to point out that I believe this is - it's important for CMS in the Affordable Care Act to rely upon a consensus development process so that they can then use a measure or a set of measures related to readmissions in their payment policy.

So I'm not asking NQF to resolve it. I think I'm just hopefully validating that that is a possibility should this measure be endorsed.

Male: Thank you.

Don Casey: So that may just be a comment. We intend to vote no against this measure. Part of our longstanding concern over the past year has been the inability to explain in the current measures that are used for public reporting for AMI and heart failure, an inverse relationship between organiz- HRRs with better then expected 30 day risk adjusted mortality rate for AMI.

And that correlation with a worse then expected readmission rate for two-thirds of the HRRs that are better then expected for mortality. We believe that there's not been enough analysis that readmissions are certainly a significant problem that we need to work on but that using this measure for purposes of ranking a potential payment is counterproductive especially since there's this, also additional evidence of an under current of lack of adjustment for things like CSC.

And we just don't think this is, by itself, ready and should be studied further especially as it relates to real outcomes and, hence, as I said, we intend to vote no on this measure.

Female: Thank you.

Male: Thank you.

Operator: And we do have a follow up question from Nancy Foster.

Nancy Foster: Hey, thanks. It's nice to get in again. And I share Don Casey's concerns about the unintended impact of this measure or both measures, but particularly the CMS Yale measure and the potential ways in which CMS might use it. And I'm curious about the question that we raised in our comment letter about testing.

Because as we said in the comment letter, to me it really - sufficient testing to be able to judge what's going on with the measure requires that someone other than the measure developer has sort of kicked the tires on it and be able to point out some of the potential unintended consequences, some of the ways in which the data are aligning that may not reflect an adequate adjustment of one stripe or another in the measurement.

This hierarchal condition modeling sounds interesting, sounds like an interesting way to approach it but, you know, we've never really seen it. And it's unclear to me how NQF can judge something to be sufficiently tested when no one else has been able to, as I said, kick the tires on the measure.

So help me understand that because it really is frustrating, quite frankly, to think that a measure could be pushed out for national implementation so it's less - people suppose it's something about hospital performance when nobody's been able to really look at it and know.

Male: Okay, so the NQF criteria within the scientific acceptability which is how the steering committee evaluated these measures looked at the reliability and validity of the measure as constructed.

And the particular measure that your referring to, the CMS measure, attempted to demonstrate reliability and validity testing, both at the data element level and at the measured score level.

And both of these testings - both testing at the reliability and validity was generally received as adequate by the steering committee. Now the concern that you raised around whether it's been in use is actually kind of a separate issue from the actual scientific testing - statistical testing - of the measure.

Since you could demonstrate reliability and validity without the measure actually being in use by demonstrating statistical relationships between the measure and other reliable measures of quality.

Now one can question that as others have and that's reasonable. However, the question of usability is sort of a separate concern.

Nancy Foster: (True) and I get that. And I understand you can test reliability and validity and know that a measure is reliable and valid but it may not give you a portrait of quality that you really want which you don't figure out until you've actually seen how the measure plays out in reality.

And some of the questions that have been raised about socioeconomic status and other factors that play in here and whether or not a clinical - and adjustment for differences in clinical status is sufficient. I mean, the - so I'm really trying to probe at this issue of what is considered sufficient testing? Is it only around reliability and validity?

Or is it anything having to do with how the measure actually works and whether it's, in fact, accounts for enough of the variation in data to be - and what is left open? What's unaccounted for in this measure that may or may not be appropriately left on the table? And that's a bigger, broader question on whether it's reliable or valid.

Male: That's correct. That's correct.

Nancy Foster: And it is one of the reasons we will join Atlantic here in voting no on this measure. It is troublesome to us to say the least to think that it could be imposed on the hospital without anybody else having the opportunity to review it and understand the impact and raise some questions about it. That's the nature of our concern.

Male: That's fair Nancy. Thank you.

Operator: We do have another question that will come from Daniel Brotman with Johns Hopkins Hospital.

Daniel Brotman: Hi. Can people hear me?

Male: Yes.

Female: Yes.

Daniel Brotman: Yes, this is a follow up to the last point related to, you know, how to make sure that there aren't unintended consequences. And it extends beyond just the socioeconomic factors with I think are probably the biggest ones that we've seen when we've dug down into our readmissions at the hospital a very large percentage of planned readmissions.

And when we've looked at the Yale CMS plans, it seems that there's an acknowledgement that we need to exclude these from the numerator and the denominator, but the process of doing so seems to be iterative and somewhat cumbersome and I'm very concerned that we're going to really have an incentive, for instance, not to admit patients for their cancer surgery after three weeks but push it out to four weeks.

And that seems almost silly, but we're seeing really about 20% or more sometimes of our readmissions planned and not necessarily clearly included in the Yale methodology. And we want

to make sure that there's a process in place to have a low threshold to exclude potentially planned readmissions so that we can avoid that problem.

I'd rather have them excluded in the numerator and the denominator and in the process to allow some - quote - legitimate readmissions then have them included unnecessarily and really cause consternation for people on the ground level trying to take good care of patients.

Female: Thank you.

Operator: And there are no further questions in queue.

Male: Okay. Thank you all for those thoughtful comments. So we'll just finish up here with next steps.

The NQS member voting will end on Monday, March 1, 2012 at 6:00 Eastern time. Voting results will be forwarded to (C pack) for discussion on March 7, 2012 in (first in) meeting.

We wanted to make sure we took a moment here to thank Dr. Elliott Lazar for joining us on this call as we (chaired) this group. And if there are no questions - if there're any other questions, we'll be happy to take them otherwise we thank you all for taking the time out in your day to participate in this project.

Operator: And ladies and gentlemen that will conclude today's conference. Thank you again for your participation. You may now disconnect.

Female: Thank you.

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