Below please find the Fall 2010 edition of *News from ORDI*, a quarterly publication summarizing recent work undertaken in ORDI and the results we've produced. Highlights from this quarter's *News* include:

- The 2010 version of the CMS Statistics Handbook.
- The 2010 version of the Wallet Card.
- New research reports by CMS staff
- Updates of demonstrations and research projects

I hope you find this information useful. For additional ORDI-related information, please visit our **website**.

Tom Reilly

Acting Director, Office of Research, Development, and Information

1. 2010 *CMS Statistics*

The 2010 edition of *CMS Statistics* is now available. *CMS Statistics* is an annual publication prepared as a handy reference document for CMS leadership and staff. (*CMS Statistics* is also available to the general public and is uploaded to the CMS website.) The data are comprehensive, with summary CMS program information that can serve as background for briefings, position papers, or a source for answering questions from Congressional staff and the public.

The electronic version of the 2010 *CMS Statistics* is available here. For additional information, please contact Maria Diacogiannis at 410-786-0178 or maria.diacogiannis@cms.hhs.gov.

2. 2010 *Wallet Card*

The *Wallet Card* provides our most frequently requested data, presented in a concise, easy-to-read format. This publication is a quick reference on program and financial statistics.

The electronic version of the 2010 *Wallet Card* is now available here. For additional information, please contact Maria Diacogiannis at 410-786-0178 or maria.diacogiannis@cms.hhs.gov.

3. New Research Reports

Evaluation of the Premier Hospital Quality Incentive Demonstration: Phase I Final Report

CMS undertook a 6-year demonstration to determine whether paying incentives to hospitals would increase their quality. CMS contracted with RTI, International to conduct an evaluation study. This report analyzes the trends hospital scores for measures included in the demonstration over the first four years (FY 2004-2007) of this six-year demonstration. Please note that hospital quality overall rose during this time period but this report only examines Premier hospitals that participated in the demonstration.

Major findings include:

- Nearly all process, outcome, and CQS scores had positive percent changes between Q1 and Q16, however, the rate of change during Year 1 was much greater than the rate of change during the later years.
- Over the four years, hospital performance was clustering around a mean value without a wide range between high and low performing hospitals. Hospitals that were high (low) performers in year 1 of the demonstration were likely to remain high (low) performers in year 4. Low-scoring hospitals in year 1 were more likely to drop out of the demonstration by year 4 than hospitals that had high scores in year 1.

For more information or to obtain a copy of the report, contact Linda Radey, Ph.D., at 410-786-0399 or linda.radey@cms.hhs.gov.

Volume-Outcome Relationships and Abdominal Aortic Aneurysm Repair

This report utilized data from the Medicare program to investigate the relationship between institutional volume for open and endovascular abdominal aortic aneurysm (AAA) repair and outcomes, examine trends in volume, and explore the implications for physicians making referrals for AAA repair. Trends in institutional volume were

measured for the time period 2001–2006, whereas outcomes were assessed with the use of a previously assembled propensity score–matched cohort covering the time period 2001–2004. Between 2001 and 2006, there were 230,736 repairs of either an intact or a ruptured AAA for traditional Medicare beneficiaries. During this time, the proportion of endovascular cases increased from about 22 in 2001 to more than 50 of AAA repairs in 2006, but there was little shift in procedure volume to high-volume institutions. For endovascular repair, adjusted mortality by quintile showed a marked decrease between the first and second quintile, with continued smaller decreases over quintiles 3 to 5. For open repair, adjusted mortality showed a steady decrease across the quintiles of volume.

The electronic version of this report is available here.

For more information, please contact Philip Cotterill at 410-786-6598 or philip.cotterill@cms.hhs.gov

Medicare Health Care Quality Demonstration Evaluation: Indiana Health Information Exchange Final Case Study Report

The purpose of this case study is to provide an in-depth understanding of the Indiana Health Information Exchange, which is one of three sites participating in the Medicare Health Care Quality Demonstration (MHCQ). The case study synthesizes information collected from site visits and telephone interviews conducted in the spring and summer of 2010. The Indiana Health Information Exchange (IHIE) provides medical information and data-sharing services in the Indianapolis region. The Quality Health First program, which is the focus of the MHCQ demonstration, combines data from the Indiana Network for Patient Care (INPC) data repository with claims from private payers, Medicaid, and now Medicare to produce monthly and quarterly quality reports. Primary care physicians use the quality reports to identify health screenings and other recommended tests for managing preventive care and chronic diseases. Fourteen quality measures targeted towards Medicare beneficiaries will be used in the quality reports as part of the demonstration, including diabetes care, heart health, and breast and colon cancer screening. The primary challenge since beginning in July 2009 was converting Medicare data and appropriately attributing Medicare beneficiaries to participating primary care physicians.

The electronic version of this report is available here.

For more information, please contact Normandy Brangan at 410-786-6640 or normandy.brangan@cms.hhs.gov

Medicare Health Care Quality Demonstration Evaluation: North Carolina-Community Care Networks Final Case Study Report

The purpose of this case study is to provide an in-depth understanding of the North Carolina-Community Care Networks (NC-CCN) program, which is one of three sites participating in the Medicare Health Care Quality Demonstration (MHCQ). The case study synthesizes information collected from site visits and telephone interviews conducted in the spring and summer of 2010. The North Carolina-Community Care Network (NC-CCN) uses a medical home model to provide Medicaid enrollees with access to a primary care provider, who provides comprehensive and preventive care. NC-CCN began in the MHCQ demonstration in January 2010 with the goal of expanding their services to dually-eligible Medicare beneficiaries in 8 networks, covering 26 counties. By the third year, Medicare beneficiaries without Medicaid will also be included. Performance measures will be collected on care for diabetes, congestive heart failure, hypertension, post myocardial infarction, and transitions. Challenges reported include obtaining Medicare data, exchanging health information across networks, relying on claims instead of real-time data, and a shortage of clinical pharmacists.

The electronic version of this report is available here.

For more information, please contact Normandy Brangan at 410-786-6640 or normandy.brangan@cms.hhs.gov

Medicare Health Care Quality Demonstration Evaluation: Gundersen Lutheran Health System Advanced Disease Coordination Final Case Study Report

The purpose of this case study is to provide an in-depth understanding of Gundersen-Lutheran's Advanced Disease Coordination program, which is one of three sites participating in the Medicare Health Care Quality Demonstration (MHCQ). The case study synthesizes information collected from site visits and telephone interviews conducted in the spring and summer of 2010. The Gundersen Lutheran Health System in LaCrosse, Wisconsin created a "Next Steps" conversation for patients with progressive diseases that involves discussions between patients, family members, and a trained facilitator about the progression of their disease, the patient's preferences for care, and what can be done to maintain their goals and wishes. To support patients' preferences, Gundersen Lutheran developed a delivery model called Advanced Disease Coordination (ADC), which is the focus of the MHCQ demonstration. ADC features an interdisciplinary team that provides care coordination, primary care, palliative care, pastoral care, social worker services, and hospice discussions. Medicare fee-for-service beneficiaries age 65 and over with a prognosis of 24 months or less due to a specified chronic condition and who have completed the "Next Steps" conversation will be eligible for the demonstration. Performance measures will include monthly communication to assess symptom management, completed power of attorney, patients with active symptoms

being offered a visit within one week, and hospice discussions. The second year will add measures for depression, pain, and dyspnea assessment as well as spiritual support, symptom control, and goals of care. Since beginning in February 2010, the primary challenge has been using their internal systems to identify potentially eligible beneficiaries.

The electronic version of this report is available here.

For more information, please contact Normandy Brangan at 410-786-6640 or normandy.brangan@cms.hhs.gov.

Adverse Events among Chronically Ill Beneficiaries: Time to Readmission among Chronically Ill Community-Resident Beneficiaries

Among a cohort of community dwelling, chronically ill beneficiaries, this work explores the impact, of proxy measures for care continuity by providers, upon risk of hospital readmission, adjusting for demographic and health risk factors. Employing a survival analysis methodology, a high degree of care continuity was associated with a lower risk of hospital readmission, while a previous admission, older age, and male gender were associated with greater risk for readmission.

The electronic version of this report is available here.

For more information, please contact Carol Magee at 410-786-6611 or carol.magee@cms.hhs.gov.

Adverse Events among Chronically Ill Beneficiaries: Event Analysis of All-Cause and Ambulatory Care Sensitive Hospitalization of Long-Stay Nursing Home Residents

Using nursing home characteristics, this work explores effects of measures of care on the time to acute hospitalization. The long-term nursing home cohort (in-stay and for => 90 days duration, as of 12-31-1999) was identified using the CCW and nursing home databases. Their in-patient admissions were identified from claims data for all-cause hospitalizations or the subset of ambulatory-care-sensitive (ACS) hospitalizations during year 2000. Survival analysis modeling was used to estimate the impact of nursing home characteristics, including staffing, upon time to any hospitalization, while adjusting for individual beneficiary characteristics, particularly health and disability status. A number of nursing home factors were significant predictors of shorter time to both all-cause and to ACS hospitalization.

The electronic version of this report is available here.

For more information, please contact Carol Magee at 410-786-6611or carol.magee@cms.hhs.gov.

Evaluation of Cancer Prevention and Treatment Program Demonstration

The Centers for Medicare & Medicaid Services funded six demonstration projects to test the effectiveness of patient navigation (PN) in reducing ethnic/racial disparities in cancer screening and treatment. Although the demonstration began on October 1, 2006, the sites experienced difficulties in enrolling participants and in starting the actual process of navigation. As a result, definitive findings on the demonstration's effectiveness will not be available until 2012. This report presents preliminary data based on site visits, document review, baseline (pre-demonstration) Medicare claims and participant surveys, and satisfaction surveys of participants in the intervention group. At the time of this report, sites had made substantial progress in enrolling participants into the screening arm of the demonstration, but enrollments in the treatment arm remain very low. Participants in the screening arm who were randomized to receive PN were generally satisfied with those services in five of the six sites. However, services were generally limited to help with setting up appointments and making referrals. The lay navigator model used by most of the sites suffers from a lack of day-to-day clinical supervision, which may have limited the services provided. Using Medicare claims, demonstration participants were compared with non-participants in order to ascertain whether the results from the demonstration could be applied to the Medicare population at large. Demonstration participants were significantly more likely to be younger and female. They were also more likely to have received cancer screening services and an influenza vaccine before the start of the demonstration.

For more information or to obtain a copy of the report, please contact Bill Clark at 410-786-1484 or william.clark@cms.hhs.gov

4. Current Demonstrations and Research Projects

Frontier Extended Stay Clinic Demonstration

The CMS Medicare Demonstrations Program Group has implemented the Frontier Extended Stay Clinic (FESC) demonstration, mandated by section 434 of the Medicare Modernization Act. The demonstration allows remote clinics to treat patients for more extended periods than are entailed in routine physician visits, including overnight stays. A clinic must be located in a community that is at least 75 miles from the nearest acute care hospital or critical access hospital, or that is inaccessible by public road. The law mandates that the project last for 3 years. CMS has certified one FESC in Washington and two in Alaska, while the certification of another in Alaska is almost complete. The

CMS Seattle Regional Office has conducted the health services surveys, coordinating with State agencies, who have conducted the life safety surveys.

For additional information, please contact Siddhartha Mazumdar at 410-786-6673 or siddhartha.mazumdar@cms.hhs.gov.

Rural Hospice Demonstration

Under this demonstration, which ended recently, Medicare beneficiaries who were unable to receive hospice care at home for lack of an appropriate caregiver were provided such care in a facility of 20 or fewer beds that offers, within its walls, the full range of services provided by hospice programs under section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)). The demonstration provided two waivers: (1) the need to provide care in the community and (2) the twenty percent inpatient care limit for rural beneficiaries who lacked an appropriate caregiver. It showed that the hospices were able to care for all patients appropriately under the traditional Medicare Hospice Program and that this provided a more sound business model. Effectively, the waivers in the demonstration were ultimately not necessary and one site never had any. The other site became a traditional Medicare Hospice by becoming certified for and servicing patients in the community and not using the 20-inpatient cap. The demonstration learned much from the collection and reporting of quality measures, which were implemented using rapid response learning. In addition, each site took on a project to increase awareness of and use of hospice services to underserved populations.

For additional information, please contact Cindy Massuda at 410-786-0652 or cindy.massuda@cms.hhs.gov

---

Previous Listserv newsletters are available under the heading “ORDI Research News Listserv Archive” **here**.

Click **here** to subscribe/unsubscribe to this listserv.