Public Comment Summary Report

Hospital-level 30-day risk-standardized days in acute care after hospitalization for heart failure

Hospital-level 30-day risk-standardized days in acute care after hospitalization for pneumonia

Hospital-level 30-day risk-standardized days in acute care after hospitalization for acute myocardial infarction (AMI)

July 2014

Yale New Haven Health Services Corporation — Center for Outcomes Research and Evaluation (CORE)

Introduction

Dates of public comment period:

Monday, July 14, 2014 through Thursday, July 31, 2014

Web site used:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html

Methods used to notify stakeholders and general public of comment period:

- Email notification to the Centers for Medicare & Medicaid Services (CMS) listserv groups
- Email to relevant stakeholders and stakeholder organizations, including:
    - Business, consumer, and patient advocacy organizations
    - Electronic Health Record (EHR) vendors
    - Healthcare quality-focused organizations
    - Insurance and purchaser organizations
    - Medical associations and societies
    - Research organizations
    - Topic knowledge-related organizations
- Posting on CMS Public Comment web site
- Posting on Twitter
- Posting on web-based forums

Volume of responses received:

We received comments from three commentators during the public comment period; specifically:

- One healthcare improvement organization (Premier, Inc)
- One business, consumer, and patient advocacy organization (LeadingAge)
- One individual (Dr. Daniel J. Brotman)

Stakeholder Comments—General

Summary of general comments:

We received comments on various aspects of the measures of days in acute care after hospitalization for heart failure, pneumonia, or acute myocardial infarction (AMI). Comments focused on the measure objective and the measure methodology, including the outcome, risk adjustment, and testing.

All commentators were supportive of the objective to measure risk-standardized days in acute care after hospitalization for heart failure, pneumonia, or AMI and agreed with the value of the measures beyond existing CMS 30-day readmission measures.

Proposed action(s):

See proposed action under the measure-specific comment summaries below.

Measure-Specific Comment Summaries

Measure name:

Hospital-level 30-day risk-standardized days in acute care after hospitalization for heart failure

Hospital-level 30-day risk-standardized days in acute care after hospitalization for pneumonia

Hospital-level 30-day risk-standardized days in acute care after hospitalization for acute myocardial infarction (AMI)

Summary of comments:

General comments

There were three general comments about the measures' focus

- Three commentators expressed support for the focus on evaluating acute care utilization after hospitalization for heart failure, pneumonia, or AMI, and the potential impact on health outcomes and quality improvement.

Response: We appreciate the commentators' support for the measures' focus.

Outcome

Three comments addressed the outcome definition and calculation methodology.

- Three commentators expressed support for the proposed outcome – the number of days the patient spends in acute care (emergency department [ED] visits, observation stays, and

readmissions) during the first 30 days after discharge from the hospital. One of these commentators expressed support for excluding mortality from the outcome. The same commentator recommended excluding hospice patients from the measure, if including mortality. The same commentator also expressed support for counting ED visits as a half-day and the method for counting observation stay days

Response: We appreciate the commentators' support for the outcome definition. We agree that if the outcome were to include mortality, we would consider excluding hospice patients.

Risk model

Two comments addressed risk model variables.

- Two commentators recommended adjusting for sociodemographic factors in order to reduce potential harm to patients and disparities in care. In particular, one commentator recommended adjusting for socioeconomic status (SES). A second commentator recommended adjusting for prior ED utilization or excluding unrelated ED visits from the measure.

Response: We appreciate your comments and understand the importance of SES in the care of patients. The goal of risk adjustment is to account for factors that are inherent to the patient at the time of admission, such as severity of disease, in order to put hospitals on a level playing field during assessment of their performance on the measures. While this measure does not currently adjust for sociodemographic factors (e.g., SES, prior ED utilization), we will conduct exploratory analyses to investigate whether including sociodemographic factors in the model affects hospital performance. In particular, we will conduct exploratory analyses to understand the impact of ED utilization one year prior to the index admission on hospital performance scores.

Testing

- One commentator requested results of planned reliability and validation testing to be made public when available.

Response: The measures are presently undergoing testing; these results will be released when they are complete. CMS seeks public comment during measure development to allow developers to address concerns or issues raised during the public comment period prior to completion of the measure development and testing processes.

Proposed action(s):

We plan to incorporate the suggestions received during public comment into the development of our measures. Specifically:

- CORE will conduct exploratory analyses to understand the impact of patient sociodemographic factors on hospital performance scores.

Overall Analysis of the Comments and Recommendations to CMS

The feedback on the measure focus and measure methodology overall was positive. Commentators identified a concern about socioeconomic status, prior ED utilization, and healthcare access that we will address through additional measure testing.

Risk-Standardized Days in Acute Care after Hospitalization for Heart Failure, Pneumonia, or Acute Myocardial Infarction
Public Comment Verbatim Report

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commentator	E-Mail Address	Type of Organization	Recommendations/ Actions Taken
07/31/2014	Days in Acute Care after Hospitalization for Heart Failure, Pneumonia, or Acute Myocardial Infarction	July 31, 2014 Leora I. Horwitz, MD, MHS, Project Lead Susannah M. Bernheim, MD, MHS, Project Director Yale New Haven Health Services Corporation/ Center for Outcomes Research & Evaluation (YNHHSC/CORE) *Submitted via email to cmstransitionsmeasures@yale.edu* Re: Call for Public Comment: Hospital-Level Measures of 30-Day Post-Hospital Discharge Days in Acute Care for Patients with Heart Failure, Pneumonia, or Acute Myocardial Infarction (AMI) Dear Drs. Horwitz and Bernheim: On behalf of the Premier healthcare alliance, we appreciate this opportunity to comment on three patient-centered measures of post-discharge outcomes, one each for heart failure, pneumonia, and AMI, currently under development by the Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE). These measures focus on acute care utilization after discharge (i.e., return to the emergency department (ED), observation stay, and unplanned readmission).	Blair Childs Senior Vice President, Public Affairs - Premier Healthcare Alliance Submitted by: Seth Edwards MHA, Manager, Federal Affairs - Premier Healthcare Alliance	seth_edwards@ PremierInc.com	Healthcare improvement	Stakeholder comments reviewed by measure developers and will be reviewed with Technical Expert Panel; detailed responses are provided in the Public Comment Summary Report. No changes to the measure in response to public comment recommended.

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		The Premier healthcare alliance is a healthcare improvement company uniting an alliance of more than 2,900 U.S. hospitals and nearly 100,000 other providers to transform healthcare. Premier, a 2006 Malcolm Baldrige National Quality Award recipient, maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments primarily reflect the views of our owner hospitals and health systems, which, as service providers, have a vested interest in the development of sound quality measures, especially those that will be ultimately used by the Centers for Medicare & Medicaid Services (CMS). Overarching Comments Premier supports the concept encompassed by the three separate measures and believes these measures would fill an important gap in quality measurement. We also agree with the decision to exclude mortality as an outcome under these three measures. If mortality were to be included, we would agree that patients in hospice or in palliative care should be excluded. We also agree with the proposed weighting of ED visits and the proposed method for calculating observation days. We look forward to learning the results of planned reliability and validation testing, which we consider a very key determinant of sound measure development.				

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		Risk-Adjustment We continue to believe in the need to incorporate social determinants of health, in particular socioeconomic status (SES), into the risk adjustment methodology for measures such as these three measures of post-discharge outcomes. Comparing hospital performance between markets of widely varying SES, without taking the SES of the populations served into account, is flawed. Social determinants play a major role in influencing health and wellness. There is a substantial body of evidence that sociodemographic factors—such as patients' income, housing, education and race—influence a variety of patient outcomes and some processes that are out of a provider's control. As noted by Christine Cassel, "not adjusting for patients' sociodemographic factors might actually harm patients, exacerbate disparities in care, and produce misleading performance scores for a variety of providers, which means that no one has accurate information to use for comparison."[1] Moreover, the National Quality Forum Board (NQF) of Directors voted on July 23, 2014 to initiate a trial period for assessing the impact and implications of risk adjusting relevant quality measures for sociodemographic factors. This vote follows an NQF technical report that recommends adjusting for sociodemographic factors the performance measures used to determine provider payment.[2] A robust risk-adjustment approach will strengthen the reporting process and help to minimize the potential for unintended consequences. The preceding comments notwithstanding, we recognize that the				

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		YNHHSC/CORE has given the matter of SES considerable thought. However, the draft measures would adjust for age, comorbid diseases, and indicators of patient frailty but not for SES. Conclusion In closing, Premier appreciates the opportunity to submit these comments on the hospital-level measures of 30-day post-hospital discharge days in acute care for patients with heart failure, pneumonia, or AMI. Please do not hesitate to contact Seth Edwards, manager of federal affairs, at seth_edwards@PremierInc.com if you would like to discuss further. Sincerely, Blair Childs Senior Vice President, Public Affairs References 1. Cassel, Christine. “Should Provider Performance Measures Be Risk-Adjusted for Sociodemographic Factors?” Health Affairs. 2014, March 27. Accessed online at http://healthaffairs.org/blog/2014/03/27/should-providerperformance-measures-be-risk-adjusted-for-sociodemographic-factors/ 2. National Quality Forum, Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors,				

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		Technical Report, July 2, 2014, and July 23, 2014 press release available at: http://www.qualityforum.org/Press_Releases/2014/NQF_Board_Approves_Trial_Risk_Adjustment.aspx				
07/31/2014	Days in Acute Care after Hospitalization for Heart Failure, Pneumonia, or Acute Myocardial Infarction	July 31, 2014 Ms. Faseeha Altaf, MPH Yale/YNHH Center for Outcomes Research and Evaluation (CORE) 1 Church Street, Suite #200 New Haven, CT 06510 RE: Public Comments on Hospital-Level Measures of 30-Day Post-Hospital Discharge Days in Acute Care for Patients with Heart Failure, Pneumonia, or Acute Myocardial Infarction Dear Ms. Altaf: LeadingAge greatly appreciates the opportunity to provide input on the Centers for Medicare & Medicaid Services and Yale's New Haven Health Services Corporation/Center for Outcomes Research and Evaluation proposed hospital-level measures for patients with heart failure, pneumonia, or Acute Myocardial Infarction. The LeadingAge Community includes 6,000 not-for-profit organizations in the United States, 39 state partners, hundreds of businesses, research partners, consumer organizations, foundations, and a broad global network of aging services organizations that reach over 30 countries. We promote home health, hospice, community-based services, adult day service, PACE, senior housing, assisted living residences, continuing care communities, nursing homes, as well as technology solutions and person-	Cheryl Phillips, MD Senior Vice President, Public Policy and Advocacy, LeadingAge Submitted by: Heather Boyd, MPP Director, Long Term Care Finance & Policy, LeadingAge	cphillips@leadingage.org	Business, consumer, and patient advocacy	Stakeholder comments reviewed by measure developers and will be reviewed with Technical Expert Panel; detailed responses are provided in the Public Comment Summary Report. No changes to the measure in response to public comment recommended.

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		centered practices that support the overall health and wellbeing of seniors, children, and those with special needs. LeadingAge supports the inclusion of event days as a quality measure. We believe tracking emergency department visits, observation stays, and readmissions within 30 days after hospitalization will provide important data on the quality of care a patient has received. As noted in the public comment draft, we are also concerned that current readmission measures are not capturing the full range of unplanned acute care in the post-discharge period. With a significant increase in the use of emergency department visits and observation stays, we are concerned that a high rate of observation stays may cause an artificially low calculation rate of readmission rates and will not accurately reflect the quality of care a patient may have received. By capturing emergency department visits, observation stays, and readmissions, we believe this data will contribute to a better understanding of how care transitions should be handled to ensure the patient receives the appropriate care needed to avoid unnecessary trips back to the hospital. Again, LeadingAge appreciates the opportunity to submit these comments. If you have any questions, please feel free to contact me at cphillips@leadingage.org. Sincerely, Cheryl				

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07/31/2014	Days in Acute Care after Hospitalization for Heart Failure, Pneumonia, or Acute Myocardial Infarction	July 31, 2014 Daniel J. Brotman, MD, SFHM, FACP, Professor of Medicine Director, Hospitalist Program, Johns Hopkins Hospital Dear Measures Development Team: Overall, the concept behind quantifying post-discharge utilization (after, for instance, a CHF hospitalization) is an improvement on the prior readmission-only measures for the reasons your team outlined. Readmissions, as binary measures, are too crude to capture the reality that utilization post-discharge is not binary. That said, I am concerned about the subset of patients, particularly underserved patients in urban centers, that uses the ED as a primary care site. As such, I would recommend some accounting for prior ED utilization in a measure like this. Imagine a patient who happens to have CHF, but also happens to have no PCP, so comes to the ED about once per month or two for a variety of medical issues (skin laceration, sinusitis, headache, GI illness, fever, etc.); this patient will be more likely to go to the ED for an issue unrelated to a CHF exacerbation than a similar patient who uses a PCP's office for these typical ambulatory conditions. One strategy to deal with this would be to try to exclude unrelated conditions (ie, headache would not count after a CHF exacerbation as being related), but this approach is challenging and prone to gaming. Another approach would be to account for baseline ED utilization, which	Daniel J. Brotman, MD, SFHM, FACP Professor of Medicine Director, Hospitalist Program, Johns Hopkins Hospital	brotman@jhmi.edu	Individual	Stakeholder comments reviewed by measure developers and will be reviewed with Technical Expert Panel; detailed responses are provided in the Public Comment Summary Report. No changes to the measure in response to public comment recommended.

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		would perhaps be a better approach. As such, a patient who typically has 10 ED visits per year that do not lead to admission would be risk-stratified differently in the model from an otherwise identical patient who has an average of 2 ED visits per year that do not lead to admission. There may be other ways to handle this issue, and obviously we do not want patients to have to use the ED as a primary care site, but we are often stuck with that reality; most CHF patients will go to their PCP or an urgent care center for something like a sinusitis, but not someone who cannot get into a PCP office or urgent care center, and even if we do line up a PCP for the patient, urgent care needs to happen during non-business hours. Imagine patient A with CHF and no access to outpatient care. She gets admitted to the hospital for 4 days for CHF exacerbation and goes home. Then gets a laceration on the ankle while moving furniture on a Saturday. Goes to ED. Gets stiches. Goes back to the ED to get stitches out. Patient B with CHF and access to outpatient care has same scenario occur. She goes to urgent care center (which takes insurance), then gets stitches out at the PCP's office. Even if we assigned patient A a PCP prior to discharge, this does not mean the patient has the same access to care as patient B (on weekends or after work, etc), so patient A will continue to be more likely to use the ED for acute issues that are unrelated to the CHF.				

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		As such, unless we account for access to PCP care AND urgent (non-ED) care, we are likely to penalize institutions that care for underserved populations. Thank you for considering this concern. Daniel J. Brotman, MD, SFHM, FACP				