

**Meeting of the Advisory Panel on Medicare Education (APME)**  
**Centers for Medicare & Medicaid Services (CMS)**  
**October 20, 2009**  
**Hilton Washington Hotel Embassy Row**  
**Washington, D.C. 20036**

**Location:**

The meeting was held at the Hilton Washington Hotel Embassy Row, 215 Massachusetts Avenue, NW, Washington, D.C. 20036.

***Federal Register Announcement***

The meeting was announced in the Friday, September 25, 2009 *Federal Register* (Volume 74, Number 185, Pages 48981-48982). (Attachment A)

**Panel Members Present:**

**Gwendolyn T. Bronson**, SHINE/SHIP Counselor, Massachusetts SHINE Program  
**Yanira Cruz, Ph.D.**, President and Chief Executive Officer, National Hispanic Council on Aging  
**Nan-Kirsten Forté**, Executive Vice President, Consumer Services, WebMD  
**Cathy C. Graeff, R.Ph., M.B.A.**, Partner, Sonora Advisory Group  
**Carmen R. Green, M.D.**, Professor, Anesthesiology and Associate Professor, Health, Management, and Policy, University of Michigan  
**Jessie C. Gruman, Ph.D.**, President, Center for Advancing Health  
**Cindy Hounsell, J.D.**, President, Women's Institute for a Secure Retirement  
**Gail Hunt**, President and Chief Executive Officer, National Alliance for Caregiving  
**Deeanna Jang, J.D.**, Policy Director, Asian and Pacific Islander American Health Forum  
**Andrew Kramer, M.D.**, Professor of Medicine, Division of Health Care Policy and Research, University of Colorado, Denver  
**Sandy Markwood**, Chief Executive Officer, National Association of Area Agencies on Aging and APME Co-Chair  
**David W. Roberts, M.P.A.**, Vice President, Government Relations, Healthcare Information and Management System Society  
**Julie Bodén Schmidt, M.S.**, Associate Vice President, Training and Technical Assistance, National Association of Community Health Centers  
**Rebecca P. Snead, R.Ph.**, Chief Executive Officer and Executive Vice President, National Alliance of State Pharmacy Associations and APME Chair

**Panel Members Absent:**

**Stephen P. Fera, M.B.A.**, Vice President, Social Mission Programs, Independence Blue Cross  
**Kathy Hughes**, Vice Chairwoman, Oneida Nation

**Open Meeting**

**Lynne G. Johnson**, Designated Federal Official, Office of External Affairs (OEA), Centers for Medicare & Medicaid Services (CMS)

Ms. Lynne Johnson called the meeting to order and confirmed that there were no lobbyists in attendance.

### **Welcome and Introductions and Review of Previous Meeting**

**Rebecca Snead**, APME Chair

**Teresa Niño**, Director, OEA, CMS

Ms. Rebecca Snead welcomed participants and asked the panelists to briefly introduce themselves. Following the introductions, Ms. Teresa Niño thanked the members for their participation and stressed the importance of the Panel's feedback and suggestions for improving OEA's products and outreach and education efforts.

Ms. Snead summarized the July 8, 2009 meeting (Attachment C), which featured:

- A listening session with CMS Acting Administrator, Ms. Charlene Frizzera. The session focused on recent changes at CMS and CMS' responses to the Panel's suggestions generated following the April meeting.
- A demonstration of Web slide shows for consideration for use with expanded *Medicare & You* handbook outreach.
- Discussions on integrating the Medicare comparison tools and the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) program roll out.
- Recommendations for possible topics – cultural competency, health literacy, reducing and eliminating disparities, and emerging issues – that will be addressed during the winter meeting.

Ms. Deeanna Jang, Policy Director, Asian and Pacific Islander American Health Forum, took the oath of office and was officially seated as a member of the APME.

### **Listening Session with CMS Leadership**

**Charlene Frizzera**, Acting Administrator, CMS

Ms. Frizzera expressed that she hoped the panelists have seen an increased commitment from CMS to share information with the panel and incorporate its recommendations in Medicare outreach and education activities.

She looked forward to the re-write of possible new legislation regarding the *Medicare & You* handbook. She stated that currently, approximately 66,000 beneficiaries have elected to receive the handbook electronically. The Web version of the handbook is very simple and includes quick links that improve usability.

Ms. Frizzera briefly addressed issues that are currently being addressed by CMS:

- The agency is working on a limited English proficiency plan. OEA will be working on the plan activity with the Office of Civil Rights, which is the lead office for this activity.
- The health disparities area, which is led by Mr. Terris King, will soon announce a diabetes initiative in Mississippi and a demonstration project on obesity in Native American populations. Both focus on education and prevention.

- Part B premium notices went out on October 16. Because there will be no increase in Social Security benefits, those beneficiaries who currently have the Social Security Administration (SSA) withhold their Part B premium and have incomes of \$85,000 or less (or \$170,000 or less for joint filers) will not have an increase in their Part B premium for 2010. New Part B beneficiaries and those with higher incomes will pay an increased premium amount.
- CMS has been working on the mental health parity regulations that define how managed care plans implement the mental health parity law. The new regulations, which were developed jointly by the Departments of Treasury, Labor, and Health and Human Services (HHS), include many protections for beneficiaries. The regulations should be published by the end of the year.
- DMEPOS competitive bidding is moving ahead. CMS anticipates that approximately 2,000 suppliers will have their licenses revoked due to failure to apply for certification or to obtain surety bonds. Letters are being sent to beneficiaries whose current suppliers will not participate in the program containing information on how to find and transition to a new supplier. CMS extended the period for the second round of suppliers to apply for accreditation. Those suppliers that did not submit documentation will have their licenses revoked. CMS will send out letters to beneficiaries affected by this round of implementation in mid-November.
- CMS is also working to determine whether pharmacies are exempt from the DMEPOS regulations because durable medical equipment (DME) represents such a small portion of their business. If they are not and the law is not changed to exempt them, CMS will look for ways to support the personal, one-on-one relationship beneficiaries have with their pharmacies and ease the transition to new suppliers if pharmacies do not continue to participate.
- CMS developed a mapping tool to show the location of DME suppliers by county and the equipment that they supply. Ms. Frizzera expressed hope that this would be available to the public soon. The map has helped the agency identify gaps in supplier coverage and prioritize outreach based on risk. Currently, beneficiary knowledge about where to go for supplies is a bigger issue than access to suppliers. CMS is working on educating beneficiaries about where to go for information and assistance. The agency hopes to apply the mapping capability and lessons learned to the Child Health Insurance Program (CHIP) providers.
- The Office of Beneficiary Information Services and OEA are working on a redesign of the CMS Webpage. The improvements relate to better organization and improved ease of use, with the goal of making information easier to find.
- CMS is currently tracking health reform legislation on a daily basis and planning for the future no matter which approach is ultimately implemented. There are several consistent elements among the various bills, and CMS is focusing on these as they seem to have the greatest likelihood of being included in the final legislation. Once something passes, there will be challenges for everyone involved in healthcare. Ms. Frizzera suggested that the panel hold an extra meeting once health legislation passes to identify issues on which the panel would like to partner with CMS.

Ms. Frizzera concluded her remarks by congratulating Ms. Sandy Markwood on her appointment as co-chair of the APME and welcoming Ms. Jang to the panel. She expressed her appreciation for the Panel's ongoing support and input.

#### Discussion

Member Comment – Ms. Gail Hunt asked how CMS is planning to communicate with beneficiaries about any program changes resulting from health reform implementation.

CMS Response – Ms. Frizzera replied that CMS' response will be tailored to match the legislation that gets passed. Whether the changes are significant or minor, CMS needs to explain the changes quickly and truthfully before beneficiaries are bombarded with information from other sources. The agency needs to show that it knows what it is doing. CMS also needs to help its partners prepare for these changes. If there are major changes, CMS will implement a comprehensive education program.

Member Comment – Ms. Hunt indicated that she thought the DMEPOS map was an excellent use of technology and encouraged CMS to make it available to beneficiaries as soon as possible.

CMS Response – Ms. Frizzera stated that CMS is in the process of testing the map function to ensure that it contains the correct information. Once the testing is complete, the DMEPOS map can be released.

Member Comment – Ms. Cathy Graeff asked how many of the 2,000 revoked licenses belonged to pharmacies or suppliers that served underserved populations.

CMS Response – Ms. Frizzera stated that no licenses held by pharmacies have been revoked. Pharmacies are unofficially on hold until a final decision is made about them.

Member Comment – Ms. Nan-Kirsten Forté suggested that CMS consider using mobile technology to communicate with beneficiaries. The technology is fairly simple – mostly a database and interface. CMS should also consider Internet-based listservs and other channels that allow it to communicate quickly with beneficiaries and caregivers.

CMS Response – Ms. Niño cited an example of the Centers for Disease Control and Prevention (CDC) project that uses text messaging to reach out to young mothers. CMS' Partner Relation Group (PRG) is working on a partnership with CDC to expand this project to include messages about CHIP. This project is a good example of working across HHS agencies. She anticipates that HHS will also work collaboratively with other departments when they are reaching out to the same groups, not just internally across agencies. CMS is aware that many beneficiaries, their providers, caregivers, and families are online and using mobile tools.

Member Comment – Dr. Jessie Gruman requested that CMS provide a presentation on DME including topics such as how much CMS spends on DME, the top 25 products/services, how many people use the various categories of DME, and how beneficiaries receive education on using DME, etc.

CMS Response – Ms. Frizzera replied that CMS could provide statistics on money spent, technologies used, and frequency of use but could not provide information on distributors’ educational efforts. She indicated that CMS needs to take a look at its educational approach beyond general pieces such as factsheets. CMS is considering undertaking a pilot project to test the use of a seal of approval for suppliers and would like the Panel’s input on this or other means of providing beneficiaries a visual reassurance of quality.

Member Comment – Dr. Gruman suggested looking at how group health plans/Kaiser handle DME and compare that to CMS’ approach.

Member Comment – Dr. Andrew Kramer suggested that it might not be too early to look at beneficiaries’ reactions to the passage/non-passage of health reform and to develop messages. There is much fear among beneficiaries about their benefits, and different categories of beneficiaries have different fears. CMS should look at targeting messages to these various groups, while keeping the overall message consistent.

CMS Response – Ms. Frizzera assured the panel that CMS is planning for reform and doing much of what Dr. Kramer suggests. The agency is developing multiple options based on the various forms reform legislation could take. She agreed that CMS should consider grouping the Medicare population into different categories based on needs rather than just population groups.

Member Comment – Dr. Carmen Green stated that CMS needs to carefully tailor its messages. She asked CMS to consider how it could have responded to the “killing granny” rhetoric and if being more proactive would have reassured beneficiaries. Another area of opportunity is how CMS will approach the issue of dual-eligibles, who consume large amounts of resources. Finally, she asked that CMS provide more information on the background, parameters, and selection criteria for the diabetes and obesity demonstration projects.

CMS Response – Ms. Frizzera indicated that CMS is partnering with the National Institutes of Health on the diabetes project (which will be announced on October 29) and that the obesity project is only an idea at the present. With regard to the idea of death panels in the reform debate, CMS was surprised by the perceptions that developed. It is very hard to counter perception because it is not based in fact. CMS needs to do a better job of educating beneficiaries before perceptions get ahead of the facts.

Member Comment – Dr. Green suggested that CMS needs a crisis response team that can get in front of issues and prevent mistaken perceptions.

Member Comment – Ms. Gwendolyn Bronson stated that it is very important to educate beneficiaries about the content of reform legislation and how it will affect them. Regarding Website redesign, she cautioned CMS to make sure that the initial Webpage retains a level of familiarity and retains most of the valuable information currently available.

Member comment – Ms. Julie Bodën Schmidt stressed the importance of making information on reform usable for beneficiaries. She also indicated that CMS needs to proactively communicate

with beneficiaries about the care being taken in the development of electronic health records (EHRs), especially with regard to privacy.

Member Comment – Ms. Jang asked where the health disparities area is located in the CMS organizational structure. She also asked about the status of the collection of race, gender, and ethnicity data for quality measures, as authorized by the Medicare Improvements for Patients and Providers Act.

CMS Response – Ms. Frizzera replied that Mr. Terris King leads the disparities group, which is housed under the Office of Clinical Standards and Quality (OCSQ). She indicated that CMS could arrange for him to make a presentation to the panel on his group's work.

### **Subgroup Reports: Legislative Language for Medicare & You Handbook** **Cathy Graeff, APME Panel Member**

Ms. Graeff identified Ms. Bronson, Mr. Stephen Fera, Dr. Green, Ms. Schmidt, and herself as the panelists who addressed the issue of rewriting legislative language relating to future distribution and format of the *Medicare & You* handbook.

The group shared many ideas on what the legislation should address. The ideas they generated fell into three broad areas:

- Access options – Beneficiaries should be able to access the information in the handbook through more technologically up-to-date ways than just paper copies.
- Maximizing use of technology – Use new and emerging technology to bring the language of the handbook to beneficiaries.
- Customization – CMS should be able to customize handbooks based on beneficiary needs/preferences.

Ms. Schmidt indicated that the group was not able to fully flesh out all of the ideas in time for this report. The committee recommended that the handbook be available in multiple languages and that beneficiaries be able to access specific parts of the handbook based on need.

*How is Medicare Funded*, CMS Publication 11396, provides beneficiaries the opportunity to alert CMS via email that they prefer to access the handbook online. Ms. Graeff indicated that the group's suggested language requires CMS to notify all beneficiaries of the option of accessing the handbook online or via email and letting them respond via mail as an indication of their desire to do so (instead of requiring beneficiaries to initiate the interaction).

### Discussion

CMS Response – Ms. Niño indicated that CMS did send out postcards. A portion of the 66,000 who currently access the handbook online responded to the postcards.

Member Comment – Ms. Snead asked whether the postcard asked beneficiaries to respond via email, the Web, or by postage paid mail.

CMS Response – Ms. Niño indicated that she would provide an answer.

Member Comment – Ms. Graeff noted that the group discussed the idea that some beneficiaries might hesitate to send back postcards with their email addresses.

**Subgroup Reports: Medicare & You Handbook Instructional DVD**  
**Gwendolyn Bronson, APME Panel Member**

Ms. Bronson thanked her fellow group members, Dr. Gruman and Ms. Graeff for their contributions. She then asked CMS how much work has been done with regard to the instructional DVD and was informed that not much has been done to date.

The group felt that the current handbook is well written and formatted. They did not feel that there is a need for a related instructional DVD. Ms. Bronson expressed their reservations about developing a DVD unless CMS could demonstrate a need for it. Production of such a DVD without a proven need could be seen as a waste of government funds.

CMS Response – Ms. Frizzera told panelists that CMS struggles to identify the needs of specific categories of beneficiaries. With regard to the instructional DVD, CMS needs to determine whether the current beneficiaries will use it and for what purposes.

Member Comment – Ms. Markwood pointed out that this issue shares common themes with the information dissemination issues raised by Ms. Forté and Dr. Kramer. People who might be interested in the DVD might also appreciate mobile tools. Overarching all of the issues discussed is the need for consistent messaging, which might be better addressed through an ad campaign.

Member Comment – Ms. Forté reiterated panelists' comments that an instructional DVD needs to be clear and easy to understand, to be designed for targeted audiences, to answer users' top 10 questions, and to establish a high level of trust regarding CMS. She suggested that Web-based slide shows can do all of this. Ms. Forté promised CMS that she would supply examples of slide shows that make a good use of imagery supporting messaging.

Member Comment – Dr. Green expressed her concerns about the group's opinion that CMS does not need the DVD when they had no idea how much effort has already been invested in its development. She hoped that in the future, development of similar products would be done in tandem with the APME to prevent the unnecessary use of resources. She added that the individuals who would be most likely to use the DVD are not necessarily the ones who would be most likely to use mobile technology.

CMS Response – Ms. Frizzera assured Dr. Green that CMS had not yet committed significant resources to an instructional DVD. Ms. Johnson indicated that the DVD was only in the conceptual phase when the group began work on this issue.

CMS Response – Ms. Niño asked for clarification on whether the DVD was targeted to beneficiaries or those who help them (caregivers, etc.).

Member Comment – Ms. Bronson replied that the group understood the DVD to be aimed at beneficiaries and that it would be used as an instruction manual for the handbook.

### **Subgroup Reports: Sharing Research**

**Dr. Andrew Kramer**, APME Panel Member

Dr. Kramer reported that researchers often have difficulty finding other researchers addressing similar or related topics within their own institutions let alone in the larger research community. Because of this, informal networks play an important role in identifying potential links between researchers at all phases of a project.

CMS provided the group with a detailed document on its research agenda, which is very impressive. The research CMS is now undertaking with regard to quality comparison is very sophisticated and poses significant challenges and complexities at all steps – developing metrics, defining “good” and “bad,” presenting results to people, and tracking who CMS reaches with this information (targeted subpopulations). These same challenges are being addressed by other groups within CMS, other government agencies, and private sector groups. The group encouraged CMS to reach deeper to identify entities within and outside of CMS to determine if any of the methodological challenges have been solved or if some of the research questions have already been addressed. Additionally, once the research is complete, CMS should reach out to these other entities to disseminate the findings.

Dr. Kramer pointed out that his university has been conducting extensive focus group testing of ratings systems (five-star) for the Center for Medicaid and State Operations, but expressed concern that it has not yet found its way to OEA.

### Discussion

CMS Response – Ms. Frizzera explained that similar research may occur in different parts of CMS because they deal with different groups (e.g., beneficiaries, nursing homes, etc.). CMS struggles with the tension between research and action and between developing the perfect tool and taking action on data already in the public realm. For the most part, CMS consolidates existing data and uses the compare tools to present it in a way that beneficiaries can use. Once tools are established, the agency works to continually improve them. When CMS developed the nursing home five-star rating system, the agency tried very hard to clearly indicate that this is only one source of information. Beneficiaries like the five-star system and use it as a resource for getting started in their decision making. It is difficult to track the effect of the tool, but CMS has not seen a pattern of beneficiaries avoiding one-star facilities. Additionally, facilities are conscious of their ratings, and many have contacted CMS to discuss what they can do to improve quality. This facility-initiated contact has enabled CMS to talk to nursing homes about quality before an inspection finds that they are not in compliance.

Member Comment – Dr. Kramer indicated that he had not meant to focus on the five-star rating system, but rather hoped to focus on the sharing of what has been learned before, during, and after research projects to help enrich individual projects and reduce or eliminate redundancy. He

suggested that CMS establish a research committee to reach out to all entities in CMS to identify the topics of study, identify gaps in research, and ensure that completed research is shared. Dr. Kramer also pointed out that the group received the research agenda for Mr. Frank Funderburk's group only. The group's discussion focused on the topics included in that agenda. It became apparent that Mr. Funderburk was unaware of some of the related research going on within CMS.

CMS Response – Ms. Frizzera stressed that Mr. Funderburk's research focuses on how to communicate CMS messages to beneficiaries. She committed to going back and discussing how to improve the sharing of learning within the agency. She offered to provide a sample research project for the group to critique and make suggestions for identifying ways to improve the process.

Member Comment – Dr. Kramer indicated that many panelists have experience with developing messaging that could be helpful to CMS. Like Ms. Frizzera, he had trouble defining the problem. Because this type of research does not have a defined home or defined group, it is important to identify and connect researchers.

Member Comment – Dr. Green suggested that CMS provide an overview of the research portfolio to the panel. She indicated that it might be necessary for APME to provide advice and counsel on the research.

Member Comment – Ms. Hunt stated that she thought that the panel had already heard a presentation about CMS' research agenda.

Member Comment – Ms. Snead confirmed that after OEA presented its research agenda, the panel recommended that OEA do an environmental scan about research already being done on consumer messaging to refine the questions OEA wanted to address. The fundamental question was whether CMS had a process for doing this scan.

### **Future of Hospital Compare (Attachment D)**

**Shaheen Halim, Ph.D.**, Division of Hospital and Medication Measures, Quality Measurement and Health Assessment Group, OCSQ, CMS

Prior to the meeting, panelists received a briefing from Dr. Shaheen Halim concerning composite measures under consideration for hospital compare, namely two measures of inpatient safety and mortality and outpatient quality measures.

Dr. Halim prefaced her remarks on the future direction of CMS' hospital compare effort by noting that CMS is the lead agency responsible for quality and clinical issues and works with other such as the Center for Disease Control (CDC), the Agency for Healthcare Research and Quality (AHRQ), and the Department of Veterans Affairs (VA).

Dr. Halim's office selects the quality measures for the hospital pay-for-reporting programs that feed into the hospital compare Website. Inpatient pay-for-reporting programs were authorized in 2003 and CMS began reporting them in 2004. They now include outcome, survey, and structural

measures. There are currently 11 outpatient pay-for-reporting measures. New measures are adopted through an annual rulemaking cycle. Inpatient measures are finalized in August, and outpatient rules are finalized in November. CMS is required to make the data collected under this program available to the public and the compare tools are the primary way this is done.

CMS has similar goals related to measuring outcomes for both programs, measuring coordinated care efforts, aligning incentives, and expanding alternative sources of data collection (registries and EHRs). Both focus on conditions that occur frequently, have high morbidity and mortality, are associated with high volume and cost, and show documented disparities in treatment. Other information included in the compare data includes hospital characteristics, Medicare payment information, volume data, and children's asthma care measures. There are currently 46 hospital compare measures.

At this time the session turned to a discussion of composites, specifically the merits of relative versus absolute scoring. CMS is currently considering a combination of relative and absolute scoring due to the small variation in hospital performance on many of the measures.

#### Discussion

Member Comment – Ms. Schmidt asked whether the primary purpose of the measures is to promote change in hospital performance or to provide consumers with information.

CMS Response – Dr. Halim indicated that the tool has multiple purposes: educating consumers, promoting transparency, and improving the quality of care provided to patients.

Member Comment – Dr. Gruman, citing University of Oregon researcher Dr. Judy Hibbard's work, asked if there is a real need for the measures if reputation is the most important factor for consumers.

CMS Response – Dr. Halim replied that CMS had considered weighing scores (with measures on which hospitals perform uniformly well carrying less weight), but had concerns that some composites would contain few measures.

Member Comment – Ms. Gruman asked if CMS saw the tool as a tool of leverage. From a consumer education perspective, it is known that there are problems with consumers finding, using, and understanding comparison tools.

Member Comment – Dr. Kramer suggested that CMS identify those measures on which all hospitals do well and then focus on the areas in which greater variation exists. This would alert consumers that it is good that all hospitals do well on certain things and allow them to make decisions on those things that distinguish individual hospitals. Combining them could mask the differences. CMS needs to do research into consumer responses before deciding whether to use relative or absolute scales.

Member Comment – Dr. Yanira Cruz pointed out that CMS needs to include factors such as patient satisfaction, cultural competency, and ability to serve older populations in the ratings.

Member Comment – Ms. Schmidt pointed out that many consumers do not have any choice in the hospitals they use due to factors such as location, physician affiliation, and insurance limitations and do not use this tool as a result. Given this, she asked what CMS thinks is the best way to get this information to hospitals to help them improve their performance.

Member Comment – Mr. David Roberts questioned whether the measures are a good idea in the larger picture. It may not be possible for a single tool to address all of the characteristics and medical issues of individual consumers.

Member Comment – Ms. Snead noted that the panel should consider the dual role of the tool in serving beneficiaries and providers as well as the utility of the data collections. Once measures are made public, the data needs to be reported, even if it does not get used as a decision-making tool.

The discussion then addressed the integration of AHRQ's inpatient safety and mortality indicators into the measures. Dr. Halim explained that CMS added AHRQ's patient safety and inpatient mortality indicators in the inpatient reporting program in order to provide more outcomes information to the public. The five patient safety indicators relate to adverse events in the hospital, postoperative complications, infections, and care-related injuries. CMS consumer testing showed that physicians were concerned that patients would overinflate the importance of these events in their decision making. She asked panel members for input on how best to highlight these measures given that what they measure are rare occurrences.

## Discussion

Member Comment – Dr. Gruman pointed out that the patient safety measures highlight the divergence between the reputation system problem and the consumer problem. Ms. Hibbard has found that the greatest effect of this type of reporting is on the system through the system. Hospitals react to their ratings and work to improve them. Very few consumers, approximately 14 percent, have ever used a hospital comparison tool. She asked if CMS knows how hospitals are responding to the reporting of this information.

CMS Response – Dr. Halim indicated that individual consumers participating in the focus groups wanted to see this information. Although the measures have been adopted by the Hospital Quality Alliance, physicians participating in the focus groups were not as positive as hoped.

Member Comment – Dr. Green stated that she was challenged by these measures because the transfer of patients to tertiary care facilities, the degree of sickness of patients, and the diversity of patient populations can affect the scores. There is currently no easy way to measure indicators such as cultural competence and language proficiency. She asked if these measures add value to those already offered by organizations such as the Joint Commission and AHRQ.

CMS Response – Dr. Halim replied that the measures are adjusted for risk. They are AHRQ indicators and CMS uses AHRQ's software. This information is also reported by 17 states. The

added value will come from the additional measures on complications and in-hospital adverse events.

Member Comment – Dr. Kramer identified an issue with how the results are categorized. Different organizations use different scales for rating. This suggests a level of disagreement regarding how to best report these measures to consumers. CMS should first determine what consumers want to know most (e.g., doctors' opinions of a hospital, which hospital cares for the sickest people, or cultural sensitivity) and then determine how people respond to these factors. Consumers' greatest concerns might not be rare patient safety events.

Member Comment – Dr. Gruman asked Dr. Halim to confirm that the panel is only concerned with the specific content of the measures, not the overall value of rating hospitals.

CMS Response – Dr. Halim confirmed that CMS wants the panel's input on specific questions about the measures.

Member Comment – Dr. Green suggested that people do consider this data, but they do not do it in a way that CMS can control. Hospitals use the favorable parts of the data to promote themselves within their communities. Ultimately, CMS needs to decide whether this is how it wants the information used.

Member Comment – Dr. Green pointed out that as a physician, she wants to know the characteristics of the patient populations treated by hospitals when she is determining where to send her patients.

Member Comment – Ms. Forté stated that WebMD took its cancer and hospital tool off the public side of its Website because it had concerns over how helpful it was for consumers, but they anticipate putting it back at some time in the future. Consumers need to have access to tools like this to begin to understand what is included in the ratings. Issues such as patient satisfaction need to be included. CMS might consider allowing consumers to rate patient satisfaction on the tool and allow institutions to reply. This is more of a discovery process, not a definitive measure.

With regard to the outpatient measures, Dr. Halim indicated that the 11 measures will be reported by CMS for the first time in 2010. Five measures relate to emergency department acute myocardial infarction treatment, two to surgical care measures (infection prevention), and four to imaging efficiency. Challenges associated with these measures are consumer lack of understanding about efficiency (more care is not always better care), confusion over what services are outpatient services, and the difference between outpatient care and ambulatory surgery center care. CMS implemented the outpatient imaging measures to address the extreme waste in outpatient imaging and the potential for radiation exposure and kidney damage related to the use of contrast materials. CMS is interested in the panel's thoughts on how to educate consumers on the role of the measures in promoting appropriate care and in holding facilities accountable for care.

## Discussion

Member Comment – Dr. Green stated that it is good that CMS is being proactive about considering how to communicate with consumers about the measures. She pointed out that consumers understand the idea of added value. Dr. Green also noted that the measures offer CMS an opportunity to educate beneficiaries about medical risk and its implications for the cost of healthcare.

Member Comment – Ms. Snead expressed her appreciation that CMS is bringing in the APME at this point in the process and underscored the need for more thought on how CMS communicates with beneficiaries about these measures.

Member Comment – Ms. Hunt encouraged CMS to learn from the “death” panel experience and think about the messages it provides to beneficiaries. Message should reassure beneficiaries, not scare them (e.g., educate them that efficiency does not mean cuts in benefits).

CMS Response – Dr. Halim replied that CMS is aware that there will be press surrounding the roll out of the measures and is preparing for it.

Member Comment – Ms. Forté suggested that the idea of getting ahead of the press should be shared with Ms. Frizzera. While the tool will never be the ultimate comparison tool, it can open the door to a great discussion about quality. CMS needs to shape the conversation through its efforts to educate consumers and institutions (through different approaches) about the tool.

Member Comment – Ms. Markwood suggested that CMS identify words that bring added value to both groups and use these in its communications.

### **Faith and Community Based Partnerships (Attachment E)**

**Robert E. Adams**, Deputy Director, Partner Relations Group (PRG), OEA, CMS

**Renard Murray**, Regional Administrator for External Affairs (Atlanta and Dallas), CMS

Participants had the opportunity to participate in a pre-meeting briefing and received copies of the slides used during the presentation.

Mr. Robert Adams began his remarks by stating that the PRG involves the Regional Offices (ROs) in all its undertakings. He then reported on the pre-brief conference call, which included the participation of Mr. Ben O’Dell, Deputy Director, White House Office on Faith-Based and Neighborhood Partnerships, who provided a broad backdrop for the Administration’s efforts in this area. Central to the discussion was the idea that partnerships with faith-based and community organizations are essential to reaching the grassroots. Partners have the capacity and track record of service, as well as the trust of those they serve, to communicate with individuals within their communities. This is the guiding principle for the development of purposeful partnerships, those with a specific goal, at CMS. Faith-based partnerships proved to be one of the strongest sectors in assisting CMS in educating individuals about the Part D benefit. The role of these partnerships in increasing enrollment rates in Medicare programs has been validated through research.

Moving forward, the White House's efforts to make community groups an integral part of recovery, complement OEA's work to educate beneficiaries about Medicare and Medicaid benefits and the economic benefits of taking advantage of them. CMS will work with other agencies to leverage the work they have done to open doors in communities nationwide. CMS is looking for panel input on how it can use faith and community-based partnerships to extend its outreach capacity.

PRG works to build partnerships in multiple sectors including beneficiary advocates, providers, and employers/business that have the trust of the communities in which they are located. Partners have shared lessons learned with CMS that were then incorporated into the agency's tools and outreach efforts.

Most of CMS' partnership efforts take place at the local level, with ROs focusing on local agencies and affiliates of national organizations and CMS headquarters working with parent organizations to encourage participation throughout their networks. In many cases, ROs have established local relations that eventually translate into national ones. Mr. Adams noted the many opportunities for outreach offered at both local and national levels by faith communities, many of which have health-based ministries. He stressed the importance of identifying the appropriate administrative/structural level within each denomination responsible for developing partnerships and communicating with member congregations.

CMS partners fall into three broad categories: those that receive information from CMS only, those that receive information from CMS and distribute it via listservs, and a smaller number of those that not only receive and distribute information but also commit resources to working with CMS. The most successful partnerships are distinguished by a willingness to enhance the reach of CMS messaging to populations it might otherwise have difficulty reaching, by an ability to provide credibility within the communities they serve, by the willingness to commit financial and human resources to outreach efforts, and by the ability to help influence changes in behavior through personal interaction.

Mr. Renard Murray offered a sampling of successful faith-based partnerships in the Atlanta region. The RO recently held its first event for the Gay, Lesbian, and Transgendered community. Participants, many of whom are caregivers for Medicare beneficiaries, carried the messages back to their churches, expanding the outreach beyond just the event. CMS also partnered with the Progressive National Baptist Convention to promote the Low-Income Subsidy (LIS) benefit. The trust the ministers had within their communities enabled CMS to broaden its outreach much further than it would have been able to do on its own.

CMS has completed several stages of research into partnership development with an emphasis on input from partners on perceptions of their partnerships with CMS and what they believe works best within the partnerships. The agency is developing a partnership business plan to identify effective ways to organize partnerships as reform moves forward. CMS also has a contract to develop metrics to measure the effectiveness and performance of partnerships.

## Discussion

Member Comment – Dr. Gruman inquired whether any of the partnerships included the transfer of funds or other payments.

CMS Response – Mr. Adams replied that PRG has no funds for payments and is prohibited from making grants or contracts to non-government entities. [Note: CMS does award grants in some specific instances but has not awarded money strictly for the purpose of faith-based partnership at this time.]

Member Comment – Ms. Bronson asked if CMS’ activities are limited to disseminating information or if CMS trains partners to provide information or guidance.

CMS Response – Mr. Murray replied that while there are no funds for this in CMS, some of the grants it makes to other government agencies for partnerships do include funding that may find its way to the churches. CMS does offer a wide range of training programs to help partners assist their members’ access services CMS is working to promote.

CMS Response - Mr. Adams identified the design of materials for congregation-based education (toolkits, drop-in articles, etc.), teleconferences/Webinars with denominational leaders about their churches’ perceived information needs, and goal-oriented workgroups addressing specific topics (LIS, open enrollment, CHIP, etc.), as examples of the support CMS provides its partners. He noted that it would be possible to develop a program that revolves around Medicare as a message in itself. CMS is just beginning to understand the actual dynamics of how churches and denominations influence the health and well-being of their members and employees. He asked panelists for their input on CMS’ approach to growing faith-based partnerships and any special approaches that CMS should consider as it begins dialogues with individual denominations.

Member Comment – Dr. Gruman cautioned CMS about talking too much about health promotion instead of focusing on helping people get their benefits. There is a danger that the agency will be perceived as telling people how to live their lives. She also suggested that CMS look at lessons learned from organizations such as the American Cancer Society that successfully manage large numbers of volunteers over a prolonged period of time.

Member Comment – Ms. Hunt stressed the importance of reaching out to individual congregations rather than denominational headquarters.

CMS Response – Mr. Adams noted that a top down approach works best in some denominations while direct congregational outreach works better in others.

Member Comment – Dr. Cruz stressed the importance of targeting community organizations, such as senior centers, as effective mechanisms for communicating with specific populations.

CMS Response – Mr. Adams replied that CMS is targeting both faith-based and community organizations as channels for outreach.

Member Comment – Dr. Green noted the importance of recognizing the great diversity within different religious groups. She suggested that resource centers in minority aging research are good sources for partnership ideas. She identified that the commitments of time and resources that CMS asks partners to commit to the government’s outreach as potential barriers to participation.

Member Comment – Ms. Jang suggested that CMS have a plan for translation of materials for partners to distribute instead of relying on community organizations to do the translations. She encouraged CMS to consider using ethnic media and community health workers to disseminate messages within immigrant communities.

CMS Response – Mr. Murray indicated that CMS does not ask for much in its initial requests of partners, usually only a few minutes during services or placement of drop-in articles for ethnic media.

Member Comment – Ms. Schmidt asked Mr. Adams to clarify what CMS is trying to accomplish with faith-based organizations, specifically whether CMS is developing a network that can be employed when CMS needs to broadly and rapidly educate people about a new issue or whether it is developing one more general avenue for education. She indicated that CMS will have to make decisions about the relative value of these partnerships given the work it needs to invest to establish them.

CMS Response – Mr. Adams reiterated that there will always be levels of value within the program, with a relatively small number of organizations providing the greatest value. CMS is developing a system of metrics to help it predict the most productive partnerships for a particular need. The agency hopes that it will be able to measure whether it achieved its goals with a specific partner while taking care to avoid becoming too mechanistic and eliminating the creative factor.

Member Comment – Ms. Markwood noted that the discussion has not touched on CMS’ significant commitment to being a resource for partners and for engaging partners in an ongoing dialogue. Previous CMS partnerships focused on shared messages and shared efforts to achieve positive outcomes. Lessons learned were then applied to other issues. Many congregations use the CMS education components to provide ongoing resources to members, particularly those who are most vulnerable. She expressed that CMS’ partnership model should be emulated throughout the federal government.

Member Comment – Mr. Roberts asked whether CMS has considered how to approach the growing number of nondenominational mega churches as potential partners.

CMS Response – Mr. Adams replied that CMS worked with mega churches on Part D enrollment because they provided broad outreach to their communities. He stressed the need to be aware of the individual characteristics of each church/denomination.

Member Comment – Dr. Green stated that she saw several opportunities within the partnership objectives including projecting Baby Boomers’ future needs and their relationships with faith-

based organizations as well as addressing grandparents raising their grandchildren. She suggested that CMS use demonstration projects to test ideas and approaches that encourage a sense of ownership among partners.

Member Comment – Dr. Cruz pointed out that there are no aging issues reflected in the HHS partnership objectives.

CMS Response – Ms. Niño noted that the HHS objectives form an umbrella under which the agencies develop their objectives to match their specific missions and goals

CMS Response – Mr. Murray pointed out that CMS has worked with other agencies on specific issues and populations (e.g., aging network, Agency for Children and Families). There is a longstanding generational piece in CMS that addresses what Medicare will look like in the future and the role of families in beneficiaries' care.

Member Comment – Dr. Kramer asked Mr. Adams to clarify whether the objectives listed on the slides were HHS objectives or White House initiatives for HHS.

CMS Response – Mr. Adams confirmed that the slide was incorrectly labeled as HHS objectives and the objectives are indeed White House objectives. Ms. Niño explained that the White House Office on Faith-Based and Neighborhood Initiatives has a representative in each of the executive departments. The HHS representative implements the White House goals within HHS. CMS' goals are CMS' goals only.

### **Public Comment**

No comments were offered at this time.

### **Meeting Recap, Recommendations, Next Steps**

**Rebecca Snead**, APME Chair

**Sandy Markwood**, APME Co-Chair

Ms. Snead stated that the panel will continue to work with CMS on improving the processes for following up on discussions, recommendations, and loose ends as well as scheduling calls and meetings to maximize the availability of panel members.

Ms. Markwood briefly recapped the major themes of the meeting as well as commitments made on behalf of both CMS and the panel regarding information needs. The overarching theme running throughout the day's discussion related to healthcare reform and the roles CMS, HHS, and the panel can play in communicating about reform. There is a need for consistency of messaging, even when messages are tailored to specific audiences; for building on the existing view of CMS as a trusted source of information; and for a need to quickly implement communications as reform evolves. With regard to the hospital compare tool, the panel discussed the importance of understanding the audiences that use the tool, the reasons they use it, and how CMS can develop messages that support CMS' goals for the tool.

Panel members expressed interest in hearing presentations on the technology side of health information technology (i.e., e-prescribing and EHRs) and how it effects beneficiaries, prescribers, and communities and on comparative effectiveness research and how it ties in with the issues of value and effectiveness.

Ms. Johnson thanked Mr. Dwayne Campbell, who has supported APME activities for many years, as he leaves CMS to work on partnership issues at the Center for Minority Veterans. She announced tentative dates for the next two APME meetings as January 26 and April 20, 2010.

### **Adjournment**

**Lynne Johnson, OEA, CMS**

With no additional business to discuss, the panel adjourned.

*Minutes composed by Teresa Lucas, BL Seamon Assigned Note Taker and Lynne G. Johnson, DFO and approved by Rebecca Snead, APME Chair.*

## Attachments

- A. Federal Register
- B. Sign-in Sheet
- C. Meeting Summary, Advisory Panel on Medicare Education, July 8, 2009 meeting.
- D. *Future Direction for Hospital Compare*, CMS Presentation
- E. *Faith and Community Based Partnerships*, CMS Presentation