

Centers for Medicare & Medicaid Services
Special Open Door Forum:

Assessment of CMS Quality Measures

Thursday, May 10, 2012
2:00pm – 3:30pm Eastern Time
Conference Call Only

Purpose: To discuss the impact assessment of CMS measures and measurement programs on better quality care, better health, and lower costs in order to inform measures selection and implementation policies. Items on the agenda include:

1. Review of CMS quality measurement framework and purpose.
2. CMS' March 2012 assessment of the impact of quality measures.
3. CMS Technical Expert Panel (TEP) for future impact assessments.

After CMS' presentation, participants will have an opportunity to ask questions.

Who: This Special Open Door Forum is designed for providers, healthcare services researchers, health policy professionals, beneficiaries and their families, and advocates.

Why: The Secretary of the Department of Health and Human Services is required to assess the impact of consensus-endorsed quality and efficiency measures used in federal healthcare programs and to make that assessment available to the public.

Special Open Door Participation Instructions:

Dial: (866) 501-5502 & Conference ID: 75683548

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

A transcript and audio recording of this Special ODF will be posted to the Special Open Door Forum website at http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at <http://www.cms.gov/opendoorforums/>.

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Audio File for Transcript:

<http://downloads.cms.gov/media/audio/051012SODFAssessmentofCMSQltyMeasures75683548.mp3>

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Michael Rapp
May 10, 2012
2:00 p.m. ET

Operator: Good afternoon, my name is Scott and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Assessment of CMS quality measures special open door forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad.

If you would like to withdraw your question, press the pound key. Thank you. Dr. Michael Rapp, you may begin your conference.

Dr. Rapp?

Michael Rapp: Yes, thank you, Scott.

Good afternoon. I am Michael Rapp. I am a supervisory medical officer at CMS, I'm the director of the quality management and health assessment group in the office of clinical standards and quality here at CMS.

As I'm sure you know, the Affordable Care Act has expanded greatly, the use of quality measures through quality reporting, public reporting, and value based purchasing. The overall purpose of these quality measures is to

improve quality and to deal with the quality at the individual level, at the population level, and to lower costs through better quality.

So I'm glad you were able to join us this afternoon and we appreciate your being part of this conversation. Today, we are hoping to share with you a report on the impact of quality measures, Congress, in addition to simply expanding the use of quality measures, has shown an interest in being clear as to what their impact might be.

And so, we were required to produce a report by March of this year, which we did, and to share that with the public.

And so we want to do that in particular, today, and give you an opportunity to ask questions and to perhaps, suggest ways that we should approach this in the future.

So again, thank you for joining us. And at this point, I will turn it over to Julie Mikulla.

(Julie Mikula): Yes, this is Julie Mikulla and I will be talking today about the requirements of the Affordable Care Act, and I will be reviewing those with you. So the Patient Protection and Affordable Care Act and I'm on slide six just so you know, the Patient Protection and the Affordable Care Act was signed into law March of 2010, section 3014 directs CMS to employ a new pre-rule making process in the selection of quality measures.

These steps include making publicly available, measures considered for selection by December 1 of each year, providing for multi-stakeholder input by February 1, publishing rationale for measures that are not endorsed by the national quality forum, and reporting every three years on the quality impact of the use of quality measures.

The first impact assessment report was published just this past March but – and the results of the report will be presented by Dr. Fermazin later in the presentation.

The next slide, slide seven, measure selection is an iterative process, this slide gives us a visual presentation of the measured selection process and includes the new pre rule making requirements. Starting at the bottom of the slide was currently–implemented measures that undergo review and maintenance testing every three years.

The new impact assessment requirements inform program staff and stakeholders who suggest measures for use. The list of measures under consideration is published December 1 and submitted to the Measures Application Partnership for multi-stakeholder input. The measures are then published in the Federal Register Notice of Pre Rule Making, which allows for public comment.

Responses to public comments and the final selected measures are then published in the Federal Register Final Rule and implemented in CMS public reporting programs and quality initiatives.

So the next slide, the National Quality Strategy serves as our framework for quality measurement and measure development. The three aims, better care for individuals, better health for populations, and lower cost overall, through the achievement of six priorities, focus on improving the overall quality of care by making more patient-centered, reliable, accessible and safe; improving the health of the U.S. population by supporting interventions to deliver high quality care and to address behavioral, social and environmental determinants of health, and reduce the cost of quality health care for individuals, families, employers and government.

The next slide, this is slide 9, CMS's objectives for measure selections include aligning measures with the National Quality Strategy, as well as across the Department of Health and Human Services Programs. It also includes focusing on patient outcomes and experience, developing more meaningful measure sets that can be used in multiple settings, and retiring measures that are no longer appropriate.

Next slide, this is slide 10.

These are examples of how we focus our quality measures on the National Quality Strategy. Each of our measures are mapped to one or more of the national quality strategy priorities. For example, under care coordination, we

have measures that focus on transition of care, we have readmission measures. Under population or community health, we have measures that look at health behaviors and access to care.

Under patient safety, we have provider safety and patient safety measures, so as you can see, each sub domain could map to more than one national quality strategy. The next slide, slide 11, measure concepts to roll up to align quality improvement objectives from the individual physician level to the group practice or hospital level and to the community level or hospital referral region.

The hope is to decrease practice variability and increase the use of best practices at all levels.

Next slide. Slide 12.

CMS quality reporting and performance programs are presented here. They include hospital in-patient and out-patient quality reporting, physician reporting, post-acute care reporting including nursing homes, hospice, home health and in-patient rehabilitation settings as well as new payment models such as the Medicare Shared Savings Program with the Affordable Care Organizations and the Hospital Value-based Purchasing Program.

Upcoming quality reporting programs may include quality reporting for the Children's Health Insurance Program as well as for Medicaid and Medicare parts C and D.

So at this point, Scott, I would like to open up the line for any questions or comments.

Operator: At this time, I would like to remind everyone, in order to ask a question, press star then the number one on your telephone keypad.

We will pause for just a moment to compile the Q&A roster.

Again, if you would like to ask a question, press star then the number one on your telephone keypad.

There are no questions in the queue at this time. Ms. Mikulla), I turn the call back over to you.

(Julie Mikulla): OK, thank you, Scott.

At this time, I would like to turn the call over to Dr. Mary Fermazin who will discuss the report results from our March 2012 report. Mary?

Dr. Fermazin?

Mary Fermazin: Yes, good morning. I'm here and good morning, everybody. This is the first report conducted by CMS and to assess the overall systematic evaluation of the quality impact of all measures that have been used in a variety of programs, and as Julie said, it was published in March of this year.

Next slide, please?

We are now in slide 17. The measures included in this report are those that are implemented and that have at least two years of performance information available. And also, the report includes the measures under consideration by CMS for inclusion in the rule-making process.

Next slide, please.

The – to meet the required timelines set forth by the law for the publication of the first report, CMS determined that the criteria for selecting the measures to be included in this initial report are those publicly available measures that have at least two years of data that are readily available between 2006 and 2010.

Data used in this report were not specifically collected or recalculated for the analysis and this report also include measures that are endorsed either currently or have been previously endorsed during the study period. Based on this criteria, the measures included in this report are a subset of the total number of measures associated with each program. The measures that are not endorsed but are still being used by CMS may be included in the future impact analysis.

Next slide, please.

These are the eight Medicare programs included in this assessment and other CMS programs have quality measures and Web sites that are either under development, in the planning stage, or in the early implementation stages. The trend data from these new CMS programs are not included in this report as they do not meet the inclusion criteria.

Future reports may include these programs as well as such programs funded by Medicaid and the children's health insurance program.

Next slide.

CMS made publicly available, the list of measures under consideration on December 1 of last year, this list was presented to the (NQF) measure application partnership and their input was sought on the 367 new measures. 11 CMS programs are considering adopting these new measures through the rulemaking process this year.

Since these measures are not yet implemented, there is insufficient information to assess the impact, so we can only assess their anticipated impact relating to the national quality strategy priority. As some of these measures are being selected for use and moved into implementation, these measures will be included in the future report for impact analysis.

Next slide, please.

The result included in this report came from a variety of data sources including CMS measure contractors and the CMS Web sites that report on quality measures.

The measures associated with each of the eight programs are organized conceptually by measure type, such as process, outcomes and survey, or by service type such as outpatient imaging, and the results were plotted on trend charts to highlight performance over time. The measures were also assigned specific national quality strategy priority domains and the impact on these domains was assessed.

Quality measures results were based on the archived data and were not recalculated using updated measure specification.

Next slide. There are important limitations that should be considered when attempting to interpret the results of this report. First, the results presented are descriptive in nature and are intended to provide a national context for current performance trends.

The results are not sufficient to draw conclusive findings regarding the direct impact of CMS programs on the reported measure outcomes.

Second, we did not use any statistical tests to evaluate whether the trends noted were real. So caution should be applied when comparing results across measurement periods.

Any noted increase in rate may or may not denote real improvements in performance. Third, the rates reported in some of the chapters represent unweighted results or simple average across the facilities.

This means that differences in the size of the facility or the health plan membership were not taken into account for some measures when producing the national rates.

So some of the measures may not provide an accurate picture of the national performance and instead, reflect the average performance reported at the facility level.

This limitation was generally related to the type of data available for this report.

Next slide, in some cases, changes in specifications within a measure over time may affect the meaningful comparison of the measures. These changes may include altered cut off values, inclusion or exclusion criteria, or recommended frequency of service. Such changes may result in differences in performance from year to year that do not necessarily reflect an accurate change in the quality of care provided.

When applicable, these limitations are discussed in each chapter. For many of these programs, the result of the analysis may only include a subset of the measure set, therefore, the results are insufficient to draw conclusive findings about a program's overall impact on quality.

The primary reason for reporting on the subset of measures is that some measures did not meet the inclusion criteria. And finally, the results are unable to highlight disparities among the sub-population.

Next slide, please?

Since we don't have sufficient time to go through each chapter during this session, we will highlight only two other chapters. The first one is the hospital in-patient quality reporting program.

Next slide.

Information and data for 43 hospital process outcomes and survey measures are included in the chapter. The data for the chart abstracted process measures were obtained hospital compare. Data for the client space, we have readmission and mortality measures which were obtained from CMS and the (HCAHPs) data were obtained from the HCAP's online Web site.

Apart from the general limitations noted earlier, there are other limitations related to this chapter. The national average – facility averages for the process measures are not national aggregate means, and therefore, are not risk-adjusted with hospitals characteristics or facility population distributions. The (NQF) endorsed AMI, heart failure, pneumonia outcome measures are endorsed at the facility level, but the rates in this report are reported at the national level.

Next slide.

So the Hospital IQR program contains measures addressing five of the six national quality strategy priorities. Most of the measures address the effective prevention and treatment domain. The only domain not addressed by this set of measure is the affordable care domain.

The data presented in the reports contain performance rates for the period of between 2006 through 2010. The time period for the rates depicted may vary depending on the implementation dates and the data availability of the respective measures on hospital compare.

Data for the chart abstracted process measures were obtained from hospital compare and the data in this chapter display the national average facility rates for those hospitals submitting measures and are not limited to Medicare beneficiaries.

Data for the outcome measures for mortality and readmission rates were obtained from quality net. This standardized – risk standardized readmission in mortality measures were calculated using administrative claims to Medicare fee for service beneficiaries age 65 and older.

Next slide.

So here on the slide, you can see four of the AMI process measures, AMI – aspirin at arrival, beta blocker at arrival, PCI within 90 minutes and fibrinolytic medications within 30 minutes. As you can see, all four of the measures showed positive trends.

Next slide.

Here is another subset of the AMI measured process measures and as you can see, even though the increases are smaller, they are all showing a steady upward trend as well.

Next slide

It is harder for hospitals to positively impact the rates of the outcome measures. As you can see here, there is little change in the risk-adjusted mortality and readmission rates during the three year under review. In the interest of time, we want – we will not be reviewing the results of the pneumonia and heart failure measures because this – their results are generally similar to the AMI measures.

So now, we will move ahead to a summary of the SCIP measures.

Next slide.

Overall, all four of the SCIP infection measures in this slide showed a steady increase in rates across all the measurement years with two measures showing an increase of at least 19 percentage points. Next.

This figure shows that overall, the number of hospitals participating in HCAHPs increased by 1,232 between 2007 and 2010, with most of the increase occurring between 2007 and 2008.

This slide also displays the response rates for each of the HCAHP's reporting periods. Zero or no change in the response rates was observed across each of the time periods.

Next slide, as an example of one of the HCAHP's measures, we have chosen the one with the most positive trend and that is the overall hospital rating measure. This graph shows that in 2007, the rating was 64 percent and it went up to 68 percent in 2010.

Next slide, please? In general, the results of the NQF endorsed hospital inpatient quality reporting program measures included in this report indicate consistent increases in rates for nearly all of the measures under review.

Overall, 24 of the 43 NQF endorsed measures reported rates of 90 percent or higher. Seven of the process measures showed rate increases of over 20 percentage points during the five year period. In 2010, hospitals reported rates above 90 percent for all of the heart failure and pneumonia process measures and all but one of the AMI process measures.

All of the SCIP measures also demonstrated positive trends over time with the magnitude ranging from eight percentage points to 22 percentage points. In 2012, all hospitals reported 100 percent success for the SCIP measure removal of hair prior to surgery. The risk adjusted mortality and readmission measures show little or no change and in general, HCAHPS results show small gains in all but one measure between 2007 and 2010.

The only measure that remains constant was the measure on communication with doctors.

Next slide.

The next chapter we want to highlight is the nursing home chapter. Next slide? The measure included in this report are based on MDS 2.0. And so there are 14 chronic or long-staying measures, five short stay measures, and one nurse staffing measure included in this report.

Next slide.

The nursing home quality measures address three of the six national quality strategy priority and most of them address the effective prevention and treatment remain. Reporting for each quarter is based upon the most recent six months of data for the post acute care measures and the most recent quarter for the chronic care measures.

The only exception to this is the influence of vaccination measures for chronic care and post acute care. Data are aggregated nationally for the most recent flu season which is October 1 through March 31. The noted decrease of reporting facility may be due in part to a general decline in the hospital based facilities and the increased availability of alternative care settings.

Data for the MDS 2.0 measures were obtained from CMS survey and certification group. The nursing home staffing measures are derived from the online survey and certification reporting system.

These data are reported by each of the nursing home to the state survey agency, and CMS obtains the nursing home staffing data from those states and publish them on nursing home compare. Next slide.

This slide shows that the national rates for both the influenza and pneumococcal vaccination for chronic care residents have increased steadily over time. At the end of the third quarter of 2010, nursing homes were showing approximately 90 percent vaccination rates of both quality measures.

Next, this figure shows that between quarter two of 2006 and quarter three of 2010, the national rate associated with influenza and pneumococcal vaccination for post acute residence increased 14 percentage points and 16 percentage points respectively. By quarter three of 2010, four out of the five acute care residents have received influenza and pneumococcal vaccine.

Next slide, this figure illustrates the decline in the percentage of both the high and low risk residents with pressure ulcers, this decline represents a positive trend.

Next slide, this figure displays the national rate for post-acute residents with delirium, pain, and pressure ulcers. These three measures represent some of the negative outcome among patients who are admitted to a nursing home following an acute care hospitalization.

For all of these measures, lower rates represent better performance, in general, this figure shows a decline in the rates of post-acute residents how have delirium, pain or pressure ulcers.

Next slide.

So in summary, for this chapter, of the 14 chronic care measures, 12 show positive trends and two immunizations for chronic care increased by about 10 percentage points and all five of the post acute care measures showed favorable trends.

Next slide.

So now, we come to the conclusion for this report. The graph on this slide number 43 shows the overall percentage of measures on each program associated with positive or negative trends. The green color representing positive trends.

As you can see, the two programs, ESRD and hospital OQR have 100 percent of their measures included in this report exhibiting positive trends. However, caution should be used when interpreting the results for the ESRD program where there was only one measure from this program included in this report.

The same thing applies to Part D programs with only two measures included in this report.

The nursing home program with 23 measures and hospital IQR program with 43 measures included in this report show positive trends for 91 percent of their measures. Part C program has 83 percent of it's measures showing positive trends.

Next slide, so the majority of the quality measures assessed across the Medicare programs evaluated in this report showed positive trends in rates during the study period. Excluding the PQRS measures, about 86 percent of the measures in these seven programs show actual increase or no change in the reported rates during the study period.

The person and family center care domain had the highest center of it's measures with positive trends. Overall, 95 percent of the measures within this MQS priority exhibited some improvement or no change. The safety domain had the second highest percentage of it's measures with positive trend.

Within the 23 measures in this domain, only two measures showed a decline and that is – and they are the high risk medication measure in Part D and the residents with urinary tract infection in nursing homes.

In the next two years, CMS intends to conduct a variety of studies and impact analysis on the different set of quality measures implemented through different programs. The information gathered through this evaluation studies will provide CMS with ways to enhance the future development implementation and the user policy measures.

And through the use of these enhanced quality measures, CMS hopes to ultimately impact the quality and outcomes of care delivered to individuals covered under Medicare, Medicaid and the children's health insurance program.

That concludes the report on the national impact assessment, the first report, and let me turn this over now to Dr. Cheryl Damberg. She is our co-chair of the measured impact analysis technical expert panel.

She is a senior policy researcher at RAND and a professor at the Pardee RAND graduate school. Cheryl?

Cheryl Damberg: Thank you, Mary.

I am now on slide 44. If you are following along.

What I would like to do in the next few slides is explain that some of the work that the technical expert panel is doing to try to assist CMS with conducting these impact analysis.

If you flip to slide 45, you can see the list of individuals who are members of the technical expert panel, they derive from a variety of backgrounds and both methodologic as well as individuals representing various stakeholder perspective as well as folks who have really spent much of their career looking at the quality of care being provided to the various populations or the target for the many of these performance measured programs.

If you move to slide 46, the technical expert panel has several responsibilities and so immediately, we are asked to provide input on the short-term analytic plan that will cover sort of the next three years moving beyond the analysis that Mary has described for you covering the time period 2012 to 2014.

And this will allow more time to do what I'm going to call sort of a deeper dive – more robust look at these various programs as well as provide an opportunity to potentially look across these programs to see where the impact has been.

The other thing that the tep is being asked to do is to provide input looking beyond 2014 because we know that both as a function of many of the provisions of the ACA as well as other work that CMS is likely to undertake in the future that these programs will evolve, there may be new programs that come into play and so as we think about trying to inform their work, we are really trying to help build a framework for thinking about a valuation over a much longer time frame.

The other piece, and Julie touched on this in her presentation is that the ACA is requiring that CMS also assess the impact of measures that are included in the pre-rule making process as well as the potential impact of non implemented measures and so the TEP will be considering ways in which we can help guide how CMS does that as well.

And then just cut it more broadly, you know, issues related to quality measurement activities and trying to understand, you know, what has been the impact of these programs and potentially, how to strengthen the programs.

Moving to slide 47, so the timing of these various reports, the one that Mary just described has been posted. The link for that report is provided here. The subsequent reports are required to be made available every three years and those will be publicly available documents as well.

And as I just noted in the previous slide, the next report that is being teed up will be available March 1, 2015 and it will cover the three year period, 2012, 13 and 14.

And if you go to the next slide, slide 48, you can see the timeline that we are under and while this deadline seems far off in 2015, there is much work to be done and CMS is really trying to start this process very early. The TEP has had several meetings both in February and March and will be coming back again and is trying to help inform the development of this analytic work plan.

You know, you can see here where we are in May of 2012 at the open door forum and over the next couple of months, we will be trying to finalize the plan that will guide the work for this 2012 analysis and those will commence sort of later this year, early part of 2013 because it does take time to really dig in deep, you know, compile the data, do the analysis and then synthesize that information to produce that report that will appear in 2015.

Moving on to slide 49, so, this is a very high level diagram to help you have some sense of you know, how the TEP has been sort of creating a logic model if you will for the thinking about impact analysis and on the left hand side of the diagram, CMS has implemented an array of various programs, some are focused on quality improvement, some are pay for reporting, some are pay for

performance and moving into more of a value-based purchasing model and these measures are embedded into these various types of programs and the focus is on really changing performance of the delivery system, the providers who operate in that system as well as patient behavior.

And so the focus of the impact analysis is really looking at that right hand side of the diagram in terms of those three brown boxes, looking at changes in patient and provider behavior. And as a function of those programs as well as changes in health systems and looking at how those changes in behavior have impacted performance measure rates, for example how have we been able to get more of a diabetic population blood sugar under control.

And then ultimately really trying to impact these three aims, so better health for individuals, better care in that experience, greater involvement in things like shared decision making as well as lower cost for healthcare system and for us as individuals because out of pocket costs have increased for consumers so we all have a stake in that piece.

So those sort of give you some general sense of the areas of impact that will likely be assessed in these analyses. If you move to slide 50, what we would like to do is pause at this point and tee up some questions that we would very much welcome your feedback and input on related to how CMS approaches the impact assessment and what kinds of things should be considered.

So are there particular issues that are of importance that you want to call out for us in this process so as we are thinking about guiding CMS in this effort that we consider those issues and then also from your perspective in assessing the impact, you know, what are those key questions that we should be trying to answer.

Are there key populations that we need to you know, carefully consider, should we be, say, not only looking, say within program but also across programs to see what the impact is and there may be other questions that I have not identified here that I certainly welcome you raising them at this point.

So at this juncture, we are now in slide 51, I would like to now open it up to hear feedback from those of you who are participating in today's phone call.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press the star and one on your telephone keypad.

There are no – we have received a question from the line of (Amita Sangley) your line is open.

(Amita Sangley): Hello.

Cheryl Damberg: Hello, yes go ahead with your question. Hello?

(Amita Sangley): Yes, can you hear me?

Cheryl Damberg: Yes, we can.

(Amita Sangley): Yes, I have a general question that is a little bit outside the scope of this presentation and I was hoping you could help me out. Last week, I saw that CMS posted the (risk) adjustment for fiscal year 2010.

The summaries are no longer on CMS's Web site and I was wondering when they would be posted again and in the meantime, if facilities are allowed to use that number in their calculations.

Cheryl Damberg: You are right, that is outside the scope of this call. Mike, I don't know if you or Julie want to respond or signal how (Amita) should follow up?

(Kelly Anderson): Hi there, this is (Kelly Anderson) and I'm the communications manager for the CMS quality program and if you would be willing to e-mail that question to us, we are not the ones who can answer it for you but we can forward it on the people who can. I can give you our e-mail address if you have a paper...

(Amita Sangley): Sure. Thank you.

(Kelly Anderson): it's O-C-S-Q-box-that is all one word, @ CMS dot HHS dot GOV.

(Amita Sangley): It's O-C-S-Q box – all right – at CMS HHS dot GOV. Thank you very much.

(Kelly Anderson): You are welcome. Thank you.

Operator: There are no further questions in the queue at this time. I will turn the call back over to the presenters.

Excuse me, we have received a question from the line of (Erica Preston Rhoda) from NCHA. Your line is open.

(Erica Preston Rhoda): Hi, thank you so much for the presentation. This may be coming from a naïve perspective but – I mean, you ask what questions will be like to be and have answered and I would like to see – it seems to me that impact analysis would really – isn't complete until you answer the question of why are these process measures going up and these outcome measures not budging.

And in particular, you are dealing with this public data which is on different groups of beneficiaries that is limited in all sorts of ways and it seems to me that you have available too much larger and richer data set at CMS that might allow you to track specifically the Medicare beneficiaries and do some more in depth analyses to try to really dig in to whether these process measures are ultimately making a difference in outcomes or not.

Because the story in this report is not – you know, we are not seeing that bottom line outcome in terms of mortality and the other thing I would say is you know, I was – just would see some return or investment analysis, you know, what kind of – what kind of effort is being put in to collecting these measures, how much time – staff time is involved and what are we getting out of it?

Will it bring it down to that financial bottom-line as well would be extremely interesting from an impact if you try to measure the impact of this program and whether or not we are doing a good thing.

Cheryl Damberg: Thank you, (Erica) and I know that the TeP has been you know, starting to explore that space about that link between process and outcomes and you know, I think, we have all been challenged by you know, the clinical evidence

says that you know, based on these findings) these things should be happening and we are not necessarily seeing them happen.

I do think that that is potentially within the scope of the work that is done here and certainly a conversation that is being had within the team and you know, I have not yet heard anyone talking about ROI so I very much appreciate that suggestion.

(Erica Preston Rhoda): Thank you.

Cheryl Damberg: Do other folks have suggestions? You know, the last two comments were very much on point and would very much appreciate any other thought such as those.

Operator: Your next question comes from the line of Dr. (Jodwin Bath). Your line is open.

(Jodwin Bath): Hi, this is Dr. (Bath) I have the same question as the previous person was talking, slides number 26, 27, and 28. Well, it looks like we have maxed out as to patients given aspirin and beta blocker and ace inhibitors but if you look at the slide number – the last slide that you have for two years, nothing has been – much has happened as far as the mortality of the readmission rate is concerned.

Some of these measures where you have maxed out, is there a possibility that you could probably say that this is what it is going to be and then we move on to something else, like say, you have some of these measures where there are about 99 of 100 percent the (inaudible) keep gathering the data even though that particular data probably will not give us any kind of a meaningful results, where do we go from here especially for acute M.I. betablockers, ACE inhibitors, that time of (inaudible) and data collection.

Michael Rapp: And this is Michael Rapp, and on that point, we agree with you that after the measures get topped out, where the performance is so high, we should consider retiring or removing those measures from the program on the one that you just mentioned, aspirin at arrival, that is one that we did not

completely retire but we suspended the data collection for it and the reason was is because of the high performance.

On the other hand, some people have a strong feeling that well, even if the measure is – has maxed out in terms of performance, it should still be collected because – or one has to address, well, what – some say it's really very closely tied to outcomes which might ask for an arrival for AMI is considered to be closely related.

Well then, perhaps if the measures no longer collected, the performance would trail off. So we did suspend collection of that but we did receive comments that I just mentioned that we really shouldn't eliminate it all together.

But the point that you make is a good one, we are always looking for better process measures or ones where there is gaps in care, we think the burden of collection is an important one to be considered always.

(Jodwin Bath): Let me ask a follow up question on that, when these measures are picked out, they may not be in this particular (inaudible) but let us say, public reporting of hospital readmission and (inaudible) the whole idea was if the public knows about it, maybe the behavior of the whether the changes in the behavior of a (inaudible).

And I think this and that (inaudible) was put out in a newspaper saying that even after they are doing these things, it did have much of an impact on the readmission rate (inaudible) or certain other things that CMS is measuring. Do you have any kind of a comment on that whether those are the right kind of things to be looking at...

Michael Rapp: All right, I think the response we have to that is we are relatively new into the readmission measurement and so when we calculate the readmission rates, we are calculating them based upon claims that have occurred in the past.

So if for example, year one, where we implement readmission measures, we are measuring what happened at a baseline prior period. So to see the real

impact is after you start collecting the measures and after you start publishing the data, then what happens after that?

And in the readmission measures and the mortality measures. We use three years worth of data so you are not going to necessarily see at the individual hospital level, a dramatic impact. I think these rates, Mary, correct me on this, these are U.S. national rates, are they not?

So they are not a compilation of what happens at the individual hospital but then...

Mary Fermazin: Yes.

Michael Rapp: And I would have to look at the dates in terms of what data we used but we just started publicly reporting the readmission measures a couple of years ago and so I would expect there to be impact over time and certainly, the mortality for AMI, we did publish an article on this, going back quite a few years and the AMI mortality rate is successively dropped over the years.

The readmission is always a little bit of a tougher target because there is a lot of reasons people may have to be admitted, there is a lot of factors that go into that so there is – I know a lot of work being done by people to try to figure out all the different factors, hospitalized – what happens within the hospital is one thing but there are lots of other things that impact that too.

(Jodwin Bath): Thank you.

Female: Are there questions that TeP and CMS should be considering as we think about how to design these impact assessments?

Operator: Again, if you would like to ask a question, press star then the number one on your telephone keypad.

Your next question comes from the line of a participant whose information was not recorded. If you have queued up for a question, please state your name and organization, caller, your line is open.

If you have queued up for a question, please state your name and organization, your line is open.

(Joe Francis): It might have been me, I'm Dr. (Joe Francis) from the department of veterans affairs, are you able to hear me?

Cheryl Damberg: I am, hi., (Joe).

(Joe Francis): Hi, Cheryl.

So I'm sending to you and to Mike, actually, some observations that we have made in our data sets related to the dissociation between process and outcome measures which is something we have been keenly interested in and it actually, for some of the data we have looked at, it turns out to be an artifact of unit of analysis where you know what at the patient level, something like aspirin or beta blockers reduce mortality.

But when you measure the same phenomenon at the hospital level, across level or ecological bias is introduced, and with a large enough data set, you can see how these things can change so it doesn't mean that the process measures are unimportant, it just makes it hard to show real progress being made when you are looking at the hospital level as opposed to the patient level.

Cheryl Damberg: That is are really helpful comment because I do think we have to be mindful of what is our unit of analysis. So we very much appreciate that.

Michael Rapp: Thank you, (Joe), this is Mike Rapp again and it's also true that there are just numerous factors that can affect mortality and so just because – or many other outcome measures so we measure one process and just because the outcomes don't necessarily correlate directly to it, it doesn't really mean that the aspirin at arrival is not an important component, it's just that there are so many other things that go with it that could affect it.

Other examples are the surgical site infections, the prophylactic antibiotics and so we don't measure, for example, washing one's hands but that is the important factor too and so that element that we are not measuring wasn't

being taken care of adequately. Well then, the fact that they get prophylactic antibiotics would not necessarily be the determining factor.

(Joe Francis): I agree totally. So I'm sending this study your way, it was published a few months ago in (HAPH) and I know the investigators would love to chat further. They are on the West Coast as well, Cheryl, if that makes it any easier for you.

Cheryl Damberg: Yes, that would be terrific, we would certainly welcome speaking with them so thank you.

Operator: There are no further questions in the queue at this time. I would turn the call back over to the presenters.

Female: OK, with that, we conclude our open door forum for today, unless there are any other questions. We appreciate all of the listeners and we appreciate all the questions and comments and this recording will be available online for, I believe, the next 48 hours.

If you need to pass it on to any colleagues or anyone who might be interested in listening.

So again, we thank you for your participation and this concludes the open door forum.

Thank you.

Operator: Thank you for participating in today's assessment of CMS quality measures conference call. This call will be available for replay beginning at 5:30 pm eastern today, through 11:59 pm eastern on May 12, 2012.

The conference ID number for the replay is 75683548. The number to dial for the replay is 855-859-2056.

Thank you, you may now disconnect.

END