**Centers for Medicare & Medicaid Services**

**Moderator: Barbara Cebuhar**

**September 8, 2011**

**1:00 p.m. ET**

Operator: Good afternoon, my name is (Alicia) and I will be your conference operator today. At this time, I would like to welcome everyone to the PPS-Exempt Cancer Hospital Quality Reporting Listening Session.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be an opportunity for comments. If you would like to make a comment during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your comment, please press the pound key.

I would now like to turn the call over to Ms. Barbara Cebuhar. You may begin your conference.

Barbara Cebuhar: Thank you very much, (Alicia). Good afternoon, my name is Barbara Cebuhar, and I work in the Office of Public Engagement here at the Centers for Medicare and Medicaid Services.

I want to make sure that folks know that I am not an expert on PPS-exempt cancer hospitals or quality measures, but I had been asked by my colleagues in the Office of Clinical Standards and Quality to help moderate this session in order to get maximum input from the industry and advocates about the best way to measure quality in the PPS-exempt cancer hospital world.

Our hope today is to use this phone call as a chance to gather your insights about the proposed quality measures, identify best ways to conduct public reporting, or put together data infrastructure storage issues, and how we go about protecting patient privacy.

Through this listening session, CMS is seeking to learn what metrics stakeholders in the cancer community have used to drive meaningful improvement in patient care. Areas for consideration include but are not limited to catheter-associated urinary tract infections, central line-associated bloodstream infections, and adjuvant chemotherapy for stage III colon cancer. A list of the proposed measures was included in the invitation for this call on the bottom of page two.

Your thoughts and insights about measures will be considered as part of our effort to further our public reporting program. Because CMS is in the process of rulemaking for the quality incentive program, we will be unable to answer questions during this listening session, but we are very interested in your input and do appreciate it.

Just a couple of preliminary notes about our phone-based listening sessions, a transcript and a recording of this call will be available in approximately two weeks at the following web address, http://www.cms.gov/hospitalqualityinits/. It'll be available in the Download section, so you can read and listen to the various thoughts offered during the call later.

I would also appreciate participants limiting their answers or comments to the questions to about two or three minutes when we open the line for answers to the questions. It would be so helpful if you would please identify yourself and your organization each time you respond so the transcriptionist can appropriately attribute your remarks.

Let's start with the first question. What are your thoughts about the measures under consideration?

(Alicia), could you please tell our listeners how they can respond to the questions? I’d appreciate it.

Operator: Absolutely. In order to respond to this question, you may press star and the number one on your telephone keypad. We will pause for just a moment to compile the roster.

Again, in order to respond to this, you may press star then the number one on your telephone keypad.

We have no responses in queue at this time.

Barbara Cebuhar: OK. We are just very interested in hearing what your thoughts are about the measures. Do I need to go ahead and read them again so that people know about them? It is – there are five quality measures that have been recommended to CMS, adjuvant chemotherapy for stage III colon cancer, combination chemotherapy for AJCC T1c, or stage II or III hormone receptor- negative breast cancer, , hormone therapy for AJCC T1c, or stage II or III hormone receptor-positive breast cancer, catheter-associated urinary tract infections, or central line-associated bloodstream infections.

We are very interested in hearing what measures you think are going to be most effective in driving quality improvement at your facilities, so (Alicia), if you could encourage folks to queue up, I'd appreciate it.

Operator: Absolutely. Again, in order to respond, you may press star, then the number one on your telephone keypad. Please remember to state your name and organization before making your answer.

We do have one person in queue at this time. We have Ronald Walters with M.D. Anderson. Your line is open.

Ronald Walters: Hi, this is Ron Walters at M.D. Anderson, and it's important to point out that the three of the measures, the chemotherapy ones that are sponsored by ASCO are cancer-specific, the other two, catheter-associated urinary infections and central line bloodstream infections are not cancer-specific, and certain factors do have to be taken into consideration for side effects (inaudible) of the cancer patients when reporting those measures. Thank you.

Barbara Cebuhar: Thank you, Mr. Walters. Do we have any other people in queue?

Operator: We do. We have Kristen McNiff from ASCO. Please state your name and organization. Your line is open.

Kristen McNiff: Yes, good morning. This is Kristen McNiff with ASCO, the American Society of Clinical Oncology, and I'm commenting on behalf of our 30,000 plus members.

ASCO submitted some comments about the PPS-exempt hospital measures that were released, but just to briefly recap, we feel the CMS should establish an option for the PPS-exempt hospitals to voluntarily report on a more expansive set on quality measures. And a possible model is the PQRS measure group reporting option through registries.

This would help CMS to adopt a more robust and comprehensive site quality measures for oncology that could be used in all settings of cancer care delivery under CMS-sponsored quality reporting programs.

ASCO specifically has very extensive experience in developing and testing new quality measures, and we feel like we're uniquely positioned to assist policymakers in finalizing sets of quality measures, again, seeking an expanded set for oncology providers.

To drill down a little bit, we would like to propose or, like to underscore the fact that although we want to be very sensitive to the significant administrative burden being placed on cancer providers right now, we also feel that the five proposed measures taken in isolation will have a limited capacity to improve patient care.

We have significant experience in implementing quality measures and in seeking quality improvement through our Quality Oncology Practice Initiative (QOPI) and would like to offer the success of that program as a model to be pointed towards in the federal program.

We have developed more than a 100 quality measures that are actively in use and implemented right now, and feel that the broad spectrum of cancer diagnoses needs to be represented either through cost-cutting measures or through diagnosis-specific measures.

However, there is a lot of complexity and work to be done there, and again, we really encourage CMS to work with ASCO and to benefit from the experience and the work that's already been done.

We also strongly recommend the use of existing registry programs that are in the field right now. We have positioned our QOPI program as one that not only can meet federal reporting needs, but also that can provide a very robust system which is much more comprehensive than is likely to be realized through federal programs within oncology practice sites. Thank you.

Barbara Cebuhar: Thank you, Kristen. Do we have any – anyone else in queue?

Operator: We have no further responses in queue at this time.

Barbara Cebuhar: OK, great. We are grateful for everybody's help with this.

The next question is, which measures do you feel are meaningful to include in this initiative? Which measures do you feel are meaningful to include in this initiative?

And if you could help people queue up again, I'd appreciate it, (Alicia).

Operator: Absolutely. Again, in order to make a comment, you may press star, then the number one on your telephone keypad. We'll pause for just a moment to compile the roster.

Again, in order to make a response, you need to press star, then the number one on your telephone keypad.

We have someone in queue, (Jeremy Moranski) with Memorial Sloan-Ket. Please state your name and organization. Your line is open.

(Jeremy Moranski): Thank you. Hi, it's (Jeremy Moranski), Memorial Sloan-Kettering Cancer Center. I think that going forward – first of all, I applaud the work that's been done by the (test) in CMS and the various other groups that have been working on this. We obviously had to start somewhere, and I think where we have started is a good spot to start from.

I think while going forward, one measure that we in the exempt cancer centers, if I may speak for some of us, think is very important is survival. That's something that's very important to patients, obviously. It's a measure that has not yet been considered, and clearly it's going to take some work to figure out how to measure and how to get the information accurately, but I would like to propose that as a measure going forward. Thank you.

Barbara Cebuhar: Thank you. Anyone else, (Alicia)?

Operator: Again, in order to make a comment, you may press star, then the number one on your telephone keypad.

We have another response from the line of Ronald Walters with M.D. Anderson. Please state your name and organization. Your line is open.

Ronald Walters: Ronald Walters, University of Texas M.D. Anderson Cancer Center. I would like to echo what (Jeremy) said, is that when any of us as clinicians walk into the room, one of the highest priorities that we're dealt with immediately from patients is survival, and it's, "What are my chances of being alive," at some period of time following their diagnosis.

Survival is, as (Jeremy) stated, a difficult thing to attribute to a given practitioner or a given institution. There's a lot of methodology to be worked out in how to do that as an appropriate measure. But it is, after all things are considered, the number one measure that patients are concerned about. Thank you.

Barbara Cebuhar: Thank you. (Alicia), do we have anyone else in queue?

Operator: We have no further responses in queue at this time.

Barbara Cebuhar: OK. Our next question is what lessons have you learned from your quality measurement and improvement activities that may be useful for CMS as we implement this initiative? What lessons have you learned from your quality measurement and improvement activities that may be useful for CMS as we implement this initiative?

(Alicia)?

Operator: Absolutely. Again, in order to make a comment or give a response, you may press star, then the number one on your telephone keypad.

We have a question or comment from the line of Kristen McNiff with ASCO. Please state your name and organization. Your line is open.

Kristen McNiff: Thank you. It's Kristen McNiff with ASCO.

Again, having several years now of experience implementing national quality improvement programs at ASCO, we have learned quite a bit and we are very – we very much look forward to being able to share that in more detail with CMS, especially around this program.

A few high notes – the ability through a disease-specific registry program, a quality improvement service registry, to offer a broad array of measures that are applicable to a wide variety of patients I think is very important. And that I know we've been able to achieve.

So we have both disease-specific and we have cross-cutting measures that have been very widely vetted, have been tested and are now implemented throughout our program.

We also have found that the ability to provide very robust feedback to the practices in almost real time is also a key component of a quality improvement program. And they – so we have built within our system reporting that can go back to the providers and can be drilled down to different levels. The provider level is important, but perhaps most important for quality improvement is actually the practice or the institution setting, and to be able to really participate in system-based quality improvement activities. And so that's another key that's available.

And then a third is to be able to provide resources to drive improvement, and that's also an area that we have worked on over the course of many years. Tools drive from our guidelines that are linked back to the specific measures, local collaborative projects that bring together organizations to hone in on specific areas for improvement and other resources that we are able to provide. Thank you.

Barbara Cebuhar: Hey, Kristen, just out of curiosity, is the ASCO measures NQF-approved?

Kristen McNiff: Some of them are, and some of them have not yet gone through the NQF.

Barbara Cebuhar: OK. Thank you.

Kristen McNiff: We have a combination. You're welcome.

Barbara Cebuhar: Any other comments?

Operator: We have another comment in queue from the line of Ronald Walters with M.D. Anderson. Please state your name and organization. Your line is open.

Ronald Walters: This is Ronald Walters of M.D. Anderson Cancer Center again. I would like to echo again what Kristen and (Jeremy) have said. The one thing we've learned is that this is not easy, and I'd like to applaud the work being done also by CMS to deal with a difficult issue.

One of the biggest issues is, of course, the data systems that are available, and I would reinforce the concept of using available, currently-existing data collection mechanisms when possible.

We all know the great limitations that administrative databases have, and their specificity as to the cancer population is very limited for the detail that's desired, so I would encourage the continued improvement in the direction of using nationally-available certified databases, where we know that the quality of the data put in has been tested. The recent discussions about American Oncology of Surgeons and about CDC database that have occurred in multiple venues are an important area.

I also think that we need to keep the burden of data collection that's performed by both the physicians and the hospitals in mind as we move forward would be either these measures or others. ASCO does have an established mechanism for doing that, and people are utilizing a system that they've put in place for data collection. So again, I echo what the two previous commenters have said. Thank you.

Barbara Cebuhar: Thank you, Mr. Walters. Are there any other commenters, (Alicia)?

Operator: We have no further comments in queue at this time.

Barbara Cebuhar: OK, great. We have another question, which is, are the current measures or potential future measures for your facility that you feel would be better options for this initiative, what are they, and explain your thoughts on why they are better. If you could instruct them how to queue up again? Thank you.

Operator: Absolutely. Again, in order to make a comment, you may press star, then the number one on your telephone keypad. We'll pause for just a moment to compile the roster.

Again, in order to make a comment, you may press star, then the number one on your telephone keypad.

We have a question or comment from the line of (Jeremy Moranski) with Memorial Sloan-Ket. Please state your name and organization. Your line is open.

(Jeremy Moranski): Hi, I'm (Jeremy Moranski), Memorial Sloan-Kettering. I have no specific comments, but from the point of view of an exempt cancer center, I agree with the commenter from ASCO that we have to broaden the diagnoses with which we're – at which we're looking.

At the same time, comprehensive – exempt comprehensive cancer centers and other comprehensive cancer centers deal with quite specific diseases which are probably less seldom seen in more general hospitals, but which may comprise the majority of the types of diseases seen here. If we are going to improve our care, we need to figure out some way of capturing those data as well.

Barbara Cebuhar: Thank you, Ms. (Moranski). Any other comments?

Operator: Our next comment comes from the line of Ronald Walters with M.D. Anderson. Please state your name and organization. Your line is open.

Ronald Walters: Ron Walters at M.D. Anderson. Again, I think finding the proper mix of process measures and outcomes measures is very critical. Unfortunately, it's usually much easier to measure process measures than it is to measure ultimate outcome measures. To keep in mind, the latter is what really matters, and that's why survival's so high on the list.

The Affordable Care Act also specifies other categories that are not in the initial set of measures, that movement needs to be made in those directions. It specifically alluded to structural elements, cost elements, efficiency elements, and most importantly, the patient perceptions of care elements. Our systems are not well-geared to capture patient perceptions of care, but they are very, very critical, and that is – that should be at a finer level of detail than just an overall (age gap) or type mechanism.

So I would also encourage movements to really show the true value and really what is delivered, addressing those other aspects of the process. Thank you.

Barbara Cebuhar: Thank you, Mr. Walters. Do we have any other commenter’s?

Operator: We have one further comment from the line of Barbara Jagels with Seattle Cancer Care. Please state your name and organization. Your line is open.

Barbara Jagels: Hi, this is Barb Jagels calling from Seattle Cancer Care Alliance. I'd like to once again applaud the work that the Ket has done. I know the Ket considered some measures related to palliative care and end-of-life care and actually set those aside during this first round, but of course, as we all recognize, one of the struggles we have in cancer care is when to understand that we should continue to pursue a cure versus really change the goal to comfort care or other measures to control the disease but not necessarily cure it.

So I think the NQF endorsed measures around visits to the emergency department, days spent in ICU and amount of chemo given in the last 14 or 30 days of life are valid for consideration. I would encourage us during the next round to consider any of those for measurement.

Barbara Cebuhar: Thank you, Ms. Jagels. Do we have any other comments?

Operator: We have another comment in queue from the line of Kristen McNiff with ASCO. Please state your name and organization. Your line is open.

Kristen McNiff: Hi, yes, thank you. It's Kristen McNiff with ASCO. I want to echo a few of the comments that have been made, completely agree with Dr. Walters about the importance of starting to integrate some wider variety of measures more – beyond the process measures, and these are areas that ASCO is working in actively right now.

I also want to support the suggestion of the end-of-life measures. We implement all of those that were just mentioned, which have been NQF-endorsed within the QOPI program, and have found that this is an area of extreme interest for quality improvement activities, for quality measurement, monitoring and improvement activities. And so want to – want to reinforce the inclusion in the future of those sorts of measures.

One thing that's important when talking about additional measure types is the actual mechanism of how those data will be collected and how those will be reported. And I know that that's moving on to a different topic, but it's hard to disentangle the two from each other. So wanted to raise that flag that as CMS is considering additional measures for this program, some of the reporting mechanisms that have been used in the past for the non-exempt hospitals and ambulatory settings may prove to be problematic for some of this more sophisticated type of quality reporting.

Again, ASCO has developed 100 – more than 100 quality measures. We're in the process of ongoing development as we speak, and we'll continue to focus on that as a strategic area for the society. So we, again, you know, are very open to and encourage ongoing discussions with CMS about how to work together to expand the measure set across all CMS reporting programs. Thank you.

Barbara Cebuhar: Thank you, Kristen. Any other comments, (Alicia)?

Operator: We have no further comments in queue at this time.

Barbara Cebuhar: OK, great. We're moving on to the next topic, which is the Affordable Care Act Section 3005 mandates the establishment of a quality reporting program for the 11 PPS-exempt cancer hospitals effective with the fiscal year 2014 payment determination for discharges occurring on or after October the 1st, 2013.

This section does not specify any payment incentive or penalty for quality data reporting by PPS-exempt cancer hospitals. The program is designed to link payment to the quality outcomes and promote transparency to inform consumer choice for health care.

Given the lack of payment incentives or penalties, what benefit does your facility see to participate in this initiative? (Alicia), if you could instruct people how to cue up, I'd appreciate it.

Operator: Most certainly. Again, in order to make a comment, you may press star, then the number one on your telephone keypad.

We have a comment from the line of Ronald Waters with M.D. Anderson. Please state your name and organization. Your line is open.

Ronald Walters: Ronald Walters, M.D. Anderson Cancer Center. And again, unfortunately, the fear of being linked to payment is what can prohibit these sorts of things from happening.

We need to remember that the primary purpose is improved patient care and our own performance improvement around whatever measures are adopted, and that that the linkage payment is an important consideration, but that naturally follows once we show the value of measuring these things and improving them.

So we support the concept of a program that does recognize that relationship, but too often, it is painted as the primary objective, whereas improved patient care is the primary objective. Thank you.

Barbara Cebuhar: Thank you, Dr. Walters. Any other comments?

Operator: Our next comment comes from the line of (Jeremy Moranski) with Memorial Sloan-Ket. Please state your name and organization. Your line is open.

(Jeremy Moranski): Thank you. (Jeremy Moranski), Memorial Sloan-Kettering. I'm speaking on behalf of C4QI, which is the Consortium of Comprehensive Cancer Centers for Quality Improvement, an organization which has been in effect for about 10 years. We have started benchmarking data among our currently 18 organizations in order to be able to improve care, as Dr. Walters mentioned.

Our major goal is to make our care the best that it possibly can be by learning from other institutions which are involved in the same kind of goals.

Having said that, I agree with Dr. Walters that penalties tend to be more of a deterrent than they are an incentive to improving care, and tend to lead to perhaps not the best data collection that will possibly be possible going forward.

I would also like to stress that most organizations that we have dealt with in our health care organizations are very interested in improving the best care that can possibly be given to their patient populations, and would appreciate assistance learning how to do that. Thank you.

Barbara Cebuhar: Thank you. Do we have another comment?

Operator: We have no further comments in queue.

Barbara Cebuhar: OK, great. One of the things that we are wondering is if any of your facilities use electronic medical records, and does this help with chart abstraction? (Alicia), could you help people queue up again?

Operator: Absolutely. Again, in order to make your comment, you may press star, then the number one on your telephone keypad.

We have a comment from the line of Ronald Walters with M.D. Anderson. Please state your name and organization. Your line is open.

Ronald Walters: Ronald Walters at M.D. Anderson Cancer Center. I would applaud all the efforts that are going on also in tying the quality reporting initiative to meaningful use of an electronic health record.

Unfortunately, of course, the meaningful use program is catching up with what has been reported for quality measures in diabetes, heart failure, hypertension, et cetera, for about 10 to 12 years now, and has not yet advanced to the point where those two are definitively linked for our area of expertise.

We do find that it is a challenge getting our – getting the – designing the EMR to capture structured clinical information is not difficult, getting people to input the data in that sort of format, certainly in a point-and-click-type format, is very time-consuming and very cumbersome and has a poor linkage to actually improving quality care, whereas newer technology, such as voice recognition and natural language processing are probably going to bring more the movement forward and allow us to actually utilize electronic health records to capture these quality data elements and improve the care that we talked about.

So there's a lot of work yet to be done in those areas. Many of the EHR vendors are actively pursuing leads to accomplish this, and we would strongly encourage continued movement in this area, because real meaningful use really does tie into quality improvement. Thank you.

Barbara Cebuhar: Thank you, Dr. Walters. Any other comments?

Operator: We have no further comments in queue.

Barbara Cebuhar: OK, our next series of questions talks about facilities' infrastructure regarding data collection and abstraction.

The question is what is your previous experience in reporting data to the Commission on Cancer, Joint Commission Registries or other entities? (Alicia)?

Operator: Again, in order to make a comment, you may press star, then the number one on your telephone keypad. We'll pause for just a moment to compile the roster.

Again, in order to make a comment, you may press star, then the number one on your telephone keypad.

We have a comment from the line of Ronald Walters with M.D. Anderson. Please restate your name and organization. Your line is open.

Ronald Walters: Ronald Walters, M.D. Anderson Cancer Center, and as the medical director of our chemo registry, I'm waiting for the day we can put the easy collect all the data automatically and submit it to the American College of Surgeons for our reporting requirements.

Unfortunately, as is true of most all other institutions, it still requires painful and labor-intensive card abstraction from non-structured dictated clinical documents and review of pathology reports to input the appropriate mechanisms.

In the safety world for both NHSN and database, and most other reporting mechanisms, in the quality world, if the same unfortunate labor-intensive processes are in place, we would love to be able to structure our EHR into a direct data input mechanism, and are actively working on ways to accomplish that.

That world does not exist right now, from both – not only our institution, but all other institutions. Thank you.

Barbara Cebuhar: Thank you, Dr. Walters. Do we have other comments?

Operator: We have no further comments at this time.

Barbara Cebuhar: Right. I am interested in hearing your thoughts about CMS collecting cancer data from multiple settings, including PPS-exempt cancer hospitals, acute care and long-term care acute care hospitals. (Alicia)?

Operator: Again, in order to make a comment or response, you may press star, then the number one on your telephone keypad. We'll pause for just a moment to compile the roster.

Again, in order to make a comment, you may press star, then the number one on your telephone keypad.

We have a comment from the line of Ronald Walters with M.D. Anderson. Please restate your name and organization. Your line is open.

Ronald Walters: Ronald Walters at M.D. Anderson Cancer Center, and I would strongly support those initiatives to collect the appropriate data elements from all elements of the continuity of care.

A typical example of how not such a system can lead to distorted data such as readmissions measures is early discharge rate. So if your – if the world was incentivized to get people out faster, and yet – and yet dis-incentivized to count readmission rates, it creates tension and conflict between acute care hospitals and different kinds of post-acute care providers, and they all go chasing after their own measure, and sometimes that can lead to the detriment of high-quality patient care.

So we do need to be cognizant of all the continuum of care in the way measures are devised and how they are applied. Thank you.

Barbara Cebuhar: Thank you, Dr. Walters. Any other comments?

Operator: We have a comment from the line of Andrew Stewart with the American College of Surgeons. Please restate your name and organization. Your line is open.

Andrew Stewart: Hi, this is Andrew Stewart from the American College of Surgeons Commission on Cancer. While I echo and applaud Dr. Walters's comments and I think they're very much on target, I wonder out loud about the relative complexity that would be introduced to the CMS reporting system having to manage multiple reporting sources as we've heard in prior comments today with, you know, multiple, you know, data structures and data definitions, and so on and so forth.

And one other due consideration is in taking to understand the added time, expense and effort on CMS' part in being able to bring, you know, such a palette of data sources together into a meaningful reporting structure that would, you know, be, you know, generally acceptable and reflect, you know, some level of accuracy and the quality of care that the reporting sources are able to demonstrate.

Barbara Cebuhar: Thank you, Mr. Stewart. Any other comments?

Operator: We have a comment from the line of (Jeremy Moranski) with Memorial Sloan-Ket. Please restate your name and organization. Your line is open.

(Jeremy Moranski): Thank you. (Jeremy Moranski), Memorial Sloan-Kettering Cancer Center. I wasn't sure at the beginning whether the question had to do with only CMS entries. There is a proposed rule, of which I'm sure we're all aware, to expand data collection to private entities as well. While I agree with Mr. Stewart that this can only affect complexity, I think it's very important to take a look at all of our patients, not only those that are – that are under the auspice of CMS. Thank you.

Barbara Cebuhar: Thank you. Any other comments, (Alicia)?

Operator: We have no further comments at this time.

Barbara Cebuhar: OK, great. Can your facility's current data reporting system support this initiative, or how can your facility's current data reporting system support this initiative? If you could help people queue up, (Alicia), I'd be grateful.

Operator: Absolutely. Again, in order to make a comment, you may press star, then the number one on your telephone keypad. We'll pause for just a moment to compile the roster.

Again, in order to make a comment, you may press star, then the number one on your telephone keypad.

We have a comment from the line of Ronald Walters with M.D. Anderson. Please restate your name and organization. Your line is open.

Ronald Walters: Ronald Walters at M.D. Anderson Cancer Center. So there's the data structuring side of things, there's the data input side of things, there's the data extraction side of things and then there's the data submitting side of things, and each of those brings different complexities into the situation.

That is why I'm very much in favor of when possible, utilize currently-existing standardized national data input and reporting systems such as that utilized by the American College of Surgeons for the measures that they have – or American Society of Clinical Oncology, for the measures that they have, because the middle steps in those processes have all been standardized and worked out.

It does impose a significant burden on each of the institutions to replicate each step of that process, and introduces the potential for tremendous variability despite the very best of – attempts at standardization.

So again, a plea to use a standardized process that already exists as the easiest solution. Thank you.

Barbara Cebuhar: Thank you, Dr. Walters. Any other comments?

Operator: We have a comment in queue from the line of (Jeremy Moranski) with Memorial Sloan-Ket. Your line is open.

(Jeremy Moranski): Hi, (Jeremy Moranski), Memorial Sloan-Kettering. This is going to be a very brief comment: hear, hear, Dr. Walters. I could not agree more.

Barbara Cebuhar: Thank you. Any other comments?

Operator: We have a comment in queue from the line of Kristen McNiff with ASCO. Please restate your name and organization. Your line is open.

Kristen McNiff: Kristen McNiff with ASCO. I also want to underscore Dr. Walters's comments that – how crucially it's important that we have some alignment around common data standards, data elements and measures, and making sure that we are not confusing the world of quality improvement, but actually promoting quality improvement within the oncology community, the broad oncology community.

And there's going to be additional complexity when we need to start implementing the EHR standards, HIT standards as well, and very careful work devoted to specification of measures that do leverage existing standards in the HIT world. I would argue that we are already there, it's already been mentioned with the meaningful use, it's been an ongoing effort to make sure that we are aligning and that we are using existing infrastructure and resources rather than recreating. Thank you.

Barbara Cebuhar: Thank you, Ms. McNiff. Any other comments?

Operator: We have no further comments in queue at this time.

Barbara Cebuhar: All right. I guess one of the things that would be very interesting to hear is how CMS can efficiently collect data from all the cancer facilities with the least impact for those facilities. (Alicia)?

Operator: Again, if you would like to make a comment, please press star, then the number one on your telephone keypad. We'll pause for just a moment to compile the roster.

We have a comment from the line of Kristen McNiff with ASCO. Please restate your name and organization. Your line is open.

Kristen McNiff: Kristen McNiff with ASCO. We very much encourage the type of reporting structure that is being developed through PQRS, which is the registry reporting structure. However, there's additional flexibility that's needed within that system, and so we would really like to see, again, alignment with ongoing and successful programs that are engaging in quality reporting to reduce duplicative reporting requirements, reduce administrative burden and really maximize the improvement opportunities.

Barbara Cebuhar: Thank you, Ms. McNiff. Any other comments?

Operator: We have another comment from the line of Ronald Walters with M.D. Anderson. Please restate your name and organization. Your line is open.

Ronald Walters: It's Ron Walters at M.D. Anderson Cancer Center. At the risk of being extremely repetitive, I agree completely, try to utilize currently-existing mechanisms for doing that as much as possible. The ones that we have are not perfect, they're being improved, but they're better than all the other alternatives put together. Thank you.

Barbara Cebuhar: Thank you, Dr. Walters. Any other comments?

Operator: We have another comment in queue from the line of Andrew Stewart with the American College of Surgeons. Please restate your name and organization. Your line is open.

Andrew Stewart: American College of Surgeons, this is Andrew Stewart. I'm being repetitive. I think what Dr. Walters just said echoing Kristen McNiff's comments are right on target.

There are a number of already-established standardized mechanisms by which these sorts of metrics can be reported, and leveraging those without introducing a duplicative effort or design development is probably, you know, among the most important things that need to be considered. The College of Surgeons and ASCO and other organizations are very much interested in being in alignment with one another and being able to help facilitate those processes where the opportunity arises.

Barbara Cebuhar: Thank you very much, Mr. Stewart. Any other comments?

Operator: We have no further comments at this time.

Barbara Cebuhar: Great. Do you have concerns about turnaround time to get data back for comparison of your facilities? Do you have concerns about turnaround time to get data back for comparison to your – of your facility? (Alicia)?

Operator: Again, in order to make a comment, you may press star, then the number one on your telephone keypad. We have a comment in queue from the line of (Jeremy Moranski) with Memorial Sloan-Ket. Please restate your name and organization. Your line is open.

(Jeremy Moranski): (Jeremy Moranski), Memorial Sloan-Kettering Cancer Center. I think one of the things that we have to realize is that we are going to be working with aged data, and turnaround has to do not only with the time that it takes to submit the data, but also the time that it takes the folks working with the database to actually analyze the data and then get it back to the institutions.

I think all of us would agree that the closer the feedback to the actual event, the more success we will have in improving quality. It's very difficult to improve based on the – on two-year-old data, which is basically what we're talking about right now.

Barbara Cebuhar: Thank you, (Dr. Moranski). Any other comments?

Operator: We have another comment from the line of Ronald Walters with M.D. Anderson. Please restate your name and organization. Your line is open.

Ronald Walters: It's Ron Walters with M.D. Anderson Cancer Center. So I agree with (Jeremy), in the world of performance improvement, we know that there are two types of problems, there's a long-term look at trends in various data elements, and there's processes and techniques we have to learn from a performance improvement basis about trends that are occurring over longer periods of time, but we also have processes in place to learn what we need to learn from more immediate types of events that occur, and this situation will replicate that.

What you're alluding to is very definitely true. It takes a long time to get certain kinds of things reported. That's OK, because our perspective needs to be long-term on certain types and certain viewpoints of those measures.

On the other hand, there are processes in currently to deal with things that need to be dealt – need to be dealt with on a more immediate basis, and we know how to do that. Not having the measures available, though, is a poor start to accomplishing either of those. Thank you.

Barbara Cebuhar: Thank you, Dr. Walters. Do we have any other comments?

Operator: We have a comment in queue from the line of Andrew Stewart with the American College of Surgeons. Please restate your name and organization. Your line is open.

Andrew Stewart: Andrew Start, the American College of Surgeons. It's a well-taken and constant point about the agedness of data used in many of these quality reporting systems that exist around and about the country.

The college itself has invested a significant amount of time recently in developing mechanisms by which data can be exchanged for information in a much more rapid format in an effort to reduce the two-year, sometimes three-year time span in action and metrics to, you know, something, you know, closer to a number of months, moving into almost a prospective sort of reporting system.

So we see opportunities not just for ourselves, but for a number of other, you know, interested constituents to begin to think about addressing the timeliness issue, which is certainly, you know, a key factor in understanding, assessing and being able to more appropriately, and probably acutely, comment on quality and demonstrated quality delivery to patients, the PPS as well as non-PPS-exempt hospitals.

Barbara Cebuhar: Thank you, Mr. Stewart. Any other comments?

Operator: We have a comment from the line of Kristen McNiff with ASCO. Please restate your name and organization. Your line is open.

Kristen McNiff: Thank you. Kristen McNiff with ASCO. ASCO's quality programs, we have several, and one that's being built right now which actually is based on real-time data pulled from electronic health records systems. So the timing issue of the actual data themselves is something that we're all working on, and I think we are making great strides across the board, and you will start to see – I mean, I can speak for ASCO specifically – start to see real dramatic improvement in the timeliness of the data themselves.

Basing quality improvement on data that are several years old obviously has a very different impact than basing quality improvement activities on data that are from the past six months, that's the case in the QOPI program, or in the case of the new programs that we are building, in the past, you know, few weeks or even yesterday.

So this is a goal that we're all striving for, and I would just reiterate that there is significant progress being made with these existing programs as we all continue to evolve them and that that's important to know.

But in terms of your specific question about the timeliness of the feedback, I have stated this before, but just want to reiterate that we have found this to be an incredibly crucial component of quality improvement, and I think that the quality improvement literature bears that out as well.

And this has been an area where there's been some concern, for instance, in the PQRS programs, with the timeliness of the reporting, the ease of accessing the reports, and see the barriers – other barriers that must exist that have led to what seems to be a very poor actual rate of viewing of those reports.

So incredible focus on making sure that they are available in a usable format, that they're available as quickly as possible, and that there are real support programs put in place to aide improvement, are all on really crucial. Thank you.

Barbara Cebuhar: Thank you, Ms. McNiff. Any other comments?

Operator: We have no further comment at this time.

Barbara Cebuhar: OK, great. I'd like to move to the next section, which is, which measures do you recommend reporting to the public as part of this effort? Which measures do you recommend reporting to the public as part of this effort? (Alicia)?

Operator: If you would like to make a comment, please press star, then the number one on your telephone keypad. We have a comment from the line of Ronald Walters with M.D. Anderson. Please restate your name and organization. Your line is open.

Ronald Walters: It's Ronald Walters at M.D. Anderson Cancer Center. So, when asked questions like that, I always tend to put myself in the position of a patient – fortunately, I've not had to be one – but what would I like to see? And that actually is a tricky question, because there's not a lot of data out there about what patients actually do base their decisions on or would like to see reported on a regular basis, let alone whether or not they actually use that data, when it's reported, in making decisions.

What we do seem to know is that, as I mentioned earlier, survival is very important. Survival is probably the first question that comes out of everybody's mouth.

Secondly, is a strange one, and it's one that kind of goes through everybody's mind, health condition-independent, which is, do you know what you're doing? Do you have some experience in this area? And there's a lot of surrogates around that, whether it's volume or credentials or training, et cetera, et cetera. But that is another one that everybody wonders, is this person any good, and how do I know they're any good?

And then the third one, amazingly enough, is not the process methods that we choose. Actually, you know, think about it a second, I support the use of the chemotherapy guidelines administration process metrics because they're good and we know how to measure them, and they're standardized, but don't you think if you're a patient that that is actually a given assumption, that your doctor is going to treat you correctly?

And so while I think that's a good place to start, it actually is one that will probably fade over time because people assume that's going to be true. We need to measure it and make sure it does happen.

The one that actually bumps up in the third place is, again, safety, and all of the safety measures. That's why qualities and (quantities) are not unreasonable as a good place to start, because nobody wants to come into a health care situation and anticipate that they're going to be sicker because of that due to something that might've been preventable.

So I support the measures that we started out with, but that's why we do need to keep those other considerations in mind as we move forward in this process. Thank you.

Barbara Cebuhar: Thank you, Dr. Walters. Do we have another comment?

Operator: We have another comment from the line of Kristen McNiff with ASCO. Please restate your name and organization. Your line is open.

Kristen McNiff: Kristen McNiff with ASCO. I want to reiterate Dr. Walters's comments, a few of them. First is that we do need more research about what patients are – what data are useful for patients and for what goal, and we need research that's specific to the oncology patient population. Until then, we won't be able to really produce a meaningful public reporting program.

There are obvious issues in terms of the validity of the measures, especially at the unit with which they're – at which they're measured. So some of the measures that have been proposed for public reporting in other programs, say sample size, if the individual physician level is not adequate for valid and meaningful reporting.

So there are issues like that that we're all aware of, the methodologic issues that need to be addressed as well. So I'll just, you know, kind of state that those are real. They shouldn't necessarily be a barrier, but they are real and need to be addressed before data are made public.

And then finally, I want to absolutely agree that there's an important distinction between measures that are useful, actionable, implementable for clinicians in doing their quality improvement work, and measures that are meaningful to patients.

So while we need to learn more, we absolutely do know that these very specific process of care measures in and of themselves are going to have much different and much less, you know, overall meaning towards – for the patient population than they do for the clinicians, who might be able to identify system errors that can be addressed to really move the needle as high as possible, and in some cases, close to 100 percent for some of these measures.

But patients really would like to see a much – probably much more rolled up reporting that reflects an overall quality of care. So the patient got their chemotherapy perfectly but they also should've gotten radiation and they didn't, then, you know, you could look like they got – and in fact, no one would argue that that patient was well-served overall by this health care system. So we need to figure out how to really provide meaningful information to patients, and I would argue we need to do that before we really launch into a sophisticated public reporting program. Thank you.

Barbara Cebuhar: Thank you, Ms. McNiff. Do we have any other comments?

Operator: We have no further comments at this time.

Barbara Cebuhar: All right, I would like to move on to another question, which is what potential unintended problems do you anticipate from public reporting of PPS-exempt cancer hospitals, specifically, fulfill the level of data? (Alicia)?

Operator: Again, in order to make a comment, you may press star, then the number one on your telephone keypad. We'll pause for just a moment to compile the roster.

We have a comment from the line of Ronald Walters with MC Anderson. Please restate your name and organization. Your line is open.

Ronald Walters: Ronald Walters, M.D. Anderson Cancer Center. So probably the biggest unintended consequence could be managing to the number rather than managing to the patient. And we know I alluded to earlier like readmission rate vis-à-vis length of stay. If managed to the number, that can result in an outcome that is exactly the opposite of what you want for the best care of the patient, and yet certainly, the more that's tied into comparative measures or certainly reimbursement, it's a natural tendency that people are going to try to manage to the number.

So the overall arching theme is, as we develop these measures, we certainly do need to keep unintended consequences in mind as we start rolling these out, so that we don't end up developing perfect measures, perfect definitions, things that everybody can agree on, but will actually inhibit patient care. Thank you.

Barbara Cebuhar: Thank you, Dr. Walters. Our next question – or, comment?

Operator: We have no further comments at this time.

Barbara Cebuhar: OK, do you support measures separated by health disparity concerns? That's age, race or gender, and locality, i.e. urban versus rural, among cancer patients? (Alicia)?

Operator: Again, in order to make a comment, you may press star, then the number one on your telephone keypad. We'll pause for just a moment to compile the roster.

Again, in order to make a comment, you may press star, then the number one on your telephone keypad.

We have a comment from the line of Ronald Walters with M.D. Anderson. Please restate your name and organization. Your line is open.

Barbara Cebuhar: Dr. Walters?

Ronald Walters: I'm sorry. This is Ronald Walters, M.D. Anderson Cancer Center. I switched locations on you.

We are so far behind. So we consider all the other dimensions that need to be considered, and you certainly mentioned a lot of good ones, those are things that we are going to make – have to make sure that we take into consideration as we move forward in this, but I think on a scale of things, those things are probably version 2 or 2.0 or 3.0, and we're way back at version 1.0.

Yes, as continued development occurs, that's exactly the path and the other dimensions that have to be considered, and we'll get there, but we have to start first. Thanks.

Barbara Cebuhar: Thank you, Dr. Walters. Any other comments?

Operator: We have another comment from the line of (Jeremy Moranski) with Memorial Sloan-Kettering. Please restate your name and organization. Your line is open.

(Jeremy Moranski): (Jeremy Moranski), Memorial Sloan-Kettering Cancer Center. I think in theory, yes, of course we would support those measures. I think we have to keep in mind, however, if we are looking at things through the point of view of performance improvement, what efforts are going to be made to address issues of gender and – such as gender and age, what efforts can be made to address issues such as gender and age versus, as Dr. Walters said, the very important issues that I think we have to start with. Thank you.

Barbara Cebuhar: Thank you, (Dr. Moranski). Do we have other comments?

Operator: We have no further comments at this time.

Barbara Cebuhar: Fine. I have one more question in this category, which is, are there certain aspects of reporting that you think could make it confusing to consumers? (Alicia)?

Operator: Again, in order to make a comment, please press star, then the number one on your telephone keypad.

We have a comment from the line of (Jeremy Moranski) with Memorial Sloan-Kettering. Please restate your name and organization. Your line is open.

(Jeremy Moranski): (Jeremy Moranski), Memorial Sloan-Kettering Cancer Center. I think we have a lot of work to do in educating consumers about data, about what data mean and about how they can be interpreted.

We in New York State have been reporting data to the state for quite a while, and it's been made available to patients for quite a while. I have to say that when I look at those data, I have trouble understanding them, and I can't imagine what a patient is taking out of there.

So when we actually work on what we are going to be showing patients and what's going to be acceptable to them, I think we also have to think about how we are going to educate patients about what these data mean, what's the confidence interval – you know, with what confidence can you take these data as given, can you – can you rely on one year's worth of data as opposed to a trend, and many other such things which I don't think we've done a great job of yet.

Barbara Cebuhar: Thank you, (Dr. Moranski). Any other comments?

Operator: Our next comment comes from the line of Ronald Walters with M.D. Anderson. Please restate your name and organization. Your line is open.

Ronald Walters: It's Ronald Walters in M.D. Anderson Cancer Center. Yes, and – yes, and as confusing as the data is to all of us, it's undoubtedly confusing to consumers, and I echo what (Jeremy) said. There's going to have to be an education process attached to as to what these different things mean.

I'll give you an example. As much as I believe in survival, and I do believe that's the most important thing, try to – try to explain the Kaplan-Meier curve to anybody who's not involved in research or other aspects of statistical analysis, and they will quickly – although – come to the conclusion that this is – this is very difficult science.

And so you can express certain things as percentages, there's a lot of different ways to express survival, but most people don't ask us a simple question like, "Am I going to be alive five years from now?" they ask, "How long am I going to live?" and our statistics try to answer that as percent improvement and five-year survival.

So we have a lot of work about very basic measures that we hold near and dear in the education area as to how people interpret these different things and what they mean. Thank you.

Barbara Cebuhar: Dr. Walters, what would you suggest in terms of an education process? Have you got ideas about what we're going to need to do?

Ronald Walters: Yes. Well, again, I think for like CAUTIs and CLABSIs, there – once you get over what the actual abbreviation stands for, and once you get over the fact that the intuitive response is going to be those should happen never, it's easier to explain in that particular circumstance what a 0 percent number means, because that's what people want.

Unfortunately, the world we live in is not one of 0 percent numbers, and so there's baseline rates, and there's complicating factors, and so on. And that's where a lot of the difficulty comes in.

I alluded earlier to guideline compliance, and again, in a patient's mind, the administration of the ASCO and ACoS measures should be 100 percent. Why not? That makes sense; my doctor's treating me like they're supposed to. Anybody who's tried to measure guideline compliance and concordance knows that very rarely is the answer 100 percent.

So how do you explain to someone that 90 percent is actually probably pretty good, given all the considerations that go into effect in applying a given guideline to a given patient? Those are the tricky parts of how we post the numbers, and that's going to take a lot of education. Thank you.

Barbara Cebuhar: Thank you, Dr. Walters. Any other comments?

Operator: Our next comment comes from the line of Barbara Jagels with Seattle Cancer Care Alliance. Please restate your name and organization. Your line is open.

Barbara Jagels: Hi, this is Barbara Jagels calling from the Seattle Cancer Care Alliance. And just to pile on what Ron was saying, I think the public deserves rigorous education regarding the definition of the denominators, particularly as they relate to central-line infections and catheter-associated UTIs.

For instance, are we talking about ICU-only patients when we talk about central lines and catheters? Are we talking about inpatients only, recognizing that many patients, especially many cancer outpatients, exist for long periods of time entirely outside the hospital setting with central lines?

So I don't necessarily have a comprehensive patient education program in mind, but I do think as we approach this, you know, when you go into Hospital Compare today and look at whether a hospital delivered Aspirin in prescribed timelines or discharged the patient on beta blockers, it's intuitive for a patient to understand what was expected and what was delivered. I think we need to be cautious and thoughtful as we define these for patients.

Barbara Cebuhar: Thank you, Ms. Jagels. Any other comments?

Operator: Our next comment comes from the line of Kristen McNiff with ASCO. Please restate your name and organization. Your line is open.

Kristen McNiff: Thank you. Kristen McNiff with ASCO. Most of my comments have been stated, so I'll just agree with the past speakers, and reiterate the importance of – or, to caution of assuming that a patient is able to assess the quality of a specific cancer program based on a small number of very narrow quality measures.

And so that would be a primary concern, is that the public reporting component didn't give the – didn't imply that a patient would be about to judge quality at one setting over another based on, again, a small set of narrow measures. And I think it would be hard not to give that impression.

So still a significant amount of research is needed to understand what is meaningful to patients, what the burden is to collect those data, how those data can best be collected, how they can best be analyzed and aggregated, potentially, to report to the patients in a – in a meaningful and actionable way.

It's very important to give patients the information that they need to be informed consumers and informed decision-makers in their care, but we could end up providing so much data that is not meaningful that it would actually turn patients off a little bit in the process. Thank you.

Barbara Cebuhar: Thank you. Any other comments?

Operator: We have no further comments in queue at this time.

Barbara Cebuhar: OK, great. I know we are – we have 20 more minutes, but I wanted to probe a little bit deeper on another question, and I was hoping that people could give us an idea of how should CMS reach out to patients regarding this education? Other than posting information electronically, what are ways that you would recommend educating patients? (Alicia)?

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

We have a comment from the line of Kristen McNiff with ASCO. Please restate your name and organization. Your line is open.

Kristen McNiff: Kristen McNiff with ASCO. In the oncology space, there is an incredibly active cadre of patient advocacy organizations. And many of them are highly-engaged in these specific areas, so I would definitely recommend having some specific conversations with those organizations, and ASCO is certainly helpful – very willing to help make those connections if that's helpful. Thank you.

Barbara Cebuhar: Thank you, Ms. McNiff. Any other comments?

Operator: We have another comment from the line of (Jeremy Moranski) with Memorial Sloan-Kettering. Please restate your name and organization. Your line is open.

(Jeremy Moranski): Hi, it's (Jeremy Moranski), Memorial Sloan-Kettering. I think that, as a cancer survivor myself, and a very educated one, what has worked best for me is hearing from people directly. And by that I mean clinicians in the field. I don't think anybody can expect a very busy doctor to sit down and go over data with patients, but I do think that we have to think about ways of educating patients face to face, and not only through written material or what's available online.

Barbara Cebuhar: Thank you, (Dr. Moranski). Any other comments?

Operator: Our next comment comes from the line of Ronald Walters with M.D. Anderson Cancer Care. Please restate your name and organization. Your line is open.

Ronald Walters: This is Ron Walters at M.D. Anderson Cancer Center. So I think one of the initiatives that I've seen started up recently was Partnership for Patients. And I think buried in that is the right idea. The Partnership for Patients is more of a grassroots from the ground up. What are the good examples that are going out there in the community, what are hospitals doing? And it's specifically geared towards patients and their experiences.

Of course, that has not been, nor was it intended to be, cancer-specific in its origin, but it is another example of an area that could be developed so that people knew that not only was the Partnership for Patients of a very general nature, but also about delivering better cancer care in the process also.

And I was just – I'm just back on their website again now, and again, I think there's lots of opportunities there to leverage an initiative that's already been started.

Barbara Cebuhar: Thank you, Dr. Walters. Any other comments?

Operator: We have no further comments at this time.

Barbara Cebuhar: I am going to probe a little bit deeper on another issue, and I would appreciate anybody's insights on this one, do you currently post your data for patients? This is the quality performance data. Is it currently posted for patients? (Alicia)?

Operator: Again, in order to make a comment, you may press star, then the number one on your telephone keypad. We'll pause for just a moment to compile the roster.

We have a comment from the line of Ronald Walters with M.D. Anderson Cancer Care. Please restate your name and organization. Your line is open.

Ronald Walters: It's Ron Walters at M.D. Anderson Cancer Center. We do not. And it's not for a lack of interest or belief; it has really been for a lot of reasons that we've already alluded to today in the discussion. We're having very active discussions about Internet field and what exactly would we put out there, and they tie very much back into what Kristen alluded to, actually, the research is not terribly strong in this area about what patients actually want to see on the web page.

I would say that one of the best examples from our institutions that is out there, it has been done by Roswell Park in Buffalo. They have somewhere about 150-page document that is on their web page and can be accessed by anybody who accesses their web page. It is certainly a very extensive document, certainly very detailed, and it takes – it's going to take a certain motivated patient to sift their way through that to find, potentially, some information that they would be interested in.

Nonetheless, that is a very good example, in PDF format, of one of our institutions starting to address that issue, and I applaud them for doing it. The question at hand remains, if you're going to put something out there for patients, how is that done in a way that's useful and meaningful to them. Thank you.

Barbara Cebuhar: Thank you, Dr. Walters. Any other comments?

Operator: Our next comment comes from the line of (Jeremy Moranski) with Memorial Sloan-Kettering. Please restate your name and organization. Your line is open.

(Jeremy Moranski): Hi, (Jeremy Moranski), Memorial Sloan-Kettering Cancer Center. We have posted some information on our Internet for awhile, patient satisfaction. We have just started posting our survival data, and we, I think, have just started posting some patient safety data.

What we found was that we thought that this information was going to be a lot more accessible and understandable to patients than it actually wound up being when we did some focus groups. And we have thought that we need to do, again, which is probably the reason I mentioned this before, a much better job of explaining to patients what these data mean and what all of these little either numbers or figures or graphs or tables mean.

So what we are planning going forward is posting data in the six domains of care mentioned by the IOM, but it's a work in progress. Thank you.

Barbara Cebuhar: Thank you, (Dr. Moranski). Any other comments?

Operator: We have no further comments at this time.

Barbara Cebuhar: All right. I would like to go to our final area of discussion. And I'm interested in monitoring and evaluation of the program. Do you have concerns or considerations you'd like to share with us regarding the monitoring and evaluation of the effort? (Alicia)?

Operator: Again, in order to make a comment, you may press star, then the number one on your telephone keypad. We'll pause for just a moment to compile the roster.

And we have a comment from the line of Barbara Jagels with Seattle Cancer Care. Please restate your name and organization. Your line is open.

Barbara Jagels: Thanks, this is Barb Jagels in Seattle. I just would actually like to answer your question with a question, how do you currently evaluate the customer satisfaction with the hospital conveyor website and the data that's listed there?

Barbara Cebuhar: Barb, I don't have the answer for you. I am, like I said, a newbie to this effort, and I don't have an answer, but I think that I'm just interested in what you all would propose is the best way to evaluate and monitor the effort.

Any thoughts?

Barbara Jagels: Essentially, I believe many of us post information on our websites, and do focused customer workgroups to understand if what we posted there would be suitable for public consumption or absorption.

Obviously, on a grand scale, for CMS, that sort of resource-intensive effort seems unrealistic. So I'm wondering if we can mirror some other processes that are already in play on a national level to understand, once again, customer satisfaction with these publicly-reported data.

Barbara Cebuhar: Let me reframe the question a little bit. Have you experienced issues or problems with being monitored on other CMS performance initiatives, and what feedback do you have to provide for us?

Barbara Jagels: So I'll speak for Seattle, and then I'll bow out. To echo what Ron said, most of us PPS-exempt cancer centers do not have experience in public reporting. So I think that we're new at this as well.

Barbara Cebuhar: Thank you. Any other comments?

Operator: Our next comment comes from the line of Ronald Walters with M.D. Anderson Cancer Care. Please restate your name and organization. Your line is open.

Ronald Walters: This is Ron Walters in M.D. Anderson Cancer Center. And Barb kind of said what I was going to say. I mean, unfortunately, what you have to realize is that this is relatively groundbreaking field for most of us.

Even on a state level, the variation across different state reporting requirements and how publicly available that is has meant that only a minority of us have really delved deep into this field.

I would echo what she said though, and I think the point is very much that whatever is the mechanism for doing it, we need to get out of the mode of thinking of, "We know what the customer wants to see, and that's what we're going to show," and periodically, through some mechanism, we have to take temperature checks every so often about, are we really showing you the kinds of information that is important for you to know?

Now, I don't pretend to understand how to do that right now, but it is all part of that true value delivery back to our customers, the patients, to make sure that we don't assume things for them, and that we really deliver on what they need. Thank you.

Barbara Cebuhar: Thank you, Dr. Walters. Other comments?

Operator: Our next comment comes from the line of (Jeremy Moranski) with Memorial Sloan-Kettering. Please restate your name and organization. Your line is open.

(Jeremy Moranski): (Jeremy Moranski), Memorial Sloan-Kettering Cancer Center. I have a slightly different take on the question than I've heard responses to. So my perspective is no, we have no problem with monitoring and evaluation. We do have experience not reporting to CMS, but as I mentioned, we do have experience reporting to New York State, and we have been monitored by others on several occasions.

I think the issue that we would have is the understanding that certain things that occur in cancer patients as defined by other institutions are not always valid, and I think that needs to be taken into account.

Let me just mention CLABSI, where we've had some differences of opinion about whether a central-line infection is a true central-line infection caused by – A, some failure in care, or whether it is a colonization of bacteria already existing in the patient which, because of the disease process, has transferred. Ron, I'm sure you can do a much better job than me in describing this clinically.

But the other issue is that if CMS is going to get data from our already-existing databases, I would say that those – that those data have been validated, evaluated and monitored several times over, just by the – by the agencies to which those are already set. So I think that process already exists, to a certain extent.

Barbara Cebuhar: Thank you, (Dr. Moranski). Any other comments?

Operator: We have no further comments at this time.

Barbara Cebuhar: We are very grateful to everyone for their input and ideas. I just want to make sure that folks know that CMS is depending on your input for – as we consider the proposed measures.

Just a reminder, in about two weeks, you will be able to find the transcript and the recording of the call at the following website. So if you know of others that might be interested in listening or reading the transcript, it will be available at http://www.cms.gov/hospitalqualityinits.

And we are – if you have further comments or would like to submit something for the record, please send it to donald.howard@cms.hhs.gov by October the 31st, 2011.

Thank you again, everyone, for your participation and your insights into this very important work. We do appreciate your assistance.

(Alicia), you can tell people to disengage now.

Operator: And this concludes today's conference call. You may now disconnect.

END