READMISSIONS FALL 2019 MEASURE EVALUATION MEETING

Moderator: Kim Patterson

February 4, 2020

1:00 pm ET

Woman: Hey everyone, this is NQF. We'll be getting started pretty soon. Thanks everyone who's joined us far.

Just a brief reminder for our committee members, please who dial in on the phone and then also connect both to the webinar where we'll be displaying slides and to the voting software link, the voting platform link rather, that we sent you this morning. And then you can just send us a chat if you are having any trouble accessing that.

In the meantime, we'll get started in about 10 minutes probably. So if you could just put your line on mute unless you have a question that would be great. Thank you.

Hello, this is NQF. We'll be getting started pretty soon.

Man: Thank you.

Woman: Hello?

Woman: Hi. Thanks for joining. This is NQF.

Helen Chen: Oh, hi. Helen Chen.

Woman: Great. Thanks for joining.

Helen Chen: Sure.

Woman: Please try to stay tune.

Helen Chen: And, you know, I have to leave. I'm sorry, I have to leave early.

Woman: That's all right. Thank you. We'll look forward to having you on the call for as long as you can stay.

Helen Chen: Okay thank you. Also one question is, do I need to have the poll open? I only have one screen I'm sitting at someone else's desk. So, open the poll now or?

Woman: Yes.

Helen Chen: Okay.

Woman: You could have the poll open so that you are ready once we start voting. We will be going over some introductory slides before we get started but you'll want to have that available.

Helen Chen: Okay.

Woman: Thank you.

Helen Chen: I'm going to put you on mute.

Woman: Hello, this is NQF. Thanks for joining. We'll be getting started pretty soon.

Christy Howell: It's just Christy.

Woman: Hi Christy.

Christy Howell: Sorry.

Woman: Great. Thanks for joining. We'll be getting started shortly.

Man: I think there is probably no one left.

Woman: Hi, this is NQF. Who's just joined?

(Susan): Hi, this is (Susan) I had joined earlier but I haven't announced myself.

Woman: Great. Thank you. We'll be getting started pretty soon.

(Susan): Sure.

Dheeraj Mahajan: Hi, guys Dheeraj Mahajan just joined.

Woman: Great. Thank you. We'll be getting started probably about five minutes.

Hi everyone, we'll be getting started soon we would ask that you puts your line on mute if you are not actually speaking just to reduce feedback. And we'll go mentioning this again as we do our general opening remarks.

But please turn off your computer's speaker if you have both the speaker and the phone connected, just to reduce the feedback.

Dheeraj Mahajan: So we are going to be polling today for the Poll Everywhere during call.

Woman: Yes, the Poll Everywhere link is what we'll use to collect your votes. So, we will need you connected to that link throughout the call.

Dheeraj Mahajan: Okay.

Woman: Hi, we've heard a couple of beeps. Who's joined?

(Amy Lynn): (Amy Lynn).

Woman: Great. Thank you.

Leslie Kelly Hall: Leslie Kelly Hall.

Woman: Great. We'll be getting started in just a couple of minutes.

Woman: Hello?

Woman: Hi there. This is NQF. We are waiting for a few lines to connect and we'll be getting started in just a moment.

(Chloe Slocum): Hi, this is (Chloe Slocum).

Woman: Great. Thank you. We'll be getting started momentarily.

Matthew Pickering: Okay. Well, good afternoon, everyone. Welcome to this Readmission Standards Committee Fall 2019 Measure Review Cycle webinar meeting today.

We really want to appreciate the time that you are investing into this cycle this year as well as for the consideration of the measure that we'll be going through on the call today.

Just as a reminder, so the Standing Committee really, you all serve as proxy to our NQF members. You provide a multi-stakeholder perspective and considered various different types of priorities based on your stakeholder group that are presented and considered by your peers here at this Committee.

And as such, there is that level of respect of differences of opinion and so we welcome that. And we also ask that you respect other's differences of opinion through these types of meetings.

We have a, somewhat of a new staff with us for the standing committees, myself in particular. And so, we'll do a little bit of a brief introductions for those of us around the room and on the call before we go through the agenda and have the committee members introduce themselves.

So first off, my name is Matthew Pickering, I'm the Senior Director here at NQF and I will be overseeing and facilitating this Standing Committee. So, I'll go to Suzanne on the call.

Suzanne Theberge: Hi, everyone. This is Suzanne Theberge, I'm the Senior Project Manager on the team. And for those of you who are returning, I'm excited to work with you again and welcome to the new folks.

Man: Great Suzanne. Hello?

Woman: Hi, good afternoon. This is (unintelligible), Project Manager.

Matthew Pickering: Okay. And (Asaba), who is also listed on here. She is out on maternity leave, but instead we have Hannah.

Hannah Bui: Hi, everyone. My name is Hannah Bui, I'm a Project Analyst here at NQF.

Matthew Pickering: Great. And I'll turn it to Apryl.

Apryl Clark: Hi, this is Apryl Clark, I'm the Acting Vice President of Quality Measurement here at NQF.

Shantanu Agrawal: And this is Shantanu Agrawal, I'm the CEO of NQF.

Matthew Pickering: Great. And then listed also on here is Taroon. Taroon have you joined the call?

Taroon Amin: Yes. This is Taroon Amin. Welcome everyone and look forward to this next cycle review.

Matthew Pickering: Great, thanks Taroon. So again, we are working on the Standing Committee and look forward to working with you all on this process, in this cycle.

I do want to pause as well and ask if our two co chairs John or Christy if you've joined, would you like to provide any welcoming remarks to the committee for this Fall Cycle.

Christy Howell: Well, this is Christy. I just want to thank everybody as Matt just did for the work that you've put in prior to today's meeting as well as being active participants today. I have no doubt that you will be. But thank you so much for engaging us in this very important work.

Matthew Pickering: Great. Thanks Christy. And John.

John Bulger: Yes thanks it's John.

Matthew Pickering: John, you are a little muffled, a little...

Sorry, John. Still a little muffled. We might have to redial back in but I will go ahead and proceed. Maybe we can check in with you in a little bit, John. But thank you.

So on the slides that are on the webinar and we're on Slide 7 as well. So this is just the agenda. We've already did a welcome. So again, thank you everyone for your time this afternoon and all of your time leading up to this meeting.

We are going to be turning it over to Apryl, who will do some introductions or allow you all to do some introductions and also disclose of interest, then we will touch on an overview of the evaluation process.

So just a reminder of how this meeting will flow as well as touch on some forum related types of issues and things to consider. And then we will enter

into the consideration of the candidate measure today. So there's just going to be one measure that we are looking at today.

And so we'll be going into that and that's where we'll talk about each one of the evaluation criterion. And also providing votes, getting votes from you all on those criteria.

Then we'll open it up for NQF member and public comment. And then we will close with next steps and eventually just adjourn the meeting.

I do want to just check in, John, were you able to dial back in? Okay.

John Bulger: Yes, I didn't - I don't know what button I hit but it was the wrong button. So yes, I'm back in. I was in all the time but wasn't in the right place.

Matthew Pickering: Great. Well, thanks John. We can hear you loud and clear now. Okay. So next, we'll go into the introductions and disclosures of interests. I'll turn it over to Apryl.

Apryl Clark: Yes, thank you. So one, just to reiterate from that, thank you very much for all of you spending some time with us today to review our measure. We know that you do this on a volunteer basis and did appreciate your time and expertise as we complete our endorsement process, so just a big thank you from NQF for all of your time and help.

So we are going to combine the introductions with disclosures of interest. You should have received this measure specific disclosure of interest form from us.

In that form, we ask you a number of questions about your professional activities. Today, we'll ask you to orally disclose any information you provided that you believe is relevant to this committee.

We are especially interested in grants research or consulting related to the committee's work.

Just a few reminders. You sit on this group as an individual, you do not represent the interests of your employer or anyone who may have dominated you for this position.

If you are interested in your disclosures, we are interested in your disclosures of both paid and unpaid activities that are relevant to the work in front of you.

Finally, just because you disclose does not mean that you have a conflict of interest. We do oral disclosures in the spirit of openness and transparency.

I will say that I am relatively new to this position. So I will just apologize in advance if I mispronounced your name. Please feel free to correct me in your introduction.

So we are going to start with the co-chairs. So the co-chairs, I'll call your name and then please state your name, who you are with and if you've anything to disclose.

So I'll start John Bulger.

John Bulger: Yes, John Bulger. I'm the Chief Medical Officer of Geisinger Health Plan and I have nothing to disclose.

Apryl Clark: Cristie Travis.

Cristie Travis: Hi, Cristie Travis. I'm the CEO of the Memphis Business Group on Health. And I have nothing to disclose.

Apryl Clark: Frank Frick? (Mace Antino)? Helen Chen?

Helen Chen: Helen said Hi, I'm Helen Chen, Chief Medical Officer of Hebrew Senior Life in Boston. I have nothing to disclose.

Apryl Clark: Edward Davidson? Richard James Dom Dera?

James Dom Dera: Hi, I'm James Dom Dera down there, I'm the Population of Health Medical Director of New Health Collaborative. And I have nothing to disclose.

Apryl Clark: Paula Minton Foltz?

Paula Minton Foltz: Hi, I'm Paula Minton Foltz and I'm the Associate Chief Nurse at Harborview Medical Centre in Seattle, Washington.

Apryl Clark: Brian Foy?

Brian Foy: Hi, I'm Brian Foy. I'm the Chief Product Officer at Q-Centrix. I have nothing to disclose.

Apryl Clark: Lisa Freeman? Faith Green?

Faith Green: Hi, I'm Faith Green and I work at Humana. I'm one of the Clinical Quality Directors. And I have nothing to disclose. Thank you.

Apryl Clark: Leslie Kelly Hall?

Leslie Kelly Hall: Hi, I'm the founder of Patient Engagement Strategy and also Board Member for (unintelligible) Conference Health System and I have nothing to disclose. Thank you.

Apryl Clark: Great. Michelle Lyn?

Michelle Lyn: Hi, I am employed by the Mount Sinai Health System as a Professor and Director of Performance Improvement. I do receive grant funding from the NIH on some Asthma Quality Measure Development. And I do unpaid work for the American College of Emergency Physicians around myth measures development, but nothing relevant to this particular committee's work.

Apryl Clark: Okay, great. (Ed McConaghy)? Dheeraj Mahajan?

Dheeraj Mahajan: Hi, this is Dheeraj Mahajan, I'm an internist in geriatrician, I own and operated medium-sized practice here in Chicago Hospitals as in Post Acute Networks.

Fortunately or unfortunately, I did submit and the society who prosecute for the MACRA funding for QM development, but it wasn't funded. So I guess no conflict there.

Apryl Clark: Zeyno Nixon? Amy Olin?

(Amy Olin): Amy Olin, hospitalist and physician lead for enterprise readmission reduction for Clinton Clinic. No, nothing to disclose.

Zeyno Nixon: Sorry, I was on mute. This is Zeyno Nixon, I am the Senior Epidemiologist at Washington State Health Care Authority. And I have nothing to disclose.

Apryl Clark: Okay, great. Gaither Pennington?

Gaither Pennington: Good afternoon. I'm Gaither Pennington. I am the Nurse Clinician and Product Owner at Bravado Health. I have nothing to disclose.

Apryl Clark: Great. Pamelo Robert?

Pamela Robert: I'm the Executive Director for Physical Medicine and Rehab and to the office of the CMO. And I have nothing to disclose Cedars-Sinai.

Apryl Clark: Sheila Roman?

Sheila Roman: Good afternoon. Currently, I'm a clinical endocrinologist and currently holds a part-time faculty position at Hopkins in Baltimore and have an independent healthcare consulting business where I do consulting with quality measures, improvement in patient safety.

Prior to that, I was one of the Senior Medical officers at CMS on both the quality and payment side of the house during my time there and prior to that spent 20 years in academic medicine.

I have nothing to disclose in my current independent healthcare consulting work. But during my time at CMS, this is just, you know, to be free and open, I did work with the Yale Core on our cardiovascular mortality rate measures.

Apryl Clark: Okay, great. Terry Silver?

Terry Silver: Hi, I'm Terry silver. I'm the Chief Quality Officer for Hospital Sisters Health System, headquartered in Illinois. And I have nothing to disclose.

Apryl Clark: Chloe Slocum?

Chloe Slocum: Hi, this is Chloe Slocum. I'm the Associate Director (unintelligible) for Spaulding Housing Rehabilitation Hospital Network in Boston. I also received some NIH grant funding, but I have no relevant disclosures for this committee.

Apryl Clark: Okay, great. So, is there anybody's name that I didn't call or anybody's name that might have joined late?

Kenneth McConnochie: This is Kenneth McConnochie. I joined just now so that's late.

Apryl Clark: Can you state your name, where you are from and then if you have any disclosures of interest?

Kenneth McConnochie: Kenneth McConnochie from the University of Rochester Medical Center. And no conflicts of interest.

Apryl Clark: Anybody else? All right, well, I'd like to remind you that if you believe that you might have a conflict of interest in any time during a meeting, please speak up.

You may do so in real time during this web meeting or you can send a message via chat to your chairs or to anyone on the NQF staff.

If you believe that a fellow committee member may have a conflict of interest or behaving in a bias manner, you may point this out during the meeting, send

the message to your chairs or to the NQF staff. Do you have any questions or anything you'd like to discuss based upon the disclosures made today?

I will take silence as no and turn it back over to Matt.

Matthew Pickering: Great, thank you so much. And I will ask Helen not to call you out like this but I know that you have to drop off after an hour. If you could just let us know that when you are dropping off just so that we can kind of keep track of quorum.

Helen Chen: Will do. Thanks.

Matthew Pickering: Thank you so much. And with that, I'll turn it over to Suzanne who will go through a major evaluation process and also the process for today.

Suzanne Theberge: Great. Thanks, Matt. So before I do that, I will just go over our general housekeeping notes of it. As you know, you do need to be dialed into the phone line to speak. But we would ask that you put your phone on mute if you are not speaking.

And please don't put this call on hold as we then get your hold music on the line. And we would also remind you that we do need you to just connect to the Poll Everywhere voting link that we sent out earlier via email in order to cast your votes to the committee member.

So as you know we are looking at one measure today 3495. The hospitalized 30-day all-cause, unplanned readmission rate for clinician groups and we will go over this in a bit more detail in a few minutes. This is a measure from Yale Core and this is coming back to the committee. We'll get into that shortly as

we begin to measure evaluation. But just to be very clear, we are doing a full review of this measure today.

So as you know, NQF does have a number of steps involved in our process and a number of pieces of input go into the standing committee's work. And so we do have - you see that as our multi-stakeholder committee to evaluate all the evaluation criteria and make a recommendation for endorsement.

We will also have received input from our scientific methods panel on this measure, a group of methodological - experts of with statistical and methodological expertise, who looked at the reliability and validity. And then of course, we also get public comments and NQF member votes of support or non-support.

This measure did go to the message panel as a complex measure and it did pass the measure - the message panel so it comes forward to you.

As I said, if it goes to the to the message panel and was rated both moderate on both reliability and validity. I'm going to pause quickly here for any questions before I start talking a little bit more detail about what we'll be doing today.

Chloe Slocum: Hi, this is Chloe Slocum. I didn't get a Poll Everywhere link. So if it's possible to resend that if we are going to be doing that today, that'd be great.

Suzanne Theberge: Yes, we will send that to you directly shortly.

Chloe Slocum: Thank you.

Suzanne Theberge: You'll get that via the chat box on the webinar.

Chloe Slocum: Awesome.

Suzanne Theberge: Any other questions? Okay. So we are going to be voting. And as we mentioned in our emails, we do need you to vote on the computer. Unfortunately, the voting platform doesn't work very well on a tablet or phone. So if you are not on a computer, either a laptop or a desktop, let us know and we can set up some alternate arrangements.

And if anyone else is having any trouble or can't find the link, just let us know and we will get that over to you.

So, you know, I don't think I need to go over this in detail. But just a quick reminder that we do ask you to base your evaluation and recommendations on the criteria and guidance that you keep your comments, concise and focus and try not to repeat what other folks have already said to the extent possible that helps the discussion move more quickly.

We are going to have a brief introduction to the background of this measure, by our chairs. We are going to have an introduction from the measure developer. The Yale Core team will be providing an overview. And then we will turn it over to our lead discussion to give us some input on what the committee said.

Most of you filled out the preliminary evaluation survey and we thank you for your time on that. Those comments have been collated and put back into the preliminary analysis that was on our SharePoint and our lead discussion will be reviewing that as a prepared and see up the discussion.

And then once that's done, the chairs will open up the call to everyone on the committee to discuss. Of course, the developers are available to respond to the questions that you may have as needed. And as you know, we discuss each criteria individually, and then vote on that criteria and then move on to the next one.

So as mentioned, we do have a lead discussion for this measure. And that's just someone who has been asked to kind of tee up the conversation and that will be - Pam Roberts will be doing that for this call. And she has just been asked to kind of be the first person to speak on each of the criteria and kind of summarize what the committee member have said prior to beginning, the committee's discussion.

And quickly I'm going to go over the voting process. So as mentioned, we do discuss each of the criteria in turns, important to measure and report consisting of both evidence and yes our vote must pass criteria meaning you must vote to recommend those for the measure to continue to move forward.

Reliability and validity, the committee may choose to discuss reliability and validity or may choose to accept the methods panel votes, which were both moderate.

The feasibility again you discuss and vote on feasibility. And then on feasibility and usability and use are not must pass criteria for this measure. And then finally, you will vote on overall suitability for endorsement.

There are 22 active members of the committee in this cycle of work. So we have a huge quorum, which is 15 people. So by our count we have 18 of you. So we are in good shape there.

As we discussed on the orientation call, we do have thresholds for what we consider recommended or not recommended and that is greater than 60% of yes votes, which would either be passed or high plus moderate for each of the criteria. And then does not pass or not recommended is less than 40%.

Anything in that 40% to 60% range inclusive of both 40 and 60 is considered content is not reached or the gray zone as we sometimes call it at NQF. And for anything that doesn't reach consensus on one of the must pass criteria that measure continues forward through the criteria, except the committee doesn't vote on an overall recommendation at this time, you would vote on the post-comment call.

I'll pause right here to see if there are any questions on that process before I turn it over to Hannah to run our voting test.

Amy Olin: It's Amy Olin, forgive me, I cannot find the link for the vote either.

Suzanne Theberge: Okay, we'll send that over to you momentarily.

Amy Olin: Thank you.

Suzanne Theberge: And now…

Zeyno Nixon: I'm sorry, this is Zeyno Nixon. I have the platform in front of me, but it says, "We will update this area to give you the voting options." Is this what I should be seeing right now?

Suzanne Theberge: Hanna, I'll turn that over to you.

Hannah Bui: That's correct. We haven't activated the poll yet. Once we activate the poll, you'll see your screen change.

Zeyno Nixon: All right. Thank you.

Hannah Bui: Great. Maybe I just try to do the voting link…

Zeyno Nixon: Thank you. I see it. Thank you, yes.

Hannah Bui: Is there anyone else who needs the voting link?

Kenneth McConnochie: Yes, I guess I need the voting link. This is Kenneth McConnochie.

John Bulger: So, and this is John Bulger quick. The link was - it was an email sent this morning at 10:29 a.m. that had six things in it, one through six. The voting link is in Item Number 3.

Chloe Slocum: Yes, I don't - this is Chloe Slocum. I don't think I received that email because I've looked for it.

John Bulger: Okay.

Dheeraj Mahajan: And the link is in the body of the invite itself.

Man: Correct.

John Bulger: Okay. So folks, if you want to go into your outlook calendar, it is within the body of the invite.

Man: Thank you.

Hannah Bui: And so right now we are suppose to hit the link. And because right now it says, just hang tight, you are ready to go that's all I need.

Suzanne Theberge: Yes, I'm about to activate a test poll right now it's open, you should see your screen change and your options are, A for Yes or B for No.

Gaither Pennington: Yes, I see it. This is Gaither.

Suzanne Theberge: Thank you.

John Bulger: Yes, so if everybody just picks one. You could pick no and we'll still know you could see it so…

Kenneth McConnochie: I'm not seeing it. This is Kenneth McConnochie.

Woman: Yes, I see voting test.

Kenneth McConnochie: There's a problem with my email configuration at the moment.

John Bulger: So, you still don't have the link to even get in the voting website, correct?

Kenneth McConnochie: Correct.

John Bulger: Okay.

Kenneth McConnochie: Again, it says - strong possibility is a problem at my end and we may not be able to fix that on the slide here.

Man: Was that - sorry, was that Ken?

Kenneth McConnochie: Yes.

Dheeraj Mahajan: It's fairly easy URL so if you guys want to read it out it's poll EV. So…

Suzanne Theberge: No, actually, wait. Please don't actually read that out. We have to keep that voting link to the committee members only. So we will just send an email to the committee members who have requested it. Sorry about that. Ken, we have emailed that to you and…

Kenneth McConnochie: Okay. Yes, I think I…

Suzanne Theberge: So, I think you can do. And so we do run this test and find that this is helpful so we are not running into these problems as we start to vote.

John Bulger: How many do we have on assess that responded.

Hannah Bui: I'm seeing 13 votes on the test right now. We have 18 members, so we are waiting on about five more responses.

We have 15 responses right now. We are waiting on three.

Chloe Slocum: Thanks so much. I just got the email with the attachments. I think I'm also missing the calendar invite for today.

Hannah Bui: Who's this? Who's speaking?

Chloe Slocum: This is Chloe Slocum.

Hannah Bui: Hi, Chloe. But you got the link via chat. Is that correct?

Chloe Slocum: I did, yes. There's a link and I got the attachments. Thank you.

Kenneth McConnochie: I just got a message that says, "This page can't be displayed." I don't know whether that's a security problem with my security settings or what, I'll double check the…

Hannah Bui: Are you using Internet Explorer? It works best on Chrome or a Mozilla Firefox.

John Bulger: Okay, I'll try with Chrome.

Hannah Bui: Thank you.

John Bulger: Thank you. All right, how many responses do we have?

Man: We have 15 so far. Is there anyone else having an issue still?

John Bulger: I think I have got mine resolved.

Man: Now, we have 17. Is there anyone else that has not voted or has not response or is having difficulties? And Ken that was you who just voted, right?

Kenneth McConnochie: Yes, I just voted. Yes, and it works fine on my phone. For some reason on Internet Explorer on my laptop is not working. I will continue to use my phone.

John Bulger: So we're good. We're on a standpoint 17, correct?

Man: Okay.

Hannah Bui: Yes, that's correct.

John Bulger: Okay. And, we have 17 good votes.

Man: Yes. Okay.

John Bulger: All right. Maybe someone dropped off within a couple beeps in.

Man: Yes, potentially.

John Bulger: So, okay.

Man: Okay. All right. So, John and Christy we'll hand it over to you all to start us off.

John Bulger: Okay, thank you. So, you know, first to give the committee and, you know, as we said about half of the group was here and about half of the group wasn't here. But just to give a quick background on the measure, we did begin to review this measure during the last cycle.

The biggest issue we had and why we spent so much time in the last couple of minutes is to make sure everybody could vote. And we had a quorum and we had quorum issues with our phone calls.

So we weren't able to vote while on the phone if we don't have a quorum, we were doing follow up votes which I think changes the - and we didn't have a quorum on the call to be able to have everybody hear the discussion all once.

And even though we do take these and, you know, if you go look afterward, there's very detailed transcripts to be able to see what's going on. It isn't the same as being here listening to it. So we had an initial call where we reviewed the measure and then went to the vote afterward. Then we had a follow-up call after the deliberations were out for comment, which we could potentially reconsider what we did.

That call, we didn't have a quorum either and interestingly, we had kind of one part of the group for the first call and the other part of the group for the second call, which really I think heard the discussion.

And as you've seen in the process that the hope is the initial process, that you're able to discuss the measure come to either consensus or not come to consensus. And then have a second call where you could reconsider that reconsideration call was more of a consideration again of the original question than a reconsideration.

And then during that call there was some discussion of some data around the measure. And the verbal telling of that data from some of the content experts was misread. It wasn't done in a way that was meant to deceive anyone but the correct information was not given on the call.

So then, when that was realized after the call, some discussion was held between all the parties involved. And since it was late in the process and it was bumping up against the need to get the measure to the next level, which is a review by the NQF CSAC, we decided to move the measure from last fall the discussion with the new committee here in the winter of 2020.

So, you know, if you were wondering kind of how we got from Point A to Point B. That's how we got here. So and the decision was made to reconsider

the measure from the beginning. So that is the plan for today is to go back through.

The developer was given a chance and will be, you know, he's with us today and we'll talk about and he was given a chance to update anything that needed to be updated on the forums that we saw. And, you know, each of you was given a full opportunity to review everything beforehand, before this meeting.

So we just wanted to set out for everybody, you know, going in. If you had questions or, you know, why the measure was, where we are today, that's the high level of how we got from Point A to Point B.

Hannah Bui: Hey, guys…

((Crosstalk))

(Eva): Oh this is (Eva) I was just going to say I just wanted to also just mention that the committee, the Regional Standing Committee determination last year was to recommend the measure for endorsement. So I think that's just an important data point for the folks to know.

John Bulger: Great, thanks. What was, there was someone was asking a question.

Amy Lynn: You know, it's (Amy Lynn). So, just so I understand the material that was sent out ahead of time with some of the, you know, it's like very long I mean. And it looks like a lot of input has already been made to it. Does that mean that was the original fall committee's input as well in that or was it all the winter committee people, these new people?

Christy Howell: Yes, all of the committee input, which is summarized in those orange boxes is this committee. It's from you all, the new round of review. The preliminary analysis is from the staff and then the full submission is from the developer.

John Bulger: And then there is there is some information from the scientific methods panel that's in there as well. So, and sometimes that can be confusing because it's a different group of people that are making those comments. So, that may be also what but, you know, it was stated that the comments are what everyone on this committee had a chance to put in over the last few weeks.

(Amy Lynn): Great. Thank you.

John Bulger: Are there questions?

Woman: Hey John, can you see if the developers, you know, has any additional comments that they'd like to add?

John Bulger: Yes, great. Yes?

Lisa Suter: Hi, this is Lisa Suter from Yale Core. Can you hear me?

John Bulger: Yes, loud and clear.

Lisa Suter: Great. Thank you very much for the opportunity. I will take just a few minutes because I know everybody's time is precious. Just to further orient people, this measure under consideration is actually a revision of a measure that is already in use by Medicare in the MIPS Quality Payment Program and it's already been reported at the physician level.

That measure is called the All-Cause Readmission Measure or ACR measure. And it attributes the readmission outcome to a single outpatient provider that is defined as the provider with a plurality of care during the 12-month measurement period. And Medicare asked us to revise that measure based on stakeholder input in order to ensure that the attribution approach for the measure satisfied stakeholders concerns about action ability of stakeholders to influence the readmission outcome.

And therefore during the revision process for this measure and the measure that's now in front of you, the outcome of readmissions is attributed to three-clinician group. Those clinician groups represents the three primary clinician entities that our tactical expert panels that was made up of both clinicians, inpatient and outpatient clinicians as well as patients and family members felt were responsible for the readmission outcome and are measured in the MIPS program.

They include the primary inpatient clinician, the discharge clinician and the primary outpatient clinician. We modified the primary outpatient clinician from the existing measure, which is a plurality of care over the 12-month period but not necessarily prior to the admission that leads to a readmission to making sure that it is the 12-month prior to the actual index hospitalization that brings the patient into the measure.

So that ensuring that the outpatient provider that is being attributed to actually has seen the patient prior to their hospitalization and potential readmission.

There were other five that were raised previously, one of which was the reliability, which was noted, and we we're asked today to ensure that we address a minimum case volume requirement. This measure as it is intended to replace the current measure in practice. CMS has informed us that their

intention is to replace this measure with the same minimum case volume that the current measure has, which is a minimum case volume of 200 patients per clinician group.

And this measure with that cutoff has the reliability ranging from 0.82 for the surgical cohort within the measure to 0.92 for the neurology cohort, which usually interpreted high reliability.

I'm happy to address issues around important performance gap, scientific, acceptability, reliability and validity. As it was noted before the scientific method panel passed this measure on both reliability and validity the current performance gap as the clinician group level ranges from a risk standardized readmission rate for clinician groups from 7% on one end to 25% on the other end.

And I'll stop there but we are, I'm here with a number of team members including Jeff Heron and Eric Norton who are our team leads to ensure that we're here to answer any questions that are raise by the committee. And thank you again for letting us participate.

(Kerry Shad): Hi, this is (Kerry Shad). I just had a question. You said the 0.82 was the ortho cohort?

Lisa Suter: No, let me just check my numbers, surgery cohorts.

(Kerry Shad): Surgery cohort. Thank you.

Lisa Suter: And the 0.92 was for the neurology cohort.

(Kerry Shad): Thank you.

Christy Howell: So, are we ready to get started? This is Christy.

John Bulger: Yes, this is John. I just have one question. And those numbers were based on 200 samples size of 200 per visit clinician?

Lisa Suter: For clinician groups, yes. But the measure is only being proposed in this cycle at the level of a clinician group or practice and that is a 200 case minimum for the clinician group.

John Bulger: Thank you.

Christy Howell: Okay. Well, this is Christy and we will have an opportunity to kind of discuss in a little bit more detail some of the comments that were just made and have more in-depth discussion as we go through the criteria. So if it's okay with everyone and I'm asking lot of NQF staff too, I'm not sure what the next slide is, but is it fine for us to get started?

Matthew Pickering: Yes, this is Matt. We can go ahead and get started and I'll just remind everyone that we'll be going through each criteria. So any of the comments that you have to share, if you'd like to summarize your overall comments, try to sort of keep them to each criterion that we are on currently until that sort of vote happens and then we'll move on according to the next criterion.

So we'll just have common share for each criterion and then vote and then move on to the next. Yes, Christy and John go ahead.

Christy Howell: Okay. Well, I'm going to start out just so that John can have the more difficult criterion to discuss. Just kidding. But I'm going to take up the first criterion, which is important to measure and report. And that criterion has

two components. One is evidence and we will discuss evidence first and then we will as I understand it votes on evidence at that point.

And then we will move into opportunity for improvement or gap. And we will discuss that aspect of this first criterion and then vote on that as well. And then we will move on to scientific acceptability.

So I will at this Point ask our lead discussion to kick off the discussions from the committee. After Pam does that, we will open it up for full discussion from the committee. As was just described, the measure developer is on the line and can respond to specific questions that the committee has in order for us to be able to vote appropriately on the measure.

So Pam I'll turn it over to you for some lead discussion opening remarks.

Pamela Robert: Sure. So I'm going to summarize some of the feedback that we all provided prior to this meeting. I'm not going to go back over the measure, it was just discussed. Some of the issues that seem to still remain with the important measure is about fair attributions.

And I believe that the developer just give us an update on that, that there were still questions about whether the account of folk groups proposed have sufficient involvement in the group level activity of medication reconciliation, discharge instructions and outpatient follow along.

One of the issues was aside from medication reconciliation, the remaining to a discharge instructions and outpatient follow-up or orders that they are implemented by a non-physician. So there was concern about the fair attribution of that.

Some of the other issues that were brought up had to do with concern with the clinician group measure intended for use in the MIPS program as has been described and was recently just reiterated that it's already in existence there.

And there is also a question about clarity regarding the provider and admit definition. And that was sort of a summary of what was sent in. So with that I think we can open it up for the group for a further discussion.

Christy Howell: Thank you, Pam. And just as a reminder, we'll focus right now on evidence and I just want to confirm with the NQF staff that we'll vote on evidence before we move to performance gap, is that correct?

Man: Yes, that is correct.

Christy Howell: And the other piece that I will remind everybody is that evidence is a must pass so that's very important. So, if we can kind of keep our promise right now focus on evidence that would be great. And if there's any committee members that would like to make a comment at this time, please do stand and state your name so that we can be sure we're getting to know your voice and also have it for our record.

Leslie Kelly Hall: This is Leslie Kelly Hall and I had a question. It's probably, my lack of understanding but the way that I read it is that the attribution was for the providers that had the most charges. And I heard that in one case, it was a definition of 12 months for outpatient services.

But I'm concerned about a patient who is in an observation stay or a short stay in the ED where diagnostics might actually overwhelm the previous billing events of an entire year in a primary care setting.

And that is still considered an outpatient service. And the diagnostics physician is the least likely to participate in any activity that would promote a reduction in readmission. So I may have misunderstood that if I could get some clarity. Thank you.

Lisa Freeman: This is Lisa Freeman. May I respond to that question?

Christy Howell: Yes, please.

Lisa Freeman: Great. Thank you. So, emergency department visits and observations stay or hospital outpatient setting events, but the primary care primary, outpatient clinician is from true outpatient encounters that are coded using primary care of code that can include encounter visits coded by specialists, but they do not represent emergency department visit or observation stay.

Further, the measure itself does not include inpatient. It only includes acute care facility inpatient hospitalizations and emergency department visits and observations stay or not, index hospitalizations that bring a patient into the measure.

So I think we can reassure you that your concerns are addressed in this measure both from the fact that only inpatient hospitalizations trigger a patient being in the measure cohort. And only clinicians who are seeing patients in a true outpatient setting, not a hospital outpatient settings such as an emergency department or an observation stay would be attributed as the primary outpatient clinicians.

Leslie Kelly Hall: Thank you, just a follow-up question then. So that means that we do have a different definition of stay across our measures. Is that correct?

Lisa Freeman: I'm not sure. I understand your question.

Leslie Kelly Hall: In some cases, a readmission includes an observation stay or an emergency room visit and some it doesn't. So we do have differences of that definition across this, correct?

Lisa Freeman: In this measure, a readmission is only define as an inpatient hospitalization. And an emergency department visit or an observations stay are not considered an unplanned readmission.

Leslie Kelly Hall: Thank you very much.

Lisa Freeman: Sure.

Christy Howell: Thank you. Are there any other comments or questions from the committee?

Sheila Roman: This is Sheila Roman and I do believe that this measure is directly supported by multiple RTCs. I am the commenter that expressed a concern that this clinician group level measure was intended for the mixed program.

And, you know, my concern is the difference between you know, a pick for purpose between the difference between quality improvement which, you know, throughout the PA, it's referred to as a quality improvement measure, not as a value-based purchasing measure.

And I'm just wondering how NQF would like us to separate those two things out.

Christy Howell: Well, will the NQF staff like to kind of respond to that?

Matthew Pickering: Sheila, this is Matt. And just to make sure that I understand you're wanting us to provide more clarity around how to distinguish between quality improvement type of assessment versus a measure for value-based purchasing?

Sheila Roman: Yes. So that's my one concern here because the evidence is there for quality improvement. I'm not sure it's there for, you know, value-based purchasing.

Apryl Clark: So, this is Apryl. So, we do not make a differentiation between value-based purchasing and quality improvement for our measure endorsement. We have an evidence criteria and our measures need to meet that evidence criteria regardless of whether they are a quality improvement measure or if they are going to be used in a value-based payment or any kind of payment or reporting.

So we would ask the committee to consider this measure as it relates to evidence overall rather than they were specifically meant to you. Does that make sense?

Woman: Yes that make sense. I guess, just a quick follow up to decide that it would come up under other criteria.

Aidan Dixon: Sorry, this is Aidan Dixon from Washington State Health Care Authority and I represented Medicaid agency. So I don't really know if there is all about, you know, healthcare records in for a Medicare or commercial settings.

And I guess my question is about coming from Medicaid, in our data collection, we require all the provider information for the billing provider. But provider information for other providers in a claim is usually optional and we don't always receive, you know, that information.

So coming from the Medicaid perspective and not knowing about, you know, Medicare or commercial data claims data collection, my question is, you know, is this information available in records for us to…?

Christy Howell: Yes. No, this is Christy. That's a really good question. And when we get to the use and usability of this measure which is a criterion that's near, it's a little bit of a, it's not one of the ways we're looking at right now. But I would suggest that, you know, we address that at that time.

I think one of the difficult things we have is that we all start thinking about different questions as we go through the criterion, but it is important for us to kind of try to focus on evidence. But I hope you'll bring that back up again when we get to use and infeasibility to be sure that the data is available. So thank you.

Aidan Dixon: Sure, thank you.

Christy Howell: For bringing that up. I do want to remind the group just some of the things we're supposed to be focusing on for evidence. One, we want to see that there is a relationship between the outcome in at least one health care structure process intervention or service. And assuming that the data is from a robust number of providers' result are not subjected to a systematic bias.

For measures derived from patient supporting evidence should be demonstrated the target population value is to measure. This particular one doesn't fall into that category. But I do think that there was a good question kind of asked as a follow-up that just fits under this category.

And NQF staff, I know that you indicated that for evidence we're to be looking at this, not based on whether it's a quality improvement or value-based purchasing overly how it will be used, but for the evidence as a whole. And the follow up question was, is that true for all the other criteria that we evaluate today?

Matthew Pickering: So this is Matt. So I would say yes it is. I mean there is a use and usability criteria to keep in mind, use in different types of programs or for quality improvement type of initiatives. So, Sheila, you know, your question I think really ties really well with and aligns really well with that criteria and specifically the use and usability.

But as Apryl had mentioned, when these other types of criteria that will go through, it would be very similar how we evaluate measures for quality improvement for these measures for value-based purchasing.

Christy Howell: Thank you. That's very helpful.

Helen Chen: Christy, it's Helen Chen.

Christy Howell: Yes, Helen?

Helen Chen: Hi.

Christy Howell: Hi.

Helen Chen: So, I'm going have to drop off the call in a few minutes. And I just wanted to help move the conversation along a little bit. So we've been doing this work for a long time out in the world and I was actually surprised to see some of the dates on these RCTs. My goodness, am I that old? Yes, I am. Anyway, so

this is the database that's under lay of 1789 and a lot of the other readmissions measures.

I think we can all agree that there's a significant body of evidence out there that supports that. There are things that we can do either at systems level or clinician group levels or even a clinician levels that do drive to some degree readmission rates.

And I think some of the things people commented on in the preliminary evaluation that there isn't always consistency. Yes, that's true. But there is evidence and there is also a reported performance gap. And so, I think that's the question I had.

Christy Howell: Thank you very much. I would like to see if we're ready to move to vote on evidence. So one last call if it's something very specific to the evidence criterion. Okay NQF staff, let me teed it up.

Woman: Thank you. Voting is now open for evidence on Measure 3495. Options are A-Pass or B-No Pass.

Voting is now close for evidence on Measure 3495. We have 17 votes for Pass, 0 vote for do not pass. This measure passes on evidence.

Christy Howell: Thank you. This moves as we can to gap and care and opportunities for improvement. And I wondered, if Pam if you had anything that you wanted to share before we open it up to the committee?

Pamelo Robert: Sure. And I think that the performance gap that there was comments that there is a performance gap and does warrants a national performance and there is variability and performance that has been noted.

There are some concerns about adequate attention to the social determinants of health and need for further clarity on transportation access to care including if there is any providers at community health program including security, education, economic challenges related to prescription costs.

And I think that's where most of the comments has had to do with that that there was definitely variability in performance.

Christy Howell: So, thank you for that. Thank you, Pam. And just to let the committee know, we'll have an opportunity to look deeper into social risk factors under our scientific acceptability. So if we can, it seems like there is a performance gap and there is performance variation. And that's the main aspect of what we need to look at under this criterions. Any questions or comments from the committee?

Okay, I'm hearing none, I think that we're ready to move to voting.

Woman: Voting is now open for performance gap on Measure 3495. Options are A for High, B for Moderate, C for Low and D for Insufficient.

Matthew Pickering: I just want to just check. This is Matt from NQF. Helen, are you still on the line?

Helen Chen: Yes and I voted but I'm going have to leave in a minute. So I'm not going to interrupt the call again but I just want to let you know that.

Matthew Pickering: Great, thank you.

Helen Chen: Sorry. I'm really sorry about that.

Matthew Pickering: No, it's okay. Thank you very much for your participation.

Teri Sholder: I'm not getting a new voting option. It's still on the evidence on my screen.

Matthew Pickering: Sorry, who was that?

Teri Sholder: I'm sorry. This is Teri Sholder.

Christy Howell: Is it possible if you hit refresh that it would bring a new question up?

Matthew Pickering: Yes. So, we do have 17.

Christy Howell: Is it possible if she had to refresh that it would bring a new question up?

Matthew Pickering: Yes. So we do have 17 votes. Teri, were you able to vote on performance?

Teri Sholder: No, it didn't give me the option. I still have - it's almost as if it's frozen on the screen for evidence still (unintelligible).

Woman: Okay. Can you try either refreshing or using a different browser please?

Teri Sholder: Refresh, I got it. A important measure. Okay, got it, thank you.

Woman: Voting on top of the performance gap on Measure 3495. We have two votes for high, 14 for moderate, one for low and zero for insufficient. This measure passes on performance gap.

Christy Howell: All right, thank you. It's time to move on now to scientific acceptability and I'll turn it over to John.

John Bulger: Thanks Christy. So the first area in this is reliability and there're two parts of reliability: specifications and reliability testing. And for staff, we vote on reliability in total, correct?

Matthew Pickering: So John, this is Matt. Thanks for the question. We are going to be asking about the SMP if the committee would want to uphold what the SMP has already provided or they want to pull it for discussion and vote.

John Bulger: And the scientific committee suggested moderate, correct?

Matthew Pickering: Yes.

Christy Howell: Correct. They passed it on in moderate.

John Bulger: So we can - first, we could say it's a yes/no if we want to agree with what they discussed, correct?

Matthew Pickering: Correct.

John Bulger: All right. So - and in the lead discussions, (Helen) is off, so who is - sorry.

Pamela Robert: It's (Pam). And I would - it's the issue of social determinants of health that keeps getting brought up as one of the areas of these clarification.

John Bulger: Yes. And that was clearly the most of the comments from the committee members on the pre-work?

Pamela Robert: Correct.

John Bulger: So is there any other discussion from committee members and I just say regarding whether we should accept the moderate from the Scientific Methods Panel versus have further discussion ourselves?

Christy Howell: And John, this is Christy. Are we specifically discussing this relative to reliability right now and we'll do it again on validity or…

John Bulger: That's the way I was treating it.

Christy Howell: Okay, good, thanks.

John Bulger: Does the staff agree with that or no?

Matthew Pickering: Yes John.

John Bulger: Okay.

Kenneth McConnochie: I have a comment on reliability. This is Ken McConnochie.

John Bulger: Go ahead.

Kenneth McConnochie: The admissions is a dichotomous measure either it happened or didn't, that's the beauty of the admission, readmission measure and so in terms of that is a very important criteria. Hospitalization yes or no, you can't beat it. The issues come from our perspective regarding validity. What does it mean? Whose fault was it that the (ambulatory) care system didn't avoid in admission, but that discussion is for later.

John Bulger: Yes, thank you. Other comments on reliability and whether, you know, to accept the Scientific Methods Panel versus have further in-depth discussion amongst the group?

Okay, hearing not much. Go to vote on that particular question and this will be yes and no I believe.

Woman: That's correct, thank you. You are now voting on whether or not you accept the Scientific Methods Panel's voting rating for reliability, the vote was moderate for this one.

Woman: Hey guys, so I just wanted to be clear when you say that you accept the SMP vote, it means that we were not going to have a discussion on reliability on the measure.

John Bulger: Correct. So - but yes means we're not going to have discussion and you are essentially agreeing that it's moderate. So we're foregoing a discussion, because we agree that the reliability is moderate.

Woman: Yes, absolutely. I just wanted to be clear with folks.

Kenneth McConnochie: I think the reliability is beyond moderate. I mean it's a dichotomous measure, either it happened or it didn't. The issue is whether it's a valid measure of quality of care.

John Bulger: Understood. But that's - I mean from a procedure wise standpoint, it - this is almost like a - it's the ability to forgo the further discussion except the…

((Crosstalk))

Kenneth McConnochie: I'm fine with that.

John Bulger: …the methods panel. If people, you know, feel one way or the other, if you feel it's really important to make it high reliability then we should - you should say no, if you feel it's really important to make it to low reliability you should say no, otherwise you should say yes. So how we're doing on voting wise? Staff?

Woman: Hi, thank you. The voting is closed. We have 17 votes for yes to accept the SMPs rating of moderate for reliability and zero votes for no.

John Bulger: Okay, great, thank you. So the second question is around validity and with same process. So the Scientific Methods Panel recommended moderate for validity and any discussion around - again this is the discussion around accepting the Scientific Methods Panel versus having a forward discussion on validity.

Kenneth McConnochie: When you say accepting the Scientific Panels assessment, what was their assessment?

John Bulger: Their assessment that the validity was also moderate. So the - you know, in the documents we have - there is a explanation of, you know, the summary of the Scientific Methods Panel, you know, to vote on validity and that their suggestion was is that the validity of the measure was moderate.

Kenneth McConnochie: Okay.

John Bulger: And they go through the signal-to-noise ratio and, you know, the threats to validity and some other pieces of the testing around validity.

Sheila Roman: This is Sheila Roman. And I guess I have three points that I want to make. The first point is just that I found some of the testing look excellent and some of the testing, you know, of the model, some look good and some less than good, you know, I would say moderate to low moderate.

And the other two issues that I would bring up and I don't know if this is the right place is the issue of the hospitalist and how that might impact validity as a primary inpatient care provider. I know we have the hospitalists on the panel. I'll be curious what they think. And then whether the lack of use of social determinants of health ultimately in the risk adjustment is – we want discussions here.

John Bulger: Yes, that's good point. Other comments?

Zeyno Nixon: Yes. This is Zeyno Nixon. I was also wondering the effect of the competing risk of debt, because we are mostly talking about implementing this measure in elderly population and then the deal that elderly populations, especially in acute stations the possibility of dying right after index hospital discharge is somewhat high. And I don't - I didn't get the, you know, feeling that - impression that it just when models, really it's just for the competing risk of dying rather than being readmitted.

John Bulger: Great. It's a good comment. Is there any follow up on that comment from anybody or the developer especially?

Woman: So this is (unintelligible). So it's about just figure whether or not the measure itself does reflect the quality of care and currently proposed. And then regarding I think the hospitalist's role in it, once the reach - like once the patient reach the hospital, it's past like the gateway. So I don't know what role the hospitalists play in…

Kenneth McConnochie: I mean I see the hospitalist is just the guy on the receiving end. They don't play much of a role in the decision to admit.

Woman: Right.

Lisa Suter: This is Lisa Suter from the developer. I just - I want to try and respond to some of the concerns that have been raised. First is the competing risk of mortality. We - the measure does try to mitigate this risk by excluding some patients from the measure cohort. So for example, if you have been or on hospice within the last 12 months, you are excluded from the measure denominator or cohort as these patients presumably survival to 30-day - for a 30-day period may not be the primary objective for that patient population.

In - for the hospital measure, we do have a paired hospital wide mortality measure. But I think there are some challenges with attributing mortality to an individual or groups of clinicians. So this measure does not have a paired mortality measure and it is a 30-day window. But the readmission - the mortality rate from our - at the hospital level we know is in and around the 8% level in the 30-day period between admission and the 30 days after admission which is when the hospital level measure captures the mortality outcome.

The other thing just to decide in terms of attribution, the concerns are coming up. So first of all, the MIPS eligible clinicians are - I did want to come back to some earlier comments. Did you include non-physicians, by far the most common clinicians in the MIPS program, our physicians, but they do include non-physician clinicians in the MIPS program.

The three that are attributed, again the primary inpatient clinic, talking about the hospitalists, these are - well, they are certainly impacted by the care that they received in the triage area.

The measure is attributing the outcome after discharge and it attributes to the three primary clinicians who are technical expert panel of clinicians and patients as well as the MIPS clinical champion which is a group primarily of primary care clinicians many of whom actually serve as hospitalists and primary care clinicians. That I remember on the call that we spoke with who actually follow patients through - from the outpatient setting into the inpatient setting and they felt that the attribution scenarios of three clinicians, the primary inpatient clinician, the person who is actually discharge - writing the discharge order and then the primary outpatient clinician with an appropriate way to spread responsibility.

And again, no individual clinician is actually being held responsible. These are all clinician practices or groups of clinicians.

John Bulger: Great, thank you. Any further questions or comments from the group that we'd like to make on whether we should accept the Scientific Methods Panel suggestion of moderate validity or move on to an even further discussion of validity?

And this is for people - this is I believe the first time we've done it this way. People that have seen this in the past, it's almost like a consent calendar where you, you know, agree to take the consent calendar which is the Scientific Method Panel versus pulling the topic for more discussion if you're familiar with doing that at other board meetings or other such things. Any further questions, concerns around piece of validity we're talking about?

Kenneth McConnochie: I'm just wondering about end of life care. There are certainly individuals who've made a conscious decision that they don't want to be admitted ever again and they'd just like to die peacefully at home. And if you respect that decision then you need to take at (identification) regarding whether or not the patient was admitted.

John Bulger: Okay, thank you. Other comments, questions?

Leslie Kelly Hall: I have a process question. So this type of consent agenda - this is Leslie Kelly Hall, is the process that we'll be going forward with then on each measures going forward or is this unique to today?

John Bulger: No, this is not unique to today, but it's unique to certain pieces of the measures which, you know, validity and where the Scientific Method Panel makes comment. But I believe this is part of the new process. Is staff want to follow up with that?

Leslie Kelly Hall: My concern is that many of our comments, without them we could have scientifically valid reliably - reliable, but nonsensical measures. And so the power of this group in review is that we don't necessarily comment specifically on - we look at the whole, we look at the global, one of the questions asked of our group in our face-to-face meeting I believe last year was are you just a rubber stamp? Do you review? Had you ever said no? Some of those kinds are very challenging and high important questions get worked through when comments and when review are allowed to be more general, more specific or less specific.

And so my concern just as a process that I'll raise is that consent agendas often allow for only acknowledgement and approval of what's in a document

and not allow for global comment or critique on something as a whole. So I just like to raise that as a concern.

John Bulger: Thank you. Yes, and this was - I mean I'll have to go ahead with the staff and then I can go ahead with your comments on the new process.

Woman: Yes, this is (Abro). So I mean I was going to say overall, you know, certainly you're always welcome to make overall comments. We do - you know, as part of our endorsement process, we do ask that all of our measures need a level of criteria that is, you know, kind of what we go through in these meetings.

Certainly if you have concerns about validity or reliability or in this case, validity and you think that it you want another discussion, you should absolutely raise that and vote in that way. At the end of the meeting, we also ask you to give an overall endorsement recommendation providing that each of the measure has passed each of the criteria. And so I think that's also an opportunity for you to have a comment about kind of what you think overall the general - what you think the measure is and whether it's something that we should sort of be thinking about endorsing. So - but I appreciate your comment on the process and I'm sure it's something maybe we can certainly get back in and think about it as well.

John Bulger: But yes, and just…

Leslie Kelly Hall: Well, this is an indicator when you go forward, when you're asking us to review, let us know prior if that's going to be a consent agenda or whether or not that's going to have opportunity for discussion.

Woman: Okay.

John Bulger: Yes. Well, let me take a step, because that didn't answer my question. This is a new…

Woman: Sorry John.

John Bulger: …yes, so this is a new process. So in the past we would have just discussed reliability and then the committee would have voted high, moderate, low or, you know, inadequate. And we wouldn't have - I don't remember ever having a vote to say do you accept the Scientific Methods Panel and essentially be able then to move forward by just accepting the Scientific Methods Panel.

And I know that with the last (SESAC) we had a lot of discussion about streamlining the process, you know, and how we could use the Scientific Methods Panel to a greater degree. And obviously we've had a lot of discussion with that at this committee, because we've been blessed by having a number of members of Scientific Methods Panel who were members of the committee. So it became a little bit of a redundant process to have the Scientific Methods Panel and then to have - but I just want to clarify, I don't - am I correct in saying that this yes/no is a new process since this committee last reviewed measures in the past.

Woman: Hey John, thanks so much. And I apologize, I did mean to not answer your question. Yes, this is a relatively newer process. It's been in effect for about two years. So yes, going forward, this will be the process. We use the Scientific Methods Panel as an advisory group to our standing committee to provide more in-depth analysis on the reliability and validity.

And, you know, three years ago we did - we had a session where we reviewed our endorsement process. And one of the feedback that we got is that many

times we've seen in committees do not have as much expertise in those reliability and validity places and so we'd really like some expertise from our Scientific Methods Panel.

Again, those are just an advisory group and that's why we ask you to vote that you like to uphold their recommendations. And standing committee at any time can choose not to uphold that and then have a more forward discussion and vote specifically on high, medium, lower and physician validity and reliability, I don't know.

John Bulger: Yes, that helps. And just for everybody in the committee, to the previous question and I don't remember who asked that is that any time we review these moving forward, those two questions, basically the two yes/no questions, the one which we already answered and the one which we're on right now will exist for reliability and validity, but only for reliability and validity.

So if there is a Scientific Methods Panel opinion that's part of our review which they pretty much will always be, we're going to go through the process and I use the consent agenda example. But through the process to say do you agree with the Scientific Methods Panel and if the answer is yes, then we will go on to the next measure. If the answer is no, then, you know, we will go through more discussion on whatever that happens to be, reliability or validity and then we'll vote on the, you know, high, low, medium - or high, medium, moderate, low, I think there is a fourth one, that's a choice. But - and do it that way. But at least until the process changes, that's the way it will be.

Christy Howell: So John, this is Christy. Just to kind of build on that, you know, when I was looking at on the feedback from the committee in those orange boxes and I

kind of referred to this earlier. It seems like there were several comments around social risk adjustments.

And, you know, my question for the group is that if you feel like you would like to discuss it, you may end up at the same place that the Scientific Methods Panel ended up. But if you feel like that's something you would like to discuss as well as anything else you would like to discuss about this measure, then I would suggest you both know on the yes/no. It doesn't mean that you - it's more you want to hash through it as a committee ourselves to Leslie's point earlier. So we do have the ability to have a further discussion if that's what the committee wants.

Woman: Christy, do you want to continue the discussion or would you like us to move to a vote?

John Bulger: So I would like you…

Christy Howell: I'll let John do that.

John Bulger: Yes, thanks. I think we're ready to move to the vote on the yes/no question around validity.

Woman: Voting is now open. Your voting on whether or not you accept that the Scientific Methods Panel's rating of moderate per validity option…

John Bulger: So it's actually you're voting two things I would say here. 1, do you agree with the Scientific Methods Panel and 2, do you agree that no further discussion by the committee is needed around validity? If - you may agree with moderate, but have for some - but want to discuss it more, I would - you should vote no as Christy just said if that's your view.

Kenneth McConnochie: And this is for validity of - this is for?

John Bulger: The validity of the measure.

Kenneth McConnochie: I can - please just state the measure once again.

Matthew Pickering: Sorry, who is asking the question?

Kenneth McConnochie: This is Ken McConnochie.

Matthew Pickering: Okay. So Ken, it's the same measure. It's the readmissions or they're readmissions all-cause for the clinician group, same one we voted on for evidence.

Kenneth McConnochie: Okay.

John Bulger: And the question is do you have any concerns regarding the validity of the measure, EGE exclusions, risk adjustment approach, et cetera and then…

((Crosstalk))

Kenneth McConnochie: …do you accept the scientific panel validity, not whether I have questions about it.

John Bulger: And so this - yes, the Scientific Method Panel said that the validity was moderate.

Kenneth McConnochie: Okay.

John Bulger: If you say yes to this question, you're basically saying I believe it's moderate and I would - and I don't feel that we need to discuss validity anymore as a group.

Kenneth McConnochie: Okay. Thanks for the clarification.

John Bulger: Yes, thank you. All right, how are we looking at votes?

Woman: Voting is now closed. We have 11 votes for yes and five votes for no. We will be discussing validity.

John Bulger: Okay. So that's - and you said we will be, correct? Just to clarify.

Woman: Yes.

John Bulger: Yes. So the committee members, they already had the preamble on it. The committee members have further questions or comments they'd like to make around the validity of the measure.

Sheila Roman: This is Sheila Roman. And, you know, I brought up before the issues of social determinants of health. And it seem to me that in the measure write-up that the measure developers were acknowledging that there were social determinants for readmission that had to do with community factors and quality of hospital that, you know, were not, you know, accounted for.

Kenneth McConnochie: Yes. I think that's a very important observation. There are social factors that the - that strongly should affect the decision to admit if for example, this is an obvious example, if the person lives alone has nobody around them who can help them with taking medication or whatever needs to be done then that patient just needs to be admitted. If the caretaker is seem

unreliable then that patient may need to be admitted, yes. Did the developers want to speak to your process around addressing social determinants with the measure?

Lisa Suter: Yes, thank you. This is Lisa Suter.

John Bulger: Thank you.

Lisa Suter: So when we think about social determinants of health in this measure, we started with accounting for patients level core morbidity case mix and to account as much of the case mix differential at the patient level as possible and trying to refine that as much as possible. And actually we have a risk model that accounts for patients case mix to go back and then look at social determinants of health and social risk factors, because often times social risk factors are associated with poor health status and core morbidities and some of that is captured by core morbidities when the case mix is captured in the model. So that's the step - the first step.

The second is based on, you know, the most up-to-date NQF and the other national guidance, we look for social risk factors that are with minimal burden to providers cap - consistently captured on all patients.

And for the current measure under review, the two social risk factors that fall into that categorization are something called dual eligibility which is an acknowledgement if you're a Medicare and fee-for-service beneficiary and you're also enrolled in Medicaid, you are considered a dual eligible individual.

The second is a Socioeconomic Status Index that is created and reported by ARC and that is based on a nine digit zip code that allows us to drill down to

community factors within a very small few block range. It's not just your zip code, but the subdivision of your zip code. So it's a quite granular measure and it…

Kenneth McConnochie: Yes. We've found that to be very useful.

Lisa Suter: Great. So those are the two indicators of social risk that we investigate and investigated for this individual for this measure. We do find that if you look just at dual eligibility or the ARC SES Index as a univariate or bivariate analysis, we're just looking at readmission individual - sorry, group practices with higher level of patients with dual eligibility or higher levels of low Socioeconomic Status Index do have higher readmission rates.

However, a lot of this affect is minimized when you fold those risk factors into the risk model that incorporates the patient case mix and all the core morbidities. And there is a 0.99 correlation between a group level readmission score with and without social risk included in the model. And for any individual group practice, there is a two one-hundredth of a percent or a one one-hundredth of a percent change in their absolute measure results if you include dual eligibility, that's the two one-hundredths of a percent or the ARC SES Index which is one one-hundredths of a percent change in their measure results when you add those measures. That's the maximal change.

So this measure is harmonized with hospital level measures. In those measures, we also did the - in that measure we also did a decomposition analysis that tried to tease out whether the clinical risk factors were attributing more of the case - of the predictive power of readmission and hospital level factors we're capturing - you know, we were trying to assess the difference between a patient level characteristic and a hospital level characteristic in those hospital. In the hospital level measure we found that social risk tracks

more closely with the hospital level effect and the core morbidities like cancer or heart failure tracked more closely with patient level effects.

I do not believe we've repeated this analysis for the group level measure, because the assumption is that the risk prediction will be similar. We're just changing the attribution, we're not actually changing the patient for the clinical risk prediction. And so we did not repeat that decomposition analysis for this measure. But for these reasons and also for the reason that (MedTech) and other organizations including NQF have encouraged the consideration of considering social risk at the payment level and not necessarily at the measure level to ensure that we can be transparent about disparities.

The decision for this measure was not to include social risk in the risk adjustments, but to continue to monitor for potential unintended consequences. CMS has multiple avenues for monitoring for unintended consequences that include their work that they do on an ongoing basis to monitor for the NQF endorsed measure as well as their program evaluation and measure - ongoing measure reevaluation work all of which serves as potential avenues for monitoring.

(Karen) or (Jeff), do you want to add anything to our response?

(Jeff Heron): Yes, this is (Jeff Heron). I'll just add that in addition to the point that Lisa just made, you know, we have a number of readmission measures out there including in particular the existing the hospital wide readmission measure for hospitals. And those measures do not account for social risk.

And our goal - you know, one of our goals in constructing this measure was to align that with the existing hospital wide readmission measure. And so we had kind of a - you know, a high - you know, we felt like changing the risk

adjustment to increase social risk factors would - you know, could be justified only if there were really compelling reasons, you know, and basically we didn't see that in the data, so.

((Crosstalk))

John Bulger: Great, thank you.

Woman: It's such a great - it's a great explanation and so comprehensive. I appreciate that. So did I understand correctly that when you look at the social health factors, the dual eligible and the area of deprivation and information. Did you say that ultimately it had a very small effect on the way you found the hospital readmission and was it more towards case mix or did I totally misunderstand that?

Lisa Suter: No, you understood correctly. So if you look - if you will do a scattergram of clinician group level measure result with and without either dual eligibility or ARC SES Index in the measure, the correlation is 0.99. And any given individual group practice's readmission rate changes at an absolute value of equal or less than two tenths - two one-hundredths of a percentage point.

Woman: Thank you.

John Bulger: Okay. Other questions at all on any particular - around validity that could be on social determinants or other pieces?

Kenneth McConnochie: Well, just as a reflection of social determinants and looking at asthma in children and using zip code as a proxy for socioeconomic status in the Rochester, New York area, it's a very good proxy I would like. What we found is that for intercity children compared to suburban children that the risk

of hospitalization for asthma was fourfold that of, you know, the suburban children, so 400% and there is no way that you're going to account for that based on biologic differences. That's a clear indication of quality of care.

John Bulger: Great, thank you. Other questions or comments around validity? Okay. Hearing none, we'll move to voting on the validity of the measure. Do you want to pull the poll up and then we can. So the four choices are high, moderate, low and insufficient. You can only vote for one as it noted. And this is validity in total, so this is 2B which includes six different areas, 2B1 through 2B6.

Gaither Pennington: This is Gaither Pennington. And can you - can somebody on staff give me a sufficient - a reasonable definition of insufficient precisely and the contest for vote now?

Matthew Pickering: So insufficient, this will be that there wasn't enough information provided to adequately weigh in on the assessment of a high, moderate or low type of evaluation. So it's just they're - the specifications weren't very clear or the testing was not appropriate potentially would allow for an insufficient.

Gaither Pennington: Okay, thank you.

John Bulger: All right, thank you. Other questions about the voting before we close it? Okay. So people take the chance and I'll wait for staff to.

Woman: We have 14 votes and we're just waiting. 15 votes and we're just waiting on a couple more.

John Bulger: So we had (Helen) drop off. I know there were a couple of other beeps there. I don't know if we had - 15 out of 22 is still 68%, correct?

Woman: Voting is now closed for validity on Measure 3495. We have 14 votes - well, I'm sorry, we have zero votes for high, 14 votes for moderate, three votes for low and zero votes for insufficient. This measure passes on validity.

John Bulger: Thank you. All right, I'll pass it over to Christy.

Christy Howell: Well, thank you John and I appreciate it. So my next criterion is feasibility and let me just kind of outline quickly what we're supposed to be focused on in this criteria and to the extent to which the specifications including measure logic require data that are readily available or could be captured without undo burden and can be implemented for performance measurements.

And so that's really the area that we're focused on. (Pam), I didn't know if you had any opening comments.

Pamela Robert: Most of their comments were that these are claims data, so it's feasible. There was one comment that it's expensive, it's measured on provided data is a concern, but the majority do not have concerns.

Christy Howell: Thank you. I think there was a question earlier today about whether or not all this information is captured on these claims. You know, hopefully we stated that correctly. But does the developer want to address that question?

Lisa Suter: This is Lisa Suter. I apologize. Could you help me understand what question you need me to address?

Christy Howell: Well, there was a question earlier about whether or not the information…

Lisa Suter: All right.

Zeyno Nixon: Sure. And I can - this is Zeyno Nixon, I can step in. I don't have wide exposure to different claims data in regards to Medicare and commercial. But my background is in Medicaid. I represented Medicaid agency. And as far as our claims data is considered, we require providers to submit filling provider information. But all the other provider information is optional. And I'm just thinking implementing this measure from - for that reason will be difficult for us. But I don't know if it is also the case for Medicare or commercial carriers.

Lisa Suter: Thank you for repeating your question, yes. Medicare data is very different than Medicaid data. It is much more consistently submitted. And in addition, the data that we are using is pools from a number of sources. So all the risk variable data is inpatient data from the 12 months prior to the hospitalization. So we have both history data as well as data at the actual time of the index hospitalization.

In addition, hospitals submit data in addition to clinicians that bill Medicare. So we have backup data from hospitals if in certain fix or consensus which is highly unlikely. We do not have clinician level data. The attribution and the algorithms for attributing to those three clinician groups were actually preferentially selected by our technical expert panel, because they are physician submitted primarily defined using physician or a clinician submitted billing claim. So we have a very, very low rate of missing data for this measure.

Christy Howell: Thank you, sure.

((Crosstalk))

Woman: I have a question regarding, you know, the clinician groups that will be measured. Do the clinician groups have access to claims data with respect to attribution specifically? And then if the patient is for example readmitted to another facility, if it's not their facility, because I know this is often an important issue with acute care you don't know about attribution and how much later. And then obviously if the patient goes elsewhere within three days, you may or may not know.

Lisa Suter: Right. So clinicians do not know ahead of time who is being attributed to them that will be very hard to anticipate. But for participating clinicians in the MIPS program do get report that delineate their measure results and the patients and the events that go towards calculating those measure results. So they do have transparency and can look and understand and there are appeals processes if they have concerns.

Woman: Thank you.

Leslie Kelly Hall: This is Leslie Kelly Hall. I have another question related to that. So we always talk about the ease with which the data can come and reside the claims data as a great way to do that. But the second part of your question, you rarely talked about which is the ease of the burden with which the operational improvement can happen with access to data. And I think the earlier speaker mentioned the fact that the data is often not available and it - and admit might not even be known to a provider.

So that second part of the question that you asked, how does this - how do we evaluate it towards that second part of the question and are they always conflated?

Lisa Suter: So this is Lisa Suter. I don't know that we have anyone from CMS on the call. This is somewhat of an implementation question for a measure such as this. But as I mentioned before, CMS has a process for all of their measure programs where they see data back to participants in those programs that the intention of feeding that data back is so that the measure entities can understand how they're being measured, what their performance is relative to the nation or the state and their colleagues. It helps them understand the cases that went towards their measure result as well as the outcome events that went towards their measure results.

This allows them information to understand where quality improvement activities might be direct to board. And, you know, this is a primary component in all of CMS's measurement programs, not just MIPS.

Leslie Kelly Hall: Thank you. I understood the data collection. It will be operational improvement access across multiple settings of care. That's okay. I think you answered it. Thank you.

Christy Howell: Thank you Leslie. Any final questions or comments about feasibility? Okay. Not hearing any, I think we can move on to vote.

Woman: Voting is now open for feasibility on Measure 3495. Options are A for High, B for Moderate, C for Low and D for Insufficient.

Christy Howell: How many more are we waiting for?

Woman: I think we're just waiting for one more. We have 15 votes in right now.

Christy Howell: Okay, because I'm beginning to hear some beeps and I know we have one more staff that we need to get through. So if you all can stay on the phone until the top of the hour, we'll be through then.

Woman: Voting is now closed for feasibility on Measure 3495. We have seven votes for high, seven votes for moderate, one vote for low and one vote for insufficient. This measure passes on feasibility.

Christy Howell: All right. Thank you so much. And I'll pass it back to John.

John Bulger: Great, thanks Christy. So the last criteria is usability and use. You know, this is the extent to which the audience use or could use performance results for both accountability and performance improvement activities. As this is noted before, that's not separated as part of this, as part of use, you know, it's approved for both of those things. And then usability is to evaluate to the extent that which audience is use or could use performance results for the same thing, for the performance improvement or accountability. So comments from the discussions first?

Woman: Most of the comments were okay. There were some questions on how the measure is being reported publicly and there is just some - there seem to be some uncertainty with how it will be used and if it was being used already even though you talked about that. We might have covered some of this.

John Bulger: Yes. And I think we clarified that. I have one question, is there any - from, you know, the developers in the beginning talked about the fact that it's currently used and then they talked about this being used at the group level with a - and there was discussion about a minimum number of cases. Is that envisioned as part of the measure or not?

Lisa Suter: This is Lisa Suter from the developer. So two things, one is this measure was publicly presented to NQF Measures Application Partnership in December and advanced for use in the MIPS program at ask - assume - conditional upon NQF endorsements. And as we noted before, it is - this measure is intended to replace the measure that is already being used in the MIPS program. And yes, I think you can vote for the measure being used at a clinician group level with a minimum case volume of 200 cases.

John Bulger: Thank you.

Woman: Thank you.

John Bulger: Are there - we got other questions?

Woman 6: Hi, this is (Savannah). This question was kind of on earlier around the 23-hour admissions and I understand that - I mean the 23-hour observations and I know that the comment was made, it wasn't part of the readmission - unclaimed readmission. But thinking about like the usability and alignment to other measures in like similar measures, was there any discussion around why they wouldn't include the 23-hour admissions in the unclaimed admissions?

Lisa Suter: So it's a great question. This is Lisa Suter again. So there are - you said there - as you noted, there are related measures. So there is an outpatient measure that looks at a complex clinical core morbidity population with multiple complex product condition and they have an admission measure. That admission measure I believe also looks at inpatient only readmissions or admissions.

If there is an inpatient admission, I believe that excludes readmissions that occur within a period of time after discharge, because the assumption is that

the inpatient setting clinicians and hospital has an impact on that readmission and so it's moved out of this sort of outpatient population health measure to the extent that's possible our measures are aligned. The technical expert panel was made aware of the related measures and the decision was to move forward this measure as it's defined, because the other measure isn't currently - I don't believe used in the MIPS program, but this particular measure is in the MIPS program and there was some urgency to revise this measure to make it more addressable to stakeholder concerns.

In terms of the ED hub issue, CMS does have a number of measures that look at this phenomenon. They have a measure of the excess days in acute care that is complementary. It's at the hospital level that it's complementary to the readmission measures by categorizing the days that patients come back into the inpatient setting whether it's an emergency department and observation state or a readmission. At that - at this point, those measures are not attributed to the clinician level, but it does address your concern by capturing these other events. I don't know (Karen), if you want to add anything else on.

(Karen): And those are condition specific measures. There has not been an attempt to create a hospital wide measure using that kind of a composite outcome. There is a lot statistical methodological hurdles to doing so, but they do exist at the condition level. And when we've looked in the past at the relationship between readmission ops and ED, you know, there has been some stakeholder concern of excluding ops and ED. We're not really characterizing post-hospital utilization that we're trying to get, you know, maybe negative experience with patients.

But we've found that with and without consideration of the trends in ED and ops, we don't - it doesn't really have an impact on the characterization of

hospitals as high or low performing on readmission. So we've looked at that in past as using our measures.

John Bulger: Thank you. So we have a couple of minutes left here. Do we have any other questions on usability and use?

Sheila Roman: This is Sheila Roman. And, you know, I don't want to be a book on record. But I think that this measure is a great quality improvement measure. I have personal uncertainties whether it meets the bar of value-based purchasing in the MIPS program. And I would ask the developer to respond to that.

Matthew Pickering: So I just want to - I wanted to just chime in if - we have like one minute until three. If those committee members can stay on for a couple of minutes just so that we can potentially wrap this up.

(Karen): Yes, I would just say that I understand those concerns. I don't want to press them aside or negate them, but I want to say two things about. The first is that this is already a measure that's used with, you know, what most stake - in the program with what most stakeholders feel is less appropriate attribution strategy. So this is an improvement of an already used measure. So to the extent that you're thinking about whether this measure is probably a more reliable and valid alternative is one issue.

The other issue is that, you know, NQF and, you know, I don't need to speak for staff, but just to describe our understanding, sort of divide into the responsible way of thinking about what's appropriate for value-based purchasing and what's a valid measure purposely so that the standing committee is responsible for ladder and the map is responsible for the former.

So to the extent that this - that standing committee talk about using this ability, they do not necessarily have to think about specific program applications that is something for the map and the map, it has considered that and has approved this measure for use with the same consideration that is actually replacing the existing measure with a more valid measure. Not that it is a new concept being introduced into that value-based purchasing program. So just submitting that for your consideration as you think about this visibility.

John Bulger: Great, thank you.

Matthew Pickering: So John, may I ask - this is Matt from NQF. May I ask the committee for those to stay on a couple of more minutes and ask if we vote on usability, vote on use and then we'll vote on the overall recommendation if those on the committee just stay - hang on for a couple of more minutes to see if we can get through this voting. I think there has been a lot of discussion around the use and usability component. So we can just vote on both of those back-to-back and then we'll go to the overall voting.

John Bulger: Great. Can you put the vote up for use please?

Woman: The voting is now open for use on Measure 3495. Options are A for Pass, B for No Pass. Voting is now closed for use on Measure 3495. We have 15 votes for pass, two votes for no pass. This measure passes on use.

John Bulger: Great. Can you put up the usability please?

Woman: Yes. Usability is now open. Options are A for High, B for Moderate, C for Low and D for Insufficient. Voting is now closed for usability. We have

three votes for high, 12 votes for moderate, two votes for low and zero for insufficient. This measure passes on usability.

John Bulger: Great, thank you. And can you put up the final vote please?

Woman: Voting is now open for overall suitability for endorsement. Options are A for Yes, B for No. Voting is now closed for overall suitability for endorsement. We have 16 votes for yes, one vote for no. This measure passes.

John Bulger: Great, thank you. So do you want to speak the next steps please?

Matthew Pickering: Yes, thank you John. I'm going to turn over to (Suzanne).

Suzanne Theberge: Great. Thank you everybody. So at this time we do open the lines for public comments. If the committee can just stay on for a couple of more minutes, we now want to see if any members of the public or NQF members that are on the phone wish to submit a comment either verbally or via the chat, we will pause now for that.

Matthew Pickering: Again. This is Matt from NQF. I just want - you also mentioned does anyone from the AMA on the line at all to submit a comment? Okay.

John Bulger: Okay, thank you.

Suzanne Theberge: All right. Hearing no comments, we will just - thanks everybody for participating today and I will turn it over to (Oroma) for the next step.

(Oroma): All right, thank you. This is (Oroma) speaking. Thank you everyone for your time and your commitment and most importantly your attendance today. So a few next steps, steps (unintelligible 01:03:28) this call the project team will

distributing a recording, a transcript and a meeting summary for this call, all of that will be at SharePoint and email.

After that we will be preparing for the draft report comment period which will take place post the comment which will close on April 16. And then following that we have the committee post-comment web meeting on April 28.

A reminder that there are several ways to reach us if you have any questions or concerns, please reach our project page, readmissions@qualityforum.org or by telephone. You can also access our project page for all information that's up-to-date as well as SharePoint site where the materials are (unintelligible).

Again, we really thank you for your time today. Are there any last questions before we close the call?

Teri Sholder: This is Teri Sholder. I was just wondering if - there is a lot of people bending off the call, there is lots of beeps while you were discussing the next steps. Is there any chance that you can just email us a bulleted list of next steps so that we can…

((Crosstalk))

(Oroma): Absolutely.

Teri Sholder: Thank you.

(Oroma): Actually what we'll do to combine the next steps with the information about the call, so recording, transcript, all of that. We'll try to (unintelligible) all of that as one. So if there are any other questions, please share them now.

John Bulger: Thank you everybody. We appreciate your time and patients.

(Group): Thank you.

Matthew Pickering: Yes, thank you all so much. Have a great rest of the week.

(Group): Thank you, bye-bye.

END