National Quality Forum
All-Cause Admissions and Readmissions Standing Committee
Friday, June 24, 2022

The Committee met via Video Teleconference, at 1:00 p.m. EDT, Chloe Slocum and Amy O'Linn, Co-Chairs, presiding.

Present:

Amy O'linn, DO, FHM, FACP, Co-Chair
Edward Davidson, PharmD, MPH, FASCP, InsightTherapeutics
Lisa Freeman, Connecticut Center for PatientSafety
Dheeraj Mahajan, MD, MBA, MPH, FACP, ChicagoInternal Medicine Practice and Research
Sonya Pease, MD, MBA, Cleveland Clinic Florida
Gaither Pennington, RN, BSN, Bravado Health
Rebecca Perez, MSN, RN, CCM, Case ManagementSociety of America
Sheila Roman, MD, MPH, Johns Hopkins MedicalInstitutions
Teri Sholder, RN, BSN, MHA, CPHQ, CPC, BayCareHealth System
Lalita Thompson, MSN, RN, CRRN, TIRR Memorial Hermann
Cristie Travis, MSHHA, Memphis Business Group on Health
Milli West, MBA, CPHQ, Intermountain Healthcare

NQF Staff:

Leeann White, Director
Nadia Angelidou
Matilda Epstein
Matt Pickering
Victoria Quinones
Isaac Sakyi
Tristan Wind

Also Present:

Marsida Domi, AHCA
David Gifford, AHCA
Janine Savage, Net Health
Kiran Sreenivas, AHCA

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## Proceedings

(1:01 p.m.)

### Welcome and Review of Meeting Objectives

Ms. White: Okay, I have 1:01 p.m. Eastern Time and so we will go ahead and get started. Greetings and good afternoon, everyone, it is Friday and it is our Spring 2022 All-cause Admissions and Readmissions Measure Evaluation Meeting.

I welcome you to our call today, my name is Leeann White and I am the Director supporting this project team for the cycle. I'd like to start off by first thanking everyone for your time and participation.

I do understand it's a significant amount of time to review the measures and prepare for today's review. I'd also like to extend a thank you to our developers for being on the call today.

We recognize there is a significant time and effort that goes into the testing, the preparation of the materials and the measure submission. So, we definitely want to highlight those efforts and thank them for their time as well.

Lastly, I want to extend my continued appreciation for your patience and understanding as we continue to meet virtually in the pandemic.

I do understand there are challenges that accompany virtual meetings and I do look forward to that time when we can reconvene in person.

However, in the meantime, we will do our best to bridge those gaps in their virtual world and I do appreciate your understanding and thanks for your continued support.

I'm going to hand it over to our esteemed Co-Chair Dr. Amy O'Linn.

Dr. Chloe Slocum, she had an unexpected

commitment that came up today so unfortunately she will not be joining us but we do have Dr. Amy O'Linn as our Co-Chair today and we will do our best to support her.

I'm going to hand it over to Amy.

Co-Chair O'Linn: Thank you, Leeann and thank you to the Committee Members of the All-cause Admissions and Readmissions Committee here for NQF.

Thank you for representing the prospectives of patients, hospitals, healthcare networks, nurses and APPs, physicians and nonprofit organizations.

Your perspectives are unique and we value your input. As Leeann just said, your time is valuable as well and we appreciate the time it took to review the measures and to the discussant leadership when they review the next two measures.

And finally, clarifying questions can help so many so please don't hesitate to ask questions or raise a comment. Thank you for joining us today. Leeann back to you?

Ms. White: Thank you, Amy, so again, virtual world, give us just a brief moment, we'll pull up the slides here and we'll get to our housekeeping slides.

So, Victoria, if you can go to our housekeeping slide I'll take a brief moment to quickly review those housekeeping reminders.

Thank you so much. As most of you know, we are using the WebEx platform today to host the meeting. If you're having any technical difficulties, please let us know.

You can directly message our team in the chat, we have NQF next to our name in the participants list so please feel free to reach out to us and let us know if you're having any audio or video issues. We're here to help.

You can also contact us for any issues or just to communicate with our project inbox. So, our project inbox is readmissions@qualityforum.org. We'll make sure to monitor that as well throughout the meeting.

In the spirit of engagement and collaboration, I do encourage us all to use our video, it just helps us see each other's faces and again, bridges some of those virtual gaps that I was talking about.

If you're not actively speaking, we do ask that you place yourself on mute, it just helps us minimize some background noise and interruption. You can do this by clicking on the microphone at the bottom of your screen.

Pressing it once will mute you and then you can unmute by pressing again. We also encourage you to use the hand-raises function, you can do that by finding your name in the participants list and then a raised-hand icon will appear.

So, to raise your hand you click on that icon and then take your hand down and click on that again. We will be monitoring the raised-hand feature throughout our call today.

We also do encourage you to use the chat but also to verbally speak up during the call. We definitely want this to be an engaging time for us all.

Once we begin our meeting, our senior Director Matt Pickering will go through roll call and review of disclosures if interest.

It's important to note that we are a voting body and therefore need to establish a quorum to vote on our meeting today. So, our voting quorum is 14. To hold the call, we do require and attendance of 10.

If you do need to step away from the call, we ask you send the NQF team a direct message prior to your departure and then when you return so we're

aware of the attendance and we can keep track of quorum.

Next slide, please. This is where we're going to introduce our hardworking project team here. Again, I'm Leeann White, I'm the Director supporting this project team.

Pictured here is Isaac Sakyi, our manager, Tristan Wind, our analyst, Matilda Epstein, our associate, and our senior directors are Poonam Bal and we have Matt Pickering also on the line supporting our team today.

Our Project Manager is Victoria Quinones and then our consultant is Dr. Taroon Nameen. Here is our team. Next slide, please. I'm going to touch on a couple of agenda items today that we have listed here and that we'll be covering today.

We'll begin by conducted that roll call and disclosures of interest which is very important. We need to make sure that we have that completed prior to the call. This is where we'll take attendance and establish quorum.

We did send out a measure-specific disclosure of interest form to each of the Standing Committee Members prior to the call. We do need to receive this form and have that completed and reviewed to review any potential conflict of interest.

If we do not receive this form from you, unfortunately, you will not be able to participate in the discussions or the voting. If you are outstanding in MSBOI, we do have that ready to send to you via email and we will send that to you on the call today.

So, we do ask you do complete that and then send that back to us in a prompt manner. After we complete our disclosures of interest, Isaac will provide an overview of our evaluation and voting process.

Tristan will conduct a voting test and you should have received a Poll Everywhere link in your email right before 11:00 a.m.

Again, this will be used if we establish a minimum of 14 Standing Committee Members on the call today. If we do not achieve the quorum for voting, then I will definitely discuss our option to conduct voting.

So, after the voting test we'll do a brief introduction of our measures and review and then hand the baton over to our Co-Chairs to facilitate that discussion.

Within that discussion, we will discuss each criterion and vote on each criterion. We also want to notify you that NQF has designated a timeframe for developers to respond to questions and provide clarifications.

The Co-Chairs and Staff will collect those questions, whether verbally during the Standing Committee discussions or if they're placed in chat we will collect those.

And then prior to the vote, we will go ahead and open up the floor so that the developer can answer any outstanding questions or concerns that the Standing Committee had.

For the measure discussion, following the measure discussion we'll review our related and competing measures, we'll then host an opportunity for NQF Member and public commenting and then Tristan will wrap us up with our next steps and timelines.

Next slide, please.

So, here I will hand it over to Matt Pickering who will conduct a roll call. Matt?

Introductions and Disclosures of Interest

Mr. Pickering: Thank you very much. Can you hear me okay, Leeann? I see your head nod. Great to see

everyone again in this virtual world. Thank you all very much for your time and commitment to our work.

It's very important work and we truly value all of your expertise and input and engagement during these activities. As Leeann mentioned, I'm here to do introductions and disclosures of interest.

So, again, I thank everyone for your time. We'll be combining the introductions with the disclosures of interest today. As Leeann mentioned, you received two disclosure of interest forms.

One is our annual form, it happens every year depending on what Standing Committee you reside on, and if you participate in NQF at all you get an annual disclosure of interest.

And the second one is pertaining to the measures under review for this current cycle. So, just talking about if we have anything to disclose related to the activities for that measure development or endorsement work.

In these forms we ask a number of questions about your professional activity. So, today we'll ask you to verbally disclose any of that information provided on either of those forms that you believe is relevant to this Committee's work.

We're especially interested in grants, research, or consulting related to the work undergoing this Committee. So, just a few reminders, you sit on this group as an individual.

You do not represent the interest of your employer or anyone who may have nominated you for this Committee. We are interested in any 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 you have a conflict of interest. We do verbal

disclosures in the spirit of openness and transparency. Now, I'll go around the virtual table so starting with our Committee Co-Chairs I'll ask for your name.

So, state your name, what organization you are with and if you have anything to disclose. If you do not have any disclosures, please just state I have nothing to disclose to keep the conversation moving.

If you have trouble unmuting yourself, please raise your hand so that one of our Staff can assist you with unmuting. I'll stop from the top and I know there are some individuals who are not here today.

So, just for the record we'll go ahead and call their names and see if they're present even though we know they're not. And I do apologize, as I go through the list of names, if I mispronounce your name in any way I do apologize so please forgive me.

So, starting at the top, Chloe Slocum, we know she's not here, Amy O'Linn?

Co-Chair O'Linn: Amy O'Linn, Cleveland Clinic and I'm a physician hospitalist and enterprise lead for reduction for the enterprise. Thanks.

Mr. Pickering: Do you have anything to disclose today?

Co-Chair O'Linn: No, I have nothing to disclose, thank you.

Mr. Pickering: John Bulger? Edward Davidson?

Member Davidson: Yes, Ed Davidson, faculty at Eastern Virginia Medical School, owner of Site Therapeutics Clinical Research Company, National Transitions of Care Coalition, and I have nothing to disclose.

Mr. Pickering: Thank you very much. Richard James

Dom Dera? Lisa Freeman? Kellie Goodson? Dinesh Kalra? Michelle Lin? Dheeraj Mahajan?

Member Mahajan: This is Raj Mahajan, I'm an physician internist and geriatrician out here in Chicagoland. No disclosures.

Mr. Pickering: Thank you, Raj. Jack Needleman? Janis Orlowski? Sonya Pease?

Member Pease: Good afternoon, I'm Sonya Pease, I'm serving as the Chief of Quality, Safety, and Patient Experience for the Cleveland Clinic, Florida region. I am an anesthesiologist and I have no disclosures.

Mr. Pickering: Thanks, Sonya. Gaither Pennington?

Member Pennington: Present, I am the data scientist for Bravado Health. I'm a clinical nurse and I have nothing to disclose.

Mr. Pickering: Thank you very much. Rebecca Perez?

Member Perez: Good afternoon, I'm Rebecca Perez, I'm the Senior Manager of Education for the Case Management Society of America and I have nothing to disclose.

Mr. Pickering: Thank you very much. Sheila Roman?

Member Roman: Good afternoon, everybody, I am an independent healthcare consultant and also part-time associate professor of medicine at Johns Hopkins University and I have nothing to disclose.

Mr. Pickering: Thank you so much, Sheila. Teri Sholder?

Member Sholder: Good afternoon, my name is Teri Sholder, I am Chief Quality Officer for Hopeful solutions Health Network and I have nothing to disclose.

Mr. Pickering: Thank you so much, Teri. Lalita Thompson?

Member Thompson: My name is Lalita Thompson and I'm a registered nurse. I'm a program coordinator at Terrman Morgan Herman Hospital and I have nothing to disclose.

Mr. Pickering: Cristie Travis?

Member Travis: I am Cristie Travis, I'm the CEO of the Memphis Business Blue Blood Health and I have nothing to disclose.

Mr. Pickering: Finally, Millie West?

Member West: Millie West, I'm the Systems Director of Quality in the Office of Patient Experience at Intermount Healthcare and I have nothing to disclose.

Mr. Pickering: Thank you, Millie, and I'm going to circle back, I think, Lisa Freeman, you're on? Are you able to chime in?

Member Freeman: I just unmuted myself. Yes, Lisa Freeman, I'm the Executive Director at the Connecticut Center for Patient Safety, a regional or local nonprofit and I have no conflicts to disclose.

Mr. Pickering: Thank you so much, Lisa.

Anyone else join late that was not recognized, I called your name but you weren't here? Anyone not speak up? That was Chloe, John, Richard, Kellie, Dinesh, Michelle, Jack, and Janis.

Any of you on the line?

We'll just keep moving forward so thank you all very much. I'd like to let you know that if you believe you might have a conflict of interests at anytime in the meeting as topics are discussed, please speak up.

You may do so in real time during the meeting or you can send a message to our chairs, our Chair today, which is Dr. Amy O'Linn, or to anyone on the NQF Staff and you can see our names at the very top there, it has NQF in brackets.

So, if you're not sure who you should send it to, you can send it to one of us. If you believe that a fellow Committee Member may have a conflict of interest or is behaving in a bias manner, you may point this out during the meeting.

You can send a message to the chair or you can send a message to the NQF Staff. Does anyone have any questions or anything they would like to discuss based on the disclosures made today? And so far, they weren't any disclosures.

Thank you again, and as a final reminder, NQF is a nonpartisan organization.

Out of mutual respect for each other, we kindly encourage each other that we make an effort to refrain from making comments, innuendos, or humor relating to, for example, race, gender politics, or topics that otherwise may be considered inappropriate during the meeting.

While we encourage discussions that are open, constructive, and collaborative, let's all be mindful of how our language and opinions may be perceived by others. With that, I will thank you all once again and turn it back to the team.

Leeann, I'll turn it back to you.

Ms. White: Thank you, Matt, and thank you everyone for your participation today. We did achieve quorum to host the call, we have 12 active participants on our call today, thank you so much for joining us.

We're able to go through the two measures under review but we did not achieve the 14 for voting

quorum. So, we will change up our process a little bit here. In our slides and in our agenda, we have a voting test.

We'll no longer conduct the voting test since we will not be voting live on the call after each criterion.

What we'll do is our team has taken the attendance down and they are momentarily going to send everyone on the call today and email that has a SurveyMonkey link attached to that email.

That will be the voting platform that we'll be using offline because we were not able to achieve that 14.

We welcome you if you would like to vote after each discussion of the criterion through that SurveyMonkey link, you can do so for those who are actively on the call today.

Following the meeting, we will also send out that same SurveyMonkey link to those that are not in attendance today along with an official transcript of the discussions. And then we'll have a due-back date within that email correspondence at that time.

So, you should see that following the measure evaluation meeting today. So, again, our team will be sending out an email here shortly with a SurveyMonkey link for the voting criterion for each measure.

You should receive that. If you do not receive that please let us know, you can directly message us in the chat or you can email us at readmissions@qualityforum.org and we'll get that to you.

Before we move forward, does anyone have any questions about the voting process? We are changing course a little bit right now. Hearing none, I'm going to turn it over to our manager Isaac Sakyi, who will go over our evaluation and voting process.

Isaac?

Overview of Evaluation Process and Voting Process

Mr. Sakyi: Thank you. I'll go over the evaluation process that will be followed today. Our Standing Committee Members act as a proxy for the NQF stakeholder membership.

They evaluated each measure against each criterion, and with that indicate the extent to which each criterion is met and the rationale for the rating.

They also respond to comments submitted during the public commenting period, make recommendations regarding the endorsement to the NQF membership, and oversee the portfolio of measures.

To go over some ground rules, we'd like to emphasize that this is a shared space and there is no renting the room. We encourage you to remain engaged in the discussion without distractions and hope you are prepared and have already reviewed the measures.

Please base your evaluation and recommendations on the measure evaluation criteria and guidance. Keep your comments concised and focused, be cognizant of others and make space for others to contribute to the conversation.

Next slide, please.

In terms of how the discussion will proceed, we'll start with an introduction of the measure by the measure developer.

The lead discussant will then briefly explain the information provided the developer on each criterion, followed by a brief summary of the pre-evaluation comments from the Committee, which will emphasize areas of concern or differences of opinion.

The lead discussants will also note preliminary ratings by NQF Staff, which is intended to be used as a guide to facilitate discussion. Developers will be available to respond to questions from the Standing Committee.

Afterwards, the full Standing Committee will discuss and under circumstances where we have quorum, vote on the criterion if needed and move on to the next criterion.

The following is a list of our endorsement criteria. Five areas that are outlined here, namely importance to measure and rapport, which includes evidence and performance gap, scientific acceptability, which include reliability and validity.

Please note the first two bullet points are a must-pass criteria. We also have feasibility, usability and use, and related and all competing measures.

The use of the subcriterion is a must-pass for maintenance measures. The next point of discussion is the comparison to related oral competing measures, which is a discussion and does not require a vote.

That discussion only takes place if the measure is recommended for endorsement. These are the criteria the measures are evaluated and voted on. Next slide, please.

During the time where we have quorum and there's live voting, if a measure fails in one of the must-pass criteria, there's no further discussion or voting on the subsequent criteria for that measure.

The community discussion will move on to the next measure if applicable.

If consensus is not reached on a criterion, the discussion will continue to the next criterion but ultimately, there will not be a vote on the overall suitability for endorsement.

As far as achieving consensus, quorum is 66 percent of active Standing Committee Members and that is 14 out of the 20 active Committee Members for this project.

We need greater than 60 percent yes votes to pass a criterion or recommend a measure for endorsement. Yes votes are a total of high and moderate votes. 40 to 60 percent of Committee Members voting yes will be consensus not reached.

A less than 40 percent vote of yes means the criterion does not pass or the measure is not recommend depending on what we're voting on. The consensus not reached criteria and the vote on the overall suitability for endorsement would be postponed should a CNR take place.

If a measure is not recommend, it will also move on to the public and NQF Member comment but the Committee will not re-vote on the measure during the post-comment meeting unless the Standing Committee decides to reconsider based on the submitted comments or if a developer submits a reconsideration request.

As mentioned before, please let us know if you need to step out of the meeting.

We need 50 percent of the Standing Committee Members on the call to continue the discussion and in a moment where we have quorum, should we lose quorum at any point in time, we would be sending an offline survey, which is the scenario for today's meeting.

So, an email will be sent out shortly containing the standard voting survey link for voting to take place offline. Next slide, please. At this moment, I want to pause to see if there are any questions.

If there are none, I will turn it over to Leeann.

## Measures Under Review

### 2827 PointRight Pro Long Stay Hospitalization Measure (American Health Care Association/PointRight Inc.)

Ms. White: Isaac, next slide, please. We will go ahead and start our measures under review. The product team received two maintenance measures for the Spring 2022 cycle. Next slide, please.

The two measures we received for review is 2827, PointRight Pro Long Stay Hospitalization Measure. And 2375, PointRight Pro 30. The measure steward is American Healthcare Association and the developer is PointRight.

Next slide, please. Both measures were reviewed by the Scientific Methods Panel for the Spring 2022 cycle but I'd like to take a moment to describe the Scientific Methods Panel and their role as part of the measure review process.

The Scientific Methods Panel is a group of researchers, experts, and methodologists in healthcare quality and quality measurement. The panel reviews complex measures and provides comments and concerns to the developer.

The developer has the opportunity to then provide further clarification and update their measure submission before the Standing Committee evaluation. Again, I reiterate, there was no measures that were reviewed by the SMP.

Next slide, please. With that, we'll begin the review of our first measure. I do want to remind everyone on the call today that the measure evaluation materials are attached to your invite and were sent also in email.

We sent out the measure evaluation worksheets that include the NQF Member and public comments as well as the Standing Committee feedback during

the pre-evaluation phase.

So, please let us know if you need us to resend those. They will be located in your meeting invite.

Our Co-Chair, Dr. Amy O'Lin, will start by introducing the measure today and the developer will have an opportunity to provide a brief three to five minute overview of their measure.

Our lead discussants will introduce the criterion and highlight their main takeaways. Our supporting discussants will then respond to the lead discussants and add their own insights as well.

During the criterion discussion, Dr. O'Lin will collect questions for the developer. Once the initial discussion on the criterion is complete, the Co-Chair will ask the developer to respond to questions and clarify any information. Once the Standing Committee has completed its discussion, we will move on to the next criterion and the voting will take place offline via the SurveyMonkey link.

Our first measure that we will be reviewing today is 2827 PointRight Pro Long Stay Hospitalization Measure and this is a maintenance measure. The measure steward is American Healthcare Association and the developer is PointRight.

The brief description of the measure is on your screen today.

The PointRight Pro Long Stay Hospitalization Measure is a minimum data set-based risk-adjusted measure of the rate of hospitalizations of long-stay patients, also known as residents, skilled nursing facilities, average across the year weighted by the number of stays in each quarter.

I will now hand it over to our Co-Chair Dr. Amy O'Lin to lead us in the discussions of Measure 2827. Amy?

Co-Chair O'Linn: Thank you so much. This is the

PointRight Pro Long Stay Hospitalization Measure, 2827 as mentioned.

This is looking at the long-term care patients in our skilled nursing facilities looking at the rate of hospitalization averaged across the year and weighted by the number of stays in each quarter which accounts for heavy viral seasons or other reasons why people go to the hospital a lot.

Let me first introduce our patient advisors on the call, this is going to be three for the Committee but two that are represented today are the patient advisor groups who are looking at the measures through the lens of the patient and their family.

And I'm hoping that Dr. Sonya Pease or Lisa Freeman can help frame the discussion on 2827 with a comment about how the patients or families would be affected by this measure.

Member Pease: This is Sonya Pease, you can hear me? From the patient perspective I think this is a good measure in the sense that we want to make sure we're getting the right care in whatever setting we're getting that care.

And so ensuring that we're getting the appropriate care in the skilled nursing facility is certainly as valid as making sure we're getting the appropriate care in the hospital.

I think this measure, it meets a lot of the goals that we as patients would want in making sure that we're doing the preventative things to prevent complication so that we don't have a space that extends too long or have things that require us to go back to an acute care setting.

I think from a patient perspective, this is a very valuable measure.

Co-Chair O'Linn: Thank you so much, Dr. Pease. Any comment from Ms. Freeman?

Member Freeman: Yes, I do actually. I think that from patient perspectives, being cared for in a skilled nursing facility long-term residence is a very frightening prospect and there are a lot of health issues about you're now in a community.

So, you are subject, as we saw during the height of the COVID-19 pandemic, these were the facilities that were hit the hardest, and there's a reason why.

So, I think that measuring admissions into hospitals points out that it's not that something went wrong but maybe that something could have gone better.

So, if this information is available to patients, which I don't see anywhere in the information that it is, but if it should be and can be then it helps patients to differentiate perhaps one nursing home from another.

And it certainly highlights the people involved in the running of them where there might be areas that they need to attend to, why are people going into the hospital from their homes?

Because there are certain problems that are directly related to some of certain hospital admissions.

So, I just want to say I think this is a very valuable measure and it also points out the disparity in care between certain populations and things like that, that we need to focus on and give attention to.

Yes, thank you for letting me speak and I'm glad it's included.

Co-Chair O'Linn: Thank you so much for your comments both. Let's turn now to Kiran Sreenivas, who will present an overview of the measure.

Mr. Sreenivas: Thank you for those perspectives as well. It's always important to keep the patients in mind, that's the reason we do this work. So, my name is Kiran Sreenivas, I'm with the American Healthcare Association, also known as ATA.

Two of my colleagues are actually also on the call, Marsida Domi and David Gifford. For those who don't know, ATA is a trade association and we represent approximately 10,000 to 15,000 nursing homes in the nation.

Given that we represent two-thirds, though, we see that our work needs it for the whole industry, not just our members.

And case in point, for these measures the data that we produce every quarter for these, we actually publicly release the raw data on our website. You don't have to be a member to get the data, you don't have to even create an account.

And we've done this since this initial endorsement.

We have a mission as an organization to improve the lives by the living solutions for quality care and both of the measures before you reflect us trying to continually live that mission.

We pursue this measure because we saw this as a solution to reduce preventable hospitalizations that can improve the lives of residents within the nursing home.

As you know, hospitalizations are risky and potentially traumatic events for frail or elderly patients previously associated with decline in independent functions, delirium, cognitive decline.

This puts nursing home residents at risk for new pressure ulcers and hospital-acquired infection. As the old saying goes, if you want to go fast go alone but if you want to go far, go together and go with others.

And this is a great example of that I believe. Something that we've been really trying to go from with it, from initial endorsement to reendorsement.

I'm thrilled in our application we reported out that we had both of these measures used in the state

Medicaid evaluation purchasing programs which help align financial and clinical incentives to improve lives.

We also have a great partner in PointRight. It's an analytics company that is in the post-acute care space.

PointRight has a relatively new parent company, Met Health so I apologize if there's some confusion when reviewing the application of EC Net Health, mentioned alongside PointRight.

They're essentially one and the same. We have two people from Net Health with us today, Nadia and Janine, and I think the other partner is really the NQF and the Standing Committee and providing that throughout the endorsement process.

And we've done the STS Trial and other things. The NQF Committee has helped us examined our measures and really make it the best that it is so I'm really looking forward to the discussion today.

Let's talk a little bit specifically about the prolonged-stay measures that were here which is what I'll first we'll talk about. We're doing this application with no real changes in a risk-adjustment model or measures.

Our application mainly contains updated information on trends, validity, testing, and use and usability. And I think there's an elephant in the room when we put that out there because it's COVID-19.

COVID-19 happened in between. I want to take a minute to talk about that. In light of this COVID-19 pandemic, which started in 2020, the decision not to include any COVID-19 risk adjustment wasn't something we took lightly.

We look forward to really hearing the Committee's thoughts and views on this. Ultimately, we believe it is too early and possibly unhelpful to add COVID-19

diagnosis to the risk adjustment model.

For most of 2020, nursing homes had to manage a spectrum of regulatory directives and clinical guidelines to manage COVID-19 case surges that prevent hospital overcrowding.

So, hospital discharges and admission processes vary unevenly in such a way that we now believe we can accurately assess the benefits of adding COVID-19 to the risk model.

Additionally, most of the underlying conditions that exacerbate the effects of COVID-19 and increase the likelihood of hospitalization such as COPD, heart failure, diabetes, they are being included in the risk adjustment model.

We're not really sure how much is to be gained by including COVID-19 in the model and furthermore, the vaccination and anti-viral treatments picking up, we're seeing hospitalization rates and deaths decline precipitously.

With these rates less than those associated with influenza, it is not clear to us about COVID-19 now or in the future is appropriate.

We don't adjust for other respiratory pathogens that increase hospitalizations each winter.

Let me close with a couple of thoughts on validity testing and use. Regarding validity, we continue to see the measure prolonged stay be associated with five-star ratings and other measures such as pressure ulcers and urinary tract infections.

Regarding use, there's no other NQF endorsed long-stay hospitalization measure. We do know that in between CMS has released a Medicare fee-for-service claim space measure. They use this on Care Compare and they use this on the five-star ratings.

And while our measure is specifically significant, has a significant association with that measure, we do

think it's important that it still remains alongside this other measure.

And mainly because that distinction between using what the data source is, our measure is based on minimum data set assessments, NDS for short.

The beauty of using NDS is that it is no extra burden for providers if they complete this regardless of the measure because they're regulatory requirements and they represent all payers, not just Medicare fee for service.

Because it's all-payer, that's why we believe you see Medicaid APP programs such as New Mexico and Colorado adopting it. We also see managed care organizations have gravitated towards using our measure.

Let me end there. Thanks, everyone, again for taking the time the time out to be part of this process. I'm looking forward to the discussion and my colleagues and I are happy to answer any questions at any point in time.

Member Sholder: Hi, Kiran, this is Teri Sholder. I do have a clarifying question about the risk adjustment with this metric.

Since it's a long-term resident, is the risk based on their existing MDS or is it based on the MDS that's done upon admission to the Smith?

Mr. Sreenivas: It's done on their existing MDS.

Co-Chair O'Linn: Let's also bring that question up again, Teri, I love that you brought that up right off the bat when it comes to validity down the road with our discussion if that's okay.

Thank you so much. Let's begin with our lead discussants then. I do believe Dr. Dom Dera is unable to be here this afternoon?

Member Freeman: Amy, can I interrupt for one

second? This is Lisa Freeman. As a patient, when I go through the paperwork, I have to look up all these acronyms to get through it.

Can I request that when we're having our conversations here for those of us who are not always speaking in acronym language that they be identified as what they represent?

Co-Chair O'Linn: That's a good point. I can hardly keep track of them myself.

Mr. Sreenivas: Sorry about that.

Member Freeman: It's okay, everybody does it, it's just that I get lost.

Co-Chair O'Linn: Good point. So, if you hear an acronym, we could raise some flag to say we don't know. We could also chat it. I bet somebody might know in the chat if the conversation is moving.

But great point, Lisa, thank you for bringing that up. Dr. Dom Dera is not with us this afternoon. Is there any chance that our other discussants being Dr. Sonya Pease or Lisa Freeman can start the discussion on this measure?

Member Pease: Yes, I'm happy to. Since this is a maintenance measure, I think in terms of looking at the evidence of how this measure came to be, I think the evidence strongly supports having this measure.

I think clearly, when you go through the different sections here and the gap in care and the opportunities for improvement, I think these are all very valid points and I had a couple of clarifying questions myself but I don't know if that's going to be out of order in terms of some of the discussion that we probably want to have around COVID-19 risk stratification as well as some of the exemptions.

Co-Chair O'Linn: Right, Leeann should we go through Criteria 1, the evidence, and then collate

our questions and ask all the questions at the same time, Leeann?

Ms. White: That's a great question. So, we'll proceed with the normal flow, we just won't be voting between each criterion.

We'll start with evidence first and have the evidence discussion and highlight what the developers submitted for the evidence and then any highlights, takeaways with evidence. And those questions that we gather will open the floor up to the developer to address those if need be after Standing Committee discussion and then we'll move to GAP.

And so we'll do the same sequence of events across throughout all the criteria.

Co-Chair O'Linn: Any questions that come up, Dr. Pease has some questions and I know other questions will come up. Do we earmark them for after the evidence is presented?

Ms. White: Yes, exactly, so Teri's question with the validity, we'll capture that and then we'll bring that up during our discussion on validity when we review the threats to validity.

We'll gather those questions so if we can focus on evidence first and present the highlights of the evidence that the developer submitted for 2827?

If there is any questions that come from the Standing Committee that the developer needs to address, we'll pause there and allow them to focus on just the evidence criterion and then we'll move to performance gap.

Mr. Pickering: Like Leeann was saying, the Committee can ask all the questions related to evidence. Sonya, if you have questions related to evidence, Amy will capture those.

And then once all the questions are captured related to evidence, Amy will then go to the developer to

answer those questions.

And then if there's no other questions from there from the Committee related to evidence, we'll go to -- we won't be voting today but you'll move to the next criterion after that.

Member Pease: The only question I had around evidence was when you got to the logic model, the logic model is a little bit different than the Pro30 because the logic model also now includes the use of anti-psychotics.

I was wondering is there evidence around that that supports adding that to this logic model?

Co-Chair O'Linn: Let's put that in our discussion question as we go through the evidence. Regarding reliability, I believe, is that the first one we talked about? No, the evidence, anything on the evidence we have to talk about right now?

Should we go related to the questions later?

Ms. White: If the Standing Committee doesn't have any further highlights or takeaways, they would like to discuss among themselves then we can open the floor up to the developer to address the question related to the logic model.

And I just want to preface that the developer, and this is in the preliminary analysis in the measure worksheet, the developer attests that the underlying evidence for the measure has not changed since the last NQF endorsement review.

And so the evidence has been unchanged and so we can discuss if the Committee raised that the basis for this measure has not changed and that we don't have to have a repeat discussion but we can ask those questions to the developer.

Mr. Sreenivas: This is Kiran, do you want me to chime in about the use?

Ms. White: Absolutely, that would be great, thank you.

Mr. Sreenivas: There have been studies that have shown the anti-psychotic use over time increases risk of hospitalization and so that's one of the rationale for including it in the model.

Co-Chair O'Linn: Any other questions on the evidence? If that's the case, do we move on to --

Ms. White: We'll move on to performance gap. Co-Chair O'Linn: Great, thank you. Does Lisa or Dr. Pease want to comment on the performance gap?

Member Freeman: I'll be happy to, this is Lisa. I think what's been presented to us is that a couple points were made and one is that the national average of hospitalization rate has increased by 6.5 percent.

And it went from 14.7 percent and 14.8 percent to -- I lost my place. The bottom line is it increased by 6.5 percent.

When they referred to the disparities, the finding was that facilities that were located in the lower SEI counties had a lower risk-adjusted long-stay hospitalization rate.

And the difference in average readmission rates between facilities with low SVI and high SVI counties, and I'm trying to find where I defined SVI.

That might be one that I couldn't figure out so if somebody could tell me what SVI stands for I'd appreciate that.

I got the gist of it but I'd like to know.

Co-Chair O'Linn: The CVC's social vulnerability index.

Member Freeman: I took it to be that. But the difference in the average readmission rate between

facilities with low and high SVI decreased over time which I think is a good thing but it's still there.

There is a difference and the usage is different but it reflects a need for this kind of a measure so that we can stay on it and watch it. And I guess that's what I basically took out of that.

Ms. White: Thank you so much, Lisa. Do we have any questions about the gap in care, the opportunities for improvement and disparities?

Co-Chair O'Linn: I was wondering why would the difference in the average readmission rates between facilities with low and high SVI counties decrease over time, is that because of them getting the data from the PointRight Pro so they understand where they are compared to everybody else?

I wasn't sure how to explain that.

Mr. Sreenivas: It's a great question and honestly I don't have answers to it. I'm not really sure what's driving that change for that specific population.

Co-Chair O'Linn: Go ahead, Lisa, what were you going to say?

Member Freeman: I was going to say that I think that this is what's needed to improve care because we absolutely can't fix what we don't know.

And I think that a lot of people were looking at all the disparities through many different measures across the board.

So, it could be that to your question I was thinking about that also and I think that we are addressing certain issues, we're focusing on certain kinds of infections, healthcare-acquired infections, things of that nature.

So, in some way, we might be closing the gap a little bit. It would be interesting to see what factors are actually influencing it specifically but in my mind

as a patient, I'm just glad to see that it's happening.

Co-Chair O'Linn: Excellent point, thank you, it's reassuring despite the lack of figuring out how or why that's happening. Shall we move on to Criteria 2?

Ms. White: Amy, would you like me to also summarize the performance gap that the team put down in the preliminary analysis to address? We did have preliminary rating of moderate for GAP.

So, I just wanted to highlight that. The developer did highlight it provided rehospitalization statistics for the skilled nursing facilities nationally for the two most recent quarters.

So, that would be Quarter 4 of 2019 and 2020. So, for 2019 and 2020, the risk-adjusted mean rate was 14.7 percent and 14.8 percent respectively between those two quarters, 2019 and 2020.

And so the developer also did provide rehospitalization rates from the American Healthcare Association Member facilities as well. And I know that Lisa did touch on the rate did increase by 6.5 percent.

I also want to note that in the Committee pre-evaluation comments there were no concerns raised regarding the gap in care and also the opportunities for improvement and disparities.

I just wanted to highlight that the pre-evaluation comments from the Committee, there were no concerns raised.

Co-Chair O'Linn: Thank you so much, Leeann.

Ms. White: So, if we have no further questions from the developer and we can take a brief pause here, then we can move on to our next criterion, which will be the testing portion, the scientific acceptability and we'll move on to the reliability section.

But we can pause here to see if anyone has any questions that they would like to pose to the developer before moving on. Hearing none, we'll move on to the reliability section.

I would be happy to review the testing that was done if need be or I can definitely hand that back over.

Co-Chair O'Linn: I'd much prefer you do it unless Lisa wants to.

Member Freeman: No.

Ms. White: We're focusing on reliability, which we look at the specifications of reliability. So, we're looking at are they consistent and credible results about the quality of care when implemented?

And so for reliability testing this was done at the patient or encounter level.

The developer compared the prevalence of the risk-adjusted co-variates between a testing sample of 2584 skilled nursing facilities and the national population using that minimum data set, or otherwise known as the MDS assessment 3.0.

The developer continued to note that 45 percent of the risk adjustment model covariates were found to have prevalence within 5 percent of the prevalence found in the national sample.

They also continued to note that 65 percent or 13 of 20 risk adjustment model co-variates that were comparable were found to have prevalence within 10 percent of the prevalence found in the national sample.

The developer did acknowledge that although the measure testing sample was not a random sample of all skilled nursing facilities nationally, the Model 4 cohorts are sufficiently represented within the sample.

So, again, that was at the patient or encounter level and I'll just pause here to see if anyone has any questions or feedback for the reliability testing at the patient or encounter level.

Member Pease: Is there a time period of when this data sample was taken? What was the period of time?

Ms. White: Kiran, would you like to answer that? You were a bit soft in my ear, when was the timeframe for the data that was used for the patient or encounter-level testing?

Member Pease: Yes, it would be interesting to see if this was within COVID-19 time periods.

Mr. Sreenivas: It was before COVID-19 was part of the initial endorsement back in 2017 I believe.

Co-Chair O'Linn: And I can see on my worksheet, it comes up to be Page 42, there's the testing sample facility level descriptive statistics.

If I'm not mistaken, that's the 2584 sniffs using 4 snapshot dates of Quarter 3, 2013, Quarter 4, 2013, Quarter 1, 2014, Quarter 2, 2014.

When they compared the sniffs with PointRight and not with PointRight, I feel like that table, Table 1, summarizes the differences and similarities between the facilities for the entire nation in 2014, it says.

It was a while back.

Ms. White: Is there a reason why we wouldn't redo those data sampling on a more recent cohort?

Mr. Sreenivas: We didn't review the reliability to be managed. There was nothing underlying that changed, essentially, that would change regarding the reliability aspects of it.

Co-Chair O'Linn: That's an interesting point because I wondered aloud.

I'm not a sniff expert, the PointRight sample contained facilities of various bed counts, chain versus independent, hospital-based versus non-hospital-based, nonprofit versus for-profit, and they were saying the PointRight sample had a greater proportion of large for-profit chain facilities than the national sniff population.

And even the chains, I don't know if chains for sniffs have increased over the last eight years. I wouldn't be surprised if that was the case, independent sniffs being snuffed out. Sorry about that.

But being a part of chain in 2014 data for the nation is 56.4 percent and for the PointRight, 83.5. So, I just wonder aloud if that happens to be shifting and I don't know if it would benefit to take a look again.

Because PointRight is still only on 2000, 2500 sniffs, right, Kiran?

Mr. Sreenivas: Correct. There hasn't been much shifting in the demographics in terms of the nation as well as for the primary sample.

Ms. White: Amy, would you like me to go through the accountable entity level testing that was conducted for reliability?

The reliability testing at the accountable entity level has not been updated but there was two types of testing at the accountable entity level so there was reliability of rates over time.

The developer analyzed change from quarter to quarter and we observed an adjusted long-stay hospitalization rates.

The developer explained that their reasoning was that the underlying probability of skilled nursing facilities long-stay patients hospitalizing and the characteristics of its long-stay patient population were unlikely to change greatly in a three-month period.

So, mostly the change from quarter to quarter would be due to limitations on measure reliability. Correlations from one quarter to the next range between 0.884 to 0.894 for the parametric statistic and 0.877 to 0.886 for the rank order statistic.

The developer did note and suggest that the measure is adequately stable over short periods but sufficiently variable to affect clinically meaningful changes.

And the second type of testing that was conducted at the accountable entity level was the stability of facility-level adjusted rate bootstrapping.

The developer re-calculated adjusted rates for the measure for calendar year 2014 using the random sample of stays.

The developer then reviewed the distribution of differences between facilities' original adjusted rates and the rates calculated with a new sample.

The developer interpreted a distribution of differences with a small variance and a mean of zero as acceptable measure stability or reliability.

The developer continued to note that 64.8 percent of the PointRight sample had a difference in adjusted rates of less than 2 percent and only 4.6 of facilities had a difference greater than 5 percent.

The mean difference was 0.1 percent. I will hand it back over to you, Amy.

Co-Chair O'Linn: Sounds good. It looks like when the Committee had a question about it as a prelim no one had any comments about it but the preliminary rating for reliability came out as moderate.

Any other questions about reliability for the developer? Hearing none, we'll move on to then to validity, validity testing.

Ms. White: And I did want to note in the Committee pre- evaluation comments, there were no concern with the reliability testing conducted for this measure.

For validity testing, this was done at the patient or encounter level and it was also done at the accountable entity level. So, we'll begin with the patient or encounter level testing for validity. This was the agreement of model- dependent variables.

The developer compared the identification of hospitalizations of Medicare fee for service beneficiaries between the minimum data set and Medicare fee-for-service claims. The developer used the 2012 minimum data set data, claims data and enrollment data because it was the most recent available. The developer did note that there was 241,857 discharges to an acute hospital from long-stay discharges.

That was N, a number of 15,091 skilled nursing facilities. The developer noted that 86 percent of hospitalizations of Medicare fee-for-service patients identified by the minimum data set are confirmed by Medicare fee-for-service claims.

The developer further noted that in the the other direction, 98 percent of acute inpatient claims found near a minimum data set discharge have a minimum data set discharge code of acute hospitalization.

Overall, the developer explained that the minimum data set discharge assessments appear to be overstating the rate of acute hospitalizations to a moderate degree and noted that the accuracy of the dependent variables for patients with other payers was not feasible as data for residents is not available.

That was at the patient or encounter level so I'll pause there and hand that over to you if the Standing Committee has any questions questions or

discussions.

Co-Chair O'Linn: Any questions or discussions on that? I was wondering for the MDS minimum data set discharge assessments if it's overstating the rate of acute hospitalizations to a moderate degree.

Is that because observation status patients were in the MDS data set versus Medicare fee for service? Or was it other procedures like tubes, pegs, catheters that needed attention?

Is that why there would be that difference to monitor degree?

Mr. Sreenivas: That's one of our beliefs, that the observation phase was one of the reasons for the difference.

Co-Chair O'Linn: And any chance that changed over time? I'm just not sure, it seems like that could be a moving data-point.

Mr. Sreenivas: I don't know of anything, we haven't done any additional testing on that specifically. Thank you.

Member Freeman: It's a good question, though, Amy, because when you say a moderate degree, what is a moderate degree? Is that 5 percent? Is it 14 --

There's a 40 percent difference between -- is that right, Karen? I'm saying 40 percent between the Medicare fee for service patients identified versus the MDS patients identified?

I mean the confirmed claims versus the MDS patients?

Mr. Sreenivas: Yes, I believe so.

Member Freeman: Yes, it's the fourth point under validity testing at the patient or encounter level. That piece is it looks like 86 percent of

hospitalizations of Medicare fee for service patients identified by the MDS are then confirmed by claims, 86 percent.

I don't know if that changes.

Co-Chair O'Linn: That's a significant variance.

Mr. Sreenivas: We're talking about potentially the over -- capturing more information on people that are just going in for observation phases.

We did speak a little bit about fixing this perspective and observation, hospitalizations, they're quite similar.

They're both the destruction of it and everything. So, the fact that our measure is capturing people who are just going for observations is not such a bad thing necessarily, it actually might be helpful, one of the reasons being that it was acceptable.

Member Freeman: I think that's a great point.

Co-Chair O'Linn: It feels the same just pays different for the hospital.

Member Freeman: Additionally, I understand that observation, initially it was being overused in a sense because the people in the hospitals didn't want to have their reimbursement impacted so they were trying to follow the ruling as it came out.

I think that over time recently they've gotten to understand better what it's intended for and admissions are actually happening a little bit more so that the patients don't get -- because patients don't do as well when they go in on observation as when they go in as a condition.

And I think that got clarified so if anything, I think that while it's good that we're counting both, I think we're also miscategorizing some of the admissions less, at least that's what I've been hearing.

Co-Chair O'Linn: Thank you, Lisa. Let's move on to then to the validity testing at the accountable entity level.

Ms. White: Absolutely, there were several testings conducted at the accountable entity level. So, I'll start with the first one.

The developer performed construct validity testing by testing the relationship between this measure and the various components of the CMS 5-star rating program skilled nursing facilities and it's correlation with the CMS long-stay quality measure.

The developer showed that high star ratings were associated with lower adjusted long-stay hospitalization rates.

The developer also identified the five CMS long-stay measures that were significantly correlated with the prolonged-stay adjusted hospitalization rate, which were the high-risk residents with pressure ulcers, residents who lost too much weight, residents who suffer moderate to severe pain, residents who need help with activities of daily living have increased and residents with urinary tract infections.

So, those five measures were significantly correlated with this measure. Then lastly, the developer calculated the correlation between this measure and the prolonged-stay measure.

Since the original endorsement, CMS added a Medicare claims base long-stay hospitalization measure to Care Compare that was mentioned by Kiran earlier.

And the five stars, the developer calculated the correlation between this measure and prolonged stay.

That prolonged-stay adjusted hospitalization rates had a statistically significant positive relationship with the Medicare fee-for-service claims long-stay

hospitalization measure that is used in the five-star and reported on Care Compare.

That correlation coefficient was reported as 0.77 and was statistically significant. I just want to mention the exclusions. The developer indicated that there were no exclusions for this measure, which we cover in validity.

However, the measure will not be reported for a skilled nursing facility if the denominator population over the measure period's four snapshots dates is less than 30.

The developer continued to note that all patients in the facility on the snapshot date who met the long-stay criterion on that date are included in the denominator.

And so that wraps up the exclusions and I'll definitely pause and hand that over to Amy before we go into risk adjustment.

Co-Chair O'Linn: Thank you, any comments or questions about that, the validity testing on accountable entity level?

Ms. White: Sonya has her hand raised Member Pease: Yes, maybe just a clarifying question.

It says no exclusions so when patients get readmitted for a planned readmission, if they're having staged or things like that, that is not counted as a readmission if it's a planned readmission, is that correct?

Mr. Sreenivas: That's correct.

Co-Chair O'Linn: I also felt like it was reassuring that the star ratings correlated opposite with the readmission rates, that made sense to me, and I like how it's now noted on Care Compare for everyone to see.

That's the patient-facing information I think Lisa

was mentioning earlier that the patients can use this information to help guide their choices.

Do we understand that correctly, Kiran? Do I understand that correctly?

Mr. Sreenivas: This measure is not on Care Compare, it's the other one, the CMS Medicare Claims one that is publicly available.

Co-Chair O'Linn: Lisa, do you have your hand up?

Member Freeman: Yes, I'm just curious why are SNFs that have an N of less than 30 not included?

Mr. Sreenivas: It's largely with the reliability of the measure. When you have less than that you have a lot of swings in their rates and stuff.

Member Freeman: If they were included, though, would that not highlight something about, I don't know, that maybe the smaller facilities offer more attentive care? I'm just saying that, that's not necessarily fact or anything.

Or would it just be too sensitive to the swings?

Mr. Sreenivas: I think it would be too sensitive to the swings. I do know that within the trend tracker on the portal we allow members to see their actual rate and stuff.

We allow them to see if they are not meeting the denominator criteria and stuff, so if they were less than that 30 so they're aware of that.

Member Freeman: Thank you.

Member West: Kiran, I think I may have had a sound issue but I didn't hear the answer to your question about planned readmissions.

Mr. Sreenivas: Those are not counted, the numerator. I think when we said that, we were focusing mostly on the denominator, so they are not

--

Member West: Milli, I can put it in the chat as well if you're having audio issues, I'll put that in the chat.

Mr. Sreenivas: Sorry, my coworkers are actually correcting me. It does include planned hospitalization in it, I think thinking about ProRight, sorry.

Member Pease: So, now you've got me confused.

Mr. Sreenivas: Sorry about that. Planned hospitalizations are included and counted in this measure here.

Member Pease: So if you have a planned readmission it counts as a readmission?

Mr. Sreenivas: Yes.

Member Pease: So, that's now --

(Simultaneous Speaking.)

Member West: Is there any sort of facility-specific data drill-down to where the facility could parse those out?

Because I would think that would create some white noise in the metric and inability to really know what action to take in terms of improvement.

Mr. Sreenivas: Since this is a long-stay measure, there's actually very few planned hospitalizations for these long-stay residents.

Member Pease: It makes me concerned about the unintended consequences because the reason that patients are staying for a long time is because they've had some very complicated acute care stay.

And so these are patients that are going to the skilled nursing facility with a tray, with feeding tubes, but now they've improve and they have an opportunity to improve their quality of life by

getting back to how procedure is done and improve their quality of life.

It's going to require another long-term stay to get them through that next stage of whatever they're getting back to what normal looks like.

So, it would be interesting to see what that is because I know it's pretty significant on the hospital side and I would imagine it would be pretty significant on the skilled nursing facility side.

Co-Chair O'Linn: This is a really good question and I'm so glad it's been raised. I wonder if this does lay in usability, unintended consequences section?

Because this is a big one actually and I think Dr. Pease's point is really important.

And Milli's point too because you need to understand what you're going to do to improve the outcome and if our goal is to improve our patients' quality of life and a planned readmission improves quality of life, that needs to be addressed.

I apologize, I was corrected, this is validity. So, yes, we are continuing the discussion on this, thank you, may I please go ahead and call on Janine Savage?

Ms. Savage: Thank you, I'm with Net Health. We have looked with our clients at planned admissions and readmissions, it's one of the things that they were interested to know.

When we look at that across our client base, we saw that planned admissions were extremely rare, even more rare than we had suspected.

Some facilities had none in a 12-month period, most facilities had less than 10 planned admissions to the hospital.

And with the emergence of most procedures being done as outpatient procedures, we think that probably has had an effect on actual overnight

hospitalizations.

So, in discussions with our customers, they're very comfortable in having planned admissions counted.

Ms. White: Amy has her hand raised?

Co-Chair O'Linn: Go ahead, Sonya.

Member Pease: I think the challenging thing with readmissions, especially the planned readmissions, is that it has to be clearly documented as part of the discharge summary that the patient is going to be readmitted and it would have to be clearly documented on the patient being readmitted that this was a planned readmission.

Probably upwards of 5 to 7 percent of our acute care hospitals fit into that category and were just not properly documented.

Co-Chair O'Linn: Janine, do you have your hand up?

I just wonder if the planned readmissions, which is a sticky point with this group because it's a concern, is it similar throughout the nation or throughout the sniffs?

Or is there any difference in the sniffs that are doing the planned readmission with their patients versus the folks and sniffs who are not? I'm just wondering if that's been looked at.

I think as my colleagues are chiming in and get in the chat and stuff, seeing as this is a long-stay measure, we don't really see that many planned readmission. There would be a hospitalization, a planned hospitalization, for this measure.

You have to be in the facility for over 100 days to be included in this measure. Co-Chair O'Linn: May I call on Lalita Thompson?

Member Thompson: I just had a quick question.

I work for an acute inpatient rehabilitation facility and a lot of times we will send patients to a skilled nursing facility, maybe they have wounds or some other things that they're medically unstable to -- they're not at a point where they can really sufficiently do inpatient rehab for the three hours required and at the intensity that's required for inpatient rehabilitation.

So, we do have planned admissions as far as readmissions, so we'll send the patient out to the sniff, they may stay there a little bit and then they'll come back to us.

I was just wondering if the acute inpatient rehabilitation facilities are also counted as the acute care hospitalizations.

Mr. Sreenivas: They would need to be in the nursing home for over 100 days for them to be counted, so it's unlikely for a lot of those types of residents to be counted.

Ms. White: I do want to bring up some chats we're receiving.

We do have a chat from David Gifford, this is not a readmission measure as the denominator is for people who have been a resident in the facility for more than 100 days.

And that is rare for a long-stay resident being in the facility for greater than 100 days to go home. So, I just wanted to call that out for the record. That's in our chat.

Co-Chair O'Linn: Thank you, Leeann.

Regarding the patients in our long-term care facilities who are there for 100 days, regarding the ability for them to avoid hospitalization with the right process and systems, I feel like we can potentially talk more about this validity testing on the accountable entity level or move on to the risk

adjustments. I feel like the risk adjustments need to be talked about if we can move on. Okay, thank you, let's go onto the risk adjustment then.

Ms. White: I just wanted to make sure Lalita, did you have your hand raised still? I just wanted to check before moving on, thank you. So, for the risk adjustment model, I want to highlight that the developer noted that this measure employs four logistic regression models applied to four discrete subgroups of the denominator population to estimate the risk of any hospitalization during the quarter.

The developer noted that while lack of Medicaid status was found to be significant and at least one of the fixed effects models, they found a minimal impact on the overall performance of the models as measured by the C statistic.

For risk model diagnostics, the two assess overall performance of their risk adjustment model.

The developers compared their model coefficients to the mean coefficients from bootstrap analysis expressed as actual values, standard deviations, and percentages.

The developer performed the Hosemary Leman Chao test for the goodness of fit of the logistic regression model. This test assesses whether or not the observed event rates matched expected event rates in subgroups and the model population.

So, for the risk model discrimination statistics, there were four groups. Again, the C statistic range from 0.62 to 0.64 and the linear regression model rate of all hospitalizations had an R squared of 0.96.

I will hand it back over to the Standing Committee.

Co-Chair O'Linn: Any comments on risk adjustment? Is this a time when we talk about whether COVID-19 should be brought in here, or as the developer

suggested to leave it out because its significance is unclear at this time.

Ms. White: That's a great question and so we're evaluating the measure as specified so we're going to stick to the specifications and the submission that were provided by the developer.

Great questions, though, and discussions that can be had but we are reviewing the measure as specified.

Co-Chair O'Linn: Thank you. Any comments on the risk adjustments? I just want to make sure Teri Sholder's comment from earlier, has that been addressed appropriately?

Member Sholder: Yes, it has, I appreciate that, Dr. Lin.

Co-Chair O'Linn: Let's move on to meaningful differences and missing data.

Ms. White: Just to confirm, were there anymore questions regarding the adjustment model just for the record? I'll do a quick scan real quick of the hands raised?

Perfect. So, for meaningful differences, the distribution of change in adjusted rates was similar across all four quarters where for each quarter, the average change percentile 2 through 8 were less than plus or minus 3 percent.

Percentile 1 and 10 had average changes greater than plus or minus 3.5 percent. The distribution of differences was larger for facilities with smaller denominators and this indicated that recommendations of clinically meaningful differences should be dependent upon facility size.

Per missing data, I'll go through that and then I'll pause and hand this back over to the Standing Committee.

The developer provided distribution data of the minimum data set 3.0 known outcome rates across the sample as well as the relationship between the observed rate of hospitalizations and the known outcomes rate. The developer noted that on occasion, a facility may fail follow the deadline for submitting a minimum data set assessment, resulting in the inclusion of the patient in a quarterly denominator but unable to provide them with a known outcome following the snapshot date.

This is vital to the measure's accuracy. In response, the developer has reviewed the known outcome rates across their samples to ensure that missing data is not a major factor.

The developer also selected known outcome rates of 90 percent to be the minimum threshold for missing data.

The median known outcome rate in their full sample of PointRight facilities was 100 percent concluding that missing data was not an issue for the majority of the facilities.

And then lastly, additionally, the developer noted a slight positive correlation between the known outcome rate and the observed hospitalization rate with a Persin correlation of 0.8 and a Spearman correlation of -0.006.

I will hand it back over to the Standing Committee.

Co-Chair O'Linn: Thank you so much, Leeann. Any comments, questions, concerns about the meaningful differences in the missing data? I don't see anybody raising their hand.

I guess when we ask the Committee ahead of time do we have any concerns about this there was no comment on that, and the preliminary rating for validity was moderate.

So, now we move on to feasibility.

Ms. White: I'm just getting my notes up, feasibility. So, this is the extent to which the specifications including the measure logic.

It required data that are readily available and can be captured without undue burden and can be implemented for performance measurement. That's just a high-level overview of the feasibility criterion.

The developer noted that all of the data elements needed to compute the measure score can be generated and collected by healthcare personnel, excuse me, during the provision of care and that all data elements are defined in the electronic clinical data.

So, this could be clinical registry, nursing home, minimum data sets and home health. The developer also noted that computation of the measure requires a license to use software for large-scale data measurement and calculation of risk estimates using the logistic regression models.

And lastly, the developer noted that while utilization of the measure specifications does not require a fee, there is a requirement that display, disclosure, or publication of the measure must include the measure's trademark and the measure specifications that are operated by PointRate.

So, we did rate this preliminary analysis as a moderate rating for feasibility and I'm going to scroll through the Committee pre-evaluation comments.

We had two comments, one comment said data collected can indicate appropriate measures to reduce admissions and the other comment is that all elements are already collected electronically.

So, there was no concerns raised by the Standing Committee during the pre-evaluation. I will hand it over to you, Amy.

Co-Chair O'Linn: Thank you so much. Let's have any comments or questions about feasibility. I had a question for the developer. For the ProRight software that requires the license, and it's a really big software program which allows large-scale data management and calculation of risk estimates using the logistic regression model, is there any concern of just wondering that since it's one company with one copyright and it's proprietary then, is there any concern that there might not be a drive to improve upon the model.

Or is there any concern that we're putting all our logistical regression eggs in this one software program? One basket I mean?

Mr. Sreenivas: So I'm not sure if I have the exact answer. Feel free to push back and give me some more questions. So some of it -- the measure itself, the rates are publicly available in the sense of we publish the rates on our website.

So you can download the data and see the rates for all of the nursing homes. The trademark stuff is just if you were going to take that download and use it somewhere else and, like, if you were going to put it on your own website, this is the readmission rate that you label it as a point, right, and you'd put the trademark on it. That's about the licensing, that aspect of it.

Using the software and stuff like that, I mean, that is just -- there's so many of them it takes a while and stuff like that. We posted our coefficients and stuff like that, and so they're available. If another vendor or someone else wanted to run it, we have those coefficients available that people can use to run the regression.

Co-Chair O'Linn: And who pays for it? I'm just questioning just for my -- I just don't know. Is it --

Mr. Sreenivas: I mean, we are just starting the cost to buying the MDS assessment from CMS. That's

part of our research budget, the member dues and other, like, non-dues revenue and stuff. But there's no specific line item payment that's coming to calculate this measurement or anything.

Co-Chair O'Linn: Okay. Got you. Any questions about feasibility from the group? I don't see any hands. So we'll move on to use and usability, Criterion 4.

Ms. White: Okay. So I always find it helpful to provide an overview of the use and usability. So I'll start with use as our first criterion. So use evaluates the extent to which audiences -- so these would be consumers, purchasers, providers, policy makers -- use or could use performance results for both the accountability and performance improvement activities.

So we look at accountability and transparency for use. So our performance results use at least one accountability application within three years after initial endorsement. And then are they publicly reported within that six years after initial endorsement?

If not, then of course we would like to see if there is a credible plan for the implementation. So when we conducted our preliminary analysis, we noted that the measure developer has indicated that this measure is publicly reported and is currently used in accountability applications and programs and that the developer noted that this measure is utilized in several state Medicaid programs as part of their value-based purchasing or pay-for-performance programs for the feedback on the measure of those being measured or others. So there's three criteria that demonstrate feedback.

One, are those being measured given the performance results or data as well as assistance with interpreting the measure results and that data? The second subcriterion is those being measured in other users, have they been the opportunity to

provide feedback on the measure performance or implementation? And the third point is, is this feedback -- is this considered when changes are incorporated in the measure?

So those are the three criteria that demonstrate feedback for use. So for the feedback on the measure of those being measured or others, the developer polishes the prolonged stay rates on the AHCA's long-term care trend tracker tool quarterly for members to track and benchmark their organization's prolonged stay performance. The developer also publishes facility level rates publicly on their website on a quarterly basis.

Results are available in three Net Health PointRight solutions, quality measures, scorecard, and New Mexico value-based purchasing. Net Health Solutions offers educational materials on demand. Feedback on those being measured is shared through direct conversations with analytics, product management sales, and client services team members.

And lastly, feedback is also submitted through in application messaging, via email and in conjunction with responses to net promoter scores, customer satisfaction surveys. So the team's preliminary analysis on the use criterion was a pass. And I will hand it back over to Amy and the standing committee.

Co-Chair O'Linn: Thank you so much. Any questions or comments about the use of the measure?

Member West: Yes, what is the public data look like on the public version of the website? It is just a snapshot number? Are there trend charts? What does that look like for those that aren't members and can get into the deeper dive tracker tool?

Mr. Sreenivas: It's a great question. So the public based, it's more kind of a spreadsheet of the raw data in terms of just for each facility. We do have a

couple of more, I think, public based that are more friendly to view in terms of we have a quality initiative where we included readmissions. We use this measure. So we've had some, like, issues raised and stuff where we talk about updates to the quality initiative on a quarterly basis where we talk about the performance and number of people that have achieved the goal or reduced -- made reductions.

Co-Chair O'Linn: Thank you for that great question, Milli.

Member Freeman: Taking that question, going just a little bit further, I see this as very valuable information for the consumers. And I'm just wondering if any effort or intention is in place to make it so that the data is truly useful and understandable to consumers, particularly those living in SNFs where it can be posted.

Mr. Sreenivas: That's great feedback. And that's actually something I think one of the big takeaways I'll actually take away from this conversation is looking and seeing about how we can do some more of that. So I think there are some opportunities for that to do more of that public showing of the measures.

I do know one of the things we like about this measure in terms of the public, it's easier to understand in terms of the other measures that we've talked about, the claims-based measure. It's a rate. It's a percent. You get, like, a readmission rate of 14 percent. So one, to compare, it's per 1,000 patient days.

So you get, like, 2.15, and it's, like, the difference -- you get differences in the tenths. And I feel like as a patient or a family member, like, what does that mean, 0.2. Or as a percent, I think it makes more sense intuitively, 14 percent versus 16 percent.

That makes sense. There's two less people per 100

people that are getting hospitalized. So I do think we have some more opportunity we can kind of maybe push this more publicly facing.

Member Freeman: Yeah, and also, I think when patients are going into long-term care facilities, they're limited usually to a certain somewhat small geographical region because they want to try to be near family or something like that. So it's really the sole difference is make a difference in choosing where people want to be. So I think that this particular rating -- along with others. But this particular rating is a very important one that tells a lot.

Co-Chair O'Linn: Great point. And thank you for taking the feedback from this committee, Kiran, and group. If no further comment --

Ms. White: Amy, so I would like to bring up we can ask the developer to respond. I know we had mentioned COVID a few times prior, but we can ask the developer to respond on how they plan to address COVID in the future in this measure if the standing committee wishes for use.

Co-Chair O'Linn: Good point.

Mr. Sreenivas: So the question is how are we planning to use COVID -- or account for COVID for use in the future? So we kept the rates -- we'd keep publishing our rates. We have not blinded anything, quarter rates during the COVID period.

Partly something we've seen CMS do as well on Care Compare that they paused them for a little bit. But then they actually went ahead and released them. So we have not censored any data during the COVID pandemic to not produce their hospitalization rates. I'll just put that out there.

And so that's kind of how we continue to keep -- so we don't see any adjustments from that part. I mean, I think mostly we're looking at kind of

tracking, see how it goes. And then potentially looking forward to doing additional testing later on about whether or not to include COVID in the risk adjustment model.

Member Freeman: So if I could just add, from a patient safety standpoint, this is a very sensitive topic because, yes, the stress and strain of our different systems and facilities is extremely high at times during COVID. But that doesn't necessarily mean we shouldn't be using measures like this to indicate where we can do better and what needs to be fixed. When we have problems, we have to learn how to respond to them and not just say, well, it's okay to lose a few more lives because we had a big problem. It's not.

And I think everybody pretty much agrees with that. So to factor something like this out particularly since right now we think that COVID is going to be with us one way, shape, or form for a while. I think it's very important to just look at this as kind of a test of our systems.

And there may be reasons from payers' points of views why it should impact things. But not in terms of what we're learning about quality. So that's just my say going forward.

Co-Chair O'Linn: Go ahead, Dr. Pease.

Member Pease: I mean, I think COVID is so challenging on some many levels. I think from the risk stratification standpoint, it's incredibly challenging because it does impact a patient's immune system. So not even the acute care and the acute infection but the long COVID and the fact that it's going to really compromise your immune system.

It's going to make your -- from a clinical standpoint if I have a patient who otherwise I probably would've started antibiotics on and kept in my skilled nursing facility versus I know this is post-

COVID from 30 days, I'm more likely to take that patient more quickly to the hospital for severe sepsis. So I think it does change your clinical decision making when you're dealing with patients with acute COVID as well as with long COVID or just the immune impact from post-COVID. Then I think the other level that needs to be looked at is that clearly COVID impacts different communities and different demographic regions at different times.

And it's very hard to be comparing facilities or peer-to-peer facilities when you have some facilities that will not take COVID patients or even a post-COVID patient. And so there's a lot of steerage that happens with patients. And I think most of its's done because you're trying to cohort patients in area where you can provide the level of care they need.

But I think that skews the data in a way that going back to something that Lisa said much earlier is that not every readmission is a bad thing. There's reasons why patients may need to be moved out. So I don't know.

I think it's very difficult. It'll be very interesting to see how the data shakes out over time. I think you go to look at it from the different layers of how COVID is impacting your patient population and your demographics around who's in that skilled nursing facility.

Co-Chair O'Linn: That's a great point. And I'm sure -- I'm hoping that Kiran and his team is grateful for the feedback here about the COVID question as it's not included as a risk adjustment factor now which is what we're going to vote on eventually. But for the future, I think our input I hope does help you, Kiran.

Member Pease: Yeah, thanks for listening.

Mr. Sreenivas: No, thanks for sharing.

Co-Chair O'Linn: Well, we've got the usability. If there's no further comment from anybody, I see Dr. Pease's hand is still raised. But I believe that is -- okay, no problem. Then we'll move on to usability.

Ms. White: Okay, wonderful. So for usability, we look at how this measure evaluates the extent to which audiences could use performance results. I'm sorry. I apologize. My computer froze a little bit on me for my notes.

So we're looking at improvement results for this measure. So the developer provided four figures demonstrating improvement of hospitalization rates in the Mexico nursing facilities. They noted improvement in average performance from 15.27 percent in 2020 of first quarter to 7.81 percent in Quarter 4 of 2021.

So there was an improvement between those two quarters. They also noted an improvement in median performance from 15.08 percent in the first quarter of 2020 to 7.01 percent in the 4th Quarter of 2021. They noted that there's no current national value-based or pay-for-performance incentives tied to reducing long stay hospitalizations and Medicare's national skilled nursing value-based purchasing program only accounts for a short stay re-hospitalizations.

Lastly, they also note that there's been no significant improvement to the national prolonged stay rate from 2014 to 2020. In their measure submission, the developer did not identify any unintended consequences with their measure. And they did not identify potential harms. I will hand it back over to you, Amy.

Co-Chair O'Linn: Thank you so much. What questions or comments about the usability from the committee?

(No audible response.)

Co-Chair O'Linn: I do have a question about usability and unintended consequences. The vulnerable patients in the long-term care facilities, they live there. They've got high hospitalization rates as was already mentioned in the beginning of this discussion.

And is there any monitoring of mortality in this group? Because if they get sick in their long-term care facility where they live, they either go to the hospital and get the care they need or they might expire if the care they need is not adequate. Any look at that side of that coin, the mortality side?

Mr. Sreenivas: We haven't done anything related to that specifically about mortality. It's tricky. Some of this I think with some of, with respect to residents' wishes, they don't want to go back to the hospital for some of that. So I don't know.

Co-Chair O'Linn: Yeah, it's a good point about not wanting to go back to the hospital. But then some people are ready for not going back to the hospital, and then some patients are probably not ready for not going back to the hospital. Oh, we've got Janine. Go ahead, Janine.

Ms. Savage: Yeah, I think mortality is an interesting question. And there's so many dimensions to looking at mortality. One of the things that we strive to do with our providers that we work with is to help them identify and have the right discussions around end of live wishes and advanced care planning.

And so often, mortality is not only kind of the expected outcome. But having a better patient experience around their end of live is what they strive for. So it would not necessarily hold true that if a facility has a higher mortality rate that there is really any correlation directly to their hospitalization rate or a correlation that can be inferred in any way because there are so many other considerations around the issue of mortality and end of life.

There are advanced care planning practices, the way that they interact with their patients and family conferences and how their medical providers are having those discussions. And the list goes on and on. And I think this is one of the most challenging areas for providers.

And the ones that we work with that are very kind of leading edge are being very open and honest about identifying end of life indicators and having those discussions. So mortality is very complicated. And I would just say very much like COVID, needs to be approached very carefully.

Co-Chair O'Linn: Thank you so much. Any other comments or questions about unintended consequences or usability for this measure?

(No audible response.)

Co-Chair O'Linn: I don't believe when the questions for the committee came up there were no comments on this as far as I know. And the preliminary rating for usability and use was moderate. Okay.

Ms. White: Amy, before we move on to the next measure, I just want to make a correction to the record. Earlier, I believe I may have stated that there was no new validity testing conducted. But there was. I want to make that correction for the record.

The developer didn't indicate that there was new validity testing conducted for this submission since the original endorsement. And that was that correlation between this measure and the prolonged stay and the Medicare claims-based long stay hospitalization measure. So just wanted to correct that that there was updated validity testing completed by the developer for this submission.

Co-Chair O'Linn: Thank you very much. May I ask a question then? So for the SurveyMonkey, are we,

committee members, allowed to vote? We haven't -- I'm sorry, I haven't yet which means I just want to clarify. We can go alongside the discussion and vote, like, at this time, right? Yeah.

Ms. White: That is correct, yes. And please let us know if you did not receive that SurveyMonkey link. We can definitely send that out to you.

Co-Chair O'Linn: Well, if there's no further comment, let's move on to -- go ahead, LeeAnn.

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Ms. White: I was going to move on to the next measure then. And we can give a second for Victoria to pull up the next measure description for us. Perfect. Thank you, Victoria.

So the next measure we'll be reviewing is Measure 2375. This is PointRight Pro 30 that the measure steward is American Health Care Association/PointRight. This is a maintenance measure.

This is an all cause were suggested re-hospitalization measure. It provides the rate at which a patient regardless of peer status or diagnosis who enters a skilled nursing facility from the acute hospital and is subsequently re-hospitalized during their skilled nursing facility stay within 30 days from their admission to the skill nursing facility. So I will hand that over then to you, Amy, to lead the discussion.

Co-Chair O'Linn: Thank you so much. As we begin this discussion, this is the idea being can SNF re-hospitalization be prevented with systems or processes to help support patients so they don't have to come back to the hospital for avoidable re-admissions that would be ways to keep people out of the hospital from nurse practitioners' support in the SNFs or helping patients get the care they need

when they get sick in the SNF after a hospitalization. I want to mention to -- well, the patient advisories are on the phone.

That's Dr. Pease and Lisa Freeman. Do you want to frame the discussion from a patient standpoint? And Dr. Pease, is see your hand is up.

Member Pease: I think I forgot to take it down previously. But no, I would like to -- I mean, I definitely think this is a very critical measure because we want to make sure that we're setting our patients up for success in that post-acute space. And as a patient, you want to make sure that if you don't get to go home that you're going to the best place that's going to get you better the fastest. So yeah, I think this goes back to a lot of what Lisa was saying earlier that it's a very meaningful measure because I think that continuity of care and ensuring a good outcome is vital. This is an important way to measure it.

Co-Chair O'Linn: Lisa, any framing comments from a patient advisor standpoint?

Ms. White: Lisa, I believe you're on mute.

(No audible response.)

Ms. White: Okay. We will work with you on the side to try to help you with your audio. Thank you.

Co-Chair O'Linn: Thank you. And so we're very excited to have lead discussant Raj Mahajan help lead us through this discussion of this measure. Oh, wait a minute. I didn't let the developer do their thing. Mr. Kiran Sreenivas, can you present this and the 35-minute overview of the measure, please? And thank you so much.

Mr. Sreenivas: Yeah, I'll keep this short because it's really very similar to the other measure. And so I don't want to say the same thing. So this is -- again, this is our short stay version of our measure

in re-hospitalization.

So this is looking at 30 days after admission from a hospital stay looking at re-admissions. It's updated on a quarterly basis, and it represents a 12-month period. Again, like the prolonged stay measure, we have no changes to the risk adjusted model. Mostly in our application, we have updates to performance trends, testing, and usability.

We've also seen this measure opted in state value-based purchasing programs in California and Hawaii, for example. We continue to see some validity testing and strong associations with the Pro 30 measure and five-star ratings and other quality measures such as pressure ulcers, urinary tract infection, things like that. And yeah, so I'll end it there and support the discussion.

Co-Chair O'Linn: All right. Thank you so much, Kiran. I'd like to invite our lead discussion, Raj Mahajan, to help move us right into the measure discussion.

Member Mahajan: Thank you, everyone. So most of the information is included in the slide deck. So I'm not sure if we are putting that up on the screen. So are we just going right into the evidence discussion first?

Co-Chair O'Linn: Yeah, Criteria 1 evidence, yes, importance to measure report. Thank you.

Member Mahajan: Okay. So on the evidence, the evidence requires for a health outcome measure include providing the empirical data that demonstrate the relationship between the outcome and at least one healthcare structure. So that discussion -- so the developers' comments, Kiran, do you want to weigh in on that so we can have our discussion started? Or is there anything in particular on the evidence do you want to say from a developer's perspective?

Mr. Pickering: So this is Matt from NQF. Sorry, maybe before we go there, thanks, Raj, for that summary of the evidence. Just make sure that any of the committee members have some questions related to evidence. We'll capture those and then triage to the developer. Thanks, Raj.

Member Mahajan: Okay, sure.

Mr. Pickering: Go ahead, Amy. You can start.

Co-Chair O'Linn: That's it, yeah.

Mr. Pickering: And it looks like Sheila has her hand raised.

Member Roman: Yeah. To me, this measure is a bit of a chicken and egg measure. And I'm wondering if someone can speak to the evidence to sort that out because one could assume that it's a hospital accountability measure that the patient was inappropriately sent into that setting rather than a long-term care accountability measure.

Member Freeman: This is Lisa. And I'm having a trouble hitting the buttons. The bottom of my screen is not accessible. But we've been talking about this in the patient safety community for quite a few years now, particularly with regard to that.

And what I think is the consensus that I'm hearing is that it's not -- yes, it is, chicken or the egg, which comes first. But it's really about communication and it's about hand-offs and transitions. And it's about the SNFs knowing what they're looking for before they accept the discharged patient.

It's about the hospitals knowing what the patient needs when they get to their next place. And I always understood that that is the underlying message that has to be heard by these things. And CMS is trying to bring attention to is in various ways as does this particular measure.

And I think it's a hard one to get through because

everybody likes to kind of say, well, it's their fault. But it's not about fault. It's about working together so that patients have a proper positive experience.

Member West: Yeah, I appreciate that, Sheila and Lisa, because we just had the -- on the acute side, the Medicare spend per beneficiary metric data released which covers the three days prior to acute inpatient, the inpatient stay, and then the 30 days post-discharge. And it's all attributed back to the hospital, right, and the hospital value-based purchasing. So I like the idea of having related metrics attributed in the SNFs because the hospitals are incentivized to work with the post-acute space. And this type of metric then incentivizes the SNFs to do the same and connect in that work.

Member Mahajan: This is Raj, and I just wanted to weigh in on the first few comments. It's very interesting. I don't think there has been a lot of discussion about this measure being a measure for acute care to have discharged these patients/residents to a facility prematurely.

Since my work is in the field on post-acute, from the very beginning, this has been a measure for the facilities and their ability to manage and be able to not have them readmitted. So I think it's a very good point. And I am not sure if there is work being done on somehow using a methodical approach to come to a premature discharge being the issue. And yeah, definitely a great point there.

Co-Chair O'Linn: Thank you so much. I see Ed Davidson has his hand raised.

Member Davidson: Yeah, I just wanted to add that, again, I think to echo the other comments, this is a very important measure. And just with regard to the evidence, there's been a couple peer reviewed papers published in the last two to three years that kind of highlight the value of looking at this 30-day readmission. And not a lot of -- all of this work that was -- these two papers that I wanted to highlight

was one by Kumar and PLOS Medicine and another in the Journal of American Geriatrics Society by Rivera-Hernandez look at two important issues.

One is what's the impact of Medicare Advantage versus fee-for-service. And the other is looking at racial disparities. And I bring them up to point that they might be useful to add to the peer reviewed literature basis that the developer had developed as part of his measure.

Co-Chair O'Linn: Thank you very much. Go ahead. Was someone going to say something?

Member Mahajan: This is Raj. I think since we're discussing evidence here and per developer there's no change in evidence since the last time this was reviewed. So I just wonder if the committee has any further discussion on the evidence and the change in it as it stands.

Co-Chair O'Linn: Preliminary ready for evidence is a pass. And so if there's no further discussion, we'll move on into the gap in care opportunity for improvement and disparities.

Ms. White: Ed, did you still have a question or feedback? I see your hand raised. I just want to make sure we don't skip you before moving on. Oh, okay.

Co-Chair O'Linn: Thank you, Raj. Can you take us into the gap in care opportunities for improvement?

Member Mahajan: So for 1B on performance gap, the developer has provided the statistics for the most recent quarters. And for 2019 and 2020, the risk adjusted mean rate was 16.6 percent and 16.3 percent. The standard deviation was 4.9 percent, and so with range of zero to 58.7 in 2019 and 5.2 percent with a range of zero to 81.9 percent in 2020.

And then from AHCA member facilities for Q4 in

2011 through Q4 of 2020, the developer noted that re-hospitalization rate has steadily declined from 2011 to the Q3 of 2020. The average improvement was 10.4 percent. And then also it was noted the increase in the national average rate for Q4 2020 could be related to COVID-19. That has been discussed for the other measures as well. So any discussion on performance gap? Any comments?

(No audible response.)

Member Mahajan: If not, we can go to disparities. And then in disparities, the developer provided disparities data for the entire population of the individuals admitted skilled nursing facilities following hospitalization, including all races and ethnicities regardless of peer status. The numbers there are 715 SNFs and it's 3,739,243 residents.

And the difference between in average readmission between facilities with low, less than 5 percent, and high, greater than 35 percent of minorities has decreased over time. And that is 16.5 percent and in 2011 Quarter 4, and 14.9 percent in the Quarter 4 of 2022. Facilities with fewer minorities have lower risk adjusted Pro 30 readmission rates.

The difference in average readmission rates between facilities with low and high percent of minorities in Quarter 4 of 2020 was 2.8 percent compared to 4.1 percent in Q4 of 2011. Also the developer provided data by geographical location relative to CDC's social vulnerability index, SVI. And the facilities located in lower SVI counties had lower risk adjusted Pro 30 readmission rates.

And the difference in readmission rate between facilities in low and high SVI counties has decreased over time. And that decrease is 2.7 percent in 2011. And it went down to 1.4 percent in Q4 of 2020. And that is the data provided on disparities. And any comments from the committee on disparities?

Member West: So the gap in disparity is narrowing.

Has there been any statistical testing on whether or not that's a significant reduction? Do we have any information about that, or just random variation?

Mr. Sreenivas: This is Kiran from AHCA. We have done any testing yet on that.

Member West: Okay.

Member Pease: I'd be interested to know why the disparity is decreasing. Are the hospitals doing a better job in that post-acute space? What interventions are proving successful?

Co-Chair O'Linn: Correct. I agree. So the preliminary rating for opportunity for improvement was moderate. All right. So you can vote silently on the SurveyMonkey if you want. And if there's no further comment, we'll move along. Criteria 2, scientific acceptability of measure properties. Thank you, Raj.

Member Mahajan: So on the scientific acceptability. So on that, on the specifications, it requires a measure as specified to produce consistent and reliable and credible which is valid results. And on reliability testing, it demonstrates if measure data elements are repeatable and printing same results with high proportion of time when done again.

So on this reliability testing, the developer performed parallel forms reliability testing by calculating several measures based on MDS 3.0. That was submitted by over 2,800 facilities and to the MDS super-data. And the developer calculated rates of admission, tracking, observed re-hospitalization and expected re-hospitalization.

The developer showed that 206 cases at 7 percent to match exactly both the numbers of admission and tracking rate. In 1,869 cases, which was 6 percent CMS data observed rate calculation minus a SNF data observed calculation was 1 percent. And in 2,652 cases which is 94 percent, the CMS data

expected rate calculation minus the SNF data expected calculation was within 1 percent. The developer noted the results of the testing between CMS MDS 3.0 data and the data from a skilled nursing facility was reliable. So any discussion on reliability testing?

(No audible response.)

Member Mahajan: Do we have any concerns that the measure cannot be consistently implemented based on this?

(No audible response.)

Member Mahajan: And the preliminary rating for reliability was moderate.

Ms. White: Yes. Thank you, Dr. Mahajan. Yes, so I did want to call out that in your SurveyMonkey the question for reliability, the highest rating will be a moderate rating as the developer did conduct a reliability at the patient encounter level. So the highest rating would be moderate. So I just wanted to let you know in case you're wondering. I wanted to call that out.

Member Mahajan: So we'll go on to validity testing next. And so the developer has compared hospitalization claims submitted to CMS with the MD as the point of discharge assessment. And developer noted 82.9 percent of MDS 3.0 discharge assessments indicating an acute care hospital discharge location could be verified with inpatient claim data.

An additional 3.7 percent MDS 3.0 discharges could be verified with outpatient claim data. And a total 10.9 percent of MDS 3.0 discharges could not be verified with the Medicare claims data. Developer noted that validity and reliability of this tool has been confirmed by previous analyses and presented in the peer review literature. So any discussion with that data presented?

(No audible response.)

Member Mahajan: If not, we have validity testing at the accountable entity level. And with that, the developer notes an inverse correlation which is -0.152, p-value of less than 0.001, between short stay quality measure for a pneumococcal vaccination rates at facilities re-hospitalization rate. Also an inverse relationship were noted between re-hospitalization rate and the overall five star rating which is -0.157 to -0.206, again, the p-value less than 0.001.

Also inverse relationship with health inspection component, a five-star. And I'm assuming that majority of nonpost-acute folks on the committee and calls are aware of the three components of the five star rating that can positively makes the overall five star rating. And if there are questions, please ask. But health inspection is one of the three components of five star rating and which is the health department survey.

And so for that, it was noted an inverse relationship with -0.123 to -0.150, again, p-value of less than 0.001. The second component of nurse staffing which, again, is one of the three components of five star. And that relationship was -0.110 to -0.174 and p-value of less than 0.001. Facilities that are recipient of AHCA's Baldrige based award have significantly lower re-hospitalization rate to non-AHCA members.

Recipients on that data is shown there, 17.2 versus 17.7 in Quarter 2 of 2013. And that p-value is 0.01. Also, developer compared the measure to two of CMS short stay measures, the Medicare, fee-for-service claims space re-hospitalization and five star. And the developer hypothesized that Pro 30 measure performance would correlate positively with the Measure No. 2510 which is the skilled nursing facility 30-day all cause readmission measure, SNFRM, and Medicare claims-based re-

hospitalization measure which is NHC-RM.

The developer found Pro 30 has a statistically significant positive correlation with both Medicare claims space re-hospitalization measures which is NHC-RM. It's 0.622 with a p-value of less than 0.0001 and SNFRM with the value of 0.586 and p-value again less than 0.001. With that, any discussion up until that point on the validity testing at encounter level or validity testing at the accountable entity level?

(No audible response.)

Member Mahajan: Should we move it along?

(Simultaneous speaking.)

Member Mahajan: Sorry, go ahead.

Co-Chair O'Linn: No. Yes, you may go along. So about that, Raj.

Member Mahajan: No worries. So we do have some exclusion mentioned here. And then although there are no exclusion, however, SNFs with fewer than 30 readmission from hospital were excluded during the 12-month period from re-hospitalization rate reporting. That's a number there.

The developer indicated that average change rates decrease as the number of admissions increased. And that's true. We have a very small facility. It's always hard to interpret that data.

One readmission could make, like, 30 percent increase in their values. So it's hard to manage that. And so also developer noted while rates for the excluded facilities are not reported, admissions and re-hospitalization from these facilities are used to calculate national rate used in the calculation of the adjusted re-hospitalization rate.

So that is on the exclusions around validity. And then we go along and discuss risk adjustment. Matt,

is there -- so is this data on risk adjustment and the meaningful differences, is that shared with the larger group?

Ms. White: I can answer that. So yes, we do want to review all of the threats to validity which do include the meaningful differences and performance and the missing data.

Member Mahajan: Okay. So we'll go ahead and go over that. So on risk adjustment, so the developer noted that the measure is risk adjusted and uses statistical risk model with 32 risk factors. Developer conducted a bootstrap and stability analysis to test the select patient level risk factors.

The developer had a clinical panel review, the MDS, and identified variables that might be expected on the clinical grounds to correlate 30-day readmission risk. And that would unlikely change between the hospital discharge and the day of the first MDS assessment. The counter variables identified include demographics, chronic condition diagnosis, treatments that begin prior to hospital discharge with orders to be continued at the SNFs.

And the functional status items that change slowly, for example, 2 percent assist. The counter variables were screened for significant univariate association with dependent variable which is readmissions to any acute care hospital directly from SNFs, the 30-day of admission. Next, a logistic regression formula was then utilized.

And as for utilizing 39 candidate variables, this was progressively refined into one that utilized 33 independent variables. Of the 33 independent variables, 31 of the variables all had relatively low prevalence in the model building sample with the exception of ventilator status and suction. And the variables all had relatively low prevalence in the model building sample.

The C statistic of the Pro 30 model is 0.669 with 95

percent confidence interval which is the range of 0.6662 to 0.6851. This means that there is 67 percent probability that a case, i.e., a person who is readmitted to acute care facility from SNF has high predicted risk than a non-case. The p-value of the Hosmer-Lemeshow statistics for Pro 30 model at facility level is 0.85.

So developer accepted the hypothesis of no discrepancy between observed versus expected proportions concluding that the logistical model is a good fit. The developer noted that this model assumes that an independent variable rarely change between the date of admission and the assessment for the admission MDS. The developer tested this assumption by looking at the change from the first and the second assessment.

That number was 203 and 386 assessment that were done seven days apart. To roughly estimate variable stability, the developer identified four variables demonstrating rates of change greater than 10 percent which is bowel incontinence, cognition not intact, 2 percent assist, and oxygen use. The developer concluded that the facility level estimates of expected readmission rates are unlikely to be affected greatly by variable instability between the date of admission and the assessment reference date on the initial MDS assessment.

And lastly on that, the developer noted that when the risk model is applied to data collection on the day of admission, it will slightly overestimate the expected risk because patients with values of one for the least stable IVs will be zeros by the day of the first MDS assessment. Anything on the risk adjustment before we move on to meaningful differences in the performance? Quite wordy.

Co-Chair O'Linn: I have a question about the C statistic. Is 0.67 adequate how they group? I thought 0.7 was, like, the cutoff as to it being good enough. But I don't know. Comments from Karen or

anybody else? Yes, hi, Nadia. Go for it.

Ms. Angelidou: Yes, hi. Based on our research with AHCA and PointRight as well as some literature that's been published, using claims for MDS data, these are the best statistics that one can find for the re-hospitalization models. So 6.7 -- 0.67 or 0.68 are pretty good in our opinion based on literature that's also published by other researchers and the CMS measures that have already been published as well.

Co-Chair O'Linn: Thank you, Nadia. Thank you, Raj. Any other questions on the risk adjustment?

(No audible response.)

Member Mahajan: So next up is meaningful differences in performance. So developer noted that from Q4 of 2011 to the 3rd Quarter 2019, there was an 80 percent decrease in the national average re-hospitalization rate. And it went from 18.2 percent to 16.7 percent.

And then the developer noted that American Health Care Association provided data on re-hospitalization for all SNFs nationally. For Q4 of 2020, the developer showed that risk adjusted mean rate on a performance of 16.3 percent with a standard deviation of 5.2 percent. The developer also provided a minimum performance of zero percent to max performance of 81.9 percent. It is unclear if these differences in performance are statistically significant before anybody asks that question. So any comment on meaningful differences?

(No audible response.)

Member Mahajan: So we do have some missing data and developer provided distribution of data MDS 3.0 and discharge records and the levels of types of missing data by the state. And that is available as a hyperlink. And the developer noted that the level of completeness is high, defined at 95 percent of admissions have either a discharge

assessment completed by another MDS data indicating that the person is staying in the facility.

And the developer excluded all facilities within 5 percent missing data and when the re-hospitalization analysis was done. And developer noted overall the frequency of missing data is low and that it is recommended to calculate the degree of missing data in the numerator and not report facilities where MDS assessment data is missing at least 95 percent of the time. So then we have the comparability.

The measure uses one set of specifications for the measure. And that is the data on the validity testing exclusion risk assessment, meaningful difference in performance, and any missing data. Any comments from committee members?

Co-Chair O'Linn: Dr. Pease, do you want to go ahead?

Member Pease: This just brings back the same conversation around COVID because, again, looking at the data and the time period selected, especially looking at the meaningful differences, the time period is pre-COVID. So it doesn't change the overall intent of the measure. But I assume if we did it with more current data, it would be significantly different.

Co-Chair O'Linn: Good point. Ed Davidson, please. That might've been -- I thought I saw your -- go ahead, Ed. Thanks.

Member Davidson: Yes, sorry. I wonder if the developer could comment for the committee about the compression of the skilled nursing facility census during COVID and just observations from AHCA looking at this measure with that regard.

Mr. Sreenivas: This is Kiran. So we -- I think we saw some facilities. They no longer have the 30-day. So their rates were kind of suppressed based

on the measure itself. So we kept it at 30 for the requirement. Other than that, I mean, we saw the rate go a little bit higher in 2020, Q4.

But overall, I don't think we -- we haven't really teased that out specifically regarding, like, change in census and that impact on the measure. And also it's difficult because it varies so much from different areas. We know COVID raised, kind of went around in different time periods and stuff. So making sure it's looking at apples to apples comparison to find out which census is decreasing.

Co-Chair O'Linn: So the preliminary rating for validity was moderate. And if there's no other comments or questions for the developer on this validity topic, why don't we move on to feasibility.

Member Mahajan: So on feasibility, the developer noted that the data elements needed to complete -- I'm sorry, to compute the measures can be generated for collecting the personnel during provision of care. All data elements are defined fields for electronic clinical data, for example, clinical registry, the MDS, in OASIS or Home Health. Developer noted that the computation of the measure requires a license to use software for large scale data management and calculation risk estimates using logistical regression models.

Also, the developer noted that wide utilization of the measure specification does not require a fee. There is a requirement that display disclosure or publication of measure must include measure trademark and that the measure specifications are copyrighted by the vendor, PointRight. So any comments from the committee on feasibility discussion?

(No audible response.)

Member Mahajan: If not, we can move to the next criteria, number 4 on use and usability. I see some heads nodding there. So then before --

Ms. White: I don't see any hands raised.

Member Mahajan: Thank you. So for use and usability, we have use in that. First subsection is accountability and transparency. So in there we have currently is this publicly reported? Yes. Is the current use in an accountability program? Yes.

And planned use and accountability program is not applicable. So on the accountability program details, the measure utilized in two state programs. We discussed that before in California and Hawaii as part of their value-based purchasing and/or pay for performance programs as well as individual providers and networks.

And then the developer noted that Pro 30 is an all-payer measure and it's utilized in negotiating reimbursement rates and incentive payments with Medicare managed programs and managed care organization with other referral partners. Anything on the accountability and transparency? Any discussion or comments?

(No audible response.)

Member Mahajan: So then we have subsection 2 of feedback on the measure by those being measures. And so for that, the developer publishes Pro 30 rates on AHCA long-term care trend tracker tool quarterly for the members to track and benchmark their organizations for Pro 30 performance. The developer publishes facility level rates publicly to AHCA's website on a quarterly basis.

The Net Health PointRight Pro 30 re-hospitalization and QASP performance data are updated on an ongoing daily basis and available to all Net Health consumers -- I'm sorry, customers who subscribe to the web-based software solution. The developer noted that results of all participating facilities nationwide is 200 facilities are presented to PointRight ScoreCard solution which updates every month. The developer noted that Net Health

customers share feedback through the following ways: direct conversation with analytics, product management sales, the client service team members in application messaging email, and in conjunction with their net promoter score customer satisfaction surveys.

Next, the developer highlighted feedback obtained from Net Health customer who used Pro 30 to monitor and manage their re-hospitalization outcomes. Some of these are in a competitive position as a preferred partner for post-acute care. Users achieve and sustain excellence in reducing the re-hospitalization rates.

Users feel they can leverage the benefits of communicating with their -- regarding their re-hospitalizations. And users can prepare for that position for their organization for value-based incentive and penalties. So that is the feedback from the entities that are being measured by this measure and overall positive comments. And any discussion on this?

(No audible response.)

Member Mahajan: I personally think there are so many different ways for them to provide the feedback and chances of tracking that because if these are calls to the sales and client success team members, I'm not sure if every single one of those is being logged. Kiran has a smile on his face. I'm not sure if it's related. Any comments on overall preliminary rating?

Member Freeman: I just want to mention as I did with the other measure that, again, I think that the use can go beyond the facility and be used by the facility to communicate to the patients and their families -- not patients, residents and their families. I think it will just create a positive energy and proper information, more helpful information for them to use.

Co-Chair O'Linn: The feedback from the customers were so positive, I was wondering -- and there's another comment in the standing committee whether or not there was any feedback that helped with possible changes to the measure from the customers.

Mr. Sreenivas: This is Kiran. I can talk a little bit, I guess, about some of the feedback we received. Is that kind of the question?

I know one question when I was thinking a little bit about this. One question we've gotten -- some feedback we've gotten is looking at potentially this measure for, like, specific conditions. So, like, you're a CHF patient, so specific to specific diseases and stuff.

We've gone back and forth a little bit about that. Some of it is hard because you have small numbers with that. So it creates some trouble actually getting that minimum sample size to create the measure if you subset it to that.

I think there has been some facilities that are large enough. I think PointRight Net Health has been able to actually create the measure if they have large enough sample size for the specific -- and so I think they've gotten some good use out of that. So I don't know if that kind of touches on getting feedback from customers and kind of adapting to it.

Co-Chair O'Linn: Go ahead, Nadia.

Ms. Angelidou: Yeah, just to what Kiran said, we do report when appropriate the rates for re-hospitalization for certain conditions that are relevant to the short stay populations in the facilities. And we do that because the Pro 30 model has been very, very stable and robust, not only across time but also for specific conditions when we subset and we have adequate numbers to report the rates on. So when we are able to do that scientifically, we do it. And this is very helpful to the

customers to identify where to focus first which patients do pay more attention to.

And the other way, we are also reporting when visible it's by day of the week which, again, can be very, very helpful to the clinics because sometimes it's not the conditions themselves that are problematic but maybe staffing issues. So if clinics see, for example, an increase in their rates on specific days of the week, they can gather together and discuss whether staffing changes are appropriate and shifts of their staff members to appropriately care for the patients in their clinics. So whenever we can do it, we report rates in different ways to help the clinics and the nurses and the doctors to identify where they could concentrate more in order to achieve better results faster.

Co-Chair O'Linn: Great. Thank you. Thank you, Raj. So no other comments. We'll move on to usability.

Member Mahajan: All right. So usability has a couple of subtopics. So one is improvement and improvement in results in that developer provider re-hospitalization rates from AHCA's member facilities. And they noted that an improvement in re-hospitalization rates of 10.4 percent from Q4 of 2011 to Q4 of 2020. And that was from 18 to 18.5 percent to 16 to 16.5 percent.

Also, developer noted that an increase in the national average rate of Q4 2020 could be related to COVID-19 pandemic. And then the other subtopic, there is benefit versus harm in that. The developer did not indicate any unexpected findings associated with implementation of this measure.

And no potential harms were noted by developer. Now the questions for the committee is, how can the performance of results be used for further goal of high quality efficient healthcare? I personally whenever this question comes up with any readmission measure, there is a robust discussion of unintended consequences.

So I would open that up to see if -- and again, a lot of it is more anecdotal where facilities do try to keep residents longer to avoid readmission. And conceptually, that could lead to harm or unintended consequence. But definitely open it up for rest of the committee to comment.

(No audible response.)

Co-Chair O'Linn: Thank you so much for bringing that up too. Roman, do you have a comment?

Member Roman: Yeah, so I would say that I agree with you, Raj. And I think this comes up frequently on this committee as you noted that when readmission measures are created really without the intent of value-based purchasing as their goal which I think is true for most readmission measures that the measures themselves have the potential for unintended consequences. And I think where I'm going is that I think under the usability criteria, we really need to be looking at usability for value-based purchasing. And it's, I think, the experience of many that readmission measures have the potential to actually become cost measures when they're used in value-based purchasing settings.

Co-Chair O'Linn: Thank you for that comment. Any comment from the developer on this part of the discussion?

Mr. Sreenivas: I think these are great points. And I think it's one measure. That's why we sometimes need multiple measures to kind of show the whole perspective for both residents, families, as well as for partners and stuff as we're thinking about it.

I think one of the things that's been -- this measure actually isn't used in placed like Mexico, for example as well as Hawaii, I believe. So this measure is used value-based purchasing on the Medicaid side for the state. Janine, you're going to have to remind me. I'll let Janine chime in.

Ms. Savage: Yeah, I would just say that unlike the federal value-based purchasing program that uses one claims-based readmission measure, the state VBP programs that are using this measure contain a balance of measures that include clinical and utilization oriented measures and a number of measures between 4 and 12 measures typically. So this is not a sole -- this is not being used as a sole source of evaluation of a VBP state level program to my knowledge but as part of a much larger complement of measures.

Mr. Sreenivas: That's very helpful.

Co-Chair O'Linn: It is. Thank you for saying that. I think the other comment that has been drifted around is the request to the developers when you do the next evaluation to please further consider how COVID impacts these measures specifically in the next evaluation as it comes around.

So thank you so much. Thank you for this rich discussion. Any other comments on this measure here today? Because if not, we can move into the question of related competing measures.

Related and Competing Measures

Ms. White: So Amy, because we're voting offline using our SurveyMonkey poll, we will actually need to postpone our related and competing measures discussion to the post-comment meeting. So we will definitely focus on that on our post-comment. But I will -- I do have a few more slides, and I know it's approaching almost 4:00 o'clock on the East Coast.

So I definitely want to be mindful of everyone's time. So if we can have Victoria just pull up our last few slides. It's just a few more to do items our call.

NQF Member and Public Comment

So I'm going to pause a moment. We do want to have time allocated for our NQF members and

public to provide comments on this call. So we are going to open up the floor and see if any of the NQF members in public comment on the call today would like to provide their feedback. So I'm going to pause.

(No audible response.)

Ms. White: Okay. Hearing none, we will go on to the next slide, please. Okay. So I'm going to hand over the baton to Tristan Wind who will go through our next steps in our upcoming timeline. So Tristan?

Next Steps

Mr. Wind: Thank you, LeeAnn. Next slide. Perfect. Thank you for attending today's measure evaluation meeting. NQF staff will prepare the draft report consisting of the standing committee's discussion and recommendations.

The report will be released for a 30-day public member comment period in which all comments received will be compiled into a comment brief. And that will be shared with the standing committee and developers. These comments will also be discussed during a post-comment call.

NQF staff will then incorporate the comments and response to comments into a draft report which will then be reviewed by the CSAC team during the CSAC meeting. Additionally, there will be an option for an appeals period to provide the public an opportunity to appeal the endorsement decision. Next slide, please. So due to achieving today's meeting objectives, the measure evaluation follow-up meeting will not be taking place.

Therefore, you will receive a cancellation notice for the meeting on June 29th from 1:00 to 4:00 p.m. following the conclusion of today's meeting. Additionally, the draft report comment period will occur from August 3rd to September 1st. Additionally, the dates for the post-comment web

meeting, CSAC review, and appeals period have not yet been finalized.

So once those do become finalized, we will communicate those dates accordingly. Next slide, please. Now here's the project contact information, our email, remissions@qualityforum.org, our phone number, project page, and committee SharePoint site. If you are to have any questions or concerns, please reach out to us here. And I'll turn it back over to LeeAnn for outstanding questions and closing remarks.

Ms. White: Wonderful. Thank you, Tristan. So yes, I will pause here to see if anyone on the standing committee has any questions about today's call or following the measure evaluation meeting today to include the voting that will occur offline with the SurveyMonkey link.

(No audible response.)

Ms. White: Well, hearing none, if you do have any questions once we adjourn the call today, please feel free to reach out to our project team. Again, we're here to assist you, provide you support. We will send out that SurveyMonkey link to the committee members that were not in attendance today along with a copy of the official transcript.

So they will be able to review those materials and place their vote. We will also provide the due date of that vote once we send out that email communication. So I do appreciate you bearing with our new process today on the call.

And I'd also like to go ahead and provide my thank you remarks to everyone today. I really do appreciate your patience and your engagement and participation. I definitely want to thank our co-chair Amy for leading us through the spring 2022 measure review.

Thank you to our lead and supporting discussants

for your facilitation and preparation leading up to our meeting. A big thank you to our patient advisors who were on the call to provide that valuable patient perspective to the work we do. We greatly appreciate those words and that feedback that were provided all throughout the call, so a very big thank you.

Additionally, I'd like to thank our developer team for your time and effort leading up to the meeting and attending today to present and address any questions that the standing committee had during the conversation. So we definitely greatly appreciate your participation and your attendance today.

And then I'd like to also thank my team who works so hard to put all this together for you, Isaac, Tristan, Victoria, and Matt. Thank you for your hard work and dedication to our project. We'll take down our slide, and I would hand over the baton to Amy to provide her closing remarks.

## Adjourn

Co-Chair O'Linn: Thank you so much for the rich comments, the great questions. I appreciate all your input here today, and I appreciate everybody who unmuted and contributed to the conversation so much. Special hats off, thank you to the discussants, Milli West, Ed Davidson, Dr. Pease, Lisa Freeman, Raj Mahajan, and then to the NQF staff who helped this whole call go so smoothly.

So thank you so much to LeeAnn and team and the developers who brought this to our discussion today. Have a great weekend. This is about it for this meeting I do believe. Thank you for all your help today.

Ms. White: Wonderful. Thank you.

(Whereupon, the above-entitled matter went off the record at 3:58 p.m.)