NATIONAL QUALITY FORUM

Measure Applications Partnership

Coordinating Committee In-Person Meeting

January 25-26, 2018

Welcome

Disclosures of Interest

MAP Coordinating Committee Members

Committee Chairs: Charles Kahn, III, MPH; Harold Pincus, MD

Organizational Members (voting)	
Academy of Managed Care Pharmacy	Health Care Service Corporation
AFL-CIO	The Joint Commission
America's Health Insurance Plans	The Leapfrog Group
American Board of Medical Specialties	Medicare Rights Center
American Academy of Family Physicians	National Alliance for Caregiving
American College of Physicians	National Association of Medicaid Directors
American College of Surgeons	National Business Group on Health
American HealthCare Association	National Committee for Quality Assurance
American Hospital Association	National Partnership for Women and Families
American Medical Association	Network for Regional Healthcare Improvement
American Nurses Association	Pacific Business Group on Health
AMGA	Pharmaceutical Research and Manufacturers of America (PhRMA)
Consumers Union	

MAP Coordinating Committee Members (cont.)

Individual Subject Matter Expert (Voting)
Richard Antonelli, MD, MS

Federal Government Liaisons (Non-Voting)
Agency for Healthcare Research and Quality (AHRQ)
Centers for Disease Control and Prevention (CDC)
Centers for Medicare & Medicaid Services (CMS)
Office of the National Coordinator for Health Information Technology (ONC)

Meeting Objectives and Agenda

Meeting Objectives

- Finalize recommendations to the Department of Health and Human Services (HHS) on measures for use in federal programs for the clinician, hospital, and post-acute care/long-term care settings;
- Consider strategic issues that span all of the MAP Workgroups;
- Discuss potential improvements to the pre-rulemaking process

Day 1 Agenda

- Review pre-rulemaking approach
- Finalize pre-rulemaking recommendations
  - *PAC/LTC programs*
  - *Clinician programs*
  - *Hospital programs*

Day 2 Agenda

- Pre-Rulemaking Cross-Cutting Issue: Attribution
- Review Potential Improvements to the Pre-Rulemaking Process
  - *Voting*
  - *Voting Decision Categories*
  - *Decision Algorithm*
- Input on Measure Removal Criteria
- MAP Rural Health Presentation

Review MAP Pre-Rulemaking Approach

Approach

The approach to the analysis and selection of measures is a three-step process:

- Provide program overview
- Review current measures
- Evaluate MUCs for what they would add to the program measure set

Evaluate Measures Under Consideration

- MAP Workgroups must reach a decision about every measure under consideration
  - *Decision categories are standardized for consistency*
  - *Each decision should be accompanied by one or more statements of rationale that explains why each decision was reached*

Preliminary Analysis of Measures Under Consideration

To facilitate MAP's consent calendar voting process, NQF staff will conduct a preliminary analysis of each measure under consideration.

The preliminary analysis is an algorithm that asks a series of questions about each measure under consideration. This algorithm was:

- Developed from the MAP Measure Selection Criteria, and approved by the MAP Coordinating Committee, to evaluate each measure
- Intended to provide MAP members with a succinct profile of each measure and to serve as a starting point for MAP discussions

MAP Measure Selection Criteria

1	NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective
2	Program measure set adequately addresses each of the National Quality Strategy's three aims
3	Program measure set is responsive to specific program goals and requirements
4	Program measure set includes an appropriate mix of measure types
5	Program measure set enables measurement of person- and family-centered care and services
6	Program measure set includes considerations for healthcare disparities and cultural competency
7	Program measure set promotes parsimony and alignment

MAP Decision Categories

Decision Category	Evaluation Criteria
Support for Rulemaking	The measure is fully developed and tested in the setting where it will be applied and meets assessments 1-6 of the MAP Preliminary Analysis Algorithm. If the measure is in current use, it also meets assessment 7.
Conditional Support for Rulemaking	The measure is fully developed and tested and meets assessments 1-6. MAP will provide a rationale that outlines the conditions (e.g., NQF endorsement) based on assessments 4-7 (reference Table 2 below) that should be met. Ideally the conditions specified by MAP would be met before the measure is proposed for use. However, the Secretary retains policy discretion to propose the measure. CMS may address the MAP-specified conditions without resubmitting the measure to MAP prior to rulemaking.
Refine and Resubmit for Rulemaking	The measure meets assessments 1-3, but needs modifications. A designation of this decision category assumes at least one assessment 4-7 (slide 29) is not met. MAP will provide a rationale that outlines each suggested refinement (e.g., measure is not fully developed and tested OR there are opportunities for improvement under evaluation). Ideally the modifications suggested by MAP would be made before the measure is proposed for use. However, the Secretary retains policy discretion to propose the measure. CMS may address the MAP-specified refinements without resubmitting the measure to the MAP prior to rulemaking. CMS may informally, without deliberations and voting, review these refinements via the "feedback loop" with the MAP. These updates may occur during the web meetings of the MAP Workgroups scheduled annually in the fall.
Do Not Support for Rulemaking	The measure under consideration does not meet one or more of assessments 1-3.

Guidance on Refine and Resubmit

- Concerns were raised about this category during the fall web meetings
- The Coordinating Committee created this category with the thought that MUCs receiving this designation would be brought back to MAP before implementation.
- HHS Secretary has statutory authority to propose measures after considering MAP's recommendations.
- The feedback loop was implemented to provide MAP members updates on measures on prior MUC lists.
- The Coordinating Committee will review the decision categories at their January meeting.

Guidance on Refine and Resubmit

- The Coordinating Committee discussed the concerns raised by the Workgroups during its 11/30 meeting
  - *Reiterated the intent of the decision was to support the concept of a measure but recognize a potentially significant issue that should be addressed before implementation*
- The Committee suggested this category should be used judiciously
  - *The Coordinating Committee recommended that the Workgroups use this decision when a measure needs a substantive change*
  - *The Committee also noted the need for Workgroups to clarify the suggested refinement to the measure*

MAP Voting Instructions

Key Voting Principles

- MAP has established a consensus threshold of greater than 60 percent of participants.
  - *Multiple stakeholder groups would need to agree to reach this threshold.*
  - *Abstentions do not count in the denominator.*
- Every measure under consideration receives a decision, either individually or as part of a slate of measures.
  - *All measures are voted on or accepted as parted of the consent calendar.*
- Workgroups will be expected to reach a decision on every measure under consideration. There will not be a category of "split decisions" that would mean the Coordinating Committee decides on that measure. However, the Coordinating Committee may decide to continue discussion on a particularly important matter of program policy or strategy.

Key Voting Principles

- Staff will provide an overview of the process for establishing consensus through voting at the start of each in-person meeting.
- After additional introductory presentations from staff and the chair to give context to each programmatic discussion, voting will begin.
- The in-person meeting Discussion Guide will organize content as follows:
  - *Measures under consideration will be divided into a series of related groups for the purposes of discussion and voting. The groups are likely to be organized around programs (Hospital and PAC/LTC) or condition categories (Clinician/Medicaid).*
- Each measure under consideration will have been subject to a preliminary staff analysis based on a decision algorithm approved by the Coordinating Committee.
  - *The discussion guide will note the result of the preliminary analysis (i.e., support, do not support, or conditional support, refine and resubmit) and provide rationale to support how that conclusion was reached.*

Voting Procedure

Step 1. Staff will review a Preliminary Analysis Consent Calendar

- Staff will present each group of measures as a consent calendar reflecting the result of the preliminary analysis using MAP selection criteria and programmatic objectives

Voting Procedure

Step 2. MUCs can be pulled from the Consent Calendar and become regular agenda items

- The co-chairs will ask the Workgroup members to identify any MUCs they would like to pull off the consent calendar. Any Workgroup member can ask that one or more MUCs on the consent calendar be removed for individual discussion. Workgroup members are asked to identify any MUCs to be pulled off for individual discussion prior to the in-person meeting, if possible.
- Workgroup members should clarify if they are pulling a measure for discussion only or if they disagree with the preliminary analysis and would like to vote on a new motion.
- Measures pulled for discussion will focus on resolving clarifying questions.
  - *If during the course of discussion, a Workgroup member determines the discussion has shown the need for a new vote a Workgroup member can put forward a motion.*
- Potential reasons members can pull measures:
  - *Disagreement with the preliminary analysis*
  - *New information is available that would change the results of the algorithm*
- Once all measures that the Workgroup would like to discuss are removed from the consent calendar, the co-chair will ask if there is any objection to accepting the preliminary analysis and recommendation of the MUCs remaining on the consent calendar
- If a measure is not removed from the consent calendar the associated recommendations will be accepted without discussion

Voting Procedure

Step 3. Discussion and Voting on Measures Identified for a New Motion

- Workgroup member(s) who identified the need for discussion describe their perspective on the use of the measure and how it differs from the preliminary recommendation in the discussion guide.
  - *If a motion is for conditional support or refine and resubmit the member making the motion should clarify and announce the conditions or suggested refinements.*
- Workgroup member(s) assigned as lead discussant(s) for the relevant group of measures will be asked to respond to the individual(s) who requested discussion. Lead discussant(s) should state their own point of view, whether or not it is in agreement with the preliminary recommendation or the divergent opinion.
- The co-chair will then open for discussion among the Workgroup. Other Workgroup members should participate in the discussion to make their opinions known. However, one should refrain from repeating points already presented by others in the interest of time.
- After the discussion, the Workgroup member who made the motion has the option to withdraw the motion. Otherwise, the Workgroup will be asked to vote on the motion.
  - *If the motion is for conditional support or refine and resubmit the chair can accept additional conditions or suggested refinement based on the Workgroup's discussion.*
  - *If the named conditions or refinements directly contradict each other, the chair should ask for a separate motion after the original motion has been subject to a vote.*

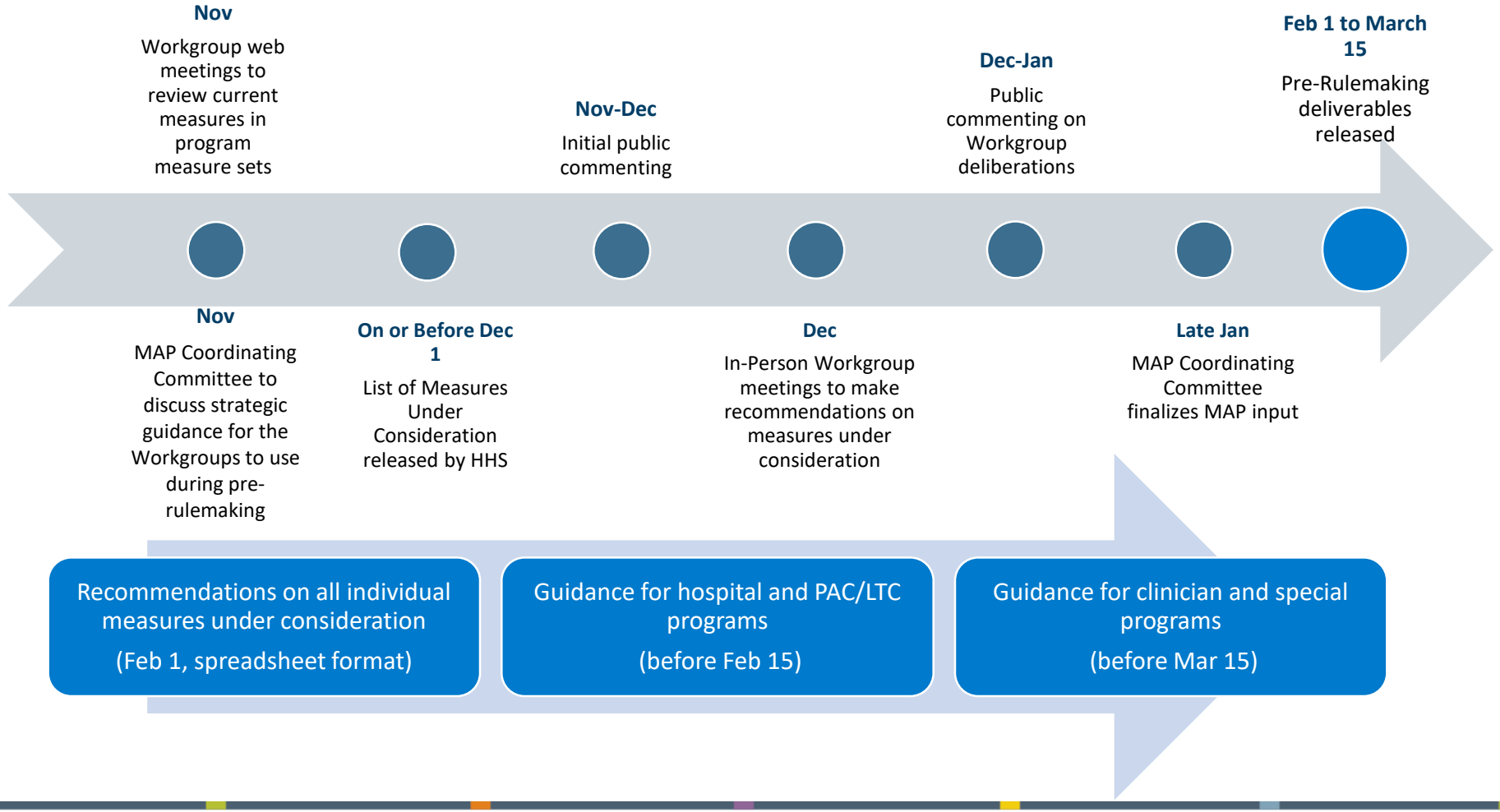
Voting Procedure
Step 4: Tallying the Votes

- If the motion put forward by the Workgroup member receives greater than 60% of the votes, the motion will pass and the measure will receive that decision.
- If the motion does not receive greater than 60% of the votes, the co-Chairs will resume discussion to develop another motion. To start discussion, the co-chairs will ask for another motion. If that motion receives greater than 60% of the votes, the motion will pass. If not, discussion will resume.
- If a no motion put forward by the Workgroup achieves greater than 60% the preliminary analysis decision will stand.
- Abstentions are discouraged but will not count in the denominator

Commenting Guidelines

- Comments from both public comment periods have been incorporated into the discussion guide
- There will be an opportunity for public comment before the discussion on each program.
  - *Commenters are asked to limit their comments to that program and limit comments to **two minutes.***
  - *Commenters are asked to make any comments on MUCs or opportunities to improve the current measure set at this time*
- There will be a global public comment period at the end of each day.

MAP Approach to Pre-Rulemaking: A look at what to expect



MAP Rural Health Workgroup Feedback on MUC

- During their December 2017 web meeting the Rural Health Workgroup engaged in a high-level discussion of the MUC list
  - *Workgroup members emphasized the importance of considering the low case-volume challenge for rural providers for several of the measures on the MUC list. For example:*
    - » Applicability to rural providers may be challenging for the cancer readmission measure
    - » On the other hand, the shingles vaccination measure likely would be "resistant" to the low case-volume challenge
  - *Workgroup members identified the topic areas of diabetes care, vascular care, opioid-related care and events, HIV screening, prostate screening, and simple pneumonia hospitalization as areas of interest and rural relevancy on the MUC list*

Q&A

Finalize Pre-Rulemaking Recommendations

Opportunity for Public Comment on PAC/LTC Programs

Commenters are asked to:

- Limit their comments to the PAC/LTC programs recommendations
- Limit comments to **two minutes**
- Make any comments on MUCs or opportunities to improve the current PAC/LTC measure set at this time

Finalize Pre-Rulemaking Recommendations for PAC/LTC Programs

Presented by:
Gerri Lamb and Paul Mulhausen, Workgroup Co-Chairs
Jean-Luc Tilly, Senior Project Manager, NQF

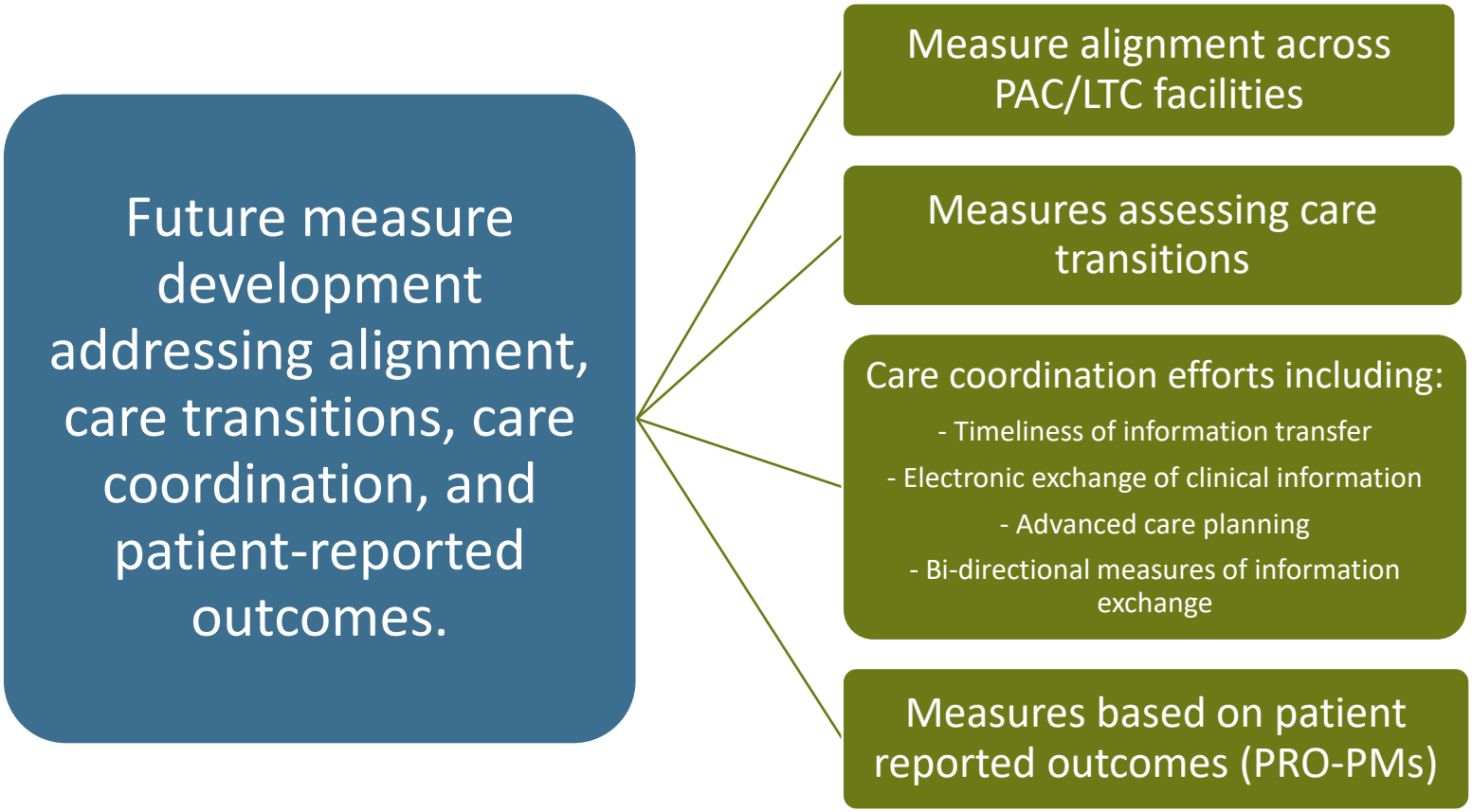
MAP Pre-Rulemaking: Finalize Pre-Rulemaking Recommendations for PAC/LTC

The MAP PAC/LTC Workgroup reviewed 1 measure under consideration for one setting-specific federal programs:

Program	# of Measures
Skilled Nursing Facility Quality Reporting Program (SNF QRP)	1

PAC/LTC Workgroup Meeting Themes

Move to High-Value Measures



MAP Pre-Rulemaking: Finalize Pre-Rulemaking Recommendations for PAC/LTC Programs

- The MAP PAC/LTC Workgroup reviewed 1 measure under consideration for the Skilled Nursing Facility Quality Reporting Program:
  - *MUC17-258: CoreQ: Short Stay Discharge Measure*

IMPACT Act

- MAP encouraged alignment of measurement across settings using standardized patient assessment data and acknowledged the importance of preventing duplicate efforts, maintaining data integrity, and reducing burden.
- Overall, the MUC introduced represents progress toward promoting quality in PAC settings.

Continued Opportunities to Address Quality

- Patient-reported outcome measures:
  - *Key to understanding quality*
  - *Increase patient and family engagement*
  - *New tools, such as PROMIS, have potential to spur groundbreaking measurement*
  - **The measure under consideration addresses this quality opportunity*

- Other measures important to patients:
  - *Transfer of information*
  - *Care preferences beyond end-of-life*
  - *Medication management*

Shared Accountability Across the Continuum

- Partnerships between hospitals and PAC/LTC providers are critical to successful transitions and improved discharge planning.
- Health information technology and interoperability-focused efforts offer an opportunity for improvement
- Settings share accountability to treat the 'whole' person, including care preferences

Considerations for Specific Programs

Skilled Nursing Facility Quality Reporting Program

New opportunities for measurement:

- Bi-directional measures that hold hospitals and SNFs equally accountable for the provision of care
- Measures that address the appropriateness of transfers
- Measures that address the patient/caregiver transfer experience
- Measures focusing on detailed advance directives

Measures under consideration:

- MUC17-258: CoreQ: Short Stay Discharge Measure
  - » Support for Rulemaking

Considerations for Specific Programs

Inpatient Rehabilitation Facility Quality Reporting Program

New opportunities for measurement:

- Measures addressing the transfer of patient information
- Measures addressing appropriate clinical uses of opioids in IRF facilities

Refine existing measures:

- Infection measures, given the low incidence in IRF facilities

Long-Term Care Hospital Quality Reporting Program

New opportunities for measurement:

- Measures addressing mental and behavioral health

Considerations for Specific Programs

Home Health Quality Reporting Program

New opportunities for measurement:

- Measures addressing social determinants of health
- Measures that assess a home health agency's success in stabilizing a patient's ability to perform activities of daily living
- Measures focusing on patients' maintenance or stabilization

Hospice Quality Reporting Program

New opportunities for measurement:

- Medication management at end of life
- Providing bereavement services
- Measures of effective service delivery to caregivers
- Safety and functional status measures
- Symptom management measures related to pain

Skilled Nursing Facility Quality Reporting Program Workgroup Recommendations

- CoreQ: Short Stay Discharge Measure (Workgroup Recommendation: Support for Rulemaking; Public comments received: 1; MUC ID: MUC17-258)

Measure Ratification by MAP Coordinating Committee

- MAP CC Chairs will ask CC members if any individual measures need to be pulled for discussion
- CC member will identify which part of the WG recommendation they disagree with
- All other measures will be considered ratified by the MAP CC

Lunch

Opportunity for Public Comment on Clinician Programs

Commenters are asked to:

- Limit their comments to the Clinician programs recommendations
- Limit comments to **two minutes**
- Make any comments on MUCs or opportunities to improve the current Clinician measure set at this time

Finalize Pre-Rulemaking Recommendations for Clinician Programs

Presented by:
Bruce Bagley and Amy Moyer, Workgroup Co-Chairs
John Bernot, Senior Director, NQF

MAP Pre-Rulemaking: Finalize Pre-Rulemaking Recommendations for Clinician Programs

The MAP Clinician Workgroup reviewed measures under consideration for two federal programs:

Program	# of Measures
Merit-Based Incentive Payment System (MIPS)	22
Medicare Shared Savings Program	3

Clinician Workgroup Meeting Themes

Cost Measurement

- Importance of incorporating cost measures into value-based payment programs
- Cost measures should appropriately risk adjust to ensure clinical and social risk factors and evaluate a heterogeneous population
- Cost measures need to be routinely re-evaluated and tested during early stages of implementation

Clinician Workgroup Meeting Themes

Composite Measures

- Composite measures are well suited to capture the care provided for a condition and serve as a comprehensive view of performance

- Composite measures could pose additional challenges:
  - *Technical challenges in the measurement development process (i.e. target different target subpopulations; collection of data)*
  - *Challenge at the clinician level if a particular clinician or specialist does not have complete control over the care for that particular condition*

Considerations for Specific Programs: Merit-Based Incentive Payment System (MIPS)

CMS Priorities and Needs for MIPS:

- Outcome measures
- Measures relevant for specialty providers
- High-priority domains for future measure consideration:
  - *Person and caregiver-centered Experience and Outcomes (Specific focus on PROMs)*
  - *Communication and Care Coordination*
  - *Efficiency/Cost Reduction*
  - *Patient Safety*
  - *Appropriate Use*
- MACRA requires submission of new measures for publication in applicable specialty-appropriate, peer-reviewed journals prior to implementing in MIPS.
- Available for public reporting on Physician Compare
- Measures are fully developed and tested and ready for implementation
- Not duplicative of measures in set
- Identify opportunities for improvement – avoid "topped out" measures

Considerations for Specific Programs: Merit-Based Incentive Payment System (MIPS)

MAP Clinician Workgroup Input:

- Desire to see more outcome measures
- Use of composite measures with consideration to attribution
- Importance of efficiency and cost reduction measures
- Encouraged the use of appropriate use measures with consideration of inappropriate use as well

Considerations for Specific Programs: Medicare Shared Savings Plan (MSSP)

CMS Priorities and Needs for MSSP:

- Outcome measures that address conditions that are high-cost and affect a high volume of Medicare patients
- Measures that are targeted to the needs and gaps in care of Medicare fee-for-service patients and their caregivers
- Measures that align with CMS quality reporting initiatives, such as MIPS
- Measures that support improved individual and population health
- Measures that align with recommendations from the Core Quality Measures Collaborative

Considerations for Specific Programs: Medicare Shared Savings Plan (MSSP)

MAP Clinician Workgroup Input:

- Desire to see more outcome measures
- Use of composite measures with consideration to attribution
- Importance of measures that align with other programs including MIPS

Merit-Based Incentive Payment System Workgroup Recommendations

- Continuity of Pharmacotherapy for Opioid Use Disorder (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:1; MUC ID: MUC17-139)
- Average change in functional status following lumbar spine fusion surgery(Workgroup Recommendation: Support for Rulemaking; Public comments received:1; MUC ID: MUC17-168)
- Average change in functional status following total knee replacement surgery(Workgroup Recommendation: Support for Rulemaking; Public comments received:2; MUC ID: MUC17-169)
- Average change in functional status following lumbar discectomy laminotomy surgery (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:1; MUC ID: MUC17-170)

Merit-Based Incentive Payment System Workgroup Recommendations

- Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received: 0; MUC ID: MUC17-173)
- Average change in leg pain following lumbar spine fusion surgery (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:2; MUC ID: MUC17-177)
- Optimal Diabetes Care (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:2; MUC ID: MUC17-181)
- Optimal Vascular Care (Workgroup Recommendation: Support for Rulemaking; Public comments received:1; MUC ID: MUC17-194)
- Diabetes A1c Control (< 8.0) (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:1; MUC ID: MUC17-215)

Merit-Based Incentive Payment System Workgroup Recommendations

- Ischemic Vascular Disease Use of Aspirin or Anti-platelet Medication (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received: 0; MUC ID: MUC17-234)
- Routine Cataract Removal with Intraocular Lens (IOL) Implantation (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:3; MUC ID: MUC17-235)
- International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) change 6-12 months after diagnosis of Benign Prostatic Hyperplasia (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:1; MUC ID: MUC17-239)
- Screening/Surveillance Colonoscopy (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:2; MUC ID: MUC17-256)

Merit-Based Incentive Payment System Workgroup Recommendations

- Knee Arthroplasty (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:4; MUC ID: MUC17-261)
- ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:3; MUC ID: MUC17-262)
- Revascularization for Lower Extremity Chronic Limb Ischemia (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:2; MUC ID: MUC17-263)
- Zoster (Shingles) Vaccination (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:1; MUC ID: MUC17-310)
- Patient reported and clinical outcomes following ilio-femoral venous stenting(Workgroup Recommendation: Refine and Resubmit Prior to Rulemaking; Public comments received: 0; MUC ID: MUC17-345)

Merit-Based Incentive Payment System Workgroup Recommendations

- Elective Outpatient Percutaneous Coronary Intervention (PCI) (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:3; MUC ID: MUC17-359)
- Intracranial Hemorrhage or Cerebral Infarction (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:4; MUC ID: MUC17-363)
- Simple Pneumonia with Hospitalization (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:1; MUC ID: MUC17-365)
- HIV Screening (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:1; MUC ID: MUC17-367)

Medicare Shared Savings Program Workgroup Recommendations

- Optimal Diabetes Care (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:4; MUC ID: MUC17-181)
- Diabetes A1c Control (< 8.0) (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:6; MUC ID: MUC17-215)
- Ischemic Vascular Disease Use of Aspirin or Anti-platelet Medication (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:1; MUC ID: MUC17-234)

Measure Ratification by MAP Coordinating Committee

- MAP CC Chairs will ask CC members if any individual measures need to be pulled for discussion
- CC member will identify which part of the WG recommendation they disagree with
- All other measures will be considered ratified by the MAP CC

Break

Opportunity for Public Comment on Hospital Programs

Commenters are asked to:

- Limit their comments to the Hospital programs recommendations
- Limit comments to **two minutes**
- Make any comments on MUCs or opportunities to improve the current hospital measure set at this time

Finalize Pre-Rulemaking Recommendations for Hospital Programs

Presented by:
Cristie Travis and Ron Walters, Workgroup Co-Chairs
Melissa Mariñelarena, Senior Director, NQF

MAP Pre-Rulemaking: Finalize Pre-Rulemaking Recommendations for Hospital Programs

The MAP Hospital Workgroup reviewed 9 measures under consideration for seven setting-specific federal programs:

Program	Number of Measures
Ambulatory Surgical Center Quality Reporting (ASCQR)	1
End-Stage Renal Disease Quality Incentive Program (ESRD QIP)	3
Inpatient Quality Reporting Program (IQR)/Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals	3
Hospital Outpatient Quality Reporting (OQR)	1
Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR)	1

Hospital Workgroup Meeting Themes

Promoting Alignment and Harmonization to Reduce Provider Burden and Provide Better Information to Patients

Alignment across payers	Harmonizing similar constructs	MAP role in advising on harmonization	Patient and Family Engagement
• *Importance of aligning the measures across CMS programs and public and private sector payers*	• *Need for increased harmonization of measures that evaluate similar constructs across settings and programs.*	• *Growing importance of considering parsimony, alignment, and measure harmonization at MAP.* • *Active MAP role in examining the measures used in CMS programs more broadly.*	• *Importance of engaging patients and families in efforts to improve measure harmonization*

Hospital Workgroup Meeting Themes

Balancing the Need to Address Quality Concerns with the Need to Ensure Fair Measurement

Timing Challenges

- *Need to address quality concerns in a timely manner and that some programs may require multiple years between MAP input and measure implementation.*
- *MAP providing input on measures that are currently under development and testing or have not been reviewed for NQF endorsement.*

Status of Measure Development

- *MAP members expressed concerns regarding how best to provide recommendations to CMS on these measures that are not fully developed and tested or measures that have not been evaluated for their scientific acceptability.*
- *MAP struggled with balancing critical quality issues and addressing patient outcomes with ensuring measures are reliable, valid, and actionable for providers.*

Considerations for Specific Programs

- End-Stage Renal Disease Quality Incentive Program
  - Emphasized the importance of medication management for ESRD patients and the need to help patients receive kidney transplants to improve their quality of life and reduce their risk of mortality. MAP members had divergent opinions on the ability of dialysis facilities to address these important quality gaps related to wait listing.
    - » Supported MUC17-176: Medication Reconciliation for Patients Receiving Care at Dialysis Facilities for rulemaking.
    - » Conditionally supported two related measures for rulemaking, MUC17-241: Percentage of Prevalent Patients Waitlisted (PPPW) and MUC17-245: Standardized First Kidney Transplant Waitlist Ratio for Incident Dialysis Patients (SWR).
  - MAP received a total of 13 comments on the proposed measures for the ESRD QIP program.
    - » Commenters supported the MAP recommendation on MUC17-176 noting broad support among stakeholders.
    - » Commenters noted the importance of improving transplantation rates for all patients with ESRD and recognized the issues of equal access to transplantation. Several commenters did not support MAP recommendations on MUC17-241 and MUC17-245 due to concerns with attribution to dialysis facilities for successful/unsuccessful wait-listing. Several commenters supported the recommendations and the conditions placed on the measure, and encouraged CMS to address them before implementation in federal programs.

Considerations for Specific Programs

- PPS-Exempt Cancer Hospital Quality Reporting
  - MAP reviewed one measure under consideration for the PCHQR program
    - MAP supported MUC17-178: 30-Day Unplanned Readmissions for Cancer Patients for rulemaking.
  - MAP received three comments on this measure. Two commenters supported the measure and one recommended that the measure not be included in the program due to concerns with measure exclusions.
- Ambulatory Surgical Center Quality Reporting Program
  - MAP reviewed one measure under consideration for the ASCQR program
    - MAP conditionally supported MUC17-233: Hospital Visits following General Surgery Ambulatory Surgical Center Procedures for the ASCQR program pending NQF review and endorsement.
  - MAP received seven comments on this measure.
    - Most comments supported the Workgroup's recommendation of conditional support, noting that further measure development is needed, and that the measure should be NQF endorsed before the measure is implemented in the ASCQR program. One commenter stated the MAP should issue a "Do Not Support for Rulemaking" recommendation for this measure due to numerous concerns, including the attribution model.

Considerations for Specific Programs

- Hospital Outpatient Quality Reporting
  - MAP reviewed one measure under consideration for the OQR program
    - » MAP did not support MUC17-223: Lumbar Spine Imaging for Low Back Pain for rulemaking.
      - Measure was not recommended for continued endorsement by the NQF Musculoskeletal Standing Committee in 2017.
      - The Standing Committee expressed a number of concerns:
        - Potential misalignment between this measure being specified for Medicare Fee-for-Service beneficiaries and the inclusion of "elderly individuals" as one of the red-flag conditions in the Appropriate Use guidelines
        - Use of Evaluation and Maintenance visits as a proxy for antecedent conservative care as this may not capture all types of conservative care that cannot be captured in claims data
        - Concerns about coding and appropriate look back periods for exclusions
  - MAP received one comment on this measure, supporting the Workgroup's recommendation.

Considerations for Specific Programs

- Inpatient Quality Reporting Program/Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals
  - MAP reviewed three measures for rulemaking for the IQR and the EHR Incentive Program.
    - » Conditionally supported two related measures for rulemaking, MUC17-195: Hospital-Wide All-Cause Risk Standardized Mortality and MUC17-196: Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure pending NQF review and endorsement.
    - » MAP recommended that MUC17-210: Hospital Harm Performance Measure: Opioid Related Adverse Respiratory Events, be revised and resubmitted prior to rulemaking.
      - *MAP voiced concerns that the measure has not been tested in enough hospitals to assess reliability and validity across facilities, and noted that the measure needs to be further refined and developed.*
  - MAP received a total of 20 comments on the proposed measures for the IQR program.
    - » Comments on MUC17-195 and MUC17-196 varied, some supported the conditions placed on the measure and some did not support the inclusion of the measure in program, though commenters generally agreed that the measures required further work before implementation. Commenters noted concerns with the data sources, potential unintended consequences, the scope of further measure development needed, and duplicity with measures currently in program as concerns.
    - » Five of six comments for MUC17-210 supported the MAP recommendation, noting that the measure is in an early stage of development and requires further development before implementation. One commenter recommended the Coordinating Committee to consider a “do not support” recommendation, and instead suggested that CMS to gather stakeholder input into the measure development process to refocus this work in a more meaningful way.

Ambulatory Surgical Center Quality Reporting Program Workgroup Recommendations

- Hospital Visits following General Surgery Ambulatory Surgical Center Procedures(Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:7; MUC ID: MUC17-233)

End-Stage Renal Disease Quality Incentive Program Workgroup Recommendations

- Medication Reconciliation for Patients Receiving Care at Dialysis Facilities(Workgroup Recommendation: Support for Rulemaking; Public comments received:2; MUC ID: MUC17-176)
- Percentage of Prevalent Patients Waitlisted (PPPW) (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:6; MUC ID: MUC17-241)
- Standardized First Kidney Transplant Waitlist Ratio for Incident Dialysis Patients (SWR) (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:5; MUC ID: MUC17-245)

Hospital Inpatient Quality Reporting and EHR Incentive Program Workgroup Recommendations

- Hospital-Wide All-Cause Risk Standardized Mortality Measure (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:8; MUC ID: MUC17-195)
- Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:6; MUC ID: MUC17-196)
- Hospital Harm Performance Measure: Opioid Related Adverse Respiratory Events(Workgroup Recommendation: Refine and Resubmit Prior to Rulemaking; Public comments received:6; MUC ID: MUC17-210)

Hospital Outpatient Quality Reporting Program Workgroup Recommendations

- Lumbar Spine Imaging for Low Back Pain (Workgroup Recommendation: Do Not Support for Rulemaking; Public comments received:1; MUC ID: MUC17-223)

Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program Workgroup Recommendations

- 30-Day Unplanned Readmissions for Cancer Patients (Workgroup Recommendation: Support for Rulemaking; Public comments received:3; MUC ID: MUC17-178)

Measure Ratification by MAP Coordinating Committee

- MAP CC Chairs will ask CC members if any individual measures need to be pulled for discussion
- CC member will identify which part of the WG recommendation they disagree with
- All other measures will be considered ratified by the MAP CC

Opportunity for Public Comment

Adjourn for the Day

NATIONAL QUALITY FORUM

Measure Applications Partnership Coordinating Committee Meeting

Day 2

January 26, 2018

Day 2 Agenda

- Pre-Rulemaking Cross-Cutting Issue: Attribution
- Review Potential Improvements to the Pre-Rulemaking Process
  - *Voting*
  - *Voting Decision Categories*
  - *Decision Algorithm*
- Input on Measure Removal Criteria
- MAP Rural Health Presentation

Day 1 Recap

Pre-Rulemaking Cross-Cutting Issue: Attribution

Review of NQF's Attribution Work and Guidance on Attribution Challenges in PAC/LTC Settings

Phase 1 Work

Current Landscape

- Recent legislation such as IMPACT and MACRA demonstrate the continued focus on value-based purchasing to drive improvements in quality and cost by re-aligning incentives.
- Implementing pay for performance models requires knowing who can be held responsible for the results of the quality and efficiency measures used to judge performance.
  - *Increasingly challenging as quality is assessed on outcome measures rather than process or structural measures.*
- Attribution can be defined as the methodology used to assign patients, and their quality outcomes, to providers or clinicians.
  - *Attribution models help to identify a patient relationship that can be used to establish accountability for quality and cost.*
- Moving the system away from fee-for-service payment to alternative payment models has highlighted the need to better understand how patient outcomes and costs can be accurately attributed in a system increasingly built on shared accountability.

Environmental Scan Highlights

- 163 models in use or proposed for use
  - 17% currently in use
  - 89% of total models use retrospective attribution
  - 77% attribute to a single provider, mainly a physician
- Models categorized by:
  - Program stage
  - Type of provider attributed
  - Timing
  - Clinical circumstances
  - Payer/programmatic circumstances
  - Exclusivity of attribution
  - Measure used to make attribution
  - Minimum requirement to make attribution
  - Period of time for which provider is responsible

Commissioned Paper Findings

- Best practices have not yet been determined
  - *Existing models are largely built off of previously used approaches*
  - *Trade-offs in the development of attribution models should be explored and transparent*
- No standard definition for an attribution model
- Lack of standardization across models limits ability to evaluate

Challenges

- Greater standardization among attribution models is needed to allow:
  - *Comparisons between models;*
  - *Best practices to emerge.*
- Little consistency across models but there is evidence that changing the attribution rules can alter results.
- The authors of the commissioned paper noted a lack of transparency on how results are attributed and no way to appeal the results of an attribution model that may wrongly assign responsibility.

Addressing the Challenges

- To address these challenges the Committee:
  - *Developed guiding principles*
  - *Made recommendations*
  - *Created the Attribution Model Selection Guide*

- These products allow for greater standardizations, transparency, and stakeholder buy-in:
  - *Allow for evaluation of models in the future*
  - *Lay the groundwork to develop a more robust evidence base*

Guiding Principles Preamble

- Acknowledge the complex, multidimensional challenges to implementing attribution models as the models can change depending on their purpose and the data available.
- Grounded in the National Quality Strategy (NQS) as attribution can play a critical role in advancing these goals.
- Recognize attribution can refer to both the attribution of patients for accountability purposes as well as the attribution of results of a performance measure.
- Highlighted the absence of a gold standard for designing or selecting an attribution model; must understand the goals of each use case.
- Key criteria for selecting an attribution model are: actionability, accuracy, fairness, and transparency.

Guiding Principles

1. Attribution models should fairly and accurately assign accountability.
2. Attribution models are an essential part of measure development, implementation, and policy and program design.
3. Considered choices among available data are fundamental in the design of an attribution model.
4. Attribution models should be regularly reviewed and updated.
5. Attribution models should be transparent and consistently applied.
6. Attribution models should align with the stated goals and purpose of the program.

Attribution Model Selection Guide

- **Current state:**
  - *Tension between the desire for clarity about an attribution model's fit for purpose and the state of the science related to attribution*
  - *Desire for rules to clarify which attribution model should be used in a given circumstance, but not enough evidence to support the development of such rules at this time.*
- **Goals of the Attribution Model Selection Guide:**
  - Aid measure developers, measure evaluation committees, and program implementers on the necessary elements of an attribution that should be specified.
  - Represent the minimum elements that should be shared with the accountable entities

The Attribution Model Selection Guide

What is the context and goal of the accountability program?	• What are the desired outcomes and results of the program? • Is the program aspirational? • Is the program evidence-based? • What is the accountability mechanism of the program? • Which entities will participate and act under the accountability program?
How do the measures relate to the context in which they are being used?	• What are the patient inclusion/exclusion criteria? • Does the model attribute enough individuals to draw fair conclusions?
Who are the entities receiving attribution?	• Which units are eligible for the attribution model? • Can the accountable unit meaningfully influence the outcomes? • Do the entities have sufficient sample size to meaningfully aggregate measure results? • Are there multiples units to which the attribution model will be applied?
How is the attribution performed?	• What data are used? Do all parties have access to the data? • What are the services that drive assignment? Does the use of those services assign responsibility to the correct accountable unit? • What are the details of the algorithm used to assign responsibility? • Has the reliability of the model been tested using multiple methodologies? • What is the timing of the attribution computation?

Recommendations for Attribution Models

- The recommendations build on the principles and Attribution Model Selection Guide.
- Intended to apply broadly to developing, selecting, and implementing attribution models in the context of public and private sector accountability programs.
- Recognized the current state of the science, considered what is achievable now, and what is the ideal future state for attribution models.
- Stressed the importance of aspirational and actionable recommendations in order to drive the field forward.

Use the Attribution Model Selection Guide to evaluate the factors to consider in the choice of an attribution model

- No gold standard; different approaches may be more appropriate than others in a given situation.
- Model choice should be dictated by the context in which it will be used and supported by evidence.
- Measure developers and program implementers should be transparent about the potential trade-offs between the accountability mechanism, the gap for improvement, the sphere of influence of the accountable entity over the outcome, and the scientific properties of the measure considered for use.

Attribution models should be tested

- Attribution models of quality initiative programs must be subject to some degree of testing for goodness of fit, scientific rigor, and unintended consequences.
  - *Degree of testing may vary based on the stakes of the accountability program, attribution models would be improved by rigorous scientific testing and making the results of such testing public.*
- When used in mandatory accountability programs, attribution models should be subject to testing that demonstrates adequate sample sizes, appropriate outlier exclusion and/or risk adjustment to fairly compare the performance of attributed entities, and sufficiently accurate data sources to support the model in fairly attributing patients/cases to entities.

Attribution models should be subject to multistakeholder review

- Given the current lack of evidence on the gold standard for attribution models, perspectives on which approach is best could vary based on the interests of the stakeholders involved.
- Attribution model selection and implementation in public and private sectors, such as organizations implementing payment programs or health plans implementing incentive programs should use multistakeholder review to determine the best attribution model to use for their purposes.

Attribution models should attribute care to entities who can influence care and outcomes

- Attribution models can unfairly assign results to entities who have little control or influence over patient outcomes.
- For an attribution model to be fair and meaningful, an accountable entity must be able to influence the outcomes for which it is being held accountable either directly or through collaboration with others.
- As care is increasingly delivered by teams and facilities become more integrated, attribution models should reflect what the accountable entities are able to influence rather than directly control.

Attribution models used in mandatory public reporting or payment programs should meet minimum criteria

- In order to be applied to mandatory reporting or payment program attribution models should:
  - *Use transparent, clearly articulated, reproducible methods of attribution;*
  - *Identify accountable entities that are able to meaningfully influence measured outcomes;*
  - *Utilize adequate sample sizes, outlier exclusion, and/or risk adjustment to fairly compare the performance of attributed entities;*
  - *Undergo sufficient testing with scientific rigor at the level of accountability being measured;*
  - *Demonstrate accurate enough data sources to support the model in fairly attributing patients/cases to entities;*
  - *Be implemented with adjudication processes, open to the public, that allow for timely and meaningful appeals by measured entities.*

Current Phase

Project Purpose and Objectives

- Develop a white paper to provide continued guidance to the field on approaches to attribution

To accomplish these goals, NQF will:

1. Convene a multistakeholder advisory panel to guide and provide input on the direction of the white paper
2. Hold two webinars and four conference calls with the panel
3. Conduct a review of the relevant evidence related to attribution
4. Perform key informant interviews
5. Develop a white paper that summarizes the evidence review, interviews, and recommendations
6. Develop a blueprint for further development of the Attribution Selection Guide
7. Examine NQF processes for opportunities to address attribution in measure evaluation and selection

Committee Discussion

- Does the Committee have any guidance for the Attribution Expert panel?

Potential Improvements to the Pre-Rulemaking Process: Voting Process

Proposed Improvements to Voting Process

- Revise the process to more closely follow Robert's Rules of Order:
  - *Add a vote to accept the consent calendar (yes/no)*
  - *Clarify that lead discussants should not be putting forward alternative motions*
- Create a role for staff to clarify the preliminary analysis if necessary and to help chairs theme the conversation
- Address technical issues to allow for anonymous voting and easier remote voting
- Determine if the Workgroups should have a default position (i.e. staff Preliminary Analysis) or continue voting until consensus on a decision category is reached
- Clarify abstentions prior to each vote

Discussion

- What is the Committee's reaction to the proposed changes?
- Are there additional changes the Committee would suggest?
- How should MAP define consensus? (Currently greater than 60%)

Break

Potential Improvements to the Pre-Rulemaking Process: Voting Decision Categories

MAP Measure Selection Criteria

1	NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective
2	Program measure set adequately addresses each of the National Quality Strategy's three aims
3	Program measure set is responsive to specific program goals and requirements
4	Program measure set includes an appropriate mix of measure types
5	Program measure set enables measurement of person- and family-centered care and services
6	Program measure set includes considerations for healthcare disparities and cultural competency
7	Program measure set promotes parsimony and alignment

Current MAP Decision Categories

Decision Category	Evaluation Criteria
Support for Rulemaking	The measure is fully developed and tested in the setting where it will be applied and meets assessments 1-6 of the MAP Preliminary Analysis Algorithm. If the measure is in current use, it also meets assessment 7.
Conditional Support for Rulemaking	The measure is fully developed and tested and meets assessments 1-6. MAP will provide a rationale that outlines the conditions (e.g., NQF endorsement) based on assessments 4-7 (reference Table 2 below) that should be met. Ideally the conditions specified by MAP would be met before the measure is proposed for use. However, the Secretary retains policy discretion to propose the measure. CMS may address the MAP-specified conditions without resubmitting the measure to MAP prior to rulemaking.
Refine and Resubmit for Rulemaking	The measure meets assessments 1-3, but needs modifications. A designation of this decision category assumes at least one assessment 4-7 (slide 29) is not met. MAP will provide a rationale that outlines each suggested refinement (e.g., measure is not fully developed and tested OR there are opportunities for improvement under evaluation). Ideally the modifications suggested by MAP would be made before the measure is proposed for use. However, the Secretary retains policy discretion to propose the measure. CMS may address the MAP-specified refinements without resubmitting the measure to the MAP prior to rulemaking. CMS may informally, without deliberations and voting, review these refinements via the "feedback loop" with the MAP. These updates may occur during the web meetings of the MAP Workgroups scheduled annually in the fall.
Do Not Support for Rulemaking	The measure under consideration does not meet one or more of assessments 1-3.

Concerns about Refine and Resubmit

- Workgroups and the Coordinating Committee agree with the intent behind the Refine and Resubmit category which is to support the concept of a measure but recognize a potentially significant issue that should be addressed before implementation
- Concerns arose around the implementation of refine and resubmit
- Propose renaming the category “Support Continued Development”
  - *Clarify the intent to signal the support of the concept but a significant change is needed*

Discussion

- What is the Coordinating Committee's reaction to proposed change?
- Are there other changes the Committee would suggest?

Potential Improvements to the Pre-Rulemaking Process: Decision Algorithm

Decision Algorithm

- Purpose of MAP review by Workgroups and Coordinating Committee is to evaluate the measure for appropriateness for a federal reporting program not to review against NQF endorsement criteria

- Concerns were raised that the algorithm may lead to conversations more appropriate for measure endorsement

Decision Algorithm – Proposed Changes

- Currently the decision algorithm has 2 separate criteria on testing
  - *Is the measure reliable and valid for the level of analysis, program, and/or setting(s) for which it is being considered?*
  - *Is the measure NQF-endorsed or has been submitted for NQF-endorsement for the program's setting and level of analysis*

- To focus the conversation, staff recommend combining the reliability/validity criteria with the NQF-endorsement criteria.

Discussion

- What is the Coordinating Committee's reaction to proposed change?
- Are there additional changes the Committee would suggest?

Opportunity for Public Comment

Lunch

Input on Measure Removal Criteria

Coordinating Committee Discussion

- What criteria should CMS consider as it reviews the measure sets for its quality reporting and value-based purchasing programs?

Considerations for Measure Removals

- **Meaningful to patients and providers**
  - *Patient-centered high priority quality measures current with clinical guidelines. May also need to meet specific statutory requirements.*
- **Measure type**
  - *Outcome measures are preferred.*
- **Variation in performance**
  - *Measure should demonstrate variation in performance.*

Considerations for Measure Removals

- **Performance trend**
  - *Should consider trends in performance.*
- **Burden**
  - *Consider amount of burden associated with the measure.*
- **Unintended consequences**
  - *Consider unintended consequences from use of the measure.*
- **Operational issues**
  - *Consider operational issues that may impact the measure.*

Considerations for Measure Removals

- **Alignment**
  - *Consider alignment of similar measures with private payers, and across and within CMS programs.*
- **Deduplication**
  - *Minimize unnecessary duplication of measures and measure concepts within measure sets.*
- **Quality improvement**
  - *Consider ability to drive quality improvement.*

Considerations for Measure Removals

- **Overall measure set**
  - *Consider impact and contribution to overall measure set for the program.*

MAP Rural Health Presentation

2015 Rural Project: Purpose and Objectives

- To provide multistakeholder information and guidance on performance measurement issues and challenges for rural providers
  - *Make recommendations regarding measures appropriate for use in CMS pay-for-performance programs for rural hospitals and clinicians*
  - *Make recommendations to help mitigate measurement challenges for rural providers, including the low-case volume challenge*
  - *Identify measurement gaps for rural hospitals and clinicians*

Key Issues Regarding Measurement of Rural Providers

- Geographic isolation
- Small practice size
- Heterogeneity
- Low case-volume

Previous Rural Work: Overarching Recommendation

- Make participation in CMS quality measurement and quality improvement programs mandatory for all rural providers, but allow a phased approach for full participation across program types and explicitly address low-case volume

Previous Rural Work: Supporting Recommendations for Measure selection

- Use guiding principles for selecting quality measures that are relevant for rural providers
- Use a core set of measures, along with a menu of optional measures, for rural providers
- Consider measures that are used in Patient-Centered Medical Home models
- Create a Measures Applications Partnership (MAP) Workgroup to advise CMS on the selection of rural-relevant measures

Objectives for 2017-2018 MAP Rural Health Workgroup

- Advise MAP on selecting performance measures that address the unique challenges, issues, health care needs and other factors that impact of rural residents
  - *Develop a set of criteria for selecting measures and measure concepts*
  - *Identify a core set(s) of the best available (i.e., "rural relevant") measures to address the needs of the rural population*
  - *Identify rural-relevant gaps in measurement*
  - *Provide recommendations regarding alignment and coordination of measurements efforts across programs, care settings, specialties, and sectors (both public and private)*
  - *Address a measurement topic relevant to vulnerable individuals in rural areas*

Interaction With Other MAP Workgroups and Coordinating Committee

- NQF staff introduced the Rural Workgroup and represent rural perspective at Nov-Dec 2017 Workgroup and Coordinating Committee meetings
- The MAP Coordinating Committee will consider input from the MAP Rural Health Workgroup during pre-rulemaking activities
- MAP Coordinating Committee will review and approve the Rural Health Workgroup's recommendations before finalizing (August 2018)

Progress to date

- Seated the Workgroup
  - *18 organizational members*
  - *7 subject matter experts*
  - *3 federal liaisons*
- Obtained guidance from the Workgroup on criteria for identifying core-set measures
  - *NQF endorsement*
  - *Addresses low case-volume*
  - *Cross-cutting*
  - *Several "must-have" topic areas/conditions*
- Presented a draft core set of measures to the Workgroup, based on their feedback to-date
  - *Will continue to refine the draft core set via post-meeting surveys*

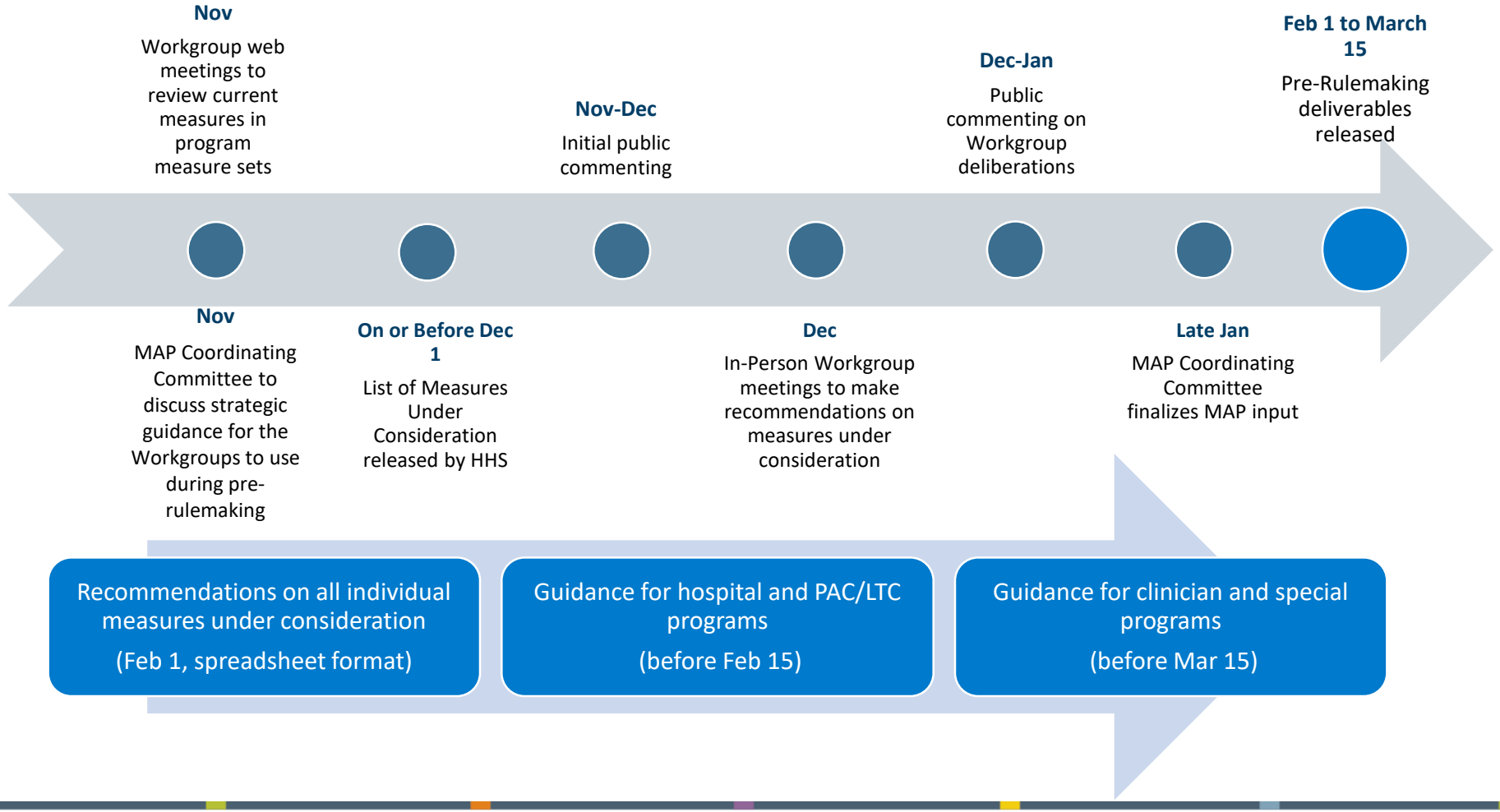
Discussion Questions: Your Advice to the Rural Health MAP Workgroup

- What key measurement or programmatic issues do you want the RH WG to keep in mind when identifying core sets of measures?
- What are your reactions to the core set(s) selection criteria? Do you think the RH WG should consider others?
- Do you have any advice for the RH WG in terms of what would be important to emphasize as they explain their work and results?
- Going forward, what information/guidance/input from the RH WG be helpful to your work on MAP?

Opportunity for Public Comment

Closing Remarks and Next Steps

MAP Approach to Pre-Rulemaking: A look at what to expect



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Adjourn