NATIONAL QUALITY FORUM

Moderator: MAP Hospital Workgroup
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OPERATOR: This is Conference #: 87952873

Operator: Welcome, everyone. The webcast is about to begin. Please note today's call is being recorded. Please standby.

(Desmirra Quinnonez): Hello, everyone. And welcome to the Hospital Workgroup Web Meeting for the Measure Applications Partnership.

We're going to begin with introducing our co-chairs, Cristie Travis and Ron Walters.

Ron Walters: Cristie, you can go first.

Cristie Travis: Well, thank you, Ron. Hi, this is Cristie Travis. I'm the CEO of the Memphis Business Group on Health. And I have been on this Hospital Workgroup since the beginning of the MAP process. So, I'm looking forward to working with all of you again this year, and to Ron, as my co-chair, who I'll now turn it over to.

Ron Walters: Hi. And welcome to all of our friends from the last few MAP years and to the new people. We're so happy to have you join us today on the call. I have to head next door to the Attribution meetings. So, I will be signing out pretty quickly here.

But, we wanted to let you know again today is to give you the detail, to go over the details of each program, what are the goals and objectives to review

some of the work done in the past as far as gaps identified to see if you see any other opportunities that present themselves in the programs. And try to get all that done.

I will also tell everyone on the group, we're experimenting something for the first time. And I don't know if we'll do this in December yet or not, but as all of you who've been doing this know that first day and a quarter is usually trying to get through IQR and as much of OQR as we can do.

So I'm going to flip the order up and see if that works a little better, Queuing Theory says actually, you should do the simplest things first and then do the hard ones which is counterintuitive, I know. So we're going to try to do those five "easy" programs in about five minutes a piece.

And there is a hard stop by doing that, oh, when we actually really do want to get to IQR and the Value-Based Purchasing Program and the ones that prompt a lot more discussion.

So let's see how that goes and so we're going to be a little bit of task masters for this to make sure we get to the ones that really do impact everyone on the call.

Let's see how it goes and please feel free to give us feedback as whether you thought this was successful or not, and whether that's the way we might want to consider doing December.

So with that, again, thank you very much for being on the call and I'm going to run next door.

Cristie Travis: Yes, thanks a lot, Ron.

Ron Walters: I'll see you if the room blows up.

Female: Thank you, Ron.

Ron Walters: Thanks, Cristie.

Cristie Travis: Bye.

Ron Walters: Thanks.

Cristie Travis: So, (Desi), are you going to take us through the roll call?

Desmirra Quinnonez: Yes, ma'am. I'll go ahead and start right now.

So we had our co-chairs on the call. You can – we've spoken with Cristie Travis and Ron Walters.

So when I say your name, you can feel free to say, "Here", or announce your presence. And we'll go ahead through the list. We have quite a few names.

Do I have Nancy Foster, representing the American Hospital Association?

David Engler representing America's Essential Hospitals? Marisa Valdes representing Baylor Scott & White Health? (Lee Young) representing Blue Cross Blue Shield of Massachusetts? Sally Turbyville representing Children's Hospital Association? Heather Lewis representing Geisinger Health System? Allen Nissenson representing Kidney Care Partners?

Allen Nissenson: Here.

Desmirra Quinnonez: Thanks, Allen.

(Carolyn Shahad) representing Medtronic-Minimally Invasive Therapy Group?

We have Helen Haskell representing Mothers Against Medical Error? Frank Ghinassi representing National Association of Psychiatric Health Systems?

Frank Ghinassi: Present.

Desmirra Quinnonez: Thank you.

(Brex Levatt) representing National Rural Health Association? (Kimberly Glassman) representing Nursing Alliance for Quality Care?

(Kimberly Glassman): I'm here.

Desmirra Quinnonez: Hi, (Kimberly).

Woody Eisenberg representing Pharmacy Quality Alliance?

Woody Eisenberg: I'm here.

Desmirra Quinnonez: Hello. Mimi Huizinga representing Premier, Inc.? Martin Hatlie representing Project Patient Care?

Female: Thank you.

Desmirra Quinnonez: Thank you.

Sarah Nolan representing Service Employees International Union? Jeff Jacobs representing the Society of Thoracic Surgeons?

Jeff Jacobs: Hi, I'm here. Thank you.

Desmirra Quinnonez: Thank you, Jeff.

Marsha Manning representing University of Michigan?

Marsha Manning: I'm here.

Desmirra Quinnonez: Hello, Marsha.

So we'll now move onto our individual subject matter experts.

Representing nursing, we have Gregory Alexander?

Gregory Alexander: I'm here.

Desmirra Quinnonez: Hi, Gregory.

Elizabeth Evans representing renal?

Elizabeth Evans: I'm here.

Desmirra Quinnonez: Thank you.

Lee Fleisher representing measure methodology?

Lee Fleisher: I'm here.

Desmirra Quinnonez: Hello, Lee. Jack Jordan representing patient safety?

Jack Jordan: I'm here.

Desmirra Quinnonez: Hi, Jack. R. Sean Morrison representing palliative care?

R. Sean Morrison: (Present).

Desmirra Quinnonez: Hello.

Ann Marie Sullivan representing mental health?

Female: Hi. Dr. Sullivan is on her way. She's in route back from a meeting and should be here in about 10 minutes.

Desmirra Quinnonez: Perfect, thank you.

Female: Thank you.

Desmirra Quinnonez: And we have Lindsey Wisham representing health informatics?

Lindsey Wisham: I'm here.

Desmirra Quinnonez: OK, hello, Lindsey.

Now, we'll move onto our MAP dual workgroup liaison. Do we have (Eileen Holmes) on the line from New Jersey Hospital Association?

(Eileen Holmes): I'm here.

Desmirra Quinnonez: Awesome. Welcome.

And we also will move to our federal government liaison. Do we have Pam Owens from AHRQ? (Dan Pollock) from CDC? And Pierre Yong from CMS?

OK. And I just wanted to welcome you all again for the call. My name is (Desmirra Quinnonez) and I am a project analyst with NQF. And this is actually my first encounter and positive experience with the MAP team. So, I'm excited to be working with the Hospital Workgroup this year.

Melissa Mariñelarena: Hi, everyone. This is Melissa Mariñelarena. I'm the senior director on the MAP Hospital Workgroup. This is my second year with MAP. I was with you last year.

I'd like to welcome all of our workgroup members who are with us last year and all of you, new members, I like to welcome you. And we are looking forward to a successful and productive MAP season. Thank you.

Kate McQueston: And my name is Kate McQueston. I'm a project manager. And this is my first MAP cycle.

And just a quick reminder, you can always be in touch with our team at MAPHospital@qualityforum.org.

And Elisa?

Elisa Munthali: Hi. This is Elisa Munthali. I'm vice president for Quality Measurement at NQF. I just wanted to welcome everyone and thank you so much for the work that's ahead.

(Desmirra Quinnonez): So we're going to go over the meeting objectives one more time very quickly.

During this meeting, we'll discuss an orientation to the MAP 2016 pre-rulemaking approach. Then we'll review each of the Hospital Workgroup program and we'll look for your input on potential measures gaps for these programs.

Next slide, please.

(So) the MAP pre-rulemaking approach. So where we currently are is the second on this arrow. From October to November, we're having our web meetings interviewing the current measures in the program measure sets.

On or before December 1st, we'll receive the list of measures under consideration, which will be released by HHS. From November to December, there will be a period of public commenting. In December, we will have our in-person workgroup meetings. Ours will be held on December 8th and 9th.

If everyone could please – if you're on the phone, turn off the sound from your computer. It reduces feedback. Thank you.

In late January, we will have the MAP Coordinating Committee meeting which will finalize MAP input. And then, our final guidance will be received – will be due for the MAP Hospital Group before February 15th.

Next slide, please.

In September, the MAP Coordinating Committee examined two strategic issues to inform the preliminary analyses of the measures under consideration. We will be holding an all-MAP web meeting on November 11th, which you all should have received the invitation to, which will cover the MAP standard decision categories and the MAP preliminary analysis algorithm. And this is an important meeting to attend because it will describe how decisions will be made at the MAP meeting.

The MAP workgroups will then use the preliminary analysis completed by NQF to inform their evaluation of the measures under consideration during the December in-person meetings. And the MAP Coordinating Committee will meet on January 26th to 27th to examine key cross-cutting issues identified by MAP Workgroup.

So for today's meeting, we will review the program type incentive structure and goal for each program. We will review the finalized measure sets for

each program and review CMS's high-priority domains for future measure consideration.

This document is included in the materials attached to the meeting invite for this meeting and covers CMS-identified high-priority domains for future measure considerations. We will then review gaps identified by the 2015-2016 MAP Hospital Workgroup for each program, and provide input on high-priority domains and gaps that will still need to be addressed.

The MAP Hospital Workgroup provides input on measures to be implemented through the federal rulemaking process for the following nine programs. We'll be reviewing each program in detail in the coming slides.

Before we get started reviewing the programs, we want to share some of the overarching themes from last year's workgroup.

The three themes identified were measurement to improve quality across the patient-focused episode of care. This includes more integrated measures that assess quality across the health care system.

Second was engaging patients and their families as partners in care delivery. MAP stressed the importance of shared decision making and discuss the roles providers, patients and their families play in making informed decisions regarding their care.

Last was driving improvement for all. MAP noted a need to expand that the population is covered by the programs reviewed by the Hospital Workgroup.

In particular, MAP was – MAP expressed the need for better measured – better measures of perinatal and pediatric care because these patients represent almost 25 percent of hospital discharges.

When evaluating measures, we would like to consider them not only as they relate to their program goals, but also as they relate to the continuum of care.

Keep in mind that there are three committees examining different sets of measures during this process, hospitals, clinician and PAC/LTC.

And with that, we'll begin with the first program. So, we'll begin with End-Stage Renal Disease Quality Incentive Program.

This is a pay-for-performance and public reporting program. Under the program, payments of dialysis facilities are reduced if facilities do not meet the required total performance score. Payment reductions are in a sliding scale for a maximum of 2 percent per year. The goals of the program are to improve the quality of dialysis care and produce better outcomes for beneficiaries.

Just a note, we won't be going over each measure individually when reviewing the measures included in programs, but we encourage you to use these slides as a reference when examining what measures are currently included in programs.

For End-Stage – for the End-Stage Renal Disease Program, there are currently 13 measures. 10 relate specifically to patients undergoing dialysis and three are more general process measures.

CMS identified the following demands as high-priority for future measure consideration. These are care coordination. (EDSR) patients are a vulnerable population that depends on a large variety of medication and utilization of multiple providers. As a result, dialysis facilities also play a substantial role in preparing patients for kidney transplant, and coordination of dialysis related services among transient population has consequences for non-trivial proportion of the ESRD dialysis population.

Safety, ESRD patients are frequently immune compromised and experience high rates of bloodstream infections, vascular access-related infections and mortality.

Patient and caregiver-centered experience of care, sustaining and recovering patient quality of life was among the original goals of this program. This includes issues such as physical function, independence and cognition.

And finally, access to transplantation. Obtaining a transplant is then extended process for dialysis patients including education referral, weight lifting, transplantation and follow-up care. The care and information available from dialysis facilities are integral to the transplant process.

Last year's MAP Hospital Workgroup also identified several domains for future measure consideration. This included fluid management infection, vascular access, patient-centered care and medical therapy management.

Female: Oh, thank you. Thank you very much.

(Desmirra Quinnonez): And now, I hand it over to Cristie to lead a brief discussion regarding any future high-priority domains.

Cristie Travis: Sure. Thank you very much. That was a great overview.

Our task right now as a committee is to – can you go back one slide for me please – is to look at the previous gaps that we identified last year which are listed here. And then, also going back another slide to keep in mind what the priorities were that CMS itself has identified for ESRD.

So, I'll turn it over to the committee members that are on the call to see if you have any additional gaps or priority domains that you think we need to be thinking about for the ESRD program.

Elizabeth Evans: This is Elizabeth Evans. I …

Cristie Travis: Yes.

Elizabeth Evans: … I would like to suggest two. One of them is a probably, we would work in conjunction with one of the other groups on diabetes since over 50 percent of our ESRD patients have diabetes is the – you know, the cause of that disease process. And I feel that at times it's not continued to be monitored or managed. So, that was one.

And the second one is also a bone mineral. I think the measures we have, need, don't really demonstrate the quality of care or lack of care and I think a more relevant bone mineral project or ...

(Off-Mic)

Elizabeth Evans: ... is needed.

Cristie Travis: Thank you, Elizabeth.

Female: Can you please …

Allen Nissenson: Hi. It's Allen Nissenson. Just …

Cristie Travis: Yes, Allen.

Allen Nissenson: … two quick comments. One, to Elizabeth's first point, I think one of the things that hopefully we'll have time to discuss at our meeting is – and I know we've discussed these things previously, is the attribution of accountability and diabetes care is a good example.

And I think the discussion will be around what should be an appropriate accountability of a dialysis facility versus an integrated health care system versus a nephrologist, or this comorbidity management that these patients have which we could expand from diabetes to congestive heart failure, to hypertension as the most common ones.

So I think that's a very rich discussion and it – in the context of ACOs or in our case, ESCOs, and other integrated care programs, that is an easier discussion than when we're talking about dialysis facilities.

The second comment I'd make is around gaps is the whole area of patient-reported outcomes, which is one of the areas that I think really needs attention going forward.

Cristie Travis: Thank you, Allen. And thank you for teeing up a conversation that I'm sure we will get to at our in-person meeting. So, thank you for laying the ground work for that.

We are about through with the time allotted for this program. If there is another comment – one other comment, I want to be sure that we do cover this. Anybody else have one last thing to say?

OK. But we will have more opportunities in December. So, we'll move onto the PPS-Exempt Cancer Hospital Quality Reporting Program.

(Desmirra Quinnonez): Thank you. The PCHQR is a voluntary quality reporting program in which data is publicly reported on a CMS site. The goals of the program are to provide information about the quality of care that is provided in cancer hospitals, specifically 11 cancer hospitals that are exempt from the IPPS and IQR programs.

Additionally, the program is used to encourage hospitals and clinicians to improve the quality of care to share information and to learn from each other's best practices.

There are currently 16 measures included in the program. The five measures highlighted in orange are measures from the National Healthcare Safety Network related to infection. The highlighted green measures are for radiation oncology. The blue highlighted measures are for breast cancer and purple for prostate cancer. There are also included measures for colon cancer and bone cancer, as well as the HCAHPS Survey and influenza vaccination coverage among health care personnel.

CMS identified the following categories of high-priorities of future measure consideration. Communication and care coordination, including measures regarding care coordination with other facilities and outpatient settings such as hospice care and measures of the patient's functional status quality of life and end of life, making care affordable, including measures related to efficiency, appropriateness and utilization of cancer treatment modality such as chemotherapy, radiation therapy and imaging treatment. And person and

family engagement including measures related to patient-centered care planning, shared decision making and quality of life outcomes.

Last year, the Hospital MAP Group also identified quality of life measures for patients living with cancer as a gap.

Cristie Travis: OK. So now, it's our turn again as a committee. Does anyone have any additional areas or domains for priority consideration as well as gaps that they would like to add to this list?

OK. Well, thank you all for your consideration of this and thank you for going through the program.

Woody Eisenberg: Oh, Cristie, I'm sorry. This is Woody. Can I add one?

Cristie Travis: OK, Woody. Glad to hear your voice.

Woody Eisenberg: Has the end-of-life care been included in any of the domains that have been reviewed?

Cristie Travis: I don't – I'm going to look to staff to answer. But I know it was a gap that was discussed under communication and care coordination.

(Kate McQueston): Yes. That's right, Cristie. There is not currently a measure included in the program related to that topic, however.

Cristie Travis: Do you think we should consider – Woody, would you like to consider pulling that out as a specific versus just having it be kind of subsumed under communication and care coordination?

Woody Eisenberg: Yes. I think it's important enough to be separated.

Cristie Travis: I would agree with that. Are there any other examples such as that when that, you know, or maybe had been embedded, if you will, in the CMS categories that we feel need to be brought out as specific gaps?

OK. Well, thank you, Woody. I really appreciate you bringing that topic up, and we'll be sure and identify it as its own gap.

Woody Eisenberg: Thank you.

Cristie Travis: Thank you. OK. We'll move onto the next program, which is, Ambulatory Surgical Center Quality Reporting.

(Desmirra Quinnonez): Thank you, Cristie. So, the Ambulatory Surgical Center Quality Reporting Program is a pay-for-reporting program and it's now also publicly reported. The incentive structure for this program is a 2 percent reduction in annual payment update for (ACS X) that either do not participate or failed to meet the program requirement.

The program goals include promoting higher quality and more efficient health care for the Medicare beneficiaries through measurement and allowing consumers to not only find but also compare the quality of care given to (X) to informed decisions on where to get their care.

If you look at the next slide, this is actually the current ambulatory surgery current measure set. And you'll notice as in the other program that Kate mentioned, they're similarly shaded measures and they're related. The blue measures you'll notice that they are measures that occur in the operating room. The purple measures are measures that are related to colonoscopies. And the gray-shaded measures are the general surgical procedural measures and there's also one cataract measure included.

Then this will go to CMS's high-priority domains for future measure consideration. CMS identified the following categories of high-priority for future measure consideration and you can see them listed above making care safer, person and family engagement, best practice of healthy living, effective prevention and treatment, communication, care coordination.

In the next slide, you'll actually see examples of the measure types within each domain.

Last year, MAP agreed with the priority areas as identified by CMS, which were the same as these that we just mentioned, and they stressed its support

for adding measures of – in surgical quality including both site infections and complications and measures of patient and family engagement.

So at this time, Cristie, I'll turn it back over to you to lead in the workgroup discussion on suggestions or refinements to the high-priority domains for future measurements.

Cristie Travis: Can you go back one slide, please? I just wanted to be sure I knew how to interpret these slides. Are these – these examples, are they already in the program or are they examples or gaps that have been identified?

Melissa Mariñelarena: This is Melissa. So, these are examples of measures within the domain. So, under making care safer, infection rates was an example of a measure. Under person and family engagement, an example was measures that improve experience of care for patients, caregivers and families and measures that promote patient self-management.

And then the best practices of healthy living were measures that increase appropriate use of screening and prevention services, measures that improve the quality of care for patients with multiple chronic conditions and measures that improve behavioral health access and quality of care.

For the domain effective prevention and treatment, there's measures for – recommendations of measures for surgical outcome measures. And the domain of communication and care coordination, (there are) examples of measures that embed best practice to manage transitions across practice settings, measures that enable effective health care system navigation and measures that reduce unexpected hospital emergency visits and admissions.

Cristie Travis: And just as a clarification, I'm sorry, take up our extra time here. But, do – if you went to the current measure set, are these already included in that or are these kind of some examples that aren't included in our current measure set?

Melissa Mariñelarena: These are examples that are not included in our measure set.

Cristie Travis: OK. Great. Thank you. Because it looks like a really great list of measure examples to me.

Melissa Mariñelarena: All right. These are …

(Crosstalk)

Melissa Mariñelarena: Go back, Desi. So, these are the ones that are in our measure sets. So we have some – like Desi said, some – the blue are measuring processes that occur in the O.R.

Cristie Travis: Right.

Melissa Mariñelarena: Then we have three measures that are related to colonoscopy procedures and then just some kind of general measures around surgical procedures and then there's one around cataract surgery.

Cristie Travis: So, I'm drawing the right conclusion that for instance we don't have anything about infection rates at this time.

Melissa Mariñelarena: That is correct.

Cristie Travis: OK. Thank you. And maybe go back to that nice chart that you had where you had the examples underneath the – yes, this one right here. So, you know, we had previously identified surgical quality such as site infections and I can't remember what the other gap we had previously considered was ...

Melissa Mariñelarena: Site infections and complications and patient and family engagement.

Cristie Travis: OK. So, is anyone on committee have any other suggestions? These are hospice list or not hospice list. It could be something that hasn't yet been identified as potential gaps or changes in their priority areas.

Lee Fleisher: Hi. It's Lee, Cristie.

Cristie Travis: Yes, Lee.

Lee Fleisher: So, one of the areas in – you know, I'm not sure exactly where would fit is appropriate testing. One of my areas of domain expertise is in appropriate pre-op testing. We have way too much testing for this. So, I don't know if

that would fit within any of these five categories. It's more efficiency measure.

Cristie Travis: Right. Well, we will definitely make note of it. We'll figure out where it fits.

Lee Fleisher: All right.

Cristie Travis: Or it can be an addition. It doesn't, you know, have to fit perfectly.

Lee Fleisher: Right. It may be a little in care coordination and that patients get way too many incremental test inappropriately.

Cristie Travis: OK. Great. Thank you. Any other thoughts from others, or?

Melissa Mariñelarena: This is Melissa, and I don't know if this would apply to Ambulatory Surgical Care. But in the Hospital Outpatient Program, there is a measure for cardiac imaging, for pre-operative risk assessment, for non-cardiac low-risk surgery that kind of gets to that. The programs are a little bit similar because they do both have outpatient surgery procedures, just so you know when we get to that program.

Cristie Travis: Thank you. Any other comments?

OK. Well, we will move onto the next program which is Inpatient Psychiatric Facility Quality Reporting Program.

(Desmirra Quinnonez): Thank you. So, the Inpatient Psychiatric Facility Quality Reporting Program is both the pay for reporting and public reporting.

The incentive structure encompasses a 2 percent reduction in annual payment update for inpatient psychiatric facilities that do not submit data on all required measures.

The program goals include providing consumers with quality of care information, so they can more – so that they can make more informed decisions about health care options and also to encourage hospitals and clinicians to improve the quality of inpatient psychiatric care by ensuring that providers are aware and reporting on best practices.

On the next slide, you'll see the existing current measure set for IPFQR. And you'll notice that this is the measure set currently as it exists right now. I will point out two measures, measure 1664, which is the SUB-3 Alcohol and Other Drug Use disorder treatment. It's actually one of the last purple ones in the middle of the page. And that measure, as well as the last measure on the page, the 30-day all-cause unplanned readmission measure, those two measures are actually new, new for this. And actually, you can look at them if you want to check them out in federal rule guidelines on page 5-7-2-4-7, so 57,247.

Cristie Travis: Thank you. It's a lot of pages.

(Desmirra Quinnonez): It is. OK. So now, we'll go to – this is a list of the – this graph shows the CMS high-priority domains for future measure considerations that include patient and family engagement, effective prevention and treatment, best practices on – of healthy living and making care affordable.

So, similar to the previous program that we did, you'll notice those priority domains for IPFQR from CMS listed as well as some example types of measures for each domain.

So, under patient and family engagement, you'll see patient experience of care. Under effective prevention and treatment, you'll notice inpatient psychiatric treatment of geriatric patients, other adults and adolescents and children, and the quality of prescribing antipsychotics and antidepressant.

Under best practices of healthy living, you'll notice screening and treatment of non-psychiatric comorbid condition as well as access to care. And in the last section, you'll notice making care affordable. They have efficiency and value based.

So last year, MAP recognized and noted some of the gaps that are listed above. And the overall general consensus that came away from that meeting was that a huge part – a huge part of it was the – of the conversation was that you can't separate substance abuse from mental illness. So you notice under substance abuse, they have alcohol, tobacco and opioid. Under connections in care and the community, they have integrated inpatient and outpatient care

and primary care provider. And lastly, they have avoidable readmissions and emergency department visits.

And with that, Cristie, I'll turn it back over to you to begin the discussion.

Cristie Travis: OK. Great. Does anybody have any lead-off points they'd like to make?

Gregory Alexander: Well, this is Greg Alexander. And I just have a question in regards to the antipsychotics there on effective prevention and treatment.

So, does this specifically call out just psychiatric facilities or does this include like dementia care units where people have dementia and psychiatric, different kinds of psychiatric diagnosis and like nursing homes, skilled nursing facilities that have a section of their facility for different kinds of gerontological psychiatric issues. And – because I know in those situations, psychotic – antipsychotic reduction is becoming a big issue, and I just wondered how much this crossover into that realm, or if this is completely separate from that.

Melissa Mariñelarena: This is Melissa from NQF. Is anybody from CMS on the phone that could answer that question?

Jeffrey Buck: This is Jeff Buck. Can you hear me?

Melissa Mariñelarena: Yes.

Cristie Travis: Yes.

Jeffrey Buck: Yes. Generally, those – the facilities who participate in the program are those that are paid under the IPF/PPS payment program and those are certified as inpatient psychiatric facilities. That generally does not include the kinds of units the person was just describing.

Melissa Mariñelarena: Great. Thank you.

Jeffrey Buck: You're welcome.

Ann Marie Sullivan: Yes. Hi, this is Ann Sullivan. I just want to emphasize the area of screening and treatments of the comorbid conditions. And that, you know, they have some stronger measures, I mean, there's measures of gap, but it's really very critical, you know, these patients often really don't get the kinds of medical care that they need. And an opportunity to deal with some of that is when they hit a psychiatric unit.

So, I do think it's important that we integrate both medical care in – when they're on the inpatient psychiatric unit.

And then the other point is emergency department visits. You know, many emergency department visit's mental issues are not in specialized psychiatric emergency rooms and often, you know, follow-up care after that is quite limited. And I think that's another gap, but that's another point of contact where often people get lost. They really don't get good connections to follow-up care after emergency visits.

Jeffrey Buck: So, if I could just ask you, I'm not quite sure if your point is about what happens to people after emergency room visits or the fact of emergency room visits following discharge from the inpatient facility.

Ann Marie Sullivan: Well, it's both. I mean – well, I think it's …

Jeffrey Buck: Keep in mind the focus of this facility is – I mean, of this program is inpatient psychiatric facilities. And so we're measuring the performance of places like psychiatric units and psychiatric hospitals.

And so I think the only kind of measure …

Ann Marie Sullivan: Yes. Your point is – yes, your point is well taken on that. That basically it would be – that's not what I was talking about. I was talking about people with the emergency room, and maybe don't get admitted, which would not be for this in particular.

Jeffrey Buck: That's right.

Ann Marie Sullivan: You're right.

Cristie Travis: That's right.

Jeffrey Buck: But, it’s a good point.

Ann Marie Sullivan: OK.

Cristie Travis: It will not be lost.

Ann Marie Sullivan: But I do think the medical comorbidities – we could do a better job among the inpatient side.

Cristie Travis: Yes.

Ann Marie Sullivan: And one thing you could measure is whether or not they leave with a primary care appointment even. You know, we never kind of do that, but that would be something to say, do they have a connection to a primary care doctor at discharge.

Jack Jordan: Yes. This is Jack Jordan. I was actually wondering if there is kind of a quality of the environment that the patient is discharged into kind of a measure that could be developed. I'm not aware of one existing.

But I do think that there are, you know, things that can be done in the discharge planning to help remediate some of the challenges that patient, you know, with mental health issues can have. And that I think working on a measure that helps get into that mindset and the quality of discharge may be a useful thing to be thinking about.

Jeffrey Buck: Yes. Well, I would call attention. We totally agree with you. We have several measures that are explicitly focusing on exactly those kinds of issues. We recently, not this year but the previous year, we adapted two fairly robust transition planning measures. We have this year adapted a readmissions measure. And we also about, so I think three years ago, adapted the – actually both – yes, adapted the – I'll find it here. Thanks for pulling up this list, but follow up after hospitalization from mental illness.

So, we have several measures already in the program that one way or another are trying to get at the issue of effective transitions.

Cristie Travis: Well, thank you so much for that and it is helpful to know that some of those measures are already working their way into the system. And part of what we talked about last year was avoidable readmissions and emergency department visits for patients that are treated in the setting.

So, thank you for that. I think we do need, if we can, to move on, we will have another opportunity obviously to look at this program at our in-person meeting.

So, let's go on and move to the next program.

Melissa Mariñelarena: Thank you, Cristie. So the next program that we're going to review is the Hospital Outpatient Quality Reporting Program. This is a pay for reporting and public reporting program.

Hospitals that do not report data on the required measures would receive a 2 percent reduction in their annual payment update. And the goals of the program is to provide consumers with quality of care information to make informed decisions. And to establish a system for collecting and providing quality data to hospitals providing outpatient services, such as emergency department visit, outpatient surgery and radiology services to name a few.

So here is the list of the current program measure set. We try to organize these two in similar measures. The first set of measures are all related to the emergency department when you come in. So measuring timely for patients to be seen timely.

The next set of measures, which are highlighted in orange, are related to either AMI or stoke.

The next set of measures, that's highlighted green, are all related to radiology department, C.T., MRI, mammography.

The purple measures are all related to colonoscopies. And then we go into the bluish-grayish highlighted measures are related to surgical procedures sort of general surgical procedures and a cataract surgery measure. The greenish – the two greenish measures are HIT-EHR related measures, and then we have the influenza vaccination coverage among health care personnel.

So the high-priority domain for outpatient that CMS considered for – or (being those) high priority was making care safer, best practices of healthy living, patient and family engagement and communication and care coordination. And so, in greater detail, under making care safer, examples of a measure were processes and outcomes designed to reduce risk in a delivery of health care specifically E.D. overcrowding and wait times.

Under the domain of best practices of healthy living, they described measures of primary prevention of disease. And general screening for early detection of disease unrelated to a current or prior condition.

For patient and family engagement, they described measures of patient and family engagement in care, and patient decision making that reflects culture sensitivity and patient preferences.

For communication and care coordination, they're looking for measures that embed best practices to manage transitions across practice settings. Measures that enable effective health care system navigation and measures that reduce unexpected hospital admissions and emergency room visit.

Last year, MAP agreed with the gaps that were identified by CMS particularly the patient and family engagement, communication and care coordination among multiple providers. MAP also discussed the importance of measures of high-volume outpatient services such as screening and primary care visits. And then MAP also noted the importance of recognizing patients and family partners to drive shared decision making. And support patients as they navigate multiple providers.

So I'll turn it over to Cristie to lead the discussion.

Cristie Travis: OK. Well, this is obviously one of those programs that includes a broad range of services and therefore measures. So thank – I'm going to thank the staff for trying to help us think about them in some type of organized fashion.

Last year, it does appear that we concurred with CMS's high-priority domains and many of the suggested measures that are included on the slide that we just saw.

So, does anybody want to make any comments about either reinforcing some of last year's recommendations or any new gaps that you think we need to include on our list?

Ann Marie Sullivan: This is Ann. I'm not sure if it fits, but there are a number – you know, it's a follow up after an opioid or a drug overdose. Many of those clients go home from the EDs. And often, there's not very tight follow up.

Cristie Travis: Thank you for that.

Lee Fleisher: This is Lee again. I mean, the issue of opioids is an interesting one. And I'm wondering if we could drive, going back to the ambulatory surgery or the outpatient, some sort of appropriate opioid prescriptions, particularly up to the ambulatory surgery, because one of the major problems in this country is, everyone is given 30 days of pills even though they need five.

Cristie Travis: Or none.

Lee Fleisher: Or none, you are correct. So …

Cristie Travis: Yes, that's …

Ann Marie Sullivan: I think that's a good idea. That is a good idea.

Lee Fleisher: Yes, you triggered …

Cristie Travis: That's a very good idea.

Lee Fleisher: Thank you. Yes, your question triggered it.

Cristie Travis: So, you know, our team, NQF staff team, you know, I think that's kind – that is something that may be more of a cross-cutting type of issue we could hit. You know, this outpatient quality reporting could hit the ambulatory surgery, there may be places in the hospital. You know, IQR program.

So, I think that would be something good for us to think about from a cross-cutting issue in terms of opioid follow up, and prescription, and appropriate prescribing. Thank you both for bringing that up.

Any other thoughts around hospital outpatient quality reporting?

Is this where the testing measure was? I was trying to – I can't remember who brought it up earlier.

Melissa Mariñelarena: Yes, it is. The C.T., the cardiac (imaging) …

Cristie Travis: Yes.

Melissa Mariñelarena: … or the risk assessment for non-cardiac low risk surgery. Yes.

Cristie Travis: And I just want to be sure I was remembering or was, you know, understanding is the issue is that we maybe – that we need to be sensitive to overuse for this as well as just measuring.

Lee Fleisher: Yes.

Cristie Travis: OK.

Lee Fleisher: You are correct, Cristie. And that would expand for the ambulatory surgery setting other types of testing.

Cristie Travis: Right.

Lee Fleisher: For non-cardiac low risk surgery. So it would be an expansion. And that's also applicable to the ASC setting, too. There's no reason …

Cristie Travis: Right.

Lee Fleisher: … it shouldn't be in both.

Cristie Travis: Yes, you know, in an earlier MAP season, I think they've been called, you know, we – I think we did look at a – how aligned were the ambulatory surgical center measures with any inpatient surgical measures in hospital outpatient surgery.

You know, thinking about the fact that it's surgery and that, you know, site of care may be different and therefore it's covered in a different program. And there may be some differences because of the site of care where it's being provided, but there are some things that are just basic to surgical procedures.

So, it's beginning to come across that maybe the appropriate use of imaging, you know, not overuse, but the appropriate use is kind of a common threat for us to think about as well.

Any other comments?

All right, well, I want to – first of all, tell you all that you deserve a medal, because we actually are five minutes early getting to IQR. So …

Melissa Mariñelarena: OK.

Cristie Travis: We'll see if you get another medal after this second half of this meeting.

But no, I do want to thank everybody, I know it's kind of speed program review here, but thank you so much. And I will turn it over for the next program.

Melissa Mariñelarena: OK, moving on to IQR. And the Medicare and Medicaid EHR Incentive Program for Eligible Hospitals and Critical Access Hospitals. So this is IQR and the previously known meaningful use which has merged as of last year or this year.

So this program is pay for reporting and public reporting. And this is hospitals that do not participate or meet the program requirements, they receive up to a quarter reduction at the annual payment. The goals for the

program is progress towards paying providers based on the quality rather than the quantity of care that they give patients.

Another goal is interoperability between EHRs and CMS data collection. And of course, to provide consumer's information about hospital qualities, so they can make informed choices about their care. And we see how the program has evolved overtime, when you – we look at the measures where they are now as of the final rule.

So, this is the measures in the rule, we look at the finalized rule. The ones with the ask (direction), it might be kind of hard to see, but if you have a copy of the presentation, those were finalized for fiscal year 2019. But the first set we look at the NHSN rule, so those are your CAUTI, your C. Diff, CLABSI, SSI, MRSA and then there's the flu vaccine for health care personnel.

Then there's the claim-based payment measures. So they are all of the hospital level risk standardized payment measures for different conditions, AMI, heart failure, pneumonia, the overall Medicare spending per beneficiary, then we go into the knee and hip measure, cellulitis, GI bleed, kidney, UTI, the AAA, a chole, and the spinal fusion. So if you look at the last three, those were just recently finalized.

The next ones, again, try to categorize these, so the first set of measures are all of the mortality, the risk-standardized mortality rate measures for different submissions, AMI, CABG, COPD, heart failure, pneumonia and stroke.

The next step are the readmission measures, again, for the same conditions, AMI, there's CABG in there, COPD, heart failure, and unplanned – the hospitalized all-cause unplanned readmission measure, pneumonia, stroke, hip and knee. And then we have the three excess days in acute care. The one for pneumonia was just recently finalized in the rule, then there's the knee and hip measure. And then there's the new complication measures which includes the PSI 90.

And we go on. Over the years, this shows how the program has evolved. We are down in the last finalized rule, we are only down – it'll be – looks like only

six chart abstracted measures. And the eCQMs that you see there. So that's how the program has evolved back from when they're used to be mostly chart abstracted measures.

We go on to the next slide.

Now, for the patient surveys, there are still HCAHPS and then the three – if somebody can put their phone on mute. Thank you.

We have HCAHPS and three-item care transitions measure and then the structural measures is the hospital survey on patient safety culture, and then the safety surgery checklist use within the finalized rule and then of the registry, the hospitals will not be required to participate in any of the registries anymore.

So, the priorities identified, the high-priority domains identified by CMS, included patient and family engagement, best practices of healthy living and making care affordable.

So examples of these domains included for patient and family engagement, those are measures that foster the engagement of patient and families as partners in their care. Best practices of healthy living include measures that promote best practices to enable healthy living. And making care affordable include measures that effectuate changes inefficiency and reward value overtime.

Last year, MAP identified gaps in OB pediatrics, measures addressing the cause of drugs particularly specialty drugs, and there was a lot of discussion of an all-harm or global harm eMeasure.

I will turn it over to Cristie now to lead the discussion.

Cristie Travis: OK. Well, with a program that has been in existence for as long as this one has been, it is interesting to see how it is evolved overtime, but it's also grown significantly overtime, although I know there has been care to try to retire measures as necessary.

So, this is another one of the programs that has a broad range of topics that are being covered. So thank you to the staff for trying to help us think about them in their major buckets.

I'd like to kick it off and see if anybody has any initial comments regarding the priorities or gaps that we've identified in the past or new ones that 'd like to put on the table.

Woody Eisenberg: Cristie, this is Woody. Oh, I'm puzzled about the measures that have to do with the cause of medication, specialty medications. Could I – could we hear a little bit more about what that is?

Cristie Travis: Yes. Staff, I'm not sure if – I know this was a topic that we talked about last year at the MAP. And so, I think trying – I don't know if there was anymore additional detail in terms of the notes from our in-person meeting around this.

Melissa Mariñelarena: I would have to look, this was in our report and we just talked about, you know, we identified (OBPs) and measures addressing cost of drugs, particularly specialty drugs. I can go back and look in the transcript and get more specific ideas or more specific in the context around the conversation to see if we talked about certain drugs.

Woody Eisenberg: Yes. Or any ideas that were already discussed. I think it would be helpful to us to know them.

Melissa Mariñelarena: OK, I can put that together and send it out to the group.

Woody Eisenberg: Thank you.

Cristie Travis: Thank you. Thank you, Woody. And there's somebody else who was trying to queue up.

Jack Jordan: Yes, a couple things. Well, one, when the transition from old PSI 90 to new, it's kind of sad they named them both PSI 90, so it's always confusing clarifying that.

But then also the risk standardization for the readmission seems to have some real quirky things in it, in that it's heavily biased toward age being the driver, it seems to very much annoy kind – I mean, avoid socioeconomic status driven type of things in it.

And even with the Star ratings, when they came out, really hospitals that were eligible for, you know, additional payments for vulnerable populations look widely different on it. It seems to almost be an anti-socioeconomic status adjustment. So, it doesn't seem to be kind of fair and appropriate. And probably should be looked at with far more scrutiny.

Cristie Travis: Well, thank you. May I ask you to identify yourself, I'm not recognizing your …

Jack Jordan: Yes, this is Jack Jordan.

Cristie Travis: OK, thank you so much. I'm sorry.

Well, I know – thank you for your comments, you know. As you know, we – our charge is really to focus on filling the gaps and then also what's the measures under consideration list is released to focusing upon the measures that are on that list.

And so, I know it's difficult because when we look at these programs, you know, we do need to understand what the other measures are that are already in the program, so that we can think about how the new proposed measures would fit within the programs portfolio as well as helping us to identify gaps.

But our charge is to focus on those measures under consideration in gaps and not to go back and re-adjudicate or reconsider any of the measures that are already in the program. But I do appreciate your comments and I'm sure you're not alone with your thoughts on that. So, thank you. And thank you for appreciating what we are being asked to do.

Any other comments about gaps or priorities?

OK. Well, I think we can move onto the next program.

Kate McQueston: Thank you. The next program is the Hospital Value-Based Purchasing Program. This is a pay-for-performance program. The way it functions is Medicare withholds 1.75 percent of its regular hospital reimbursements from all hospitals paid under inpatient prospective payment system, to (fund a pool), a value-based purchasing incentive payments.

Hospitals are then scored based on their performance on each measure within the program relative to other hospitals as well as on how their performance on each measure has improved overtime. These scores are then used in determining incentive payment.

The program goals are to improve health care quality by realigning hospital financial incentive and to provide incentive payments to hospitals that meet or exceed performance standards.

The measures include in this program must be specified under the hospital quality reporting program or other public reporting programs. The current measure set includes measure of safety, readmission, patient engagement, and efficiency and cost reduction.

The first measures incorporated to the program include under safety, which you'll see is the first block of measures included here. Seven patient safety measures related to hospital infections including the PSI 90 survey and elective delivery.

Following this are four readmissions related measures and a measure on Medicare spending as well as the HCAHPS Survey.

As of fiscal year 2020, five measures on mortality and complication rates will be included. Following this, in fiscal year 2021, two measures on payment for AMI and heart failure as well as mortality following CABG are also added.

CMS identified two categories of high priorities for future measure consideration. These are patient and family engagement, including measure that fosters engagement of patients and families with partners in their care,

and making care affordable, that is measures that can be used to improve efficiency and reward value over volume.

Cristie Travis: OK. Well, thank you. Do any of the committee members have any initial thoughts?

Oh, yes, thank you. It's funny, it looks like you're going forward when you're actually going backwards on here.

So does any of the committee members have any thoughts on priorities and gaps in the value-based purchasing program?

OK. Well, thank you very much. I think we're ready to move onto Hospital Readmissions Reduction.

Kate McQueston: Thank you. The Hospital Readmissions Reduction Program is a pay for performance and public reporting program. The measure results are publicly reported annually on the Hospital Compare Website.

HRRP provides an incentive for hospitals to reduce the number of excess readmissions that occur in their settings. The incentive structure is based on DRG payment rates, which are reduced based on a hospital's ratio predicted to expected readmissions. The maximum payment reduction is 3 percent.

Next slide, please.

Currently, the HRRP includes six measures related to readmissions for AMI, heart failure, pneumonia, COPD, elective total knee and total hip arthroplasty. CABG will be included with the fiscal year 2017 payment determination.

CMS has outlined priority domains for future measure consideration for the program to include measures of focus on the NQF priority of communication and care coordination, as well as care coordination measures that address high-impact conditions as identified by the Medicare Payment Advisory Commission or AHRQ Healthcare Cost and Utilization Project Report.

Cristie Travis: OK. Any thoughts from the committee about these priorities and/or gaps?

Jack Jordan: I think your slide should remove refinement from them if that's actually off the table.

Cristie Travis: Can you point out …

(Desmirra Quinnonez): Thank you, we'll make a note.

Cristie Travis: Yes. Thank you for noticing that.

Any other comments or thoughts about the high priority domains for future measurement?

Ann Marie Sullivan: I'm just trying to understand what they're asking for. They want specific communication care coordination measures that impact readmissions? Is that what they're saying there's a gap is, or? I mean, the readmissions are, you know, they measure the readmissions, period. But what are they saying they …

Cristie Travis: Right.

Ann Marie Sullivan: … what are they asking for here?

Melissa Mariñelarena: Hi, this is Melissa. Are any of the program leads on the phone?

Cristie Travis: It doesn't appear so.

I think that's a really good question. Maybe that would be something else you all could follow up on for us. And you know, maybe send out to us as well or maybe just brief us when we have our in-person meeting.

Melissa Mariñelarena: Yes, we can do that for you.

Ann Marie Sullivan: OK, thanks.

Cristie Travis: Because we are focused on the readmission itself, we're not really looking at process measures.

Melissa Mariñelarena: Right, and in the document …

Cristie Travis: Or structural measures.

Melissa Mariñelarena: Right, and in the document we attached, which is where we get this information, it says – it just says what Kate said, measures that address high-impact conditions identified by the Medicare Payment Advisory Commission or AHRQ, or the AHRQ Healthcare Cost and Utilization Project Report.

What we can do is also go through those reports and can see what conditions have been identified and see if they …

Cristie Travis: Yes, they may be talking about readmission measures for those conditions.

Melissa Mariñelarena: For those conditions.

Cristie Travis: Versus …

Melissa Mariñelarena: We can go and take a look at that.

Cristie Travis: Yes, as a reflection of communication and care coordination.

Lee Fleisher: Could we get access for this or even just send us a link?

Melissa Mariñelarena: The report is in …

Pam Owens: This is Pam Owens from AHRQ.

Melissa Mariñelarena: Yes.

Pam Owens: And I work on the Healthcare Cost and Utilization Project.

Cristie Travis: Well, good.

Pam Owens: So, what we have is – yes. And we have the nationwide readmission database and perhaps that is what you're speaking of here. I have not been part of the conversation. It is possible. We actually have our own each HCUPnet, which is a, you know, interactive query system, anybody could to this

hcupnet.org.gov. And you could look to what the most frequent conditions are in that kind of thing.

We do have some reports that speak directly how to use that nationwide database. I'm not sure what reports you all are referring to that's coming out of AHRQ.

Cristie Travis: Well, thank you for that additional information, I think that is helpful. I do think – it reads to me probably that they're talking about looking at some additional conditions over the ones that are already in the program measure set.

So maybe if our NQF colleagues can take a little bit of time to better understand what they're asking for in terms of our priority domain here, and it sounds like people might like to have some links to information that they could review prior to our in-person meeting.

Melissa Mariñelarena: Absolutely, we'll get that for you.

Cristie Travis: OK. Well, thank you for that very good question that teed up issue that I'm sure several of us were wondering about. Any other comments or thoughts on the priority domains for readmissions?

OK. Well, we'll move onto the Hospital-Acquired Condition Reduction Program.

(Desmirra Quinnonez): Thank you, Cristie. Well, I'll go ahead and provide an overview of the Hospital-Acquired Condition Reduction Program. And what this does is, it provides an incentive for hospitals to reduce the number of HACs. This is both a pay for performance and a public reporting program. And hospitals are reported on the Hospital Compare website. And they've been reported there since December of 2014.

The incentive structure for this program is a 25 percent of the hospitals with the highest rates of HACs based on the measures in the program. We'll have their Medicare payments reduced by 1 percent.

Now, the measures in the program are classified according to two different domains. The first domain includes the PSI 90, which is a composite of eight administrative claims-based measures. And the second domain includes the infection measures developed by CDC's National Health Safety Network.

So, HACRP program goals include an increased awareness of HACs in order to eliminate the incidence of responsible preventable HACs, improving patient outcomes and the cost of care by reducing HACs, and improving care of Medicare beneficiaries privately insured and Medicaid patients by improving the care process within the hospitals.

Well, if you look at the next slide, this table actually shows the measures that are currently included in the HACRP and it's organized according to domain. As we mentioned earlier, the first domain includes the PSI 90, and the second domain includes CAUTI, CLABSI, SSI which begins in 2016, MRSA and C. Diff which will begin in the fiscal year of 2017.

Now, this is according to the finalized measure set of – for the fiscal year of 2017 as of the last final rule. And you can actually find that in the federal rule on page 5-7-0-1-1, 57,011.

So the high-priority domains for future measure consideration identified by CMS with the NQF priority of making care safer are listed above. You see in the blue prevention of the first drug event, pressure ulcers, (all) with harm, acute renal failure in the hospital, and general surgical site infection measures instead of procedure specific measures.

You'll notice below in the green, you'll see the Hospital MAP identified gaps which include adverse drug events, ventilator-associated events, additional surgical site infection location, outcome risk-adjusted measures, diagnostic errors and all-cause harm.

And at this time, Cristie, I'll turn it back over to you to start the discussion for the refinements of the high-priority domains for future measurement.

Cristie Travis: Thank you. Does anybody have at their fingertips the eight measures that are included in the PSI 90 composite?

Melissa Mariñelarena: We can get it for you.

Cristie Travis: Maybe that would be helpful just for us to kind of understand what's being looked at in that domain.

As you're pulling that together, any comments or suggestions from the committee members?

Pam Owens: This is Pam Owens. And I actually am in charge of PSI 90.

The eight components measures of PSI 90 originally were pressure ulcer rate, iatrogenic pneumothorax rate, central venous catheter-related bloodstream infection rate, postoperative hip fracture rate, perioperative pulmonary embolism or deep vein thrombosis rate, postoperative sepsis rate, postoperative wound dehiscence and accidental puncture or laceration rate.

What happened is they revised or they modified PSI 90 that uses the exact same methodology with the exception that this new one includes the harm's (way). Now includes three additional indicators but removed the CLABSI measure, the Central Venous Catheter-Related Bloodstream Infection rate.

I think it would be important to clarify for the HAC reduction which version of PSI 90 is actually being reviewed here. Whether it's the one that was endorsed December of 2015 or whether it's the one that was originally with the eight items. It is in the rulemaking. But just to be clear, the reviewers know what we're talking about, so.

Cristie Travis: Well, thank you for …

Pam Owens: The three additional ones were perioperative hemorrhage or hematoma postoperative physiologic or metabolic derangement rate, which was changed the name to acute kidney injury with dialysis and postoperative respiratory failure rates.

Cristie Travis: Well, thank you very much. I think it is certainly important to know which version of PSI 90 is in the program because I think that will help us be sure

that we're looking at gaps appropriately for whatever version they're using, you know, we need to know that so that we'll know how to identify gaps so when we get our measures under consideration list how to consider the measures on that list as well.

So maybe that is something else to our NQF colleagues can either – if you know it now, feel free to let us know now, or if you need to do some research, I think that would be helpful.

Melissa Mariñelarena: Sure, we can do that. I have the rule in front of me but we'll have to go through and make sure that we get it right for the different versions.

Cristie Travis: Right. Thank you.

So, looking at the slide that's in front of us, the blue is what CMS identified as topic areas for making care safer that may be considered for the future and then the green are the ones that we identified last year as gaps that might be appropriate for this program.

Any other thoughts or comments on either of these two listings?

OK. Well, thank you all very much and you do deserve a medal, for the second part of this as well.

We always have so much to cover and I really appreciate everybody staying on task and on time. So thank you so much for that.

We are going to go in just one moment to public comment and then we will cover next steps after that. So operator, would you please see if anyone wants to make a public comment?

Operator: And at this time, all lines are open for public comment.

Jennifer Eames Huff: Jennifer Eames Huff representing the Pacific Business Group on Health.

Cristie Travis: Yes, Jennifer.

Jennifer Eames Huff: Hi. I would like to add. I heard it discussed in one of the areas, I think a measure gap in regards to the cancer hospitals. But I think it would also be appropriate for other programs. And that was patient-reported outcomes, and having that as a gap (area), particularly in the IQR program and the Hospital Value-Based Purchasing Program.

Cristie Travis: Thank you. Any other public comments?

OK. Well, thank you all very much for listening in. And we do appreciate your thoughts and thank you, Jennifer.

I'm going to turn it over to Kate now for a description of the next steps for our workgroup.

Kate McQueston: Thank you. So just a remainder ...

(Off-Mic)

Kate McQueston: Thank you. Just a reminder of where we are. So, the next items coming up on our agenda is that, on or before December 1st, we'll receive the list of measures under consideration by HHS, followed by the initial public commenting period.

During – before the December meeting, we will conduct preliminary analysis and then during the meeting, the MAP Hospital Workgroup will develop its preliminary recommendations. This will go to public commenting in December and January.

And then in January – late January, the Coordinating Committee will finalize the MAP input and the guidance for hospital programs will be completed before February 15th.

And as a reminder for our more immediate next steps, our all-MAP web meeting is November 11th and our in-person meeting is December 8th and 9th. For committee members, our meetings department should be in touch with you regarding travel and accommodations.

Next slide, please.

And that is all for today. Please remember that you can reach out to the NQF project team at any time. Our e-mail address is MAPHospital@qualityforum.org. And thank you so much for taking the time to go over this program for us today. And especially, as Cristie said, I'm doing so in record speed.

Cristie Travis: Yes. Thank you all very much and I look forward to seeing you in December. And thank you to the NQF team for putting together all these background materials. It's been a real help.

Melissa Mariñelarena: Thank you, everyone.

Cristie Travis: OK. Thank you.

END