NATIONAL QUALITY FORUM

Moderator: NA
October 31, 2019
6:10 pm CT

(Christy): Hi this is (Christy).

(Madison): Hi (Christy) this is (Madison) of NQF.

(Christy): Hi.

(Karen Heller): (Karen Heller) is also on from Greater New York Hospital Association.

(Madison): Hi (Karen). Thank you for joining.

(Karen Heller): Hello.

(Nicholas): Yes (Nicholas) from (Presqani) as well.

(Madison): Hi everyone. So we'll actually do roll call…

(Nicholas): Oh good.

(Madison): …as we get into the web meeting.

(Nicholas): Oh good.

(Madison): But thank you everyone for joining us. We'll get started in a few minutes. I see a - quite a few people are dialing. But thank you everyone for joining us today.

(Sean Morrison): Hello it's (Sean Morrison). I joined for you guys.

(Madison): Hi (Sean). This is (Madison) (Unintelligible) with NQF. I know we've got (Christy) and a few other people on the line as well. So we're going to just give everyone a few more minutes to dial in before we get started.

(Sean Morrison): Guys. Are we open line or closed at the moment?

(Madison): This is an open line through the whole webinar.

(Sean Morrison): Never mind then. Thank you. Just so I know.

(Madison): Hi everyone this is (Madison) (Unintelligible) with NQF but we'll get started in a few minutes.

Man: Thank you.

(Madison): His everybody this is (Madison) (Unintelligible) with NQF. We're going to go ahead and get started. But before we kick this meeting off we'll just like to do a few housekeeping reminders and ask that everyone mute their lines when they are not speaking.

And then I would also like to note that if you have a comment we have a raise your hand function that we can see. Or there's also the ability to chat via the chat function on this webinar. But thank you everybody us for the MAP Orientation Web Meeting for the hospital workers. I'll pass it to our co-chairs (Christy) and (Christy) (Unintelligible) and (Sean Morrison) to kick us off and give some opening remarks.

(Christy): Thank you (Madison). And thank you to all who joined us today. And we're beginning our MAP season which we know that today is really an important component of that so that we'll be prepared for our in person meeting that we have in December.

I want to thank all of our returning members. And I know that we also have some new participants this year. I especially want to welcome them to the group.

And I look forward to working with you all. And thank you for your time, your commitment, and your thoughtful preparation for all the work that we have. So I'll turn it over to (Sean).

(Sean Morrison): Yes. Good afternoon everybody and morning for those not on the east coast. And I just wanted to echo (Christy's) words of welcome.

And also for those of you who are returning members know how fortunate and spectacular lucky we are to have (Christy) as a co-chair. And for those of you who are just joining you are really in for a spectacular treat. I have never seen somebody run meetings as well as (Christy).

So I know it's a very, very large agenda. And the in person meeting will feel very packed but I am very confident that (Christy) is going to steer us through

that. I just wanted to walk through a little bit of what we're going to be doing today.

We're going to talk a little bit about in objectives and our fabulous NQF staff are going to do that. They're also going to review the MAP pre-will making approach. Particularly for those who have not gone through this before.

And for those of us who have what changes we might expect. We're going to talk a little bit today what the programs we are that we are going to be considering at our in person meeting. But also talking about particular areas of gaps within the existing programs.

There will be an opportunity for public comment. And then we're going to talk a little bit about next steps in preparation for getting together in December. (Melissa), (Christy) did I miss anything?

(Christy): And thank you for joining us (Sean) as a co-Chair.

(Sean Williamson): I have big steps to fill. So - yes. (Melissa) I think it's on to you now correct?

(Melissa): Yes. It is. My name is (Melissa Maria) (Unintelligible). I am the Senior Director for the Hospital Work Group. For those of you who have been in this work group for a while this would have been my 5th year with MAPS. I'm (unintelligible) in NQF so tomorrow's my last day. So I'm saddened that I will not be there for MAP.

I love MAP. I call it my hospital super bowl. But I'm glad that I'm able to join you for the orientation today. And we have several MAP members that I would like to welcome as well.

And we're going to go through the introductions and get everybody to know each other. Yes so that looks like - well we have (Madison) to kick it off. The Leading Project Manager and soon to be the (Unintelligible) MAP member.

We used to work with (Doug Mariez) who has also gotten out. So (Madison) is going to be - carrying the torch for us. And then (Jordan Herse) if you have been listening in on the other webinars he's sort of working across all of them.

He' a (Private) Analyst. He had an emergency today. So he's not here with us today but he will be here (unintelligible) as well.

And then I have a very French (John Booth) (Unintelligible). I think he just came to join us. (Sam) who runs the Coordinating Committee and Clinician Workgroup. And do you do long-term care?

(Sam): Formally I'm long-term care. But now that's been handed over to (Andy Morrow) who was the former Chair of (Unintelligible) Clinician. (Unintelligible) Clinician has lost his co-Chair because their loss was our gain of staff. Now it's not entirely that we'll - have some plans for who will be helping to run hospital after (Melissa) leaves.

It will be both myself (Tarun) (Unintelligible) who will be working with the hospital group moving forward. So delighted to be able to join you guys. And appreciate you having some flexibility as we're making some adjustments with the staff.

(Melissa): And we have…

(Jermaine Bond): (Jermaine Bond).

(Melissa): (Jermaine).

(Jermaine Bond): (Jermaine Bond) yes.

(Melissa): Would you be joining MAPS?

(Jermaine Bond): My pleasure. I am here I guess to observe. I'm not sure what my role will be Currently Senior Director leading the maternal, morbidity, and mortality work. And the social risk trials, and on a couple other parties as well. So happy to join.

(Melissa): Well glad you could.

(Madison): So this is (Madison). Needless to say we have a full room here at NQF. But we are very pleased to be moving forward and kicking off this season of MAP with this new team.

To get started I'll just start with taking a quick roll call. As you can see on the slide we have the organizational member - or the organization on the MAP Hospital Work Group listed. And if the representatives could just announce their name and maybe a brief sentence of their role at the organization.

That would be great. So we can start to get familiar with everybody's voices and where they're coming from. But I know we've got our co-Chair's (Sean Morrison), and (Christy (Ogshelltravis) on the line. Do we have anyone from America's Essential Hospitals?

(Mary Ellen Guinan): Hi everyone. It's (Mary Ellen Guinan) from America's Central Hospitals. I am a Senior Policy Analyst here focused in quality measurement and pay for performance, as well as alternative payment models and the like.

And it is I believe my 3rd year on the MAPS. So happy to be back.

(Madison): Okay. Thank you (Mary Ellen). Anyone from the American Association of Kidney (unintelligible)?

How about the American Case Management Association? Okay. The American Society of Anesthesiologist? American Hospital Association?

(Haquem Demahan): Good afternoon. It's (Haquem Demaham) with the American Hospital Association. Glad to be back with this group.

(Madison): (Haquem). Association of American Medical Colleges?

(Katie Ramsey): Hi it's (Katie Ramsey) from the AAMC. And happy to be here.

(Madison): Thank you. City of Hope?

(Denise Morris): Hi I'm (Denise Morris). And I am representing (unintelligible) and we are new members.

(Madison): Thank you for joining. Dialysis Patient Citizen?

(Jackson Williams): Hi this is (Jackson Williams). I'm the Vice President for public policy. So I'm a professional staff member not a patient. But we do have one of our volunteer board members who's a patient who participates in other NQF activities on our behalf.

(Madison): Thank you for joining. Greater New York Hospital Association?

(Karen Heller): Hello. This is (Karen Heller). I for 30 years here at Greater New York. I've been doing payment policy and performance measurement. And I finally stepped down from being Executive Vice President to Senior Advisor. So I am so happy I have time for wonderful activities like this.

(Madison): Okay. Thank you (Karen). Henry Ford Health Systems?

(Jack Jordan) Hello this is (Jack Jordan) for Henry Ford Health System.

(Madison): Great. Thank you (Jack). (Jack) was formally a (unintelligible) on our committee. But now has moved to an organizational representative. So thank you for joining. Anyone from (Intermissive) Healthcare?

(Michael Drift): Hi this is (Michael Drift). I'm the Medical Director of our office that manages quality, safety, and (unintelligible). And all though we're not new members, I'm new to this workgroup. So it's nice to join you.

(Madison): Great. Thank you (Michael). (Metronics) Minimally Invasive Therapy Group?

(Karen Shahatey): Hi everyone it's (Karen Shahatey). And I work in Healthcare Economics and Health Policy at (Metronics) Minimally Invasive Therapy Group. And thrilled to be back on the MAP.

(Madison): Great. Thank you. (Muena) Healthcare?

(Debbie Wheeler): Yes this is (Debbie Wheeler). This is my 2nd year on the committee from (Mauena) Healthcare.

(Madison): Thank you (Debbie). Mothers Against Medical Error? Okay.

(Helen): Yes this is (Helen) (Unintelligible) Mothers Against Medical Error. And I think (Lisa McGifford) is also on the phone.

(Madison): Great. Thank you (Helen).

(Lisa McGifford): Yes I'm on the line. I'm the backup.

(Madison): Okay. Thank you (Lisa). National Association for Behavioral Healthcare? Okay. Pharmacy Quality Line?

(Anna Leggerdoff): Hi my name is (Anna Leggerdoff). I am a Pharmacist. I work for the American Society of Health (unintelligible) Pharmacist. But we're members of - proud members of PQA and proud to be representing them on the Hospital MAP. This is my 3rd year on MAP. And looking forward to working with everyone again this year.

(Madison): Great. Thank you. (Premier)?

(Isha Pinman): Hi good afternoon. This is (Isha Pinman). I'm the Vice President of Policy with (Premiere). I think this is my 3rd year on MAPs. So happy to do that.

(Madison): (Unintelligible)?

(Nicholas Martez): Yes hi this is (Nicholas Martez). I'm Vice President for Research and Analytics our clinical business unit. And so very involved with our, you

know, I have been involved with NQF in the past both on technical advisory panels for outcome measures, and our NQF endorse measures - or actually (unintelligible) Nursing Association in through MNMQI. And I think on the call is probably also my backup (Casey Glavich) are you there?

(Casey Glavich): Yes. Hi everyone (Casey Glavich). I am the Director of Policy at (Presginy). And as (Nicholas) said I'm the backup. But happy to join and excited as this is my first time being able to be involved in any sort of MAP workgroup. Thank you.

(Madison): Thank you. Project Patient Care?

(Marty Hatley): Hi this is (Marty Hatley). I'm the President and CEO of Project Patient Care. I'm a veteran. I've been on the group for a number of years. Happy to see you (Sean) as co-Chair. You and (Christy) are going to be a great team. Good morning everybody.

(Madison): Service Employees International Union? Society for Maternal Fetal Medicine?

(Kelly Gibson): Hi this is (Kelly Gibson). I'm in SMFM in Cleveland, Ohio. And I'm representing the Society. I'm on the patient, paging, and quality committee for SMFM.

(Madison): Thank you. And UPMC Health Plan.

(Amy Helwig): Hi this is (Amy Helwig). Chief Quality Officer at the UPMC Health Plan. Representing not only the health plan in our populations for commercial Medicare, Medicaid. But also our providers side for their hospitals and clinics.

(Madison): Thank you so much everyone. Just a friendly reminder for organizational members with substitutes and back-ups we do ask that only one representative speak on behalf of the organization during these web meetings. So just a little rules and regulations. So thank you everyone. Next we'll move to our individual subject matter experts. Do we have (Angie Vanacohen)?

(Angie Vanacohen): Hi this is (Angie Vanacohen). I'm a Vice President at Impact. This is my second year at MAPs Hospital Group. I'm looking forward to working with everybody again.

(Madison): Thank you. (Lindsey Wishom)?

(Lindsey Wishom): Yes good afternoon everybody. This is ((Lindsey)). And I look forward to working with you all again. I'll be providing subject matter expertise in health and (unintelligible) at ECQM.

(Madison): Thank you ((Lindsey)). And then we'll move on to our Federal Government Liaison that we have supporting the work group. Do we have anyone from ARCH on the line?

Do we have any colleagues from CDC on the line? And then our CMS colleagues let us know that they might not be able to make this meeting. But anyone on the line from CMS? Okay.

Great. Okay. So that concludes our roll call. Thank you so much again everyone for joining us today. I'll turn it over to (Melissa) to give us a quick overview of the pre-rule making approach before we get started on our program.

(Melissa): Thank you (Madison). So for those of you that are - have been with us for several years this looks familiar. For those of you that are new this is new for you. So MAPs happens very quickly.

This is now us kicking it off. If you've been paying attention there have been other Web meetings. So now everything is happening try to get it all done in November. The kick-off in October and November and then waiting for the monthly (unintelligible) considerations so that we can meet in December.

So October's where the work mans and the coordinating committee meet via web. I think most of us have by now to review the pre-rule making approach. And how we do the (unintelligible) of measures under consideration.

We're not actually looking at any measures in this orientation. And familiarize yourself with these finalized program measures that for the program year. Because I think our certainly we don't live in this programs every day.

Some people might but we sort of have to go back and look at them every year to be able to get to work with them. November the rural health workers will be meeting via Web meeting to provide rural professions on the prevention of quality measures in MAPS. That is the effect this year.

That was a new addition. There has been some rural health work in the past. But now this has been added on to all of our MAPs work weeks. The meetings will occur in December. The Hospital Workgroup, the Clinician, and the long-term care.

These will be held in early December. And then In January the MAP coordinating committee will look at all of the MAP workgroups recommendations. And look at the cross-cutting issue.

And put out their report and the recommendations. But they do have to come out by February I think, right? Yes. So this is just a visual of what we just talked about right now and with some actual case.

Yes it's the same thing. The MAP pre will make an approach. These are the goals for today.

We're going to review the goals in (unintelligible) Reach programs. Review the critical objectives of each program. And then identify some measured gap areas if there are any.

And the hospital program has the largest amount of programs. But (unintelligible) takes a little bit longer for us to get through. But every time we've done it, we have done it in the time that we were allowed.

So in 2000 these are the overarching themes that we had last year. The big ones that came out of the workgroups work were informed consumers regarding their care. Or about their care.

And then person and families focused care. Think we changed it. We had patient and families.

But CMS is using more of the person and families focused care. So we want (unintelligible) to understand. So to inform consumers and their care and those of you that were part of the workgroup last year, recall having this conversation because there was a need.

An (unintelligible) for mind measures across hospitals and other studies. And this was around patient (unintelligible) having procedures in a hospital, in an outpatient, in an ambulatory surgical care center. But to them they don't know that there any different or how they're working or billings are coming.

But the - other procedures move from the inpatient to these other settings. And so they should be able to receive the same quality of care. And they should be measured in the same way.

So yes the second (unintelligible) it says, right, you know, these are the (unintelligible) they have. Some challenges distinguishing that. And right now the way the programs are set up they all have sort of just a basket of measures where you can't really compare one to the other.

They're all very different. But there's also discuss importance of aligning the measures for surgeries and procedures that perform again in both inpatient and outpatient. And then aligning measures for similar surgeries that also occur in different settings.

That would also help patients and families to be able to make better choices about where they want to get their care. And then one last point was increasing the alignment of measures used across programs. To provide some (unintelligible) on providers.

And (unintelligible) report to private and public spectra payers. And those are the big ones. I remember a lot of conversations around that.

Next one was MAPs we talked about CMS's meaningful measures initiative with the (unintelligible) rolled out I think the year before. And it's - we spent

focused on minimizing the dissertation of measures across programs. Again for those of you that we were with us last year the meaningful measures initiative made a pretty big impact on the hospital program, specifically IQR. It took all the measures out of IQR that were already being reported in other programs.

That they were already in value-based purchasing. Or in the - they already (unintelligible) and re-admission. So - but they wouldn't have to be reported twice.

It still doesn't take away the number of measures. But they just don't have to be in all these multiple programs. And then they also had - came up with their criteria for removing measures.

I understand it is different for every program. So hospital has its own. Does it have to do with, like, their topped out or the (unintelligible) report starting to continue measuring then it is the - I think it's like the (unintelligible) for patient care or something like that.

But it's in the Federal rule. So MAP also supported CMS and its continued focus on reducing administrative burden for the (unintelligible) providers. And noted how important patient and family prefaces are when considering the plan of care.

So some future high-priority measures MAP wanted included, prep the family and focused care minimizes the patient's overall (unintelligible) of care and preferences. So it was very (unintelligible) and family focused last year. Which we tend to have a lot of that.

But it think it's - we're seeing a lot more of it over the years. Okay. And I'm going to turn it back to (Madison). Unless anyone have any questions. Any questions?

(Madison): Are there any questions before we start talking about the program. Okay. So this slide just displays all the programs that we'll be discussing today and considering in the MAP hospital by the MAP hospital work group. As (Melissa) said earlier MAP Hospital does have the most work programs to review and discuss.

I have all the workgroups. So hopefully we can move through this content relatively quickly. But we do recognize that we do have a significant workload ahead of us. So to dive right in well get started with NCH (unintelligible) Oversees Quality and Incentives Program.

This program is a paper performance and public reporting program. And (unintelligible) structures out of 2012. Seeing as today failed facilities are reduced if facilities do not meet or exceed the requiring (unintelligible) performance score.

Fee and reduction will be on the sliding scale which could amount to a maximum to 2% per year. The program aims to improve the quality of the (unintelligible) care. And produce better outcomes for the beneficiaries.

This slide displays the measures that are currently in the ESRGQIP program. And well we can get - we can flip back for discussion later. But before we discussed the gaps we wanted to highlight some of the high priority meaningful measure areas as far as the ESRGQ program.

They are care coordination safety, patient and caregiver - and patient and care giver center experience of care. And these priorities are noted and CMS need this priorities document for 2019. So with that I'll turn it over to (Christy) to get started and facilitate our workgroup discussion.

(Christy): Thank you so much. Well it's our time now to kind of join in and hopefully you all have had an opportunity to do a little pre-thinking about this. So what we're going to do right now is identify if there's any refinements or additions to these high priority areas for future measurements.

Or another way of looking at this is if there are any gaps. And I do think that we may move back to the listing of measures so that you can have that in front of you. Thank you very much. And I would be glad to hear form MAP hospital work groups members at this time who would like to make some comments.

Woman: So do you want to raise our hand through the thing?

(Christy): Is that the right way to do that (Madison)?

(Madison): It's whatever you prefer. We can call them out as we see them if you'd like. But it's up to you (Christy).

(Christy): (Unintelligible) will I see them on my computer?

(Madison): Should be promoted to - I'll promote you now if you're not already. So you can see them.

(Christy): I'm promoted. Would somebody just raise their hand on the computer so I can see if I can see it? Whoever made that comment just a moment ago that would be great.

Woman: My hand is raised.

(Christy): Yes I don't see it. So why don't you just offer your comments and thoughts. And do say your - do indicate who you are so we can get used to voices.

Woman: Okay. So I feel a little nervous about making this question or suggestion because it's not an answer to either of the questions your posed. I asked about this particular issue on the general orientation a few weeks ago.

And it has to do with the fact that the Innovation Center has proposed a mandatory participation model for dialysis providers. And this is not a MAP subject per say. But that program introduced new two measures that my members personally thought were infeasible

And if they're in - I know CMS is not on this call today. But I just wanted to raise it again. Those two measure were the percent of patients on home dialysis.

And the percent of patients receiving transplant. So I just thought that was interesting that those measures I think appropriately are not in this measure set. But if there's ever an opportunity to talk with CMS about that conflict. That will be appreciated.

(Christy): Well thank you. And we'll certainly take note of your comment. So thank you for bringing it up at this time. Any other comments that anyone has?

(Madison): (Christy) I see a raised hand from (Jackson Williams).

(Jackson Williams): His this is (Jackson Williams) from Dialysis Patients Citizen. I would echo the previous speakers concerns about the measures that are being introduced in this mandatory model. Which I hope will be revised significantly before it's implemented.

I just wanted to share that we survey our members every year. Last year we did a survey on patients - ESRD patients priorities for quality measures. And I would have to say that overwhelmingly the dimensions of care that resonate with our members are the patient experience of care measures.

There's a lot of interest in specific questions that are on the ICH Cap survey that are not broken out and reported separately that perhaps ought to be. And we've raised this issue with the folks at CMS. I do not know the role of NQF or the MAP is in looking at breaking those out into separate measures.

Right now all of the ESRD patient experience measures are composites. So I just wanted to raise that. And I'm happy to bring the results of the survey to the in person meeting if that would be an appropriate place to share them.

(Christy): Well I think - thank you so much for your comment. And for today this is exactly what we are interested in is getting your feedback and ideas about where there are some gaps. And so we will be sure to note the gaps that you have said. If there's anything particular that you would like to add about specific measures in NQF, what would be the right way to do that?

(Madison): If you know - excuse me. If you know off the top of your head right now, like, if - is there certain sections of the CAP survey that they want separated

out and why. And if you don't know that now, if you could send it to staff so that we can look at that and include it, that would be helpful.

(Jackson Williams): I will send it to staff. Thank you very much.

(Karen Heller): And..

(Christy): Well thank you.

(Karen Heller): …this is (Karen Heller) again, if you could distribute those comments to the rest of us we'd really appreciate it.

(Madison): Yes so all of this - right now the information we're getting it's sort of organic but we talk about gaps and anything that comes up. Because we will write a report - there's a thing in there that report that we write in addition to the recommendations for the measures that you will be reviewing. There's a section before. And some programs there tend to be a little bit more about it if not. But this is good information to have. So, you know, if you're stakeholders are asking for this it just seems as good to know why and what, like, what sections of it is it. Because this does go straight to CMS. So, you know, they'll be your audience.

(Jackson Williams): I'm not going to be able to shed much light on why these are important from them. I guess it will have to be inferred from the results.

(Christy): Okay.

(Madison): And that's fine…

(Christy): Well just share what you can with the staff. And it will be - it'll be recorded as part of our gaps.

(Jackson Williams): Great. Thank you.

(Christy): You're welcome. Anybody else have any thoughts or comments before we move on?

(Madison): I see a raised hand from (Marty Hatley).

(Christy): Hey (Marty).

(Marty Hatley): Hi (Christy) and team. I'm trying to wrap my head around the goal of aligning measures across different care settings and different work groups I guess. And I'm just wondering, you know, how we're going to be able to weigh in on that.

How we'll be prepared. If we'll know what staff will do. I'm trying to formulate this in - just how to be aware of that?

And how to make, you know, how to advance that? Either today or in December. I'm wondering if there are any thoughts about what I should be thinking about or just how I should be preparing to do that.

(Christy): So I'll ask NQF staff what you're thoughts are on that.

(Madison): I think CMS has already started to move that way. It's programmed a lot probably some of the surgical procedures as one month procedures are moving from the operating room into the hospital to outpatient. I also noticed

in the pre - the (unintelligible) rule for ambulatory care or outpatient. They had - CMS had asked for comments.

They're considering that some measures are neither outpatient or ambulatory. I can't remember which. But they asked for comments about (unintelligible) ban for the other study.

Now this isn't - these measure aren't' being discussed now. But that's I think what they're thinking. Re-specifying them for the other study.

And then they would be aligned to put them in the two different programs. So if, you know, you're having whatever surgery it is, having the measures for that. But specified for that study.

And maybe thinking about as you look at the program sets, you know, are there measures that we can do that. I know that there's some (unintelligible) edit. But it's probably mostly around the surgical measures and how to do that. Because usually…

(Marty Hatley): Okay.

(Madison): …they have to do with, like, how they get paid I think. So we can come back like thank you CMS as well. They're not here but, you know, what kind of feedback would they like from this group to help them with (unintelligible) into the group - the measures.

(Christy): I think that sounds like a good idea. Because to (Marty's) point it is important for us to be putting that lenses on what we're doing. We will have a little bit of insight if it's a hospital base - well in our hospital groups. Some of the stuff is not hospital based as we well know, including ESRD…

(Madison): Right.

(Christy): …has a lot of non-hospital based. But we'll have a little bit more of an idea in our own work group. But if there are opportunities for alignment with other groups, you know, hopefully that's where NQF can step-in and say this is being also looked at in another program that maybe we're not familiar with. And especially…

(Marty Hatley): Yes.

(Christy): …if the (unintelligible) under consideration come in. We'll see whether in our work group activity there's opportunities for alignment.

(Sam): Hi this is (Sam). And as you know I'm overseeing the Coordinating Committee this year. And some portion falls directly on this Coordinating Committees list of responsibilities.

But as you saw it's also something for each of the work groups to consider. And this is something that's fast. It's going to take some extra steps to make sure that you have the information in front of you from other programs that are part of the pool - pre-making process as well. Once the muck list is release we'll be putting together a series of discussion guides.

And within those discussion guides we'll provide links that'll connect directly to the measure sets. And included in that is a fairly large spreadsheet that in the calms of which will have checkboxes around priorities as articulated in the meaningful measurement areas. And the degree to which any given program has fulfilled the requirements to warrant checking off all of those boxes.

So you'll be able to see where the measures fall, and which programs their currently being used in. As well as teak into consideration to the extent it's possible to digest the 19 programs the MAP is going to be looking at this year. As to the extent there is alignment with measures but you'll be considering as well.

(Christy): Great (Sam) that's very helpful. And for the new people on the committee - in the workgroup the amount of work that the team has to do between now and our in person meeting is astronomical. So really appreciate you all taking those steps then to give us the information that'll be helpful to us. So hopefully..

Man: Thank you.

(Christy): …(Marty) that addresses some of your issues.

(Marty Hatley): Yes it's helpful. You know, one other I would just add is it might be helpful also just if we could ask CMS to address this in their opening comments. But I'd like kind of the bigger trajectory or progress report on how their doing this from their end too. That would be - that's helpful for me as a citizen I think.

(Sam): Thank you.

(Christy): Thank you (Marty). Okay we'll probably going to need to move on. And so I'll give one last call out for any gaps in ESRD? If we can keep it focused there. Because we're going to move on to cancer next? Okay. Well I'm going to turn it over to (Sean) to lead - oh and the team. First the NQF team and then (Sean) to lead that discussion.

(Sean): Yes I was going to hope the NQF team was going to talk to us a little bit about the cancer (unintelligible) measures first.

(Christy): Well they will. Thank you again.

(Madison): We have you covered (Sean).

(Sean): (Unintelligible) (Madison).

(Madison): So now we'll start with the PCS exempt cancer hospital quality reporting program. This is a voluntary quality reporting program where the data is published for hospital compare. The goals of the program are to provide information about the quality of care in cancer hospitals.

In particular the select cancer hospitals that are exempt from the IPDF and the IQR programs. Encourage - the other (unintelligible) encourage hospitals and clinicians to improve the quality of their care. And share information.

And to learn from each other's experiences and best practices. This slide displays is currently in this PCHQR program measure set. This next slide lists the high-priority meaningful measure area for cancer hospitals.

So it's being communication and care coordination. So looking at measures regarding care coordination about our facilities and outpatient settings such as hospice care were measures that address patient functional status, quality of life, and end of life. Another category - meaningful measure area of importance being making care affordable.

So looking for measures that relate to efficiency appropriateness and utilization of cancer treatment (unintelligible) such as chemotherapy,

radiation, and (unintelligible) treatment. CMS also noted person and family engagement as another high-priority area. So measures related to patients that are planning, shared decision making, and quality of life outcomes.

As well as measures that address patients end of life according to their preferences. And the last meaningful measure area that they noted was to promote effective prevention and treatment of chronic disease. So looking for measures related to appropriate opioid prescribing and pain management and best practices for cancer patients. We'll turn it to (Sean) to get us started in our discussion.

(Sean Morrison): Thank you so much (Madison). So can we just quickly go back to the list of measures? And then I'll open it up for questions, comment, about gap areas in this program.

And just for those that may not be aware, this relates to the - 11 cancer hospitals in the United States. So it's a relatively small but important group of providers. And I'm sorry (Melissa), (Madison), I can't' see hands. So you're going to…

(Madison): I see (Denise Morris) has a hand raised.

(Denise Morris): Yes hi. I am at City of Hope which is one of the 11. Very familiar with the program.

I'll say with my discussions with other cancer centers as well as looking at what's outside of the other programs. There are potential missing measures regarding patient reported outcome, access to care, and survival is a measure that we hear a lot.

(Sean Morrison): And just push a little bit on - I think to help move the conversation on this. Specific PROs that you've heard are missing. In areas around…

(Denise Morris): Those related to - it was kind of - it was on the next slide as well related to functional status and patient quality of life.

(Sean Morrison): Okay.

(Denise Morris): So within those areas yes.

(Sean Morrison): Thank you. Other gap areas that people would like to raise.

(Lisa McGifford): This is (Lisa McGifford) could I ask a question about the survival issue? Or are you talking about reporting periods of time of survival? Or yes or no survival? What kinds of survival measures.

(Madison): Yes it would be a bit of a stretch because of the time frame. It'd be more of a longer term survival in comparison to some of the other hospital measures that tend to be in patient mortality kind of measures.

(Amy Helwig): This is (Amy Helwig) with UPMC. I'm wondering with the survival issue one that we look at with our oncologists is whether or not they have done a formal survivorship plan? Because really a significant number of people survive cancer.

And there's a lot of ongoing long-term quality issues regarding - essentially basically hand-off back to primary care or to their ongoing care. And it has to do with whether or not you have a survivorship plan in place.

(Sean Morrison): Thank you very helpful.

(Madison): I know that that answers - yes that one…

(Amy Helwig): Thank you.

(Madison): …is controversial. Which I now that can be discussed further later.

(Sean Morrison): Other hands that I'm not seeing since I'm not seeing any hands.

(Melissa): I don't see other hands.

(Sean Morrison): All right. Then…

(Karen Heller): Wait (Sean).

(Sean Morrison): Yes.

(Karen Heller): I'm holding back again. And..

(Sean Morrison): Yes.

(Karen Heller): …I'd like- I want to make the same comment I did for. So radiation, oncology is also the subject of a mandatory participation program for the hospitals that are not the 11. And one of the - it's a bundle payment program.

And one of the problems that we had with it was that the bundle payments were based on just each providers historical spending. And it would be interesting to be able to align this program with that in terms of just producing some of the information because these programs - these cancer centers are

very notable. And I think they're experience for how they handle as patients would be very instructive for the other side of the hospital community.

(Sean Morrison): Fantastic. And as you can imagine this has come up before in terms of alignment of the measures. Specifically this program and other hospitals that provide cancer care in the United States.

(Karen Heller): Yes I mean, you know, because I'm representing my organization and not me, you know, I don't want to, you know, volunteer additional burden. But it certainly would be nice to be able to evaluate general hospital performance at a clinical service lying level with aligned measures.

(Sean Morrison): I think we can certainly report that to CMS. Right guys? Staff?

(Madison): Yes.

(Sean Morrison): Yes.

(Madison): That's something we've taken note of - we've captured this in our notes.

(Sean Morrison): Yes. Any objection from anybody if we move on to I think it's ambulatory surgery? Ambulatory surgery it is.

(Madison): Great. So this next program is ambulatory surgical center reporting program. It's a paper reporting and public reporting program within incentive structure that if the AS - APS that do not participate or fail to meet the program requirements, they will receive a 2% reduction in their annual payment updates.

The goals of the program are to promote higher quality and more efficient healthcare for Medicare beneficiaries through measurement. And to allow consumers to find and compare the quality of care given ASEs to inform decisions on where to get care. This slide which you can flip back to shows the current program - or current measures in the ASQ - ASBQR program measure site.

CMS identified 6 meaningful measured areas that were of high-priority for this program there. Making care safer, patient and family engagement, best practices of healthy living, effective prevention and treatment, making care affordable, and communication slash care coordination. So I'll just flip back to the program - the measures that slide for us. And (Christy) we can begin our discussion there.

(Christy): Sure. And please help me see the hands that might be raised as we can't see them on our computer. But I'll open it up to the workgroup to see if you have any gaps that you would like to be sure we record and share with CMS.

(Lisa McGifford): This is (Lisa McGifford) I'm not able to raise my hand. But I'd like to get in the queue.

(Christy): Well why don't you just kick us off.

(Lisa McGifford): Okay. I'm wondering if -why there's no infection related measures on this list.

(Madison): Very good (unintelligible) we'll just put it that way.

(Christy): Yes. Very good question. In fact I was going to raise that if nobody else did. So thank you (Lisa).

(Lisa McGifford): There's quite a bit going on at the FDA about the inability to clean a lot of scopes and things like that. So it seems like it would be important.

(Christy): I think it's also an example of looking across programs. Because certainly surgical site infections are important in other programs as well. So in the ASC environment, you know, it's another way to kind of - to fill a gap as you're suggesting.

Did you have anything else? Did you have anything else (Lisa) that you wanted to mention before we move to someone else?

(Lisa McGifford): No I think that's a really good point. I think consumers are often looking, you know, at should I get this done in a hospital? Or should I get it done at AFC? And as much as we can do to kind of provide some comparison is useful.

(Christy): Thank you. Anyone else? Well if it's okay with you all I'm going to take my co-Chair hat off and make some other comments.

I can swipe the surgical site infection one. And - but as was talked about when we were thinking about themes early on, you know, a lot of them were around surgeries that are being performed in different settings. And the expectations as patients that, you know, you would expect the same level of quality of care.

You know, more and more of the surgical procedures that used to only be done in an inpatient environment are moving to the hospital outpatient environment. And then they're also moving into the ambulatory surgery center environment. And it seems to me that it would be important to measure

really for particular surgical procedures, you know, what the quality and safety of those procedures as they move into a different setting.

So this is kind of a possible outpatient department as well. Which I'll try to remember to bring it up then to but, you know, we're beginning to see what very complex surgical procedures done in an outpatient or ambulatory setting. So I think it is incumbent to be sure that the safety and quality of care is being measured so that we can see if these have been, you know, good decisions to move them into these settings.

The other comment that I would like to make is around medication safety. This is another important aspect that really is in every setting that we would be focused on. So looking at medication safety in the ambulatory and outpatient settings as well.

With some emphasis on opioid prescribing and stewardship but not solely limited to that. But that is an important component. And I do believe that there are measures that are existing around opioid prescribing and stewardship and that applying those in an ambulatory surgery environment would also be helpful.

And then the last piece is around patient reported outcomes. Similar to the ones we talked about I think other settings especially for cancer looking at functional status. As well as more traditional patient reported outcomes. So if we could capture those as well I would appreciate it.

(Sean Morrison): (Christy) this (Sean). Since you're no longer the co-Chair I'm going to be the co-Chari.

(Christy): Great.

(Christy): Can I ask you to just elaborate a little bit on your first topic. Are you - I guess what I'm asking is are you suggesting that there really needs to be fundamental realignment that looks across procedure rather than across settings? Or are you more saying that the measures in ambulatory surgery should align with out - hospital outpatient which should align with hospital inpatient.

Or is it that that the measures - we would should be looking at - not (unintelligible) that's a poor example. We should be looking at endoscopy for example. Does that make sense?

(Christy): Yes. And, you know, my answer would be both honestly. Because - and probably for the high risk - traditionally high-risk, you know, procedures that have not been done in the - this outpatient or ambulatory surgery settings. Obviously there's a lot of issues related to patient selection.

You know, getting patients that maybe are - don't have the medical issues perhaps that would say they need to be done more in an in-patient or hospital setting versus an ambulatory setting. So as we begin to see more and more move into ambulatory setting, you know, I feel like its focus a procedure level because the procedures are different in and of themselves from each other. They have different characteristics and risk levels- clinical risk.

But also looking at the cross-cutting issues being the same regardless of setting that would be applicable as well. So my answer to your question is both.

(Helen Haskell): This is (Helen Haskell). I have another question you - we're looking at outcomes here. And you're talking about patient selection.

I'm thinking about the other end that emergency backup in case of patients, you know, going into cardiac arrest. The 911 is there some kind of standardization and criteria so outcomes of patients who have had to have emergency backup called. And just what the criteria are for that. Is that's something to be concerned about for patients with outpatient surgery.

(Madison): Good point.

(Helen Haskell): Think (Joan Rivers).

Woman: This is (unintelligible) NQF. The other day I believe it was (unintelligible) scientific panel or maybe on CPAC brought up that the fact that the state's surgery checklist use measures is released from the program. And they thought that was concerning.

And they would - they talked about some literature behind it. I don't know if we want to have a discussion about it. It's probably removed because it was topped out. But if anybody has any thoughts on that?

(Madison): (Unintelligible) hand is raised. I don't know if it's related to this comment.

(Christy): Okay.

Man: It is. Well it's more related to the comment that (Helen) raised about what kind of standards there are for backup. I will say that for in the case of hospital outpatient's departments and for AFCs there are Medicare conditions of participation that lay out some requirements for the kind of processes and procedures you have to have in place including back-up. I mean I think one of the challenges with this setting that I happen to really agree with the comment

that, I don't know if it was you (Christy) or who raised about (unintelligible) of infection rates being measured. I think the challenge for AFVs is really kind of a data collection one.

By their very nature ambulatory procedures are done on the same day. And so the ability to detect an infection is a lot more challenging. In a hospital setting you can measure infections because you can actually do the testing for the infection while the patient is with you.

So it - I think it is a gap. I'm a little challenged to figure out the best way to measure it just from a methodology perspective.

(Karen Heller): That's interesting. So you're suggesting maybe some sort of, like, did the center do a 7 day follow-up to check about infections? I mean this would be brand new.

Man: I mean that is one way to look at it. But I mean if you're looking to get a reliable infection rate I'm not a follow-up call alone would necessarily get there.

(Karen Heller): Yes.

(Christy): This issue has been brought up. This is (Christy). This issue has been brought up before around the way that ambulatory surgery centers operate.

And the setting within - really the place in the healthcare delivery system with in which they operate. But I do think the suggestions included on the gap understanding that they're - we may be challenged in how to collect the information. At least keeps it front and center in terms of an important quality

and safety issue in this setting. But you bring up a really good point in terms of getting that information.

(Karen Heller): Yes and - (Karen Heller) again I want to follow-up on (Helen's) point. I don't - I'm not very - not familiar with the AFC build. Is it - does anybody know if there's a discharge destination? In other words, can you tell from the bills that the patient is transferred to an in-patient setting? Like, on hospital bills did you go home, did you go to another hospital, did you die?

(Ira): There is a structural measure -- 0265. The entrust number is ASC-4, which is all cause hospital transfer/admission.

(Karen Heller): Oh, yeah. I see that.

(Ira): So, I don't know the specifications of that measure, but I would think that it would be addressing your question.

(Karen Heller): But, it's interesting a structure measure. I'll have to read up about that because it seems like if there was a sort of discharge destination you would be able to do a rate.

(Ira): Right.

(Karen Heller): So, I'll have to look at what that is actually.

Man: And, that...

(Lisa McGifford): Hi, this is Lisa. I spoke

((Crosstalk))

(Lisa McGifford): Go ahead.

(Ira): Lisa?

(Lisa McGifford): Oh. Isn't there a measure about being in the hospital after a certain period of time that would match up with, say, the CDC definition of when something could be a healthcare acquired infection? In fact, I've seen that measure somewhere.

(Ira): Well, we'll take a note of that.

((Crosstalk))

(Lisa McGifford): Maybe a transfer. But, transfer within a number of days. I guess, maybe for Medicare patients.

(Karen Heller): You're bringing up a - I hear...

Man: I was just going to...

(Karen Heller): Yes, please.

Man: Sorry. I was just going to say that there is a measure in here -- ASC-12 -- that looks at hospital visits within seven days of the ASC procedure. Now, whether you would actually pick up an infection from that measure alone, I'm not sure that you can. It tells you that somebody was admitted to the hospital or admitted to the ED, that it could be for any other kind of (unintelligible) as well, so.

(Karen Heller): Yes. I think that you're on to something with that particular measure. Certainly, this would be very difficult. I'm not sure. I'm not sure about, you know, computer programming these days. But, hospitals measure where - the hospitals code where the patient came from. And, I'm not sure if you can identify a particular ASC. But, regardless, they have - if it were possible to hook up patients that had had a procedure at a freestanding facility and then a hospital admission, they code whether there was an infection present on admission.

(Lindsey Wishom): So, this is (Lindsey). I mean, that is - that would be - and, I know we're not here to necessarily develop some structure here on the class. But, I hear talking - I'm listening. I mean, I think this may be a good option for a candidate we'd call like a hybrid measure, right. You're going to take a combination of clinical data that you're maybe getting from it from an ASC. But, yet you're going to inform it, right, as far as the outcome using potentially claims data now.

But, obviously, that - there's hand-waving over a lot there. But, there are opportunities to use a combination of data sources for something just like what you guys are trying to measure.

(Karen Heller): Yes. In other words, I think it's still an ASC measure. But, you can get information from hospital claims, right?

(Lindsey Wishom): Absolutely.

(Karen Heller): Okay.

(Ira): Well, thank you. Thank you for getting us there. And, the last comment I'll make is, it's my understanding that for high-volume ASCs that CDC has a

program through their NHSN where their high-volume ASCs can actually report this information in to CDC. Although, I think the adoption rates are pretty low because it's a voluntary program.

But, I think suffice it to say that we've heard a lot of comments around infections and I think that will definitely be prominent in the notes that we have around gaps.

(Karen Heller): And, one last thought from Karen. Also, thought, to match it up with physician data because a lot of people who have an infection from an outpatient something go to their doctors office.

(Ira): Right. That's right. Well, thank you all. And, I hope we have taken notes on some of the potential ways that we can actually get to a measure even though we're not in the measure building process. This is one of the things we need to take advantage of is some of the great thoughts from the stakeholders around the table. So, if there's not an objection -- I love the way (Sean) worded that -- we'll move on to inpatient psychiatric.

(Karen Heller): Okay, great. Thank you, (Ira). Great discussion.

(Ira): Thank you.

(Melissa): So, next program up is inpatient psychiatric facility quality reporting program. It's a pay for reporting and public reporting program. And, for this program the incentive structure is if the inpatient psychiatric facility do not submit data on acquire measures those facilities receive a 2% reduction and annual payment update.

The goals of the program are to provide consumers with quality of care information to make more informed decisions about their healthcare options. And, to encourage hospitals and clinicians to improve the quality of inpatient psychiatric care by ensuring that providers are aware of reporting and best practices.

So, this is the IPFQR measure set right here. And, this next slide, CMS identified two high-priority meaningful measure areas for this program. They are strengthen in person and family engagement as partners of their care. And, for that they noted measures such as depression measure or caregiver and engagement measure -- as those being high-priority. For the other high-priority areas, they noted make care safer by reducing harm cause in the delivery of care. And, for that they noted the aggregate harm measure of being a high-priority important.

So, with that, I will turn it over to (Sean) to facilitate this discussion.

(Sean): Thank you. Floor is open for comments around gaps. Or, the World Series if there's none.

(Karen Heller): Baby shark. So, it's Karen again. And, one thing that I have - multiple on hospital compare, but it's not there. This isn't about the measure, but it's about identifying the provider as to whether the unit is general population or geriatric. The reason I'm curious about this is geriatric units tend to provide, you know, very appropriate care for geriatric patients. And, they're going away.

So, I think it would be very interesting to be able to report the type of unit so we could -- at CNS -- could see if there are differences in quality.

(Sean): As a geriatrician, I am certainly not going to argue with that one.

(Karen Heller): Thank you for being a geriatrician.

(Sean): Others. So, I'm hearing identifying the patient population within the unit. Anybody else? Okay. Hearing no objections, we will move on.

(Melissa): Okay. This is Melissa. The next program we will cover is the hospital outpatient quality reporting program. This program is pay for reporting and (unintelligible) reporting. There is a 2% reduction in annual payment updates for hospitals that do not report. And, the goal of this hospital - of this program is to provide consumers with information about the quality of care so that they can make more informed decisions.

And, it was established to collect and provide quality data to hospitals that were providing outpatient services. Such as, emergency (unintelligible), visits, outpatient surgery, and radiology services. And, some of these services sometimes get blurred with inpatient and, again, it's very confusing for patients sometimes.

These are the measures here. The program's (unintelligible). Everybody has to memorize. I always think of it as homework -- you have to memorize it, you know. And, the high-priority meaningful measure areas that CMS has identified includes making care safer, person and family engagement, best practices of healthy living, effective prevention and treatment, making care affordable, and communication and care coordination.

So, we'll flip the slides back and turn it over to (Christy).

(Christy): Okay. Well, thank you.

(Melissa): Yes.

(Christy): So, I'll open it up to the workgroup and see if anybody has any recommendations regarding gaps for a hospital outpatient quality reporting.

Woman: So, I just have a question. You know, Measure 1822 -- External Beam Radiotherapy for Bone Metastases -- that was listed in the cancer section as endorsement removed. I just wondered if the endorsement was removed for the cancer measure set and not for this one. Or, if it's just, you know, just not aligned.

(Karen Heller): We might have just missed it. It was removed. So, we just need to fix it here, but it has been removed.

Woman: So, when NQF removes endorsement it's not for specific measure sets, it's like in general?

(Karen Heller): Yes.

Woman: I mean, would they always be consistent across the different hospital settings?

(Karen Heller): Yes, that's correct. And, we had tried to kind of identify what the different types of endorsement and non-endorsement means. So, sometimes endorsement removed just means that the developers decided not to resubmit the measure for endorsement. I think that's what happened with this one. There are some where they have been submitted for endorsement and then failed, which is different.

And then, there we have - I think there might be few here that are under review. And, this will be updated as well by the in-person meeting because we have measures that are going through the process right now. So, those will also be updated. There may be some that have an NQF number because they were submitted, but then failed or just didn't get through the whole process -- and you'll see that they're not endorsed.

So, we try to keep it as simple as possible because, you know, there can be a lot of information embedded within endorsement, non-endorsement. But, if you have any questions regardless -- and thank you for checking that -- just let us know and we can find the status of the measure.

(Christy): One comment that I will make is that during the endorsement process you look at the level of analysis. So, the setting is usually - well. Is usually part - is part of the measure specifications. And so, all the testing has been done based on that specification. And, one of the issues that from time to time the MAP has to deal with is that it may be an endorsed measure, but at a different level of service or a different setting. And, from the NQF endorsement process you really need to have it specified for the setting within which you're going to use it and have the testing done at - with that setting so that you can see if it is indeed valid and reliable. And if...

(Karen Heller): So, are you saying...

Woman: Go on.

(Karen Heller): Well, this - the particular measure I noticed. So, would it have been - would the measure have been tested only in the 11 cancer hospitals for that measure set and perhaps in all hospitals for this measure set.

(Christy): I can't answer that particular question.

(Karen Heller): Okay. Yes, I was just...

(Christy): But, when we do run across those kinds of issue for the in-person meeting we will know whether it - you know, whether it's endorsed for the particular setting within which we're looking for it.

(Karen Heller): I see. Okay.

Woman: And, for the cancer hospitals, a lot of those measures - I know a few years ago we had a question if it's - some of them have been... and, I believe 1822 is at the clinician level. You know, let's see. (Unintelligible) is it clinician level. Because, I know some of the older cancer measures were - (unintelligible) not in the facility? Okay, no. So, it is facility.

So, it's appropriate. It's appropriate for the hospital for the cancer centers as well at each facility. I know there's some older cancer measures that originally endorsed at the clinician level and facility level. Now, we require measures (unintelligible) specified per multiple settings and levels, but they have to be tested in both.

(Karen Heller): I understand.

Woman: Right.

((Crosstalk))

(Karen Heller): In general, we've talked about site of care and differences in that. At some point in the future it would be nice to line up the facilities and the practitioners

because if there were alignment there that would be very -- from a consumer perspective - this clinician at this hospital. This clinician at this surgery center, right. To be able to look at the combination because if we ever get to payment reform where you're bundling payments like that it would be - I think that's necessary information.

I thought about that because in the radiation oncology bundles payment demonstration that the innovation center has proposed they provided a Excel file that had all the combinations of practitioner and technical component -- which was fascinating.

(Christy): Thank you for that. It's a good example of how to align a (clause). And, if you think about it from the patient's standpoint not necessarily the CMS program data...

(Karen Heller): See, that's the point. I mean, a lot of people use US News and World Report to actually choose things because it does combine some clinician element with the facility. And, I think that's - from a consumer perspective you really want to see both together. Because it's not the nursing care that you're choosing a hospital for.

(Christy): That's right. Very good comment. Are there some other hospital outpatient quality reporting gaps? Okay. Well, let's move on into the hospital inpatient quality reporting program.

(Melissa): Okay. So, this is the big one. It was also renamed last year. We'll still call it I2R, but its government name is Hospital Inpatient Quality Reporting Program and Medicare and Medicaid Promoting Interoperability Program for eligible hospitals and clinical access hospitals. And the purpose of this was...

Woman: Wow.

(Melissa): Yes. And, I think this was because they were bringing together the HER incentive program into I2R. So, they are no longer two separate programs -- they are one very big program.

Woman: Oh, really?

(Melissa): Yes, it's not separate anymore.

(Sean): I don't think that's correct...

Woman: Yes.

(Sean): ...from an overall perspective. I mean, they're still two separate programs, but the ECQM reporting component is shared in common across the two.

(Melissa): Yes.

Woman: In the federal rule, that's what - like, this last time that's what changed is, like, the number of ECQMs that are voluntarily reported and how many, and when, is what's changing. But, they used to have two separate ones but now they've combined it. It's probably two maybe decreased versions. I don't know.

(Karen Heller): So, in the inpatient perspective payment system they're listed as two separate payment adjustments. So, the adjustment is different depending on whether the reporting and the EHR stuff - outcomes -- those are different.

(Melissa): Right.

(Karen Heller): So, yes. That's not what you were saying. They're not combining...

(Melissa): No.

(Karen Heller): Because, quite frankly, the whole first - the first slide -- Slide 44 -- those are all claim-based measures. Hospitals don't report anything, literally.

(Melissa): Yes. I think the only - there's only a few measures left. (Sepsis) is the only, like, attractive measure. There's, like, maybe a couple left, but they all are claims-based. And then - but, here they included the EHR measures and then they threw in the critical access hospitals which are, you know, voluntary in the program.

(Karen Heller): Yes. That's your (unintelligible) measures.

(Melissa): Yes.

(Karen Heller): So, the only two reported measures are the sepsis, elective delivery, and vaccinations.

(Melissa): Yes.

(Sean): HCAHPS too.

(Karen Heller): And, that's reported by the vendor though.

(Melissa): Yes, they're all claims-based. So, this program is - they get paid for reporting and publicly - and it gets publicly reported. The hospitals that do not participate or participate but fail to meet the program requirements receive one-fourth reduction of the applicable percentage increase in the annual

payment. And here, one of the goals was the interoperability between EHRs and CMS data collection. So, they are still working on that. If you go to the next slide.

So, this is the program when they took out all of the measures last year that were in multiple programs. It looks smaller than it was just because of the number of (prog) measures. So, you're right. There's a lot of the claims-based measures, cost and resource use measures and not a lot of chart-extracted measures anymore.

And then, on the left side you see the ECQMs for the (unintelligible) options. And, what's changed is the - when they have to report them and how many of them. And then, there's the big chart-extracted composite -- Sepsis 0500 -- elected delivery, HCAHPS. And then, the influential one.

(Karen Heller): So, you just made the point about measures in other programs are not included in this. But, CAHPS is certainly included in VBP.

(Melissa): I don't know why - unless it's a mistake. I'm not sure why - I'll have to double-check. That might be our mistake. But, I mean, technically they all are, right. Because they have to be publicly reported before they could be in value-based purchasing. So, they were but they weren't. They just deduplicated everything. So, they're still technically there in probate after we remove them from the program. But, makes it a little bit easier too to do these presentations.

(Karen Heller): So, IQR is kind of the warm-up.

(Melissa): Right.

(Karen Heller): Pay for performance except for ECQM.

(Melissa): Right.

(Christy): And, that's a fair summary.

(Melissa): The high-priority meaningful measure areas for this program includes (unintelligible) person and family engagement as partners under care. Examples of those are functional outcomes and that care is personalized and aligned with the patients' goals. This group has already talked about this today. Promoting effective communication and coordination of care which would be a seamless transfer of health information. That would include measures of EMR safety such as patient matching and correct identification.

Promoting effective prevention and treatment of chronic disease and that would be prevention and treatment of opioid and substance use disorders. And, making care safer by reducing harm caused from the delivery of care or preventable healthcare harm. And, I think that the big goal of this program is, is if any new measures come in that they would be ECQMs. I believe the (unintelligible) may be - I know one of these programs they want ECQMs if possible.

So, big goals are back here. And, turn it over to...

(Sean): I think it's me.

(Melissa): It's all you.

(Sean): It's all me. Yes. So, just before I open up let me preface this by saying that the IQR program and the HVBP program tend to generate a lot of comments and a lot of opinions. And, I get that. And, there's a lot of - a motion behind some

of these. But, I think - what I'm going to hope is that we can focus on measurement gaps on this call because I'm conscious of we've got about 30 minutes and still agenda to move through.

So, with that little preface let me open it up for comments/concerns about gaps.

(Lisa McGifford): Hi, this is Lisa. I'd like to get in the queue.

(Sean): Lisa, you can be right on top.

(Lisa McGifford): Okay. On the promote effective communication area/goal, are there measures that are really pretty concrete and about how transfer information is communicated. Like, some kind of infection that the patient has or has had, or things like that. Because I know there's a lot of discussion in this area of trying to improve, you know, these - the information that goes with the patient from hospitals to nursing homes and other places. Are there measures like that that we have an opportunity to fill in this gap?

(Sean): Is that a rhetorical question or an open question?

(Lisa McGifford): Well, I guess the - if there's...

(Sean): I'm being serious.

((Crosstalk))

(Lisa McGifford): ...for that there is a gap. I guess that's what I'm saying.

(Sean): So, around care transitions?

(Lisa McGifford): Yes.

(Sean): And, yes, there are measures around care transitions.

(Lisa McGifford): That's going on in this program?

(Sean): And, what I'm hearing is it's a gap in this program.

(Lisa McGifford): Oh, okay. But, it's not in this program yet. Thank you.

(Sean): I'm sorry. I can't see hands. So, are there others?

(Melissa): I don't see any hands in the queue right now.

(Sean): I didn't mean to scare anybody.

(Karen Heller): This is Karen. I really had nothing to say.

(Sean): Okay.

(Christy): That's funny.

(Sean): Touché. All right. Then we'll move on, I think, to value-based purchasing.

(Melissa): Okay, value-based purchasing. This is (unintelligible) favorite too. This is only a pay for performance program. The incentive structure for this one is the amount equals to 2% of base operating DRG that is withheld from the reimbursements to the participating hospitals and distributed to them as incentive payments.

The goals are to improve healthcare quality by realigning hospital financial incentives and then the hospitals are provided payments - incentive payments that either depending on whether they meet or exceed their performance standards. So, sometimes they give and sometimes they take away. There's not a lot of measures here. So, there's a lot at risk. All your safety measures. So, you have your MHSN measures around catheter associated urinary tract infections, your C diff measure, CLABSI -- your central line associated bloodstream infection measure.

There is the specific surgical siting measure here. And, there is a universal measure. And then, the - what was originally called the CM - the CSI 90, which is now CMS patient safety and adverse events composite -- which is a big composite. And, there's a payment for standardized Medicare funding per (unintelligible). I think that's the favorite of a lot of people. Here's a HCAHPS as previously mentioned. And then, you have several mortality measures. One for AMI. One is a heart (unintelligible) measure. One's all cause and one's for COPD. And then, HSME (unintelligible) complication and then one for coronary bypass as well.

And these have been - this program hasn't changed in quite a while. The high-priority meaningful areas for this program were identified by CMS includes strengthening person and family engagement as partners in their care, looking at functional outcomes, and promoting effective prevention and treatment of chronic disease which includes prevention and treatment of opioid and substance abuse disorders. And then, risk adjusted mortality.

So, I can go back to the measures and turn it over to (Christy).

(Christy): Sure. And, I will ask the workgroup if you have any suggestions regarding gaps in value-based purchasing measure set.

(Haquem Demahan): So, this is...

(Karen Heller): Okay. Yes, sorry.

(Haquem Demahan): This is (Haquem) from AHA. I'm a little confused I have to say as I look at the slide that identifies the meaningful measures areas. And then, I compare that to the list of measures that we actually have, and it feels to me like the meaningful measures priority areas are very narrow. And, it feels like the measure set in the program is quite a bit broader than that.

Can you just sort of refresh our memories? Maybe this is a question for NQF staff around how, like, this particular slide was put together. Was this a CMS slide that identified the areas that they thought were priorities for the programs or gap areas? Sensing a disconnect between the two and I'm having some trouble bridging it.

(Melissa): Sure. So, these priority areas come from a document that CMS releases every spring. And, it's titled Programs, Specific Measures, Needs, and Priorities. And, it gets better every year but that's where these come from. They identify the priorities for every program, and they've changed a little bit over the years. I don't think that there was much changes this year. But, that's where these come from.

And, if while we're going through these if they don't seem to fit or you want to add something or include something, we can include that. Because all this information we're taking is going to go into the report. We start writing the report - at least the brunt of the report after this meeting. So, if there's

something that doesn't feel right to you, yes, we can include that because this will go to CMS again. This is not an NQF product, this is what we use as a resource.

(Haquem Demahan): Okay. That is helpful. I mean, you know, the risk adjusted mortality and functional outcomes - I mean, functional outcomes is a broad enough area that frankly any number of measures could potentially fit under that rubric. But, as important as addressing the opioid epidemic is and looking at a variety of mechanisms to address it is for the country, it just feels a little strange to me that if we're looking at the program as a whole that CMS identified opioid use disorders as like the priority for the VBT program.

When, in fact, the measure set that it has a much broader import. And, anyway. I guess in terms of specific priorities. Some of the priorities identified under the IQR were including things like enhanced measures of preventable healthcare harm I think are a gap area. Something that would use a more sophisticated approach than is included in something like TSI 90, I think, from our perspective would be a high-priority.

(Melissa): Got it.

(Lisa McGifford): And then, this is Lisa. I could follow-up on that. Now, that you raised it I'm a little confused why a harm area is not part of this high-priority.

(Melissa): I think it is in one of the other priorities in one of the other programs. But...

(Lisa McGifford): Yes. But...

(Melissa): But, we could include it in here and make that suggestion in here. Definitely.

(Lisa McGifford): Well, since a lot of these have to do with harm it seems - and I think that's intentional. It seems odd that that is not on this priority list.

(Karen Heller): Is it possible that CMS was just thinking about gaps mostly?

(Christy): That's what I was wondering.

(Lisa McGifford): Yes. If it's gaps then that makes sense. But...

(Karen Heller): Yes. I mean, it's - because there's a - there are certainly the whole first - the whole Slide 50 is about complications.

(Lisa McGifford): Right.

(Karen Heller): And, essentially replicates once you're in the hospital acquired condition...

(Lisa McGifford): Right. Yes. I think at least - and maybe Melissa you can help us understand again. I was thinking that their priority areas were for in a way where they need more gaps - to a certain extent gaps. OR, having more measures in those areas versus their priorities for the whole measure set.

(Melissa): All right. They say - so, I'm looking at value-based purchasing right now. So, they say CMS identified the following domains as high-priority for future measure consideration.

(Lisa McGifford): Okay.

(Christy): So, that helps a lot. Thank you for (unintelligible).

(Haquem Demahan): That does make more sense.

(Christy): Yes, thank you. That's very helpful.

(Karen Heller): So, this is Karen. And, I do have a specific suggestions in this part.

(Christy): Okay.

(Karen Heller): And, I did not have a chance to coordinate with teams because I didn't realize I could. So, first of all, this is not for measurement but it's for reported information hospital compared in that data set. I've been asking for his for about 10 years. To provide the CAHPS scores before the patient mixed adjustment. And, the reason that I want that is to be able to calculate the effect of the patient mixed adjustment because I've been concerned since the beginning that there is some inherent bias against safety net hospitals.

And, that's because generally people are who are Hispanic or less educated they - the patient mixed adjustment says that they like their care more often than other people, so those scores are downgraded. And, you know, on the keels of, you know - with all the discussion about disparities and the new Berkley article about, you know, severity adjustments discriminating against blacks - a patient. You know, I've just always wanted to be able to see the effect of the patient mixed adjustment and to just appose with other measures of patient population at the hospital.

(Christy): Okay.

(Karen Heller): So, that's...

(Christy): We'll make a note of it. Yes.

(Karen Heller): Then, next I have a question for Nicholas from (unintelligible) and maybe (Haquem) as well. I don't know if the technology is ever going to get to the point where you could fill out this, like, at the bedside on a tablet or something. But, at some point from a hospital perspective you want to think about a unit like a service. Like, I'm on the cardiac floor. It would be great to have CAHPS measures and MSPB and mortality readmission for this at the service level.

Because what you want to be able to do is encourage a team effort for the service which is, you know, the doctors, and the nurses, and the social workers, and everybody. Which is, you know, make this whole thing more actionable. And, it would be - I know that the surveys are very difficult, but at some point it's just to think about the future being able to be - you know, get many more respondents through an electronic, you know, submission at the end of the stay would allow us to look at patient satisfaction at this service line level.

(Christy): Okay.

Man: Yes. I can just plan to do that. Yes, we do e-surveying with clients. And, I think sort of service line or unit-specific, you know, patient experience data is very interesting. We've actually done a research project together with the Johns Hopkins School of Public Health funded by AHRQ a few years ago where we looked at, you know, some of the heart failure patients that were apart of inpatient quality reporting.

And then, related - were able to pull out those patient experience responses specific to heart failure patients and were able to look at relationships between the clinical measures for heart failure and, you know - and for patient

experience. So, I think, you know, from a segmentation perspective that's definitely an interesting suggestion.

(Karen Heller): Yes. And, that's why my last suggestion then would be - and I - and this may have been in and then taken out -- I don't remember. But to be able to provide -- at least in the hospital compare even if it's not in the measure set itself -- the MSPB measures for the conditions that match the mortality and readmission would be also very helpful.

Man: Yes. And, CMS currently doesn't allow for, you know, e-surveying. And, that's also an interesting point where, you know, you could potentially capture a lot of groups of patients.

(Karen Heller): My last comment was actually about the Medicare spending for beneficiary measures.

(Christy): Okay.

(Karen Heller): But, in general, my theme is to make this stuff more actionable for hospitals. You know, think about their ability. What they could do to encourage. Like, with CAHPS, you know, it's great. I mean, you know...

(Christy): Okay.

(Karen Heller): Yes, you get it.

(Christy): So, this is very helpful. And, I think, you know, your point around making it more actionable I think is a theme that runs across these. I'm not really meaning to kind of quickly get through the conversation, but we've only got about 10 minutes left to go through the rest of the program and our final

pieces. So, thank you very much though Karen. I appreciate your comments around these.

I think, if it's okay - does anybody else have their hand raised. I can't see them on my computer.

(Melissa): No. No additional hands raised.

(Christy): Okay. Well, why don't we go on and move then to the hospital readmission reduction program.

(Melissa): So, our second to last program is the pay for performance and public reporting program of hospital readmissions reduction program. The incentive structure is it's a Medicare fee for service base operating diagnosis. The related group payment rates are reduced for hospitals with excess readmissions. The maximum payment reduction is 3%.

The goals of the program are to reduce excess readmission in acute care hospitals paid under the IPPS which includes more than three-quarters of all hospitals. Another goal of this program is to encourage hospitals to improve communication and care coordination efforts to better engage patients and caregivers with respect post discharge planning.

It is a smaller measure set, as you can see here. And, the high-priority meaningful measure area that CMS identified was to promote effective communication and care -coordination of care. Specifically looking for all cause admission and readmissions measured hospitals.

(Christy): For (Sean)?

(Sean): Gaps, folks?

(Karen Heller): Okay. This is Karen. My one comment I - something also I've been asking for for 10 years and especially since the reduction program went into the ACA. Is, we need 7-day readmission rates. These 30-day rates are not a measure of what the hospital can do, but a combination of that and the community care. Okay. But, since we're penalizing hospitals we ought to be able to look at the 7-day readmission rate.

(Sean): Got it. Well, we've got it.

(Karen Heller): Okay.

(Sean): Other hands?

(Haquem Demahan): Hey, (Sean). Two quick comments from (Haquem). Number one, I think it'll be important for CMS to continue assessing and reassessing the approach to peer grouping that it's applied for accounting for the impact of social risk factors. They do have some flexibility in how they apply their methodology. So, I do think doing some ongoing analysis around that will be important to make sure that it's working as intended.

The other thing that comes to mind here is some of these measures have been in the program a long time. And, a couple of them may be approaching the point where they're topped out. So, doing some analysis there to figure out which ones may have potentially outlived their usefulness. The only other thing I'll make a plea for is for CMS to continue exploring the potential interface between mortality and readmissions.

And, in particular, there've been a couple of studies around the heart failure readmission measure and the potential for that to be (unintelligible) related to mortality. So, taking a look at that and considering whether the measure has some other underlying issues that need to be addressed I think would be important.

(Sean): So, just...

(Karen Heller): And, it's Karen.

(Sean): Yes, go ahead.

(Karen Heller): This is just - you know, statutory changes would be needed because it's just a really screwed up set. But, the - Akeen raised something that I forgot to say -- it's very important. So, in providing different expected rates based on the level of dual eligible, those expected rates have got to be monotonic and they're not. Meaning, as your dual eligibility proportion increases the expected readmission rate should increase. If it doesn't, that means you have to combine two levels. Okay. I mean, this is so obvious, but we say it in every letter, and nothing happens.

(Sean): I hear you.

(Christy): Senior, this is (Christy). I think that some of these comments I'm going to ask the staff to be sure kind of make their way back into the endorsement work that we do. And, since I co-chair the readmissions committee it's really helpful for me to hear them. So, if we can just be sure that we coordinate some of these comments back, you know, with the standing committees just so - and the scientific methods panel. I think that would be important.

(Karen Heller): Well, this is - this thing that they do -- this extra risk adjustment -- that's not part of the measure itself. It's how CMS uses the measure to figure out if you're above or below expected.

(Christy): Oh, okay. Thank you for that clarification, Karen. I appreciate that.

(Sean): I hear you. The others I think you're absolutely right, (Christy). Need to go back to your group.

(Christy): And, they do. We look at all of these.

(Sean): Yes, I had a feeling you might.

(Christy): When they come up for maintenance we look at all of them.

(Sean): Other comments? Gaps that are - things that are missing here that you guys want to see in. Okay. If no further comments, we have one more group to discuss which is the HACs. And, turn it back over to staff.

(Melissa): Great, thank you. So, our final program being the Hospital Acquired Condition reduction program. So, it's a pay for reporting and public reporting program. And, the incentive structure is based on the measures in the program. There worse performing 25% hospitals in the program will have their Medicare payments reduced by 1%.

The goals of the program are to encourage hospitals to reduce HACs (unintelligible) and to link Medicare payments to a healthcare quality in an inpatient hospital setting.

Again, the shorter or smaller measure set here. But, the high-priority meaningful measure areas for consideration that CMS identified are making care safer. So, looking for measures such - related to things like adverse drug events, ventilator associated events, additional surgical site infections, risk adjusted outcomes, diagnostic errors, all cause harm or multiple harm, and safety and/or pyrolyzed OB practices and outcomes.

So, for our last program -- (Christy).

(Christy): Yes, thank you all. Thoughts around the HAC program?

(Karen Heller): Okay. So, it's Karen. And, one of the things that I've been concerned about - I've never had an opportunity to do research in this area that maybe my colleague from AAMC can be helpful. But, it seems to me - so, go through the PSI 90. It's a reliability adjustment. Meaning, if your volume is so low that you can't get a good adjustment. A certain portion of the national average is imputed.

And, what that does is because all of those hospitals, you know, bunch up in the middle it makes other hospitals with reliable results all at the bottom. Which might be a reason for teaching in other academic places -- always being subject to the cut. So, it's something that I think we ought to consider is, maybe if the national average is a certain proportion of a hospital score that they be removed from the ranking. Something like that. So, it's just something to discuss at some point.

(Christy): Thank you, Karen. Any other points on this program? Well, okay.

((Crosstalk))

(Melissa): I see that Mary-Ellen has a hand.

Mary-Ellen: Hi, sorry. I just wanted to hop in. Thanks.

(Christy): Sure.

Mary-Ellen: I don't know if it's under this, but I see that adverse drug events are included. And, I think just to slide. I know we have had some concerns in terms of the correlation of kind of hospital harm related to adverse events and opioid prescribing. And, the unintended consequences that could come from having the prescribing in the case of one measure I'm thinking of, you know, Naloxone prescription being the indicator that there's been a harm in terms of folks prescribing when it's actually needed. Or, potentially taking other methods to treat the patient that are more invasive or drastic. So, I just wanted to flag that point in terms of the opioid interaction.

(Christy): Thank you. Okay. Why don't we move on then to the rest of the agenda? Thank you all for getting through the programs.

(Sean): Thank you, guys. Yes.

(Melissa): Thank you so much, everyone. Actually, right now (Christy), I'd like to do public comment just so we stay relatively close to the time. But, I'll circle back to the MAP rural health workgroup update after that.

(Christy): Okay. That sounds good. So, we will open it up for public comment. Are there any comment? Okay. I'm hearing none. I'll turn it back over to staff.

(Melissa): Okay, great. Thank you, everyone. So, we wanted to provide you an update on the MAP rural health workgroups involvement in the pre-rule making and

mock process. So, the MAP rural health workgroup actually has been charged this year with providing input to all the workgroups and committees for (unintelligible). Last year they were only - they only looked at the clinician workgroup. But, this year they are providing insights to all their workgroups.

So, they're charge is to provide the timely input on measurement issues to other workgroups. To provide the rural perspective on the selection of quality measures for received programs under review. And then, to also help address our priority rural health issues, including challenges such as low case volume and updating the rural core measure set.

So, this year the rural health workgroup will review the mocks and provide the feedback to those setting-specific workgroups for this - I won't read all the topics, but for the topics listed on this slide. So, rural health workgroup feedback will be hopefully provided to you in time for the in-person meeting. But, if not it will circle back to you at some point and that'll either be incorporated into the measure discussion guide. And, it'll involve a qualitative summary of the rural health workgroups discussion on the mock and the voting results of their discussion.

In addition, the rural health workgroup will have an in-person liaison at our meeting in December. So, I'll pause there for any questions. Okay. Otherwise, we will move on to next steps. So, for those of you familiar with the MAP process, as you know the (muck) list will be released by December 1. And, following that release of the (muck) list there will be a public commenting period.

The rural health workgroup -- this is new this year -- will be having a series of web meetings to weigh in on what we just discussed. Those dates are November 18, 19, 20, and they're open to members of the public and other

workgroup members if you would like to join in with them. In the first week of December we'll have our in-person meeting. So, the first in-person meeting being the (PACLTC) workgroup on December 3, us on the 4th, and the clinician workgroup on the 5th. The coordinating committee will meet on January 15 to review all the workgroups recommendations and input.

Prior to the coordinating committee meeting, there will also be another public commenting period on our recommendations. So, on this slide are just some resources that we would encourage you to take a look at prior to the web meeting - to the in-person meeting. Of note though, there's that CMS needs and priorities document as well as the MAP member guidebook. I'll pause here for any questions about (unintelligible). Oh, also something of note I wanted to flag for everyone is our travels and meetings team will be reaching out to you about your travel arrangements for the December 4 meeting. We've gotten a few emails about that, so I just wanted to let you know that that communication is coming, and they will be in touch with you. Be on the lookout for communications from meetings@qualityforum.org.

(Karen Heller): You don't happen to know off the top of your head what the recommended hotel is, do you?

(Melissa): So, actually, our meetings team books a block of rooms at a hotel. I don't know which hotel it is this year. But, they will be able to coordinate that with you.

(Karen Heller): Okay. Thank you

(Melissa): So, on this slide is just our contact information. So, feel free if you're having trouble coordinating your travel or can't get in touch with our team. Please, feel free to reach out to us at MAPhospital@qualityforum.org.

Woman: Okay. And then, the last announcement before I pass it to Melissa and their co-chairs to close out the web meeting is just - we are have the dates confirmed and the location confirmed for our annual conference. This year's theme is driving value through the next generation of quality. And, the dates for annual conference are March 23 to the 25. We will be at the Omni Shore room Hotel here in D.C. and it will be our 20th (unintelligible) annual conference. Some of the speakers or some of the sessions that we already got scheduled are listed on this slide. Such as, the process of driving group value and the pharmaceutical landscapes, the RI of 20 years of quality and the road ahead. With that, those are all the information updates we have to give you. I'll turn it over to Melissa to close us out.

(Melissa): Thank you guys. And, thank you everybody. To (Christy). And, it's been great working with you. And, with (Sean), I regret that I'm not going to get to work as closely with you. But, enjoyed having you on the workgroup. I will be following very closely all the MAP activities. That is one of my favorite topics here at NQF. So, I won't be far away. But, if anybody has any questions or needs anything from me I will send an email out with my personal information. You can get ahold of me.

But, I wish you all luck. It's a lot of work. And, you're volunteers but everybody always steps up to the plate. And, my colleagues here (unintelligible) as well. So, thank you all for dedicating you time to this very, very important work. And, to anybody else who's listening on the phone. (Unintelligible) to participate as well. I greatly appreciate it.

(Christy): Well, I want to thank you too (Melissa) for all the assistance you've been to the workgroup. We've really appreciated your support and leadership. And, wish you well.

(Sean): Indeed. Thank you so much for everything.

(Melissa): Thank you.

(Christy): All right. Well, we did it.

Woman: Great work everyone.

Woman: Right on time.

Woman: Great job.

(Christy): Thank you, all.

((Crosstalk))

Woman: …in December.

(Sean): See everybody in December. Yes, thanks again.

Woman: Bye.

(Sean): Bye, all.

Woman: Bye.

END