NATIONAL QUALITY FORUM

Moderator: MAP Hospital Workgroup
November 8, 2017
1:00 p.m. ET

OPERATOR: This is Conference #: 6487638.

Operator: Welcome to the conference. Please note today's call is being recorded. Please standby.

Melissa Mariñelarena: Good morning or afternoon, everyone. Welcome to the Measure Applications Partnership Hospital Web Meeting.

We're going to begin by passing it over to our Chair, Ron Walters, to go ahead and introduce himself and welcome everyone.

Ronald Walters: Fortunately, this is something – hi, everybody. This is something I can do fairly well. My name is Ron Walters. I've been Ron Walters my whole life. I am the co-chair of this workgroup along with Cristie Travis who many of you know, and work with over the years. Cristie couldn't be on the phone today at this particular time, so I will be chairing things in her absence.

We have a copy of the – I'm an Oncologist at MD Anderson. I think most of you are returning and know me from previous meetings. On the slide we have now, the agenda, and rather amazingly enough, we are doing the welcome introductions, review of the meeting objectives first, which is why I'm talking.

Then, we will be going to some opening remarks in Meaningful Measures by Pierre and leading into the staff doing Meaningful Measures and the MAP pre-rulemaking approach. And then, we'll do the reviewing the federal programs followed by the CMS update under measures under consideration,

as you know that we'll accomplish later on, hopefully within the next three weeks before our meeting.

Then, we're going to have an opportunity for public comment and we'll talk about some next steps. So we hope to get through all of that during today. I would like to also acknowledge and you probably already heard from Kate and Melissa. And, Melissa, one of these days, I will get as good than you are at pronouncing your last but I'm not there yet.

Melissa Mariñelarena:OK.

Ronald Walters: I apologize. And (Dessi) is both – well, as you know, we have excellence staff and they do a great job of putting those things together. And we'll serve as valuable resources for you as we go through this. Next slide.

Sorry, I have the …

(Desmirra Quinnonez): OK. Ron, I'll take it over from here. This is (Dessi). And I'll go ahead and take a roll call for those who that are – were on the call. And if you could just say hello or here if you're here and we'll mark you present.

On behalf of the American Association of Kidney Patient, we have Paul Conway. American Hospital Association, Nancy Foster. America's Essential Hospitals, David Engler. Association …

Ronald Walters: Can we call the roll call of people who are here?

(Desmirra Quinnonez): I know ...

Ronald Walters: I'm kind of worried about Paul as I – because it's his first meeting, OK.

(Desmirra Quinnonez): It is true.

Ronald Walters: All right, keep going.

(Desmirra Quinnonez): And I don't see him in the call just yet. I did see Nancy Foster on the call.

Ronald Walters: Nancy?

(Desmirra Quinnonez): Operator, do they have access to announce that they are present or not?

Operator: Yes, their lines are open if they're on the call.

(Desmirra Quinnonez): OK, thank you.

Ronald Walters: All right, keep going then. Thank you.

(Desmirra Quinnonez): Right, you're welcome. Let's see. Do you see Nancy Foster on the call? Association of American Colleges, Janis Orlowski? Baylor Scott & White Health, excuse me, Marisa Valdes? Blue Cross Blue Shield of Massachusetts, Wei Yang? Children's Hospital Association, Andrea Benin? Geisinger Health System, George Godlewski?

Ronald Walters: Now, I'm ...

(Desmirra Quinnonez): What was that, Ron?

Ronald Walters: Well, this is – how often do you get sort of – so most of these people are listed.

(Desmirra Quinnonez): They are. And I see quite a few are actually on the call, but I'm not sure if maybe their phones are on mute.

Ron Walters: Could one of you that we called just send a text through the messaging on the app and just say "Yes, I'm here", Nancy maybe, because I'm beginning to get a little worry about the audio part. Keep going though.

(Desmirra Quinnonez): And I see in the audience questions, it looks (Cathy), our operator, has sent out the new – the log-in number, the dial-in number for their open lines. Maybe we'll give folks a couple of seconds, we'll see they will begin to log-in. I see they're logged into the web portal.

Ronald Walters: Yes.

(Desmirra Quinnonez): So we're hoping.

Ronald Walters: Yes, I see that too, I'm just worried about the audio part.

(Desmirra Quinnonez): Yes.

Ronald Walters: It is rare that we do a roll call and nobody says …

(Desmirra Quinnonez): Right.

Helen Haskell: Can you hear me? I'm on the phone.

(Desmirra Quinnonez): Yes, who are we speaking with?

Helen Haskell: This is Helen Haskell. I was just wondering if any of the audio was working.

Ronald Walters: Good, yes.

(Desmirra Quinnonez): Oh, thank you, Helen. Yes, we appreciate that.

Lindsey Wisham: This is Lindsey Wisham, can you hear me?

(Desmirra Quinnonez): Yes, Lindsey, thank you.

Ronald Walters: Yes, OK.

Lindsey Wisham: OK. And I'm unable to join the web meeting. I am following along with the slides, but I don't know if it's because there was another streaming audio option perhaps.

Melissa Mariñelarena: So, this is Melissa, I just want to remind all of our workgroup members that you have to dial-in as well as the online platform to be able to speak on the webinar.

Ronald Walters: Maybe that …

Melissa Mariñelarena: We saw Nancy is here.

Lindsey Wisham: Yes. In the invitation, there was streaming audio option but I dialed instead. So I'm wondering if other folks may be did the streaming audio.

Ronald Walters: OK. Well, what we know – the three, they're still there, good to hear. OK. Go on, sorry.

(Desmirra Quinnonez): OK. No worries, we'll keep going. On behalf of Kidney Care Partners, Keith Bellovich? Medtronic's Minimally Invasive Therapy Group with (Karen Shahidi)?

Female: Karen is (on a soccer).

(Desmirra Quinnonez): OK.

Female: Her phone is not working yet.

(Desmirra Quinnonez): Got it. We'll keep going through the roll, operator, I don't have access to move the slides. I see Jack Jordan is raising his hand. Hi, Jack.

Ronald Walters: Hi.

(Desmirra Quinnonez): He is waiting to put on the call. Thank you.

Ronald Walters: Thank you.

(Desmirra Quinnonez): OK. I'll just keep going for now. MAP Hospital Workgroup members, we have, on behalf of Mothers Against Medical Error, Helen Haskell? Thanks, Helen. National Association of Psychiatric Health System, there is Frank Ghinassi?

Frank Ghinassi: I'm present. Frank is here.

Ronald Walters: Thank you. We're happy to hear someone.

(Desmirra Quinnonez): Yes, we are. National Rural Health Association, hello, we have Brock Slabach? Nursing Alliance for Quality Care, Ms. Kimberly Glassman?

Kimberly Glassman: I'm here.

(Desmirra Quinnonez): Hello, Kimberly. Pharmacy Quality Alliance, PQA, we have (Anna Duff)?

(Anna Duff): Hi, I'm on the call.

(Desmirra Quinnonez): Hi, (Anna). From Premier, Inc., there's Aisha Pittman?

Aisha Pittman: On the call.

(Desmirra Quinnonez): Project – hello. Project Patient Care, there's Martin Hatlie? Service Employees International Union, there's Sarah Nolan? The Society of Thoracic Surgeons, there's Jeff Jacobs?

Jeff Jacobs: Hi, this is Jeff Jacobs.

(Desmirra Quinnonez): Hi, Jeff. University of Michigan …

Jeff Jacobs: It works.

(Desmirra Quinnonez): … we have Marsha Manning? Yes, we heard you.

Nancy Foster: Hi.

(Desmirra Quinnonez): Can we move forward – hello?

Nancy Foster: Hi, can you hear me?

(Desmirra Quinnonez): Yes.

Nancy Foster: This is Nancy Foster.

Ronald Walters: Yes, I heard Jeff. Thanks.

(Desmirra Quinnonez): Awesome, thanks, Nancy.

Nancy Foster: All right, thanks, bye.

(Desmirra Quinnonez): Please. Our individual subject matter – please, our individual subject experts, we have Gregory Alexander, Elizabeth Evans, Lee Fleisher, Jack Jordan …

Female: Jack is on, I see. He has his hand up.

(Desmirra Quinnonez): Yes, he has his hand up. Hi, Jack. R. Sean Morrison – thank you. With Ann Marie Sullivan, Lindsey ...

Female: He will be here shortly by phone. Thank you.

(Desmirra Quinnonez): OK, thank you. Lindsey Wisham.

Lindsey Wisham: Yes, I'm here.

(Desmirra Quinnonez): Hello. And on the federal government liaisons, we have from AHRQ Pam Owens, we have Dan Pollock from CDC, and Pierre Yong from CMS.

Pierre Yong: Hi, I'm here.

(Desmirra Quinnonez): Oh hi, Pierre.

Ronald Walters: And we do appreciate those of you that have raised your hands, because yes, we can see then who is here. So thank you.

(Desmirra Quinnonez): Well, while we're waiting for the slides to continue loading, I will just go ahead and introduce the project staff team. We have Melissa Mariñelarena, our Senior Director. We have Kate McQueston, our Project Manager, and I'm (Desmirra Quinnonez) and I'm the Project Analyst on this project.

And just for all of you who have questions or need information about the project. You may access by reaching our project e-mail which is maphospital@qualityforum.org.

Ronald Walters: So we were getting concerned, all of the staff, I'm sorry, please.

(Desmirra Quinnonez):We're finished, we're ready. Take it away, Ron.

Ronald Walters: So we were getting, beginning to get concern if I was going to have to do a song and dance for a while, and you don't want that under any circumstance. So I will introduce the objectives, meaning objectives. So I did just like probably a few of you are doing quickly flip over to the PDF version of the slides.

Here we go now. We're back on the webinar, good. Keep on going, on going, keep on going. Here we go.

So the objectives are, again, orientation to the MAP 2017 pre-rulemaking approach, review of the workgroup programs, provide input on the measure gaps. Now, I'm going to make the statement right now and I'll repeat it later on. Historically, we have done that after the review of each program. We're going to purposely have you take some notes and jot down, and provide the input after we've gone through all of the programs. I think it will fall a little more efficiently, and we won't get to bug down in one particular program for a long period of time.

So as we go through this, as you'll slide comes up that say, is there any input or suggestions or gaps just to start writing down and we'll get back to them at the end. And the CMS update as we mentioned earlier, on the MUC List and prior measures under consideration, OK.

And so, now, I think I'll turn it over to Pierre who will give us an update from the CMS perspective. Thank you very much, Pierre.

Pierre Yong: Thank you so much, Ron. It's good to hear you voice and I'm really happy that we are able to kick off the – and the MAP season for this year. So really, want to start by thanking all of you for taking time out of your extremely busy schedules to really devote and advice CMS on, you know, measures that we are considering for potential implementation in quality reporting programs.

We really do value the really insightful and thoughtful input that the MAP provides to us every single year on the MUC List. So thank you for doing that, and thank you to NQF staff well for helping facilitate this.

One of the things that folks may have heard of our administrators Seema Verma last week at the LAN Summit, talked a little bit about sort of the new approach to quality measures that we've launched at CMS, which is what I want to focus, spend my time talking about today. It's called Meaningful Measures.

And if you go to the next slide, next slide please.

We really see it as a way to help us achieve some of the goals that have been set out for us by this administration, including empowering patients and doctors who make decisions about their healthcare, supporting innovative approaches to improving quality accessibility and affordability, ushering safe flexibility and local leadership as well as improving the CMS customer experience.

And if you move to the next slide, thank you.

We really see that framework as being grounded and then helping us achieve a couple of things. So the origins of this framework, we really – in response to a lot of the feedback we've heard in prior, MAP sections but we've also heard in other than you such as the LAN, the Learning and Action Network. We've heard this in the (Iowa) and Vital Signs report.

But really that there is a multitude of measures that we have across all of our CMS programs, and in that multitude, it's really hard sometimes to see and discern what are the most important quality problems we're trying to tackle across the county.

And so, as we start to think about that, one of the things he wanted to respond to and sort of take forward steps and – is really trying to hone in on what are those biggest quality problems that then we can then address using the levers we have at CMS, for example, quality measurement and quality improvement for example.

We really wanted to address high impact measures areas, let's say for our public health, things that we also considered when we are developing its framework. Is that, we really want to keep the patient at the center of it and wanting this to be meaningful to patient. We want to really continue to forward push towards outcome-based measurements where possible.

We also understand it needs to be meaningful to providers in order for them to actually take steps to implement and take forward steps and being successful in quality improvement. We also understand, you know, that there is trade off often with, you know, reporting requirement. And so that increases burden on providers, and takes time away from them from doing the things that they actually went into the field to do which is take care of patients and so that certainly a big consideration for us.

We did want to look for opportunities for improvement, look for measure needs that ultimately lend themselves to population-based payment through alternative payment models. And we also want to consider alignment not just within CMS and across CMS efforts, but really with the – initiative that are happening with other payers as well.

So if you look – go to the next slide.

I mentioned that before – but we did draw on a lot of existing work which we found really stimulating and helpful that are listed at the bottom. Some of the particular thing I didn't mention before which we'll call out is there's been active work with the core. Quality measures collaborative in terms of alignment between public and private sectors payers on quality measures that we also look to.

So, if you can go to the next slide.

The folks that may be familiar with the LAN, Population Health White Paper. This is where that image comes from. They put out this sort of concept which we thought was really captured nicely in this pictogram. You can see at the bottom if you look on the right side what they called little dots or level three

dots. You can think of those as the measures, the individual measures on the MUC List, for example, or the individual measures we have in our program.

But what they thought would be helpful to the field is really moving from that (atomistic) performance measure level really to the big dot level. So if you look at the – on the right side of the slide, level one and level two dot. So really, sort of trying to capture larger sort of set the population oriented sort of measures.

And so what we thought would be a forward step for CMS is moving towards these concepts. We didn't go as far as specifying particular measures but rather we identified meaningful measure areas which identify sort of what we see at an initial set of 18 high priority quality areas.

So if we move to the next slide.

I wanted to spend a little bit of time sort of reviewing what those 18 areas are over the next couple of slides. And so, here you can see – and you keep on going forward. Yes, thank you. One more, thank you.

You can see at the center of this wheel, how it moved. I didn't realize it moved before. I haven't seen them before. You'll see the sort of goals that we – I described before. But really, we identified also in addition to grounding this in those goal really sort of crosscutting issue and principles that we thought really touch on all of our work. I'll read them here but you can see them as spokes of the wheel really eliminating disparities, tracking to measurable outcomes and impact, safe guarding public health, achieving cost saving and improving access for rural communities.

You'll see surrounding that and these sort of spokes of the wheel really do cross cut across all of these areas. These different groupings and different colors of six areas within which you have 18 totals sort of big dot measurement area.

So if you go to the next slide.

The first area is making care safer by reducing harm cause in delivery of care. We have two areas within meaningful measurement areas within this larger sort of grouping. The first is Healthcare-associated Infection and the second is Preventable Healthcare Harm, just as a way to help you sort of conceptualized and understand how we're kind of thing about applying this.

We've start to look at our measure sets across our programs, and seeing what measures we have that really tract to this meaningful measure areas. So in the Healthcare-associated Infection for example, these are not a complete listing. It's an illustrative set but you can see that we have the CLABSI measure for example. And we have in not just one program but multiple programs as a signal that we think this is actually a really important sort of problem, quality problem that we think we need to be tackling at a national level.

Another example is the MRSA bacteremia outcome measurement. Again, you can see listed where this has been used in a couple of our different programs. Again, to again illustrate and provide that sort of stronger unified signal to the community that these are specific target areas that we really want to focus on.

So, if you move to the next slide.

The next larger sort of area is strengthening person and family engagement as a partners in their care. And within this, we have three meaningful measure areas the first is care is personalized and aligned with patient's goal, the second is end of life care according to preferences, the patient preferences and the third is patient experience and functional outcome. So I won't go though on the specific – illustrative example just to save time but happy to answer any questions at the end.

Can you move to the next slide please?

The third area is promotion of effective communication care coordination. The first Meaningful Measure area within this collection is medication measurement. The second is admissions and readmissions to hospital, and the third is seamless transfer of health information.

Can you move to the next slide please?

Next here is promotion of effective prevention and treatment of chronic disease. This has several Meaningful Measures areas not depriving if you think about how broad this sort of general area is. But we included preventive care, management of chronic condition, prevention treatment and management of mental health, prevention and treatment of opioid and substance use disorders and risk adjusted mortality.

Can you move in next slide please?

The next area is working with communities to promote best practices of healthy living. Here there are two areas, equity of care and community engagement. I'll pause for a second on equity of care, we thought and believe that equity of care is a really important sort of area for us to focus on. It's been a big area of discussion and many of the stakeholder, the conversations we had, a conversations with NQF. And we put this here because we felt so strongly about it.

We will say that, you know, while the meaningful measurement area is really may target in this context measures per se, in our conversations. For equity of care, we thought it was really a little bit broader than, you know, measures, you know, it captures other things that we're doing for example for those following the hospital readmissions reduction program.

In the past year, we finalized the policy to do stratification for the scoring. So now we are comparing hospitals with similar proportions of dual eligible and that's the way that we can potentially address equity of care issues within our program. So wanted to expand upon that here because it's a little bit different than some of the other Meaningful Measures areas.

If you move to the next slide, please.

Our final grouping is around making care affordable and here we have appropriate use of healthcare, patient focus episodes of care and risk congested total cost of care, and if you move to the next slide.

We wanted to sort of share this because we thought one, if would be useful for you to understand how we are sort of thinking about quality measures, how to get that. I will say that this framework we believe is really applicable beyond just quality measure per se. We think it applies to seek programs across the CMS including a lot of work, for example, done by our QIN-QIOs on the Quality Improvement side. And in developing this framework, we did extensive – had extensive discussions with partners across CMS. We welcome feedback and questions about this. We've gotten lots the request for more information.

I would say that we are also working on setting up a webinar for this, for the public later this month. So, certainly welcome folks to join this and I apologize to the staffs who've heard me do this a couple of times. And we have two more webinars for the other workgroups so you'll hear this a few more times. But really, I hope this is helpful. I apologize fairly brief but I'm happy to answer any question.

Ronald Walters: And yes, this is Ron. Thank you, Pierre. Any questions do you have directors to Pierre, please feel free to do so now.

(Desmirra Quinnonez):Operator, can you open the lines?

Operator: Yes ma'am. At this time, if you would like to make a comment, please press star then the number one. And again, that is star one to ask a question or make a comment.

And there are no comments at this time.

(Desmirra Quinnonez):Thank you very much. And I just want to remind everyone, you can also put comments or questions in the chat box and we're checking those and we can revisit those.

Ronald Walters: Could I make one more comment please.

(Desmirra Quinnonez):Sure.

Ronald Walters: If I could ask people to lower their hands now so that we can tell when you want to raise your hand later on. Thank you very much. OK.

Female: That's OK.

Ronald Walters: Melissa and Kate.

Kate McQueston: Great, thanks so much. So, as we said before, we're going to try to go through this part of the agenda very quickly to allow as much time for our discussion as possible. And also so that we can ensure that we get to the last item on our agenda related to CMS. The CMS it is update on prior measures under consideration.

So, a brief review of our timeline. We're currently at the very beginning of the arrow in November where we're having our workgroup web meetings and reviewing the current measures in the pressure measure sets. As a reminder, on or before December 1st, we will receive the list of measure under consideration. At this point, we'll notify all workgroup and it will also out for public commenting which will happen following this publication.

In December, we will be having our in-person workgroup meeting. For hospitals is on December 14th. It's a one-day meeting. Following the recommendations by the workgroup, there's another round of public commenting. And then, in January, the MAP coordinating committee is going to meet and finalize the MAP input. And then, following that, there is the release of the final deliverables, important deliverables for the hospital workgroup are their recommendations which will be release on February 1st and our guidance report which will be released on February 15th.

Next slide, please. Thank you.

A brief overview of how our rulemaking approach will work. If you're on the call on Monday, we review the MAP standard decision categories and the MAP preliminary analysis algorithm. Those resources will also be available to you in advance of the in-person meeting. At the in-person meeting, the MAP groups will be using the preliminary analysis to inform their evaluation of the measures under consideration during the December meeting.

And then, in January, the MAP coordinating committee will meet to evaluate the workgroup recommendations and also to examine key crosscutting issues identified by the workgroup.

So our goals for today's meeting when we're discussing each of the workgroups, is to review the program type incentive structure and the goals reach program. We'll also be providing resources identifying the finalized measure of each program.

For each program, we will identify CMS's high priority domains for future measure consideration and we'll review the gaps identified by the hospital workgroup last year. And then, we will have the opportunity at the very end to discuss input on gaps for each of the program.

So this slide serves primarily as a reminder for the nine programs that the MAP hospital workgroup reviews and we'll be traveling in this order as we go through all of the programs.

Next, we'll review the overarching teams that were identified by the workgroup last year. And these were just high levels team that the workgroup discussed across all of the programs. The first was the importance to move to more high value measures within the programs. And when discussing this, the workgroup noted the needs for measures appropriate use and testing, appropriate prescribing practices especially related to pain management and opioid prescription. The workgroup noted a need for measures that assess care transitions and measure coordination between hospitals and other care settings. And finally, a need for measures based on patient reported outcome.

And then, the other area of focus of the workgroup last year also related to reducing measure burden. And the workgroup really noted that there was a balancing effort needed between the effort required for data collection as well as the potential for a measure to improve quality of care and patient outcomes. Great.

So now, we'll begin with our review of the programs. And the first program is the End-Stage Renal Disease Quality Incentive Program. This is a pay for

performance and public reporting programs. Payments can be reduced by up to 2 percent if the dialysis facilities don't meet the required performance scores. And this program has the goal of improving the quality of dialysis care and producing better health outcomes.

This is the current measure set for the ESRD program as of 2021. The program has 16 measures, eight measures in the programs clinical domain, two measures in the safety measure domain and six in the reporting measure domain.

There are two measures that are stern because these measures are new for 2021 and are replacing the previous measures for vascular access that we're in the program previously. So these are new measures standard fistula rate and long term catheter rate. And these two measures were recently endorsed by the National Quality Forum and they're replacing measure number 0257 and 0256. The rest of the components of the program or the measures included in the program are the same as we discussed last year.

There are few high priority domains for the ESRD program. These are care coordination, safety patient and caregiver experience of care and access to transplantation. In addition to this, the workgroup last year discussed several gap areas and this included measures relating to pediatrics, management of comorbid condition such as congestive heart failure, diabetes and hypertension and patient reported outcome.

Yes. And so, we're skipping over the – please, remember to write down your notes of other gaps that you wanted to discuss and we will address those at the end of this item on the agenda.

So, the next program that the hospital workgroup will be reviewing is the PPS-Exempt Cancer Hospital Quality Reporting Program. It's a quality reporting program where data are published on hospital compare and it is specifically for the 11 cancer hospitals that are exempt from IPPS and IQR.

And then here, you should have the slides for your reference attached to the calendar invites, that these are the measures that have remain the same from

the workgroup review from last year. And so we won't go over them in detail but we would ask you to please review them.

In this next slide includes the four new intermediate outcome measures for the program for 2022. And also note that three process measures slated to be removed from the program which are three process measures.

There are several high priority domains noted for cancer hospitals by CMS also. These areas where communication and care coordination making care affordable in person and family engagement.

Last year, when discussing this program, MAP noted the need for measures including PROs that can be used for patient with different types of cancer, and also noted gap areas such as measures address global harm for our patient and inpatient settings. And also, measures that address the understanding of informed consent from the patient perspectives.

(Desmirra Quinnonez): OK. Thanks, Kate. And now I will be going over the Ambulatory Surgical Care Center, Surgical Center Quality Reporting Program.

And this program is a pay-for-reporting and public reporting program. And the incentive structure is that ambulatory surgical centers that do not participate or failed to meet the program requirement received a 2 percent reduction in annual payment update. The program goals include promoting higher quality and more efficient health care for Medicare beneficiaries throughout measurements as well as allowing consumers to find and compare the quality of care given at the (ACS) to inform decision on where to get their or receive their care.

On the next slide, you won't notice very similar to the other programs like Kate presented on. But what I will point out is that, there is one measure does an outcome measure ASC teams, the Outpatient and Ambulatory Surgical Consumer Assessment Measure, and that one is delayed for the calendar year of 2020. There's also one measure ASC 16, the toxic anterior segment syndrome which is proposed for the calendar year of 2021.

There are two measures that you'll notice with the purple star that are proposed for the calendar year of 2022 and three measures that will be removed from the calendar year 2019.

So, on here you'll notice, last year MAP agreed with the priority areas that – or identified by CMS which are before you. And what they did was they stressed the importance for adding measures of surgical quality, surgical quality, including both side infections and complications, and measures in patient and family engagement.

The previous gap areas that were identified, MAP noted that the need – there was a need for measures address in surgical quality regardless of where it is done, include inside infections and complications, and measures of patient and family engagement. MAP did highlight the need for measures of efficiency noting the need for appropriate preoperative testing.

And now, we'll go on to Inpatient Psychiatric Facility Quality Reporting Program. This is a pay-for-reporting program and public reporting program as well, and their incentive structures that inpatient psychiatric facilities that do not submit data on all required measurements receive a 2 percent reduction in their annual payment update.

Their program goals include providing consumers with quality of care information to make more informed decisions about healthcare options, and encouraging hospitals and clinicians to improve the quality of inpatient psychiatric care by ensuring that providers are aware and reporting on best practices.

You all know this. I'll draw your attention to the one measure, the process measure 3205 and that's the medication continuation following inpatient psychiatric discharge and that is an endorsed measure by NQF and it isn't going to be new for 2020.

So, here you'll notice on the slide, the high priority domain for inpatient psychiatric program. And this is – these listed here on the left, you'll see CMS' high priority domains for future measure consideration. And I'll draw your attention to under patient and family engagement, patient experience of

care under effective prevention and treatment as inpatient psychiatric treatment and quality of geriatric patients, and other adult, adolescence and children, as well as quality of prescribing for antipsychotic and antidepressant.

Under best practices of healthy living, the screening and treatment for non-psychiatric home morbid conditions for which patients and mental or substance use disorders are higher risk and access to care.

And I'll just pause for a brief moment to remind those who are on the line to mute their lines if they're not going to be speaking right now. Thank you. And under making care affordable, there is efficiency and value-based purchasing.

So, on the next slide, I'll bring your attention to the performance gap that were identified by MAP last year. And MAP identified area for further development including medical comorbidity, emergency department patients not admitted to the hospital, discharge planning and readmission. Another gap area related to the access to inpatients psychiatric services, especially in the rural areas. MAP also suggested aligning the measures for this program with the measures in IQR program whenever that was possible.

So, at this time, I will turn it over to Melissa to discuss the hospital outpatient quality reporting program.

Melissa Mariñelarena: Thank you, (Dessi). So, a quick overview of the Hospital Outpatient Quality Reporting Program, this is a pay-for-reporting and public reporting program. The incentive structure includes hospitals that do not report on data on required measures will receive a 2 percent reduction in annual payment. And the goals of the program are to provide consumers with quality of care, information to make more informed decisions about healthcare options, and to establish the system for collecting and providing quality data to hospitals that are providing the outpatient services which can include emergency department visits, outpatient surgery and reality services.

The next slide, I'm not going to go through all of these, but here is the current program measure set for outpatients. There haven't been any changes. This

year we included, I think it only change was one measure is no longer NQF endorse. That is 0514. Did have endorsement removed earlier this year. Otherwise all of the measures remain the same. And you have the copy of this. We'll just go on to the next slide.

Here is the list of the high priority domains that were identified by CMS. They include making care safer, the best practices of healthy living, patient and family engagement, and communication and care coordination.

Last year, MAP agreed with the gaps that were identified by CMS, particularly the patient and family engagement, communication and care coordination among provider. MAP also discuss the importance of measures of high volume outpatient services such screening and primary care visits.

And lastly, MAP noted the importance of recognizing patients and family, partners to drive – as partners to drive share decision making and support patient as they navigate multiple providers.

The next slide we're looking at the previous – I'm sorry, the previous gaps that were identified. So, last year if you recall, the group has suggested that the measures set would be improved by adding measures that allow consumers and purchasers to make inform choices when choosing outpatient facilities. So, an example would be does that – could include measures and incentivize facilities of evidence-based practices.

MAP also noted the greater, a need for greater emphasis on communication and care coordination. An example of this would be the importance of appropriate follow-up care for patients discharge from the emergency department following a drug overdose. And finally, the group suggested the addition of measures around falls and accurate diagnosis.

So, the next program and, again, we'll hold the discussion of gap until the end of the presentation then we'll move on to IQR. And the IQR EHR Incentive Program, this is also a pay-for-reporting, pay-for-reporting and public reporting program. Hospitals that do not participate in this program requirement received a quarter reduction of the annual payment update. And

goals of the program include a product for paying payers, providers based on the quality rather than the quantity of care that they give patients. Interoperability between EHR and CMS data collection and to provide consumers information about hospital qualities so they can make informed decisions about their care.

So, this is the largest program for hospitals. And we have a list of this again just want to highlight the few. There's just a couple of changes. And yes, go to the next slide. And there at the very last slide, keep going. There you go.

So the difference is and I think you will get more information about this for the HCAHPS. So a change with HCAHPS, they are replacing the pain management measures that were discussed last year during MAP. So, there's a slight change to that. And then, they have included this measure number 2879 which is NQF endorse, the Hybrid Hospital-Wide Readmission Measure with claims in EHR record data. That will be voluntary beginning calendar year 2018.

So, the high priority domain for this program includes patient and family engagement, best practices of healthy living and making care affordable. Overall MAP previously identifying patient reported outcomes as a gap and measures around dementia was also a gap for this program.

So, the next one is, our Hospital Value-Based Purchasing Program. This is a pay-for-performance program. The incentive structure is include the amount withheld from reimbursement, increases over time. So, beginning at fiscal year 2017, if a (future fiscal) years is at 2 percent. So, we starter at 1.75 percent of fiscal year 2015 and has went up from there.

The hospitals are scored based on their performance on each measure within the program relative to other hospitals as well as on how their performance on each measure has improved over time. The higher of these scores I need to measure is used in determining incentive program.

So, here, there's a couple of slides that includes a measure in the value based purchasing program. Again, HCAHPS, it is impacted. As you all recall, you have to be – measures have to be publically reported through (IV IQR)

program before they can be a value-based purchasing. So, the three pain management measures will be removed from HCAHPS. So, I just wanted to show that there and, again, more of the measure.

Quickly, the high priority domains for this program that CMS identified, was patient and family engagement and making care affordable.

OK. Now, going to turn it back over to Kate, she'll provide the overview of the readmissions program.

Kate McQueston: Thanks, Melissa. So, the Hospital Readmission Introduction Program is a pay-for-performance and public reporting program where the reports are reported annually on hospital compare. The program provides an incentive for hospitals to reduce the number of excess readmission that occur in their settings with a maximum payment reduction of 3 percent.

Overall, the program goes on to reduce readmissions in acute care hospitals that are paid under (IPPS). And the program also focuses on providing consumers with information on top to make decisions about their care.

Currently, there are six measures on the program related to the conditions of AMI, heart failure, pneumonia, COPD, elective, knee and hips replacement and CABG. There as a high priority domain for readmissions around care coordination, specifically measures that address high impact conditions as identified by MedPAC, AHRQ or at health care cost and utilization project. And last year, the committee didn't have anything to add to this domain or gaps to – gap or no gaps were identified.

So, I'll pass it up to (Dessi) for the last program.

(Desmirra Quinnonez): Thanks, Kate. So now, we'll talk about – we'll discuss the Hospital Acquired Condition Reduction Program. And this is a pay-for-reporting and public reporting program. The incentive structure is the 25 percent of the hospital that has a highest rate effect at as determined by the measures in the program. We'll have their Medicare payments reduce by 1 percent.

The program goals includes providing an incentive to reduce the incident effects, to improve both patient outcomes and the cost of care, and to drive import improvement for the care of Medicare beneficiaries. But also privately insured and Medicaid patients through spillover benefits improved care practices within the hospital.

Now, the incentive structure I mentioned to you is 25 percent of the hospital with the highest rate (HACs). And they'll have their payments reduce by 1 percent. But I also want to point out that the measures in the program are classified according to two domains. Domain one, includes the PSI 90 which is a composite of eight administrative claims-based measures. And the domain two includes the infection measures developed by the CDC's National Health Safety Network.

The HACRP program goals include increasing the awareness of (HACs) in order to illuminate the incidents, the reasonable, preventable (HACs).

And I'll move forward to the current measure set. And you notice that this table shows current measures included in the HACRP program. And it's organized according to domain. As I mentioned earlier, domain one includes the PSI 90 and domain two includes the CAUTI, CLABSI and SSI which begin in 2016, MRSA and CDI which will begin the fiscal year of 2017.

On the next slide, you'll see the CMS high priorities for this program which our all topic areas under the NQF priority of making care safer. This includes adverse drug events, then later associated events. Addition surgical site infection location and outcome risk adjusted measures. OK.

And next, we'll go ahead and discuss CMS. We'll turn it over to Reena to discuss CMS' update on prior measures under consideration.

Ronald Walters: I think before that though, we have a discussion about the group site.

(Desmirra Quinnonez): Yes. Thank you, Ron.

Ronald Walters: Yes. Thank you very much, Melissa, Kate and (Dessi) for those slides.

If I could make an editorial comment, I think that was the most efficient and concise presentation that we've had in all of our years of talking about the workgroup preparation. You could see how the slides were formatted very identically and similarly. You could a number of slices across some as far as the current measure set. And not only the current measure but what changes were coming over the next couple of years as far as a new measures or the other direction retired measures.

You could slice in a different way and look at the domains that we're deemed important to each particular reporting program. Or if you wanted to you could look at those domains across different programs and kind of put that together in your heads.

And you could see the previous to identify gaps which I know we spent a lot of time talking about over the years. And that we want to make sure we have those categorized right. So, I really think that that was very well-organized.

And now having done that, we wanted to open it up to any input from the committee members about did the slides capture the current state, did they get you informed adequately about the measure set as was changing over the next couple of years. And most specifically, did you think the domains, we captured the domains right, do you have any refinements to the domains, do you have any other suggestions, and then also the same thing about the gaps.

So, feel free to provide all your comments right now. We can open up the lines. Indicate – Operator, are you there?

Operator: Yes, I'm here. And if you would like to make comment or ask a question, press star one.

Nancy Foster: So, Ron, it's Nancy, can you hear me?

Ronald Walters: We can.

Nancy Foster: I have a question that may not fall directly into the subject matters you suggested, but I'm going to ask and you can rule it out of bounds then.

Ronald Walters: I would never rule you out of bounds.

Nancy Foster: That's OK, everybody else does. So I'm trying to envision the conversation we're going to have. The organization to which you referred of the slides in the presentation today, give me great confidence that NQF staff will continue to have as well-organized.

In the past, however, we have had more than one day of meeting in order to process a lot of measures. And so, my question is do we have any indication yet from Pierre and his colleagues as to how many measures we'll be reviewing. And whether or not the one day will be sufficient?

Ronald Walters: Pierre, you're more than welcome to try to answer that. I can tell you, we ask the same question internally. And I think the only answer we – we did notice and I was going to point out towards the end to remind everybody, yes, we have one day. And that scared me a little bit going through all these things for one day. But you're right it depends on how much work there is to do.

And I will say from my perspective. We're going to be focusing and we've been asked to focus less on gaps which is why we're trying to work it into this presentation. And the domain type of portrayal as well as to review the current measure sets so that we could really focus during the meeting on the measures that were in the measures of consideration. And you're right, if that comes back 30-ish, one day is going to seem very short. If it comes back in the low double digit range then I think I'm not quite as concerned about it.

Pierre, feel free to contradict or enhance anything I said to the extent you can at this time. He ran away.

Reena Duseja: This is Reena from CMS, can you hear me?

Ronald Walters: Yes, Reena, we can hear you. Thank you.

Reena Duseja: OK, yes. So Pierre has to step out for a few minutes but he'll be back shortly.

So good question, Nancy, and unfortunately we are limited at this point to let you know how measures we'll be bringing to the workgroup. But we certainly

look forward to the discussion we have. And we'll let you know. We were confident hopefully we'll have enough time to get the feedback that we want from the workgroup then we can address accordingly as we move forward.

Ronald Walters: That's it. That's the answer I expected. We have talked internally and I will figure it out, Nancy, some way. When we see the list then we'll work on how to accomplish that in the time we have.

Nancy Foster: Ron, if I could just tag on one other comment, maybe two comments. One is that when we see the list, I trust the NQF staff to do this but I thought I heard the comment was we were going to proceed in the order they were just presented to wander through the measures that were under consideration. And maybe when we see the list a different order would be appropriate in order to most affectively match to those critical discussions we have to have. So …

Ronald Walters: All right. I can guarantee you that I will promise to do that.

Nancy Foster: OK. And the second thing I would say is that Pierre spoke eloquently about the recognition of the measurement burden that exists. We've done a recent report that suggest it's about just under $200 per patient or just the data collection and reporting, nothing about the actual improvement of care.

So, you know, when you think about that and the investment patients are making in this enterprise. Making wise choices about the measures is critically important. And for that reason, I would hope that at some point we would have the opportunity to talk about what's currently on the list that ought to be considered for elimination to get to a point where we have better measures.

Ronald Walters: Point taken, got you. We did a lot last year, you're right. And I don't think there was any input. Well, I think somehow were going to have to figure out how – as we're saying, we're all waiting to see it. So I don't know how to tell you right now what that looks like but I think it's an important feedback lead for us to give you, right.

We'll figure out that one too. Is there – Is that it, Nancy?

Nancy Foster: That's it for me.

Ronald Walters: OK. Does anybody else on the call have any suggestions for refinement or additions to the high priority domains or any other comments in general about the presentation about the measure sets, about the gaps, about the domains?

Melissa Mariñelarena: Hearing none. I guess we can …

Ronald Walters: Well …

Melissa Mariñelarena: Yes.

Ronald Walters: I am …

Melissa Mariñelarena: Does anybody – Does anybody has any additional thoughts later, you can always e-mail them to us and we'll share them with everyone. And we'll include them in the material for the (meeting) as well.

Ronald Walters: Now, let's go to Reena then for the update on the measures – prior measures under consideration.

Reena Duseja: Well thank you, Ron. And thank you everyone for the workgroup, you're taking your time today to join us. What we wanted to do today was to build in time during this webinar, to provide updates on the measures under consideration that we received feedback from the workgroup on last year.

And so the purpose of the time we have together is to get feedback to you on the measures that we want to have updates on. And we purposely selected those measures that had a robust discussion within the workgroup last year. Our time is somewhat limited so we did, can't go over all the measure that received to refine and resubmit. But as reference for the work group, we did include on the appendix of the slide deck the list of all of the measures that received, the refine and resubmit.

And so for today, we selected a few measures for discussion. And those will be in the IQR, OQR, ASC and IPS programs. So first we'll talk about one measure within IQR Program. And before I hand the presentation to my colleague (Bill Lerman), I want to frame the discussion a little bit.

So the measures that we selected to discuss and get feedback from the workgroup on, was around the communication about pain and HCAHPS. And not only did we have a quite robust discussion on these questions last year, but in light of the recent recommendations from the Opioid Commission, to remove these questions in our program. We would be really interested in hearing from the workgroup today your thoughts with regard to these questions.

So, (Bill), I'll hand it to you now.

(Bill Lerman): Thank you, Reena. Can you hear me?

Ronald Walters: Yes.

(Bill Lerman): OK, great. OK. As Reena mentioned, we did come to the MAP (Inaudible) last year, about the communication of pain items on HCAHPS Survey. Let's go to the next slide.

Ronald Walters: Yes, slide – advance the slide, please. There we go.

(Bill Lerman): OK. So a couple items of background. We have created a new communication about pain measure. And the questions in the new measure focus on how well the hospital staff communicates with patients about the patient's pain during the hospital stay.

We have added these items to HCAHPS Survey and they will be administered to patients beginning with those patient discharged in January of 2018. The new pain items which I'll deliver remove ambiguity and the wording about the patient – in the wording of the questions or about the intent of the questions. As you may recall that the original pain questions asked about needing medicines for pain. And how well the patients felt, the patient's pain was controlled.

The new items focused more on communication to hospital staff with the patient about the pain. We presented the new communication about pain composite measure to the MAP group last year. And that you should refine

and resubmit recommendations because the testing at that point in time had not yet been completed.

So the next slide, we can see the actual content and response option – response options for the new and items in the survey. I'll note first of all, there are currently three items in the survey. And we are replacing these three items with the three new items in the same order, the same sequence. And in fact, the same position of the survey to make things very simple to replace the current in items.

The first new item asks about – did you have any pain? That's the screener item, the nest ask of whether it's the hospital staff talked with you about how much pain you had, followed by the hospital staff talked with you about how to threat your pain. OK

And next slide. And while we saw this last year but this is a brief update on our empirical testing of new pain composite.

So last year, we hadn't yet finished our testing so we couldn't present to the MAP group. Now we, testing has completed. And the new communication about pain items and this composite measure has strong psychometric properties.

Just a few things to note here. The new items are not subject to sealing our (floor) effects, that is they don't tend to gather at the top or the bottom of response options. The new items have good to excellent hospital level reliability. In fact, as good as, or better than the current pain items, the new pain items are not redundant with current survey items. That is they're not highly correlated with any of the existing items in the survey.

The new items are related in a predictable manner for the standard patient with adjustment characteristics, such as patient's aid to respond et cetera. So we tested all of these aspects of the new pain items in a mode of experiment that we run early last year.

The new pain items are predicted with global hospital rating item. That's the rating zero to 10 that is at the end of the survey. And a lot of hospitals and other people like to focus their attention on that one item. And the new pain items have a predictable relationship with that item. They do not systematically vary by survey mode – mail, telephone et cetera, and as a composite, they had very high internal consistency.

We have a report on HCAHPS online website with much more detail about how we tested the new pain composite and the actual coefficient, et cetera of that testing.

In the IQR rule for 2018, we introduced the new pain items and which will be added HCAHPS Survey in January of next year. One of the things we decided to do was to not report, publicly report hospital results on the new pain composite measures until they have been in – on the survey for over one year. So during the first year of use, hospitals will see their own performance on their own confidential preview report for hospital compare. But we will not publicly report result of the new communication about pain measure until we have two years of data.

And this is the last bullet. We mentioned last year that we removed the old HCAHPS pain management dimension from hospital value-based purchasing beginning with the FY-2018 program. And we did that in the last year's out patient rule. And we have not proposed the new communication of pain item for (VVP). At least not as this point, next slide.

We find our initial proposal, as I mentioned, we refined our initial proposal to delay public reporting as the new communication about pain measure for one year. So it will become – it will be available on hospital compare beginning on October 2020 using calendar year 2019 data. And we anticipate that the first confidential preview report for hospitals will be available to them in the summer of 2019. That's the first time hospital to see their official HCAHPS scores under new communication about pain measure.

And as Reena mentioned, very recently the community probably knows the president's opioid commission recommended to remove pain question from

HCAHPS and in fact all of their CMS surveys. CMS is reviewing that report but we welcome feedback and comments about the appropriateness of pain questions and in particular in the HCAHPS Survey from stakeholders and this committee.

And with that, I'll turn it back to Reena.

Ronald Walters: So this is Ron. I think I specifically heard you ask you would like some feedback on this call? Is that what you said?

Reena Duseja: That's correct, Ron. We'd love to hear from the workgroup with regard to the recommendations as well as what we just presented regarding this.

Ronald Walters: And for this would like it – to deal this issue by issue or in summary after you presented all of them for all of the programs, either way is OK.

Reena Duseja: We can go through all the measures, and then we can leave time at the end. That would be fine.

Ronald Walters: OK. So everybody is warmed up to start jotting down their comments too, first about the refined pain measures OK, communication about pain. All right, thank you.

Reena Duseja: Thank you, OK.

So next, we're going to talk about a measure in the OQR program. In this measure, there is standardized hospital visits within seven days after hospital outpatient surgery. So now I'm going to hand it over to Lori Geary. Lori?

Lori Geary: Thank you. This is Lori at the Yale-New Haven Health Services Corporation, Center for Outcomes Research and Evaluation or CORE. Our team developed this measure for CMS in 2014. This is a measure of unplanned hospital visits following the same day surgery at hospital outpatient departments.

The measure defines same day surgery as those that are low to moderate risk, same day surgery using the version of Medicare list of covered ambulatory surgical center procedures. The procedures are approved are for patients expected to go home the same day.

The measure is designed to assess quality of surgical care at HOPDs using a risk adjusted outcome of post-surgical hospital visits. We define hospital visits as inpatient admission directly after surgery or return visits to the hospital with in seven days after discharge. And this includes hospital admission, E.D. visits, emergency department visits for observation stay.

The measure is intended to inform patient choice and health providers and hospital, an HOPD improve quality of care. Next line. OK.

So, since we have some updates to report form our measure testing on the HOPD surgery measure that was presented to the MAP couple of years ago. Specifically we did some model testing, we look the major adjust for age, sex, comorbidities and surgical procedure or complexity. We tested model performance using various metrics including the common disease statistic. And that the statistic was 0.71, indicating good model discrimination.

Model performance was similar for two validation data sets. And we also did some temporal validation and saw that over time, the models perform similarly.

In terms of the measure score, we did facility level testing that showed considerable variation and unplanned hospital visit rates following outpatient surgery. This is indicative of opportunity for improvement at the facility level. Our reliability testing should moderate score reliability within ICC of 0.5. And we conducted some disparities testing which indicated that adjustment for socioeconomic status or raise has minimal impact on the measure score. Next slide.

The measure was endorsed by the National Quality Forum in January of 2015. The MAP then review the 2015 and 2016 MAP session supported this measure for use in the Hospital Outpatient Quality Reporting Program. And we've – there had been many developments since the MAP's recommendation.

We've made some technical updaters to the measures including adding an exclusion criteria for example to exclude surgery that are build on the same day but on a separate claim as on emergency department visit. Unless the

E.D. visit had a diagnosis indicative of a complication of care, and this is because we can't tell the order of events.

Did the emergency department visit lead to the surgery or did the surgery lead to an emergency department visit?

We also applied many changes to the planned admission algorithm. And we update how the measure handled cases in which patients undergo two or more qualifying procedures within a seven-day period. There were other updates, but those are just a few example.

We also incorporated ICD-10 codes and we conducted a national confidential dry run in September 2017 during which hospital outpatient departments were able to review their measure results prior to public reporting. So, that was a confidential reporting.

And out of that we had some additional updates including facilities that we're doing detailed review of their data identified some procedure as having occurred as outpatient in the HOPD that led to an immediate admission. Those were sometimes being identified as having been inpatient procedures or inpatient only events. So, we are going to be investigating that some more in the coming months. And we will be making that update.

Also, additional updates for flag during the dry run period by facilities. So, we will be updating the planned admission algorithm again. And the measure was finalized in calendar year 2017 rulemaking for 2020 payment determination. And that's our update. Thank you.

Reena Duseja: Thanks, Lori. So, in interesting time, we'll move forward and we'll talk about the two measures and the Ambulatory Surgical Center Quality Reporting Program. And those two measures are the hospital visits after ambulatory surgery center orthopedic procedures and the hospital visits after neurology ambulatory surgery center procedures.

And I'm going to hand it over now to Craig Parzynski. Craig?

Craig Parzynski: Thank you. This is Craig Parzynski at Yale-CORE also. And I'm going to be providing brief updates on the two measures, hospital visits after Ambulatory Surgical Center orthopedic procedures and the hospital visits after urology Ambulatory Surgical Center procedures. And these are two distinct measures that we're updating here.

To go over the background, these measures include in their cohorts Medicare pay-for-service beneficiaries age greater than 65 years. And they are undergoing either orthopedic procedures performed at an ASC or urology procedures performed at an ASC.

And at urology, there's also at the – for both of these procedures we use the ASC approved procedure list for orthopedic procedures and for urology procedures. And for the urology procedures group, we include therapeutic cystoscopy procedures which are minor surgery but haven't part of outcomes.

For both of these outcome measures, that are risk adjusted outcome measures that look for hospital visits within seven days of the procedure. And these include emergency department visits, observation stays, and unplanned hospital admissions.

The last time we were at the MAP was in 2016 and 2017, and we receive a refine and resubmit recommendation for these measures, mainly citing incomplete testing and lack of NQF endorsement. So, basically, we were still in the development process. So, if we move to the next slide, I can update you on our recent testing and finalization of the measure.

So since the MAP's recommendation, we finalized the measures risk adjustment models. And the models now include measures that adjust for age, procedure complexity, and patient comorbidities.

Our model testing showed good model fit, predictability and discrimination with recent few statistics at 0.66 for orthopedic and 0.61 for urology. These measures were further fully tested for facility level results, reliability and validity.

For facility level testing, we saw a significant variation and unplanned hospital visit rates among ASC, even after risk adjusting. For reliability testing, we had fair register reliability for measure for the orthopedic measure, 0.36 in larger volume facilities and moderate reliability for urology measure with an (ICC) of 0.45.

The validity testing result demonstrated measure scores were valid and useful measures of ASC surgical quality for feedback from our technical expert panel and other stake holders.

Moving for the last slide.

Further, these measures were recently finalized in calendar year 2018 rulemaking with payment beginning calendar year 2022. And further we have planned to submit the – CMS has planned to submit this to NQF in the year 2018.

And those are all the updates I have for those two measures.

Reena Duseja: Thank you, Craig. OK. So, the last measure that we want to present to the workgroup is within the Inpatient Psychiatric Facility Quality Reporting Program. And this is the Medication Reconciliation on Admission Measure. I'm going to hand it over to Megan Keenan. Megan?

Megan Keenan: Great. Thank you, Reena. Can everybody hear me?

Ronald Walters: Yes.

Megan Keenan: OK, great. So the Medication Reconciliation on Admission was one measures concerned by the MAP in December 2016, for inclusion in the Inpatient Psychiatric Facility Quality Reporting Program. At that time, the measure was specified as a composite that look at the average completeness of three key components of the medication reconciliation process when a patient is submitted to an inpatient facility.

These three components included comprehensive collection and documentation of prior to admission or PTA medication, complete

information on each PTA medication to inform clinical decision making, and documentation of a reconciliation action to continue, discontinue, or modify each PTA medication.

During the discussion at the MAP meeting, stakeholders expressed concern about the complexity of the measures specification. Ultimately, the MAP recommended that the measure be reassigned or resubmitted when the testing was complete and the measure was endorsed by NQF.

Subsequent to the MAP meeting, the measure was reviewed by the NQF Behavioral Health Standing Committee in the spring of 20107 and we obtained additional feedback for re-specifying the measure. Next slide.

So therefore, we were by as the measure based on the feedback we received from various stakeholders. So first, the measure is no longer scored as a composite of the three components, it is now simple past fill score for each eligible admission in a denominator. We've also modified several data elements to reduce provider burden including the removal of data elements that exhibited high performance and low variation in testing data.

Finally, we increase the timeframe to complete the reconciliation action. The original version of the measure recommended completing a medication reconciliation within 24 hours of admission, but several key stakeholders noted that while it's ideal to complete the reconciliation as close to the admission as possible, there are sometimes are circumstances where that is not possible as been the station population.

We now know allow until the end of Day Two of the hospitalization to complete the reconciliation and count the admission as day zero. The revised version of the measure now assesses the percentage of patients for whom a designated prior to admission medication was generated by referencing one or more external sources of PTA medications and for which all PTA medications have a documented reconciliation action by the end of day two, the hospitalization. Next slide.

So once the specifications were revised and key stakeholders agreed that we address their main concern, we tested the new version of the measure in our

testing data. So as you can see even with the simplified specifications, there are still broad variation in performance across our nine test facilities. And this indicates that there is also room for improvement.

We also found that the measure scores are highly reliable, what we'll see with a hundred records and the sample. And that's important because as they try to protective measures, so that's good for reducing burden.

And finally, the technical expert panel representing patients, clinicians and methodologies unanimously voted an agreement that the measures score had face validity in assessing the quality of care provider at facilities.

The revised measures is out for public comments in September and was just submitted to NQF for endorsement consideration on November 1st, 2017 and we anticipate an endorsement decision by probably middle of 2018.

And that's all I have for that update. So back to you, Reena.

Reena Duseja: Thank you, Megan. So on – we go to the last slide. So this is the appendix I've mentioned at the very beginning. And these are all the measures that we seemed to have refined and resubmit the last workgroup, just wanted to have that as a reference.

Now, we'd like to just basically open it up to the workgroup. We'd love to get your feedback on the measures that we presented, in particular, are also very interested in as we flag at the beginning regarding the Opioid Commission recommendation from removing the – being questioned in the HCAHPS Survey. Ron?

Ronald Walters: Yes. So please indicate your desire to make a comment on this and anything else in this. I also want happened to – this is improvement that refine and resubmit group, kind of – is an easy group to get lost in the shuffle year to year and so on. So I really appreciate this update where you are with once that prompted a lot of discussion and a lot of times spent by the MAP.

Anybody on the phone and I see Nancy, well I turn it back to the operator or, Nancy, are you still on, open line?

Nancy Foster: I am still on, Ron.

Ronald Walters: OK. I thought you would be probably be one of the first ones to comment.

Nancy Foster: Well, do you want me to go ahead?

Ronald Walters: Go ahead.

Nancy Foster: So I appreciate that the update and I'm not quite sure what the process is for the last set of measures, the refine and resubmit measures, is the comment here on this call supposed to substitute for the resubmit part or are we going to see these measures again? Would be my first question.

Reena Duseja: So, Nancy, good question.

So, if you look at the categories that NQF has designated so the refine and resubmit is a definition that, you know, with the MAP workgroup gives us. And then what we do is we want to try with this feedback presentation to give that feedback to the workgroup. But in terms of what you recommended and is your questions does that mean, does that preclude before we actually proposed to the rulemaking? I'm just trying to follow-up with what your, from your question is alluding to.

Nancy Foster: So I guess my understanding from the conversation last year was that refine and resubmit meant that you would do for the work, which you obviously have done on the measures and then they would be resubmitted to the MAP, on the MUC List for further conversation as opposed to refine and resubmit meaning have a conversation on that conference call.

Reena Duseja: Right, right. And that's a great question. And I do remember that having – there have been a lot of discussion with regard to that last year in the workgroup. So, we did have further clarification with NQF and might hand this over back to the NQF colleagues as well.

But our understanding is when the MAP workgroup gives either support, conditional support, or refine and resubmit, those are recommendations by the

MAP Workgroup, in particular with the refine and resubmit for us to take the information and we'll do the further recommendations but we can propose it for rulemaking the following year.

And that we did get further clarification from NQF with regard to that this year as well. I'll hand it over to Kate and Melissa, they might have further information with regard to that category.

Melissa Mariñelarena: Thank you. I was actually going to ask Erin O'Rourke, our colleague who manages the coordinating committee, if you can provide a little more about on that, Erin? And, operator can you make sure that Erin has an open line.

Operator: Yes.

Melissa Mariñelarena: Thank you. I think while we're waiting for Erin …

Ronald Walters: I think it's an interesting question because I'm sitting here – this is Ron, I'm sitting here decide – trying to decide if I know the answer to that even. Although of the four you talked about, some of them are definitely going as you said being submitted to NQF at various times and not all of them have been automatically included into, in the rulemaking yet. So, I think it's a broader question than just these four measures that you talked about.

Nancy Foster: And I'm happy if we take this offline Ron in the interest of time. I just – it was not my understanding of what was meant by refine and resubmit. And so, I'd be curious as to what the answer as to how to arrive to that answer.

Ronald Walters: I think what, Nancy, I think – and (Nancy) will correct me if I'm wrong. I think it was the – I don't know that I necessarily agree with what you said Reena even though I can't point out anything to say this has been formally handled this way in the past. I think the refine and resubmit from the MAP perspective, meant refine and then run it back through the process whether that was the applicable steering committee or whether it was the MAP depending on where it was in the process before that.

Usually, it meant probably going back through to steering committee, if it didn't have that support, if it did have the steering committee support then it

probably might mean through the MAP. But I think that was the intent of what was implied but …

Melissa Mariñelarena: Yes. We've had a lot of conversations with NQF with regard to this year.

Ronald Walters: Yes.

Melissa Mariñelarena: And I really can appreciate the complexity of this and it really depends on, you know, by measure by measure in terms of what feedback we got from the MAP. But, yes, I mean, I welcome – we can take this conversation offline. I'm happy to provide more details with regard to that discussion as well.

Nancy Foster: That might be wide. And, Ron, while I have the floor because I thought that was going to be easy question.

I do have a comment on the pain measures which is – and, (Bill), really appreciate the fact that CMS took this offline or at least out of the paper reporting, a paper performance measurement and really brief thought to this question, very appreciative of that.

I think the – my comment is that when you, I understand that the first question of the three that did you have pain during your hospitalization is in your mind, and in the minds of the survey developers a screening question. But then – and then the other two follow about pain management, if you do have pain.

However, I think in part, if not in whole, that first question is what a number of clinician than others reacted to where they want to drive the answer to no. And that was what folks talked about as being the impetus for aggressive pain management which could mean a prescription of opioid.

In today's environment, I think in recognizing this enormous problem we have right now, I am leery of having that screener question in this HCAHPS Survey ever. And I don't know how to work around that. I am not a survey developer in that regard but that's my angst.

Melissa Mariñelarena: Well, that's really helpful, Nancy. Thank you.

Nancy Foster: Sure.

Ronald Walters: OK. So is there anybody else on the phone with questions or comments?

Operator: And once again to ask a question or raise comment, you can press star then the number one.

Frank Ghinassi: Oh, hi, Frank Ghinassi here. Are you able to hear me?

Ronald Walters: Yes.

Frank Ghinassi: You see, this one is in reference to the medication reconciliation at admission, the revised measure description, is this the time to ask question about that?

Ronald Walters: Sure.

Frank Ghinassi: OK. So, two things, first of all, just the – I'm looking at slide, I think it's 103 where it says, percentage of patients room with designated prior to admission list was generated by referencing one or more external sources of PTA medications and for which all PTA meds have a documented reconciliation action by the end of day two.

So, and I'm just thinking about, you know, the many institutions across the land that are safety net institutions and (work off) with individuals who, although attach to treatment in taking medications are often very sporadic in their attachment in sort of moving, not only of eligibility for service, but also in and out of continuous or consistent contact with care and that's not a rare pattern with certain SMI population, it's part of the picture.

And so, I guess from my understanding is since it's now past (fail), is a past that two attempts were made to glean the information, which is within the control of the institution. And that those were valid attempts were made to reach them within 48 hours, which is what the day two means or is a past that attempts were made and data was received from one or more external sources. I can't discern that in looking at this.

Melissa Mariñelarena:Megan, you take that question?

Megan Keenan: Sure. Thank you, Frank, for that question.

So a couple of things, so when we say external source what we're meaning to say there is that an external to the facilities on record respond. So, an external source could even just be the patient reporting their own medications or a family member bringing in on prescription bottles, that sort of things. So it could be there are patients source or an external, you know, health system source. So that might mitigate some of the issues or challenges …

Frank Ghinassi: Well the concern …

Megan Keenan: … you know, contacting.

Frank Ghinassi: The concerns that come up with this – I really appreciate that. The concerns that come up with this is that many of the people who presented psychiatric admission especially those who are coming through ERs are obviously, are many of them are in full blown symptom made, it may include psychosis, it may include sever cognitive impairment, it may include intoxication, you know, concomitant with maybe a manic episode or – and often includes suicidality.

And there were many people who don't clear within the first 24 hours or 40 – even 48 hours of the stay. So while we can ask that question of the patient the completeness of the data, especially around, you know, the full doses the exact types of medication. You know, it is a one cannot relay on the accuracy of that, especially before that individual symptoms are maintained.

And then, the second piece of it is we can call and often do, you know, within hours of somebody arriving. But if you've worked with other institution, especially ones that aren't your own, the likelihood of them giving you that data in let's say 46 hours, especially if the person arrives at 11:00 at night, is not typically something that's directly within the span of control of the asker.

And so I guess that's why I'm asking more specifically, if you ask the patient and they give you a list and you use that whether or not it's accurate. And if you make a good faith effort within the first couple of hours to reach out to other institutions to have – may have further data and they do not comply

either at all which I've seen a lot or within, you know, what would need to be like 44 hours. Is that held as a fail on the institution to have made those good faith efforts?

Megan Keenan: Just one thing I wanted to clarify. So, I think a lot of those concerns are widely expended the timeframe. So now, it does go beyond 48 hours because the admission date count as day zero. So we allow up to two days after the admission day. Now, which could give up to 72 hours to complete that? But, you know, to your point I do understand that sometimes that's not always feasible.

And I think we have some guidance in our abstraction instructions for facilities around kind of how to deal with those situations.

Frank Ghinassi: You mean how to get an institution who's not responding to you to respond.

Megan Keenan: No. Just how to count that towards whether or not you were able to get a hold of the source. And (Kyle) – I don't know if we have (Kyle) or (Marie) on the line, but I think that we did clarify something in the source, but I don't have it off the top of my head.

Ronald Walters: So this is Ron. I have a question because when you say this went through that. And again, that's why these are all in different – there are four measures but they're all kind of different flavors. This is – The top was 19-19 after you made these changes in terms of face validity 19 for 19.

Megan Keenan: Correct. Yes.

Ronald Walters: And when you say submitted to the NQF November 4th, you mean back to MAP or back – well, that's not the fair yet. Submitted back to the TEP or submitted to who?

Megan Keenan: So the (member) was submitted to the NQF's Behavioral Health Standing Committee Offices.

Ronald Walters: Yes. OK, the standing committee, all right. Good.

So all of these things, all of Frank's concerns, there is still a process yet with the standing committee that will possibly ask the same questions are possibly resolve some of them. So that will occur there.

Melissa Mariñelarena: And this is Melissa. We can send you a link to the current project that the measure has been submitted to.

Ronald Walters: Yes.

Melissa Mariñelarena: Because that'll be …

Ronald Walters: Yes.

Melissa Mariñelarena: … happening concurrently. But you can follow along with the meetings and the standing committee's discussion and also submit questions if, you know, when we do our public commenting. But we can follow up with the timeline for that project that you can follow that.

Ronald Walters: Yes. So all of the questions you ask are totally valid questions and they're going to come through the process again, I'm sure. And you will have ample opportunity to ask those questions.

Frank Ghinassi: So now, and I appreciate then. Thank you for that response. So does that mean then that this will not go into effect until NQF endorses this measure with all of that further discussion? Is that what I'm hearing?

Ronald Walters: So that's – if I – Reena, correct me if I'm wrong again because we've talked about that since day one also. The law does give the secretary the authority to put measures in effect that have not been through the endorsement process. But certainly, under the way things have operated, the preferred methodology is to have them undergo the peer review and the endorsement process and to get the support of, in this case, both the standing committee and the MAP. So …

Reena Duseja: Ron, that's correct.

Ronald Walters: That looks like it's on that path. This was really …

Reena Duseja: Yes. This is …

Ronald Walters: … intended to be feedback on previous refine and resubmit. And this happens to be one where they did refine it and they are resubmitting it.

(Inaudible)

Ronald Walters: Reena, correct me if I'm saying anything wrong.

Reena Duseja: Ron, you said everything correct. Thank you.

Ronald Walters: So you'll have ample opportunity to give all that feedback to the standing committee.

Frank Ghinassi: Thank you very much for that, no problem.

Ronald Walters: Is there anybody else on the line that would like to give some feedback to – Reena?

Reena Duseja: And our team here.

Ronald Walters: OK. Well, thank you very much. And like I said, I believe that's the first time in my memory anyway that we've caught up with some of the refine and resubmit measures. And we're – I really appreciate it because those can easily get lost in the shuffle.

Reena Duseja: Yes. I will just end – Hello, this is Reena again here. Thank you so much. I think we found it immensely helpful also to be able to do this and get the feedback from the workgroup. Then, we do welcome comments afterwards as well if the workgroup has further feedback for us with regard to these measures.

Ronald Walters: Thank you very much. We're going to turn this now this – over to the opportunity for public comments. Operator, do we have anybody from the public online?

Operator: Yes, sir. At this time, if you would like to make a public comment please press star then the number 1.

Ronald Walters: And the public may make comments on any part of the presentation.

Operator: OK. At this, there are no comments.

Ronald Walters: OK. Well, I'll turn it back over to (Dessi) for next steps.

(Desmirra Quinnonez): Thanks, Ron. So I will go through just an overview what you'll see on this, of some of our immediate next steps. We are anticipating the release of the MUC List from CMS prior to December the 1st.

And as you're aware, we'll be actually posting that list and make you aware when that's available. After which we'll have our initial public commenting period, which will lead us right up to our in-person meeting, which will be on December the 14th. And just as a reminder this will be a one day in-person meeting.

And so what I would do is also let you know, if you have any questions regarding gaps or any ideas on gap that you'd like to share with the MAP hospital workgroup. Please, you can contact us or to our e-mail at maphospital@qualityform.org. And you can also follow along in our MAP Hospital page on NQF's website and you can go to the MAP Hospital Workgroup page.

And just as a reminder for those of you who may not have arrange your travel as of yet. Now is the time to do that. And if you have any questions with that, you can contact our meetings department and they will assist you with that. And if you're unable to reach anyone or need a little more, of course, you can contact us at MAP Hospital Workgroup, maphospital@qualityforum.org for that as well.

And so if there is no other comments. Ron, do you have any other closing remarks you would like to make for this one?

Ronald Walters: Yes. I'd like to thank everyone for taking time out of their busy day to take part in this phone and WebEx. I especially want to thank Pierre and Reena for

coming over and making presentations from the CMS perspective, and most of all to staff for organizing this.

I'll say again because it's come up a couple times now. I realize right away the implications when we found out as a one day meeting, try not to let that ruin the rest of your November. We'll figure out how to do it efficiently and solicit ideas how the better the process when we see the MUC List. So we'll get there.

Melissa Mariñelarena: Thank you, Ron. And for those of you who weren't able to make the All MAP web meeting on Monday, I think that we said that we would be able to send you all of the materials as soon as the preliminary analyses are complete.

Usually, I think we wait until you get the public comment, once that closes and we send it all together. But in the interest of time and to give the workgroup as much time as possible to be able to review the materials. We'll go ahead and send those materials out and they will update and with the public commenting – with public comments once that period closes.

Ronald Walters: Thank you.

Melissa Mariñelarena: So there are no – thank you, Ron. If there's no other questions or comments, we will adjourn and give you a whole 13 minutes back of your time. And just a reminder that if there is, again, send us any questions, comments on gap anything that was presented today. And, Nancy, we will follow-up and get more clarification around the decision that was made for refine and resubmit. OK.

Ronald Walters: Thanks.

Melissa Mariñelarena: Thank you, everyone. We'll see you December 14th.

Ronald Walters: Thank you.

Male: Thank you.

Female: Thank you.

Male: Take care, guys.

Female: Thank you.

Female: Bye.

END