NATIONAL QUALITY FORUM

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MAP HOSPITAL WORKGROUP

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WEDNESDAY
DECEMBER 4, 2019

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The Workgroup met at the National Quality Forum, 5th Floor Conference Room, 1099 14th Street, N.W., Washington, D.C., at 9:00 a.m., R. Sean Morrison and Cristie Upshaw Travis, Co-Chairs, presiding.

PRESENT:

R. SEAN MORRISON, National Coalition for Hospice and Palliative Care, Co-Chair
CRISTIE UPSHAW TRAVIS, Memphis Business Group on Health, Co-Chair
ANDREEA BALAN-COHEN, IMPAQ Health, Subject Matter Expert
AMY CHIN, Greater New York Hospital*
PAUL CONWAY, American Association of Kidney Patients
AKIN DEMEHIN, American Hospital Association
ANNA LEGREID DOPP, Pharmacy Quality Alliance
FRANK GHINASSI, National Association for Behavioral Healthcare
KELLY GIBSON, Society for Maternal-Fetal Medicine*
MARYELLEN GUINAN, America's Essential Hospitals
MARTIN HATLIE, Project Patient Care
AMY HELWIG, UPMC Health Plan
JACK JORDAN, Henry Ford Health Systems
NIKOLAS MATTHES, Press Ganey
LISA McGIFFERT, Mothers Against Medical Error
DENISE MORSE, City of Hope

SARAH NOLAN, Service Employees International Union
AISHA PITTMAN, Premier Healthcare Alliance
PHOEBE RAMSEY, Association of American Medical Colleges
KAREN SHEHADE, Medtronic-Minimally Invasive Therapies Group
STANLEY STEAD, American Society of Anesthesiologists*
LINDA VAN ALLEN, American Case Management Association
DEBORAH WHEELER, Molina Healthcare*
JACKSON WILLIAMS, Dialysis Patient Citizens
LINDSEY WISHAM, Telligen, Subject Matter Expert
MICHAEL WOODRUFF, Intermountain Healthcare

FEDERAL LIAISONS:
MIA DeSOTO, AHRQ
REENA DUSEJA, CMS
RONIQUE EVANS, CMS
DAN POLLOCK, CDC
MICHELLE SCHREIBER, CMS

NQF STAFF:
SHANTANU AGRAWAL, MD, MPhil, President and CEO
TAROON AMIN, Consultant
JORDAN HIRSCH, Project Analyst
MADISON JUNG, Project Manager*
ELISA MUNTHALI, Senior Vice President, Quality Measurement
JANAKI PANCHAL, Project Manager
SAM STOLPE, Senior Director

ALSO PRESENT:
ANNESE ABDULLAH-McLAUGHLIN, CMS
BO FENG, IMPAQ International
JOEL MESSINA, KECC*
VINITHA MEYYUR, CMS
JESSE ROACH, CMS
DEBORAH ROSENSTEIN, Mathematica*
BROCK SLABACH, National Rural Health Association

*** present via. teleconference**

C-O-N-T-E-N-T-S

P-R-O-C-E-E-D-I-N-G-S

9:02 a.m.

MR. STOLPE: All right, everyone. Let's go ahead and get started.

Hello and welcome on behalf of the NQF leadership and staff. We're delighted to be hosting you here at our new headquarters for this, the 2019-2020 MAP Hospital Workgroup in-person meeting.

I'm Sam Stolpe. I'll be conducting on behalf of the NQF staff for the duration of the day. And we are joined by our two fantastic co-chairs, Sean Morrison and Cristie Upshaw Travis, whom I'll hand over to opening remarks in just one moment after I get through just a couple of housekeeping items.

So first as I mentioned, Poll Everywhere is going to be the platform that we'll be using for voting today. If at any point you have any trouble with it, simply raise your tent card, or if you're on the web platform raise your hand and a staff member will assist you.

We have meeting materials for this meeting available online. Simply go to public.qualityforum.org and search for "hospital" and it will pull up our workgroup materials if you do not have them already. They're also attached to the calendar invite that you had for this meeting.

Related to the tent cards, we're all very familiar at this point I think with our traditional approach to drawing attention to ourselves when we wanted to make a comment. It's just simply to tip your tent card up like so, and the co-chairs will acknowledge you once we get the cue from whoever is in front of you. Those on the web platform, you can simply raise your hand and we'll be able to identify you that way.

A couple of last items. We do have restrooms here. They're just inside the foyer near the elevator, so if you walk past the reception desk and through the glass doors, you'll see them on the left. And lastly, just a note to please mute your cell phones while you're

here at the meeting. If you need to step out to take a call, we understand. And for our audience members, we do have microphones throughout the room, so if you -- that will actually pick you up. So if you're going to have a conversation, please step out and conduct that in the hall.

So with that, I'll hand it over to our co-chairs to offer some welcoming remarks.

MS. JUNG: So we're going to do a few muting of the beeping in and out real quick, so if you don't mind just pausing for a second so we don't hear -- and interrupting your opening remarks.

MR. STOLPE: Very good. Thank you. And while we're waiting --

(Telephonic interference.)

MR. STOLPE: While we're waiting, would folks please just rotate their tent cards so the Chairs can see them? With some of the glare, it's a little challenging to see names. Thank you very much.

CO-CHAIR UPSHAW TRAVIS: Thank you for

that.

MR. STOLPE: Thank you.

CO-CHAIR UPSHAW TRAVIS: That is so much easier. So thank you all. Well I'm Cristie Upshaw Travis, and I'm the CEO of the Memphis Business Group on Health. And I serve on the NQF Board of Directors as well, and I've been co-chair of this Committee for a while. But I want to welcome everybody. I want to thank those who are returning. It's always good to see old faces --- not old-old, but --

(Laughter.)

CO-CHAIR UPSHAW TRAVIS: -- faces that have been on the Committee for some time, and I also want to welcome those who are joining us for the first time. This is a wonderful opportunity for us to actually as a group think about the measures that are going into the CMS programs and to make our recommendations.

So thank you all, especially the lead discussants for the additional work that you did in order to prepare for today, and I look forward

to working with you all today. And I'll turn it over to our new co-chair, Sean.

CO-CHAIR MORRISON: Hi, Sean Morrison. I am the chair of Geriatrics and Palliative Medicine for the Mt. Sinai Health System in New York and I have been chair now for I think about five minutes.

(Laughter.)

CO-CHAIR MORRISON: I just wanted to echo everything that Cristie said and to welcome all of you. This is a very important meeting. The advice that you give CMS is critical in terms of improving quality for our patients and our families.

I wanted to actually make one further comment and note, which is because some people leave early, and particularly some in the back may leave, this is Cristie's last meeting as co-chair, and I just -- I will -- we will say more formal thank yous towards the end, but I did want to publicly thank Cristie for all of her incredible work. I'm actually terrified because

if they keep me, I will be the first person in how many years who doesn't have her sort of guiding the meeting through.

But I really wanted to thank Cristie for the incredible work that she has done. For those of you who have been on this committee know just words are not enough to describe leadership and what she has done for this group. So I wanted to thank her before we started.

(Applause.)

CO-CHAIR UPSHAW TRAVIS: Well, thank you. And I'll tell you, Sean, just remember, there is hope that you get to retire as co-chair.

(Laughter.)

CO-CHAIR UPSHAW TRAVIS: Thank you, Sean.

MR. STOLPE: Well thanks very much to the both of you. At this point we'll move to our disclosure of interest portion of the agenda, and I'll hand it over to our Senior Vice President of Quality Measurement, Elisa Munthali.

MS. MUNTHALI: So, thank you,

everyone. Thank you, Cristie. Thank you, Sean. And thank you all for being here and serving on this workgroup. My name is Elisa Munthali. I'm the Senior Vice President of Quality Measurement at the National Quality Forum.

And today what we're going to do is combine our introductions with disclosures. We're going to do it in two parts because there are two types of workgroup members that serve on the workgroup. There are organizational representatives and there are subject matter experts.

The majority of you -- which is good, it will be less complicated -- are organizational representatives, and we'll start with you, first with the org reps in the room and then remote. We asked you a few questions as organizational representatives -- not as many as we did for subject matter experts. We expect you to come to the table and bring your stakeholder perspectives to the discussion today.

So what we're going to do is start to

my left, and I think we'll start with Frank. And Frank, if you could tell us your name, who you're with and if you have any conflicts. And then we'll go to the phone; just go around the room.

MEMBER GHINASSI: Sure. Frank Ghinassi, President and CEO of Rutgers University Behavioral Health. I'm representing the National Association for Behavioral Health, and I have no conflicts.

MS. MUNTHALI: Okay. Thank you.

MEMBER JORDAN: I'm Jack Jordan. I have no conflicts. I represent Henry Ford Health Systems.

MEMBER WILLIAMS: Jackson Williams, Dialysis Patient Citizens. I have no conflicts to disclose.

MEMBER WOODRUFF: Mike Woodruff with Intermountain Healthcare, and I have no conflicts.

MR. SLABACH: I'm Brock Slabach with the National Rural Health Association in the role of liaison to this coordinating committee, to

this workgroup, and I'm non-voting and I have nothing to disclose.

MEMBER HELWIG: Amy Helwig with the UPMC Health Plan, and I have nothing to disclose.

MEMBER MORSE: Denise Morse with City of Hope Cancer Center. I have nothing to disclose.

MEMBER VAN ALLEN: Linda Van Allen representing the American Case Management Association and I work for Tenet Healthcare, which is a company that owns several hospitals across the country, which is my disclosure.

MEMBER SHEHADE: And I'm Karen Shehade and I work with Medtronic-Minimally Invasive Therapies Group, and I hold stock in the company, so disclosed.

MEMBER GUINAN: Good morning. Maryellen Guinan representing America's Essential Hospitals. No disclosure.

MR. POLLOCK: Dan Pollock, federal liaison representative from the Centers for Disease Control and Prevention. Not voting. No

conflicts.

MEMBER NOLAN: Sarah Nolan, Service Employees International Union. No conflicts.

MEMBER HATLIE: Marty Hatlie, Project Patient Care. We're an improvement coalition in Chicago. I have no conflicts.

MEMBER RAMSEY: Phoebe Ramsey, Association of American Medical Colleges. No conflict.

MEMBER DEMEHIN: Good morning. Akin Demehin with the American Hospital Association. No conflicts.

MEMBER DOPP: Good morning. Anna Legreid Dopp. I'm representing the Pharmacy Quality Alliance today, and I work for the American Society of Health System Pharmacists. I have nothing to disclose.

MEMBER McGIFFERT: Lisa McGiffert. I'm representing Mothers Against Medical Errors, and they are a member of a relatively new coalition, Patient Safety Action Network, and I have nothing to disclose.

MEMBER MATTHES: Nikolas Matthes with Press Ganey Associates. Patient experience, clinical quality, engagement safety. I hold stock in the company.

MS. MUNTHALI: Thank you. So on the phone do we have Stanley?

MEMBER STEAD: Hello.

MS. MUNTHALI: Hi, Stanley. We can hear you.

MEMBER STEAD: Great. I'm Stan Stead. I am representing the American Society of Anesthesiologists, and I have no conflicts to disclose.

MS. MUNTHALI: Thanks, Stan. Amy Chin?

MEMBER CHIN: Hi. Can you hear me?

MS. MUNTHALI: We can.

MEMBER CHIN: Okay. Amy Chin with the Greater New York Hospital Association, and I have no conflicts to disclose.

MS. MUNTHALI: Thank you. Deborah Wheeler?

MEMBER WHEELER: Yes, it's Debbie Wheeler. I'm representing Molina Healthcare, and I no conflicts.

MS. MUNTHALI: Thanks, Debbie. And Kelly Gibson?

MEMBER GIBSON: Yes, Kelly Gibson. I'm representing the Society for Maternal-Fetal Medicine. I have no conflicts.

MS. MUNTHALI: Great. Thank you very much.

So we have four subject matter experts, that includes your co-chairs as well, and they received a conflict of interest form that was a lot lengthier. We asked them about a number of activities as they're related to the hospital workgroup.

And we had a couple of reminders for you because you did disclose quite a bit of information. You do not represent anyone who may have nominated you on the committee or your employer. We are interested in activities that are both paid and unpaid. And perhaps the most

important reminder is: just because you disclose does not mean you have a conflict of interest. We go through this process in the interest of openness and transparency. And so we'll start with Sean.

CO-CHAIR MORRISON: Nothing to disclose.

MS. MUNTHALI: Okay. Cristie?

CO-CHAIR UPSHAW TRAVIS: I will just disclose that I am on the board of directors of The Leapfrog Group, and that's all I have to disclose.

MS. MUNTHALI: Thank you very much. Lindsey?

MEMBER WISHAM: Yes. Good morning. Lindsey Wisham. I am a subject matter expert for health informatics, and I would like to disclose that my employer, Telligen, does have CMS contracts.

MS. MUNTHALI: Thank you. And Andreea?

MEMBER BALAN-COHEN: Andreea Balan-

Cohen. Good morning. I would like to disclose that I work for IMPAQ International. My employer also has CMS contracts, and I will recuse myself from the discussion on the various related measures.

MS. MUNTHALI: Thank you.

And before I turn the meeting over to my colleagues, we did want to let you know we have federal liaisons on the workgroup, and they're not voting members. We also have CMS representatives here. And so we're going to ask our federal partners to introduce themselves, and we'll start with Ronique.

MS. EVANS: Good morning, everyone. My name is Ronique Evans, and I work at CMS on the PCHQR Cancer Hospital Program, and I also assist with various other programs such as the Home Health Program under Post-Acute Care.

MEMBER DUSEJA: Good morning. My name is Reena Duseja. I'm the Chief Medical Officer of the Quality Measurement and Value-Based Incentives Group.

MEMBER SCHREIBER: Thank you and good morning. I'm Michelle Schreiber. I'm the Director of the Quality Measurement and Value-Based Incentives Group at CMS, and I have nothing to disclose.

MS. MUNTHALI: Dan?

PARTICIPANT: I think he went already.

(Simultaneous speaking.)

(Laughter.)

MS. MUNTHALI: Dan's representing the CDC. And then we have Mia, I'm not sure, from AHRQ.

MEMBER DeSOTO: Hi. Yes, hi.

MS. MUNTHALI: Oh. Oh.

MEMBER DeSOTO: Hi. I'm Mia DeSoto. I am from the Agency for Healthcare Research and Quality. I am lead of the Quality in Behaviors Program at the Agency, and I have nothing to disclose.

MS. MUNTHALI: Thank you very much. So if at any time you remember that you have a conflict, we want you to speak up. You can do so

in real time or you can approach any one of us here in the front, your co-chairs or anyone on the NQF staff. And likewise, if you believe that one of your colleagues is acting in a biased manner, we want you to speak up. So thank you very much.

CO-CHAIR MORRISON: Very good. Thank you, Elisa. At this point we'll also introduce the NQF staff. I've already introduced myself, but let's go ahead and start with Taroon and introduce the rest of the staff.

MR. AMIN: Good morning, everyone. Taroon Amin. I'm a consultant with NQF. It's good to see everyone again, and I'm helping to support the MAP Coordinating Committee.

MR. AGRAWAL: Shantanu Agrawal, CEO.

MS. JUNG: Hi, I'm Madison Jung, Project Manager. I've been with the MAP Hospital Workgroup these past few years, so glad to see the familiar faces around the table.

MR. HIRSCH: Hi, everyone. My name is Jordan Hirsch. I got to meet many of you

bringing you upstairs today --

(Laughter.)

MR. HIRSCH: -- and I am the Project analyst. This is my first season on MAP. I worked on PAC LTC, Hospital and Clinician. It's wonderful to meet you all.

MR. STOLPE: All right. Thank you. Well with that we can move forward into our agenda in earnest, so I'll hand it over to our co-chairs to walk us through the agenda, our objectives, and take us through the rest of the meeting. Cristie and Sean?

CO-CHAIR UPSHAW TRAVIS: Sure. So you all see the meeting objectives that we have for today. Obviously our major objective is to review and provide the input on the measures under consideration that we lovingly call MUC that are applicable to the hospital quality programs.

In addition one of our objectives has already been addressed in detail, but if there are gaps, we do need to think about where some of

those gaps may be in these programs in order to give that type of input to CMS. We had a call about that earlier in the fall, as you all will recall, but if you think of anything else today, please feel free to identify the gaps as well. And I feel like I'm reading off of a teleprompter.

(Laughter.)

CO-CHAIR UPSHAW TRAVIS: So if somebody will change the slide, that would be helpful to me.

(Laughter.)

CO-CHAIR UPSHAW TRAVIS: Okay. Those are our meeting objectives. Before I turn it over to CMS for their opening remarks, you'll see that our agenda is quite full today. We have measures that we're going to be reviewing -- and thank you all for doing your preparation for that -- but we also are going to hear from CMS this morning about the Meaningful Measures Program Initiative and Updates. And the way that we would like to do that is to make this highly

interactive.

Dr. Schreiber has said that what she's very much interested in learning is what our input is --- our reaction, but also our input. So this is important because it does help drive kind of the role that we play here at the Hospital MAP Workgroup. So we will just move straight on to that right now. Michelle, if you'd like to give us your update?

MS. SCHREIBER: Thank you very much. And first of all, Cristie, I don't know what these meetings are going to be like without you. Thank you for --

(Laughter.)

CO-CHAIR UPSHAW TRAVIS: Well thank you.

MS. SCHREIBER: And thank you to NQF. Welcome to your new space. It's really very nice. And in particular thank you to everybody here for your participation. We very much appreciate the input. I am now one year and a couple of weeks into this job. Last year when

you met me I was a couple of weeks into the job.

(Laughter.)

MS. SCHREIBER: And so it's been a pleasure to work with some of you actually in this past year.

I want to assure you that really your input into these meetings does make a difference. Some people say we come to these, we give input. Whatever happens? And I will say that we took off some measures last year that we had thought we would put into programs based on feedback from these committees. We have changed some of the measures based on feedback from these committees. And so it really does make a tremendous impact, and we look forward to hearing about it.

That being said, I just want to make sure that we all recall that although we truly take your advice seriously, decisions here aren't binding to CMS, and CMS does make the final determinations on these programs and what goes into them.

But our collaboration and our

partnership is really more important than ever. It is part of our business strategy, even it is written into CMS' plans about outreach and partnerships with associations, with specialty societies, and with patients to try and bring consensus, alignment, patient empowerment, reduced burden, and most of all value and the highest quality care to our beneficiaries. And I actually hope that over the past year some of you have sensed that even more. And so we take it very seriously.

The other thing is transparency. We're trying very hard to be transparent and to make all of these measures, and even our conversations and what we're doing transparent so that people have plenty of opportunity to comment on them.

I just want to sort of preemptively answer a few questions that I am getting frequently because some of you may have been involved in these things. Number one, many of you have provided input to the hospital stars.

We're continuing to look at what that program will look like. It goes into formal rule writing. NQF and some of you in this room participated in the NQF stars collaboration on that. And once the final proposal is out, we would be happy to entertain thoughts of bringing that group back together for further comment, but we have to do it obviously within the confines of rule writing.

The HHS Deputy Secretary Quality Summit that is underway is also something that some of you have been participating in. We don't know the final recommendations, but we certainly look forward to them. A report is supposedly due out this month, and it may have implications for what we will term the quality measurement enterprise.

Today we have somewhat fewer measures than what we've had the past. Actually this week is the whole MAP week. So yesterday was supposed to do care, today is hospital, tomorrow is clinicians. And if you look back a couple of

years, we had close to 100 measures that came through. And last year there were about 40-some measures that came through. And this year quite honestly there are less than 20, and part of that really shows that CMS is supporting and creating fewer measures, quite honestly, in development and few are going into programs in an effort to reduce burden. And many of the measures that we create and bring forward actually will eventually be replacing measures that perhaps aren't as robust or maybe they're not electronic, or maybe there's another reason for having them.

And so there's been a constant and iterative change to programs and the measures that we have. And Reena's going to go over that a little bit, but we've had substantive changes on the hospital side. I think it's like 40, 60 percent?

MEMBER DUSEJA: 40 percent for hospital --

(Simultaneous speaking.)

MS. SCHREIBER: We've had a 40 percent

reduction in the measures used in the programs. So we are really making an effort to streamline as much as possible, and again this is in an iterative way over time.

This gives us at least a little opportunity today to have more of a conversation on the directions of measurement and programs, and that's what we wanted to bring to you. Many of you are familiar with the Meaningful Measures Initiative that kicked off a couple of years ago. We are now starting what we'll term Meaningful Measures 2.0.

And so what might that look like? And I'm going to share with you where our priorities really are, but very much want to hear back what do you think? Are we on the right track? Are we not? Are there gaps? Are there things that we're missing, or is this making sense so that as we develop Meaningful Measures 2.0, you've had an opportunity to really provide some input into them and to help set our direction that is meaningful to all of you.

So if we can go to the first slide please? I'm going to try and run through these relatively quickly so that we do have an opportunity for conversation. Our primary goal of course is to ensure the highest quality, safety and value for our patients -- and by our patients, CMS has such a broad reach that although we traditionally think of the Medicare beneficiary, we're really talking about all patients in America because this impacts everybody.

There has been a significant commitment, as I said before, to patients over paperwork, really demonstrating our commitment to improving clinicians' and organizations' interaction with some of the measures in the programs so that they are less burdensome, but at the same time -- and most importantly -- providing information that is meaningful and useable to patients.

Next slide, please? This is actually the overall strategic priority of CMS with

patients right at the center. And you can see the big themes are empowering patients, focusing on results and unleashing innovation. And if you count them up, there are actually 16 different boxes within them, but they include things like inoperability, and they include things like innovation so that you can see what the key priorities for CMS are as a whole.

Next slide, please? Again many of you have heard of the Meaningful Measures Initiative. We launched it in 2017 to improve outcomes for patients, reduce the data burden, and focus this quality measurement around what we thought was most important so that we can align with what's most meaningful to patients.

Next slide? Sorry, I don't have control of the slides. There are several crosscutting themes, and even as we think of Meaningful Measures 2.0, I would ask you to think of these crosscutting themes and are there opportunities to put other things into this? So addressing high-impact measures that safeguard

public health, that are patient-centered and meaningful and understandable by patients in particular, but also clinicians and providers, are outcome-based as much as possible. So you've seen over time there's been a transition to more outcome-based, but I have to go on record by saying there are good process measures also that actually change behavior, and we shouldn't just kick them all to the side.

We obviously have to fulfill the requirements that are in statute, minimize the burden for providers, identify significant opportunities for improvement. So you've seen we retire measures that get to a topped-out status because they're topped out and there isn't a significant opportunity for improvement. That doesn't mean that organizations shouldn't still track them. What it means is that they're not going to be in our programs because there's not an opportunity for improvement.

Addressing measures that are more population-based because underlying this whole

theme is this drive to value which includes value-based payment and driving into value-based payment models. And then aligning across programs, and I just want to make a comment about alignment because we've been doing a tremendous amount of work trying to align measures across many different continuums, certainly across the federal government. And we've worked with the VA and the DoD in particular to try and align measures there and we've worked with an NQF initiative with AHIP -- America's Hospital Insurance Plans -- to determine core sets of quality measures that we can align across all payers.

So again, the nirvana dream is that we have a set of measures that are aligned across the entire continuum of healthcare no matter what the payer is because we know that some of the burden is not just the burden of what's the check box in the EHR, but it's the burden of the 10 different iterations on trying to measure the same thing.

Next slide please? This is the meaningful measures framework. Some of you may have this card. And what we have done is identified the top six domains. And under those there are 19 specific areas that we have really focused on. So the domains are: effective communication and coordination of care, effective prevention and treatment of chronic disease. Next one is really wellness. It's working with communities for best practices of healthy living, but this is about wellness. Affordability. Safety --- making care safer by reducing harm because we recognize that that remains a major problem. And of course last but definitely not least, is strengthening the person and family engagement to make sure that patients are central and partners to their care. And you can see that there are 19 within them. I'm not going to go over them because many of you have seen this before.

But as we go into Meaningful Measures 2.0, what are we missing? Are there places that

we should be focusing on more or focusing on less?

Next slide please? Reena, do you want to pick up and talk a little about what's happened with transformation over time?

MEMBER DUSEJA: Yes, I'm happy to. And I'm going to make my comments brief because I think Michelle and I agreed prior that we really want to have discussion and hear from you during the time that we have today, but I wanted to just provide some framing comments about how we implemented the meaningful measure framework in 2017 and the impact it had on rulemaking.

Michelle mentioned how it's affected the measure under consideration list over the last few years, and to the point of having less than 20 measures this year across our program shows how we really are taking a hard look at these measures as we think about putting them into our program.

For the hospital inpatient programs, if you look at what's being implemented, we've

had a 40 percent reduction of measures. So for example, in IQR currently -- we started like in 2017 with 42 measures and then we're down to 23 measures in that program. And similarly, if you look at -- across the programs, including IPF, we've had a couple of measures removed from there, ESRD. Also in the outpatient setting. So for ambulatory care we've seen three measures removed; 10 to 7. And a significant number of measures in outpatient quality reporting programs, we've gone from 21 measures to 13 measures.

Now a lot of that effort had to do with looking at, as Michelle mentioned, the -- looking at topped-out status, looking at low-bar measures, process measures. If we do have process measures, are they really linked to outcomes as the evidence shows? A great example would be sepsis. I know it's a controversial measure, but it is a measure we know from our data that has decreased mortality for our patients as we've implemented within the program.

And I think also just to give you some context -- I know this is the Hospital Workgroup. We also have the Clinician Workgroup meeting tomorrow and then yesterday the Post-Acute Care Workgroup met, and we've seen reduction across all our programs. So for example, in MIPS we've had a 20 percent reduction of measures and we just finalized the -- what we called MBPs, which is a framework for the MIPS value pathways. And so I think that's an additional opportunity for alignment across those categories, but also to have a more concise set of measures that are really trying to drive toward value.

And I'll just add just one framing thought as Michelle talks about kind of future directions, the LAN met, the Learning Action Network met in October of this year and some -- I'm seeing shaking heads here, nodding heads -- there was some very aspirational goals that were set out, and our secretary also spoke at that meeting. And one of the goals was for us to move from fee-for-service to alternative payment

models by 2025. And we're making progress, but we have a lot more to do.

But this really behooves us to think about: how are we driving toward value? And part of that is really thinking about beyond the quality measures about: how do we align that with cost? And so there's been a lot of thinking through that, especially through the MIPS program because we've developed some cost-based measures. But we want to do that across the continuum.

And then there's also really thinking about: how do we align our measures at the clinician level, at the facility level, as in for these programs as well as we think about it from the entity level?

And then last I will say I think critical is really thinking about: how do we actually measure in a way that's least burdensome patient-reported outcomes? And we've spoken about this in the Committee before, but there's a continued interest within our agency to partner with others to continue to move that effort. And

I will turn it back to Michelle.

MS. SCHREIBER: Thanks.

MS. DUSEJA: Yes.

MS. SCHREIBER: If we can have the next slide please? So we wanted to take just a moment to talk about what our development priorities are, and get your feedback on if these seem reasonable or not, and then to open up the discussion around Meaningful Measures 2.0, what you would like to see, comment on our priorities. And you can -- and comment on the program or others as well.

So as Reena pointed out, patient-reported outcomes is something that is very important to us. I know there is work that has been done here around that, so this is an ongoing pursuit to try and find not only operationally how we can best make patient-reported outcomes kind of work and fit within people's workflow, because it's clunky right now, but how can we really unleash comments from and feedback from patients? We need to understand what's important

to them, but we believe that by unleashing patient comments it will actually transform measurement and reporting as we start seeing more and more of those and they become commonplace.

A comment about electronic measures. And I'll broaden this a bit to not just electronic clinical quality measures that we traditionally associate with getting data directly out of the electronic medical record, but how do we base all of our measures on electronic data systems, because they could be data systems beyond the electronic medical record as well, although that's fundamental.

I'm going a bit out on a limb here, but we are hoping at some point in time that we can commit to at some year -- which I will not begin to predict what year that would be -- we will have all measures based in electronic clinical data systems. And we're doing a lot to drive that, including converting a number of our measures actually into fire-based standards, using APIs for exchanging information, working on

standardized data elements. And sometimes this isn't the thrilling stuff, but it's the nitty-gritty work that has to be done in order to make these work.

And so we are obviously promoting and supporting interoperability, ensuring that there's not data blocking, making sure that we at least are supporting the fire-based standards and see this as the future direction for how we interchange clinical information. So there's a tremendous amount of work going on in driving measurement towards not only supporting interoperability, but making sure that they're electronic because of the belief that this is the only way to capture data relatively with less burden once those systems are built.

I recognize the burden of building them, but once those systems are built there's less burden in capturing them. You can have much more timely feedback rather than the two to three-year wait sometimes in seeing data. We can have feedback that's relatively quick. And of

course we can leverage then artificial intelligence, big data analytics, whatever you want to call it, in order to really do much more prediction and outlier identification, and just a better understanding analytically of what it is that we have. So a lot of work there.

The appropriate use of opioids obviously is something that remains a key principle in lot of work going on here. I would expand that that it's not just opioids; it's pain management, and I think mental health has to kind of go along with that. So although it says the appropriate use of opioids, I think it has to encompass a somewhat broader range.

Nursing home infections is something that has caught the attention of CMS because of some nursing home harm issues quite honestly, and so there's more and more work coming around nursing homes in particular. Some of that is on the conditions of participation and the accreditation side, but some of that will also be around the measurement side.

Safety measures should actually be called out as a separate bullet point. So patient safety as something that we are working on. And you will be hearing today one of the electronic measures for patient safety with the hope that as we have more electronic patient safety measures that we will then ultimately develop a composite measure of the electronic patient safety measures; and I don't know that I'm really going to announce this in public, but I will, with the hope that eventually it replaces PSI 90, which I know everybody loves so much.

(Laughter.)

CO-CHAIR MORRISON: So that's just kind of future things to come. Maternal mortality -- and I know we have something that's coming here today that may be a bit controversial, but I will share with you that one of the reasons that that is here is because the fact that America has the highest maternal mortality rates in any country is something that cannot be tolerated, and there's a lot of effort at CMS to be thinking

through what is it we can do to, number one, send a signal that working on this is important.

We will over time -- and it's not ready this year, but hopefully next year perhaps at this time or the year after --- we are working on an electronic measure of maternal morbidity. Not mortality because frankly the numbers are so small for that it's hard, but a composite maternal morbidity. And we're working on that actually in combination with the Joint Commission, so we hope to be bringing that forward to you.

But the reason for the measure that you see today -- I recognize it's a structural measure. It is not quite this kind of quality measure we've thought of before, but it was meant as really just a signal and an indication to ask organizations if they're participating in quality improvement that is meaningful to reduce maternal mortality.

And finally, sepsis. You heard Reena talking about that before. We're looking to do a

more outcomes-based and again electronic measure around sepsis that over time then would probably replace the hand abstract strep and sepsis measure.

What I don't have up here is cost. We have lost of cost measures that are on the table. Most of those are on the clinical side as opposed to the hospital side, but there's a lot of focus on cost. And so this is where CMS is setting its development priorities, and we actually look forward to your comments on that.

I think we have one more slide that I've covered really pretty much already. It's my soapbox plea for electronic measures of the future. So developing more APIs, using the prototype of fire, interoperable electronic exchanges, harmonizing across registries and the idea of timely and actionable feedback and the use ultimately of artificial intelligence, or big data as you might call it.

So I would like to turn the rest of the time actually back to our co-chairs and

really have a discussion of: are we on the right strategy? Do you agree, do you not agree? What changes would you like to see? And help us craft Meaningful Measures 2.0. So thank you.

CO-CHAIR MORRISON: Thank you, Michelle. Thank you, Reena. So the floor is now open.

And Michelle, just to highlight again, you guys are really interested in really three areas: one, general reactions; two, future directions in terms of what you -- strong support for or perhaps against. And any gaps that --

MS. SCHREIBER: Yes.

CO-CHAIR MORRISON: -- people have that might be identified.

MS. SCHREIBER: Thank you.

CO-CHAIR MORRISON: Is that it?

MS. SCHREIBER: Yes. Perfect.

CO-CHAIR MORRISON: Okay. The floor is open to tent cards.

MS. SCHREIBER: And by the way, if you don't talk, I'll assume that we're all right,

so --

(Laughter.)

CO-CHAIR MORRISON: Martin, you get to start us off.

MEMBER HATLIE: I have two comments. First of all, I like structural measures a lot. I think that they get to culture, and I think as we look back now especially 20 years after the IOM Report on Safety, where we're all looking back at looking at the progress we've made and the progress we haven't made that the impediment is often culture. It's fear of litigation. It's fear of embarrassment. It's fear that our patients won't understand what we're giving them in terms of information. And I think structural measures play a real part there.

I'm looking at Jack Jordan across the table because we were involved in the network of the partnership of patients with the development of structural measures there that really brought the patient and family not just in at the point of care, but into improvement work and into

governance. And those were structural measures that are beginning to now generate data about making a difference. So I will just encourage you to keep going at that for culture change reasons because culture eats strategy for breakfast.

The second thing I wanted to say is I really hope that in the meaningful measure development priorities list you will call out patient safety the way you did verbally here as a bullet. This new data last year globally shows that more people now die from poor quality and unsafe care than from lack of access to care in 137 countries.

The World Health Organization published a brand new resolution in May calling upon this as a reminder that this is a huge priority for the world, for every country, probably because we're not really tracking well the amount of harm from preventable process failure or system failure. So I think that really does deserve to be called out as an

explicit priority. And I worry that it gets subsumed under safety in a way that loses urgency. It certainly belongs there, but there's something urgent about really calling out patient safety as an ethical imperative for us as well as quality imperative.

So those are my comments. Thank you, Sean, for the floor, and great work.

CO-CHAIR MORRISON: Jackson? I've Jackson, Akin and then Jack.

MEMBER WILLIAMS: Dr. Schreiber, as you noted, the meaningful measures card contains 16 boxes and 19 priority areas, and I think most of us at this table in our professional lives work in organizations or units that have about three priorities at any given time. So to me saying we have 19 areas is almost like saying there are none. And I realize I've worked at CMS, and I know there are stakeholders who want to get their area in there --

MS. SCHREIBER: You think?

MEMBER WILLIAMS: -- so that's why

it's there. But I think it would be helpful to this group if you could tell us I guess what your view of the real top three are.

MS. SCHREIBER: I mean I could give you my view, but frankly I'd rather hear your view. Yesterday at the PAC meeting they actually prioritized for us. And so we'd be happy to hear what you all think, if you had to vote your top one might be -- because everybody will have a different -- maybe we'll get to three.

MEMBER WILLIAMS: Okay.

(Laughter.)

MS. SCHREIBER: Don't want to go first?

CO-CHAIR MORRISON: Akin and then --

MEMBER DEMEHIN: So first of all, thank you for the overview of the Meaningful Measures Initiative. I would say that we were and continue to be very strong proponents of this approach. I think there's a real discipline to outlining the list of areas that will shape CMS' measurement programs.

Just a couple of thoughts: if I were picking a priority area writ large to focus a lot of energy and attention on, frankly it would be patient safety. It is really good to hear that you are looking at ways of transitioning away from old claims-based measures like PSI 90, of which we have many opinions and have stated them many times. I think that is a good way to really use an EHR to its greatest effect to drive safety forward.

The other thing that comes to mind as we -- as I kind of look this list, I do think that the notion of trying to align across payers is an incredibly important one. A lot of the measurement burden that we hear about from our members comes from having to report different versions of -- like is effectively the same measure. I do think eCQMs are one way of getting there because the data are agnostic to the payer, but really emphasizing the need to create that cohesion and coordination across payers in terms of measurement would go a very, very long way.

And the last thing I guess is more of a question for all of you. So this meaningful measures framework was developed two years ago. As I look at the list of priorities, it still looks like a good list and a fairly current list. Could you comment a little bit on how you see CMS maintaining, altering, expanding, contracting the list of 19 priority areas in this framework over time?

MS. SCHREIBER: I think that to address both points, one is to narrow it down even further so that we can be focusing on very key or strategic areas.

Now that being said, we think of 19 as too much. We are covering the country here in the entire continuum healthcare. But I think to focus it even more would -- is one of the things that we're looking to do.

I think the second focus quite honestly is the shift to the electronic world and how we capture that, because it's really not quite captured in meaningful measures as it

currently stands. So there are a couple of underlying themes.

And then the other thing that frankly we haven't talked about -- we had a huge debate yesterday -- is: where does disparities fit into this framework example? Is it its own domain? Is it crosscutting? Is it sort of where does it fit in? And that's another conversation that will go into this, but it's so complicated that I don't know that any of us have an answer right now.

MEMBER DUSEJA: Can I just -- can I add?

MS. SCHREIBER: Yes, please.

MEMBER DUSEJA: The other area I think that's sort of driving toward value is really thinking about resource utilization and the demand that we have around making care affordable. So I think there's a lot of work. At least I know this from the clinician standpoint that we're also thinking about it across other spaces and we're partnering with

specialty societies to really get better measurement in that area.

CO-CHAIR MORRISON: Jack?

MEMBER JORDAN: All right. So a couple things: one, it didn't seem like your key priority areas included specialty and sub-specialty care at all, which seems like a big gap. And then I wanted to comment on your statement you made about sepsis mortality getting better. There's an interesting report that the HIMSS had from their evaluation. If you look at it in a population base, it's flat. We haven't made any dent at all in the population. But it's just taking us more tries in the hospital to kill you, but we eventually do from sepsis.

(Laughter.)

MEMBER JORDAN: So looking at it at the hospital base gives you a really different answer than population, so I would ask you to maybe think about that.

When you're going down the road for cost, I think thinking about making sure you're

including the cost of avoiding a procedure altogether. You know, you get your cheapest procedures are on the lowest need kind of patients. And that's -- I think that's trickier to do, but I think it's important to think about.

And the other thing to think about on your patient-reported outcomes is we tend to always frame them as episode-based, and maybe if you think about them as time-based, that every year when you sign up for your insurance you take a PROMISE12 and that sets kind of the HCC scoring, and now we've got wonderful data for the whole country on where the population is at.

And I know a lot of the specialties are going to balk at that because they want to have the really specific question for their patient-reported outcome, but I think going global like that is something to consider that's a little bit different than how people are thinking about it.

And then my last one is the soapbox on: when you do go to eCQMs, make the turnarounds

quick. Share them with your contractors the next day, not three months later after they've been cleaned. And I think that's the real advantage to eCQMs, if you have government contractors, to seek the data the next minute to help people out.

CO-CHAIR MORRISON: Great. Lindsey. Then I've got Nikolas and Lisa.

MEMBER WISHAM: Yes, I just wanted to provide a comment that I appreciate and support the desire to move to 100 percent electronic data capture. I think that's truly been untapped. As someone that's been a part of eCQM since their inception, we've seen some iterative changes, but we've also seen big leaps in some of the standards that have been used. And I think it's just a constant reminder that you will continue to see evolvement. They will not stand still. The standards won't. And that shouldn't deter us from embracing them and utilizing them in measurement programs. I think we just have to go in with -- knowing and embracing that the standards will continue to evolve as measurement

needs change and evolve as well. So thank you.

CO-CHAIR MORRISON: Nikolas?

MEMBER MATTHES: Yes, I just wanted to say I'm really in support of the meaningful measures framework and -- so one perhaps area to think about as well, and I was just curious whether you had or what your thoughts are currently is sort of to think about the organizations' commitment to provide engagement. So like as we think about the clinical and professional work environment, the impact it has on employee satisfaction and on actually better caregiver outcomes and patient outcomes, that that may be an area for consideration as well.

CO-CHAIR MORRISON: Lisa? And then just so you're prepared, I've got -- Amy, you're next.

MEMBER McGIFFERT: Okay. Let's see. I definitely think we need to focus more on hearing from patients, especially in the arena of patient safety because I think these events overall are kind of under the radar with regard

to the public and people who have oversight of the system. And that means directly asking them if they've been harmed. What happened to them?

And I really like the idea that Jack said about doing some kind of annual feedback from people rather than just after they left the hospital. And I think we don't have any questions to patients that say did you get an infection? Did you have a complication that was preventable? Or describe some of the things that happened.

With regard to infections; and most of my comments are on patient safety, I would like to see us move towards a composite of all the infections that happen in a facility. And we are nowhere near doing that right now. The public -- people want to know how likely am I going to get an infection at that facility? They don't want to know how likely am I going to get a CLABSI or a CAUTI or a -- they want to know am I going to get -- how does it rate? So I think we really need to think about that. The current measures

are really I think more useful for providers, and they were designed to be that way. And I understand that, but it's now time to think about the public a little bit more.

With regard to disparities in the area again of patient harm, I think we just need to tread very carefully so we don't continue to support poorer care for certain populations through risk adjustment. And I think that that's very dangerous when it comes to anything relating to patient safety. And I know when these conversations first started many years ago and a few of us were going, wait, whoa, what, we were told these would never be applied to patient safety measures or about patient safety. And I'm seeing it creep in and I just want to say that from my perspective it's not an appropriate thing to happen. Thanks.

CO-CHAIR MORRISON: Amy?

MEMBER HELWIG: I just had a couple of comments on priorities. I would encourage more prioritization of functional outcome measures,

especially change in functional status and whenever that's possible and as it relates to different treatments. The benefit is that it hits patient-reported outcomes. It hits appropriate care. It hits cost of care.

I think of some specific examples within the Joint Replacement Program where we currently look at the functional status. It's required both before and after surgery, six and nine months and a year after surgery. But now moving to that new phase of actually to see, all right, not only was an assessment done, but did it make a difference? And what was -- what's the minimum difference that you need to see so that we can better determine what's appropriate care and how to best use resources? So any other areas where we can continue to incorporate those changes in functional statuses I think would be very beneficial.

CO-CHAIR MORRISON: And, Michael?

MEMBER WOODRUFF: So first of all, thank you. And the direction is perfect and I

love the frame, the lens of measures that are meaningful to patients. That's going to be really helpful. The challenge I think will be in making that operationalized in the creation of the individual measures, and I think we'll see some of that in the discussion today.

I would echo the focus on safety. And in particular what I didn't see is a focus on measures that improve transition, the safety of transitional care, which is a big area in our need in our whole system.

I also wanted to pick up on Nikolas' comment about provider engagement as that's sort of fundamental to everything we're trying to achieve for patients, and in particular your focus on trying to improve or increase time for clinicians and patients together. So I wanted to ask if there had been thought in the eCQM work about measures that actually improve the useability of EHRs and safety of EHRs.

MS. SCHREIBER: So I just want to thank you for that comment. In the promoting

interoperability piece of the IPPS rule that went out this past year, we actually had very specific RFI around that that was put in there for a very specific reason, exactly what you're talking about. And I was surprised we got very little comment back, because I think that that's important.

So I would just encourage people to comment to us on that, because even -- we even asked a question of should people be reviewing the safer guidelines that are out there, things like that, because as we use more and more EHRs we have to make sure that we're safely using EHRs and that we're promoting usability of the EHRs.

So thank you for the comment. We actually did ask it specifically in an RFI, so we will be continuing that train of thought.

CO-CHAIR MORRISON: Linda?

MS. SCHREIBER: I say that because I wrote that part.

MEMBER VAN ALLEN: Yes, thanks. I actually want to build on something that Lisa

said around patients don't understand the language we use, and that is that these measures need to be more transparent and available to the patients because -- for example, in case management many times we're sharing metrics and information when patients are trying to make a post-acute provider choice, but we're having to do a lot of education on that. They're not so -- they don't really understand what the measures mean, et cetera.

And so I'm sure for hospitals, when they're looking at hospitals, they have no idea what's going on with these measures. They -- it's a rare patient that will go, frankly, to the compare sites. I think it's the hospitals are -- the providers are going to the compare sites to see how they stack up, but patients -- I don't know, maybe you have data that says differently, but our experience is that patients are unaware.

So is there a way to push the data and make it more public to the patient and the user and to frame it in a way that makes sense to a

patient versus the way it makes sense to us?

CO-CHAIR MORRISON: Akin, is that your card?

MEMBER DEMEHIN: Sorry.

CO-CHAIR MORRISON: It is? Okay. Go ahead.

MEMBER DEMEHIN: On a kind of slightly different track just looking back again at the list of priority areas, we certainly agree with the notion of having better measures around the appropriate use of opioids. One of the points that you made earlier I think is a really important one, and that is understandably the opioid crisis is consuming a lot of attention just given the gravity of the crisis. There is a much broader need for good measures of behavioral healthcare writ large that go well beyond just opioid use. So as you continue to explore measures in that area, I would strongly encourage you to broaden your lens just a little bit on that.

And to the point that Linda just made,

it is certainly a challenge to figure out exactly how to make the data that are transparent understandable and accessible to patients. That's part of the crux of the ongoing conversations I know we've had around hospital star ratings, but that sort of translation and making sure that patients are engaged and involved and how we make that translation, I think that's part of the value of the group that the NQF convened to give input on that is to really make sure that everybody around the table has an opportunity to help shape how that information gets displayed.

CO-CHAIR MORRISON: I've got Brock, Andreea and then I'm going to give Cristie a word.

MEMBER SLABACH: Thank you, Sean.

And thank, Michelle. I always get a little nervous when my head shakes in agreement with CMS --

(Laughter.)

MEMBER SLABACH: I -- really I was

able to hear the -- some of this presentation yesterday and now today. It's been really good to get an update on some of your priorities, so thank you.

From our perspective, having worked on the Rural Measures Application Partnership Project since 2015, one of the key areas of our concern that hasn't been expressed in the materials yet is access to care, and how we develop measures and put them into use that measure how distance to care and transportation needs are critical to be able to secure healthcare in a timely and effective fashion.

I will refer to you in 2018, December, a year ago, our workgroup here at NQF published a very nice composite summary of the access to care issues. So I would refer that to you. I think it would be very helpful background on the topic without me talking all day about it. But I think that's an important area as we have hospitals closing and -- 119 so far since 2010.

And then talking about maternal

morbidity and mortality, we've had over 200 maternal delivery sites close in rural communities all over the United States since the year 2000. So these are really important issues that I think have to be addressed and needs to be incorporated somehow into our measurement systems.

CO-CHAIR MORRISON: Andreea?

MEMBER BALAN-COHEN: First of all thank you for the comments and for sharing the views. I just wanted to make a couple of comments. First of all, the priority areas. Like I wanted to echo the sentiments around like patient safety and its importance.

In addition to that, I also wanted to bring to your attention like in terms of maternal mortality and morbidity, I do think that that's really important and it's really something that it's like striking in a global context like across like the U.S. It's something that we really should be doing more towards. So I really wanted to put that like high on your list like in

terms of like priorities.

In terms of gaps I wanted to build a little bit on what Jack mentioned earlier and maybe give a little bit more thought around like low-value care, like more generally. We do have now a lot of evidence in terms of like certain procedures and other things that are lower-value care and like building towards and developing some measures and really capturing that. I think that would really help like both in terms of focusing a little bit outcomes and potentially on the cost side as well since I know that that's one of your areas as well.

I also wanted to echo like the sentiment around like moving more towards like eCQMs, and certainly like building up on what Lindsey said earlier, the standards will change, especially as we focus more towards electronic data systems, but along with that I think that there is some work that needs to be done and maybe even started thinking -- and that's maybe also for NQF as well, right? I mean the way we

test eCQMs and the we're going to do that in our electronic data system, especially if we start talking about developing measures and focusing on AI and other advanced analytic methods, are going to be different. So just beginning to do some of -- laying some of the groundwork for that to get there when we get there I think would be important as well.

CO-CHAIR MORRISON: Cristie?

CO-CHAIR UPSHAW TRAVIS: You can tell I've been on the committee too long.

Well, just a couple of comments. One, I think care -- where care is being delivered is changing and there's a significant movement out of the hospital into the ambulatory setting. I will use surgical procedures as kind of the obvious movement that is happening. So as much as I think it's important that we think about a parsimonious measure set, I think it's also important to think about where are the trends taking healthcare and where it's being delivered. And we may need -- in fact, I would suggest we do

need to be measuring how that change is happening. and so just thinking about ambulatory surgical centers especially and hospital outpatient surgical.

And those are somewhat complicated to measure, but at the same time if care is moving that direction, we need I think to be prepared ahead of time to be able to say is it being appropriately moved and are we getting better outcomes, not just less expensive. And I'm always looking at cost, but we want to be sure that we've got the cost and the quality measures.

The other -- another piece that's kind of hit me ask we've talked is really looking at system change versus individual measures, and I've kind of used the safety -- the patient safety composite as an example. And really at NQF we've been talking about measure sets and measure systems.

I think the reason we have 19 priorities; and within those 19 priorities there's lots of measures, is because we're

attacking pieces of the system versus thinking about the system as a whole. And I believe that we will never get to that latter part by only addressing top three individual measures. And so obviously the payment system is one big payment -- big system change and then a measurement system that goes along with a payment system that would probably I would suggest be more like the measure set or the measure system level.

And certainly from the private purchasers' standpoint they have a lot of the same interests that patients have, which is to get an overall view, not necessarily down at an individual measure view, because that's how they're making decisions on what health plans to offer is, and they don't know exactly what their employees and their families are going to be going and accessing the system for. So you really want to look at the system view in order to understand where you want to go.

And the only other question, the only other thought I have, and it may be because I'm

not as engaged in this, but what we hear and from -- in the private purchaser standpoint is that moving toward electronic is obviously something we support, but that there seem to be barriers in the marketplace for that. And nobody's mentioned it, so I don't know whether I'm just not understanding the situation, but there's difficulty with the different vendors.

And I don't know if we're appropriately or adequately engaging the vendors. Maybe we're trying to go through the hospitals to put pressure on their vendors, but sometimes that's a chicken or the egg. So that would just be the other piece that I would add there.

And then my final piece is to echo what's been said about mental health and actually behavioral health for both mental health and substance use disorder. The system is broken. I can't imagine that it's not broken for the CMS beneficiaries as much as it's broken for everybody else in this country.

And really taking a hard look at where

the system is broken and what we can do to try to have a short-term strategy as well as a long-term strategy, measurement-based care does not exist in behavioral health. And I think that this is something that I know we're focusing on with the business coalitions across the country right now, thinking about how we can address these problems in our regional markets.

And so I'll be glad to share with you all some of the information that we've pulled together because we've actually measured through the National Alliance of Healthcare Purchaser Coalitions -- we've actually gone out and measured health plan performance around some of this and it highlights where the issues are.

And so I really think we have to do that. And opioids is a component of that, but it's broader as everybody else is concerned.

CO-CHAIR MORRISON: So I've got five more minutes devoted to this session, guys. And as typically happens all the cards go up at that time.

(Laughter.)

CO-CHAIR MORRISON: So I'm going to try and take the cards on the table that are up now because I was told my number one job is to get people out on time.

(Laughter.)

CO-CHAIR MORRISON: So I would ask people to be succinct, and if it's already been said, it doesn't need to be said again.

That being said, we're starting with Sarah.

MEMBER NOLAN: Well, I'll be very succinct and echo what I think some people have expressed, which is a concern for large -- for sort of systemic questions. And the one thing that I don't think has been said is one part of the system that I think needs paying attention to is the workforce. That's particularly true in the case of nursing homes, but not only, where it seems to be impossible to address safety without considering the low wages nursing home workers -- and frankly, a workforce shortage due to those

low wages, lack of access to training, lack of certain -- a possibility for developing that workforce, lack of staff, staffing standards. And I would just note that some other NQF workgroups; the one a couple years ago on long-term care, did include in developing measures, workforce-related measures.

CO-CHAIR MORRISON: Lisa?

MEMBER McGIFFERT: I just wanted to address the issue that was brought up about how to get to the public better, and I think with the hospital compare; I think someone talked about people don't use it, I think that it's too big and people want to hear about their local situation. So if there was some way that CMS could break it down even by state, I think that would be something. Or be sure that state media gets a hold of when they'll update it so they can talk about the local issues. And in large cities like New York and San Francisco that is so important. They don't -- they just have to sift through so much to see how they compare to

others.

CO-CHAIR MORRISON: Dan?

MEMBER POLLOCK: Very quickly, patient-generated health data. Be it functional outcomes, be it ASCs, ambulatory surgery centers, in the patient's home who've got complications, be it hospitals where post-surgical care is frequently on the outpatient side more so than ever, we have devices that patients are using every day to communicate with practitioners where they're reporting changes in functional status or complications.

But unfortunately much of that data is getting sequestered on smart phones and tablets. It's not making its way into a shared record keeping space. I think we need more coherent and consequential policy incentives to bring the data from the smart phone and the tablet into the mainstream electronic health record resource so that it's available for quality measurement.

CO-CHAIR MORRISON: Anna?

MEMBER DOPP: Thank you. I always

appreciate the update that you provide. And I have been reflecting back two years ago when we heard about the meaningful measure framework and wondering at the time how you were going to get all the measures to start the margin line with those, and it's nice to see how they're there and starting to line up. And also thinking about the shift now from Triple Aim to the Quadruple Aim mentioned this on the workforce side.

I'm hesitant to throw in one more priority because it's been expressed that priorities should be singular and not plural, but thinking about provider burnout and well-being resilience, and especially now that the National Academy of Medicine released their consensus study, and there's also a newly formed working group that's looking at organizational best practices and measurement, I'll tell you that within that working group the very first thing we're thinking about are what are the unintended consequences of measurement within well-being resilience, but just to encourage CMS to keep

that dialog and listening ear to that work as it progresses and seeing how it might fit into this as well.

CO-CHAIR MORRISON: Frank?

MEMBER GHINASSI: Thank you very much. Thanks for the update on the priorities. I really appreciate it.

Just two quick points: One, I want to reinforce the importance of innovation. I think that's really critical for creating a safer and more effective environment.

I think I also want to point out that anything CMS can do to help in reducing the barriers to innovation -- two things that jump out are, number one -- three actually -- number one, licensure itself; I realize it's a state-related issue, limits the ability to do innovative care. An example: We talked about mental health needs and you talk about managing chronic care.

It's very, very clear that integrating behavioral health into physical healthcare,

primary and pediatric and all other areas, would help enormously in that area, and yet there are payment and licensure barriers that make that almost impossible to do without grants. And that's got to change, number one.

Number two, we should be thinking about expanding payment structures to allow for coordination of care efforts that meet patients where they want to be met, which includes smart phones, FaceTime, all the things that they do. And there needs to be ways for that to be reimbursable activity which right now it's not.

And then the second one is a related issue. Cristie mentioned system coordination before and I really laud the focus on 30-day readmissions. I realize that people coming back into the hospital is not what we want to see. I also laud 7 and 30-day follow ups. But we are focusing on one part of a complex inter-digitated system where senders have to have receivers.

And when you look at metropolitan areas or you look at frontier areas or rural

areas, a lot of work can be done to connect people to care, but if that care is simply not available, locking systems into a measurement system that says 7 and 30 is the target when the reality of a community, city, region might be 30 days is the reality.

So I think if we're going to be measuring the sender, can we coordinate measurement and expectations on the receivers as well? Just a thought.

CO-CHAIR MORRISON: Marty?

MEMBER HATLIE: I don't think I've heard this mentioned, but a continuing challenge and gap is measuring the cost of poor-quality born by families, and in the behavioral health area it was Cristie's comments that really triggered it for me. It's just financially devastating to have a family member that you're taking care of because the systems just don't exist. So as we think about value, we've got to be thinking about all those costs that don't get built into our formulations about value. And

it's not just families. It's the social networks, it's the schools, it's the law enforcement mechanisms that really absorb a lot of the costs of us not having a system in place there. So please pay attention to the costs of patients and families, too.

CO-CHAIR MORRISON: Anybody have a last dying point they have to get in?

(Laughter.)

(Simultaneous speaking.)

MEMBER McGIFFERT: I have one. I'm just going to say one thing. Medical implants. We need something, some kind of measures on that. That's all I'm going to say.

(Laughter.)

(Simultaneous speaking.)

MEMBER McGIFFERT: There's nothing going on with that.

CO-CHAIR MORRISON: Michelle, Reena, you opened this up.

(Laughter.)

CO-CHAIR MORRISON: I hope you got

what you needed from the group. I just -- I want to take chair's prerogative, take my hat off and just one quick comment, if I could. And I'm not sure what the gap is, but there's a gap, which is we've been working really hard for over a decade on value-based care and I think that we've made a tremendous amount of strides on the numerator in terms of quality. And I think that should be stated, I mean that there really has been improvement. And we're kind of working on the cost a little bit, I get that.

But every year Dan's group puts out the life expectancy numbers, and despite all of that our life expectancy is going down. So somewhere there is a big gap. And I can't believe that after 10 years of really working on this we haven't made improvements. So somewhere there's a gap in terms of our nation's health. And I think we need to step back from a very big picture and think about what is it that we're not addressing, because the big numbers are going in the wrong direction.

And I don't -- that's not your job. As I put my academic research hat on, that's my job, but I think we really need to begin to shine a light on that because we are missing something, and it's a big gap.

MS. SCHREIBER: Sure. I agree. So I may take a moment to first of all express thanks on the part of CMS and us in particular personally. These conversations are really important and they will help us shape as we move forward what Meaningful Measures 2.0 looks like. So thank you and thank you for the opportunity to do this today.

CO-CHAIR MORRISON: Thank you, guys.

All right. Sam, I think the ball is in your court now, is that right?

MR. STOLPE: Very good. Thank you.

This next portion of our agenda will be reviewing our processes and procedures before we move into discussions of each of the individual measures.

Just to make sure that we have a

general overview of how we're going to be proceeding, undoubtedly there will be some questions about this process which staff are making theirselves available during this time for you to ask and gain some clarity.

Just as a general overview of the approach, we conduct our MAP voting sessions through a three-step process. First, we provide an overview of the programming question that gives a general outline of the structure and of incentives of the quality measures, et cetera, for the program itself.

And next we jump into those quality measures just briefly so that you can understand the context of the measures that we are going to be considering. For each measure we want to evaluate, which is this last step, the extent to which the measures under consideration fit in and are appropriate for the program under consideration. So this is the application portion of the Measure Applications Partnership.

Let's go to the next slide, please.

So the evaluation of the measures under consideration will be asking each measure to receive a formal recommendation from the workgroup. We have standardized decision categories, which I will be reviewing with you briefly in a moment, and each decision will be accompanied by a statement, which we'll craft, that outlines the rationale for why we have arrived at the decision that we did.

We'll also capture the event that we have strong dissenting opinions, those opinions as well. Those will go into our final report as well as a structured field of rationale for each of the measures, which we will pass on for our colleagues at CMS, as well as to the MAP Coordinating Committee, which they will consider at their in-person meeting in the middle of January.

We do want to note that we have heard your feedback from last year about that dissenting opinion and we'll make sure that that is highlighted and if in the event that we have

-- well, we're getting pretty close to the votes.

Related to the preliminary analyses, you'll note inside of your meeting materials that staff has conducted a preliminary analysis for each measure under consideration. Now we've developed -- as the Measure Applications Partnership we've developed together the criteria and algorithm under which these preliminary analyses are conducted. This is called our measure selection criteria. The analysis is meant to offer you simply a starting point for the discussion. It's a succinct profile of the measures and is not in any way intended to override the committee's discussion. In fact it's just the very starting point for you make your considerations and share your insights.

Next slide. So let's go ahead and jump into the action analysis algorithm itself. So there are seven total steps inside of the preliminary analysis. The first is assessing whether the measure addresses a critical quality objective not adequately addressed by the

measures in the program set. If the answer to that question is yes, the review continues. If no, then the measure will receive a do not support.

The same holds true for the second criteria. The measure is evidence-based. It is either strongly links to outcomes or an outcomes measure. What we're looking for here is for process and structural measures, that there's adequate evidence to suggest that a desirable outcome is connected directly through empirical evidence to the structure or process under consideration.

For outcome measures we have a little bit of a different consideration; namely, we assume that the outcome itself is desirable and that there is some evidence base for a process, structure, intervention or service that a provider could implement to address that outcome. Obviously we would not be interested in measures around outcomes that are not actionable on the side of the provider who's being held accountable

to the measure.

Next up our third criteria. The measure addresses a quality challenge. And what we mean by that is that the measure specifically addresses a topic with a performance gap or addresses a serious reportable event such as a safety event that should never happen or that the measure addresses unwanted or significant variation in care that is evidence of a quality challenge. And as with the other two, in the event -- the criteria before this the event -- the answer to this is yes, that the measure does address the quality challenge, the measure continues. If not, the measure receives a do not support designation.

So our fourth assessment criteria is that the measure contributes to efficient use of measurement resources and/or supports alignment of measurement across programs. I feel like this is pretty self-explanatory for what we mean by that, that what we're looking at is that measures are not duplicative and they capture a broad

population and they contribute to this alignment across programs and that there's demonstrated value to both patients and consumers that outweighs any burden associated with implementation.

If we say yes to this, then the review continues. If no, the highest rating for this measure is a do not support with potential for mitigation, the assumption being that a suggestion would come from that in that instance and how the measure developer could actually improve the measure for a future support categorization.

Next up our fifth criteria. The measure can be feasibly reported. This is just simply what it says, that a measure can be operationalized. If so, review continues. If not, again potential for mitigation with an explanation from the MAP on what could possibly be done to make it feasibly reportable.

Our sixth assessment criteria is that the measure be applicable and appropriately

specified for the program's intended care settings, level of analysis, population. This is often reflected through the NQF endorsement process. We really kick the tires on measures when they come to our consensus standards committees -- or excuse me, or consensus development process committees, the standing committees that we have to evaluate the -- for endorsement of each of the measures. They'll look very carefully at the scientific acceptability, feasibility, evidence base, et cetera, of the measure.

And measures that do not have this, the highest rating can be a conditional support. And then the MAP rationale would essentially explain that categorization that should go for NQF endorsement.

Lastly, if the measure is in current use and there's been no unreasonable implementation issues or significant negative consequences that outweigh the benefits of implementing the measure and that constitutes our

final -- our priority to consider and our preliminary MAP analysis.

Okay. Now I'll pause there just briefly to see if there's any questions about the preliminary analyses or the algorithms.

(No audible response.)

MR. STOLPE: All right. Very good. Well, let's move forward to our decision categories, and I mentioned some of these in my previous discourse, but I wanted to outline the categories themselves in some detail.

Our first category is support for rulemaking, and it's fairly straightforward here. It's just simply the MAP supports the implementation of the measure as it stands and that we've reviewed the preliminary analysis algorithm for categories 1 through 6, that it's met with criteria. And if it is in current use, that it meets Criteria 7 as well.

The conditional support for rulemaking and the do not support for rulemaking with potential for mitigation are similar, but have

some distinctions that are important to clarify.

Conditional support for rulemaking implies that the first three assessments, we checked those boxes and that it's looking good in that respect. Where a measure can potentially need some refinement but receives the support of our workgroup to move forward pending the adjustments that the -- will be contained in the rationale for this decision category, then the distinction is that the CMS may address the MAP-specified conditions without needing it to come back for evaluation by this workgroup or MAP in general.

With do not support for rulemaking with potential for mitigation, this generally occurs when there's actually a structural element of the measure that needs to be addressed adequately before having the full endorsement of this workgroup to move forward for implementation in the federal program under discussion. So this is typically when a measure fails to meet one of the first three criteria. And the expectation

would be that the decision category assumes that the other four criteria we're okay with and that should this measure be appropriate, it would be because of substantial change in how the measure itself is formulated.

The last decision category is fairly straightforward and it is simply that the workgroup does not support the measure for rulemaking. And again, this would typically occur because a measure substantially does not adequately address the first three evaluation criteria.

Next slide.

CO-CHAIR UPSHAW TRAVIS: Can I just make a comment on that?

MR. STOLPE: Please do.

CO-CHAIR UPSHAW TRAVIS: To me the rewording of this was very important because it clearly distinguishes between the two supports and the two do not supports. And not to rehash what we've done in the past, it was a little confusing in those two middle.

So from my perspective I find this a lot easier for me; I hope we'll see when we go through the process, to actually distinguish between conditional support and then do not support for -- with potential for mitigation. It's just a cleaner line. And I think that's where we've had some confusion or some angst in the past. So that's kind of how I'm going to be focusing on it and just thought I'd share that with you.

MR. STOLPE: All right. Let's move forward into our key voting principles. I just want to clarify that we are at quorum, so we're sitting in a good spot here. A quorum is defined as having at least 66 percent of the voting members of the committee present in person or by phone, which we have.

We also want to clarify the 66 versus 60 members. It's easy to conflate these two. So MAP has established for our consensus threshold greater than or equal to 60 percent. We actually had a brush with 60 percent yesterday and had to

reassess whether or not that was passing, but it was -- it is indeed. So if we actually do hit 60 percent, measure passes.

Now one of the things that makes MAP distinct from our CDP process is that every measure under consideration will receive a decision. We have sort of gray area categories inside of our CDP process. That's not true for MAP.

Okay. Just next slide here. We're looking at some more process-oriented elements. So staff will be providing an overview of this process at the start of each in-person meeting. Once we give an introductory presentation that gives the context of the program itself, we'll begin going through this discussion and then we'll have voting conducted.

So the discussion guide is organized into distinct categories based on programs for hospital and each measure under consideration will be subject to this preliminary staff analysis based on the decision algorithm that has

been approved by the MAP Coordinating Committee. So please know that inside of the preliminary analyses is offered the staff's recommendation based on the analysis conducted using the algorithm that was approved by the committee.

So for the voting procedure the first step is that the staff will walk through the preliminary analysis for each measure under consideration. Following that we'll move to the lead discussants who will review and present their findings. We have Brock here representing the Rural Workgroup who will provide a brief overview of the work -- Rural Health Workgroup's review of each of the measures. So this is a new step for this year. We did this in clinician last year, but this is the first time that hospital will have the benefit of Rural's perspective.

So, Brock, thank you once again for joining us.

Next step, the second step. The co-chairs will be asking for clarifying questions.

Now we're not going to answer these questions right away. We're going to compile them first. Once we have them all compiled, measure developers will respond to questions that clarify the measure itself. NQF staff are happy to clarify any questions on the workgroup decision and to talk through any parts of the PA or other questions you might have. And lead discussants will of course respond to questions related to their analyses.

Our third step is voting on acceptance of the preliminary analysis decision. So we don't actually vote on categories. Our first step is to vote whether or not to accept the preliminary analysis as it is written by staff. So this is simply framed as a yes/no vote. If we hit 60 percent or greater, then we keep the preliminary analysis assessment. If less than 60 percent of the workgroup votes to accept the preliminary analysis, then we open for discussion on the measure further.

So discussion and voting as step four

may or may not occur, but if it does, we do not accept the preliminary analysis, then the workgroup members should participate in the discussion to make your opinions known for why you dissented with the preliminary analysis.

Now, after this discussion the co-chair will open up the measure under consideration for a vote. Staff will summarize the major themes from that discussion. Co-chairs will determine what decision category to put first towards a vote based on where they think we're landing as a group.

If the co-chairs do not feel there's a consensus position to use as the initial spot for voting, we will go first with conditional -- or sorry, with support, then conditional support, then do not support with potential for mitigation, and then do not support.

Now, if a decision category put forward by the co-chairs receives greater than or equal to 60 percent of the vote, the motion will pass and the measure will receive that

designation.

Now, if no decision category achieves greater than 60 percent to overturn the preliminary analysis, the preliminary analysis will stand. This will be marked by staff and noted for the Coordinating Committee's consideration. Okay. So that's our voting instructions in a nutshell.

I want to pause here also to make sure we've answered any questions about voting procedure.

MR. AMIN: Sam, I might just emphasize to the group that the rationale that currently stands as a preliminary analysis, sort of qualitative feedback, all of the discussion from the group, the MAP rationale will be expanded, and that's what will go to the Coordinating Committee, and ultimately the summary of that qualitative input is what will be given to CMS, which is equally as important as voting.

MR. STOLPE: All right. Very good.

Well, if there are no further

questions about our process, we can go ahead and pause here.

Are we going straight for the break, or do we have Rural?

CO-CHAIR MORRISON: I think the Rural --

MR. STOLPE: Okay. Well, let's briefly review this. Since this is a new part of our process then for a hospital, we'd like just to remind everyone and update those of you may not be aware of our -- the existence of our MAP Rural Health Workgroup, of which we actually have more than one person in the room who's been around the table for those discussions. So thanks for everybody who's been able to join, and Brock specifically here to represent that perspective.

The charge of the MAP Rural Health Workgroup is to provide input on the measurements from the perspective of rural communities, both on the provider side and on the patient side, and to lend those perspectives to the discussion that

we have here on the other setting-specific MAP workgroups. This is specifically to help address priority rural health issues including challenges associated with low-case volume.

So each of the measures under consideration was reviewed by the Rural Health Workgroup. The relative priority is assigned. They do that through both qualitative and quantitative methodologies. So they vote on the prioritization of the measure itself. And the qualitative portion of that vote is captured and then an average presented as well as the actual tally for each of those.

You can go to the next slide. The other thing that's captured inside of this, and you'll see this inside of the PAs as well, is a succinct summary of the qualitative discussion that was held by the Rural Workgroup when they convened last week.

Okay. With that being said, let's go ahead and transition to a 15-minute break, and then we can reconvene in just a few moments to

begin our discussion around the PPS-exempt cancer hospital quality reporting measures.

Thanks very much.

(Whereupon, the above-entitled matter went off the record at 10:39 a.m. and resumed at 10:57 a.m.)

CO-CHAIR UPSHAW TRAVIS: Okay, I think we're going to get started. Okay, so let's all kind of focus. We're going to come back now. We're going to actually start our measure review. So, the fun part of the meeting starts now. So the first program we're going to look at is the PPS-Exempt Cancer Hospital Quality Reporting Program measures. And we have two measures that we're going to be looking at, and I'm going to turn it over to Madison, to give us an overview of the program itself.

MS. JUNG: Great. Before we get started, I think we have one more disclosure to do. Aisha, did you want to go ahead, at least, and do --

MEMBER PITTMAN: Hi. I'm Aisha Pittman. I'm the Vice President of Policy for the Premier Healthcare Alliance, and I have no disclosures.

MS. JUNG: Great. I think we're ready to get started then. So, for the work group members around the table, this should look familiar to you. This is some of the material we went over during or orientation and web meeting in the fall, but just as a refresher, before we dive in.

The program we're reviewing right now is the PPS-Exempt Cancer Hospital Quality Reporting Program. It's a quality reporting program, and it's a voluntary one for the 11 cancer hospitals that are exempt from the Inpatient Perspective Payment System and the Inpatient Quality Reporting Program.

Some of the goals are to encourage hospitals and clinicians to improve the quality of their care, share information and to learn from each other's experiences and best practices.

In the meeting materials, we have included the measure set for this program, as published in the most recent rule, and --

Next slide.

Different from what you saw during the web meeting is, we've included the updates that have

happened since you saw this program last year. So one measure was finalized versionable and one was adopted.

These were also the gaps that we noted during the web meeting as noted by CMS during, within the Needs and Priorities document. I won't review them in depth, but as a reminder, some of the gaps that we discussed during the orientation fall web meeting for this program were, work group members have suggested focusing on measures for patient-reported outcomes, specifically for functional status, patient quality of life, also measures related to access to care and survival. Survival meaning, one suggestion was, do you have a survivorship plan? So that was just some of, a refresher of what we did before, during the October web meeting.

CO-CHAIR UPSHAW TRAVIS: Okay, so now we're going to open it up for public comment on this program, for the measures under consideration. And I'll go first to the room, if there are any public comments in the room.

(No response.)

CO-CHAIR UPSHAW TRAVIS: Okay, I don't see

any. And I assume that the lines are open, if anybody has any public comments that are on the phone.

(No response.)

CO-CHAIR UPSHAW TRAVIS: Okay. I don't hear any. So we will continue then. We'll move on to our evaluation of this. What we're going to do first, kind of going back over our process that we learned about right before the break is that the staff is going to review the preliminary analysis, and then while that's happening, we discuss and skip many, because we're going to turn to you next.

So, staff want to review the preliminary analysis for the first measure, which is MUC2019-18, NHSN Catheter-Associated Urinary Tract Infection.

MS. JUNG: Okay. For this measure, MUC 2019, the National Healthcare Safety Network Catheter-Associated Urinary Tract Infection Outcome Measure, this measure was recommended by the staff for support for rulemaking. This is a NQF-endorsed measure, and it's currently in the PCHQR program right now, as well as several other CMS programs.

But of note, this measure was just, went

through endorsement in this last cycle, the spring 2019 CDP cycle, with the Patient Safety Committee. The developer noted that there was an inclusion of our updated risk adjustment model, but otherwise that measure is identical to the existing measure in PCHQR, as well as the other programs.

CO-CHAIR UPSHAW TRAVIS: Okay. So, just as a clarification and to be sure we're on the same page, the previous version of this measure is in this program already, and now we have an updated and revised submission specifications, that is, has been NQF endorsed.

Okay, so we'll go to our lead consultant -- our lead consultants. I'm sure you all feel like you're a consultant to this committee. Maybe that's why I said it that way. We'll go first to Akin, with the American Hospital Association.

Oh, and -- for the people in the room and on the phone, if you can tell us which organization you're with -- I just said who Akin's with, but that'll be helpful because they'll be able to understand the perspective that you're bringing to

your comments.

So, Akin.

MEMBER DEMEHIN: All right, thanks. So, I won't rehash too much of this, since the measure has been in the program for quite some time.

First of all, I do think that as a general principal, and measures that have been in programs for some time, and they undergo an update like this one, it is good practice for the MAP to have another crack at them, just to make sure that they're working as intended, and there haven't been any unintended consequences. So thank you to CMS for putting this back on the list for us to consider.

A couple of technical points about the measure, and then I'll outline where I think we stand on the preliminary recommendations. So, this is a measure that has been around for a while. It assesses facility-level performance on catheter-associated UTIs.

From what I can tell in reviewing the measure specifications, it is not hugely different than what currently exists in the program. It is

still a chart extracted measure. It still is effort for hospitals to collect and report the data, using the CDC's NHSN system.

In terms of the staff's recommendation, which is to support this rulemaking, I think that is the right recommendation for a number of reasons. CAUTIs remain the most common of healthcare-associated infections. Hospitals are certainly working hard to reduce the rate of catheter-associated UTIs, and have made significant performance gains, as the recent reports from the CDC have shown. There is no significant performance variation, and there is still a ways to go here.

A couple of considerations, as CMS implements this next version of the measure. One thing that was brought up during the endorsement review that I saw was how applicable this measure would be to spinal cord injury patients. If I'm reading the concern correctly, it was that for those particular patients, leaving an indwelling catheter in could have some quality of life benefits, just because their bladder function isn't going to be the same as

other patients, so.

And I know there was a healthy debate about whether there's any evidence to support excluding them from the measure or not. I guess I would say that continuing to monitor that issue and conducting further study would be a good idea, just to be sensitive to that issue.

The other issue is a little more specific to PPS-exempt cancer hospitals in applying this measure. Infection measures certainly are important for that kind of hospital. I guess the sensitivity here is how you compare the rates generated from PPS-exempt cancer hospitals to other kinds of facilities.

Patient population treated at these hospitals tends to be much more immunocompromised then at general acute care hospitals, so constructing the performance benchmarks and comparison groups with great care, I think, is a really important thing.

The last thing, and we don't necessarily have to discuss it in the context of this, but these are updated versions of the CAUTI and CLABSI measures, so I do wonder when we might talk about those in the

context of the IQR, whether there's a benefit to it. I mean, frankly, most of the comments I would have here would be equally applicable there, but maybe just kind of a process question on when we might talk about them, so.

CO-CHAIR UPSHAW TRAVIS: Great. Thank you.

Stan, from the American Society of Anesthesiologists, I think you're on the phone.

MEMBER STEAD: Yes. Thank you very much.

I do support moving forward with this measure. I think that the issues that were just mentioned about spinal cord injury are appropriate. I don't believe that they conclude that we should be adding exclusionary criteria.

I will point out that in a recent JAMA's article in July of this year pointed out that the difference in urinary tract infection rate between the cancer hospitals and those that are not was actually significant. And the rate in the PPS-exempt cancer hospitals was 6.4 percent versus 4.0 percent with an odd ratio of 1.58.

So it seems to me that this is an appropriate measure, the measure. And it is an area that there is a significant gap in care. And I think that it's reasonable for us to move forward on this, is that sepsis still remains one of the most different care between the PPS-exempt hospital and those that are not.

CO-CHAIR UPSHAW TRAVIS: Thank you, Stan. Denise, for the City of Hope.

MEMBER MORSE: Yes. Denise from the City of Hope. We're a cancer center in Southern California. We have a lot of the same comments as we've previously heard. It is a longstanding measure. It has been one of the first measures of the PCHQR program. We continue to support it.

It's a useful and feasible metric, high resource-burning, but the benefits outweigh the cost. And there was not a lot of substantive differences between the previously endorsed measure and this one.

As was mentioned, we do support benchmarking to like centers, the other PPS-exempt cancer centers, and we've also discussed if there

would be benefit in adding additional comments regarding a standardized utilization ratio measure as well, to look at differences between the hospitals and the utilization of catheters.

CO-CHAIR UPSHAW TRAVIS: Thank you. And then our last lead discussant is Aisha.

MEMBER PITTMAN: Hey. I have the benefit of going last because I can pretty much confirm everything that we've done. In our cumulative, the focus was monitoring over time for spinal cord injury, and then ensuring that different types of hospitals are benchmarked against like hospitals.

CO-CHAIR UPSHAW TRAVIS: Okay. Wonderful. Well it does seem that our lead discussants anyway are in support of the preliminary analysis for this measure. But we'd like to hear from you for input from the Rural Work Group.

MR. SLABACH: Well thank you, Cristie.

This is going to be brief on this measure, since the 11 cancer hospitals are located in urban areas. This is not a large concern to our rural providers. However, obviously a lot of our patients

in rural communities go to urban centers for cancer care, and these are big and important safety measures.

I think the Rural MAP was in consensus that this was important and would be good to consider for approval.

CO-CHAIR UPSHAW TRAVIS: Okay, wonderful. Well thank you. Thank you for that.

We're going to move into our time right now for clarifying questions. I'm -- and I'll kind of emphasize clarifying questions. And we will -- after we get the clarifying questions, we will go to those who are most appropriate to answer those questions. And then we will have time for discussion prior to our first vote.

So does anybody have any clarifying questions either for the measure developers, for the lead discussants, for NQF staff or others? And I'll start with Jack.

MEMBER JORDAN: Is there actually an existing SIR model for cancer hospitals that they would be using?

MEMBER POLLOCK: Yes. So, thank you,

Jack. There is -- I'm Dan Pollock. I was sitting over there before. I've moved over here to --

(Laughter.)

MEMBER POLLOCK: So, I lead the unit that's responsible for this, a healthcare safety network at CDC. We have a model, a predictive model for hospital CAUTIs that was developed in 2016 using 2015 incidence data. We've been collecting data from cancer hospitals and cancer patient care locations for years.

Our strategy has been to try to use the full component of the data that we have, and take a cancer hospital's status and cancer patient location into account in the predictive model, which we do.

And so, it's a single model that we can use, both for cancer hospitals and for non-cancer acute care hospitals. And so that's what we have. And what is described as an update to the measure is really a use of a model, a predictive model that we've had in use since 2016, extending it to the cancer, PPS-exempt cancer hospitals.

In lieu of reporting rates, now we will

report a ratio of the observed to predicted number of infections in those hospitals, CAUTIs as well as CLABSIs.

CO-CHAIR UPSHAW TRAVIS: Okay. Wait. That was somebody else. That was yours?

MEMBER STEAD: I asked a --

CO-CHAIR UPSHAW TRAVIS: Yes. And please state your name and organization for the people in the room.

MEMBER STEAD: Thank you. My name is Stan Stead. I'm with the American Society of Anesthesiologists.

In the new way of reporting this, are you going to report the PPS-exempt cancer centers with other NPI-designated cancer centers in addition, so that we'll actually have that second data point? Or are these simply going to be a ratio of the PPS-exempt cancer centers against all other hospitals that provide cancer care?

MEMBER POLLOCK: So, I think the short answer to your question is, our coverage, and what we report on half of hospitals to CMS includes both PPS-

exempt cancer hospitals as well as non-PPS-exempt cancer hospitals. So we provide facility-level data to CMS for various quality measure and reporting programs on the CMS side, facility by facility, at the CMS certification number, CCN level.

CO-CHAIR UPSHAW TRAVIS: So as a -- obviously we're not following the format, but I'll ask a follow-up question to that, actually.

So, in terms of how CMS is thinking about reporting this, is there any -- and we've all thought through how you will be reporting this information. Will it be compared only with other PPS-exempt, or will it be compared with all hospitals?

MS. EVANS: Well if I could take one, this is Ronique Evans again. So yeah, it'll be our compare to other PPS-exempt cancer hospitals, but of course, CMS is always open to a discussion about how we can improve reporting mechanisms, going forward, so -- but as of now, yes. It's --

CO-CHAIR UPSHAW TRAVIS: Just to the other PPS-exempt --

PARTICIPANT: Explicit to this program,

and it will be compared within this program.

CO-CHAIR UPSHAW TRAVIS: Okay, good. Okay.

Any other questions? Any other final comments from the developer or anybody? CDC? Okay.

All right, so I think that we can move on to our first vote, which is relative to whether or not we accept the preliminary analysis, which was support for rulemaking. And this will also be our way to test the voting system, to be sure that we all know how to vote correctly. And so I'm going to turn it over to staff to kind of walk us through what we're supposed to do.

MR. HIRSCH: All right. Voting for MUC 2019-18, the National Healthcare Safety Network Catheter-Associated Urinary Tract Infection Outcome Measure. Do you vote to support the preliminary analysis as the more correct nation, which is support for rulemaking? It's now open for voting.

PARTICIPANT: Oh, I see. I was looking over there.

(Laughter.)

MS. JUNG: I think we're looking for two more votes, so if everyone could just double check. Our colleagues on the phone, please let us know if you're having any issues with the platform. And if you are, please feel free to chat your vote to us via email or the web platform.

CO-CHAIR UPSHAW TRAVIS: And just to be sure, all we have to do is click.

MS. JUNG: Yes. That is correct. Yes.

CO-CHAIR UPSHAW TRAVIS: There's no Submit button?

MS. JUNG: Correct.

CO-CHAIR UPSHAW TRAVIS: Okay.

MR. HIRSCH: Anna?

MEMBER DOPP: Mine is spinning at the moment, so I'm good.

MR. HIRSCH: Ah.

MEMBER DOPP: I'm the one you're looking for. I was logged in, but it's --

MR. STOLPE: Do you wish to give your vote verbally? You may if you wish. Or you can chat your vote.

CO-CHAIR UPSHAW TRAVIS: Or you can whisper it to --

MR. STOLPE: Or you can whisper your vote.

(Laughter.)

MEMBER DOPP: If it's --

(Simultaneous speaking.)

(Laughter.)

MR. HIRSCH: Voting confirmed, MUC2019-18, the National Healthcare Safety Network Catheter-Associated Urinary Tract Infection Outcome Measure is now closed. The workgroup has voted 24 to yes, one no, in supporting, support for rulemaking based on the preliminary analysis. Our recommendation.

MR. STOLPE: Thank you.

CO-CHAIR UPSHAW TRAVIS: Okay. Thank you, for that.

So we will move on now to MUC2019-19, which is the National Healthcare Safety Network Central Line-Associated Bloodstream Infection Outcome Measure. And you will note that there are some similarities, although obviously a different measure, some similarities to the one that we just voted on.

So I will turn it over to Madison, to go over the preliminary analysis.

MS. JUNG: Thank you.

So this measure, similar to the previous measure, just recently went through NQF endorsement in the past spring 2019 cycle. It was recommended for endorsement by the Patient Safety Standing Committee. And again, similar to the previous measure, it is otherwise identical to the existing measure, but with the inclusion of an updated risk adjustment model.

The NQF Staff preliminary recommendation for this is support for rulemaking.

CO-CHAIR UPSHAW TRAVIS: Okay. So I will come back to Brock, for any comments related to this particular measure from the Rural Work Group.

MR. SLABACH: At the risk of being repetitive I'll just say ditto on the last --

(Laughter.)

MR. SLABACH: This is the same issue, but it, we would favor this adoption.

CO-CHAIR UPSHAW TRAVIS: Okay. Thank you, Brock.

MR. SLABACH: You're welcome.

CO-CHAIR UPSHAW TRAVIS: All right. We'll move to our lead discussants, and we have a different set of lead discussants this time, so we'll start with Maryellen from America's Essential Hospitals.

MEMBER GUINAN: I will keep this brief, mainly because I don't want to start coughing. And I'm pretty sure that's why Dan moved, or --

(Laughter.)

MEMBER GUINAN: But, so at the outset, I want to say this is the, as we said before, with CAUTI, CLABSI is a process measure in multiple programs, IQR, VBP, HAC. Definitely support its use for both the fact that CLABSI has significant risk of morbidity and mortality as well as just increased cost. So we would support the preliminary result from NQF in terms of support for rulemaking.

Another thing that I just wanted to, for my own edification but clarity of, kind of, from the developer side, I know we've seen -- as it was reported, there was a 10 percent decrease that was reported from 2015-16, and it looks like now we're

kind of going down in terms of our -- a 9 percent decrease.

So I don't know if that's indicative of, this is kind of becoming more of a gap area, or what the trending going down in terms of our success with this measure would be a result of, but something definitely to monitor.

And then my other kind of comment, question is, in terms of CDC exploring different ways to incorporate other factor into the measure itself, I know it was noted that the time that a line is actually in has a significant impact in terms of infections, and whether that will be included, kind of in future measure calculations, is something that I think was of interest to us.

So with that, I will turn it over to my other lead discussants.

CO-CHAIR UPSHAW TRAVIS: Well thank you very much, and we'll come back and get some answers to some of those questions in a moment.

Jack, from the Henry Ford Health System.

MEMBER JORDAN: Yes. The group of us kind

of huddled, and none of us had any really serious concerns. I do think, though, in the future, to really look at this to say, are there differences in the patients other than the type of flora would be a good thing for moving forward.

I don't think that should hold it back and wait here, but I do think for the CDC to start to look at, are there different types of cancers or types of treatments that give you wildly different expected rates is something that should be kind of considered to look at in the future. But I don't think it's a reason to not go forward now. I think we should start with this, but then think about that as a possible enhancement in the future for more understanding.

CO-CHAIR UPSHAW TRAVIS: Thank you, Jack. Karen, with Medtronic.

MEMBER SHEHADE: Karen Shehade with Medtronic, and again, we all are in agreement with this measure and appreciate the overview, the measure itself. I will just call out that it definitely aligns with patient safety. And it does look at the observed versus predicted, so it's not looking to get

to exact from zero but, you know, is somewhat, you know, focused on trying to move the needle.

As a longstanding PA, I will say that this is something that you can actually take action on, so it is something that has real steps that you can work towards as a clinician to see improvements, and was actually called out in here by the AHRQ Toolkit so, you know, in response to anyone who might think that there's not anything you can do to move the needle, there are, you know, very real things that we can do, real steps. So I think that's what makes it very valuable.

CO-CHAIR UPSHAW TRAVIS: Thank you.

So, now we will -- oh, I'm sorry, Andrea. That's why you have a co-chair.

(Laughter.)

CO-CHAIR UPSHAW TRAVIS: Andrea, thank you.

MEMBER BALAN-COHEN: So as a subject matter expert, so I just wanted to say, again like we discussed, it's like preliminarily, definitely like no because there is an accepted way, like more like from

a technical standpoint. But I did appreciate, like the move to the center using like the centralizing conduction ratio, like moving further away, and looking like the predicted one, as well as the updating of the model, like using the latest possible data.

2015 is still like 2015, so to the extent like possible, like continue to move forward within the direction of getting even more recent data, like more up-to-date, like update to be valuable.

I also wanted to highlight, I also really appreciate the use of the ARM, so the adjusted ranking metric. In this particular case, like exposure really matters. So this is essentially a way to adjust for reliability, like due to exposure. So the use of this like for this particular metric was, works very good.

And other than that, like definitely in favor of support for the measure.

CO-CHAIR UPSHAW TRAVIS: Okay now -- thank you, Andrea.

Now we will get any input from Brock. Or did we already do that?

MR. SLABACH: We already did that.

CO-CHAIR UPSHAW TRAVIS: I knew that.

(Laughter.)

CO-CHAIR UPSHAW TRAVIS: Not really, because I was supposed to wait until after that.

MR. SLABACH: That's okay.

CO-CHAIR UPSHAW TRAVIS: Okay. So do we have any clarifying questions? I know that we had one that we'll get to in a moment, relative to the decreases kind of slowing down, that we've seen in this measure. Are there any other clarifying questions, or any issues you'd like to have covered by the developer, or the lead discussants or NQF?

(No response.)

CO-CHAIR UPSHAW TRAVIS: Okay. I didn't know if anybody wanted to comment on that.

MEMBER POLLOCK: Sure, sure. So, we are making progress with CLABSIs, but there's still thousands and thousands of CLABSIs every year in American hospitals. And so we have to continue our efforts, and we think that a measurement of CLABSIs is a very important impetus for prevention. So we want

to double down, and certainly extending the use of the observed to predicted ratio, replacing rates in the cancer program, I think is a step forward.

The opportunities to prevent, as they're used, will decrease the frequency of CLABSI events, and we are exploring now the use of another metric, the time between events metric. So much as you might see at an industrial site, the time since the last accident, that type of strategy and quantitative approach is one that we think has the potential value as CLABSIs continue to decrease.

We also are proponents of taking the volume of exposure into account, through a metric called the adjusted ranking metric. We think that volume of exposure should be taken into account when facilities are ranked. And it's part of our NQF measure that was re-endorsed this year.

In terms of capturing patient-level data for risk adjustment purposes, we would love to. We would love to be able to gather additional data for risk adjustment purposes, for purposes of having a more complete understanding of the events themselves.

There's always a tradeoff, but risk adjustment data that are captured, the risk factors data, are captured for the entirety of the denominator.

And so, in the programs that are using, the CMS programs that are using this measure, it's the intensive care units and medical and surgical wards. It's a lot of patients that are exposed, potentially, to having central lines. So when we talk about capturing risk factor data, such as comorbidities in those patients, we have to look at what the burden is, and what the availability is, electronically, of these types of data.

We would love to be able to have those data collected and submitted to us, but we also recognize that in the present state of electronic healthcare record-keeping, it would be a major, major challenge to people.

CO-CHAIR UPSHAW TRAVIS: Okay, thank you. Thank you, Dan.

Lisa?

MEMBER McGIFFERT: I just want to go back to your first, your first response, and make clear,

you don't think you've reached a plateau in the decrease? There's still so many --

MEMBER POLLOCK: Oh, right.

MEMBER McGIFFERT: -- happening that this is kind of a blip that it, the decrease went down.

MEMBER POLLOCK: Yes.

MEMBER McGIFFERT: Right, so there's --

MEMBER POLLOCK: It was -- well there's about 25,000 CLABSIs a year.

MEMBER McGIFFERT: Yes. Well that would be more than thousands and thousands, I think. Yes.

MEMBER POLLOCK: Well, however you want to separate it.

MEMBER McGIFFERT: Yes, that's --

MEMBER POLLOCK: Tens of thousands, you could say.

MEMBER McGIFFERT: Well, you probably couldn't say that, technically.

And then the other thing was, this has always been a problem with how an agency like CDC, that focuses on infection -- I think somebody brought in the integration. CMS might have that information

on claims forms about comorbidities and all that stuff. And is anyone looking at trying to merge those?

And I guess the electronic medical record is hoping to get there. I thought I'd see it in my lifetime, 30 years ago, but I don't think it's going to happen. And so it just seems like, we are collecting this data. We're collecting it over here, and over here, and how do we get them together, so we can have more analysis of who's affected, and what kind of people are affected, and how do spinal cord injury patients, or how are they affected, and all of that. It just seems like we should be there by now.

MS. EVANS: I just want to point out, CMS and CDC work together. Yes, very closely, on a lot of other initiatives and measures. So I think that's something that we can definitely continue to explore and discuss, and try to figure out whether or not there is some identical and logistical mechanisms that we could bring all the information.

MEMBER McGIFFERT: It seems like it would be really a great study to have a hospital to offer

their data integrated with the infection data, just to see if there's any possibility to look at the data as measured to which are -- so that we can have better information.

MEMBER POLLOCK: So yes, those studies are done and reported. And we have also looked at the case mix index that CMS provides, which is DRG-based. And without, you know, getting into an extensive methodologic conversation regarding some variations in coding practices that might be influencing all of that, it is a concern. I will just say the bottom line, it is a concern.

Our preference would be to get to the actual clinical record of care, and to interrogate the clinical record of care, perhaps using the finer standard as a resource to enable the acquisition of those types of data.

But, you know, like you, Lisa, I'm surprised we're not there. And again, without getting into an extensive philosophical policy conversation regarding where our $35 billion investment in electronic health record systems got us, I thought, as

did many, that the promise that was held out, for patient safety and quality measurement would have been realized, to a much greater extent than it has.

I think a fundamental there -- I'll just editorialize for one second, we lost sight of meaningful usability, meaningful usability for the front line practitioners. And now we're playing catchup with that. And we have opportunities to accelerate that catchup. And we want to have quality measurement, patient safety and public health at the table, as we're playing catchup. But it is a matter of catchup, and I don't think we're going to have 35 billion to spend again on that anytime soon.

I also am very concerned, as was expressed this morning, about the proprietary nature of electronic health record systems, and the extent to which information is blocked, and gets in the way of interoperability, notwithstanding the goals that we have. I think there's a lot of work to be done.

MEMBER McGIFFERT: Thank you, Dan.

MEMBER POLLOCK: Okay.

MEMBER DUSEJA: I just want to add that

CMS also is, you know, through our interoperability polls this year, are trying to get at some of these issues, including intra-email, that information blocking, so whatever levers we have, we are trying to push that as well.

CO-CHAIR UPSHAW TRAVIS: Thank you both.

Akin.

MEMBER DEMEHIN: I guess this is more of a clarifying question for Dan.

In terms of public reporting, can you remind me of the way in which the ARM figures in to the SIR or does not figure into the SIR? I conflate the two easily.

MEMBER POLLOCK: Sure. So, the SIR is our abbreviation for the standardized infection ratio. It's a subway measure that we use when we report facilities-level data to CMS. And so it's a ratio. It is a ratio of the number of observed infections to the number of predicted infections.

As was said earlier, it is not a ratio that takes differences in volume of exposure into account. So a hospital that has use of central lines

at a fraction of another hospital's use of central lines, and yet has the same ratio of observed to predicted infections is essentially identical with respect to the summary measure.

For a variety of reasons, not the least of which is equity, we think that the volume of exposure, the risk that a facility is taking on should be taken into account. And the ARM is a reliability-adjusted version of the SII, okay. We at one point called it that. And it was a little bit unwieldy, and we found some people were confused by it.

The SIR still has value in tracking institutional progress. But the ARM is preferred. It's an approach that has gained a great deal of traction in quality measurement circles, applying our old Bayesian methods to the prediction of the number of infections, that's an approach that we are encouraging use of. And our intent is to build the arm into the NHSN application, so that managers and users will have the opportunity to look at their adjusted ranking metric summary statistic as well as their SIR.

MEMBER DEMEHIN: That's helpful. Thank you.

MEMBER POLLOCK: Okay.

CO-CHAIR UPSHAW TRAVIS: Thank you.

I thought I saw another card, but it must have gone down. Any other questions before we move on to voting?

Yes, Maryellen.

MEMBER GUINAN: Can I ask the, any discussant, where we are on the testing stage of any electronic recording for decrease of burden?

MEMBER POLLOCK: Yes.

MEMBER GUINAN: It's pretty significant right now.

MEMBER POLLOCK: Right. So CLABSI, just about CLABSI, we have a very active help line, help email exchanges. And I would say over 50 percent of the user requests and questions we get relate to CLABSI, because CLABSI is essentially a rule-out. You've got a bloodstream infection, is it coming from a pneumonia, the urinary tract, the GI tract, some other localized source?

And you have to rule those out. And what you're left with, if there's no other source, secondary source, is a central line. And so we have to have definitions for each of those infections. And those definitions have to be applied consistently. And again it goes back to my earlier comment about the status of where we are with electronic healthcare record-keeping, and what's available, in a way that would allow the electronic capture of information about these other types of infections.

We're not there. What we are exploring, and moving toward, is hospital-onset bacteremia that would lend itself to electronic capture, because it would be using the results of our blood culture testing, and would not need to take into account the clinical definitions that we make available for these other sources of infection.

It raises other issues. It's a broader scope than CLABSI. But it raises issues of preventability. And we are doing studies right now, looking at the preventability of hospital-onset bacteremia. They're both -- again, if I could take

one more minute, go back to our conversations of this morning, the patients entering hospitals want to know, well what's my risk of X, Y or Z.

And CLABSI may not be in their mental horizon. Bloodstream infection may be an easier grasp. And so, patients rightly expect, if I go to the hospital, I'm not going to get a bloodstream infection as a result of that hospital care. So that we think there's merit, from a patient perspective, in moving towards hospital-onset bacteremia, but there are a number of challenges associated with it. Electronic healthcare data are not a panacea, but they can be helpful.

MEMBER GUINAN: Thank you.

CO-CHAIR UPSHAW TRAVIS: I think we know where you stand.

MEMBER POLLOCK: Okay, then.

CO-CHAIR UPSHAW TRAVIS: On, which is good.

Okay. It looks like we're ready to move to the vote. And the first vote that we're going to take on this is whether or not you agree with the

preliminary analysis, which was to support for rulemaking.

PARITICIPANT: Do we need to refresh, or --

(Off microphone discussion.)

MR. HIRSCH: For MUC2019-19, National Healthcare Safety Network Central Line-Associated Bloodstream Infection Outcome Measure, do you vote to support the preliminary analysis as work group recommendation? Again, the PA analysis was support for rulemaking. Voting is now open.

Okay. That's the last few. Voting is now closed for MUC2019-19, National Healthcare Safety Network Central Line-Associated Bloodstream Infection Outcome Measure. The work group is recommending support for rulemaking, with 25 votes for yes, 0 votes for no.

CO-CHAIR UPSHAW TRAVIS: The one last item that we have under this particular program is if there are any gaps that anyone would like to suggest. Am I doing this right? Okay.

PARTICIPANT: You're good.

CO-CHAIR UPSHAW TRAVIS: Everybody was talking. We need to be sure.

So does anybody have any suggestions regarding gaps? And I assume this is for the entire program, right, Madison?

MS. JUNG: Yes. This is building off of the --

CO-CHAIR UPSHAW TRAVIS: Discussion.

MS. JUNG: -- that we had in the web group.

CO-CHAIR UPSHAW TRAVIS: Right. Okay. Do you have something?

MEMBER NOLAN: Sarah. Do you mean gaps, or --

CO-CHAIR UPSHAW TRAVIS: Proposals to fill those gaps. Well it would be gaps, and if you have a proposal to fill it, that would be even better. So do you have something you'd like to add?

MEMBER NOLAN: I don't have a proposal, but I would say as more speaking from a personal than the FEIU perspective, I would say that the handoff to hospice is a huge gap. I don't know how to fill that

gap, but it's presumably a process measure.

CO-CHAIR UPSHAW TRAVIS: Thank you, Sarah.

Lisa?

MEMBER McGIFFERT: Yes, I would say handoffs, across the board, is an issue. A lot of the issues I had in my gap notes were covered in our prior conversation with CMS, certainly maternal care, most common reason people go into the hospital. We have nothing.

We really don't have much on medical errors. And we need more surgical infection information.

CO-CHAIR UPSHAW TRAVIS: We are concentrating on the cancer hospital --

MEMBER McGIFFERT: Oh, I'm sorry. Cancer hospital.

CO-CHAIR UPSHAW TRAVIS: -- program right now. Sorry.

MEMBER McGIFFERT: Okay. Sorry.

CO-CHAIR UPSHAW TRAVIS: Just related to this cancer hospital program.

Yes, Denise.

MEMBER MORSE: Yes, hi. So somebody had mentioned earlier about the survival of patient-reported outcomes function status. When you -- when -- some sort of measurement regarding standardization versus personalized medicine, with some of the new therapies that have come out, as well as appropriate genetic testing.

CO-CHAIR UPSHAW TRAVIS: Thank you.

Jack.

MEMBER JORDAN: There are about 300 cancer measures out there. I remember from having a to-do list, but I ran out those. And, you know, a lot of them get captured in, you know, kind of the tumor registries, so that they go off. Maybe the most efficient way with the least burden would really be to have CMS link to kind of the standard registries that are out there in the cancer world to, you know, let patients give to, versus building something separate, you know, here, as kind of a -- I think there are lots of gaps, but they're actually filled by existing things. And maybe partnering with them versus creating something separate from CMS might be a

strategy to pick from.

CO-CHAIR UPSHAW TRAVIS: Thank you, Jack.

Other thoughts? Okay.

Madison, do I have anything else I'm supposed to do in this section?

MR. STOLPE: No, you don't. There is one point of clarification from the staff that because -- this is not to draw too much attention to the representative from the Pharmacy Quality Alliance, but we misinterpreted your vote. It was actually supposed to be yes. So, as a matter of public record, that was a clean sweep of 25 and 0.

CO-CHAIR UPSHAW TRAVIS: Well, thank you. Thank you for that.

(Off microphone discussion.)

CO-CHAIR UPSHAW TRAVIS: Okay. What are we doing about --

MS. JUNG: I think we're going to go through, do one more.

CO-CHAIR UPSHAW TRAVIS: Okay. That sounds good.

CO-CHAIR MORRISON: So, Cristie's

experience has got us 30 minutes ahead of schedule, which is why she can't leave. So, unless there is strong dissent, I think we can probably get through the next program before pausing for lunch, before going, yes? I'm seeing nods. Okay.

So, we are going to move the Inpatient Psychiatric Facility Quality Reporting Program Measure. CMS needs somebody who can create acronyms better than this.

(Laughter.)

CO-CHAIR MORRISON: And I think, Sam, you're providing the overview, correct?

MR. STOLPE: Yes. Thanks very much. For this program, this is a pay for reporting and public recording program type. The incentive structure is such that inpatient psychiatric facilities that do not submit data are penalized, with a 2 percent reduction in their annual payment update.

The program goals, as they're stated is to provide consumers with a quality of care information to make more informed decisions about healthcare options, and also to encourage hospitals and

clinicians to improve the quality of inpatient psychiatric care, by ensuring the providers are aware of and reporting on best practices.

Our next slide shows a list of the program measures, which are there for your reference.

Go ahead and move forward, please. And we can go and -- the next slide as well.

I wanted to -- this will bring us to our high-priority meaningful measurement areas for IPFQR, the first being to strengthen person and family engagement, as partners in their care, and the second being to make care safer by reducing harm caused in the delivery of care.

Now, during our orientation call, we discussed this measure set, and identified some measure gaps, which I'll just highlight for you briefly here, as soon as I can pull up my notes. My apologies. Yes.

So then the work group suggested that CMS identify the patient populations within units for inpatient psychiatric facilities, especially as to whether units are geriatric units, or general

population. And we'll continue that discussion on measure gaps once we get through the next measure.

Let's go ahead and move forward.

CO-CHAIR MORRISON: Okay, so public comments, from the back of the room? From the phones?

(No response.)

CO-CHAIR MORRISON: Hearing none, we'll move forward to the MUC, which is MUC2019-22, Follow-Up After Psychiatric Hospitalization. We're good.

MR. STOLPE: All right. So, just a couple of highlights from this measure. This is a process measure that assesses the percentage of inpatient discharges with principal diagnoses of select mental illness or substance use disorders, for which the patient received a follow-up visit for treatment of mental illness or SUD.

This does align with meaningful measurement area of prevention treatment and management of mental health as well as the promoting effective communication and care coordination.

We wanted to note that this measure has been reviewed by NQF under a different -- under the

measure 0576, and it is in, it is currently in IPF -- excuse me, IPFQR. But it's undergone some substantial changes.

When it was last reviewed by NQF's Standing Committee, they noted that substance use disorder is a very important follow-up condition to be included as well. That was included. And the conditional support for rulemaking is based on an evaluation of that measure with the expanded conditions by the appropriate NQF committee. That's the staff analysis.

CO-CHAIR MORRISON: So let's take our discussants. I've got Linda first, from American Case Management Association.

MEMBER VAN ALLEN: Yes. We were looking at several of the recommendations. The American Case Management Association is absolutely in support of the need for follow-up care for the expanded population, not only the inpatient psychiatric discharges, but including these SUD patients.

There are some concerns, however, on behalf of the Association. And it really has to do

with the process measure itself, not the inclusion of the SUD. It's, the concern is more about measuring the patient actually, the numerator being the patient actually participating in follow-up care, and getting a follow-up visit versus a follow-up visit being arranged.

And that's the main concern that the Association has. And related to that are two other concerns that somewhat relate to that. One is, is still a challenge related to even arranging an appointment, and that is access to follow-up care. And that has to do both with timeliness, so within those 7 and 30-day time frames as well as the actual provider access and the availability of the provider.

And the second concern is risk, potential for risk for hospital providers, and specifically case managers in their profession to potentially incur some violation of referral source arrangements, that are prohibited under Stark Laws, with regard to addressing -- trying to do the right thing and address some of the barriers to these follow-up appointments, which is maybe transportation or some kind of incentive for the

patient to actually complete their follow-up care.

And that has to do, you know, with the challenges, frankly, of the patient population. So those are the concerns that the American Case Management Association would bring forward, and for that reason, at this time not endorse the measure.

CO-CHAIR MORRISON: Frank, National Association of Behavioral Healthcare.

MEMBER GHINASSI: Thank you very much.

I agree with my colleague. I just want to add a few things to that. The Slide 48 indicates that the program goal on this, these measures are to provide consumers with quality of care information to make more informed decisions about healthcare options, and to encourage hospitals to improve quality. The dilemma with this measure is, and I completely agree with the intent of the measure, the dilemma is the specificity of what's being judged and measured.

So it appears that it's attempting to measure the quality of care in a hospital. I would submit for the group's consideration that it's actually better measuring a variety of variables that

are contaminating this, which includes regional access realities.

It includes a myriad of social determinants that impact patients, including unstable housing, transportation issues, which is already raised, childcare issues, and the unfortunate realities of what can be a chaotic lifestyle.

For many people in this room, an appointment at 2 p.m. next Thursday is a very easy thing to do. For many of the people that we work with, that's an impossible thing to do. They have no idea where they're going to be or what's going to be happening at 2 p.m. next Thursday.

I would also submit that the measure and processes aggressively fail to measure if a hospital's actually doing the behaviors, with the best position the person to do it, since it's solely focused on the outcome, not what actually happened in order to affect the outcome.

And if you're really looking at quality, I think this measure could only then look at what were the actual steps taken by a hospital, because what

could happen is, you could do every single right step and fail the measure.

And then the third thing I just want to focus on is, there is an unintended consequence of this, and I see this happening in communities. I've worked in three states over the last 35 years. When you throw a rule out like this to say, 7 or 30 days, organizations should want to please CMS, even in the ambulatory world. They will focus enormously on the 7 and 30-day, but the second appointment or the third can be weeks and weeks later.

And so what you do is you create a 7-day appointment, but then the follow-up from the 7-day might be a month and a half away. And so I found the measure well-intended, but flawed, and I can't recommend moving forward, not if it's going to be put forward as a measure of quality of the hospital entity. Thank you.

CO-CHAIR MORRISON: Thanks, Frank.

Nikolas, Press Ganey.

MEMBER MATTHES: I just had sort of a high-level comment, because I can't comment to the

measure, you know, specific measure, details and communication challenges, which I suppose would have been partially discussed as part of the process already.

And I reviewed, you know, those issues when the measure was endorsed in 2017, and looked at those.

(Simultaneous speaking.)

MR. STOLPE: Just a point of clarification on that.

MEMBER MATTHES: Yes.

MR. STOLPE: And forgive me for interrupting you. So the measure is not endorsed. It's based on a measure --

(Simultaneous speaking.)

MEMBER MATTHES: No, not yet. It was the 17, the old 2017 measure.

MR. STOLPE: Correct. Okay. So --

MEMBER MATTHES: Yes. That's what I referring to.

MR. STOLPE: Right.

MEMBER MATTHES: So --

MR. STOLPE: I do want to make sure that this is clarified, if I did misarticulate it. The measure, as it's being discussed, has not been endorsed, but is based on an endorsed measure.

MEMBER MATTHES: That's right. So I wasn't going to that measure from 2017, that probably at best some of the issues that were just brought up in the discussion. So I don't want to talk, don't want to comment on that.

I just think that what was put forward in terms of expanding on an existing measure, in terms of the criteria outlaid and how they were discussed in terms of, you know, critical objective, how do we want addressed, you know, the meaningful outcomes, the addressing quality challenges, you know, measurement, effort. It's a pains based measure. And whether it's feasible, and whether it's over specified, I agree with those evaluations that have been put forward, if only narrowly, all those questions.

One general question I have is, is an expansion from mental into something in this order? And so you're expanding it with one measure. And if

you think about publicly quartering, I would be interested from the measure developers whether there had been, like a decision point, whether it could have been two measures, that look at the separately substance disorder versus, you know, mental illnesses and what the rationale was of combining to make it one.

MR. STOLPE: I'm going to hold that, Nikolas --

CO-CHAIR MORRISON: Yes.

MR. STOLPE: -- that question period. And then, who do I have last, sorry? Sarah, so Service Employees International Union.

MEMBER NOLAN: So I -- we support the -- so I believe the proposal in here is conditional.

MR. STOLPE: It is.

MEMBER NOLAN: Good, good, yes. So, I support conditional endorsement. I recognize some of the issues that have been raised, it being of very, having by prove the Health Services Advisory Group got methodologies imported from this measure. There's a clear blank to the admissions. There's variation

among facilities, which speaks to need, to the need for a measure.

And I think, to echo something Mia, you brought up in our earlier discussion, this is a measure that seems to me to reflect a potential cost to families and social networks of the measure not existing.

I would echo what Linda said about some of the concerns, particularly the actual follow-up, not just arrangements for follow-up.

I would say, in terms of the issue of failure, that CMS was very clear that they did not expect this to approach a hundred percent, and that the -- I won't quote from the report, the studies indicate that IPF can influence rates of follow-up care for patients hospitalized for mental illness or SUD.

I agree, it's a particularly challenging demographic. It happens to be, maybe say for the mental illness, a demographic, low-income, particularly that we organize all the time and we find people, and track them down. So I would suggest that

that is part of the job of facilities to do.

And I would say, frankly, that in a industry that is dominated or at least half for-profit facilities, including one for-profit health system that has had lots of problems, that these measures are particularly important to ensure quality of care.

CO-CHAIR MORRISON: So we are now going to Brock.

MR. SLABACH: Well thank you. I'll start with just a higher-level discussion, and have a couple of questions that the group were inquiring about in this measure.

The first is, obviously, it's an important area for rural patients and providers being, giving referrals into psych hospitals. The first question would be, does this apply to only psych hospitals or all psych beds? In other words, is it just for inpatient psychiatric facilities, or would it apply to psychiatric beds and SUD beds outside of that?

MEMBER MATTHES: Just facilities.

MR. SLABACH: Just the facilities. Okay. So, I thought so, but I just wanted to clarify because

that was an important point that was made. Given that, they thought that it would be appropriate that there was more enthusiasm for this measure than what the spread of the votes in the analysis shows.

There was distribution among all of the numbers of a hospital between one to five, and so it was difficult to discern a direct correlation here to the enthusiasm, but it was, because the, holding accountable, the providers of these services, for aftercare is, seemed to be of high value.

The unintended consequence that I think would really possibly come from this is, would there be selection, or adverse selection of patients from rural areas to be admitted to these programs if they're going to have exceedingly high problems of getting them referred for aftercare once they are returned back to the community.

And that goes to the fact that there's a tremendous loss, or low numbers of professionals, mental health workers and behavioral health workers in rural areas. So, we would hate to see an adverse selection from rural communities because of their not

being able to get the after care that this measure would require.

The other question would be, is if telehealth follow-up would be counted as a yes for meeting this measure. I think it would be more acceptance to it if telehealth services were being able to be counted as part of the follow-up care provided in this context. So is that -- does anybody know?

CO-CHAIR MORRISON: Brock, hang on, and I'll put that in when --

MR. SLABACH: Okay. I'll try -- I'm sorry.

CO-CHAIR MORRISON: -- for the -- no, no, just because there's discussion there, so I think the answer is, we will find out.

MR. SLABACH: Okay, thank you. Well, I just didn't want to move on -- I mean, I'm really about finished, but I think that given the advantages of this, and recognizing some of the unintended consequences that could perhaps happen with adverse selection, there was enthusiasm for this, because

after care is important. And it is necessary as part of the treatment of this problem.

CO-CHAIR MORRISON: So we're going to open up for clarifying questions before discussion now. So this is clarifying questions. And I've got Brock's question about whether telehealth is included for follow-up care, and I've got Nikolas' question about, the rationale behind including substance use disorder within behavioral health rather than splitting it.

I've got those two. You guys want to tackle those first up, and then I'll get to you, Marty?

(Simultaneous speaking.)

MEMBER DUSEJA: I just want a little bit of clarification, Brock, because we went back and looked at your question with regard to -- there are standing facilities within the program, but they're also within IPPS hospitals, the units itself, that are also, it's applicable to.

MR. SLABACH: So that --

(Simultaneous speaking.)

MEMBER DUSEJA: Yes, it is.

MEMBER MATTHES: Even for the future hospitals?

MEMBER DUSEJA: That's right. Yes. So I apologize for that.

CO-CHAIR MORRISON: And the follow-up question? Is telehealth included in after care?

MEMBER DUSEJA: It's not, but it's a very good question, and I think, you know, if we can expand that, I think that's a direction that I think would be good.

MR. SLABACH: It would change the game.

MEMBER DUSEJA: Yes.

CO-CHAIR MORRISON: And the question around the decision-making behind just putting opioid use disorder, substance use disorder into this measure rather than separating it out? Is there anything --

MEMBER DUSEJA: Do you want to speak to that? The decision from the top decision plan?

MS. MEYYUR: So, basically we did not consider reporting it separately but, I mean, we could -- so there, the intent of the measure was the earlier measure, just have the mental health diagnoses in the

cohort, and we wanted to expand that to include the substance use disorder.

So, we are looking at it as one population as of now. And so the group had combined both, because a lot of it is coexisting as well, in the setting. And so the, we have not actually made a decision to report it separately.

Well we could, but we would have to do some additional testing to see if it could actually hold good to record separately, in terms of sample size and reporting the measure itself, and if it would be reliable, if it's reported separately, so.

CO-CHAIR MORRISON: Amy, then Marty.

MEMBER HELWIG: I just had a telehealth. From the health clinic perspective, this is a hospital measure, but we do have a hospitalization measure as well as after full release, or dependence, that would lay it out at NQMPs.

And there's a trend. There has been a significant expansion in the code sets, that for virtual, televisits, et cetera, and the adoption is extraordinarily critical for states like Pennsylvania,

which is very rural, and we have lots of access problems with mental health, especially follow-up, we know it's going to be important.

So if that is not in this measure, the acceptance of those code sets, I think that's a significant error for when you look at the rapid adoption of what we're doing in virtual health.

CO-CHAIR MORRISON: Amy, is there a question in there?

MEMBER HELWIG: No, it's just a --

CO-CHAIR MORRISON: Okay. So this is questions only, folks.

(Laughter.)

CO-CHAIR MORRISON: I just want to -- I know, I just want to really highlight that, okay? I just wanted to make sure I hadn't missed it.

Marty?

MEMBER HATLIE: Sean, it's hard for us to hear, down at this end of the room, some of the comments, so this is purely a clarifying question.

I don't even know what the condition is that's being recommended here. So is it just that it

go through the endorsement process of NQF? Okay.

CO-CHAIR MORRISON: Yes. The condition is through the endorsement process with NQF with the addition of the new substance use disorder.

MEMBER HATLIE: Okay. Addition. And I do have a question. How long, estimate, does that process take? Because there seems to be a high-risk population here that's --

MR. STOLPE: It's entirely dependent upon the preparation of the measure developer. Once they have their measure submission completed, it takes about six months to go through the full process.

MEMBER HATLIE: Okay. Okay. Those are my questions.

CO-CHAIR MORRISON: Akin.

MEMBER SCHREIBER: Can I clarify one --

CO-CHAIR MORRISON: Yes, you may. I'm sorry. Go ahead, Michelle.

MEMBER SCHREIBER: Even while a measure may be conditionally approved, waiting until NQF endorsement, that does not generally stop CMS from using it in a program. Okay. Because we recognize

that there's a time gap before it gets NQF endorsement. And so if there is support from the Committee, and based on CMS's thoughts about where this lies, we will use a measure pending NQF endorsement.

CO-CHAIR MORRISON: Thank you.

MEMBER SCHREIBER: We'll propose it for rulemaking, and that'll be fine.

MEMBER DEMEHIN: Sean, are we still on clarifying questions, or are we on --

CO-CHAIR MORRISON: We are on clarifying questions.

MEMBER DEMEHIN: Okay. I'll hold my --

CO-CHAIR MORRISON: Okay. Do you have some clarifying questions?

MR. SLABACH: Yes. How many facilities are being judged?

MEMBER DUSEJA: How many facilities? It's a hundred per scan that --

MS. MEYYUR: It's total of 1,600, and about 1,400 is in the kid care at the hospital, so behavioral health units and about 400 freestanding.

CO-CHAIR MORRISON: State your name.

MS. MEYYUR: Oh, my name?

MEMBER DUSEJA: Yes.

MS. MEYYUR: Oh, it's Vinitha Meyyur, from CMS.

MEMBER DUSEJA: This is a very simple question. Could people speak up, because we're right under a blower.

CO-CHAIR MORRISON: So, a very simple answer is yes.

(Off microphone discussion.)

CO-CHAIR MORRISON: So, any last questions? So now we're going to turn it over to --

MEMBER WHEELER: It's Debbie --

CO-CHAIR MORRISON: I'm sorry.

MEMBER WHEELER: It's Debbie Wheeler from Molina. Can you hear me on the phone?

CO-CHAIR MORRISON: Yes. Go ahead, Debbie.

MEMBER WHEELER: Great. I'm going to ask a clarifying question that you can't, or the Pennsylvania Health didn't ask, is, did the measure

developer look at all of the other similar measures, including those being reported by health plans? Because there's a lot of work in this area.

And if so, is it consistent then, with the measure specifications of those other programs, to make sure CMS has a consistent approach?

MS. MEYYUR: What I can say is yes, we have tried to harmonize the measure with the NCQA, that version of the measure. And the NCQA is of the -- that we have added the SUD to the cohort. And we will be submitting documentation in that regard when we submit the measure to NQF in January for review. Yes. So we have harmonized with NCQA.

MEMBER WHEELER: Well, and can I add one last comment on that? The telehealth issue, though, has not been harmonized, it doesn't look like. So, if you can look at that again, or somewhere in this process, I think that's a bigger issue for us, to make sure everything looks the same as possible.

MS. MEYYUR: Sure, thanks.

CO-CHAIR MORRISON: Okay. We are now going to move into the discussion point, which I know

everybody is anxious about. So just, before we do that, let me just summarize what I've heard, and I'd ask people if they have new comments, to bring them up, but otherwise I think staff and CMS have been very carefully paying attention.

So what I've heard is concerns about the numerator and the population. And I think this comes down to many debates that have been heard in this room, which is, how much do you hold facilities responsible for social determinants of health and basic population. I think I would just summarize that as a big issue, and I think we have heard that before.

The second is the potential risk for hospital providers, particularly around Stark regulations and self-referral. I've heard questions of particular concern around focusing on the first appointment, rather than the subsequent follow-up, and real efforts to meet that particular requirement at the expense of subsequent follow-ups.

I've heard from Brock around simply the fact that resources just may not be there, particularly since telehealth is not included in this.

And I have heard that, just a reminder that performance on this is not expected to be a hundred percent at the moment.

Did I miss anything from the discussants that are key?

(No response.)

CO-CHAIR MORRISON: Okay. American Hospital Association, Akin, you've been waiting very patiently.

MEMBER DEMEHIN: So, I would associate myself with the comments that both, or that Frank made around their concerns around this measure. I think no one would dispute the importance of getting follow-up care after psychiatric hospitalization. I think the real question here is whether measuring the IPF is the best way to accomplish that.

I also have sort of a more specific technical problem with the measure. As we looked at the evidence that was used to support the expanded patient population, there was really a mismatch. So for expanding the patient population, included here, that's included, drug and alcohol disorders and

dementia, the evidence that's actually cited in the TEP report is really more based on schizophrenia, and not really those specific patient populations.

And there really wasn't much of a resultant drop in readmission. So if we're hinging a decision to expand the patient population on that evidence, I just don't think the evidence backs it up.

I would also strongly underscore some of the challenges around the Stark Law. I mean, it is -- in an ideal world, what a hospital could do is, at the end of a stay, make an appointment for a patient just about anywhere. But the law requires that we provide a full slate of choices to patients. We cannot steer patients to a particular facility.

And so, a measure like this does have the potential to put a lot of pressure, and it does potentially put providers at risk of violating those laws and those regulations.

The other point that was made that I think is a really important one, is that this particular measure's not the only game in town to get that sort of desired outcome, of getting patients who are

leaving an inpatient psychiatric stay to follow-up care. I would be very worried about the mismatch between this and any measures used at the health plan level.

And frankly, this measure was originally designed as a health plan measure, and I think with good reason. It is, to me, a little hard to create the mental model of the IPF being able to assure that follow-up care and to assure the network of access that you need to get that follow-up appointment.

It's a bit easier, although I'm sure very challenging on the health plan side. So if I'm looking at sort of the panoply of meaningful measure areas, I think the topic here is meaningful. I think who gets measured on this probably shouldn't be the IPF. So we would not support the inclusion of this measure in a program.

CO-CHAIR MORRISON: Jackson?

MEMBER WILLIAMS: Yes. So forgive me for asking a rookie question. This is my first meeting. But the complaints about sociodemographic issues, or regional issues, I think are relative to almost any

quality measure. And I'm just curious what the policy is here on -- I mean, theoretically, almost any of these things can be adjusted out, or they can be peer-grouped, so that facilities that serve a lot of rural patients are judged against peers rather than, you know, the suburbs of Connecticut or what have you. And I'm just curious, what is the procedure?

CO-CHAIR MORRISON: Well, that's a follow-up --

MEMBER MATTHES: Let's get the follow-ups. So I do work in this community as well. So I'm curious, since this measure rolled out, with NQF endorsement as one of these issues are general revision issues that will be addressed for those because it's provisional, I suppose on the NQF endorsement.

And what are we narrowly focusing on, on here? It seems to me, at least that I understand the endorsement process that there is some from life, some machine, some mixing of questions, that we should be looking at and addressing, and working as part of the endorsement process.

CO-CHAIR MORRISON: Jack, is that a follow-up or do you want me to try and clarify?

MEMBER JORDAN: Go ahead and clarify.

CO-CHAIR MORRISON: All right. So, I'm going to try and clarify as best I can. There really is no policy. Okay. It really depends on whether you believe, as some in this room have, that facilities and/or those who are being measured are accountable for the people who are living in their community, and that includes social determinants of health.

There are those who believe that that's not a fair practice. We have had debates back and forth, very healthy. I think that's the right word. Some of it depends on who you represent, and I will say that it has not come to the point where there is consensus. And this is one of those where you vote your conscience, or you vote your organization. Okay. Because I don't think anybody has actually come to a strong agreement on that. Okay.

Jack?

MEMBER DUSEJA: Can I just add to that?

CO-CHAIR MORRISON: Yes.

MEMBER DUSEJA: So, the endorsement process will address the measure, you know, scientific properties, right. So the questions that are being brought up about intended consequences, looking at the reliability, validity will be addressed in that process.

What we're looking for in the MAP process is really for your input on whether it's an applicable measure within the program. Is there shared accountability among facilities who are trying to arrange care coordination.

CO-CHAIR MORRISON: And that, we don't have an answer for yet.

Jack.

MEMBER JORDAN: Yes. I just, I wanted to comment, kind of, to the group as you're thinking about this, that because a measure is hard, and because a measure is going to look bad, doesn't have anything to do with if it's the right thing to do or not.

You know, so I hear some kind of comments in this that are kind of going down, oh, we're going

to look abysmal at this, or -- but it's, it is a real problem. And sometimes just drawing attention to having it, how bad it is, does help with a lot of things.

So, if you're thinking about this in some sense to say, oh wow, we're going to -- this is really terrible, that's not a reason to vote against it. It may actually be a reason to draw attention to, oh my God, only 20 percent of the people are getting follow-up, we need to get this to 50 or whatever. So just my comment on that.

CO-CHAIR MORRISON: Any last thoughts, comments before we go to a vote?

MEMBER DESOTO: Yes. Hi. I'm Mia DeSoto from AHRQ. I just had one last comment, just to throw into the mix to what Jack was saying that, you know, we also need to be mindful that as smaller practices are being bought up by bigger health systems, access is really becoming an issue.

So, it's not about whether it's going to make us look bad, but is it somewhere we start, and should we start at this point? So, that's all. Thank

you.

CO-CHAIR MORRISON: So, any last -- thank you. Any last thoughts, comments?

Sarah.

MEMBER NOLAN: So I agree that we have had robust discussions about who's responsible for social determinants of health. I disagree that I always come down on the same side about who's responsible. I think there are cases where the facility is less responsible.

I think in a case like this, where some of the issues and challenges to doing follow-up with these patients that have been identified are specifically aspects of their mental illness. And it seems to me it is the job of these facilities to be treating mental illness.

CO-CHAIR MORRISON: I didn't mean to point a finger at anybody; we are not schizophrenic on the same thing at the same thing or the same time. So --

MEMBER NOLAN: Sorry to -- in this case --

CO-CHAIR MORRISON: It is -- yes. And no.

MEMBER NOLAN: I think there is a reason

to tilt towards holding the facility --

CO-CHAIR MORRISON: Yes.

MEMBER NOLAN: -- more responsible rather than less.

CO-CHAIR MORRISON: Yes. No. I was going to say, it's, it really depends. It really depends. Akin, I don't know well. If Nancy was here, I'd pick on the American Hospital Association.

MEMBER DEMEHIN: That's fine. You can pick on me. That's all right.

CO-CHAIR MORRISON: So, shall we go for a vote, guys? So the initial staff recommendation was support with condition? Support, conditional support. So if you agree with the staff's recommendation, support with conditions, you vote yes. If you do not agree, you vote no. And depending on what that shows, we will move forward.

MS. JUNG: Do you want to kind of maybe reiterate what the staff condition was?

CO-CHAIR MORRISON: Oh, I'm sorry. The staff condition -- thank you, Madison. Thank you. The staff condition was to send it back for

endorsement, to NQF endorsement around the addition of the substance use disorder parameter. That was the condition. That was the condition.

MEMBER JORDAN: Clarifying question?

CO-CHAIR MORRISON: Yes.

MEMBER JORDAN: So if we wanted to add the other condition of allowing for e-visits or whatever, then we would vote no and come --

CO-CHAIR MORRISON: That is correct.

MEMBER SCHREIBER: Allowing for what? Can you repeat that, Jack?

MEMBER JORDAN: Telehealth, telehealth. E-visits, yes.

MEMBER SCHREIBER: Oh, e-visits.

MEMBER JORDAN: Yes.

MEMBER SCHREIBER: Thank you. Can I -- can we add a comment on that? It was looked at, because this is a claims measure, and it's not always so easy to capture that, that's why it wasn't there.

CO-CHAIR MORRISON: Did you guys at the end of the room hear Michelle?

PARTICIPANT: Yes.

CO-CHAIR MORRISON: Okay.

CO-CHAIR UPSHAW TRAVIS: May I have -- can I ask a --

CO-CHAIR MORRISON: Of course.

CO-CHAIR UPSHAW TRAVIS: -- clarifying question?

PARTICIPANT: The answer was no. Some people didn't hear Michelle.

CO-CHAIR MORRISON: The answer was no?

MEMBER SCHREIBER: So, because it's a claims-based measure and it's not always easy to capture telehealth in a claims-based measure, so telehealth is provided, and charged for. I mean, to say that's even covered, telehealth, for behavioral health, sometimes.

(Laughter.)

CO-CHAIR UPSHAW TRAVIS: So I guess what I was trying to -- my clarifying question was, if a claim was filed for telehealth, it would be in the claim. I'm going to ask if it is included in the specifications that you would capture it.

MS. MEYYUR: Yes. If it was. And then it

also depends on the diagnosis, right, so whatever is captured. Not everything, all diagnoses in the telehealth may end up in the claim. So it's still not completely synched at that level.

MEMBER DUSEJA: So I think there's some mapping that needs to be done to see if we're capturing it in a reliable way. And for what I'm hearing, it really does depend on if the claim comes through. But it has been the thought at our Technical Expert Panel, and there was a decision made not to include it in this particular measure.

CO-CHAIR UPSHAW TRAVIS: It was there and you don't know you're counting it.

MEMBER DUSEJA: Yeah.

CO-CHAIR UPSHAW TRAVIS: I mean, you might be counting some, is what I'm hearing, but maybe not all of them, so the issue still stands, apparently.

CO-CHAIR MORRISON: Okay.

MEMBER GHINASSI: Clarification question. So, the recommendation is to approve with --

CO-CHAIR MORRISON: Pending NQF endorsement.

MEMBER GHINASSI: Yes. And the idea was to include substance abuse in there. But if we believe that also addressing the idea of electronic connections with people, telehealth, whether it's provided by the hospital entity who could bill for it, or a community entity who could bill for it, if we believe that should be in the mix here, and it's not, we should vote no?

CO-CHAIR MORRISON: Correct.

MR. STOLPE: So, that would fall under the do not support with potential for mitigation, with the mitigating factor being you adjust the specifications to include telehealth.

MEMBER GHINASSI: All right, thank you.

MEMBER SCHREIBER: Thank you. Good question.

CO-CHAIR MORRISON: Thank you. Are we ready, guys? Okay.

MR. HIRSCH: Voting for MUC 2019-22, Follow-Up After Psychiatric Hospitalization, do you vote to support the preliminary analysis as the work group recommendation, and again, conditional support

for rulemaking is now open. Your options are yes or no.

CO-CHAIR MORRISON: Twenty-four? That's -- is that it? Okay. So we have our first no -- we have our first no of the day. So now, Sam --

MR. STOLPE: Now you can open it to discussion.

CO-CHAIR MORRISON: Now I can open for discussion. I will entertain a proposal as to where we should land on this, in terms of the next vote. Just to summarize from the discussants who had the pleasure of reviewing this in great detail, two voted do not endorse.

Nikolas, I didn't actually know where you landed.

MEMBER MATTHES: Sorry. I did conditionally support it.

CO-CHAIR MORRISON: I had a conditionally support, and I had a fully support. So the conditionally support and the fully support are now off the table. So we are now at support -- do not support with modifications, or do not support at all?

MS. JUNG: Don't we have to move through the other two to --

CO-CHAIR MORRISON: Do we have to move through the other?

MR. STOLPE: At the co-chairs' discretion, if the co-chairs feel like we are aggregating in general around a given category, we can move directly to that category, if you wish to vote on that. If it's not clear, then we go in sequence, starting with support for rulemaking.

CO-CHAIR MORRISON: So I'm going to suggest we start with do not support with mitigation. If we can get sort of a mitigation on the table that seems reasonable, we can go to a vote. And if we can't get that, then we are down to do not support, period. Does that work for people?

MEMBER GHINASSI: Can I just ask a question?

CO-CHAIR MORRISON: Of course.

MEMBER GHINASSI: When you say, a mitigation, does that mean ideas that people want to put on a list, from this room?

MR. STOLPE: Yes.

CO-CHAIR MORRISON: Yes.

MR. STOLPE: Yes. We would capture that in the rationale. And the material changes and specifications that the work group has identified would be communicated to --

MEMBER GHINASSI: Do you want those ideas from this group?

MR. STOLPE: Yes.

CO-CHAIR MORRISON: Yes, yes.

MEMBER GHINASSI: That's what I'm asking.

CO-CHAIR MORRISON: Yes. So if you have mitigation ideas, now is the time to speak. Oh, Frank. Frank is --

MEMBER GHINASSI: I have a couple. So one would be that we broaden the category of what constitutes a successful follow-up visit to include electronic contact, and that that's as broad as possible.

Number two, that it would be a paid service, and number three, that those kinds of follow-up care management services could equally be billed by

receiving entities who are trying to case manage as a receiver in the ambulatory world.

I would also submit that the mitigation include that the hospital, who is currently only able to bill for what happens within their walls, are also able to bill against those same ambulatory codes, and to continue to provide active case management, carrying that person to the next level of care in a way for which they can be reimbursed. Those would be my --

CO-CHAIR UPSHAW TRAVIS: Well, I just have a kind of an overarching question for that, because Frank, that included payment policy, not just, you know, what we are looking at, which is measurement. So I guess what I'm -- I guess the question I'm having is, in my own mind, if this is a payment policy or a coverage issue, that's a whole other process to go through.

So I'm trying to evaluate your comments in to how important all that component of it was, to which you saw as the potential medication --

MR. STOLPE: Mitigation, or medication,

yes.

CO-CHAIR UPSHAW TRAVIS: Mitigation. I need medication.

(Laughter.)

CO-CHAIR UPSHAW TRAVIS: I won't even try to say it right.

MEMBER GHINASSI: Mitigation.

CO-CHAIR UPSHAW TRAVIS: Mitigation, thank you. So I guess that just concerned me a little bit when we were putting payment policy on --

MEMBER GHINASSI: Well, I think I submitted those for the consideration of the group, because I think it better reflects the realities of this situation. I think that the barriers here are that the current structure is that the IPF is being held accountable for something that occurs after their direct influence is possible.

And all the procedures that happen that make it possible happen up into the moment that the person leaves the facility. Many of the factors that then affect whether that person successfully gets their's happen in a space they're not operating in.

I would submit that they be allowed to operate in that space as well, and be reimbursed for it.

And that's -- and I'm bringing it up. I realize it makes it complex, but my feeling is, it is complex.

MR. STOLPE: So the suggestion from the staff on this point, Frank, would be that you do not support the measure.

MEMBER GHINASSI: I do not --

MR. STOLPE: As we -- we would say that that's outside of the realm of the measure developer, to make it significant adjustments, that we would consider mitigatable factors. So if it's a payment policy or related issue where the structure of our current system does not allow for a good implementation of the measure, from your perspective, then we would suggest --

MEMBER GHINASSI: So I wouldn't be able to vote for mitigation then.

MR. STOLPE: That's correct.

MEMBER GHINASSI: Okay.

MR. STOLPE: Yes. You would not support.

CO-CHAIR MORRISON: Amy.

MEMBER HELWIG: I just had heard --

(Simultaneous speaking.)

MEMBER HELWIG: -- said that --

(Simultaneous speaking.)

CO-CHAIR MORRISON: And I'm sorry, I need to keep the conversation down.

CO-CHAIR UPSHAW TRAVIS: We're having a hard time hearing Amy.

MEMBER HELWIG: I was going to say, just really quick -- with what NCQA has recently published, with especially as it goes to vertical health.

CO-CHAIR MORRISON: In effect, even for mitigating circumstances?

MEMBER DEMEHIN: I will be fully transparent and say I'm not sure how mitigatable this measure really is. But if I am thinking about strategies for potentially making it better, we're still really bothered by this mismatch between the expanded population and the evidence base for that expanded population. So some further examination of that, I think would be very important.

I do think that delving into -- and I know that this is always controversial, but delving to the issues of SES, and how to account for it in this measure would be incredibly helpful, if we're going to move forward with it.

And to Amy's point, alignment with health plan measures, I think, and partnerization, at a minimum, would be an important mitigating factor. Frankly, I still have a broader conceptual challenge. I'm just not sure I can get my head around here. But if you are looking at strategies for potentially improving this, those would be a couple.

CO-CHAIR MORRISON: You will get your chance in a moment to decide. The developer has asked for a moment, so I'm going to pause here before I go to next cards. Jack, keep it up, but just -- we have the developer on the phone?

(Simultaneous speaking.)

CO-CHAIR MORRISON: Mathematica, you're on the phone.

MS. ROSENSTEIN: Mathematica is on the phone.

CO-CHAIR MORRISON: And you had a comment?

MS. ROSENSTEIN: Oh, I did want to go back to the point about telehealth. Telehealth is accepted if it's billed with a modifier of GT. So I think that goes back to somebody mentioned earlier about how it can be covered by -- you know, it covered only that specific -- it adds that modifier. So I did want to mention that.

CO-CHAIR MORRISON: Thanks. Thank you.

Aisha, you have up -- are you down, or are you up?

MEMBER PITTMAN: I was up, because of that plan.

CO-CHAIR MORRISON: Okay.

MEMBER PITTMAN: We just recently expanded it, so -- and if the measure at all pulling in the codes associated with health in -- it was either this year or last year, for expanded telehealth for some substance use treatment.

MEMBER DUSEJA: So, do Mathematica's claim agency bill this as well?

MS. ROSENSTEIN: It is, if it is actually

coded by the GT modifier, for the current measure that you guys are evaluating.

CO-CHAIR MORRISON: Anna, I think you got the last --

MEMBER DOPP: I'm in the last --

CO-CHAIR MORRISON: -- the last word, as it were.

MEMBER DOPP: Yes. I signed the back. I don't know it's, that this is compared to the medication continuation, NQF 3205 measure. And it had said that there were weak correlations with the medication continuation measure for the seven days, but moderatively positive correlations at 30 days.

I just wonder if there's some less ancillary between the two, understanding that the important access, so kind of alluding to medications and kind of alluding to follow-up care, although, and they're both claims-based measures, but they're different in the pharmacy realm, too. But just because that was part of the background, I thought that that was interesting, to kind of overlay the two, as you think about it.

CO-CHAIR MORRISON: Okay. I am going to throw just a small monkey wrench in here, because the first vote we had was based upon the fact that there was uncertainty around telehealth. And I guess my question is sort of a straw poll. Should we read this as the first vote, because would that have changed people's perceptions about how they would vote and now that we know that telehealth is included with the GT code --

MEMBER SCHREIBER: The specific elemental code.

CO-CHAIR MORRISON: -- with the specific telehealth modifier. It's easy to do. And then if we -- then we can move on.

MR. STOLPE: I agree to revote. Yes.

CO-CHAIR MORRISON: Revote, okay. All right, so first we're going to go back to staff recommendation, which was, conditional support with the condition being including substance use disorder.

MEMBER SCHREIBER: And NQF codes.

CO-CHAIR MORRISON: And NQF endorsement.

MEMBER GHINASSI: Clarification. That GT

code that approves a telehealth visit, is that a code that is usable both by the IPF and an ambulatory site, or is it only an ambulatory site can use that?

CO-CHAIR MORRISON: Frank, I love the fact you're looking at me and -- like I know the answer to this question.

(Laughter.)

CO-CHAIR MORRISON: That is --

(Simultaneous speaking.)

MEMBER GHINASSI: Because the reason I'm asking is because if the intent here is to judge the quality of the hospital, and the hospital has an ability to use a tool to help make this happen, as in, you know, telehealth, then I think it changes the stakes. If the answer to that is not really, then I don't see how that impacts the entity that's being judged in this measure. That's my question, and statement.

MEMBER SCHREIBER: It's a payment policy, and I don't know that we can answer it. We can try to find out. My best guess is, though, when a claim is submitted, it's submitted by whoever is rendering that

service. And so, for the most part, I would think that that service is who's providing the telehealth service.

MEMBER GHINASSI: The receiving entity?

MEMBER SCHREIBER: Probably the --

(Simultaneous speaking.)

CO-CHAIR MORRISON: The receiving end. The receiving end, the receiving end who's providing the service.

MEMBER GHINASSI: The telehealth addition here does nothing to further empower the IPF.

CO-CHAIR MORRISON: That is my -- that is what I'm hearing.

CO-CHAIR UPSHAW TRAVIS: But --

CO-CHAIR MORRISON: That is the basis --

CO-CHAIR UPSHAW TRAVIS: It's a payment policy.

CO-CHAIR MORRISON: But it's a payment policy which we have to check.

CO-CHAIR UPSHAW TRAVIS: Well, the one comment I'll make on that is it does expand the access to a broader array. In other words, it doesn't limit

access only to an in-person visit.

MEMBER GHINASSI: But it is broadening it for entities --

CO-CHAIR UPSHAW TRAVIS: That's correct.

MEMBER GHINASSI: -- who are not being measured by this measure.

CO-CHAIR UPSHAW TRAVIS: And I agree with you. Yes. That is -- so it does, but there were lots of concerns around access, and it does broaden access for that follow-up.

CO-CHAIR MORRISON: Phoebe.

MEMBER RAMSEY: I would just mention that, in terms of a payment policy, it's also kind of beneficiary-dependent, whether or not telehealth would be paid for, for that beneficiary, based on that beneficiary's locality, and that in general it's going to not pay for telehealth for the beneficiary from their place of service at their home. They have to be in a facility or at a doctor's office.

MEMBER SCHREIBER: And if you remember, that's why the question went to whether telehealth units are those, sometimes.

(Simultaneous speaking.)

CO-CHAIR MORRISON: Okay. So we are going to go back to vote. So, let's do it.

MR. HIRSCH: Voting for MUC 2019-22, Follow-Up After Psychiatric Hospitalization, do you vote to support the preliminary analysis as the work group recommendation, conditional support for rulemaking, is now open for voting. Your options are yes or no.

MS. JUNG: So we do not have consensus.

CO-CHAIR MORRISON: So we don't have consensus. So now we are going to move to do not support with potential for mitigation. And we have heard the mitigating circumstances.

So, yes, Cristie?

CO-CHAIR UPSHAW TRAVIS: I just would like Sam to repeat, if you can, that if it's a payment policy issue, where should we be voting?

MR. STOLPE: Yes. If your concern is that the current environment does not allow for the implementation of this measure, that there's not a mitigatable circumstance by the measure developer to

adjust the measure in a way that would be satisfactory for inclusion inside of this measure set, then you should vote do not support.

MR. AMIN: So if we're looking at the question, the next vote, which is do not support with potential for mitigation, the mitigating elements that we've heard, that seemed to jibe with the group -- well first we already have the expansion of the population, further considerations about how telehealth could be introduced into the specifications could also be an element for the measure developer to consider. It seems like that is challenging. That is all I -- that's all I got. Because everything else is payment. Right. And if that's not satisfying, then --

MR. STOLPE: There was the mention of the expansion of the evidence base, which I will acknowledge. And that would mainly come under consideration when the measure goes in for NQF, evaluation for endorsement. There's a thorough look at the evidence base, and if the expectation that there's a direct connection between the conditions of

interest and evidence that supports it.

CO-CHAIR MORRISON: Are we good to vote then?

MEMBER MATTHES: Just to repeat that piece, if the payment issue was the actual problem, it's a no on the next one?

CO-CHAIR MORRISON: That is correct.

MEMBER MATTHES: If I go to the payment issue --

CO-CHAIR MORRISON: If it is a payment issue, you should vote no because the measure developer can't mitigate a payment issue. Yes.

MR. HIRSCH: Prior to moving on, just for the official record, the vote was 11 yes and 13 no for do you support the work group recommendation for Follow-Up After Psychiatric Hospitalization measure.

CO-CHAIR MORRISON: Okay. So, vote your conscience, folks, or your organization, depending on where you're coming from.

MR. HIRSCH: For MUC 2019-22, Follow-Up After Psychiatric Hospitalization, do you vote, do not support with potential for mitigation? Your options

are yes and no.

CO-CHAIR MORRISON: Well, we're missing two. Missing two votes.

(Off microphone discussion.)

MR. STOLPE: Did we lose one? We lost one.

MS. JUNG: We're still at 24, so did everyone on the phone as well, and in the room, just make sure you selected your option. We're only seeing 23 on the screen right now. Oh, okay. We got a message that one of them is still working.

(Off microphone discussion.)

CO-CHAIR MORRISON: So we still don't have consensus. So the final vote was 12 to 12, 50. So now we'll move to the last question, and this -- you guys are going to love this. You're going to love -- so do we --

MEMBER SCHREIBER: We had 25 voting members. Did we lose somebody?

CO-CHAIR MORRISON: We lost one.

MEMBER SCHREIBER: Okay.

CO-CHAIR MORRISON: Yes. So now the

question is, do you not support the measure? Okay. So, if you vote yes, and 60 percent vote yes, so the measure is not supported. However, if 60 percent vote no, then the staff's recommendation is, moves forward. So just be -- I know, I know. I knew you were going to love this.

So a vote not to endorse means the measure is not endorsed. If that does not carry, the staff's recommendation carries forward. So just be careful how you're voting.

MEMBER GHINASSI: So a yes means no.

CO-CHAIR MORRISON: A yes means no.

(Laughter.)

CO-CHAIR MORRISON: A yes means no. Yes. Your vote -- a yes means you are not endorsing. It's a double negative. I told you this was going to be fun.

MEMBER SCHREIBER: Do not support.

CO-CHAIR MORRISON: Do not support.

MEMBER GHINASSI: Yes means do not support.

CO-CHAIR MORRISON: Yes means do not

support.

Akin, you are looking --

MEMBER DEMEHIN: I think we should vote, but if we end up voting no, I would be curious to hear more about the rationale for why the staff recommendation would carry forward, when it's clear that there doesn't -- it would be clear that there really wasn't consensus. But let's vote first.

CO-CHAIR MORRISON: Let's jump off that bridge if we come to it, please.

(Laughter.)

MR. HIRSCH: All right. Voting for MUC 2019-22, Follow-Up After Psychiatric Hospitalization, do you vote, do not support, is now open. Your options are yes or no.

MS. JUNG: We have one online vote, that is in addition for the yes vote. So we have reached consensus.

CO-CHAIR MORRISON: We have reached consensus. See Akin, no worries.

(Laughter.)

MS. JUNG: For everyone in the room, to

restate the final vote for MUC 2019-22, Follow-Up After Psychiatric Hospitalization for do not support is a yes, with 15 votes, and a no with 9 votes.

MR. AMIN: So before I move on, can I just take two seconds? So there was a lot of conversation on this measure. I just want to capture some of the key issues. Evidence, there's issues around attribution, there's issues around the Stark self-referral question. There's obviously an issue related to the telehealth component and receiving -- basically what role inpatient psychiatric facilities have in terms of being able to provide telehealth for being judged on this measure.

Anything else that's key conceptual issues of not being able to move forward on this?

CO-CHAIR UPSHAW TRAVIS: I would just clarify a little bit on the telehealth. I mean, it seems to me that it's sometimes covered and sometimes not. So it wasn't just a matter of the inpatient facility being able to provide this telehealth service, it was also that it's not always a covered service.

MR. AMIN: Okay. That's good. And then I would like to provide a quick clarification on the voting process and how we end up back with that. We can provide feedback about this, but the rationale of how we got to this point, is at the Coordinating Committee discussion, we did want to make sure -- the Coordinating Committee sort of discussion on voting was that there should be a decision on every measure. And the decision should be derived by the decision categories and the algorithm that was determined by the Coordinating Committee and the input from the MAP.

So, in the event that there isn't consensus, obviously all the rich conversation will be carried forward to the Coordinating Committee. But at the very least, the objective criteria that was used should land us in a place as a starting point for discussion.

MR. STOLPE: So what that means is that the conversation would move forward, that the Coordinating Committee would pick up where we left off, and incorporate your comments, your discussion into how they consider the staff recommendation, and

make a decision based on that.

CO-CHAIR UPSHAW TRAVIS: So it goes forward just to the Coordinating Committee?

MR. STOLPE: Correct.

CO-CHAIR UPSHAW TRAVIS: But we wouldn't know what --

MR. STOLPE: Right. I just wanted to clarify.

MEMBER HATLIE: Just a comment to underscore, because there was a lot of discussion here about the importance of this issue for this high-risk population, and so I hope that will be carried forward with some -- there was consensus about that.

MR. AMIN: Yes. Agreed.

CO-CHAIR MORRISON: So just, in communication training we call this a closed-ended question, were there any gaps that people identified that were not previously identified on our call before? And we can put those back up. But this is the opportunity to put in gaps that you believe were not previously identified.

Jack.

MEMBER JORDAN: I think just the general capacity of psychiatric care in the country is a gigantic issue. Now how you get that with measuring, you know, that you're measuring kind of the capacity, but there's nothing more disturbing than to be at a hospital quality huddle, and say, we have a patient in the ED 150 hours, there's no place we can place them for psych care.

You know, and we can fix any of the other measures we have, but if there isn't a safe place to put them, it's kind of a moot point.

MR. STOLPE: Absolutely.

CO-CHAIR MORRISON: All right, guys, I have successfully lost us all the time that Cristie has gained.

(Laughter.)

CO-CHAIR MORRISON: Why don't we take -- why don't we reconvene at 1:30 for the afternoon, and lunch is right out here. I apologize. You can come this way through the door.

(Whereupon, the above-entitled matter went off the record at 12:45 p.m. and resumed at 1:30 p.m.)

CO-CHAIR UPSHAW TRAVIS: Okay, I think we're going to get started. Okay. Well thank you all for coming back after lunch. I hope you enjoyed the time.

So the next program we're going to be looking at is End Stage Renal Disease Quality Incentive Program measures. And I'm going to turn it over to Madison, who's going to give us a review of the program.

MS. JUNG: Thank you.

So again, this is information we saw during the web meeting in the fall, but this is the ESRD QIP program. It is a pay for performance and public reporting program. The intent to structure is that as of 2012, payments to dialysis facilities are reduced to facilities who do not meet or exceed the required total performance score.

Payment reductions will be on a sliding scale, which could come out to as much as 2 percent per year. The goal for this program being improve the quality of dialysis care and produce better outcomes for beneficiaries.

Again, in the reference materials, there are the program set as of the most recent rule. And according to the most recent rule, these are the updates contained. About four measures were moved for payment year 2021, two were added for payment year 2022, and then one measure not finalized for payment year 2022.

The priorities identified for this program by CMS in the Needs and Priorities document are care coordination, safety, patient- and caregiver-centered care. And the work group identified a few gap areas to note during our discussion. So there's -- and this is on ESRD patient experience measures, specifically ones that were not part of the process, so ones that could be broken out and reported separately.

An example given was, suggested was that in-center hemodialysis caps questions could be broken out. The work group also emphasized that where possible, there should be alignment with other CMS program sets.

CO-CHAIR UPSHAW TRAVIS: Is that it?

MS. JUNG: Yes.

CO-CHAIR UPSHAW TRAVIS: Okay. I'd like to open it up for public comment, for the ESRD measures. Any in the room?

(No response.)

CO-CHAIR UPSHAW TRAVIS: Okay. I don't see any. How about on the line?

(No response.)

CO-CHAIR UPSHAW TRAVIS: Okay. No public comment. So we will move first to the staff review of the preliminary analysis.

MS. JUNG: So, this measure currently exists in the ESRD QIP. It is an NQF-endorsed measure, Measure Number 2979, but it is actually undergoing review right now in the upcoming fall 2019 cycle, with the Renal Standing Committee.

The measure was resubmitted to NQF for endorsement because it's had significant updates in the specifications. Specifically, we noted that there had been substantial updates related to the codes used in the transfusion definition and handling of Medicare Advantage.

The staff preliminary analysis conditional

support pending NQF review and endorsement. I should note that this has also been through the Scientific Methods Panel, and it did pass the Scientific Methods Panel last month for reliability validity.

CO-CHAIR UPSHAW TRAVIS: Thank you, Madison.

So we'll move to our lead discussants. Paul is not with us today; is that correct?

MS. JUNG: That's correct.

CO-CHAIR UPSHAW TRAVIS: Okay. So we'll go to Jackson Williams with the Dialysis Patient Citizens.

MEMBER WILLIAMS: Thanks. So this is a measure of a unit of management for dialysis patients. Previously there was a quantitative measure of hemoglobin. In 2010 or 2011, a researcher identified cardiac events resulting from overuse of EPOGEN. So the quantitative measure was abandoned.

Also at that time, EPOGEN seems to be reimbursed on a fee for service basis. It was, the entire dialysis payment was moved to a bundle payment, or a prospective payment system.

This is an outcome measure now, that is very important not only because of the fatigue but also because too many transfusions can interfere with the ability to receive a transplant.

This is a measure to guard stinting in the bundled environment. So patients are worried that, if their clinic doesn't have enough money to pay for EPO this month, that they may not get their full dose. To my knowledge, this is really the only check on the possibility of stinting in the bundle.

We did comment to CMS this year that it would be nice if they could somehow audit the use of medications or do something, you know, survey-wise. They said they can't. So this is the only game in town.

And anyways, because of the change to ICD-10, CMS changed this to a reporting measure, which is the participation trophy option in the ESRD QIP. I'm not sure whether reporting measure is a term of art that's only used in the QIP, as opposed to being used across measure sets. And that will be one of the clarifying questions I would ask when I get that up to

you. And I support the recommendation.

CO-CHAIR UPSHAW TRAVIS: Okay. That's what I was going to ask. Thank you so much, Jackson.

Debbie Wheeler, with Molina Healthcare.

MEMBER WHEELER: Yes, I'm here. So I think I also support this measure, so I won't go into much detail since we just talked about it. But my one question that seemed to come up during the discussion, the discussion about the measure was whether this is an outcome measure or not.

Eventually, it was decided to be one, but I'm wondering, is this really an outcome measure or is it more a process measure to, you know, look at those transfusion ratios? Because to me, I think it's more of a process or not even intermediate outcome but some sort of process measure to manage the anemia, but not an outcome measure. That's my only comment.

CO-CHAIR UPSHAW TRAVIS: Okay, thank you.

And Amy, with UPMC Health Plan.

MEMBER HELWIG: Just a couple of comments to add to the discussion. I do support it as conditional. A couple of things to add. One is, it's

entirely claims-based, which is what is reflects safety, in terms of exposure to transfusions. It also reflects appropriate care. And because it is underlying, reflects, I think, management of anemia, in that regard, almost an indirect measure of quality of life, just in terms of fatigue.

Just in terms of look at market trends, one thing that I don't think that's been mentioned here, they mentioned issues with Medicare Advantage and the data with Medicare Advantage, so just -- and other trends, in 2021, Medicare Advantage plans will start covering dialysis.

So as Medicare Advantage plans, now once patients initiate on dialysis, they're actually going to move for fee for service, so we don't bear that long-term cost. But that changes in 2021, so that members can elect to -- receiving dialysis can elect to stay in our plan, or they can come on to the plan.

So they, the health plan, it changes the things for us because suddenly we're going to be looking at trying to really heavily incentivize, and look at our products to do more home-based dialysis

when that's what the patients want, and the incentives change.

And with that in mind, just, I think it's going to be a recorded, not a score or performance measure, as it's adopted. I think I would just point out that that is a good decision, since we don't know how we even nominate, or how the populations are going to shift, because starting in 2021, they may have a very significant shift in terms of who actually stays in facilities getting dialysis versus who moves to the home environment, and also who moves to transplant, because the whole incentives change, in terms of how we're looking at this population.

CO-CHAIR UPSHAW TRAVIS: Thank you for that. Any feedback, Brock from the rural?

MR. SLABACH: Thanks, Cristie.

Yes, I think that obviously this is a priority condition for rural patients that are experiencing the need for dialysis. And so there was a general consensus in the support category, we could see from distribution of the votes taken.

And then we don't see any unintended

consequences, necessarily, except that there's some distances that are really problematic for many rural residents to have to take to get these services. And other than that, there was no -- there was general consensus.

CO-CHAIR UPSHAW TRAVIS: Okay, thank you.

All right. Are there some clarifying questions that people have? And let's try to stick to just questions at this point.

Phoebe.

MEMBER RAMSEY: I have one question that came from our review of the measure was whether mechanical assist patients, so LVADs or RVADs, if they're excluded only if they have an immediate diagnosis.

CO-CHAIR UPSHAW TRAVIS: Okay. Let's make a list, and then we'll come back and ask the developers to respond.

Lisa.

MEMBER McGIFFERT: I would kind of -- my understanding of the description is that there was, there have been changes in the codes, and some changes

in the transfusion definition, to go along with Medicare Advantage, and I'm curious on how that works with claims. And I don't understand completely the whole issue of -- it sounds like the issue of changing to ICD-10 itself made the results change, but I can't really tell.

CO-CHAIR UPSHAW TRAVIS: All right, thank you.

Jackson.

MEMBER WILLIAMS: And yes, I did wonder at the CMS folks, if you will -- whether you will determine the way the measure versus reporting measure is used in other programs. And I thought it was unusual in this case because the facility does not report this. This is based on hospital claims. So in the past, reporting measures have actually rewarded facilities who are reporting value on something that happened in their facility.

CO-CHAIR UPSHAW TRAVIS: Great, thank you.

Okay. Well, I think we do have some questions for the measure developers related to this. Do you need me to repeat them or --

MR. ROACH: No.

MEMBER DUSEJA: Jesse, can you just introduce yourself?

MR. ROACH: Oh, hi. I'm Jesse Roach. I'm a nephrologist. I'm the ESRD measure lead at CMS for equipment for dialysis.

I'm going to skip the first question and leave that for the, our measure developers. It's very specific about the LVAD, so I don't want to say something wrong. So, they're on the line, so when I'm done answering the second question, we can get to that.

In terms of the -- I'll just give a brief explanation. So, this measure was previously in the QIP. It -- where there was a non-endorsed measure that involved using value codes to determine transfusions. It was found that using those value codes introduced potential bias into the situation and was -- into the measure, and wasn't reflecting the true nature and had some geographic bias towards it.

So, then we came up with the current measure, which took those value codes out, and just

used the ICD-9 codes, because those were being used more reliably.

With the switch to ICD-10, we found that people were, began coding differently, and using the value codes more, and using the ICD-10 codes less, which then made this measure less reliable. At that point, that's when they made it -- when we realized that, that's when we made it the reporting measure, which I do realize is not typical because the facilities aren't actually reporting it.

But we have a statutory requirement to leave it, to have it in the program, and we think it's important to report this, but we didn't want to hold facilities accountable while we were figuring out what was going on.

This new measure basically goes back to the old measure, with a couple of changes, one of which is moving the Medicare Advantage patients because we found it wasn't reliable, the data, the measure wasn't reliable when those were included. But it basically goes back to using those value codes.

We've been able to demonstrate now that

the codes are, don't introduce geographic bias anymore, and do a much better job of capturing the actual transfusions now. So that's why we want to go back to something that's similar to that old measure, now that we've demonstrated that there's no bias involved with it.

So, that's the basic gist. I hope that answered your question.

CO-CHAIR UPSHAW TRAVIS: So the plan is to go back to using ICD-10?

MR. ROACH: No. Well it's to include -- it's to use ICD-10 and the value codes. We found those weren't biased, so we can use both. We can use both of them.

CO-CHAIR UPSHAW TRAVIS: Okay. Can you explain what a value code is?

(Laughter.)

CO-CHAIR UPSHAW TRAVIS: Sorry.

MR. ROACH: No.

CO-CHAIR UPSHAW TRAVIS: It isn't that complicated a question, but --

MR. ROACH: So, it's -- so you can use --

no.

CO-CHAIR UPSHAW TRAVIS: No?

(Laughter.)

CO-CHAIR UPSHAW TRAVIS: I'll accept that it's better with it in there.

(Laughter.)

MEMBER McGIFFERT: I thought the value codes were ways that you could add more information than the ICD-10.

MR. ROACH: Yes. You have your claims, and your diagnoses, and then the value codes are ways to add different things on to it. So I want to add a transfusion. You can also code for it in the ICD-10 codes, but you can also add value codes, and you can do it from either way. So there's ways to add value to your claim, basically, to add different things to your claim, so.

CO-CHAIR UPSHAW TRAVIS: Okay. And so now you're using -- in this measure, looking at it, ICD-10 plus value codes?

MR. ROACH: Correct.

CO-CHAIR UPSHAW TRAVIS: Okay. And does

the measure specify which value codes have to be included?

MR. ROACH: That -- it should. I just want to make sure, I just want to make sure, or is KECC on the line?

MR. MESSINA: Yes, Jesse, this is Joel Messina.

MR. ROACH: So what was your question again?

MEMBER McGIFFERT: Does the measure include which value codes must be included? Because my understanding is there's a lot of them, and hospitals and facilities are using them sort of ad hoc.

MR. MESSINA: So one thing I will add is, in addition to value codes, which there's one specific value code that we're using to identify one or more transfusions in some of the passwords that we've done, where we've believed that value codes are reliable indicators that blood was transfused, but whether or not they were accurate in terms of the number of units, so we took the

conservative approach.

So the value code says two units of blood. That meant one transfusion of that. The other piece that's important, for those of you who are familiar with inpatient billing, are revenue center codes. So the revenue centers of 38 and 39, those two families of revenue centers describe information about inpatient and out-patient costs associated with administration, or either administration of blood, storage and administration of blood, or purchase, storage, and administration of blood, depending upon whether the source for the blood was a for-profit blood bank or a donated blood bank.

And so the original STrR measure utilized the presence of a revenue center code with or without an ICD procedure code as evidence of a transfusion event. That was changed when we went back in 2016 to NQF because of the regional variation concerns Jesse described, and we went to requiring an ICD-9 procedure code at that time.

This current measure goes back to the original approach, which allows a revenue center code and/or a procedure code, and/or a value code for a blood transfusion as evidence of a transfusion event, and everything else Jesse said about the reliability and the reduced regional variation is correct.

MEMBER RAMSEY: And what about LVAD?

MR. ROACH: So can I get a little bit of a clarification? So, wait, who asked that? I'm sorry. So --

CO-CHAIR UPSHAW TRAVIS: Phoebe.

MEMBER RAMSEY: So essentially, when our clinicians who gave us feedback were reviewing the measure, they were concerned that there was the exclusion for anemia, but not specifically for medical assist devices, and that a patient with an LVAD or an RVAD or other one, that those patients, then they will not do PSAs. They'll do a transfusion because of the concern for pump thrombosis. Again, I'm an attorney, so --

(Laughter.)

MEMBER RAMSEY: -- simply reading the clinician notes, and they wanted to know whether an LVAD or RVAD will only be excluded in the event of an anemia diagnosis being documented.

MR. ROACH: Okay. So I wanted -- okay. So you want to know if simply having an LVAD without --

MEMBER RAMSEY: No. Without anemia.

(Simultaneous speaking.)

MR. ROACH: An LVAD, for those who don't know, left ventricular assist device.

MEMBER RAMSEY: Thank you.

MR. ROACH: So if you have that without a diagnosis of anemia listed, is that still excluded from this measure? And I do not have that specific case. Do you guys know at KECC?

MR. MESSINA: I do not believe that the presence of an LVAD excludes you from a measure. It was not raised as one of the critical conditions in the clinical technical

expert panel that was used to originally develop the measure.

And I suspect that, although it's a growing, a number of patients, the, I would still suspect that the number of individual out-patients who are on chronic dialysis with a ventricular assist device is potentially small, and it wouldn't affect the level of metric, but we don't have specific information or analyses to support that. That's just based on my clinical experience.

MEMBER RAMSEY: Yes, I think their concern was that the anemia diagnosis might not always be captured, but the device will certainly be captured.

CO-CHAIR UPSHAW TRAVIS: All right. Thank you. I think that covers the questions that we had. Any other questions from anyone?

I might ask one, and it may be that I'm a little confused, so I apologize, but with the change in the Medicare Advantage being able actually to provide this service at some point in

Medicare Advantage, do you all -- does the methodology, will it kind of compensate perhaps for patients that move out of this program and into the Medicare Advantage? Or I'm trying to figure out, you know, how that might impact this measure.

MR. ROACH: So you're saying, you're saying it's more -- how are we accounting for the fact that more patients will move into Medicare Advantage, and will that affect the reliability of the measure?

CO-CHAIR UPSHAW TRAVIS: Right.

MR. ROACH: I -- the answer is I don't know, and it's something we'll have to monitor as things go along. I think, just like we found this issue with the -- when we monitored with the switch to ICD-10, I think that we'll have to do the same thing as we go forward to see exactly how many patients switch over, and what it does to the measure as we monitor it, and we'll be on it pretty closely.

CO-CHAIR UPSHAW TRAVIS: That's fair.

MEMBER SCHREIBER: And furthermore, this really becomes something very common in MA plans, whether or not this is a measure that needs to go into --

MR. ROACH: Right.

MEMBER SCHREIBER: -- MA plan evaluations.

CO-CHAIR UPSHAW TRAVIS: And just one other followup question on that, this is just in-facility transfusions versus --

MR. ROACH: No. These are all transfusions. So --

CO-CHAIR UPSHAW TRAVIS: Oh, okay.

MR. ROACH: -- in out-patient or in the hospitals. Most --

CO-CHAIR UPSHAW TRAVIS: Or at home.

MR. ROACH: -- or --

CO-CHAIR UPSHAW TRAVIS: I mean, can it be home transfusions?

MR. ROACH: It could be if it was coded for, but most transfusions, the large -- almost no transfusions are done in the --

CO-CHAIR UPSHAW TRAVIS: Okay.

MR. ROACH: -- dialysis facility.

CO-CHAIR UPSHAW TRAVIS: Okay.

MR. ROACH: So it's other facilities, as long as it shows up in the coding, it gets counted.

CO-CHAIR UPSHAW TRAVIS: Any other questions? Yes.

MEMBER BALAN-COHEN: I would, yes, it was actually a really good question, whether there are like any plans to move some more into methodology, given the new treatment payment models, and given that, you know, for instance, there are incentivized transfusions, like at-home transfusions that might not be like a typical, you know, like at this point, but if it's something that may come out further down the road.

MR. ROACH: So it would be something that we looked at, and we are working with the CMMI, who are developing the models with their quality measures. So we're going to be

monitoring that as we go forward.

CO-CHAIR UPSHAW TRAVIS: Great. I don't see other cards up. Is there any additional discussion that anybody wants to have before we move into voting?

MR. AMIN: Can I just ask a clarifying question, Cristie?

CO-CHAIR UPSHAW TRAVIS: Yes.

MR. AMIN: I'm still perplexed by this question about whether this is an outcome measure.

CO-CHAIR UPSHAW TRAVIS: Oh, I'm sorry. We kind of missed that.

MR. AMIN: Can I get some feedback on that so we can just make sure to either update the PA as we go to the coordinating committee? Or just -- because it is a discussion criteria.

MEMBER WILLIAMS: Yes, Jackson Williams. I'd consider it an outcome measure. This is the, this is the -- what you're trying to avoid.

MR. AMIN: Okay.

CO-CHAIR UPSHAW TRAVIS: Is a transfusion.

MR. AMIN: Yes, okay. That's fine. Okay.

MR. ROACH: And I think that the process would be ESA administration, avoidance of anemia, steps to avoid anemia, and the outcome is prevention of transfusions.

MR. AMIN: Okay. Thank you.

CO-CHAIR UPSHAW TRAVIS: Okay. So the recommendation on the preliminary analysis is conditional support based on NQF endorsement, so we'll start with a vote relative to that.

MR. HIRSCH: From MUC2019-64, standardized transfusion and transfusion ratio for dialysis, do you vote to support the preliminary analysis as the work group recommendation? Conditional support for rulemaking is the preliminary analysis option. Your voting options are yes or no. We are waiting on two more votes.

MS. JUNG: We've got one coming in via

the chat, and we are at -- so that means we're at 24. We're looking for one more vote. Is anyone having any technical difficulties? If everyone could just click again and reconfirm.

We have 24. So are we comfortable closing the vote with 24? I can't tell, we can't tell who's missing.

CO-CHAIR UPSHAW TRAVIS: Who hasn't, okay.

MS. JUNG: Yes, we have quorum.

CO-CHAIR UPSHAW TRAVIS: Well, we, and we know the --

MS. JUNG: Yes.

CO-CHAIR UPSHAW TRAVIS: -- answer is yes.

MS. JUNG: Yes.

CO-CHAIR UPSHAW TRAVIS: Is that -- I'm going to look to NQF staff though. Okay. So yes, we can go on and close.

MR. HIRSCH: MUC2019-64 standardized transfusion ratio for dialysis, voting is now closed. The work group has elected to accept the

preliminary analysis of conditional support for rulemaking with 24 votes yes, 0 votes no.

CO-CHAIR UPSHAW TRAVIS: Thank you. Your turn.

(Simultaneous speaking.)

CO-CHAIR UPSHAW TRAVIS: No, it's mine. It's still --

CO-CHAIR MORRISON: No, no, it's, no, it's mine. It's mine.

CO-CHAIR UPSHAW TRAVIS: No, no, it's still mine, because I have to do gaps.

CO-CHAIR MORRISON: Oh, you have to do gaps.

CO-CHAIR UPSHAW TRAVIS: Yes.

MEMBER WILLIAMS: Right. Right, right, right.

CO-CHAIR UPSHAW TRAVIS: Yes, I can tell that Sean's getting the difficult ones this time around. And Jackson, some gaps you'd like to mention?

MEMBER WILLIAMS: Yes, I circulated results of our members' survey of about 600

dialysis patients, and I had to confess that the items that I put on here were somewhat arbitrary, but six of the top seven dimensions of care that patients think are important are patient experience issues that are on the CAHPS survey, but only three of these are reported separately. So we have urged CMS to report them separately. I don't know if that requires bringing them forward as measures, official measures here or not. But I think it's information that patients would like.

And the number eight item, which is this number two clinical item is patient safety, and I would just reiterate what Ms. McGiffert said this morning -- that it would be great if patients did have an opportunity to report safety events. Right now the CAHPS survey asks them: in the last three months, did any problems occur during your dialysis? And I consider that a patient safety question, but it's so vague and amorphous that it would really be nice to have that retooled along the lines that we discussed

this morning.

And of course, there was a tap on measures, and the patients overwhelmingly chose patient safety as an area they wanted to report on, so I hope CMS will follow up on that. And finally, I would reiterate it's absolutely critical to get measures in Medicare Advantage.

CO-CHAIR UPSHAW TRAVIS: Great. Thank you, Jackson. Amy?

MEMBER HELWIG: Just a couple of comments on some gaps. I think safety will -- it's currently looked at, but I think it also, we need to keep our eye on that as well, especially again as the payment models change, and suddenly, we might have a large shift of people who need to do home dialysis.

I'm just wondering if there will be unintended consequences? I think it's great, but I think we just have to keep our eye out for any unintended consequences of maybe shifting too many people who maybe will not be ready for that.

And the other is on functional status

and quality of life. And again, as we look at the new payment models coming, I think what someone's functional status and quality of life measures will be critical in determining really where are they best served, whether it be in the facility dialysis, in home dialysis, or again, moving more rapidly to transplant. So I think that's something that should definitely be kept on the horizon.

CO-CHAIR UPSHAW TRAVIS: Can I ask a clarifying question? Maybe Jackson can chime in here too. Are there particular safety concerns that would be in a dialysis facility? Maybe one or two examples. We don't need to go into everything, but I didn't know if there were particular safety issues that you --

MEMBER WILLIAMS: I'm a lawyer too, so I don't know the answer to that.

CO-CHAIR UPSHAW TRAVIS: Well you should know that for sure if you're a lawyer. Yes.

MR. ROACH: So I -- can I answer?

CO-CHAIR UPSHAW TRAVIS: Yes, please.

MR. ROACH: So in our, obviously with patients, one of the big ones is infection, and vascular -- and their vascular access. So those are two of the big safety issues that patients are repeatedly concerned about, and as it turns out, those are also -- those are some of the things that kill the patients the most. So --

CO-CHAIR UPSHAW TRAVIS: Right.

MR. ROACH: -- they are in tune with what's going on inside.

CO-CHAIR UPSHAW TRAVIS: All right. Thank you.

MEMBER NOLAN: Sorry. We couldn't hear the first thing you said --

MR. ROACH: Oh, sorry. Infections are one of the things that they're the most concerned about because it's very common, and then their vascular access.

CO-CHAIR UPSHAW TRAVIS: Marty?

MEMBER HATLIE: I just want to underscore, because I haven't said this yet, so

I'm another lawyer jumping in here with Jackson in this case. But we --- it's a vast underutilized resource to not have a vehicle for patients to report this sort of thing -- especially patients with chronic conditions or their family members, they develop an expertise, and we just don't learn about it because we don't have a vehicle for it.

CMS is trying to do it. There was some great design work done a few years ago at AHRQ about developing a system for patients to actually report things, because we see them using the open narrative of their patient satisfaction surveys as a proxy for that. You can look at those comments and see the events reported there that we're not getting through any other source. So we really should be thinking about this as a priority as we move forward.

And certainly patients have been calling about it for years -- calling for it for years, and you know, we've got some of the tools developed. They just haven't been implemented.

So I wanted to jump in with the other lawyers, and just stress this point.

CO-CHAIR UPSHAW TRAVIS: Jack?

MEMBER JORDAN: Yes. At the urging of a former boss, I was just sent to pick on our dialysis people once, and one of the crazy measures that we talked about, you know, dialysis rules peoples' lives. So what percent of your people can hold down a job?

CO-CHAIR UPSHAW TRAVIS: Right.

MEMBER JORDAN: You know, I think just some level of functional status for the patients of what they can do in their life. I mean, holding down a job might be pretty extreme, with the every other day thing, but still I think that's a gap that we're really missing is, how can we make dialysis something that is less intrusive in someone's ability to function in life, is, I think, a gap area. You know, that would be really helpful.

CO-CHAIR UPSHAW TRAVIS: Thanks. Yes, Frank?

MEMBER GHINASSI: To that same point, I'm very surprised that they took screening for depression off of this. That seems like a natural that you would want to screen for, behavioral disorders, and/or, you know, histories of trauma.

I mean, there are things you'd want to know about these folks. It just seems odd that they, this is not endorsed. I'm -- did we remove that from the, I don't, I don't think we did remove the, I thought it, I thought it said got not endorsed. Did I read that wrong?

MR. ROACH: Well, it might not be endorsed, but we have a depression screening measure in the clip.

MEMBER GHINASSI: It said not endorsed, based on NQF --

CO-CHAIR UPSHAW TRAVIS: Yes.

MEMBER GHINASSI: I don't know what that means.

(Simultaneous speaking.)

PARTICIPANT: -- didn't endorse it, or

does it mean it just never was --

MEMBER GHINASSI: Maybe I don't know what that means.

MR. ROACH: It means it's in the program; however, it does not have NQF endorsement status.

(Simultaneous speaking.)

PARTICIPANT: But it would be helpful to know --

MR. ROACH: So it's in the seven.

CO-CHAIR UPSHAW TRAVIS: Okay.

MR. ROACH: Okay.

PARTICIPANT: Oh, if it was reviewed and not endorsed, but we don't know that, right?

CO-CHAIR UPSHAW TRAVIS: It says based on NQF number 0418, but it says not endorsed.

MR. ROACH: Yes.

MEMBER GHINASSI: That would just surprise me that it -- that it wouldn't be a natural.

MS. JUNG: So it would -- we would designate if it failed endorsement.

CO-CHAIR UPSHAW TRAVIS: Okay.

MS. JUNG: So, yes.

PARTICIPANT: Yes, failed endorsement.

CO-CHAIR UPSHAW TRAVIS: So it just hasn't gone through it then --

MR. ROACH: Correct.

CO-CHAIR UPSHAW TRAVIS: -- I guess?

MS. JUNG: Yes.

CO-CHAIR UPSHAW TRAVIS: Okay.

MS. JUNG: That would be the implication then.

PARTICIPANT: Oh, okay.

MR. ROACH: So just to be clear, for this, so this particular measure is based on a measure that has NQF endorsement, but this measure itself has not been reviewed by an NQF standing committee.

CO-CHAIR UPSHAW TRAVIS: Okay. Okay. So it's in there. It's in the program. Thank you. Other comments on gaps? Now --

CO-CHAIR MORRISON: She still did well. Even, all right. So we're going to go

onto inpatient quality, inpatient quality reporting program. We've got two measures under consideration here, and I will turn to Sam for an IQR overview.

MR. STOLPE: Thanks, and I have the unfortunate task of reading the most lengthy name of any program under the sun. It's the Hospital Inpatient Quality Reporting Program, IQR, and Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals. That is the actual name of the program.

Now, this is a paper reporting and public reporting measure, and the incentive structure is such that hospitals that do not participate, or participate but fail to meet program requirements, receive a 140 reduction, the applicable percentage increase in their annual payment update.

The program goals, as they've been already stated, are progress towards paying providers based on the quality, rather than the

quality of care. They get patients interoperability between EHRs and CMS data collection, and to provide consumers information about hospital quality so they can make informed choices about their care.

So this is the list of the measures inside of IQR currently. They're there for your reference. Next slide. And these -- well let's go back to that one. These are the proposed updates for you to consider as well. So we're not just thinking about measures as they are currently included, but what is slated for inclusion in the future. Okay. Let's go to the next slide.

These are the high priority meaningful measurement areas for a hospital IQR, namely strengthening person and family engagement, the promotion of effective communication and care coordination, the promotion of effective prevention and treatment of chronic disease, and to make care safer specifically by reducing harm caused in the delivery of care.

We've now arrived at what I'll call the Friday afternoon of our time together. We've got two measures to go, and our co-chairs and yourselves have done a remarkable job of keeping us on time, such that we will have to come to a decision of whether or not we want to take our break or plow on after we finish this first measure. And that first measure is going to be a discussion around what we, as staff, have flagged as one of the most potentially controversial measures, and that'll be maternal morbidity.

But before that, I'll hand it back over to our co-chairs to put out for public comment.

CO-CHAIR MORRISON: Public comments in the room? Public comment on the phone? Okay. Who has the joy of describing this measure from staff?

MR. STOLPE: That would be me.

CO-CHAIR MORRISON: That would be you.

MR. STOLPE: And a pleasure it is. So this is a very interesting measure. The first

that we're going to approach is NQF2019-114, maternal morbidity. This is perhaps the -- one of these kids that is doing his own thing of the measures that we're considering today, and it's the only measure that is a structural measure, and it's the only measure that doesn't have some NQF-endorsed either basis for the measure itself, or it's the measure actually being fully reviewed and endorsed.

So this measure is a simple one-question attestation, which I'm going to read the question in its entirety for the group. And it's: does your hospital or health system participate in a QI collaborative program, i.e. state perinatal collaborative, federal collaborative, registry, or purchaser collaborative aimed at improving maternal outcomes during inpatient labor, excuse me, labor, delivery, and postpartum care, such as hemorrhage, sepsis, thrombosis, severe hypertension, preeclampsia, eclampsia, or death?

And the options are: yes, no, or not

applicable for hospitals that do not provide inpatient labor and delivery care. So we're simply stating: do you participate in a QI program?

The staff's preliminary analysis of this measure landed at do not support. Now the rationale behind that is that the evidence based, as we saw in the submission, was not adequate to say empirically that not only participation, but attestation to participation is directly connected to the sorts of outcomes that we would want to see.

Now, and not to put too fine a point on it, but there is a distinction between attesting to participation, the degree to which that occurs, and what that actually means to consumers who would be looking at IQR, presumably in determining which hospital they would want to go to, and hospital compare, and using this measure as a potential way of discriminating between two different hospitals. So that's a fairly quick synopsis of the -- of the PA for

this particular measure.

CO-CHAIR MORRISON: Thank, Sam. Lisa, and Mothers Against Medical Error, I have you as the first discussant.

(Simultaneous speaking.)

CO-CHAIR MORRISON: Oh, I'm sorry, clarifying, no, no. We --

PARTICIPANT: We had some just --

CO-CHAIR MORRISON: Okay.

PARTICIPANT: -- clarifying statements.

CO-CHAIR MORRISON: Oh.

MS. ABDULLAH-McLAUGHLIN: Yes. So I'm Annese Abdullah-McLaughlin, and I work for CMS, and I work on this measure. And we actually refined the question --

CO-CHAIR MORRISON: Okay.

MS. ABDULLAH-McLAUGHLIN: -- because when we first put the question on the MUC list, it was very early development. And I did send this over about a couple weeks ago to the MAP that stated our new question.

So it's still a one question, but it reads: does your hospital or health system participate in a statewide and/or national perinatal quality improvement collaborative program aimed at improving maternal outcomes during inpatient labor, delivery, and postpartum care, which includes implementation of patient safety practices or bundles to address complications including but not limited to hemorrhage, severe hypertension/preeclampsia, or sepsis, and the answers are the same. It will be yes, no, or not applicable if your hospital does not provide inpatient labor and delivery care.

So I just wanted to mention that before we got beyond that.

MR. STOLPE: Thank you for that.

MEMBER SCHREIBER: Can I just ask a question? Because this is very different, and it really isn't sort of the traditional measure that you think about, I'm going to ask the co-chairs: would it be helpful for us, as CMS, to frame this to begin with, or do you want to hear everybody's

conversation and then have us respond?

CO-CHAIR MORRISON: Go ahead and frame, Michelle.

MEMBER SCHREIBER: You know, this is obviously what I want to do. You know, this is not your standard measure per measure. This is really an attestation signal that hospitals who do deliveries are participating in some sort of -- we say national or state, but you know, we're willing to be pretty flexible about this, but you're participating actively in a program, such as the California Collaborative, or AIM, or a statewide initiative like used to exist in Michigan, to decrease maternal complications.

And all it is, is stating: I'm in it, or I'm not. This is a signal from CMS that maternal mortality is such an important issue that we want to make sure organizations are at least participating now in QI.

To say that there is no evidence that QI actually improves outcomes I think flies against the grain of everything that we've

learned about QI, because that's why we do it, to improve outcomes.

Whether or not an attestation measure improves it, I don't know that I can say that, but it's certainly a signal that shows that CMS feels that organizations should be participating in this, and that it may appear on Hospital Compare.

In the long run, I shared earlier this morning, that we are working on an electronic maternal morbidity measure with the Joint Commission, but as all of you know, that's a ways going in getting it, you know, onto some kind of a reporting structure. It's probably at least two years out.

And so we really wanted to ensure that organizations are aware that CMS thinks this is an important issue, and really give organizations a little prodding to be participating in these very important collaboratives.

CO-CHAIR MORRISON: Thank you.

MR. STOLPE: One other thing that was

included in the PA that I think is worth noting is that CMS stated in their submission that this will likely eventually be replaced with what we would all consider the obvious outcome measure associated with this.

So one other thing to consider here that this may be this, part of a crawl-walk-run approach with the signal, as Michelle stated, being this measure, but eventually moving towards an outcome measure.

CO-CHAIR MORRISON: Lisa.

MEMBER McGIFFERT: Okay. Well I'm an outcome measure proponent. I have problems with the attestation, because I'm not sure how meaningful it will be. I think that everybody's going to say: yeah, we're doing that.

I mean, that's what's kind of happened with antibiotic resistance programs, antibiotic stewardship, and we really don't know. What are they doing?

So my biggest concern about this is that we have a really big problem, and I don't

need to go on. Everybody read how many people are affected by this, and that there are organizations that have been working for 10 years to try to come up with a protocol to recommend for hospitals, and throughout the documents, I see no evidence, no evidence, no evidence, but maybe it was no evidence for attestation.

But there is evidence that certain protocols help. So why don't we put those out there and say: you need to participate in this protocol that has shown to work? And --

(Simultaneous speaking.)

MEMBER McGIFFERT: -- yes.

MEMBER SCHREIBER: That usually is the gist of this. You know, participate in something like --

MEMBER McGIFFERT: That's what you were going for.

MEMBER SCHREIBER: -- the California Collaborative that has --

MEMBER McGIFFERT: Exactly. That's the one that I --

(Simultaneous speaking.)

MEMBER SCHREIBER: -- shown improvement.

MEMBER McGIFFERT: -- looked at. And so I guess I have, I have a problem with like going off on this, and maybe people will be believing that we're doing something, when we're really not doing something.

And I have a -- I'd like to know how many, how many organizations or facilities you think are already doing this, and that are going to say yes. And if they all say yes, we're doing something, then, you know, we're back where we started from.

I just don't think from the public's perspective that that's going to -- I think the public's going to see that as an assurance that they're -- the hospital is doing something, and I'm not sure that that's a true assurance to the public.

And so those are my, you know, main concerns, that we're not pushing forward with

some outcome measures, and it looks like you're working on that, for morbidity. I think you said mortality, right?

MEMBER SCHREIBER: Yes, morbidity.

MEMBER McGIFFERT: Morbidity, okay. So --

MEMBER SCHREIBER: Mortality is too small numbers to measure.

MEMBER McGIFFERT: Yes. Yes. And I would just like to see some reporting that's real information about harm to women, so many women -- women of color especially -- and to document that so that the public can see it.

And I don't see that in the future, really. I see, they're going to go to a protocol. They're going to, you know, apply a protocol, and I understand that's all great, but from the public's perspective, we're not the experts. We don't care what you do. Just bring the numbers down and keep women safe, and that's the ultimate measure that we need to get for this population as well as others. So I would support

the recommendation that was made.

CO-CHAIR MORRISON: Thanks, Lisa. Who do I got? I got I think Marty. Yes, Marty. Project patient care?

MEMBER HATLIE: Yes. So I don't support the recommendation that was made. After the preliminary analysis, I think we should support this for rulemaking. This is an area where we're going backward, from the data that I read. I mean, I love the fact that CMS is sending this signal that this needs to be a prioritized area for every hospital to be working on. This is how we make change in this country; we do it collaboratively. This is our change engine for achieve large scale change is to get someone involved in a collaborative, or to get everyone involved in a collaborative. And we do have a lot of evidence of success.

I mean the one that's sort of obvious is the early elective delivery success that we achieved in this country. I mean that was something that everybody knew there were tools to

do, but until we really encouraged people to be involved in a collaborative where they shared lessons and shared data, and used that data to compare themselves to one another, we didn't see the change that we knew was possible until that kind of change actually got into place.

I know it's not an outcome measure. Lisa and I chatted about this at lunch. And there's comments that I looked at from various organizations about burden, and about lack of specificity, about whether it's connected to other initiatives like this in the same area, but that's the beauty of a collaborative -- that you can actually have multiple things going on, and the collaborative sets goals, and it gets everybody aligned to achieving those goals.

So I think it's actually a relatively low burden, and every hospital should be working on this. And so I do see it as sort of a nice big impact next step on the way to achieving change here.

I also just want to, I mean we've been

talking about this for 20 years, maybe 25, but when the airline industry really identified a safety issue like this, they didn't really wait. They went into action, trying to create these all-teach, all-learn environments, where we can, you know, problem solve together, and that's what a collaborative does.

We've got two organizations here. AHA. Akin, I haven't really met you yet, but it's nice to meet you, and Premier, who have been very involved in the handiwork, and achieving the kinds of results that I think are possible here.

So that's why I think we should all just get behind this and support this as an important signal and an important rule.

CO-CHAIR MORRISON: Thanks, Marty. Kelly, are you still with us on the phone?

MEMBER GIBSON: Yes, I am. Can you all hear me?

CO-CHAIR MORRISON: Yes. Go ahead.

MEMBER GIBSON: Okay, thanks. So I would actually agree with the recommendation. I

think it is so important that we have a measure to look at maternal morbidity. It is an incredibly important issue in this country that I don't think has gotten the attention that it really needs. But I do worry that just by having someone check a box and say they've participated in some kind of a quality project about something related to maternal outcomes is really not sufficient for saying if they're participating in a quality collaborative that's actually associated with improved outcomes.

There's a lot of work being done, maternal, or Society for Maternal Medicine just published a map that can show you, you know, which states have maternal or perinatal quality collaboratives. Most maternity hospitals participate in their state quality collaboratives, but it doesn't really tell you about what they're implementing on the ground.

So I think a better measure would be to say: are you implementing specific bundles that have been associated with improved outcomes?

The Joint Commission just brought out two new measures that are going to be looked at next year specifically relating to hypertension and to hemorrhage, two of the largest preventable causes of maternal morbidity and mortality, and I think maybe having something that's a little more specific about what a hospital is doing, rather than just saying, are you participating in some kind of a quality program, might actually give you a more meaningful assessment of what's being done, especially if this is something we're trying to then show to consumers, or present as representative of what kind of quality care a hospital is providing to women.

CO-CHAIR MORRISON: Thank you, Kelly. Brock, from the rural folks?

MR. SLABACH: Yes, thank you. There wasn't a strong notion one way or the other in the rural work MAP on the maternal measure. I think the first big question, and one that would need to be answered, is, and I think it's obvious, but the question was, what would, what

would the definition of -- it would be obviously for only hospitals with planned deliveries, so hospitals that don't do deliveries in a planned basis would not participate, and what would be the definition of the volume required in order to be considered a planned delivery site?

For rural facilities that have low volumes, that's, you know, could be, could be one issue. The -- I think that my personal experience as a hospital administrator historically, I participated in a number of collaboratives around specific issues, and they are very robust in terms of the making change to improve patient care.

So I don't think that, in general, we or the group had any aversion to this. I think that when I look at the workgroups that I've participated in on this topic, for example, at the AAMP, we had a inter-association collaborative to talk about this. We came up with working recommendations, and a collaborative like this was not one of them, but that doesn't

mean that it can't be useful.

And I know that CMS in June of this year had a full day on this topic here in Washington, and I know that there was a need to do something, and maybe this is a great start.

The other thing I will point out is that for critical access hospitals, they technically do not report in the IQR, so I am assuming that they would not be needing to attest in this particular program, so they would be excluded from this measure, which can be an issue, I think, in terms of those that are doing deliveries.

And then last but not least, and I think that this is probably the most important question is, this is making the assumption that there are collaboratives available for all hospitals in the United States to participate in. And I can tell you they've got a nice collaborative in Alaska, for example, that was reviewed on the call, but there may be, in many states, nothing organized yet. And I can tell

you that collaboratives I've participated in, it's taken really federal resources to create the collaborative environment, usually through the Flex program, which is the Medicare Flexibility Program that HRSA operates to be able to organize care around the collaboratives, around some of those kinds of resources.

So we would need a discussion as to how hospitals that didn't have access to a collaborative, how we can create that, because I think that's going to be a very important feature to this work. So --

CO-CHAIR MORRISON: Okay. Clarifying questions? Marty?

MEMBER HATLIE: I have one more thing I want to say on the attestation issue. One of the things that's happening simultaneously in our environment is that hospital boards of directors are being encouraged to pay attention to safety and quality much more.

So if you're signed up to a collaborative like this, it's likely to be on the

hospital board of directors, your report card. And I think that's another reason to think that there's some hope beyond the sort of check the box problem that's been already addressed. Thanks.

CO-CHAIR MORRISON: Okay. Clarifying questions? Lisa.

MEMBER McGIFFERT: So in the IQR program, there would be a specific penalty if they did not say yes?

MEMBER SCHREIBER: No. No.

MEMBER McGIFFERT: No?

MEMBER SCHREIBER: It's just --

MEMBER McGIFFERT: No penalty. No penalties involved. And the other thing that someone made the comment to me, and I corrected them, but I may not have been right.

Would this apply, would the measure be -- well I guess it's a facility measure, so it would apply for Medicare and Medicaid patients, right? I mean, it's a facility, whether the --

(Simultaneous speaking.)

MEMBER McGIFFERT: -- facility is participating, and that's been kind of a fear that everything going through CMS, and it's going to be Medicare, but we need these measures for --

MEMBER SCHREIBER: No.

MEMBER McGIFFERT: -- Medicaid.

MEMBER SCHREIBER: This is a facility measure, which is --

MEMBER McGIFFERT: Yes.

MEMBER SCHREIBER: -- an important distinction, because Medicaid pays for 43 percent of all deliveries --

MEMBER McGIFFERT: Right. Right.

MEMBER SCHREIBER: -- in the United States. And obviously we couldn't have a Medicare measure in practice.

(Simultaneous speaking.)

MEMBER McGIFFERT: Yes. And then in my state I think it's even higher than that. Yes.

CO-CHAIR MORRISON: Lindsey, question?

MEMBER WISHAM: Kind of a, yes,

clarifying item, which is, and I think we all know that eCQM being adopted into the IQR program has been an evolution. I do think that an introduction of a measure like this does prepare facilities to better be able to report and feel comfortable with their results being reported eventually with a longer term eCQM.

I would like to find out though: is there any idea of an auditable aspect to this, right? Can you find out, has it been considered, as far as the IQR program, to give it a little more teeth?

Is that, I'm not just attesting yes or no, but I'm actually having to declare which collaborative I'm being a part of. That may be something that may alleviate some of the value that may be lost with just a yes or no.

CO-CHAIR MORRISON: Yeah, please.

MEMBER SCHREIBER: So the IQR program is an auditable program. There is a certain sample size every year that does get audited, and this would be added to that.

I'm not going to tell you that the sample size is huge, quite honestly, but I think in the future, the other thing to think through is as there is this electronic composite maternal morbidity measure, that if somebody is doing particularly poorly, but they're attesting that they're participating in all of this, that would probably be a flag for looking at it.

MEMBER WISHAM: Okay.

CO-CHAIR MORRISON: And Michael.

MEMBER WOODRUFF: So it feels a little bit like a lost opportunity, as you hinted. If it's a single question: is there a mechanism through this type of measure to gain information and understanding from the participants on what the barriers are, or what they're facing, so we can be in more of a learning mode during this?

MEMBER SCHREIBER: So thank you for that question, because in all honesty, we had a big debate about this, and should we be requiring more information, for example, to get to the point of the person from MFM on the phone, there

was some discussion about: should we be listing out specific initiatives and making people attest to them?

Then it started getting into this question of burden, and how much are people really having to report? And that's why it landed back to really this kind of single simple question, recognizing full well that it's the beginning until we have more measures. But that's the rationale behind it. We could have, and it was thought about, but we landed on this language to be least burdensome.

CO-CHAIR MORRISON: And I've got Akin and Andreea, questions?

MEMBER DEMEHIN: So sort of along the lines of the question that I heard last, have you given any thought to in some ways tailoring the -- I don't know if tailoring the attestation is exactly the right terminology here, but to the point that Brock raised earlier, not every hospital does planned deliveries or has labor and delivery service.

So have you thought about, within the measure, laying out the kinds of things that the hospitals would have to participate in that would align with the kind of services that they deliver?

As it's framed right now, it sounds pretty wide open without a lot of definition around how and what. And I certainly get the concerns about the burden, identifying a specific initiative, or for the potential for it to be a little arbitrary for CMS to identify those measures, but could you talk a little bit about whether you've thought through those pieces.

MEMBER SCHREIBER: Thanks, Akin, for the question, and you're right. I mean, there's obviously big referral centers who take care of high-risk pregnancies, and you know, their not only resources but their participation is probably going to be somewhat different than what a community hospital might be.

The problem for us is figuring out all of that, because as you know, when we do these

reports, we don't actually always know that, so that would mean that either we get information from AHA, or the hospitals are going to have to fill out this long form, you know, this is how many deliveries that we have done. This is the services that we have, because we just don't know that. And so I understand where you're coming from with it, it's just that that's very hard for us to know.

MEMBER DUSEJA: Akin, I was just asking the second part, you know, with all of the measures we have, you know, these guidelines and specification manuals, so the hospitals sort of interpret the question, and what they should be attesting to would be provided there as well.

CO-CHAIR MORRISON: Maryellen?

MEMBER GUINAN: I think, Michelle, you said in the beginning of the day that this measure was probably more of a signal that you were sending out, versus an actual quality measure at this stage.

And so I guess am I correct to assume

that then the legwork has been done kind of CMS's side, in terms of looking at all of the collaboratives that are out there, looking at their membership lists, which are public, in terms of how many hospitals, and they're by name, and then realizing there is a gap right now, and wanting to truly send out a signal to say, you know, folks are not participating in these collaboratives, that you have kind of statistics already on who is participating?

MEMBER SCHREIBER: So, I don't know that we have looked at every collaborative, because I suspect there are many out there that we are not aware of, but we certainly have been in conversations with the big collaboratives. And there is definitely opportunity for organizations to be participating.

MS. ABDULLAH-McLAUGHLIN: All right. And so I wanted to just add to that. We did do an environmental scan and a literature review, so we do know what states are participating in quality improvement collaboratives, and I also

did my own research, as far as AIM goals, and there are 28 states that are currently participating in the AIM program.

And I also wanted to address the other gentleman's question about states being able to participate in an actual state perinatal collaborative.

And even if a state does not have one, the AIM program is national, and so they would be able to participate in that. It is free, and you can get everything offline, and it gives you also some access to data resources as well. So we do have that data.

CO-CHAIR MORRISON: Andrew?

MEMBER GUINAN: Can I just, sorry. Just a followup.

CO-CHAIR MORRISON: I'm sorry.

MEMBER GUINAN: I think it would merit though, because I think there's a big distinction between wanting to know who is actually involved in the states specific, because then you can delve into how that collaborative is actually

working, versus if they're in a national like AIM, and that's not going to be captured in a strict attestation measure. And that was not a clarifying question.

MEMBER BALAN-COHEN: And mine was actually, I think, related to some of the earlier points. Again, I'm appreciating the burden of not having this as a yes/no question, but I wonder if there's at least like the possibility of having the hospitals report which collaborative.

Like, just the name. I mean, like they're almost doing the step there, because I think that can inform, can lay like the groundwork a little bit for better understanding, you know, what's really working, right?

So later on, when you get to the point where you have like the outcome measure being developed, then you can already like, some analysis can be done on whether, you know, like what kind of methods are working and where.

CO-CHAIR MORRISON: And Cristie, I

know you had several questions.

CO-CHAIR UPSHAW TRAVIS: Maybe just one.

CO-CHAIR MORRISON: Oh.

CO-CHAIR UPSHAW TRAVIS: But maybe not. I was wondering, are there other mechanisms that CMS would have, other than IQR, to collect this information and send this signal?

MEMBER SCHREIBER: I mean, there are other mechanisms. Most of those would be frankly through conditions of participation, and mandating it, which takes years to get in, and I don't think anybody really wants.

This is, quite honestly, the simplest, fastest way to send a signal. I mean, we can do surveys. AHA, frankly, could do surveys, but it's not quite the same.

CO-CHAIR UPSHAW TRAVIS: Okay. I think that was mine --

CO-CHAIR MORRISON: That's it? Jackson?

CO-CHAIR UPSHAW TRAVIS: -- until we

get to discussion.

MEMBER WILLIAMS: Are private parties like US News and World Report, Leapfrog Group, Consumer Reports not doing anything on this issue?

MEMBER SCHREIBER: If, I can't answer for all of them. Leapfrog, I believe, has asked questions around this. I don't know it's, how it's scored in their patient safety score, but they have asked questions.

Do you remember on the Leapfrog survey? So they have. I don't think it shows on US News and World Report, and you guys can all correct me if I'm wrong. I don't know.

CO-CHAIR MORRISON: Okay. So let me just summarize what I've heard, and then we can move into discussion, if that works. And then I think, so I heard in terms of, it's a very important issue, and I've heard strong belief that collaboratives work, and that they should be supported.

I've heard concerns about whether the

attestation is meaningful. I've heard questions around the baseline, and using the, is it talked out, and I'm not sure that we've gotten information back about how many, how much, how many hospitals are participating, versus how many are not, at the present time.

I've heard concerns about, that the association may be about the quality of the collaborative, not just the collaborative itself, and that this doesn't actually get at that.

I've heard that there are concerns about what's being done is not being measured so that what people are actually doing from the collaborative, as a part of the collaborative, is not being measured.

And then I have conversely heard, we don't know a lot about the collaboratives volumes, and who's participating in the collaboratives per se, rather than from the hospital denominator.

And then, concerns about access. Those are what I've heard from the group. Did I

miss anything? Okay.

Let's open up for discussions for those things that haven't been raised, or concerns that haven't been addressed. Marty?

MEMBER HATLIE: I'm thinking about the exchange that Michelle and Cristie just had. I think there are other things that CMS can do, but this would reinforce the things that CMS is doing through its other vehicles.

And it feels like an opportunity for NQF to actually step into that role with this kind of measure, and play that reinforcing punch, and really sending that signal, strengthening the signal that this is an expectation that hospitals take this on.

I mean, I just don't know that we've had that opportunity before to consider a measure like this.

CO-CHAIR MORRISON: All right. Lisa? I'm sorry. Continue.

MEMBER McGIFFERT: No, that's okay. I just, I assume this would be publicly reported,

and I didn't hear on your list that, how meaningful it is to the public.

CO-CHAIR MORRISON: Oh, I'm sorry. I missed that.

MEMBER McGIFFERT: Yes.

CO-CHAIR MORRISON: I'm sorry.

MEMBER McGIFFERT: And you know, to have this vague understanding that they're doing something. So --

(Simultaneous speaking)

CO-CHAIR MORRISON: I'm sorry. I had that written, and I just went right over it.

MEMBER McGIFFERT: Yes. Thanks.

CO-CHAIR MORRISON: I've got Linda, then I've got Cristie.

MEMBER VAN ALLEN: Maybe I should've made a comment in the question section, because it's a comment, not a question, which is, I feel a little stupid, but my first meeting, so be patient.

It seems like we ought to be measuring morbidity and reporting it. Are we doing that

already and I just missed it? I mean, why wouldn't we just go for it?

CO-CHAIR MORRISON: I, I'll paraphrase Michelle, but the morbidity numbers are actually quite small.

(Simultaneous speaking)

CO-CHAIR MORRISON: Yes, the morbidity numbers are high, the mortality numbers are small. Was that the question?

MEMBER VAN ALLEN: No.

MEMBER SCHREIBER: And actually, even the individual morbidity numbers are relatively small, which is why the goal of the measure that's under development, it's a composite morbidity measure, so that we will have more robust data.

And it is in development, but it's not in any way, shape, or form, ready for implementation.

MR. STOLPE: Yes, but was the question not, why do we not proceed directly to the outcome?

MEMBER SCHREIBER: Because we don't have it.

MR. STOLPE: That's what, that's what you mean by just going for it, correct?

MEMBER VAN ALLEN: Yes, just, right.

MR. STOLPE: Yes, so --

MEMBER SCHREIBER: Thank you. We don't have data on morbidity. We don't have it right now.

MEMBER McGIFFERT: We don't have any data on morbidity, like coding, or, I mean, you know, the thing is I've worked for almost 20 years now on developing the infection reporting, and it took a really long time, but I can assure you that even though everyone knew there was a big problem with infections, no one was going to do anything about it until they were mandated to report what was happening.

And that kickstarted the movement to get into protocols, and collaboratives, and all that stuff, and did CMS, and gave money to help that happen.

But that's the, that's the model we have, and it's a long-term model, but it's, I don't know that it's longer than the model that you're envisioning.

MEMBER SCHREIBER: Yes, we don't know that we have it as --

CO-CHAIR MORRISON: Okay. I've got Cristie to start.

CO-CHAIR UPSHAW TRAVIS: Okay. Well, just a, just a couple of things. I'm actually a little concerned about the unintended consequences of publicly reporting, and I think this probably goes along with Lisa, where, you know, if I was looking at two hospitals, and one's in a, in a collaborative, and one is not, and you know, if I'm thinking about making a choice based on that answer, I'm not really sure that I could interpret that the quality of care I'm going to get that is better at one than the other.

So I do think it's, there's a strong communication issue that's relative to something

such as this. The other thing, quite honestly, and this is just from my experience in a marketplace, with particular hospitals and providers, it's all about execution.

It is not just about knowing what you should do. It's about knowing whether you're actually doing what you should do. And what worries me, although I see collaboratives as a good way to help you get there, you know, if, indeed, we have a lot of hospitals already in, doing collaboratives, something's missing.

And the other thing is, on the early elective deliveries, there were collaboratives, but it was public reporting that drove a lot of it, and I know in my particular market, it made a huge difference.

And I don't think we would've seen the acceleration of, you know, the, of the change and the improvement, with, had there not been also kind of public reporting and accountability.

MEMBER SCHREIBER: And we're not disagreeing with that.

CO-CHAIR UPSHAW TRAVIS: No, I know you're not. But I guess my concern is that there's this unintended consequence that, if I look on IQR, this is why I asked if there were other ways this could be done, versus being in IQR, where it's publicly reported, because we could be getting false positives for people if they saw this as, you know, a way to make a decision between hospitals, because execution makes the difference, not just participating in the collaborative.

CO-CHAIR MORRISON: Okay.

MEMBER DEMEHIN: I echo some of Cristie's concerns around, you know, that was part of the reason why I asked the question I asked earlier about sort of tailoring participating into the particular needs of a hospital.

You know, if they don't do planned deliveries, that they can choose not to say that they're participating in the collaborative, what does that say about them?

I will say it's a general principle. Marty said this earlier. We are fond of collaboratives. They do a lot of good. I don't think we would dispute the notion that in quality improvement processes and collaboratives can lead to better care. Absolutely.

There's a part of me that feels like, for something like this, maybe if you're thinking about a structural measure to get people started and to send a signal, it's less about the collaborative participation, and maybe it's more about a specific practice that you want to see.

And somebody raised the notion of the Joint Commission standards that were recently approved that outline some steps that hospitals will take, I think largely focused on perinatal hemorrhage, and the kinds of training that staff have to have.

There's a part of me that thinks that if that attestation were a little more specific to some specific set of practices, they might have a little more bite, and little more meaning

than just participating in a collaborative.

It may be that hospitals will find it the most helpful to bring those practices online to participate in a collaborative that gives that to them, that helps sort of walk them through that process.

Otherwise, it feels a bit disconnected from sort of the kinds of, the sort of behavior changes that you want to see in the field, and the kinds of practices that you want to see implemented.

It feels like we're talking more about the collaborative than we are about the care, if that makes sense.

CO-CHAIR MORRISON: So I've got Brock. I've got Kelly on the phone. I've got Marty, and then if there's not anything that people feel that burning desire they need to say, I think we'll close. So Brock. And I've got you, Anna, too. Sorry, I've got you, I've got you.

MR. SLABACH: Yes, just real quick, I will comment that the recent legislation has

funded and stood up maternal mortality review committees in each state.

So that, many states have had that already, and they're starting the work that does a little bit about what Lisa's talking about, collecting the data, doing interventions, in terms of ways to improve those situations.

I just looked up, ACOG just published in September of this year that 45, there are 45 statewide perinatal quality collaboratives in the United States.

So I did not realize that until just now, so I'm assuming that at least all the five states apparently have some kind of collaborative going on in this space, which is good to know. I don't know.

Going to the point made earlier, if it, if it applies to every one of the providers within that space, in terms of the content of their service, and then 26 are currently AIM states. So yes, that's good news to me, at least in terms of the presence of that. So thank you.

CO-CHAIR MORRISON: So I've got Anna, Kelly, and we'll give Marty the last word.

MEMBER DOPP: I'm going to go out on a limb just to try to reinforce what Marty shared, and your very thoughtful initial comments, and as a pharmacist, I'm going to shamelessly try to draw parallels to medication-related measures as much as possible today, apparently.

But if we look at the MedRec measures in their, in their early stages, and say what you will about the merit of MedRec measures, they started out a lot like this, and they led to systems being put in place.

And granted, those systems are not always evenly applied across practice settings, and, but they did start the wheels turning to make medication reconciliation more of a standard expectation with providers and with patients, and then, and then we've seen more refinement of the measures since then.

So like the medication reconciliation measure within ESRD is way more robust than the

early just yes, no, with some criteria to meet the measure.

So I, just to reinforce your point, there's precedence for taking these smaller steps to build systems first, and then come back and refining them.

CO-CHAIR MORRISON: Kelly?

MEMBER GIBSON: Just two things. So my first question was whether this would be tied to anything to do with the maternal levels of care, just in terms of kind of stratifying from smaller hospitals to larger hospitals.

The second point I just wanted to echo what some of the others have said, is that maybe this is a focus too much on being in a collaborative, rather than on the care we're giving to women.

You know, we're participating at my hospital. We're part of the State Quality Collaborative, but that doesn't mean that we have implemented some of the bundles specific to some of the causes that are really most associated

with maternal mortality, and so just participation in a quality collaborative, I just don't think that's the marker for what we're really trying to ask.

CO-CHAIR MORRISON: So at the risk of giving a lawyer the last word --

MEMBER HATLIE: I was just going to say, because the Joint Commission has come up several times through this discussion, they filed a comment strongly supporting this measure.

So I wanted to make sure we were all aware of that. They see it as a strengthening of the signal that they're trying to accomplish through their different entities.

CO-CHAIR MORRISON: So just a quick check of the room. Does anybody have a burning issue, particularly those who haven't spoken, they'd like to get on the table before we go to a vote? Once? Twice?

MEMBER DeSOTO: Just one last thing. I just wanted to say that, you know, somebody had mentioned access to collaboratives and learning

programs.

AHRQ had, in 2018, done safety program for perinatal care, which is available, and it actually allows hospitals to create their own QI kind of a program to address severe maternal morbidity. So there is, there is stuff out there, and I think it's a, it's a good idea to start here.

CO-CHAIR MORRISON: All right. Should we go to the vote? Let's do it.

MS. JUNG: So our number for this is 24. I realize that Aisha Pittman didn't come back, so --

CO-CHAIR MORRISON: Okay.

MS. JUNG: -- we're at 24 right now.

CO-CHAIR MORRISON: We're at 24. Okay. So --

CO-CHAIR UPSHAW TRAVIS: So this is one of those double negative things?

CO-CHAIR MORRISON: Yes. So what you're doing is you --

(Simultaneous speaking)

CO-CHAIR MORRISON: Yes, yes, yes, yes. So do you support the preliminary recommendation of staff and the preliminary recommendation of staff was, do not support? So if you agree with staff, vote yes.

MR. HIRSCH: For MUC2019-114, maternal morbidity, do you vote to support the preliminary analysis as the workgroup recommendation is now open for voting. Your options are yes or no.

MEMBER JORDAN: Yes means you do not want to have this --

MR. HIRSCH: That's correct.

MEMBER JORDAN: -- since hospitals know we --

CO-CHAIR MORRISON: That is correct.

(Simultaneous speaking)

CO-CHAIR UPSHAW TRAVIS: Or some other permutation.

CO-CHAIR MORRISON: Permutation or comment. Yes, which we will get to if we need to.

MS. JUNG: Okay. So we have a total

of 14 votes for yes, for this measure, and then a total of 10 votes for no for this measure, so this means the workgroup does not accept the staff's preliminary recommendations, and co-chairs, we should motion on what category we'd like to open up for.

CO-CHAIR MORRISON: What, no, no, no, no. No, no. Wait.

CO-CHAIR UPSHAW TRAVIS: What is the answer?

CO-CHAIR MORRISON: What is the answer?

MS. JUNG: So you --

CO-CHAIR MORRISON: Oh, it's 60 percent.

MS. JUNG: It's 60 percent. We needed a count of 15 --

CO-CHAIR MORRISON: Right.

MS. JUNG: -- and there was 14 in total --

CO-CHAIR MORRISON: Okay.

MS. JUNG: -- counting the one that

came in through the chat box.

CO-CHAIR MORRISON: Okay.

MS. JUNG: So the work group does not accept the staff's preliminary analysis. Co-chairs, similar to last time, I put it towards you to make a motion on what category, or ask the workgroup what category we'd like to start the discussion with.

CO-CHAIR MORRISON: We've got to start from the top.

(Simultaneous speaking)

CO-CHAIR MORRISON: We've got to start from the top. So we're going to start from, do you support the measure? The first is, do you support the measure? As it is --

MS. JUNG: Support for rule making.

CO-CHAIR MORRISON: Support for rule making, as it is written.

MR. HIRSCH: For MUC2019-114, maternal morbidity, do you support? You can vote for yes or no.

(Off microphone comments)

CO-CHAIR UPSHAW TRAVIS: No.

(Simultaneous speaking)

MR. HIRSCH: Support for rule making.

CO-CHAIR MORRISON: Support for rule making. Would you like to see this move forward for rule making?

MR. HIRSCH: For MUC2019-114, maternal morbidity, do you vote to support? The workgroup has voted 17 for no, and 7 for yes. The workgroup does not support recommendation for rule making.

CO-CHAIR MORRISON: Okay. So now we go to support with condition? Now we need to go to support with conditions, and I need to hear conditions nominated from the group as to what the conditions would be to put this into rule making.

(Off microphone comments)

CO-CHAIR MORRISON: Because we did not, we did not accept the committee's recommendation that it not be endorsed, staff recommendation, thank you. The committee voted

that it could not go through to rule making as it is currently written, so we are in no person's land at the moment.

So the next stage is, we vote on whether it should go through to rule making with conditions, and so all of those who voted no just a minute ago, I'm open to hearing conditions as to what would make it a yes.

CO-CHAIR UPSHAW TRAVIS: We still have another category.

CO-CHAIR MORRISON: We still have another category.

MEMBER McGIFFERT: So one of the conditions could be that it goes through NQF.

CO-CHAIR UPSHAW TRAVIS: Yes.

CO-CHAIR MORRISON: Okay. So yes, one of the, one of the conditions could be NQF endorsement.

CO-CHAIR UPSHAW TRAVIS: That's right.

PARTICIPANT: That's typically what --

CO-CHAIR MORRISON: And that's often a condition. Thank you, Lisa. Anybody else? All

right.

So I have a proposed modification that is, the vote is, do you approve this for rule making if it goes through NQF endorsement first?

CO-CHAIR UPSHAW TRAVIS: If it's endorsed.

CO-CHAIR MORRISON: If it's endorsed, thank you. That is, that's all I've got as the only condition. So if you'd like to see that, vote yes.

MS. JUNG: We're --

CO-CHAIR MORRISON: We're not there yet.

MS. JUNG: Not ready yet.

CO-CHAIR MORRISON: Okay.

MR. HIRSCH: For MUC2019-114, maternal morbidity, do you vote conditional support upon NQF endorsement process?

MS. JUNG: We have 23 votes. Amy, if you could send it via the chat function.

MEMBER HELWIG: I think it's me.

MS. JUNG: Oh, it's you?

MEMBER HELWIG: My battery just died.

CO-CHAIR MORRISON: Oh, no.

MEMBER HELWIG: I wouldn't know.

CO-CHAIR MORRISON: Same deal. Okay.

MS. JUNG: So I'll read out the final --

CO-CHAIR MORRISON: Yes.

MS. JUNG: -- number for the record.

CO-CHAIR MORRISON: Yes, I'm sorry.

MR. HIRSCH: Okay. The workgroup has voted 10 for yes, and 14 for no. The workgroup has not put forth maternal morbidity for a conditional support rule making.

CO-CHAIR MORRISON: Okay. So now we come to, do not support with, what --

MR. HIRSCH: Potential for mitigation.

CO-CHAIR MORRISON: -- do not support with potential for mitigation, and I think I need to hear what would be the mitigating circumstances.

MR. AMIN: I think the only thing I can offer on reflection, if the idea here is that

it's still basically a question, and an attestation would be closest to what I think Akin was suggesting, which is that the questions are, the question that's being asked is around the actual practices that we believe influence maternal morbidity.

I think that's, of the conversation, seems to be the closest thing we can offer for --

CO-CHAIR MORRISON: All right. Akin, sorry. Go ahead.

(Simultaneous speaking)

MEMBER DEMEHIN: -- then also, in addition to NQF endorsement, that --

(Simultaneous speaking)

CO-CHAIR MORRISON: Akin?

MR. AMIN: So I get what you're going through. I guess I would ask the question, I don't know if this is of staff or not, but I've asked the question whether that constitutes such a fundamentally different construct of this that it would still land here --

(Simultaneous speaking)

MR. AMIN: That's kind of where I'm stuck.

MS. MUNTHALI: So you're asking whether or not it's such a material change to what's in front of you, and you know, from the MAP perspective, it would be, but you are signaling to CMS that you'd like some additional review of the scientific properties of this measure.

So, and also, it is their discretion, as Michelle has mentioned, that, you know, this measure can go into program, but she is taking your recommendations and suggestions to heart as well.

CO-CHAIR MORRISON: Oh, I'm sorry, Kelly.

MEMBER GIBSON: Yes.

CO-CHAIR MORRISON: Did you have a comment, question, thought, life preserver?

(Simultaneous speaking)

MEMBER GIBSON: I was echoing, I was just echoing what was already said about really

making it more a question about what's been implemented, not just the participation in a quality collaborative, which may kind of change the focus, but if that's what we're really trying to ask when we title a measure maternal morbidity, not entitle it participation in a quality collaborative.

CO-CHAIR MORRISON: So what I'm hearing are two mitigating circumstances. One is NQF endorsement, and the second is a focus on what's actually being done rather than simply participation. Is that, are people okay with that to vote?

MEMBER McGIFFERT: But when we vote, we'll be voting on those two mitigation factors --

CO-CHAIR MORRISON: No, yes.

MEMBER McGIFFERT: -- not another mitigation factor?

CO-CHAIR MORRISON: Not that, not that I've heard yet, Lisa.

MEMBER McGIFFERT: Okay.

MEMBER DEMEHIN: I mean, I guess I would ask the group, and I would ask CMS too, I mean, is the, is the spirit of the measure really to encourage participation in the collaborative?

In which case, if we're making mitigating changes around the collaboratives, then I'd argue that the, refocusing the question on practices is actually something quite different than that.

So I guess that's sort of more of a philosophical question to CMS. Like, where do you want to go? Is it really the collaborative, or is it really the uptake of the practices?

MEMBER SCHREIBER: Actually, I think a good analogy was from Anna on medication reconciliation. Where we want to go is ultimately to make sure that all hospitals are implementing these practices, and that we see it in outcomes measures. Where we're starting is here, to encourage organizations to be in collaboratives.

MEMBER GUINAN: I think we could go

from the philosophical to the practical. The, what would actually happen in terms of the mitigation process if that, if that were accepted?

It would go back to the developers, the developers would then come up with what specific practices hospitals would have to attest that they're doing --

MEMBER SCHREIBER: Yes.

MEMBER GUINAN: -- and I think that's a very different measure than just saying --

(Simultaneous speaking)

CO-CHAIR MORRISON: I don't think your proposal works.

MR. AMIN: I think it's then, with just NQF endorsement, it doesn't work either.

CO-CHAIR UPSHAW TRAVIS: Well, no, because --

CO-CHAIR MORRISON: We just voted against that.

CO-CHAIR UPSHAW TRAVIS: Yes, we voted against that. It's conditional --

(Simultaneous speaking)

MEMBER JORDAN: We're really to the next phase of kill or no kill. I mean, there isn't really a feasible modification coming up here.

CO-CHAIR MORRISON: We killed or no killed already. We let live. All right. I've got Lindsey and I've got Amy.

MEMBER WISHAM: To carry on the point, it's a good one though, but I do feel like I heard that that was going to be described in the specifications manual.

So whether or not they actually discreetly report on which of the practices they're, you know, being informed about through their collaborative, that's a different reporting aspect, but actually delineating which of the practices that they should be focusing on, I think that should be part of, that can be part of the specifications manual.

MEMBER SCHREIBER: And the answer could still be yes and no. Is that what you're

saying?

MEMBER WISHAM: Yes. Yes.

CO-CHAIR MORRISON: Amy, are you going to get us out of this box?

MEMBER HELWIG: I might.

CO-CHAIR MORRISON: Good.

MEMBER HELWIG: I do though think that it -- having the attestation leads to, at first you're arguing with 98 percent, 99 percent will say yes, because it's too broad, and I'm just wondering if CMS would consider putting it in conditions of participation as opposed to a quality measure?

MEMBER SCHREIBER: I won't say that it hasn't been discussed. I will say putting it in conditions of participation takes many years.

CO-CHAIR MORRISON: Cristie?

CO-CHAIR UPSHAW TRAVIS: Well, just one kind of comment, given that we're kind of in this conundrum. You know, I was thinking, just from a personal standpoint, that being more specific in the attestation would be more

accountable for actually implementing some of these practices. But it's still early.

I mean, you know, so it's not like we expect there to be outcomes from implementing the bundles, or whatever the best practices are.

And so to me, it still sends a strong signal that the signal isn't just participating, the signal is actually doing something.

And you could also think about framing it in such a way, we're going to have this outcome measure in a couple of years, and this is your, this is like the signal in your early warning that you need to go on and put these practices into place, and we need to know how many of them you've already put in, and you know, I would think there would be a frame it to where it shows action, not just, and I hate to say just participation, because that's an important piece, but it actually shows something is happening in the care that's being delivered.

And I love the idea that maybe it can still be a yes/no, if worded correctly. Might

have to think about how to do that, but that's why I was holding out for this particular one with mitigation, because I think you sold me on the fact that we need something early before the outcome, just wanted it to be a little bit more than just being in a collaborative.

CO-CHAIR MORRISON: So Cristie, can you put into a sentence the mitigation that you would make this work?

CO-CHAIR UPSHAW TRAVIS: Well, I was thinking that we kind of were at it earlier. It was kind of what Taroon said. Actually, I didn't understand why we would put NQF endorsement in there, because it would have to come back anyway. It would be a different measure.

But for, you know, the practices, implementing the practices, and that, I mean, I would have worded it like --

MR. AMIN: So let me try again, maybe. So the distinction that we made between last year and this year, between the conditional support and the do not support was potential for a

mitigation.

The fine, the distinct line there was that if we're going to make a change to the specification, that really puts us into the two do not support categories.

Interestingly, we find ourselves now trying to distinguish between the two do not support categories, and I don't think we would've found ourselves in this place. So this is an interesting measurement challenge.

But anyway, so Akin, I think you made the very important point, which is to say, at what, like, to, when, to what extent are you making specification changes that it's, you're basically just asking for a different measure?

I don't know that we have ever found the fine line on that. However, I think in the conversation here, there has been texture around what specifically we're looking at.

It's still essentially a structural measure that's looking for potentially starting with attestation, is still what I'm hearing. So

it's conceptually still, like, the same structure.

The question is, what is the, like, what is the question? And it appears that the, where there's, appears to be some mitigation opportunity is around, the questions around, are more around the practices rather than participation in the collaborative.

I don't want to put words in anyone's mouth, but I want to try to put words out there. So if we can, at least for the sake of this process, assume that for the do not support of the mitigation is support essentially for the concept of hospitals attesting to --

(Simultaneous speaking)

MR. AMIN: -- putting into practice these elements of the, you know, I don't want, I don't know the exact words, but we'll find them.

But essentially, the practices that support improvement in maternal mortality. That would essentially be, I think, this category.

Just to draw a distinction, do not

support would essentially be that really this needs a wholesale re-look. We don't, we don't like the idea of a structural measure for this area, and we really need to go back to the drawing board, recognizing that there's, the overarching feedback to the group has said that maternal mortality is an extremely important national imperative that needs attention. There's no question about that. I just want to be clear.

CO-CHAIR MORRISON: So let me try this then. The mitigating circumstances are, wait, first of all, it's a do not support. The mitigating circumstances are, we are comfortable with the, with a structural yes/no measure.

What we would like to see is a focus on both being part of a collaborative, and the implementation of collaborative processes within the institution.

Is that a reasonable summary of where you are? It's a, it's an and, not an or. I think it's the practices seem to be, well --

MEMBER SCHREIBER: Not the collaborative, but practice.

CO-CHAIR MORRISON: I think the practices seems to be the emphasis. Well, I guess the question, the question, the question is then you're at an individual level rather than where CMS started, which is the importance of being part of the collaborative, but it's the second, it's the second piece to that.

Is it more than being part of the collaborative, are you integrating the collaborative's practices into your book of business?

MEMBER MATTHES: Would it be possible, something like a, from this, you know, where their response is either a yes or no, versus a partially implemented, you know, mostly implemented, totally implemented, something like that.

There has to be an option. So I'm kind of looking, well, I really like the idea, and I think it's a good thing to do, but I feel

constrained by the technical requirements of voting, of concerning certain technical requirements that kind of, I think what you outlined, I think specifications have to be changed.

So if the mitigation can be worded in a way that there is general support for the idea without being caught up on technical requirements that are made out here, that would be great. I don't know how to word it, but --

MS. ABDULLAH-McLAUGHLIN: So I just want to just reiterate the question. So the question that you're asking is, we are asking if the hospitals are participating in state or national collaboratives, but we also, the second piece of the question actually says, which includes implementation of patient safety practices or bundles.

So it does have that other piece. We're not just asking about participation. We're also saying that they are actually implementing the patient safety practices and bundles within

those collaboratives.

(Simultaneous speaking)

MS. ABDULLAH-McLAUGHLIN: -- related to hemorrhage, severe hypertension, preeclampsia, and sepsis. That is not what it limits to.

MEMBER McGIFFERT: Can you read the question one more time?

MS. ABDULLAH-McLAUGHLIN: Yes, let me read the question one more time. So this is the revised question that you all unfortunately didn't receive.

So it says, does your hospital or health system participate in a statewide and/or national perinatal quality improvement collaborative program aimed at improving maternal outcomes during inpatient labor, delivery, and postpartum care, which includes implementation of patient safety practices or bundles to address complications including but not limited to hemorrhage, severe hypertension/preeclampsia, or sepsis?

MEMBER McGIFFERT: Thank you for

reading that, because that is helpful. My understanding is the which includes is describing the collaborative, and, itself, and my understanding of the collaboratives, and I may be all wrong, is a hospital could go to meetings, send their people to trainings, as part of a collaborative, and not really actually implement anything, and I know the program, you've got the word implement, but that describes the collaborative is focused on implementing.

Do you see that as the hospital is actually implementing those things? Then it would maybe get to the practices. You see what I'm saying?

Because I think the collaboratives are pretty open-ended. I mean, we've got a lot of our people just get on the phone and complain, and, or just make some comments, and then they don't really participate fully.

MS. ABDULLAH-McLAUGHLIN: So let me just try to answer that question. So when I read the question, and I actually am a registered

nurse still working at a hospital --

CO-CHAIR MORRISON: Okay. Let me, let me, because we're going to go back and forth on this.

MS. ABDULLAH-McLAUGHLIN: Okay.

MEMBER McGIFFERT: Okay.

(Simultaneous speaking)

CO-CHAIR MORRISON: I have, I have two proposals on the table. One is that there's enough, there's enough uncertainty on what the question is actually saying, that I'm not sure people now know what they're voting on.

My suggestion is one of twofold. A, we could just take a break and we can huddle and try and come up with something for you guys.

B, I would suggest that we could also say the mitigating circumstances are we need better clarity on what's actually being asked, because if these guys, if we can't figure out what's in the question and what's being asked, I think it's going to be hard for the public to understand that, and it's going to be hard for

hospitals to report on it.

So perhaps what you're hearing is a lot of confusion, and that the mitigating question is we'd like actually a better, a better question as to what you guys are actually asking and what you're hoping to accomplish, because I'm hearing that there's just a lot of confusion. So are you guys okay taking a vote with that, or a break?

CO-CHAIR UPSHAW TRAVIS: Let's take a break.

CO-CHAIR MORRISON: Break. All right. Fifteen minutes, and we will come back and try and resolve this.

(Whereupon, the above-entitled matter went off the record at 3:10 p.m. and resumed at 3:28 p.m.)

CO-CHAIR MORRISON: Welcome back, everybody. I know how hard it is to break away from that and come back.

So we have two thoughts about moving forward. The first is that it's pretty clear

that we need to bring Scotch to this meeting for the afternoons.

(Laughter.)

CO-CHAIR MORRISON: I will do that next time.

The second is that, and more importantly here, is apparently some confusion over both the intent and the wording of the measure on the table, so I am going to ask CMS to give us the measure one more time, and the intent behind it. And then I, we're going to have a thought.

MR. STOLPE: Please know that it is projected first, some of you will have to turn around to see it.

MEMBER DUSEJA: Yes, I think it is helpful to put it up there. So maybe, I don't know if you can pull it up more, but --

MR. STOLPE: Yes.

MEMBER DUSEJA: So the question, as it reads, is does your hospital or health system participate in a statewide and/or national

perinatal quality improvement collaborative program aimed at improving maternal outcomes during inpatient labor, delivery, and postpartum care. And the word says which, but we actually, what our intent is, we want to say and, so there's like an additional step that the hospitals have to do, and includes the implementation of patient safety practices or bundles, and then we become, we get specific, to address complications including but not limited to hemorrhage, severe hypertension, preecelampsia, and sepsis.

MR. STOLPE: So Jordan, let's scroll down just a little bit so we can actually see that in action. So we've broken this out into two bulleted points.

The first preserves the language exactly as it stands for the first clause, and the second identifies what we just identified as potentially some area of confusion for the group, saying, and has implemented, rather than which includes implementation of. That's just a

clarification for what the expectation is for the measured entity.

MEMBER DUSEJA: So the expectation for the hospital would be, not only are they participating, but they're implementing in order for them to attest. Yes.

MEMBER NOLAN: So that means the hospital is implementing?

MEMBER DUSEJA: Yes.

MEMBER NOLAN: Yes. Correct.

CO-CHAIR MORRISON: So --

(Simultaneous speaking.)

CO-CHAIR MORRISON: Right. Before it was unclear as to who was doing the implementing.

MEMBER DUSEJA: It was clear grammatically. It was program.

CO-CHAIR MORRISON: Right. I am giving the benefit out to our colleagues at CMS. And --

MEMBER DUSEJA: Thank you.

CO-CHAIR MORRISON: You are welcome.

MEMBER DUSEJA: We appreciate that.

CO-CHAIR MORRISON: Remedial grammar may be in order.

So what I would propose to the group is that given the clarity now of the language, which appears to reflect what people were concerned about, which was are processes being implemented in the institution, that we go back up one voting step, where we will vote for conditional support on this measure, and the condition is NQF endorsement, okay?

So we go back to, we replace the and. It's clear that it is participating and implementation at the institutional level of processes, and the condition is NQF endorsement, and then we go back and re-vote at that level.

Do I hear major or even minor disagreement? And right now, I'm just looking for major. I will tell you, honestly.

CO-CHAIR UPSHAW TRAVIS: Akin is --

CO-CHAIR MORRISON: Akin?

MEMBER DEMEHIN: So I won't, I won't be, I won't make, belabor this point too much,

but I think that when the measure comes in front of the MAP, we're asked to evaluate what's in front of us, and it seems like we're kind of rewriting the measure on the fly, and being asked to conditionally support it.

To me, that feels like a step too far, and to me, if we are, if we're being asked to evaluate the measure as is, then that's what we ought to vote on. This sort of rewriting on the fly definitely makes me quite uncomfortable.

CO-CHAIR MORRISON: I guess my understanding, and I will turn to, is that we are not rewriting the measure. We are correcting the incorrect grammar, the way the measure was worded, because CMS is very clear that the language was supposed to mean you participate in the collaborative, and you, i.e. the institution, hospital in this regard, implement processes, blankety-blank, blankety-blank, not limited to, et cetera, et cetera.

If you feel very strongly that we are completely changing it, then it comes to, down to

I think where we are now, which is do not support with mitigation being, please go back and correct the grammar.

And I really, having discussed it with these guys, I really think it's grammar rather than rewriting the question. But I am, if people feel very strongly, you know, I would say don't vote for conditional support, and we will be back where we are.

MR. STOLPE: Yes, and typically, we consider serious modifications to specifications of the, of the measure as the condition for do not support with potential for mitigation.

From the staff standpoint, we see this as a very minor adjustment that reflects the intent, that would just be more of a conditional massage, if you will.

MEMBER DEMEHIN: But my challenge with this is that this detail behind it, it's the first time we're seeing it, because we didn't see it when we got the list of measures.

So we're in the room, we're redoing

the measure on the fly. That's kind of what it feels like to me, so I would urge the group not to support the measure as is, but I won't belabor the point.

CO-CHAIR UPSHAW TRAVIS: I guess just, I'm sorry, I'm just thanking you, Akin, for your comment. If you could help me maybe understand what would be different, had it been clear to you that it was and at the beginning, would there be something different?

Is that what you're trying to say? Something you would've done differently to prepare for this meeting, or --

MEMBER DEMEHIN: I'm saying the detail behind which specific bundles, and which specific kinds of practices would be implemented --

CO-CHAIR UPSHAW TRAVIS: Those were in there. Those were in the language.

(Simultaneous speaking.)

MEMBER DEMEHIN: I did not see it.

MEMBER DUSEJA: So I think what the confusion perhaps was, we did submit changes two

weeks ago, but I'm, it appears that it didn't get to the, to the workgroup.

(Simultaneous speaking.)

MEMBER DEMEHIN: Correct, but reviewing that detail and having it read to us in the beginning of the meeting is a little different than getting it at the outset.

MEMBER DUSEJA: Okay.

MEMBER DEMEHIN: But I don't want to belabor the point.

CO-CHAIR MORRISON: Lisa?

MEMBER McGIFFERT: Well, I'm going to help you. That's a surprise, because I feel, I, again, feel that if this comes to NQF, I mean, I don't want to predict what NQF is going to do, but it has to be backed by evidence, and it, you know, there's a lot of steps along that way, and that's a, that's a whole process that takes a lot of time.

And I just feel like an attestation is not something, I understand totally what you're trying to get at, but I wonder if it would be

just better to focus our attention on getting some outcome measures out as quickly as possible, and that's what my preference would be. So that's what I'll say.

CO-CHAIR MORRISON: So let me say this again. We advise CMS, we don't tell them what to do.

MEMBER McGIFFERT: That's right.

CO-CHAIR MORRISON: Okay. We can be here until 9:00 tonight doing this. I would prefer not to be.

My suggestion is that we vote as conditional support. The condition that has, was raised was NQF endorsement, which is often, I would say universally the condition on endorsed measures that have come through this group within seven years.

Again, CMS can take that or not. If that does not pass, and we will come back to do not support with mitigation. What I'm hearing the mitigation from Akin is that we'd like better clarity on the language, and an opportunity to

review it again, at which case CMS can go back and rewrite it. I will provide grammar tutoring.

And we will see it again, I suspect. And if it does not pass that, then it is not supported at all, because that was the initial vote, and I just, I'm not sure I see any way out of this conundrum except that, guys.

I know it's not satisfactory to anybody, particularly me, but I just don't see any way out of that conundrum. Should we vote?

(Off-microphone comments.)

CO-CHAIR MORRISON: Okay. Jordan, I need a vote.

(Off-microphone comments.)

CO-CHAIR MORRISON: Okay. So as Cristie points out to me, it's important to know what language we're voting on. We're voting on the substitution of and, rather than which.

So we are voting on, do you participate in a collaborative, and you have implemented process related to patient safety practices, bundles to address all kinds of bad

things.

MR. HIRSCH: On MUC2019-114, maternal morbidity, do you vote conditional support? Your options are yes or no.

MS. JUNG: I believe we are looking for 25 right now. We're not missing anyone.

CO-CHAIR MORRISON: Brock --

MS. JUNG: Oh.

CO-CHAIR MORRISON: -- yes, Brock left.

MS. JUNG: Yes.

(Off-microphone comments.)

CO-CHAIR MORRISON: Okay.

MS. JUNG: Let me check is there's one that we don't show.

(Off-microphone comments.)

MR. HIRSCH: On MUC2019-114, maternal morbidity, do you vote conditional support? There are 13 votes for yes, 12 votes for no. The workgroup does not vote for maternal morbidity with conditional support for rule making.

CO-CHAIR MORRISON: All right. So now

we are going to do not support with mitigating circumstances, and the only mitigating circumstances I have heard is clarity in rewriting the measure. So that's --

(Simultaneous speaking.)

CO-CHAIR MORRISON: I understand that, but --

MEMBER JORDAN: Maybe we should go to the, we've already voted this and moved back. Vote on the just kill it --

CO-CHAIR MORRISON: We can't do that. We've already -- Jack, we have already voted that way. We voted not to kill it. We voted not to kill it. We --

CO-CHAIR UPSHAW TRAVIS: The first vote.

CO-CHAIR MORRISON: -- the first vote. That's where we started the day. Sorry, my friend. So now, we're back to the last vote.

CO-CHAIR UPSHAW TRAVIS: We can end up there again.

MEMBER GUINAN: Wait, I'm sorry. When

we did the original, going through the four options, we did the do support or do not support?

CO-CHAIR MORRISON: We started with, we started with do you support the staff's recommendations. The staff recommendation was not to support the measure.

We said, staff, we disagree with you. We would like to vote on the other three options, and we are now on number three of those three options.

MR. AMIN: And if the --

CO-CHAIR MORRISON: I know it was a long time ago, but --

MR. AMIN: Yes. If the last do not support with mitigations doesn't pass, then it is the staff recommendation of do not support carries forward to the coordinating committee. Just to be clear. So we're almost out of this.

CO-CHAIR MORRISON: Yes.

MR. AMIN: Keep going.

CO-CHAIR MORRISON: Right. We're, yes, at the end, maybe, and say, so --

MR. AMIN: Do not support with potential for mitigation.

CO-CHAIR MORRISON: Thank you.

MR. AMIN: And I'll just emphasize that the mitigations, are, we, like balancing to make sure there's emphasis on the collaborative and the best, and the practices, making sure that practices are clear and specified, and obviously updating the question to reflect the balance of these two priorities that the committee discussed.

PARTICIPANT: And NQF.

MR. AMIN: And NQF endorsement. If we don't agree that collaboratives are the right approach at all, then just, you know, then you're not in support of this at all.

CO-CHAIR MORRISON: All right.

(Simultaneous speaking.)

CO-CHAIR MORRISON: We are ready to vote. Oh, I love it. Voting music.

(Simultaneous speaking.)

MR. HIRSCH: For MUC2019-114, maternal

morbidity, do you vote to, do you vote do not support with the potential for mitigation? Your options are yes or no.

MR. STOLPE: Unbelievable. You did it.

(Laughter.)

(Off-microphone comments.)

MR. STOLPE: That's a yes.

MR. HIRSCH: For MUC2019-114, maternal morbidity, do you vote not support with potential for mitigation, 15 votes for yes, 9 votes for no. The workgroup has moved, has recommended that MUC2019-114 maternal morbidity with do not support --

PARTICIPANT: Oh, wait a minute, that was a double negative, wasn't it?

MR. HIRSCH: -- with potential for mitigation.

CO-CHAIR MORRISON: Would anybody like to address gaps in this measure?

(Simultaneous speaking.)

CO-CHAIR MORRISON: Oh, we've got one

more measure. We've got one more measure. Okay. Hang on. Hang on. You're right. I was so far ahead of myself. We're going to the next measure.

MEMBER GUINAN: Can I just, on this measure, everyone lawyered up, so I'm going to have my lawyer moment as well. Can just staff reflect in the writeup for this measure review that the room was given a definition today, and that this vote reflects a vote on the definition that was provided today at the meeting? I think that's important.

MR. AMIN: Yes. I guess because the vote ended up with a do not support --

MEMBER GUINAN: This is a narrative for the --

MR. AMIN: Okay. Yes.

MEMBER GUINAN: -- context of the --

MR. AMIN: We will do that. We'll add it to it. Okay.

CO-CHAIR UPSHAW TRAVIS: I think that's fair.

CO-CHAIR MORRISON: Yes. All right. Hospital harm, severe hyperglycemia.

HOSPITAL HARM - SEVERE HYPERGLYCEMIA

MR. STOLPE: All right. Very good. Thank you. So moving onto our final measure. Last push, guys. Thank you very much for hanging with us through what is undoubtedly a challenging conversation for everybody.

So this Hospital Harm - Severe Hyperglycemia measure is a fully developed measure, which I'll read the measure description, which is fairly short.

This measure says that the portion of hospital days with a severe hyperglycemic event for hospitalized patients 18 or older who have a diagnosis of diabetes mellitus, that have received at least one administration of insulin, or an anti-diabetic medication during the hospital admission, or have had an elevated blood glucose level greater than or equal to 200 milligrams per deciliter during their hospital admission.

So when staff's preliminary analysis of this measure, we rated it as a conditional support, pending NQF endorsement.

There is a measure comparable to this one that was endorsed at one time that is no longer endorsed, but the measure has been submitted for a review by NQF, as measure NQF 3533.

The measure addresses a critical quality objective inside of the meaningful management area of preventable healthcare harm. It is an outcome measure.

The staff noted that the IQR currently does not include any measures assessing hyperglycemia events, and that this is a measure that could be easily reported, as it's easily extractable from the EHR. That's the review by the staff.

CO-CHAIR MORRISON: Thank you.

MS. JUNG: And --

CO-CHAIR MORRISON: I'm sorry.

MS. JUNG: And I'll just, I'll just

add some more to the previous measure that I reviewed.

This measure is in the NQF CDP process for fall 2019 being reviewed by the Patient Safety Standing Committee, and similar to the previous ESRD measure, this measure is reviewed by the S&P, and passed for reliability and validity this past month.

CO-CHAIR MORRISON: Thanks. Anna, you're the first discussant.

MEMBER DOPP: Sure.

CO-CHAIR MORRISON: Oh, I'm sorry. Public comment? No? Anna, you're up.

MEMBER DOPP: Okay. Well, the co-leads for this, co-lead discussants, we promise that this will be another robust and rich conversation, where we go back and forth between policy and practice.

On the, you provided a great overview of the measure, so I won't go into detail for that, but from the policy perspective, this represents an outcome measure that does target an

important area of preventable harm.

It's also one of the three pillars of the CDC national action plan for adverse drug event prevention.

From the practice level, there are some concerns that have been expressed from clinicians in terms of the clinical appropriateness of this, both in terms of potentially compromising patient safety to drive towards hypoglycemia.

And then also, maybe that is not as, the clinical concerns around hyperglycemia are not as strong as hypoglycemia.

But to remind everyone, last year, we had the MAP. We talked about the, we had the hypoglycemia measure, and we conditionally supported it at the time, and actually made comments that there should be a balancing measure to make sure that we don't reach the upper limit, and force towards hyperglycemia.

So this was nice to see a response come back from that comment, from this MAP group

last year. The hypoglycemia measure was not NQF endorsed last year at this time, but it was just recently endorsed in October of 2019.

So this hyperglycemia measure is following a similar path, it sounds like. Also, there is an existing, there was a measure that was NQF endorsed, had its endorsement removed in August of 2018, 2362-E, for glycemic control, for hyperglycemia, and NQF staff provided us with a detail that we didn't, we don't have, because it's not in the QPS quite yet.

And so our group was able to look at that and thought I would just call out some of the rationale for changes from that measure, where the endorsement was not maintained, to why a new measure was created.

One of them is a notable change in the higher threshold from 200 milligrams per deciliter to 300, trying to address concerns with clinicians to avoid unintended consequences of hypoglycemia.

Also, there is a difference that

metformin is not an exclusion, where it was in the earlier measure. However, they found that there was a negligible number of patients that had metformin in the denominator, so didn't feel that it needed to be excluded.

Another big change from the previous measure is how they define hospital days, and then also, the previous measure was risk adjusted.

The measure ahead of us today is not risk adjusted because of listening concerns about, in ICU patients, or other patients that might have a higher daily steroid use that were raised as concerns in the previous measure.

So I think that there's nice explanation as to why we're here with the existing measure versus the one that was previously endorsed.

I'll just add for other lead discussants get to, get to time in, and Brock asked if we would share the rural health aspect, because he had to leave.

So the rural health MAP workgroup shared that this is indeed an important patient safety area in rural settings. They expressed some concerns regarding laboratory data, and the turnaround time for that, and incorporation of it, of, into clinical data systems that might be different at the rural health setting, but in general, they ranked 3.9 out of 5 in terms of suitability from the rural health perspective.

CO-CHAIR MORRISON: Thank you, Anna. So summary, you conditionally support, you're supporting the staff?

MEMBER DOPP: Well, I knew you were going to ask that. That's where I am right now, but I, but I could see the discussion changing that.

CO-CHAIR MORRISON: Okay. Okay. Sorry. Karen, things to add?

MEMBER CHIN: So Karen is actually out sick.

CO-CHAIR MORRISON: Oh, that's right.

MEMBER CHIN: My name's Amy Chin and I

work with her, so I'm filling in. To, we are also supportive of the measure. I think it's great that we're moving towards eCQM stratifications, and you know, I think the measure is like, it's definitely feasible.

My only question, I guess, is a point of clarity, is, it seems like some of the response to issues around unintended issues is to pair it with the hypoglycemia measure, and I'm wondering if there's like any actual mechanism to like tether them together?

CO-CHAIR MORRISON: I will hold back for the clarifying question.

MEMBER SCHREIBER: Can I just answer --

CO-CHAIR MORRISON: You may just answer.

MEMBER SCHREIBER: -- since I have to step out in the few minutes?

CO-CHAIR MORRISON: Yes.

MEMBER SCHREIBER: The intent of this measure, and several others that you have seen,

is to ultimately create a composite measure that is an electronic composite measure of harm so that both hyper and hypoglycemia would be included together, along with other harms.

CO-CHAIR MORRISON: And Michael?

MEMBER WOODRUFF: Okay. I'm going to represent a somewhat different viewpoint that comes out of both discussions with my organization, as well as the public comments that are available here that bring up some really important issues.

While we clearly support the development of eCQMs that identify preventable harm, and help us prevent harm, I think there are some important issues here to identify.

The first one is the clinical reasoning that hyperglycemia isn't, an episode of hyperglycemia, the way it's defined in the measure, is actually a patient harm.

The only evidence we have for hyperglycemia being a patient harm would be in the ICU population, and would be in the surgical

population, and relates to outcomes of morbidity, infection, and so on.

So an isolated episode, which is the way this measure is written, it counts each day individually, really, they're very, it's a very different clinical process than hypoglycemia.

An episode of hypoglycemia is potentially fatal, and that can kill you. An episode of hyperglycemia, in the long-term, can impact outcomes.

And that gets to the second point, that this has been classified as an outcome measure, but it's really a process measure, because a single measurement of glucose is not an outcome.

The outcomes, and this has been established in the literature we have, is that it is mortality and infections in surgical patients. The other point that's been raised that's really important is that the scope of this, this applies to all admitted inpatients, right?

As I mentioned before, the evidence

base is, really comes in the ICU, critically ill patients, and surgical patients, and there's very little literature to support this being used broadly. And so a number of commenters brought up, rightly, that that's an issue.

I think I've hit all my points. I agree that the feasibility has been established, but I would support that we do not support this measure, but that it can be mitigated in a couple of different ways.

One would be by focusing down on the relevant population, where we know there's a strong evidence base.

CO-CHAIR MORRISON: Mike, can I ask you to --

MEMBER WOODRUFF: Yes.

CO-CHAIR MORRISON: -- hold those until --

MEMBER WOODRUFF: Absolutely.

CO-CHAIR MORRISON: -- yes. I'll come back to those. Don't worry. I've got you.

MEMBER WOODRUFF: Okay.

CO-CHAIR MORRISON: Lindsey.

MEMBER WISHAM: Yes. So obviously my other discussant is Anna, and we went through a couple of other tidbits to consider, but I think as we look towards potentially creating these eCQMs that can be reported, and actually consumed by patients and consumers to inform their healthcare decisions, this topic is of importance, and can be reported as an eCQM.

So just to keep that in the back of your mind. Also noted is that we did request initial information from NQF staff, is that they did provide us with the eCQM.

It is currently being specified using QDM, an earlier version of QDM as a measure offering tool, so I would just like to recommend that those classifications be updated as soon as, to go ahead and include this in rule making.

And then, we did review the public comments, and there were some really great ones made, some great points, and we wanted to make sure we address those.

One of those had to do with feasibility. The feasibility testing has been concluded by the measure developers. We wanted to ensure that the rural health perspective was also included in this, and as of note, there is two of them, seven or eight hospitals that were included in the testing were designated as rural, and both of them did have success in identifying that they could feasibly report these eight elements in discrete fields. So that was, you know, in a positive direction.

The one limitation that was found in the testing was that, not necessarily that the lab results were there at the point of care, but that the lab results were still codified in a local code system, and had not been migrated over fully, and that was found at one of the testing sites.

But that was the one rule limitation in the reportability of this eCQM. So all in all, my assessment is that it was a solid specification, that, although the numerator is

fairly complex, it could be, it could be derived through a period out of an EHR.

CO-CHAIR MORRISON: Terrific. Open first to clarifying questions, either CMS or their measure developments?

All right. So open for discussion. Just let me sort of summarize what I'm hearing from the lead discussants.

(Off-microphone comments.)

CO-CHAIR MORRISON: I'm sorry. Yes.

MR. FENG: Can we make a, make a clarifying point. Based on the population, the initial population with denominator of this measure is definitely the people at risk of something as severe hyperglycemia, is definitely a population of relevance. I think that was one of the questions.

(Simultaneous speaking.)

CO-CHAIR MORRISON: I think that the, another question, the point was made that the evidence base for glycemic control and adverse outcomes was in ICU populations, and surgical

populations, not general medical or all, did I get that right, Michael?

MEMBER WOODRUFF: Yes.

CO-CHAIR MORRISON: Okay. So that was one of, what I heard was a question about, was it, questions about the clinical reasoning and the evidence behind the measure was the right populations being, right populations being targeted, was there evidence to support those populations?

I heard concerns that this really wasn't an outcome measure, it was a process measure, that hypoglycemia equals death, hyperglycemia, unless it's very hyper, it does not necessarily equal death, but equals a number of other bad things that happen after that.

I did hear support in terms of this being paired with the hypoglycemic measure that we reviewed last time, and I heard support in terms of it was both feasible to collect and feasible to report, and the burden would not be terribly high. I think that's what I heard. Did

I miss anything? Other thoughts, folks? Discussion? Mike?

MEMBER WOODRUFF: I've just got one other point that the commenters made. If we, if we aggressively push on hyperglycemia, we will probably, by necessity, increase the incidence of hypoglycemia, which, as you very clearly stated, is dangerous. So there's a potential harm there.

CO-CHAIR MORRISON: Akin?

MEMBER DEMEHIN: We've heard some of the same concerns about that sort of balance between, obviously, when hyperglycemia happens, it's not a good thing, but the more dangerous condition really is hypoglycemia, which would certainly hurt folks more.

I guess I have one more clarifying question. So where, how many sites was this tested on, and how many different EHR systems was it tested on?

MR. FENG: So we've tested the measure across eight different sites with three different EHR systems.

MEMBER DEMEHIN: Eight different sites, and three different EHRs?

MR. FENG: That is correct.

MEMBER DEMEHIN: Okay. Thank you.

CO-CHAIR MORRISON: Other points of discussion? Okay. I think we're ready to vote, yes?

So the, because it's been a very long time since we've done this. We start with whether you support NQF staff's recommendation or, it's not really a recommendation, is it? It's opinion. I it's a recommendation, which is conditional support, and the condition is NQF endorsement, okay?

So if you, voting yes means that you're voting for conditional support with the condition being this needs to go through the NQF endorsement process.

MR. HIRSCH: For MUC2019-26, hospital harms, severe hyperglycemia, do you vote to support the preliminary analysis as the workgroup recommendation? Again, the recommendation was

conditional support. Your options are yes or no.

MS. JUNG: I believe --

MEMBER GHINASSI: We lost two here.

MS. JUNG: -- we've lost two. Okay.

(Simultaneous speaking.)

CO-CHAIR MORRISON: Lisa, yes, we lost Lisa.

MEMBER GHINASSI: Two here, and then one down there. That's three, four.

MS. JUNG: Yes, so we've lost three voting members. Is that correct?

PARTICIPANT: Four.

MS. JUNG: Michelle --

(Simultaneous speaking.)

MS. JUNG: Lindsey, are you on the line yet? She mentioned she may be able to cast her vote that way. Okay. So, and then, Andreea has recused? That's correct? Okay.

So we have 21 votes that we're looking for. Is that correct? Oh, and then we've got one through the chat service. Okay.

(Simultaneous speaking)

MS. JUNG: So we are, we have all the votes in for analysis.

MR. HIRSCH: For MUC2019-26, hospital harm, severe hyperglycemia, do you vote to support the preliminary analysis as the workgroup recommendation? The workgroup put forth 17 votes for yes, 4 votes for no. The workgroup has recommended conditional support for MUC2019-26, hospital harm.

CO-CHAIR MORRISON: We are now open for a gap discussion on this program. I know people are tired, but we are in the home stretch, so this is the time, this is the time.

Maryellen, you, did you have, I shut you down before, right?

(Off-microphone comments.)

CO-CHAIR MORRISON: You've got, okay. Okay. Akin?

MEMBER DEMEHIN: We're on gaps, right?

CO-CHAIR MORRISON: We are on gaps.

MEMBER DEMEHIN: Okay. So I do think patient safety at large remains a gap here, even

within the hospital IQR program, and it is good that we had some conversation about limits, patient safety related here, notwithstanding the concerns that I articulated about it.

The other, I'm not quite sure what the best way of characterizing this is, but if one of the things that's always a challenge with this process is that we, sort of by necessity, talk about things on a program-by-program, and ergo, a silo-by-silo basis, having the opportunity to look across settings and across programs a little more strategically, I think would be helpful.

You know, if there is a gap area that we can identify in common across more than one setting, it would be really nice to try to reflect it here.

I think it may help us a little bit out in the talks that we were in when we reach back to the followup measure, where we were kind of grappling with it.

Is the IQF the right place to do it or not? So I don't know if it's a gap, but I do

perceive it as a challenge.

CO-CHAIR MORRISON: Lindsey?

MEMBER WISHAM: I couldn't agree with Akin more. And you were actually talking about something earlier today, which is, you know, as much as this group is a wonderful group to work with, I think about not having a care setting specific workgroup, right, more of a longitudinal, from the true point of the patient, and that longitudinal care perspective.

And with that, I'd like a seamless transfer of health information. So I think that, with specific needs in the eye of the beholder. If you're putting the patient as the beholder, that is not happening, as to how their information, whether it's an IQR setting, to a, you know, a setting that they're being discharged to, whether it be home or not, is not happening.

That would lend itself to a longitudinal measure, but would also lend itself to, you know, really assisting and bolstering IQR programs as well.

CO-CHAIR MORRISON: Marty?

MEMBER HATLIE: Again, I want to identify, is when we talk about person and family engagement, in most of the materials I've seen here, we kind of lean into the engaging patients and families as partners in care, or at the site of care, but in fact, by example, we're engaging them in a group of work in this committee.

It's come up a couple of times with reporting today, that the patients might give us input in reporting, and it's leading me back to the, why I like the proximal metrics.

There's a need, I think, for us to bring that voice to the patient and family up from the point of care into the organization in a, in a, in a bigger way.

So CMS, through their network, has been tracking how patients and families are engaged in the hospitals in improvement work, whether there's staff that really are there to support that engagement and improvement work, and also whether there are governors of hospitals.

And after, it started in 2013. After 20, so 6 years of pushing, 50 percent of the hospitals in the country still don't have somebody who identifies as a patient or family on their board of directors.

I really think it's important that we pay attention to the, I don't want to say barriers, but just the challenges of getting that kind of patient and family engagement into the leadership of our systems.

I'm on a hospital board since January that made a decision in Chicago to actually bring the patients and families on the board, and it is amazing how the discussion changes when there's actually users of care from a relatively poor community that are, that are there, explaining what it's like to be using that hospital.

So I think it's an important thing for us to keep track of this. There's also literature on it, and frameworks about engaging patients and families at multiple levels of the process.

CO-CHAIR MORRISON: Thank you.

MEMBER HATLIE: You're welcome. Thank you.

CO-CHAIR MORRISON: No more cards, I now turn to the back for public comments. I turn to the phones for public comment.

MS. JUNG: Just to be clear, this is public comment, and not specific to any program.

CO-CHAIR MORRISON: This is public comment for anybody who wants to say anything.

(Laughter.)

CO-CHAIR UPSHAW TRAVIS: But you get two minutes or less.

CO-CHAIR MORRISON: But you get two minutes, so it's only two minutes. So --

MS. JUNG: Oh, I see one hand raised in the back.

CO-CHAIR MORRISON: Oh?

MS. JUNG: Cheryl Peterson?

CO-CHAIR MORRISON: Cheryl Peterson?

MS. JUNG: Yes.

CO-CHAIR MORRISON: You, go ahead.

Cheryl? Can we --

MS. PETERSON: Can you hear me?

CO-CHAIR MORRISON: We can hear you.

MS. PETERSON: Cheryl Peterson, American Nurses Association, and member of the MAP coordinating committee. I just wanted to say, I've listened to all of your dialogue today, and your comments, and I've taken copious notes, but really, thank you for your hard work.

It was, it was a, actually a pleasure to listen to you, and I was very glad I didn't have to be in the conversation.

CO-CHAIR MORRISON: Anybody else on the phone, Madison? So I'm going to shut up in a minute, but let me just take the minute to say thank you to Madison, to Jordan, to Sam, and Taroon, who, without this, could not have happened, and thank you for your very, very sage advice, particularly on some difficult issues today that we encountered.

To our colleagues at CMS, I know you take a lot of abuse from us, but thank you very

much. Thank all of you. I know it's been a very long day.

And most importantly, I want to thank Cristie. Cristie, as she reminded me, has been on this committee since its inception. I think I joined after the second meeting, when we were both out there.

You could always count on Cristie for, you know, sort of listening, hearing, and just hitting the exact right point in the right moment, and bringing the discussion back to where it needed to be focused. And I watched her do that over and over again.

I don't think there was a wasted, you know, word in anything that she said, and then, watching her facilitate for the past couple of years has just been a joy.

I don't think anybody could describe this type of meeting as a place they would really, really like to be, given other choices, and yet Cristie has made it fun.

She has kept us moving. Note, only

one of us kept us on time today, which she has done, and I think we are all going to miss her tremendously.

I really do wish she changes her mind and comes back, but it really has been a spectacular run, and thank you, Cristie, from all of us.

(Applause.)

CO-CHAIR UPSHAW TRAVIS: Well, thank you. I have to say, this is a trial by fire for Sean today. Notice, he got the difficult measures, and I want to thank the staff for giving me the easy ones.

I've had my share of difficult ones in prior years. I'm glad I got the easy ones today. But I want to add my thank yous to the staff, and to CMS.

Thank you all so much for, you know, really listening and hearing what our thoughts and concerns are. We really appreciate that, and to everybody here, thank you for everything you say, and to all of you, thank you.

CO-CHAIR MORRISON: And safe travels home, everybody.

PARTICIPANT: Next steps.

CO-CHAIR MORRISON: Yes, next steps.

PARTICIPANT: Jordan, I'll hand it over to you, and you can do the next steps.

MR. HIRSCH: All right. Thank you. Tomorrow, we have the MAP clinician in person meeting, which is basically right in the middle of December, the in-person workgroup meetings. So that'll be the last of the three.

(Off-microphone comments.)

MR. HIRSCH: In the end of December, into January, there will be public commenting period, and from January 24 to March 15, the pre-rule making deliverables will be released.

So public commenting period, as I mentioned, will be later this month. It will run from December 18th until January 8th. The coordinating committee will have their in person meeting to review all the measures that were put forth on January 15th, and final recommendations

are due to CMS on January 24th, and the hospital report will be presented on February 15th.

Finally, contact information, you can go to the public page on qualityforum.org. As the workgroup, you are able to access the Sharepoint page at share.qualityforum.org, and if you have any questions, please email us at MAPhospital@qualityforum.org, and I'd like to turn it back over to Sam and Taroon for final remarks.

MR. STOLPE: Thanks very much, Jordan. It just remains for us to thank you once again. It's really been a terrific opportunity for us to hear the insights from you all.

We have a fantastically quick turnaround that we require from each of you in order to participate in this discussion, and we're more appreciative of that than you probably realize.

OPERATOR: I'm sorry, there's been an internal error.

(Laughter.)

MR. STOLPE: Yes, that doesn't surprise me. That timing was impeccable. Yes. And last, we'd like to say a big thanks to our CMS colleagues for all the hard work that you do in bringing these things forward for us to consider.

It's a wonderful opportunity for us to engage with you, and it truly means a lot. Anything you'd like to add?

MEMBER DUSEJA: I'd just like to add, thank you so much for your participation. And this is my fourth hospital workgroup, actually, meeting, so I've been in other workgroups as well, and discussion at this one continues to like meet my expectations of the robust discussion around the group, and I, we really do truly appreciate it.

We take all of your comments to heart. I want to say thank you to the staff as well, and the co-chairs. And I also want to thank the CMS staff.

You know, to get us to this point

today takes a lot of work, and you have a lot of people behind the scenes, some of them you've had the pleasure of meeting today, but it really is an army of folks that have worked really hard in terms of improving the care for our beneficiaries. So I just want to extend my thanks to them as well.

MR. STOLPE: All right. Well, thank you very much, everybody. Safe travels home. We are adjourned.

(Whereupon, the above-entitled matter went off the record at 4:12 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: MAP Hospital Workgroup

Before: NQF

Date: 12-04-19

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter