NATIONAL QUALITY FORUM

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MEASURE APPLICATION PARTNERSHIP
HOSPITAL WORKGROUP

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TUESDAY
DECEMBER 9, 2014

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The Hospital Workgroup met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:37 a.m., Frank Opelka, Chair, presiding.

MEMBERS:

FRANK OPELKA, MD, FACS, Chair
RONALD S. WALTERS, MD, MBA, MHA, MS, Co-Chair
RICHARD BANKOWITZ, MD, MBA, FACP, Premier, Inc.
ANDREA BENIN, MD, Children's Hospital Association
MISSY DANFORTH, St. Louis Area Business Health Coalition
WOODY EISENBERG, MD, Pharmacy Quality Alliance
DAVID ENGLER, PhD, America's Essential Hospitals
KAREN FIELDS, MD, Alliance of Dedicated Cancer Centers
NANCY FOSTER, American Hospital Association
SHELLEY FULD NASSO, National Coalition for Cancer Survivorship
MARTIN HATLIE, JD, Project Patient Care
NANCY HANRAHAN, PhD, RN, CS, FAAN, University of Pennsylvania
EMMA KOPLEFF, National Partnership for Women and Families

JAMIE BROOKS ROBERTSON, JD, Service Employees International Union
BROCK SLABACH, MPH, FACHE, National Rural Health Association
DONNA SLOSBURG, BSN, LHRM, CASC, ASC Quality Collaboration
AMANDA STEFANCYK OBERLIES, RN, MSN, MBA, CNML, PhD , American Organization of Nurse Executives
KELLY TRAUTNER, American Federation of Teachers Healthcare
CRISTIE UPSHAW TRAVIS, MHA, Memphis Business Group of Health
WEI YING, MD, Blue Cross Blue Shield of Massachusetts

INDIVIDUAL SUBJECT MATTER EXPERTS:
JACK FOWLER, Jr., PhD
MITCHELL LEVY, MD, FCCM, FCCP
R. SEAN MORRISON, MD*
MICHAEL P. PHELAN, MD, FACEP

FEDERAL GOVERNMENT LIAISONS:
KATE GOODRICH, MD, Centers for Medicare and Medicaid Services
DANIEL POLLOCK, MD, Centers for Disease Control and Prevention
PIERRE YONG, MD, MPH, Centers for Medicare and Medicaid Services

NQF STAFF:
TAROON AMIN, Senior Director
POONAM BAL, Project Manager
ANN HAMMERSMITH, JD, General Counsel
LAURA IBRAGIMOVA, Project Analyst
ELISA MUNTHALI, Senior Managing Director
ERIN O'ROURKE, Senior Project Manager

ALSO PRESENT:

SUSANNAH BERNHEIM, MD, Yale CORE

JEFFREY BUCK, PhD, CMS

DON CASEY*

MATTHEW DAVIS, MD*

KAREN GINSBURG, CMS*

STACIE JONES

RABIA KHAN, CMS*

VINITHA MEYYUR, CMS*

BETSY RICKSICKER*

PAT QUIGLEY*

EDWARD SEPTIMUS, MD*

*** present by teleconference**

T-A-B-L-E O-F C-O-N-T-E-N-T-S

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

8:37 a.m.

CHAIR OPELKA: Good morning, everyone, and welcome. We are meeting today at the National Quality Forum for the Measures Application Partnership, the Hospital Workgroup, our in-person meeting, and we have a full agenda today.

For those of you I haven't met, I want to welcome you. I'm Frank Opelka. I am medical director for the American College of Surgeons and I am Chair of the Committee. I'm joined by Co-Chair Ron Walters.

Before we jump into this we've got some administrative details we have to go into, so I will ask Ann Hammersmith to take us through that.

Ann, welcome and thank you.

MS. HAMMERSMITH: Thank you, Frank. I'm Ann Hammersmith. I'm NQF's general counsel. I will take you through your disclosures of interest. I see some familiar faces, so some of

you are veterans of this process, but I will go through the basics and then we'll go around the room and disclose.

As you know, MAP Committees have two types of members: organizational and subject matter experts. The disclosures are different for those two groups, so we'll take this in two steps to try and lessen the confusion.

Federal Government liaisons, you don't need to disclose. I'll just ask you to introduce yourselves.

Let's do organizational members first since this is easier. Organizational members, obviously you represent an entity. We expect you to come to the table with certain attitudes and positions that align with the entity that you represent. So you're not sitting as an individual. You're sitting as a representative of an organization. Because of that, we ask you for an abbreviated disclosure.

If you recall, it's a very short piece of paper where we ask you to disclose if you have

an interest of $10,000 or more in something that's related to the work that the Committee will be doing. And that is the only disclosure that we ask you to give.

So with that, I'm going to go around the table. If you are an organizational member, organizational member only, not subject matter experts yet, please tell us who you are, who you're with and if you have anything you wish to disclose.

So, looking to my left, Dana is a subject matter expert and I cannot see the tent card of the person next to you, Dana.

Donna Slosburg. Okay. And you are an organizational member, so if you'd go ahead and disclose.

MS. SLOSBURG: I'm Donna Slosburg and I work with the ASC Quality Collaboration. We're a measure developer. I have nothing to disclose from a financial standpoint, but I did want to point out to the Committee that I do have two measures on the measures under consideration list

that we did develop. I also sit on the technical expert panel for the outpatient patient experience measures that are also being presented. Other than that, I have nothing to disclose.

DR. FIELDS: Hi, I'm Karen Fields. I'm a physician at Moffitt Cancer Center and I represent the ADCC and I have nothing to disclose.

DR. BANKOWITZ: Good morning. I'm Richard Bankowitz. I'm the Chief Medical Officer of Premier, which is an alliance of about 2,500 hospitals across the U.S., and I have nothing to disclose.

DR. BENIN: I'm Andrea Benin. I'm representing the Children's Hospital Association. I have nothing to disclose.

MS. TRAVIS: Cristie Travis, CEO of the Memphis Business Group on Health, and I have nothing to disclose.

MS. TRAUTNER: Kelly Trautner, American Federation of Teachers, Nurses and

Health Professionals Division, and I have nothing to disclose.

DR. POLLOCK: Daniel Pollock, medical epidemiologist, Centers for Disease Control and Prevention. Nothing to disclose.

DR. ENGLER: I'm David Engler, American's Essential Hospitals. Nothing to disclose.

DR. PHELAN: Michael Phelan. I'm a physician at the Cleveland Clinic, Technical Expert Panel, Emergency Medicine. I have nothing to disclose.

MS. ROBERTSON: Jamie Brooks Robertson, Service Employees International Union. Nothing to disclose.

DR. YING: I'm Wei Ying, Blue Cross Blue Shield of Mass. Nothing to disclose.

MR. SLABACH: Brock Slabach, hospital administrator with the National Rural Health Association, and I have nothing to disclose.

MR. HATLIE: I think I'm a subject matter expert, not an organizational

representative, so it's not my turn now, is that correct? Marty Hatlie.

MS. HAMMERSMITH: You're an organizational representative.

MR. HATLIE: Okay. Marty Hatlie, Project Patient Care. I have nothing to disclose. Thank you.

DR. EISENBERG: Woody Eisenberg. I'm representing the Pharmacy Quality Alliance and I have nothing to disclose.

MS. FULD NASSO: Shelly Fuld Nasso, National Coalition for Cancer Survivorship and I have nothing to disclose.

DR. STEFANCYK OBERLIES: Amanda Stefancyk. I'm representing the American Organization of Nurse Executives. I have nothing to disclose.

MS. KOPLEFF: Hi, Emma Kopleff. I'm from National Partnership for Women and Families, but today I'm representing my fellow consumer advocate Helen Haskell for Mothers Against Medical Error. I have nothing to disclose.

MS. DANFORTH: Missy Danforth. I'm the Senior Director for Hospital Ratings at the Leapfrog Group. Today I'm substituting for Louise Probst from St. Louis Business Coalition on Health and I have nothing to disclose.

MS. FOSTER: Nancy Foster, the Vice President for Quality and Patient Safety Policy at the American Hospital Association. I have nothing to disclose.

DR. HANRAHAN: Nancy Hanrahan. I'm from the University of Pennsylvania, School of Nursing, and I am also a liaison to the Dual-Eligible Group with NQF and a mental health services researcher.

MS. HAMMERSMITH: Okay. Thank you. Now we'll move to the subject matter experts.

Subject matter experts, you got a form that was way longer than the organizational representatives. The reason we ask for the longer form is because you're sitting as an individual. You do not represent your employer. You don't represent anybody who may have

nominated you for service on the Committee. You don't represent anybody who may have supported your nomination for this Committee. So we ask you for a more detailed disclosure.

Please do not recite your résumé. We want you just to disclose things only that are relevant to the work before this particular Committee. In that regard, we're especially interested in grants, research, relevant speaking engagements and things like that.

I just want to remind Michael Phelan, you are a subject matter expert, so you make your disclosure again.

So with that, let's go around the table, subject matter experts, and we'll start with Dana Alexander.

MS. ALEXANDER: Good morning. Dana Alexander. I am a nurse. I am a subject matter expert in health care IT. I am not currently affiliated with any specific organization. My focus areas has been in health care IT, historically EHRs, but now moving more into big

data and analytics in population health. I speak and write extensively in those areas. Nothing else to disclose.

DR. FOWLER: I'm Jack Fowler. I'm a part-time advisor now, though I've worked extensively with the Informed Medical Decisions Foundation, which is now part of Healthwise. I also have done a lot of work in survey research. I used to be part of the CAHPS Team, but that was a long time ago. I'm here as a patient perspective representative, I think mainly.

And the foundation and Healthwise are passionate about trying to get patients more involved and informed in decisions affecting their health. And so from time to time there may be issues that come up that relate to measuring how patients are informed and involved, and for those things I have an opinion. I don't know if I have an economic conflict, but I do have an ideological ones. But other than that, I don't think I have any other comments.

MS. HAMMERSMITH: The next subject

matter expert? That might be you, Michael Phelan.

DR. PHELAN: I'm Michael Phelan, a subject matter expert in emergency medicine. I work at the Cleveland Clinic. I am also on the Quality and Performance Committee at the American College of Emergency Physicians. I have a CDC grant evaluating homolysis in the emergency departments.

MS. HAMMERSMITH: Thank you. The next subject matter expert?

Do we have any more subject matter experts here?

Co-Chairs, you're subject matter experts.

CHAIR OPELKA: Frank Opelka. I'm the Medical Director of the American College of Surgeons here in the Washington Office, and I also serve as the Executive Vice President of Louisiana State University. I have nothing else to disclose.

CO-CHAIR WALTERS: Ron Walters. I

work at MD Anderson Cancer Center. No research grants. No dollars in from anybody. Volunteer service on the board of NCCN. That's my only disclosure.

MS. HAMMERSMITH: Okay. Thank you. I understand we have a few subject matter experts on the phone, so I will call your name. Sean Morrison?

DR. MORRISON: Yes, Sean Morrison. I'm a professor of geriatrics and palliative medicine, which is my area of expertise at Mt. Sinai in New York City. I have nothing to disclose.

MS. HAMMERSMITH: Thank you. Ann Marie Sullivan? Is Ann Marie Sullivan on the line?

Okay. At this time I want to invite our Federal Government liaisons to introduce themselves, but you don't need to disclose. So, Kate?

DR. GOODRICH: Hi, I'm Kate Goodrich. I'm the Director of the Quality Measurement and

Health Assessment Group at CMS.

DR. YONG: Hi, I'm Pierre Yong. I'm the Director of Hospital and Medication Measures at CMS.

MS. HAMMERSMITH: Okay. And, Pamela Owens, are you on the phone? Would you like to identify yourself? Pamela Owens?

Okay. Have I missed anyone who needs to disclose on the phone or in the room?

Okay. Before I leave you, I just want to remind you that in order for our conflict of interest process to really work, we rely on you as members to speak up. So if you think you may have a conflict, if you think someone else has a conflict, if you think someone is behaving in a biased manner, please do speak up. Don't sit there in silence.

We're really counting on you to help us in this effort. You're always welcome to speak up in real time in the meeting. You can go to your Co-Chairs, who will got NQF staff, or you can go directly to NQF staff.

Do you have any questions or anything you would like to discuss with each other, or any questions of me?

Okay. Thank you.

CHAIR OPELKA: Ann, thank you very much.

We also have a few others around the table who are part of your NQF staff, so if we could, beginning on my right, Laura, you want to introduce yourself?

MS. IBRAGIMOVA: Hi, I'm Laura Ibragimova. I'm the project analyst here. I'll be supporting you guys if you need any help and collecting your DOI forms if you haven't submitted them and helping you with the voting.

MS. BAL: I'm Poonam Bal and I'm the project manager on this project.

MS. O'ROURKE: Hi, I'm Erin O'Rourke. I'm the senior project manager supporting this work group.

MR. AMIN: And my name is Taroon Amin. I'm the senior director supporting this work.

CHAIR OPELKA: Great. And once again I want to welcome everybody. If we could pull up the objective list. So if you could see before you our meeting objectives that we have, they begin with the review and input into the measures under consideration. Those are in the federal program, and that's the list that we received from CMS in a pre-rulemaking timeline. We will also, as we go through this, think of and try to identify the high priority measure gaps within each one of the program sets and then finalize our input to the MAP Coordinating Committee on measures for use in the federal program.

So those are our three primary objectives. Any questions regarding those?

Okay. Well, then we're going to leap into this, and I'm going to turn this over to Taroon to get us started.

MR. AMIN: Okay. Great. Thank you very much, Frank. And let me also extend my welcome to the MAP Workgroup. Thank you for the short turnaround time in reviewing an extensive

amount of materials, and we look forward to the next two days of meetings.

So NQF has been working quite extensively over the last six to eight months on improving the MAP meetings based on input from a variety of stakeholders, including many of you on the Workgroup that provided us very extensive feedback on areas to improve our efforts.

Three changes that will directly affect this meeting that we wanted to make sure that we spent some time discussing this morning was the enhanced discussion guide. So we've obviously moved away from the large binder of materials that you have experienced in the past. Some of you who are new to this workgroup have been spared that.

We also have the preliminary analysis based on the Workgroup that was based on the Workgroup's fall Web meeting and the MAP's measure selection criteria.

And finally, we have an updated voting procedure that will also translate into the

meeting format for today. And I'm sure that you've been accustomed to the first two enhancements, the discussion guide and the preliminary analysis as it relates to the materials that you reviewed for this meeting, but Poonam will walk through these materials as we get started with our first program, which is OQR.

I would highly encourage all of you to keep some detailed notes on any feedback that you have on these three specific enhancements throughout or two days since the final session that we will be having is a 30-minute round robin that we'll be asking Committee members on how the process went and any enhancements that we can make in the next year.

We certainly do believe very strongly here at NQF in the concept of continuous quality improvements and do believe that it's our responsibility to improve your experience as Workgroup members for our federal colleagues, commenters and members of the public who are participating this process. So we take that

responsibility very seriously and would welcome that feedback as we get to the end of the two-day meeting.

Before we get into detail on the voting procedure, I also did want to point out that the scope of this meeting is to provide input on the measures under consideration for multiple federal programs. Obviously, these recommendations are grounded in the current finalized measures and we have provided that list, thanks to our federal partners, on our SharePoint site. We do encourage you to review those as we go through the programs, but I would like to point out, however, the finalized measures are not in scope for discussion and we should try to limit discussion on those.

So before I go into detail, I do want to make sure everyone is very comfortable with the meeting discussion and voting process, so I would point out that there were three materials provided to you in your seating area. The first is an agenda. The second is a material titled,

"Measures Application Voting," and I would encourage you to take that out and follow along with me as I go through this. Again, I'd just reiterate that it's very important that -- I want to make sure that everybody feels like they can contribute to this meeting, but also understands the process that we will be following.

So to begin, NQF has implemented this new voting procedure to allow the Workgroup to really move quickly through the decision making process for straightforward and non-controversial measures reserving valuable Committee time for those where sensitive consensus building may need to occur.

So the first step is that Erin and I will review the consent calendars reflecting preliminary analysis, again just reiterating that these preliminary analyses were driven by the input that we received from you during the fall Web meeting, and also the existing MAP measure selection criteria, and also the programmatic objectives that we reviewed during that time.

We will also provide a high-level summary of the comments that we received during the newly implemented pre-comment period. So again, this is an element of our Kaizen activities that's new for this work that we've had this pre-comment period. And since the comment period ended on Friday, we did send those comments to you, but obviously we recognize that that's an extremely short turnaround time for a thorough review. So NQF staff will be giving a summarization of those comments as we go through individual measures.

The second step is that Frank and Ron as the Chair and Co-Chair will ask Workgroup members if they would like to pull any of the measures from the consent calendar presently under review for discussion and to propose a different disposition for the measures under consideration.

I would like to point out here that the measures under consideration will be split into two different pathways, meaning that there's

three different dispositions based on whether the measure is a fully developed measure or if the measure is under development.

So if a measure is fully developed, there are three possible decision categories that the MAP can make: support, conditional support or do not support. For those measures that are under development, there are two possible categories: encourage continued development or do not encourage further consideration. I'll stop there and just make sure there are no questions. Obviously, we're only at step two, but I just want to make sure everyone's okay with that.

Go ahead, Emma.

MS. KOPLEFF: Just a question about the under development category. Will we get a sense of what stage some of those measures are at? I'm just noting that in the discussion guide you helpfully offer a numerator and denominator. So seemingly some of those measures look fairly specified. Or is that not scoped for this part of this discussion?

MR. AMIN: So what NQF staff has done with our federal colleagues here is to look specifically at the stage of development of every one of the measures under consideration, and we've confirmed with them whether the measure is not yet fully specified. Even though it may be specified, it hasn't completed testing. And so, form our definitional standpoint that is not a fully developed measure. I mean, it's fully developed, but it hasn't gone through testing yet. So it seemed premature to make a final decision on those measures through our fully developed pathway.

MS. KOPLEFF: Thank you for clarifying.

MR. AMIN: Frank, maybe I'll turn it over to you.

CHAIR OPELKA: Okay. Nancy?

MS. FOSTER: So, Taroon, if were talking about a measure that one might not think appropriate for use in the particular program for which it was proposed but you don't want to stop

development of it because it's right for something else, what categorization would you call that?

MR. AMIN: So, the measures under consideration -- and I'll look to my other colleagues to say if they believe otherwise. Is the measure under consideration for that particular application? So we will capture thoughts if you believe that the measure is appropriate -- or that you would encourage development for other applications, but the decision in front of you is whether this is a solid concept measure under development for this particular program. So that's the decision in front of you. But we would welcome other comments and we will provide that our colleagues at CMS.

CHAIR OPELKA: Richard?

DR. BANKOWITZ: Thanks, Frank. I have a question about the conditional support and what it is that we're supporting. So, if we vote for conditional support pending NQF endorsement, will

we see that measure again here and have a chance to discuss it having the benefit of the NQF deliberations, or are we saying by our conditional support we leave it to NQF to endorse or not and then that will be the decision?

CHAIR OPELKA: So, to me there's two aspects of that, if I could, Richard. First of all, to the NQF we leave it to the NQF process to consider endorsement. We're not in the endorsement business. But the conditional support is not a direction from endorsement. The conditional support is direction to CMS, and CMS may then decide whether or not to include the measure in the program. So it doesn't come back here again unless it's further pushed forward by a future MUC list.

Let's say it moved from PQRS Program into a Value-Based Modifier Program. We could see it again even though we conditionally supported it once. It might have gone into a PQRS Program and then in a subsequent year it could show up on a future MUC list for

consideration in a different program.

Daniel?

DR. POLLOCK: So just to be clear, one of the meeting top objectives is to review and provide input on measures under consideration. The measure specifications each have a category of endorsement status. If a measure is not endorsed, it still obviously is under consideration or it wouldn't be part of our agenda. So how are we to factor in this endorsement status? Is it relevant with respect to a measure under consideration or not?

CHAIR OPELKA: So, from the Coordinating Committee there are some general guiding principals for consideration when we support, conditionally support or do not support a measure. One of those is NQF endorsement, but it is not an absolute requirement.

So, if you support a measure, whether or not it has endorsement, you feel it is important in the program, you could vote for support. If you felt you could more fully

support it if it was endorsed, you may choose to vote for a conditional support, but it's not an absolute criteria by which you have to decide conditional support because the measure is not endorsed.

DR. POLLOCK: So, in effect if this group recommends a measure that hasn't been endorsed and reviewed by NQF and hasn't been endorsed, this group in a sense is overruling the decision of the NQF review process with respect to use of the measure for federal purposes?

CHAIR OPELKA: So I don't think that's true.

DR. POLLOCK: Okay.

CHAIR OPELKA: The NQF endorsement process is a testimony to the criteria applied for endorsement. This is an application process which does not necessarily require endorsed measurement. The endorsement process is a statement of rigor that speaks to the integrity of a measure, but the application process is a statement of implementation which may or may not

carry with it the application of an endorsement rigor.

DR. POLLOCK: Understood, and I could be off on this, but the last time I looked at the NQF measure submission requirements it included an indication as to how the measure would be used. And I would assume that that's taken into consideration in the NQF process as well as the scientific criteria. So again, in effect we've got a process that has factored in the intended use of the measure, has reviewed the measure, looked at its scientific credibility and made a decision. And then we're asked to say, well, okay, we'll hold that in abeyance and we'll reconsider the measure in this forum.

CHAIR OPELKA: I mean, I appreciate what you're saying. I don't think I fully agree with you.

DR. POLLOCK: Well, understood. I just think that there's a logical inconsistency there.

CHAIR OPELKA: Okay.

MR. AMIN: Okay. So, just reorienting us back to this voting process, what you'll see here is we just walked through step one in which I described that we will walk through the preliminary analysis consent calendars.

The second step here is that any of the measures under consideration can be pulled from the consent calendars by any member of the Committee to propose a new categorization.

So, the way this will work is that Workgroup members can put forward a motion for a new categorization for the measure under consideration with a rationale. The member who pulled the measure aside for discussion should provide some brief remarks explaining the reasoning and proposing a new categorization with their motion.

If seconded, the lead discussants may be asked to react. So we've assigned one or more lead discussants for each of the consent calendars. And lead discussants should feel free to state their own point of view whether or not

it is consistent with the preliminary analysis that staff had provided. So, Workgroup members may put up their cards to indicate that they wish to participate in the discussion at that point in time.

So step 4, the Workgroup will discuss and determine the final consent calendars and determine if an alternate disposition is needed for any of the measures being discussed. At his discretion the Chair may call for a non-binding show of hands to determine which point of view is most prevalent of the group or move forward with a more formal vote to determine the disposition of the MUC, or the measure under consideration.

If a formal vote is taken, a simple majority determines the categorization of the measure under consideration and the Chair will provide a brief summary of the Workgroup's rationale if the categorization of the measure under consideration changes from the preliminary result.

And then finally step 5. As you can

see on this graphic in front of you, and also in your notes, there will be a final vote, there will be a vote on the final consent calendars once all the categorization is completed. The Chair or Vice Chair will call for votes on the consent calendar once all the measures have been pulled and placed in their consent calendar.

The vote is binary, so you're approving or not approving the consent calendars as put forward. And if there's greater than 60 percent votes, that confirms the preliminary recommendation and establishes them as formal, official workgroup recommendations. If consensus has not been reached, if we're not able to reach the 60 percent threshold on the final consent calendars, the Chair will ask participants to -- the Workgroup members to pull additional measures for discussion and potential re-categorization of their final disposition.

I would just point out that the workgroups now, as part of the changes to our process, are expected to reach a final decision

on every measure under consideration. There will no longer be a category of split decisions. That will be sent to the Coordinating Committee. The Coordinating Committee may decide to have some additional conversations around measures that were particularly contentious at the workgroup level, but we will expect that the MAP Hospital Workgroup will make final decisions on every one of the measures in front of you.

So in summary, I'll just point out -- I know that was a lot of information. Erin and I will put up the preliminary recommendations. Any one of you are free, and we would encourage you, to pull any of those measures from the consent calendars as we have presented them. Frank and Ron will engage in a conversation around determining whether that needs to move into a new category and then we'll make a final vote on the calendars as presented.

It's pretty straightforward. The goal hopefully, maybe that's interpretation, hopefully that's pretty straightforward. There

are a few caveats I'll point out. The goal of this is again, just to try to focus the conversation on particularly contentious measures, and those that are straightforward we can move through pretty easily.

Lead discussants, don't feel like you need to raise your placard to discuss the measure that you've been prepared to discuss if there's not really a lot of controversy around it.

And finally, we do recognize that some of you would like to make statements about the measures even if it's not around the categorization. So at the end of the consent calendars, once we've completed the final vote on the consent calendars for the programs, we would welcome some conversation or position statements as it relates to the measures. Any concern around unintended consequences, things that people would like to capture for the record.

So, that is the voting process. I do have a few other topics I'd like to discuss. It's really important that we get this right from

the start, or at least we get some practice with it, but get it right close to the start. So, if there are any questions on that particular portion of the agenda, I would welcome that now.

Okay, great. So logistics. Laura, who you've been introduced to, will walk you through how to operationally use the voting tool once we get started with our first program. So we won't spent time doing that. Once you need to use it, we'll give you some tutorials on that.

I'd like to point out to the workgroup in full disclosure. We're operating in a continuous improvement environment, the voting tool and the process of developing the final consent calendar is brand new to you and to us, and you are the first workgroup to use it. So we've tested it a number of times. I want to assure you that we've tested it a number of times, but please bear with us as we pilot this and hopefully we can make this work the first time and we'll make changes in real time. These learnings will be translated to other workgroups

that are meeting later this week and next week, so you'll see some of our other colleagues from NQF here eagerly interested to see how this process works.

And so, the only other thing I'd point out is that NQF staff, if there are discrepancies between the discussion and the voting, we will ask the workgroup to provide additional clarification. Both for the purposes of our final deliverable, but also for the purposes of our colleagues at CMS so that there's clarity around the discussion and the final votes, making sure that those are consistent.

I'd also point out that we have a public comment period. During these in-person meetings there are two 15-minute public comment periods for NQF members and public commenting on the meeting days. We would be accepting those over the phone. Just as a reminder, all these meetings are open to the public, so there are members of the public who are dialed in for the two days, and in the meeting room. Any members

of the public and developers are welcome to speak during these designated public comment periods. The workgroup members are not expected to respond, but should consider these comments very thoughtfully in their deliberations.

And finally I would just point out, in my summary here, to say that -- before we get started with OQR, that the work that we're undertaking here is a multi-stakeholder effort with various perspectives, values and priorities for discussion. We would encourage everyone to respect these differences of opinion and encourage collegial interactions among Committee members is generally expected.

Since the meeting agendas are quite typically full, as you'll see right here, we want to note that all Committee members, in addition to the Co-Chairs, developers and staff, are responsible for ensuring that we're able to get our work done over the next two days.

And again, just before we get started, a very big thank you from NQF staff for the time

and the guidance that you've provided us over the last year in enhancing the materials that are in front of you. And again, we just point out that we will be having a discussion at the end of day two on how well this went, to make sure that we can continue to make these enhancements going forward.

So I would just ask the Chairs to open it up for just any other questions before we turn it over to Erin and Poonam to begin the conversation with our first program.

CHAIR OPELKA: Taroon, thank you very much. So for those of you who come from states where you get to vote early and often, we can try and get you two of these.

But anyway, does anybody have any questions about this? This is entirely new and we are absolutely the guinea pig. Nancy?

MS. FOSTER: Taroon, I'm looking forward to see how this goes. It looks like it will be a better process and I'm really excited about that. My question has to do with the

public comment period.

As you suggested, we would like to -- I think the group as a whole would like to take into account any thoughtful comments people want to offer, but it looks like the public comment comes after our voting. So I'm curious about how we incorporate those intelligent public comments into our considerations? And my specific proposal would be that, if it's not too disruptive, we actually offer public comment before the vote is taken.

MR. AMIN: So Nancy, I have some thoughts on that, but I'll turn it over to the Chairs as well.

I'd just first like to point out that there was again, another instituted change as part of the MAP deliberations, to institute an early public comment period for a week. Which was not a lot of time, but there was time. And so, Erin and I will be discussing those public comments as it relates to every individual measure as we go forward through the

deliberations. So we'd like to believe that those comments will be part of the deliberations.

However if there are additional public comments, the structure of our meeting has traditionally been to have the two of them structured throughout the day, but it obviously is up to the Chairs if they would prefer to institute additional public comments as we go through final decisions on the consent calendars. So, I would say that is operationally possible, but I would leave that to the Chairs' discretion.

CHAIR OPELKA: So, any other thoughts from the group on that? And my biggest concern is meeting our deadline, meeting our timeline. So if we're going to have public comment prior to the vote, I would be okay with that except that we go right to the votes. Because we cannot keep opening up deliberation endlessly and get through our agenda.

And for those of you who are new to the NQF process, if you haven't determined this already, if you're even thinking about speaking,

you can get your card ready and we'll try and create a queue, but once you put it up, we got you in the queue so that we can get to you.

So, yes, Marty?

MR. HATLIE: So, the potential comments we'd get today -- I like Nancy's idea, first of all. I just think it's inclusive and I like it for that reason. The comments would come from the people in the gallery here and then possibly over the phone? Do we have any sense of how many people are actually listening in today? I'm just trying to think about the volume of comments that we might get.

MS. O'ROURKE: Operator, would you be able to tell us how many people are dialed into the phone portion of the meeting right now?

OPERATOR: Yes, ma'am. We have about 13 on line.

MR. HATLIE: So, we don't have a huge group.

MR. AMIN: I would also point out that there's about 31 that are in the Web chat as

well. So, but that shouldn't -- many of them may be NQF staff, so I don't know, but I'm just saying --

MR. HATLIE: I'd like to support Nancy's comments and then suggest that we could perhaps just curtail the time for making comments to keep us on schedule. Thank you.

CHAIR OPELKA: So, one of the other just logistic points is that when you speak, if you can get the microphone in position to pick up your voice. The folks on the phone won't hear you if not. So, I almost feel like if -- since everyone's kind of turning this way, that the mics have got to be on this side, on your left. On this side, on your right. So that we are picking you up.

But I am not hearing everyone through the microphone system. I'm hearing you in the room. But if I don't hear you through the mic system, then the people on the phone will not hear your comments. So if you could do that, that would be very helpful.

All right. So let's jump in. Hospital Outpatient Quality Reporting Program is first up.

MS. BAL: Okay. Before I start, I do want to just give a little tutorial on how to use the Discussion Guide. Most of you are probably familiar with it at this point, but -- oh, sorry. I'll speak louder. Is this better?

So we have -- the first page you'll start with is the agenda, and it will just be going through the consent calendars and you'll always have a link to the program summaries. So you can click on this section, it will get you a program summary, and then you can just push the backspace button and it will bring you back to the page you were just on. You can also go to Programs and then select a program summary that you would like to review if that's a quicker way for you, and then again just push backspace and you'll be back at the page you want to be at.

Same thing with if you wanted -- we've included the description here for each measure,

but if you want to see the whole, full description -- sorry, specifications. You can just click here, and it will go directly to that measure and then backspace again, or you can go to Measures and then select whatever measure you would like to go to.

And then the last feature is just the preliminary analysis. We'll have a summary here, but if you want to see the full analysis based on the algorithm that we shared with you in October, you can just click here and it will go directly to that measure for this program. Or you can go back and go to Analysis and find the program and also which measure it's under review for.

So that's the basic -- just how to use the Discussion Guide. And now I'll go into the Hospital Outpatient Quality Reporting Program.

MR. AMIN: Poonam, can I just ask one question of the workgroup. Just want to make sure you all have this downloaded on -- this is the Discussion Guide file. If you have any questions, let us know.

Just want to make sure this is the primary material for the meeting, just want to make sure you have it on your screen. If you have any problems, let us know and we'll come by and make sure you are ready to go.

Go ahead, Poonam. Thanks.

MS. BAL: I guess I should also ask does anybody have any questions before I move forward? Okay. Perfect.

So the Hospital Outpatient Quality Reporting Program, or OQR which it's commonly known as, is a paper reporting program. The information on the measure is supported on the Hospital Compare website. If a hospital does not report their data on required measures, it will receive a two-percent reduction in their annual Medicare payment update. This focuses on outpatient services, which is clinic visits, emergency department visits and critical care services. And one of the other goals is, supply consumers with quality of care information.

So, the critical program objectives

that we came to consensus on in the October meeting were that it focuses on measures that are high-impact and support measure priorities. It aligns OQR measures with the ambulatory care measures, and that some of the gaps that were identified in previous years are emergency department overcrowding, wait times, disparities in care. Basically any disproportionate use of EDs by vulnerable populations.

Other gaps are measures of cost, patient-reported outcomes, patient and family engagement, follow-up procedures, fostering important ties to community resources to enhance care coordination efforts in an outpatient CAHPS model.

So that's the critical program objectives that we really focus on when building the preliminary analysis. And I'll give it to Erin now to go over our first measure.

MS. O'ROURKE: Thanks, Poonam. So I'd like to start by reviewing the consent calendars for the fully developed measures.

I did want to make one disclosure. You might see my voting. I am voting as a proxy for Sean Morrison on the phone. Just to let everyone know there's no funny business going on, and staff do not have votes, these are Sean's that I'm tallying for him.

DR. MORRISON: Thank you.

MS. O'ROURKE: The first measure that you'll see received a preliminary analysis of support is Advanced Care Plan. This measure addresses an important aspect of patient engagement, promotes alignment across programs and is NQF-endorsed. This measure is currently used in the Physician Feedback and the Physician Quality Reporting System Programs, and we'll also be reviewing it for the Ambulatory Surgical Center Quality Reporting Program.

I should note, this measure is in a number of MAP families of measures, including the care coordination, dual eligible beneficiaries and hospice families of measures. We received one public comment on this measure that was

generally supportive of including it in the OQR Program.

The second measure that had a preliminary analysis of support is External Beam Radiotherapy for Bone Metastases. External beam radiation can help provide patients with pain relief. This measure has a demonstrated performance gap of nearly 20 percent, and including this measure in the OQR Program would achieve a goal that this workgroup has stated numerous times, to begin to expand cancer care measurement to settings beyond the PPS-exempt cancer hospitals. We did not receive any comments on this measure.

Finally, you'll see a health-literacy measure derived from the health-literacy domain of the C-CAT. This measure would address an important aspect of patient and family engagement, a gap that this workgroup has identified for this program.

Studies have shown that better scores on measures of health-literacy are correlated

with important indicators of health care quality. We did not receive any comments on this measure.

Moving on to the next calendar, we have conditional support pending NQF endorsement. We have a measure addressing Use of Brain Computed Tomography in the Emergency Department for Atraumatic Headache. This measure is currently in the OQR Program, but public reporting has been postponed.

This measure would help to improve efficiency and reduce unnecessary utilization of imaging in the ED for patients presenting with an atraumatic headache where the clinical value of imaging appears limited. And NQF review and endorsement would address the technical concerns that have arisen about this measure.

We did receive three comments on this measure. One was generally supportive. Two commenters noted similar concerns, specifically noting there is not a clinical evidence base to support performance measurement of CT imaging in

Medicare beneficiaries with headache. Second, the commenter does not support implementation of an administrative measure, such as this one currently in the program as OP-15, without validation by chart review. Third, the commenter is concerned that implementation of OP-15 would create pressure for hospitals and emergency clinicians to reduce the use of brain CT in this older population who are at high risk of having significant intercranial findings without any evidence as to how to do so safely or appropriately.

So on your next calendar you'll see a set of seven NQF-endorsed measures. Basically they're preliminary analysis of conditional support pending the development of a single composite measure, and CMS has asked that we consider these measures as a set. So if you want to pull one for conversation, we'll be pulling the whole set. We've been asked not to pick and choose through these seven.

So the first addresses Administrative

Communication. This would help to identify -- actually I can make these comments for all of the measures. They're all aspects of transferring portions of the medical record information to the next site of care. So this measure would address a previously identified gap around improving care coordination and would ensure vital information is transferred between sites of care.

These measures are the emergency department transfer communication measure set which consists of seven components that focus on communication between facilities and the transfer of patients. This measure set assists in filling the workgroup identified priority gap of enhancing care coordination aspect.

We did receive some one comment on some of the aspects of this measure noting the importance of HIT and improving the transfer of this type of information.

And I believe those are the consent calendars for the fully developed measures, so I'll turn it over to Frank to facilitate

conversation.

CHAIR OPELKA: All right. So according to our process, we are at the point where we are considering these consent calendars and any item we wish to pull from the consent calendar with the idea of moving it to another consent calendar.

Michael?

DR. PHELAN: I would support removing conditional support for OP-15 to do not support based on the comments that were already mentioned. There were concerns about this measure from the very beginning when it was developed for the age of the patients that are being -- it's an efficiency measure looking at the utilization of head CT for patients with headaches, and it's just the wrong patient population. Our guidelines don't support using it, and even some of the data from more extensive evaluation of this from CMS, even indicates that there potentially could be two to five percent of patients within a 30-day period who didn't get a

CT that have a complication related to that visit.

So I think from the perspective of some the public comments that were made, and the concerns that the American College of Emergency Physicians have about this measure, I would recommend that we do not support the measure.

CHAIR OPELKA: All right. Second? Thank you. Nancy?

MS. FOSTER: Do you want full explanation or just a list?

CHAIR OPELKA: Well, let's start with the list.

MS. FOSTER: I'd like to pull Advance Care Plan, External Beam radiation Radiotherapy, the health-literacy measure, and the multifaceted composite measure that's suggested for conditional support. If you want to call them multifaceted, the composite measure.

CHAIR OPELKA: Well, you have to also direct them to what particular --

MS. FOSTER: You'd like to know where

they go?

CHAIR OPELKA: -- consent calendar you'd like them to go to.

MS. FOSTER: Okay. Do that one at a time. So for the Care Plan I would like to suggest do not support. For the health-literacy measure I'd like to suggest do not support. For the External Beam Radiotherapy I would like to suggest conditional support. And for the composite measure, conditional support. Sorry, conditional support but not pending NQF endorsement. Conditional support -- what was the other alternative there?

MS. O'ROURKE: We had conditional support pending development of a single composite.

MS. FOSTER: Right.

CHAIR OPELKA: Okay. And a second? Second. Thank you, Richard.

MS. KOPLEFF: Could we just restate the recommendation for the composite?

CHAIR OPELKA: So it's now moving to

conditional support pending development of a composite.

MS. O'ROURKE: So, I think -- are we okay then with it's --

CHAIR OPELKA: It's already there.

MS. O'ROURKE: -- with where it is? The one before it was conditional support pending endorsement, sorry, the composite components are actually part of calendar 3. So that's conditional support pending development of the composite. They're currently already NQF endorsed. So, it would just be if they go into a composite is our condition.

MS. FOSTER: So if they go into a composite and that is NQF-endorsed? Is that what the -- or they go into a composite that we've never seen but we're being asked to vote on it?

MS. O'ROURKE: Oh, okay. So we should perhaps add a caveat that the composite would need to be NQF reviewed and endorsed.

MS. FOSTER: Under those circumstances I'll agree with the --

CHAIR OPELKA: Okay.

MS. FOSTER: I will pull my pull --

CHAIR OPELKA: So the consent calendar --

MS. FOSTER: -- if that works.

CHAIR OPELKA: As it stands in the consent calendar. Okay?

Any other aspects of this? Jack?

DR. FOWLER: I just have a quick question. On the Brain Tomography one a low score is good score, is that right? That is the fewer X-rays you have, the better? Is that the way it works?

CHAIR OPELKA: Yes, I don't have the specifications of the measure.

PARTICIPANT: Yes.

DR. FOWLER: Thank you.

CHAIR OPELKA: All right. So, Emma?

MS. KOPLEFF: With the Brain Tomography measure, I just -- thank you for sharing the evidence based around the guidelines,

that's helpful.

CHAIR OPELKA: Emma. I'm sorry. We're only at a point of pulling --

MS. KOPLEFF: Oh, thank you.

CHAIR OPELKA: -- or not pulling from the consent calendar.

MS. KOPLEFF: Okay. Thank you.

CHAIR OPELKA: So are we set? Any other changes to the consent calendar?

Okay. The consent calendars stand. We have do we have discussion now about any ones we've moved?

MR. AMIN: Yes. So, ideally we can take them one at a time and just recognize where the -- look at the proposal on the new categorization, have some discussion and vote on hands, whatever you want to do, and then go one by one.

CHAIR OPELKA: So we're starting?

MS. O'ROURKE: Should we start with the Advance Care Plan? I believe there was a motion to move that one from support to do not

support.

MR. AMIN: Yes, we'll start at the top.

MS. O'ROURKE: Start at the top?

MR. AMIN: Advance Care Plan.

CHAIR OPELKA: So --

MR. AMIN: Nancy's motion was to move to do not support on this one.

CHAIR OPELKA: Okay, and then we've got lead discussions of Jamie and David.

So, Jamie, any comments? David?

MS. ROBERTSON: I don't have any comments.

CHAIR OPELKA: So the motion that's on the table now, is this is no longer in the support category. It's moved to do not support the Advance Care Plan.

MS. ROBERTSON: I'd be interested hearing the reasoning and rationale for moving it to do not support.

CHAIR OPELKA: Sure.

MS. FOSTER: So we actually are very

supportive of the notion that patients should have Advance Care Plans. The question is its application in the outpatient care setting, broad-based for any patient that comes in that's 65, because hospital outpatient clinics and other services are a wide variety of activities.

If this measure were centered around those clinics that had patients 65 and over who had particular conditions. So if we were talking about it in the oncology clinic and in the cardiac clinic and so forth, I get that -- or in any of the primary care clinics. I would get that but as it's written, at least as far as we can tell, asking someone to assess whether a patient has an Advance Care Plan when they come in for their colonoscopy doesn't make any sense because that kind of conversation should be taking place between the clinician and the patient when the clinician has a relationship with that patient that's more than just a test or a single service.

And so, we would like to see this

measure re-specified so that it is directed at those sites where there is that ongoing relationship between the patient and the clinician.

CHAIR OPELKA: Thank you. Mitchell?

DR. LEVY: So, now I want to act as Sean's proxy. Sean, do you want to say anything about this? You there?

DR. MORRISON: I'm here, but on mute. No, go ahead, Mitchell. I'm curious to hear what you have to say first.

DR. LEVY: Well, I strongly disagree with your comment. I think that we're trying to work towards a culture in which we encourage all providers to have these kind of conversations with their patients. And often, speaking as a critical care physician, we find ourselves in situations where we don't know patients and because they haven't happened in outpatient settings enough, we have to have them under duress, unfortunately. So to me this measure, moving it out of inpatient and more broadly,

changes the culture in a way that I think would benefit patients in the long run.

And as a safety expert, one of the things that I see that happens often are a lack of advance directives or not readily available so that when they come in patients come in and those directives are needed, they're not readily available. So I think that anything we can do to encourage these conversations is in the best interest of patients.

DR. MORRISON: Frank, it's Sean. I put my tent card up.

CHAIR OPELKA: Well, that puts you at the front of the list, Sean.

DR. MORRISON: Actually, the thing that I was going to say was -- actually slightly different from Mitchell was that I do believe that Nancy did highlight a couple of circumstances where this is not an appropriate conversation, but I would say that in the vast majority of those patient settings, it is an appropriate conversation. And given the lack of

primary care and the fact that many Americans see their specialist as their primary care doctor, I think it's much harder to sort of -- the benefit outweighs the burden in my opinion about having these widespread discussions and encouraging them in each setting.

CHAIR OPELKA: Ron?

CO-CHAIR WALTERS: So there's a very famous public case within the last six months where a person went in for an endoscopy, supposedly an uncomplicated procedure, and is not with us anymore. So I mean, yes, the measure could be split down to kind of like chance of a bad thing happening, but that gets very difficult to predict for any given measure. And I support that when people go in for outpatient procedures, from a safety perspective, their wishes need to be known.

CHAIR OPELKA: Michael, is that you? I need binoculars.

DR. PHELAN: I think the difficulty here is the idea that this is like a children's

wish list for Christmas. It is a wonderful, wonderful idea and the practicalities of implementing it though, become difficult in the current EHR environment.

I am leaning towards agreeing with Nancy on, maybe the focus should be on one place because I don't even know what percentage of oncology patients have this currently documented in their EHR. So the broad sweep would be wonderful to have, but it gets -- implementing it practically, gets very difficult.

So every ED patient that comes in who's 65 and older to be addressed, whether they have an Advance Care Plan, great idea. A lot our patients don't need that discussion to happen when they're coming in for certain care processes. Whether or not that process should happen when they get admitted to the hospital, which is already a requirement, that's perfectly fine, but it gets to the practicality of this.

CHAIR OPELKA: Nancy?

MS. FOSTER: Actually, Ron, I agree

with you. Everybody should have an Advance Care Plan. Even those of us under the age of 65 should be thinking about that and articulating what our wants are.

I'm envisioning, not a conversation taking place, but multiple conversations taking place, because patients go to multiple different providers. And the legal nightmare of trying to sort out the difference between what a patient told his or her cardiologist versus what they told the radiologist versus what they told the ER doc when they saw them, will create a quagmire that I think is unacceptable and confusing and not getting us where we want to go.

So if you said to me let's not only put a measure in, but let's figure out how we're going to encourage people to really put in writing what they want to have happen, I'm right with you. It's the multiplicity of conversations.

You know, Mitchell commented that having this conversations when the patient is in

critical care is not the most productive time to have that conversation. I agree with that, but it's probably also not the most productive conversation when they've just been rushed into the ER or they're there for a test or to have a wart removed or something else, because those aren't ongoing relationship. And that's sort of the nub of it for me.

CHAIR OPELKA: Richard?

DR. BANKOWITZ: So I think everyone agreed that this is such an important area that no one is disagreeing patients need to have advance directives and surrogates. I'm concerned about how we measure it, though.

Is this the best way to measure it? Because it seems like it's essentially a check-the-box, yes, we've documented. And I can see the unintended consequence of every time someone registers for anything under the sun, they're going to be asked the same questions over and over again. And I'm not sure if this is really a meaningful conversation. Is it really going to

get us where we need to be? Are we going to turn then to a check-the-box?

CHAIR OPELKA: Marty?

MR. HATLIE: The point Rich just made is essentially the point I was going to make. I think there can be confusion amongst providers, just if these people are exposed to different forms in different places, I've seen it happen. I'm less concerned about the legal quagmire than I am about just the practical quagmire of people signing different forms in different places without it being explained, because it's just going to be a box-checking process. I think it does take a relationship to decide what kind of advance directive you want.

CHAIR OPELKA: Mitchell?

DR. LEVY: So I'm surprised by the conversation. Maybe it's my bias, but I thought this was like mom and apple pie. So I feel if this is the conversation we're having on the first measure, we're in for a long two days.

I feel that I agree with Sean, that

the benefit outweighs the burden. I think we have a culture in which having these conversations is not routine. Most physicians are uncomfortable with it. And I think this moves the field to ask. And, yes, there are times when it's probably not necessary, but we so under-ask in every environment that moving the bar so that we routinely are expected to at least ask. Even if it's just checking a box, we know that that box checking motivates the field to actually do something. So that's why I feel in support of moving this into an outpatient venue.

CHAIR OPELKA: Donna?

DR. MORRISON: Frank, just put my tent card up again. Sean.

CHAIR OPELKA: Sean, hold on just a second.

DR. MORRISON: You got it.

MS. SLOSBURG: This is Donna Slosburg, and I just want to say that I agree with Nancy, Marty, and Michael. And I don't know if everybody's aware, but this is in the Physician

Quality Reporting Program already. I think we're going to be doing duplicate work.

But to your point, Mitchell, I understand that we do have to have that conversation. And as Nancy said, it's not that we don't think that we should have this conversation. And I may be incorrect, so, Nancy, correct me, but is it not also in your conditions for participation?

MS. FOSTER: It is for inpatients, for people who are admitted, as I think Mitchell said.

MS. SLOSBURG: And again, to Nancy's point about the fact that when somebody's coming in for a procedure, I don't think that's the point to have that conversation because they're really wrapped up in having that procedure.

CHAIR OPELKA: Sean?

DR. MORRISON: I think I would just add two points to that. The first is again it often doesn't have to be an extensive conversation, but just highlighting it I think is

absolutely key. And as Ron pointed out, I was first -- we had at our institution that very famous case where it hadn't been discussed.

The second is that I can make the same argument that taking somebody's blood pressure when they come in, on a routine 25-year-old for a wart removal, is not appropriate and yet we do it all the time because it's standard of care. And I would like to see these discussions become standard of care, and this is one way of getting them there. We don't have them enough and they're absolutely critical.

CHAIR OPELKA: I thought you were going to tell me we shouldn't be taking a blood pressure for wart removal.

DR. MORRISON: I wasn't going to tell you that, Frank.

CHAIR OPELKA: All right.

DR. MORRISON: But you can also think of how many times it's not necessary.

CHAIR OPELKA: Andrea?

DR. BENIN: It looks to me as though

this metric is defined by administrative claims, and I'm just wondering if we understand the performance of this based on claims?

At our Children's Hospital, right? We ask this when you come in, but I think it's because it's a Joint-Commission or a CMS-conditions-kind of thing, but I'm not sure that we code for it. And so is I think that I'm just not sure how this measure really performs and whether anybody has that experience? That would be my question.

CHAIR OPELKA: Any other comments? Well, so I'll raise my tent card on this one. I'm in the camp that Nancy's in. I see an enormous need for having this for every patient. I don't see a need for pushing this in every environment. I just don't think it's appropriate.

And I kind of turned to Ron a minute ago and I said, really? This is what the dermatologist has to do? I mean, I just don't understand how this would be appropriate for

every different type of clinical scenario and I think it would be more important to define those clinical scenarios where this would be a conversation that patients would be happy to have or pleased they had it.

Whether they agree with it or not is up to the patient, but just to me it would strike me as odd if somebody's out there checking boxes and asking me these questions. It's starting to feel like I'm at the rental car agency and I've got to check all those boxes in order to get the car, and I just get done to get the car. It's becoming that for the patients who are coming into the office. They're getting a list of things that they just have to check through, and they're almost to the point of saying tell me what I have to check so I can be seen and get out of this office visit. I don't think that's productive.

Dana?

MS. ALEXANDER: So in agreement that I think we're saying that having an Advance

Care Plan conversation is important. I think what we've heard, too, is that the measure is in the Inpatient Quality Reporting and in Physician Quality Reporting. So those conversations should be happening with the Physician Quality Reporting, with the physicians and the patient, in those physician offices. And then if there was an inpatient admission as well, too. Correct?

MS. FOSTER: One clarification. I just want to be very clear, Dana. It's not in Inpatient Quality Reporting, it's a condition of participation.

MS. ALEXANDER: Okay.

MS. FOSTER: So you're assessed on it when they come around and survey you.

MS. ALEXANDER: Thank you.

DR. GOODRICH: So the question was asked about the performance of this measure. It's in the PQRS Program, has been for awhile, and the PQRS Program works differently from the facility-based programs because clinicians choose

their measures. So it's not required of every physician, although last year we did finalize it as part of a set of cross-cutting measures that we required physicians to choose at least one from.

Most recent performance, which is 2013, looks like it's at about 42 percent. So for clinicians who choose this measure, on average, that is the performance rate. Obviously higher is better.

CHAIR OPELKA: Christie?

MS. TRAVIS: So just a clarification question. Can you remind us what facilities are covered under the Outpatient Quality Reporting? Like what entity is covered under OQR? Somebody?

DR. YONG: It covers a whole wide range of OQR. So it could be an outpatient physician office that's associated with the hospital. Emergency departments are covered under -- for patients who get discharged from the emergency department, it does cover a wide range of facilities.

MS. TRAVIS: Okay. So my question kind of is -- and I guess I've gotten a little confused, because it would seem to me that you would want to know if someone has an advance directive if someone shows up for a surgical procedure in the like a hospital outpatient department. Or if they're in the emergency department, wouldn't you want to know whether they have an advance directive?

So I guess I'm trying to understand why we wouldn't want to know that? Why the facility wouldn't want to know that so that they could follow it if the patient has one, and if they don't have one, it seems to me that somebody I would hope, might be able to say, well, if something happens to me when I'm getting my colonoscopy, this is what I want.

So I'm trying to be sure I understand the intent, because it seems to me that if you're coming in for a procedure that you would want to know whether or not the patient has already made these decisions, so that you could follow those

decisions if they have been made.

CHAIR OPELKA: Shelley?

MS. FULD NASSO: I think that's a good point. Christie and I would be interested to know if just asking if you have it qualifies to check the box here, because it does seem like for a lot of these we would want to know.

I think there have been some really good arguments presented on both sides of it. I just think I err on the side of changing the culture and what Mitchell and Sean said, that I think that the more we ask, the more this becomes commonplace and not something that is only if you're in a certain circumstance you need to have this function. Because everyone should have it and not everybody has relationships with their providers. And so maybe going in for this procedure or going to the ED for something that's not critical is really their only contact. So I just think if we want to change culture, we have to make it not this stigmatized thing that only needs to happen in certain situations.

CHAIR OPELKA: Michael, is that up again? Yes. Go ahead.

DR. PHELAN: I agree, but I think there's got to be some stratification here. Like Frank mentioned, coming in for a wart removal where you're not getting anesthesia when you're getting there, probably not. In the vast majority of ED visits you probably don't need to have an advance directive discussion. When the patient is being admitted for a condition, perhaps, and that's already a condition of participation.

But it brings to the forefront, every single person that comes in for an ED visit getting questioned if they have an advanced directive. It becomes like a check box. Did you give smoking cessation counseling? Sure, we gave it in the 400-thing packet that is there, and I'm not sure it gets to the point that you're trying to make. Maybe the primary care physicians need to -- this needs to be something that they own. When you say that, then you say, well, a lot of

people think my cardiologist is my primary care physician. So at least in the American health system it gets very difficult to say who will have that.

Now whether or not it should be a mandatory condition of participation for anyone who's got Medicare, that that needs to be somehow uploaded or put onto your care. Changing the onus from a measure that's going to be a burden to hospitals and outpatient clinics that don't really deal with this issue to the insurer saying you have a primary care doctor. You need to have an advance directive on place in your record, just like you have to have a Social Security number or your Medicare number or something like that, maybe that's where the onus should be.

Burdening the clinics -- the dermatology clinics who it's not going to become an high-impact question unless you're getting melanoma or something like that, but then it becomes another issue. But where the burden is going to lie is an issue that I see coming out

here.

It's a tremendously important issue. We all agree. Oh, my God, we have to have advance directives. And you're doing that, but the burden and where the measure is going to occur, seems to me it's focused in the wrong place right now.

CHAIR OPELKA: Wei?

DR. YING: I think actually that Michael's previous comment, when I tried to process it, I actually got to the opposite conclusion. I think we try to say this is more proper if we react to something. If something is truly bad going to happen, then we should ask. But in order to change the culture we need to be proactive. It becomes something that routinely we should be asking.

And we keep saying if it's a physician measure, it's okay. If it's a hospital measure, it's okay. But for outpatient clinic it's not okay. And this measure looks like the denominator is patient. It's not every single

visit. So hopefully in the environment of EHR for an outpatient setting the patient comp using that site for different procedures or different service, they only get one time, hopefully, in the EHR environment. Then they are done. The box is checked. And at least the culture gets moving in that direction instead of every time it's always reactive.

CHAIR OPELKA: Richard?

DR. BANKOWITZ: So I do agree that there needs to be a cultural shift. The question is is the payment system the way to establish that cultural shift? I don't think so. If we tie payment to a measure like this, you have to understand there are adverse consequences. If you want this to be 100 percent, you'll get it to 100 percent by having everyone comment and do a proforma at the front desk. And I don't know if that is moving us in the right direction. It's not going to change the culture. I think we're relying on the payment system here to do more than it can do. And so, I think we need to

attack this problem, a very important problem, from another direction.

CHAIR OPELKA: Brock?

MR. SLABACH: I just wanted to point out that if you look at the measure description and take it seriously, if the patient does not have an advance directive, it appears that in order to check the box, you have to have a discussion with the patient who did not wish or was able to name a surrogate decision maker, or provide an advance care plan. In these high volume settings where the turnover is pretty quick, these are discussions that aren't very productive in that environment for that to occur.

So, I think it's different from your question, Christie, about knowing whether they have an advance directive. I think that's good to know in case something happens, but then for this measurement it's going beyond that and saying you have to have that extensive discussion in order to check the box.

CHAIR OPELKA: Okay. So, we are not

at a point where I think we've got general consensus. We seem to be going from one side to the other, back and forth. So we're at a point of voting rather than trying to accept general consensus to move this to the do not support calendar, which is the motion.

So we are going to have to vote, but before we do, we're going to have to learn how to vote often.

So, Laura, are you going to walk us through this?

MS. IBRAGIMOVA: Yes. So at the beginning of the meeting you were each assigned a clicker. These things are automatically on, so don't use them if you're not voting because then that might affect the voting.

So, you only have these three choices at this point, so you can only choose one, two or three. Okay? And only the last number that you press will be captured. So if you mess up a vote or want to change your vote, then just press the last number. And you can only vote when I'm in

full screen. And you'll have only 10 seconds to vote. So once I call the vote, press your number and then we'll vote.

DR. LEVY: But the motion -- I want to make sure we're -- the motion is to move it --

MS. IBRAGIMOVA: Oh, but --

DR. LEVY: Frank, I just want to --

MS. IBRAGIMOVA: Yes.

DR. LEVY: Frank, can we clarify? So I just want to -- because the way this looks, it's support, but the motion is to move the measure to do not support. So can we clarify that?

CHAIR OPELKA: We're in agreement. We're having a conversation right now as to how we get to a simple yes/no. So the intent is that we would vote to move this to a consent calendar. And when we're done, we will then vote on the consent calendars, which hopefully should be a perfunctory vote that we're all in alignment with the consent calendars. So at this point we're --

MR. AMIN: Yes, so while we're waiting to get the slide to reflect this, what's in front of you right now; let's just clarify the vote, is that we have this advanced care plan measure. The question is on the motion that Nancy has put forward on moving it to do not support.

MS. ALEXANDER: So one is yes? Two is no? What's it going to be?

MR. AMIN: Laura, can you just change the slide to say do you agree with the motion?

MS. IBRAGIMOVA: Yes.

MR. AMIN: The motion is to move to do not support. So if you say yes, you're moving to do not support.

MS. ALEXANDER: And yes is one?

MS. IBRAGIMOVA: Yes.

MR. AMIN: Yes is one.

MS. IBRAGIMOVA: Yes is one, and two is no.

MS. ALEXANDER: And what is three?

MS. IBRAGIMOVA: There is no three in this --

MR. AMIN: There's no three.

MS. IBRAGIMOVA: -- in this voting.

MS. ALEXANDER: Okay.

MR. AMIN: So let's stop here and make sure everyone is clear. The question is do you agree with the motion that's been put forward by Nancy to move the measure to do not support? It currently is in support. One is yes, and two is no. Are there any questions on what the question is in front of us?

CHAIR OPELKA: Marty?

MR. HATLIE: This may be a broader question. I'll try to make it succinct. I thought Nancy's motion was to re-specify this measure. So I'm wondering if the discussion will be --

CHAIR OPELKA: We can't change a measure.

MR. HATLIE: Okay.

CHAIR OPELKA: - so we are just moving it to do not support. If it falls in do not support and the measure developer wants to

consider re-specification, that's something they do outside of our Committee.

MR. HATLIE: Okay.

CHAIR OPELKA: It would just be the minutes from our Committee would be something that measure developer could pick up and decide whether or not they want to do that.

MR. HATLIE: Thank you.

CHAIR OPELKA: All right. So there's a clock up there, Laura? And do you tell us when we're on the clock?

MS. IBRAGIMOVA: You can start voting now pressing one or two.

(Voting)

MR. AMIN: And as a reminder one is moving to do not support, and two remains in the category that it is, which is support.

We're also just capturing some votes via the web chat for the folks that are not in the room with us, Committee members that are not in the room with us.

CHAIR OPELKA: So this category moved

to do not support.

All right. So first of all, let me just share with the group that we started with OQR because we knew it would be the easy one.

(Laughter)

CHAIR OPELKA: So that was one measure in an hour, but we're learning.

So what's our next one?

MS. O'ROURKE: The next one was the external beam radiotherapy for bone metastases.

Nancy, you had motioned to move this measure?

MS. FOSTER: I did. I motioned to move it to conditional support. And mostly I have a lot of questions about this measure; and maybe the expertise in the room will be very helpful here, but first I'd like to understand from CMS why this measure is being brought forward for the outpatient care setting. I mean, if we're trying to build a system that would help patients choose the right place for, in this case, their cancer care, is this a measure that

you anticipated would help them make that right choice?

DR. YONG: So the measure, the intent of the measure is to check for those patients who fall into the denominator, whether they received appropriate radiation therapy. This measure has already been finalized for the PPS Cancer-Exempt Hospital Quality Reporting Program. There is still a significant number of patients who receive radiation therapy in outpatient settings not at PPS cancer-exempt hospitals, which only includes 11 cancer hospitals in the U.S.

So that's one of the reasons we wanted to put it on the MUC list for OQR is because there is that significant population who has received radiation therapy in outpatient settings and to align the quality measures across programs.

MS. FOSTER: And I get that. I guess I was trying to think about this from the purpose of the public reporting program, the dual purpose of both ensuring quality improvement -- and I can

understand how this might be a quality improvement promoting measure, but to the other purpose of trying to communicate effectively to the public about quality in a way that would help them choose the right place for them to obtain care. I would be very interested in some expert opinion as to whether this gives patients the right information.

I am eager to move measures of good cancer care into the broader programs. It's an important aspect of care, but as a sort of lone cancer measure it strikes me as maybe not quite the right thing. And that was my dilemma with this measure.

CHAIR OPELKA: Nancy, just so I'm clear, so if this moves from support to conditional support, what's the condition?

MS. FOSTER: That's a good question, Frank. I don't want to say no to cancer measures, but this just seemed a strange thing to move forward. So maybe I'm really saying do not support. But I'm trying to get -- help me

understand why this is the right lone cancer measure to put into the OQR program now. If it were coming in with a few other cancer care measures, maybe I could see that that would give a bolus of information to patients that would be effective in helping them to make choices, but that was my dilemma. So I guess the condition is that it be coupled with other cancer measures and brought forward at a time when that can --

CHAIR OPELKA: Okay. All right. I understand.

DR. MORRISON: Frank, it's Sean. I just put my tent card up.

CHAIR OPELKA: All right. Sean, hang on. Karen?

DR. MORRISON: You got it.

DR. FIELDS: So the majority of radiation therapy occurs in the outpatient setting and it's not hospital-based radiation centers.

When we reviewed this measure before for endorsement at the Endorsement Committee, we

found that variation in the schedules was varied widely and there's a potential for many fractions over a longer period of time which haven't been demonstrated to be clinically effective but are cost-ineffective. So there's a lot of abuse of over-radiation, long radiation schedules in a patient population that it would be onerous to do that in. If you have boning metastases, more than likely you're at the end of your life coming back and forth to a radiation facility for a protracted course of radiation. Because billing opportunities are higher is not an acceptable measure.

So I would personally fully support this. NQF has endorsed this and I'm sure all the cancer centers from the ADCC and most of the cancer centers in the United States would support this measure.

CHAIR OPELKA: Marty? Sean?

DR. MORRISON: Just again to echo very quickly that we're the only country in the world where single fraction RT is not the standard of

care for bone mets because of the reimbursement for multi-fraction RT. And it's been tried through professional guidelines and others to change the scope of practice, and this actually might do that and get patients what they need, which is one single fraction RT for painful bone mets and not multiple trips back to the radiation therapy department.

CHAIR OPELKA: Great. Thank you. Pierre?

DR. YONG: Just to add on what I was saying before, we do think of this because whether or not the patient received the appropriate fractions of XRT is both addressing sort of appropriate use as well as patient safety in terms of overdosage or potentially overdosage.

And then also in terms of I believe, Nancy, you also asked about performance. There was an analysis done by ASTRO, which is the American Society for Therapeutic Radiation and Oncology, which said that 34 percent of patients who were prescribed were over-prescribed

fractions of XRT.

CHAIR OPELKA: Karen?

DR. FIELDS: I also -- to a single fraction, this includes multiple fractions. It also includes appropriate solutions. We discussed all of those extensively. So it's still tailored towards the needs of the patient, and there may be patients that would get longer fractions, but certainly not the four and five-week fractions that have been used around the country.

CHAIR OPELKA: Nancy?

MS. FOSTER: So maybe I'll make this easy for us. I will withdraw my motion, but I would like the minutes to reflect the fact that I do have concern that this measure, while it may sing to clinicians and help us get to the right quality improvement, and that in and of itself is probably worth doing alone, I think you'll have a really hard time explaining this one to the public in a way that helps them make wise choices. And I want to keep that in mind for the

measures that we're selecting, that we're really trying to help the public as well. And so that's my concern.

CHAIR OPELKA: All right. So we've withdrawn the motion. Shelley, do you still need to --

MS. FULD NASSO: Just one point. I think that most of these measures are not going to make sense to consumers, so to me if it changes practice to deliver the care patients need and really address that quality gap, that's a worthwhile reason. I don't think patients are going to understand a lot of these measures.

CHAIR OPELKA: So, Nancy, thank you for that withdrawal, but we will capture this, I think in the gaps discussion. I think it fits there. And it highlights the fact that it's too much of a lone wolf. We need more.

All right. What do we have next?

MS. O'ROURKE: So our next motion was also from Nancy to move the health literacy measure derived from the health literacy domain

of the C-CAT to a do not support.

MS. FOSTER: So health literacy, an incredibly important issue. Directing materials to patients in a way that they will understand them, also incredibly important. Measuring and holding hospital outpatient departments responsible for health literacy seems to me to be misguided. I don't know how they affect that in any real way, and I've never seen any really good ways to move that bar.

So while I think we should be measuring health literacy in this country, it's the application to this program that I'm questioning, and for that reason move to move it to do not support.

CHAIR OPELKA: Other comments? Richard?

DR. BANKOWITZ: I seconded the motion and I do so for the same reason. I think that although it is important to understand the health literacy of your population, trying to grade and reimburse on the basis of that metric, which is

more community-based/population-based, doesn't seem appropriate in this application.

CHAIR OPELKA: Jack?

DR. FOWLER: Would someone sort of describe how this would work? I mean, it's a 15-item quiz. And just what standard was applied?

MS. O'ROURKE: We'll put the specs up on the screen. So the numerator of this measure is the health literacy component of patient-centered communication. An organization should consider the health literacy level of its current and potential populations and use this information to develop a strategy for the clear communication of medical information verbally, in writing and using other media. A measure is scored based on 15 items from the patient care survey of the C-CAT and 13 items from the staff survey of the C-CAT. Minimum of 100 patient responses and 50 staff responses.

The denominator is there are two components to the target populations. One staff, clinical and non-clinical, and two patients.

Sites using this measure must obtain at least 50 staff responses and at least 100 patient responses.

DR. FOWLER: So is this just a sample of patients? A random sample of 100 patients answers the questions and if the place gets a good score, then that's good?

DR. YONG: I believe so. Vinitha, are you on the line?

MS. MEYYUR: Yes, I'm here. Yes, this is a sample of patients. A minimum of 100 patient responses and 50 staff responses would be required in order to compute the data, or the numbers for this. So, right.

DR. FOWLER: And what are the questions about? I'm sorry. Because I haven't seen the instrument.

MS. MEYYUR: So the questions or the patient survey items are more about could you find you way around the hospital? Could you understand the hospital's signs or maps? Were the hospital forms easy to fill out? So it's along

those lines. And did the doctor explain things to you?

And then there's the other piece of this, which is the hospital staff survey. And the items on the staff survey are about senior leaders having taken steps to create a more welcoming environment for the patients, and it directs who provides -- if the nurse had intervened, if staff were not respectful towards patients or communication with patients. So those are some of the questions that the staff would have to respond to.

So it's two sets of questions, one for the patients and then a set of questions for the staff, and the composite score combines the score for both of those.

CHAIR OPELKA: Ron?

CO-CHAIR WALTERS: So, yes, of course this is a measure that requires people filling out another form, as we will talk about probably frequently, but if you go to the full measure specs tab on there for this one, again, one, it's

stewarded by the AMA.

Secondly, it is supposed to be a measure that's meaningful to patients that focuses on health literacy related to patient-centered communication, high impact, meaningful to patients, etcetera, etcetera. And there are actually some outcomes in the bottom derived from the entire C-CAT instrument which said a 5-point increase in the measure results in more than a one-third greater odds that patients will report high-quality medical care, more than 25 percent greater odds that patients report a belief that their medical records are kept private, and a 5-point increase is correlated with more than 25 percent decrease in the odds that a patient that believes that a mistake in their medical record or medical care would be hidden from them.

So the C-CAT in general, I mean, has some pretty meaningful stuff involved as far as downstream outcomes. This is to test the literacy question, part of that. And I think it - I wanted to read that because it is kind of

some important stuff. Okay? It's extra work, but it does translate.

CHAIR OPELKA: Woody?

DR. EISENBERG: Do we know how the sample of staff or patients is chosen?

DR. YONG: Vinitha, do you know the details about how the staff and patients are sampled?

MS. MEYYUR: No, I don't know the details.

CHAIR OPELKA: Michael?

DR. EISENBERG: Can I just --

CHAIR OPELKA: I'm sorry, Michael. If you'd hold a minute. Woody?

DR. EISENBERG: I'm assuming that there's got to be some random way that that's done, otherwise this will be a biased sample of both staff and patients and it will be a useless measure. So it would be very helpful to know that.

CHAIR OPELKA: Michael?

DR. PHELAN: I think it's moving the

ball. We want to be moving it. And I think the support of a measure like this is probably worthwhile because most -- at least the larger health care systems and hospitals that are large enough to support the number of staff and patients that they see. I think this is where we want health care to be going, so I think this is one of those measures -- I wouldn't quite say it's mom and apple pie, but it's the direction we want to go to and I think it's already been vetted by the technical expert panels that have looked at this. It's an AMA measure. I think it's kind of the direction we want to go in. So I would vote for supporting it, continuing supporting it.

CHAIR OPELKA: Dana?

MS. ALEXANDER: So can we assume then that this C-CAT tool is a standardized tool that is already being administered in hospital outpatient centers across the country? So it's then --

CHAIR OPELKA: I don't know that it --

it's a standardized tool. It's been vetted and endorsed. The last part of being utilized is separate. I can't answer that.

MS. ALEXANDER: Okay. Because I was going to say if it's already in place and being administered in a very generalized way, it would seem that again I would concur that this would be capturing then the patient literacy level, and would seem more to report.

CHAIR OPELKA: All right. I'm going to try and go down this list. Nancy?

DR. HANRAHAN: I'm coming from the dual-eligible Group, and literacy is a major issue that's related to all kinds of core outcomes including hospital readmissions, so I would support moving this particular one forward.

CHAIR OPELKA: Emma?

MS. KOPLEFF: Just wanted to second some of the comments in support of the measure because I do think measures that allow us to hear from the patients get to an aspect of culture change that we talked about relating to an

earlier measure. It provides a unique opportunity to start to really integrate the patient perspective into quality improvement activities.

MS. FULD NASSO: I may be wrong, but the way I'm reading this it sounds like the measure is not so much about the health literacy of the population, but how well the communications from the hospital are targeted to the levels of the patients. And to me that seems very important. We should move forward.

CHAIR OPELKA: I think you're reading that correctly.

Brock?

MR. SLABACH: I think I would agree that this is an important aspect of care and that patients should have high levels of literacy. I'm just uncertain, in fact I'm not sure at all that this is going to be the tool to incent a facility to do this. I mean, I think they need to have this as a behavioral issue perhaps and in a cultural assessment maybe by a Joint Commission

surveyor, but to put this into the OQR as a measure that could potentially be harmful to their reimbursement, I think that's one huge issue.

Secondly, I'm not really entirely sure. Does the hospital or the facility select a group and I go back now to the roll-out of this? And then for smaller rural facilities you may not have populations of your employees that are large enough for 50 even in some cases. And then so you get statistical aberrations in some of those facilities as far as how this plays out in your community.

So I just find this -- I think it's a laudable goal. I just don't know that this is the correct way to go about achieving it.

DR. PHELAN: Just one point. I don't think the OQR has a payment penalty associated with it. I don't know if CMS can correct on that. I think it's just a reporting program currently.

CHAIR OPELKA: It is a pay-for-

reporting program. Andrea?

DR. BENIN: I don't see an age specification on this measure, and I'm just wondering if there's any more guidance about whether or not there is an age specification on this.

My other commentary, just looking at the detail level of the questions and what these questions actually look like, is that I'm wondering if this is the kind of survey that you typically use a vendor for. So this becomes the kind of thing where you would need to hire Press Ganey or Picker, or one of these things, to supply the infrastructure for this. This is the kind of survey that this looks like.

I mean, I would actually think that a first step for this type of a measure would be more of a structural measure. Are you surveying this type of activity? And that that is an appropriate way to start moving hospitals to think about it. Much as we think about patient satisfaction on these types of questions, they're

actually good customer service questions. These are like can you find your way around the hospital? Can you understand our signs?

Like these are important things for how we think about our marketing, our business, driving our work. And they may be relevant for health literacy also of course, but I think that there are probably a couple of steps before having those exact numbers be publicly reported. So that would be my opinion on that.

CHAIR OPELKA: Mitchell?

DR. LEVY: Yes, a point of clarification. So, for payment and penalties, for inpatient you have to go through a year of IQR reporting, at least a year before it could be used in a payment program, so I assume the same thing is true for OQR. Is that not true?

DR. YONG: There is --

DR. LEVY: Can CMS, in order to introduce something as a penalty and --

DR. YONG: Well, I think you're referring to hospital value-based purchasing --

DR. LEVY: Right. Exactly.

DR. YONG: -- which is our payment --

DR. LEVY: Yes.

DR. YONG: Which is payment program. That's true that measures need to be publicly reported on Hospital Compare for one year. There's no - beyond HVBP, the only other payment penalty programs are the HAC Reduction Program and the Hospital Readmission Program, the Hospital Readmission Reduction Program. There is no specific payment program for outpatient quality patient departments.

DR. LEVY: Okay.

CHAIR OPELKA: Jack?

DR. FOWLER: Just to be clear, and maybe I guess this is for CMS. We're going to talk about CAHPS questions when we get to the next thing, and so there is going to be a new CAHPS that's for outpatient hospitals, and that looks like what's proposed. They have a communication section, though I don't think they

ask about signage. So this would be another survey that hospitals would contract for in addition to outpatient HCAHPS?

DR. YONG: That's correct. They are two separate surveys.

CHAIR OPELKA: Nancy?

MS. FOSTER: I just wanted to reemphasize a point that Andrea made, which is that hospitals have a variety of ways in which they assess the effectiveness of their communications, whether it's the signage or the things they pass out to patients and so forth. That's inherent in their business model.

This picks out one, one way that is not commonly used in hospitals now and says this is the one you should use in order to meet a CMS requirement, if CMS were to adopt this in its program, which seems to be odd to me without any sort of assessment of whether this is the most effective way to do that or not.

CHAIR OPELKA: Marty?

MR. HATLIE: I think this is more than

just a measure of health literacy. There's a culture piece of it that I think has been mentioned by Emma and perhaps others. And I'm thinking especially of the questions that engage front line staff about leadership of the organization. The AMA has done some really, really thoughtful work in this area, so I'm not worried that these questions are just kind of first iteration or whatever. I think it's probably a pretty thoughtful approach. So for that reason, for the culture change aspect of this, I really support it.

CHAIR OPELKA: So again, I'm hearing that there's not a general consensus, so we'll go to a vote at this point. And the motion is do not support, so if you agree with the motion, if you agree with moving it to do not support, that is a yes vote. If you do not agree, it is a no vote.

MS. IBRAGIMOVA: You can begin voting. Vote one for yes, and two for no.

(Voting)

CHAIR OPELKA: Did we get the online votes?

(No audible response)

CHAIR OPELKA: All right. So this continues -- for those of you on the phone who can't see it, the vote was 43 percent supported it and 57 did not. So the motion does not carry and this remains in support the measure in the program.

All right. And next?

MS. O'ROURKE: So the next measure is use of brain-computed tomography in the ED for atraumatic headache, also known as OP-15 currently. This was moved from conditional support to do not support.

DR. YONG: Frank, do we mind if we just make a few opening comments about this measure?

CHAIR OPELKA: Sure. This one always seems to draw fun.

DR. YONG: So, thank you.

CHAIR OPELKA: For those of you on the

phone, that's Pierre that's talking. So that they know.

DR. YONG: Thank you. So we're just going to offer some context for why this is on the MUC list, and I'm going to start and Kate may have some additional comments.

This is a measure we've been working on for several years now and currently is in the program, or an older version of this is in the program; this came about before the MAP came about, and data collection for that is currently suspended.

So we've been working on this measure to try to improve it. It's been a challenging measure to work on, and I think there are concerns that have been raised in public comment which were referred to earlier about whether there are appropriate guidelines to guide when it is appropriate to do CAT scans for atraumatic headache in emergency departments. And we acknowledge that.

However, in our analyses there's also

a large performance gap that we've observed, so it ranges from 0 to 34 percent in terms of performance about whether individual facilities actually do scans. There's a huge amount of variation.

This particular topic in terms of appropriate use is a huge topic of concern; I think folks know this, to consumers and to providers. It's a big topic of discussion among Choosing Wisely, among other campaigns. And so, we would love the MAP's input on whether this kind of measure you think would be useful in the program despite the limitations that I'm sure will come out in the discussion.

CO-CHAIR WALTERS: So let me go back to our primary discussants first. Sorry, let's go back to our primary discussants. Did they have any comments they wanted to make?

DR. POLLOCK: Thank you. This is Dan Pollock from CDC. I certainly agree that this is an important area. I also agree that there is an absence of standard clinical guidance with

respect to CT scan use in the context of an atraumatic headache in the emergency department. I think the fundamental problems with this measure are more methodologic with respect to how the data are ascertained.

On the plus side, use of claims data has the virtue of minimizing burden. But on the negative side, we all I think need to acknowledge the claims data in which clinical diagnoses or signs and symptoms are entered into a coded form has to bear scrutiny with sound systematic investigation of whether in fact the claims data actually reflect what's in the record of care.

And to that end, there was I think a pretty solid piece of work reported in the Annals of Emergency Medicine two years ago involving data from 21 U.S. hospital emergency departments, about 750 visits. And the bottom line was that 65 percent of the patients had a documented indication for a head CT that was not identified in the administrative data.

A company editorial by Harold Sox, who

is the former editor of Annals of Internal Medicine and is highly regarded as a leading expert on comparative effectiveness research of evidence-based practice -- the title of his editorial is, Evaluating the Quality of Decision Making for Diagnostic Tests: A Methodologic Misadventure. Sox concludes the methods for evaluating the use of brain CT in ED patients with headaches systematically over-estimates inappropriate test ordering.

The fundamental reason is that some of the indications for a head CT in the ED are not going to be reflected in the coded summary of the visit. That's the finding of the investigators who studied this in 21 emergency departments. I think unless there's a clear indication that we've advanced the knowledge and substantiated that in fact the claims data themselves reflect what's in the record of care and what's been recorded as for the indication of the head CT, on the methodologic grounds alone, I would think that this is not a suitable measure for any

purpose at this time.

CHAIR OPELKA: So, you are in favor of moving it to do not support?

Richard?

DR. BANKOWITZ: So, discussant number 2 agrees completely with moving this to do not support, and I think you articulated the reasons exceptionally well. Some of these exclusions are very difficult to code. Coding of focal neurological deficit with administrative claims data is going to be very, very difficult.

And also I think there is a potential, too, to gain the system, which is once you find out the magic code number to code as an exclusion, who cannot say there's a little bit of weakness over here on the right or the left? So I don't think it's going to be an effective measure.

CHAIR OPELKA: Nancy?

MS. FOSTER: I agree with what's been said before, especially since they're the experts and I'm not, but in reading through the NQF

materials on this, if I am correct, there is a significant potential for harm for not doing CT scans with patients with atraumatic head injury. And by significant, the measure developer, the contractor estimated it was greater than one percent and possibly as high as five percent of the population. That makes me really anxious about including a measure that pushes people not to do these.

CHAIR OPELKA: Emma?

MS. KOPLEFF: Thank you for sharing that, Nancy. And I guess I would just - I hear some of the statements that have been said, but noticing this measure has not yet been through the NQF endorsement process, I do think that that process would help elucidate some of the methodological challenges and even some of the challenges with the absence of clear guidelines. And the original recommendation pointed to conditional support pending that NQF review process. And my hope would be that in aligning with the NQF preliminary analysis of the measure

we support further examination of the measure. And I say that from the lens of not knowing -- and again, you all are the experts, but not knowing what the potential harms are related to overuse and exposure to radiation and that being a concern from the patient lens.

CHAIR OPELKA: Michael? You're deferring to Dan first?

DR. POLLOCK: Thank you. So point of clarification. The NQF staff has in fact a version of this measure then through the NQF endorsement process?

DR. POLLOCK: Okay. And this goes back to what I was trying to articulate earlier this morning, that we're asked to look at measures that have been through a process of review. And if it hasn't been endorsed, I wonder what our role is in that context, because in effect we're an arbiter looking over the shoulders of those who've taken a close look at this measure.

DR. YONG: I was just going to say it

was a previous version that was NQF -- that was reviewed.

MR. AMIN: That's correct.

DR. YONG: This is an updated version.

MR. AMIN: Right. So the version that's on the current MUC list is not the same version that failed prior endorsement. Yeah, correct.

DR. GOODRICH: We put measures that are on the program on the list again when they've undergone substantive changes. That's why it's on the list again is because we have to put it back on once it's undergone substantive changes. So that's why you're seeing it again. So the numbers that I've been quoted I think are true for the previous version of the measure, not for this version of the measure.

MR. AMIN: And that clarifies the preliminary recommendation for this measure, which is NQF review of this version of the measure.

CHAIR OPELKA: Michael?

DR. PHELAN: Regardless of the revision of it, the reason there may be variation is because populations in many of these EDs are different. And most of the guidelines including the American College of Radiology who have guidelines on appropriateness, they all eliminate patients after about 50. It varies depending on what imaging efficiency metric you're looking at. And it really failed -- the reason the initial one failed was because of lack of clinical guidelines that could drive the process to improve it.

The point that I think Nancy made is probably most critical from two perspectives: When their own evidence suggests that anywhere from two to five percent of patients could be harmed if they didn't get a CT scan, the harm to the patient -- and also from the active practitioner -- the reason we do so many CAT scans in an emergency setting is the unknown, and many of these factors that just don't play in.

And there's not good clinical

guidelines to tell us we don't have to get a CAT scan on some of these folks because they'll do fine. But there is a feeling out in the community that we don't want to miss something that could be life-threatening to a patient. And having the ability to do a CAT scan that we didn't have 15,20, going further back, years puts the onus on the physician to -- I'm worried that if a measure like this ever got promulgated, (A) there will be gaming; (B) it's going to force certain clinicians who don't fall on either spectrum of the risk tolerance side to not maybe get some imaging that could potentially save a patient's life.

So I really think from the perspective of the patient in this measure, it's probably not a good measure currently to go forward with that.

CHAIR OPELKA: Wei?

DR. YING: I think most of the discussion we are having here probably we're going to hear it again from most of the efficiency measure. Every time there is always a

push and pull between the safety and the efficiency.

I would support if this measure gets endorsed by NQF, which I assume would go through a vigorous process to make sure the measure specification would follow any guideline or strike a balance between the safety and efficiency. From our point of view just abandon this measure because there is this level of uncertainty. This level of uncertainty will not be unique for this measure whatsoever. It will always be there of any type of efficiency measure.

CHAIR OPELKA: Dan?

DR. POLLOCK: Yeah, I would just echo as well that this deserves to be re-reviewed if there have in fact been substantive changes, and still would hold out the likelihood that if the pivotal point is using administrative data with clinical findings being central to determining whether or not there was an indication for CT scan. Even if there are changes with respect to

what those findings or indications might be, there are deep flaws in relying on secondary conditions, secondary diagnoses and ED records to ascertain information about indication. So I would be very, very concerned that there is a fundamental flaw methodologically in this approach.

CHAIR OPELKA: Taroon?

MR. AMIN: So an additional point of reference here, with some of these updated measures I think one of the questions that CMS is also interested in exploring is whether additional changes to this measure or this measure concept is important enough to continue development on. So maybe I would just turn it over to Kate if there's additional feedback that you're interested in from the MAP Workgroup beyond potentially this measure as constructed potentially for the purposes of this program.

DR. GOODRICH: Yeah, just to build on that a little bit, I mean, one of the reasons we -- we understood there was going to be

controversy about this measure and we share some of the concerns that have been brought up, but this is a really, we think, very critical concept.

And I think one of the things we need to understand from the MAP is this a concept that we should continue to push forward on in some fashion or another, whether it's potentially working on an electronic measure that is all payer, so captures multiple age groups, not just 65 and over? I'm not sure what the right answer is, but we certainly hear from our purchaser colleagues and our consumer colleagues that this concept and other concepts of appropriate use are really important.

So we felt that we would be remiss in leaving it off the list and not have it open for MAP discussion; and I realize this is a tricky needle to thread, but even with the limitations of this particular measure. So I think this gets a little bit to maybe the gaps analysis that the MAP always does and if this is something that we

should really continue to pursue or not.

CHAIR OPELKA: So I'm planning on, as the prerogative of the Chair, flipping this from a vote of two to a vote of three in light of the comments that Kate just made, that we would be voting on this as an individual and which consent calendar would you want to put it in: support, conditionally support and do not support?

So if there are comments directed toward that, I'd appreciate it. Otherwise, we'll take a vote.

Michael?

DR. PHELAN: I think it still should be a two-vote -- can be the first effort to either conditional support or do not support. I think that's the two votes that should be asked of us, because the request was to move it into a do not support. It's currently in the conditional support category. I think it should stay either a conditional support. It shouldn't be a fully support measure.

And just going back, we understand

that CMS is trying to help with these efficiency set metrics. This is just the wrong type of efficiency metric to look at from a number of different perspectives that we've already mentioned, particularly because there's no good clinical guidelines and there probably are not going to be any good clinical guidelines in this arena in the next three to five years trying to identify which patients can be safely discharged home and which one -- or safely not obtaining a CT on. So I don't anticipate any clinical guidelines, and for the same issues that Dan was saying, that the claims data is not probably the best means at getting at some of this data.

CHAIR OPELKA: Nancy?

MS. FOSTER: So, Kate, I was hearing your question a little bit more broadly, and one could apply it certainly to this measure, but while I'm not in love with this measure, the notion -- and I hope we'll talk about it during the gap analysis -- the notion that we continue to build out electronically captured data to

drive measures is very appealing for any number of reasons. But getting to the right source of the electronic data, claims data, EHR, what have you, is also an absolutely critical decision to be made.

So maybe I was mishearing what your comment was, but I hope we'll get to Kate's question again.

CHAIR OPELKA: Wei, is your card back up?

DR. YING: Yeah, I would encourage CMS to look into this efficiency measure, because from consumer engagement point of view we really want consumers to pay attention to the Choosing Wisely list, but every time when we look at them, we don't know what to tell consumers or patients. Yes, this is actually in concept to one of the measure being promoted by the American College of Emergency Medicine, but when we try to measure or try to report -- tell our patients what facilities are doing, how well they're doing on these measures, we don't know what to tell them.

We can only tell them in concept.

It should not be done in these circumstance. But is really the circumstances should be measured on there is no clear indication. So if CMS can try and list -- explore a little bit more on several of these measures, it would be very helpful.

CHAIR OPELKA: Richard?

DR. BANKOWITZ: So in answer to Kate's question I do believe this is an important conceptual area in which to focus, but I think what CMS needs to do is to select conditions where there are clear protocols that are evidence-based, where we have clear inclusion, clear exclusion and where optimally we know what the baseline optimal number is. Okay? In this case we know the number lies somewhere between 0 and 100 percent, but we don't know exactly where that optimum is. So I think keep those two criteria in mind and maybe that will help.

CHAIR OPELKA: All right. So keeping in mind what Michael had said, that this is in

the conditional support category, we have the three up, so we're going to ask for a vote of the group based on the three that are showing, but conditional support is where it was. The motion was to move it to do not support. So we're voting one of you support, two if you conditionally support, and three if you do not support.

MS. IBRAGIMOVA: You can begin voting.

(Voting)

CO-CHAIR WALTERS: All right. This is a slight departure from the previous voting as far as we're voting on the measure, not the motion.

MS. KOPLEFF: I'm requesting just a rerun of the vote. There were some mumblings just interpreting what you said. I know you said it nice and clearly, but I'll take the blame. Bear with me with the new process. I hit the wrong button.

CHAIR OPELKA: Well, we have to re-vote anyway.

CO-CHAIR WALTERS: And it looks like the four percent there that support didn't --

CHAIR OPELKA: Depends on where it goes.

CO-CHAIR WALTERS: Yes.

CHAIR OPELKA: We need 51 percent.

CO-CHAIR WALTERS: So this is Louisiana. No, we do --

(Laughter)

CHAIR OPELKA: So at this point we'll vote on the motion so it will clarify everything. We'll go back to a yes/no.

MR. AMIN: So just to reiterate, what the motion is, let's go back to the motion. The motion on the table by Michael was to move the measure from conditional support to do not support. So that is what's in front of you. So if you go as one, you are supporting the motion to do not support.

The question on the floor brought forward by Michael is to change the current categorization of the measure. The

categorization that Michael has put forward is do not support. So if you agree with that, press one.

Okay. So we're working on the slides as we're talking. So the slides may not reflect what I'm saying right now, but we'll make sure that it does before we vote. Just want to make sure everyone in the room is clear. There's a motion on the floor that Michael put forward -- can we put -- yes, one should reflect yes, two is no. We're going to update that right now. We're updating the slides as we go. Again, apologize for the confusion here.

There's a motion on the floor, Michael said, with moving it to do not support. So if you support the motion, press one. If you do not support the motion, the measure will stay as conditional support pending a re-review by NQF endorsement of the updated specifications.

CHAIR OPELKA: All this confusion is just to check to see if you're paying attention.

(Laughter)

MR. AMIN: And the slides should reflect this, right? Do you support the motion, yes or no?

(Voting)

CHAIR OPELKA: So just so we're clear, this vote represents that it stays with the conditional support. All right. Let's get out of this.

(Laughter)

MS. O'ROURKE: So I believe Nancy had made one more motion to pull the ED transfer set adding -- keeping it as conditional support pending development of a single composite, but to add a caveat that that composite should be NQF reviewed and endorsed.

MR. SLABACH: I'll make a motion to that effect, if that's appropriate at this time.

CHAIR OPELKA: I'm sorry, Brock, we did not hear you. Could you say that --

MR. SLABACH: Do you need a motion to accept the proposal that Erin made?

CHAIR OPELKA: No, I think that is --

MR. SLABACH: Oh, that is the motion?

CHAIR OPELKA: -- the motion.

MR. SLABACH: Okay.

CHAIR OPELKA: So any discussion?

(No audible response)

CHAIR OPELKA: All right. So I'll just do a quick hand vote here. All those in favor of the move?

(Show of hands)

DR. MORRISON: Frank, I'm raising my hand. It's Sean.

CHAIR OPELKA: Thank you, Sean. So we'll carry that. Onto the next.

MS. O'ROURKE: So, we'll be conditionally supporting the measure pending development of a single composite, and then that composite should be submitted to NQF for review and endorsement. So just adding another condition, that -- review and endorsement

composite.

MR. AMIN: So. Erin, that is it, right?

MS. O'ROURKE: That is it for the fully developed measures. We now have one more calendar for you on measures that are still undergoing development. This is again that we be asked to consider these -- CMS has again asked us to consider these five measures as a set. These are the Outpatient Ambulatory Surgery Patient Experience of Care Survey. There's five measures here.

As a patient-reported outcome, this survey asks five specific questions regarding communications of discharge instructions and follow up after discharge. It's a high-impact measure that will improve both quality and efficiency of care and be meaningful to consumers.

As a note, this is also under consideration for the ASCQR Program and these measures would begin to fill a gap the Workgroup

has previously identified for this program. And we did not receive any public comments.

So right now we have this as a preliminary analysis that we would encourage development of these measures. Your other choice would be that you would not encourage further consideration of these. So basically to stop development, or we would not want these in OQR in the future.

MS. FOSTER: Could we add an additional suggestion or caveat that in furthering the development we think carefully about how this gets integrated in with the CAHPS survey so that we're not having competing surveys going to the outpatients, we're not confusing everybody by having two different mechanisms and so forth, that it really becomes one integrated whole?

CHAIR OPELKA: Yeah, I'm kind of confused or curious as to how you do that. I mean, we're getting to the point of survey toxicity. So if that's the motion, I'm not sure

I agree with it because I don't understand what it means.

MS. FOSTER: So the CAHPS survey -- I don't have as clear a picture of the ambulatory CAHPS survey, but I know the inpatient HCAHPS survey asks very clearly about communication with your physician, with your nurse, communication about discharge and so forth. I'm leaping to the conclusion the ambulatory CAHPS asks similar questions and I'm concerned that we seemingly are going to be fielding two surveys to the same group of patients that may ask similar but slightly different questions. And that makes me crazy. And also thinking about administratively inside the hospital, how do you bring the information together and use it in a useful way when you've got two different competing surveys? I'm just saying take these questions and integrate them into the CAHPS survey as opposed --

MS. GINSBURG: Nancy, this is Karen Ginsburg. Excuse me. Can I answer that question

or address that for you?

MS. FOSTER: That would be a question for the Chair.

CHAIR OPELKA: Please. Thank you.

MS. GINSBURG: Okay. This is Karen Ginsburg from CMS, and we feel that there will be very little overlap between HCAHPS and the outpatient survey. And we worked very carefully at making sure that there isn't overlap between those surveys. We spent a lot of time thinking about administrative mechanisms to ensure that patients don't receive different surveys for the same health care event. And we think there will be very little overlap between the Outpatient Ambulatory Survey Patient Experience of Care Survey and HCAHPS.

We are spending a lot of time thinking about the potential overlap between S-CAHPS, for example. And that's for surgeons. It's not on the -- these measures are on the MUC list. But we spent a lot of time for example thinking about the overlap between the S-CAHPS survey, should

that ever be implemented, and the O/ASPECS survey, as we call it. So we are aware of this concern and we're very sensitive to it.

CHAIR OPELKA: Thank you. Jack?

DR. FOWLER: Just to add to that, I wasn't involved with this, but clearly the two populations are different. I mean, not that somebody couldn't be an inpatient and an outpatient at some time in the same thing. So, but you have a pool that you draw from that have had an outpatient experience within a defined period of time, and they're clearly working on adapting the inpatient questions to make more sense for an outpatient experience. They have work to do, but it makes it appropriate to say they should keep working, but I don't think that -- they're not going to be the same survey and they're not going to be overlapping and confusing, I don't think.

MS. FOSTER: Just to clarify, Jack; I'm sorry I confused you when I referenced HCAHPS, there is an ambulatory CAHPS and I'm

saying don't -- try to find a way to make these questions either integrate into the ambulatory CAHPS or assure me that somehow you're going to make it easy for both hospitals and patients to understand these two competing surveys that you're asking us to fill.

CHAIR OPELKA: So I guess, Nancy -- and I'm taking my Chair hat off on this one because we actually have had conversations about the S-CAHPS and how all this comes together. I guess to me we're looking at these measures that are here, and what you're describing to me is -- I don't know if it's a gap area, but it's a future area that needs to be settled. How do all these patient survey instruments kind of get refined to avoid all the burden that both the patient and the delivery systems are feeling? And I think the CMS team is trying to answer that same question. So our vote on this really is do we encourage this but within the framework and understanding that I think you're touching on, if that's fair enough.

All right. Andrea?

DR. BENIN: My comment is very similar to yours, Frank. I think that this is a logical next step, but we did just vote on the health literacy measures. And so my I think point for consideration for CMS is as we think about the burden we pay the vendors by the survey that goes out, right? So every one of these surveys, by the patient surveys -- each one of those costs and so each one of these represents an increased financial burden on the organization in addition to all the other things. So while I wouldn't disagree with any of it, I think that as CMS is considering how to pull these things together, that that's something that's -- the amount of time, effort, and money that goes into the vendor support is not inconsequential.

CHAIR OPELKA: So I'm not hearing opposition. I'm hearing a call for efficiency in how we do this. And it sounds like everyone is encouraging this. So is that it? Are we in agreement? Because if that -- I'm seeing more

nodding of heads. Then I think we'll consider this as in agreement with these caveats that have been discussed in our report to the Coordinating Committee. All right?

Then let's move on.

MS. O'ROURKE: So that concludes our preliminary discussions about each of the measures. We're now going to show you the final consent calendars and prepare to vote on those.

Just one second while we cue those up for you.

CHAIR OPELKA: All right.

MS. O'ROURKE: So for consent calendar 1, support, we have external beam radiotherapy for bone metastases and the health literacy measure derived from the health literacy domain of the C-CAT. For consent calendar 2, conditional support pending NQF endorsement, we have use of brain-computed tomography in the emergency department for atraumatic headache. For consent calendar 3, conditional support pending the development of a single composite

measure and NQF review and endorsement of that measure. We have the slides seen before you. Then finally, for do not support we have advance care plan.

CHAIR OPELKA: So we're now voting on the consent calendars as they stand.

But before we do, Nancy had brought up to our attention earlier the request for public comment.

So, Kathy, if you would open the phones for public comment?

OPERATOR: Yes, sir. At this time if you would like to make a comment, please press star then the number one on your telephone keypad.

And there are no public comments at this time.

CHAIR OPELKA: Thank you. Do we have public comment in the room?

MS. JONES: Hi, I'm Stacie Jones from the American College of Emergency Physicians. I just wanted to in part answer Kate's question and

also for the Coordinating Committee to let them know that one of the major issues with the OP-15 measure is that it is in direct conflict with ACR appropriateness criteria and several other guidelines that indicate age and hypertension as red flags for CTs. There is no ICD for an uncomplicated headache.

We really appreciate all the effort that CMS has put in to including additional exclusions and performing additional analyses for this measure.

We also are very actively working on our own imaging efficiency measure set in conjunction with the American College of Radiology and several other specialties, and we have developed thus far three measures that have been up for public comment which we have sent to the PQMM measure contractor for the PQRS Program, which is a different program from what you're looking at today. And we do intend to develop measures for all 10 of our Choosing Wisely recommendations.

This is not one. And so what we would recommend to all measure developers is that they start with the guideline recommendations first and then work from there, because where there are clinical decision support rules, like the PECARN rule for instance in pediatrics, that's a well-established clinical decision support rule which can guide high-quality care and performance measurement.

And so, looking to those clinical decision support tools, of which there are many and some still need to be validated, that's a really good starting point for measure development and we hope to continue to collaborate with CMS, ACR and many other stakeholders in this space.

CHAIR OPELKA: Thank you. Any other comments?

(No audible response)

CHAIR OPELKA: Okay. Well then at this point we will vote on the consent calendars that have been presented to you, and we're voting

yes and no on the consent calendars.

Question about the vote?

DR. BENIN: About the logistics of the voting.

CHAIR OPELKA: Please?

DR. BENIN: So we can vote no against the consent calendar? Is that --

CHAIR OPELKA: Right. Right, you know, it's presented to you as a consent calendar. You could have moved anything you wanted on it. There are actually four consent calendars? Five. Three, four or five?

MS. O'ROURKE: Apologies. There are four. There are three for the fully developed measures and then one for the measures under development to encourage further development. Apologies. Four consent calendars.

CHAIR OPELKA: So you may have heard all the discussion. You may not necessarily agree with it.

DR. BENIN: -- know that 50 percent of us don't agree with half of the votes. That's

what I'm thinking. So how is this going to play out?

CHAIR OPELKA: Fifty-one percent agree. Forty-nine percent don't.

DR. BENIN: Forty-nine percent. I'm just saying it's going to be interesting. Okay. Just wanted to make sure I understood.

CHAIR OPELKA: Michael?

DR. PHELAN: So this is an overall vote for all four, but if you agree with three of them that you want to move forward, but one of them you don't --

CHAIR OPELKA: We can take them one at a time, if you wish.

DR. PHELAN: I think it would be better to do one at a time.

CHAIR OPELKA: We will.

DR. PHELAN: Each consent calendar separately.

CHAIR OPELKA: Okay. We can do so.

MS. O'ROURKE: Okay. We'll just need one minute to cue up the slides for you.

MS. IBRAGIMOVA: So we're ready to vote, and the question is do you agree with the consent calendar 1? Press one for yes, and two for no.

PARTICIPANT: What was consent calendar 1?

CO-CHAIR WALTERS: It was the support which included the external beam radiotherapy for bone metastases and the health literacy measure.

MS. IBRAGIMOVA: Now you can vote.

(Voting)

CHAIR OPELKA: That vote was 83 percent in support of support. Okay. So now we move to the conditional support for NQF endorsement.

MS. O'ROURKE: So, this will be the vote on if you conditionally support pending NQF endorsement OP-15, the use of computed brain tomography for a patient with atraumatic headache.

MS. IBRAGIMOVA: So now you can vote do you agree with the consent calendar 2? One

yes, two no.

(Voting)

MS. IBRAGIMOVA: So the results are --

CHAIR OPELKA: So this also passes.

MR. AMIN: Frank, if we can have Laura just read the votes for the record, please?

MS. IBRAGIMOVA: So the results are 61 percent yes, 39 percent no.

CHAIR OPELKA: We have a second conditional support, which would be calendar number 3.

MS. O'ROURKE: So it would be conditional support pending the development of single composite measure and endorsement.

MS. IBRAGIMOVA: Do you agree with consent calendar 3? One yes, two no.

(Voting)

MS. IBRAGIMOVA: The results are 95 percent yes, 5 percent no.

CHAIR OPELKA: And then the fourth calendar is the do not support?

MS. O'ROURKE: So the fourth calendar

will be do not support for advance care plan. This is for the advance care plan not support, yes. Yes, so it's not actually calendar 4. It's just the do not support calendar since we didn't originally have one for do not support. There's no number associated with it. Sorry for the confusion. So this is just a new calendar called do not support.

MS. IBRAGIMOVA: Do you agree with the consent calendar do not support for the advance care plan? One yes, two no.

(Voting)

MS. IBRAGIMOVA: The results are 59 percent yes, 41 percent no.

MS. O'ROURKE: So we'll be taking one more vote for the measures under development. This is that you would encourage for continued development the O/ASPECS survey for hospital OQR.

MS. IBRAGIMOVA: Do you agree with the consent calendar 4? One yes, two no. Five? Technically five.

(Voting)

MS. IBRAGIMOVA: The results are 95 percent yes, five percent no.

CHAIR OPELKA: Okay. So we're way past our 11:00 break and yet we're behind in our overall schedule. So we're going to go ahead and take that break now, but here's where we stand: These consent calendars need to pass by a 60 percent vote and the do not support did not pass. So we have to come back to that consent calendar, which actually only has one item on it, and we have to clarify where we stand on that one measure that's there with recommendation to the Coordinating Committee. We have to reach on that measure -- it has to either reach 60 percent or greater or it has to move to another consent calendar to resolve its position.

So let's go ahead and take a break until 11:30, and we're going to have to come back and resolve that one outstanding issue.

(Whereupon, the above-entitled matter went off the record at 11:16 a.m. and resumed at 11:33 a.m.)

CHAIR OPELKA: So if we could, we're going to move on in a minute to the next topic, which is Ambulatory Surgery Center, and Ron is going to take us through that.

But before we do, we have an outstanding matter with our last vote. And so if the Advanced Care Plan Measure that we had put forward that was in the do not support reached 59 percent. And according to the coordinating committee guidance, it has to reach 60 percent.

So at this point, we would like to inform the Coordinating Committee more specifically of where the group comes down on the three different options for this measure.

So we are going to take a vote on this measure within support, conditionally support and do not support the measure. And then we will use that information to inform the Coordinating Committee regarding the consensus of the group here.

All right. Any questions? Nancy?

MS. FOSTER: What's the condition?

CHAIR OPELKA: Is this one NQF-endorsed?

AUDIENCE MEMBER: Yes.

CHAIR OPELKA: All right. I don't have a conditional support to it. You know, just in case people have a condition in their mind. So I mean, it may fall out that everybody -- it's binary, but everyone has the opportunity to vote where they feel on this measure. All right. You are supporting the Advanced Care Plan on the MUC list.

You are conditionally supporting it, but as originally stated, you are conditionally supporting it and Nancy asked specific to what conditions, since it's NQF-endorsed, and I don't have a condition, but you individually may have a condition. And then you do not support.

So the last vote was 41 that did -- that voted against do not support, and 59 voted in favor of do not support, but that does not reach consensus to the Coordinating Committee, so we need to better inform them where you stand.

All right? Okay. Shall we vote?

MS. IBRAGIMOVA: So the question is what -- oh, we have one question?

CHAIR OPELKA: Dana?

MS. ALEXANDER: It's not sinking in. So conditional support is we're saying what?

CHAIR OPELKA: If you have a condition in your mind --

MS. ALEXANDER: Oh.

CHAIR OPELKA: -- and you are not fully supporting, but you would conditionally support this.

MS. ALEXANDER: Okay.

CHAIR OPELKA: We're not asking you to state your condition.

MS. ALEXANDER: Okay. Thank you.

DR. LEVY: What does that mean exactly? I mean, it sounds like --

CHAIR OPELKA: We can't tabulate the entire Committee's sentiment on every single aspect of this measure. You either support it, you are not in the -- you are not against, you

are not for, you are somewhere in the middle for whatever reason.

DR. LEVY: Okay. Okay.

CHAIR OPELKA: Marty?

MR. HATLIE: I'm going to go back to Nancy's opening comment on it, where she talked about respecifying this to making it narrower and less broad. If that's where I want to be, I'm conditionally supporting. Is that correct?

CHAIR OPELKA: If that's your condition, yes.

MR. HATLIE: Yes. Thank you.

CHAIR OPELKA: Okay.

MS. IBRAGIMOVA: So the question is what should MUC's decision be on the Advanced Care Plan Measure? One, support; two, conditional support; or three, do not support.

(Voting)

(Laughter)

MS. BAL: That actually may not be the result. We could be having some problems. That probably isn't the result. That's usually the --

MS. IBRAGIMOVA: This is a technical difficulty.

MS. BAL: -- default.

MS. IBRAGIMOVA: We are going to revote.

CHAIR OPELKA: But I like it.

DR. MORRISON: Frank, could you share what is so funny? I'm sorry.

CHAIR OPELKA: Sean, all the votes came out 33 percent.

DR. MORRISON: Thank you.

MS. IBRAGIMOVA: Okay. Try voting again.

(Voting)

MS. IBRAGIMOVA: So the results are support 39 percent, conditional support 17 percent and do not support 43 percent.

CHAIR OPELKA: All right. Well, that's helpful, so we will take this information to the Coordinating Committee and we will work this particular measure at that level. Okay. Thank you.

Okay. Let's move into the ASC Program, the Ambulatory Surgical Center Program Quality Reporting, and Poonam will give you an introduction to the program.

MS. BAL: So we will be speaking about the Ambulatory Surgical Center Quality Reporting Program, also known as ASCQR. So this is also a paper reporting. The information is currently reported to the center, to CMS, but it is expected to be publicly available in the future.

Okay. Okay. So the system is established for collecting and providing quality ACs and also again to provide consumers with the quality of care information that helps them make informed decisions.

The critical program objectives that came up in October were that the measures are high-impact and are meaningful to patients. They align measures of CMS various quality reporting programs, specifically OQR, and also the measure caps that we came up with for surgical care quality induction rates, follow-up after

procedure complications, cost and then cost -- I'm sorry, and patient and family engagement measures, also including CAHPS modules.

MS. O'ROURKE: So the bad news is the first measure we have under consideration for ASCQR is the Advanced Care Plan Measure. I won't repeat our analysis, since we have had such a thorough conversation, but I did want to point out we received some public comments not supporting this measure.

Noting that for -- it's based on evaluation and management codes, which are not currently used in the ASC setting. Sorry, I lost my page.

So the denominator is specified by a group of evaluation and management CPT Codes, none of which are payable in the ASC setting. As a result, the measure denominator would be zero for an ASC. The commenter further noted the measure has not been tested or endorsed for the ASC setting.

Finally, the commenter noted that the

CMS conditions for coverage for ASC's already required documentation of whether or not a patient has an advance directive.

The next calendar deals with measures that have a preliminary analysis of conditional support pending completion of reliability testing and NQF-endorsement.

The first one is unplanned anterior vitrectomy. This measure is highly impactful and meaningful to patients. According to the National Eye Institute report in 2002, more than half of U.S. residents over 65 have a cataract. Cataracts are a leading cause of blindness with more than 1.5 million cataract surgeries performed annually to improve the vision of those with cataracts.

And anterior vitrectomy, apologies if I mispronounce that, the repair of a rupture of a mainly liquid portion of the eye is generally an unplanned complication of a cataract surgery. This is an outcome measure that fills a work group identified priority gap of procedure

complications.

We have received two public comments strongly supporting this measure for inclusion in the program.

The next measure is a normothermia outcome measure. This is a high-impact measure. Anesthetic-induced thermo-regulatory impairment may cause perioperative hypothermia, which is associated with adverse outcomes including significant morbidity, decrease in tissue metabolic rate, myocardial ischemia, surgical site infections, bleeding, diathesis, colligation of drug effects and mortality.

As an intermediate outcome measure, this measure moves towards an outcome measure that fills out a work group-identified gap of anesthesia-related complications.

As a note, reliability testing has not been completed and the measure is not currently NQF-endorsed. We did not receive any comments on this measure.

Calendar 3 deals with measures that

received a preliminary analysis of do not support. We received -- this measure is ambulatory surgery patients with appropriate method of hair removal. This measure is topped out with limited performance variation among providers. Measures of appropriate hair removal have been removed from the IQR Program.

This measure is not, nor planned, to be in another program at this time. We received one public comment that was supportive of including this measure. The commenter noted that it had been used over the last seven years with usable measure data and not unduly burdensome to collect.

So those are the fully developed measures for the ASCQR Program.

CHAIR OPELKA: Fortunately, we have three calendars for this, so we won't have to change the numbers on you. So just to show that somebody has a sense of humor, yes, under the support one, the first one is Advance Care Plan. I would hope that by now that has been heavily

discussed and first we go to our lead discussant, Sean and Helen, who is actually Nancy, right? I'm sorry, it's Emma. And we will have the lead discussions reflect their deliberations about hopefully the issues confined to the ASCs and not things that we spent the last hour and a half on.

Sean, do you have anything you would like to say?

DR. MORRISON: Not that hasn't been already said or I haven't already articulated.

CHAIR OPELKA: Thank you. There was a big sigh of relief in the room over that. Emma?

MS. KOPLEFF: Just in responding to the public comments received, as we try to find a compromise regarding this measure, I would note that the commenter says the measure has not been tested at this -- in the ASC setting.

I hear that. I do think there is a challenge in having the NQF-endorsement process look at every measure for every single setting and level of analysis, but would propose,

personally on behalf of the consumer organization I'm representing, I'm supportive of this measure for the reasons stated earlier, but think that maybe there is some sort of compromise related to additional testing for this setting.

CHAIR OPELKA: Thank you very much. Now, this is where it is going to get a little tricky, because I'm going to ask for a motion and how this motion is worded is going to drive the next period of time.

Does anybody have a motion regarding this measure? Donna?

MS. SLOSBURG: I'm Donna Slosburg and I would like to pull this measure from support to do not support. And if I could, I could give you my reasons.

CHAIR OPELKA: Please do.

MS. SLOSBURG: First, I want you all to know that as everybody has reiterated, I won't go into that. We are very concerned about advance directives and do you want to honor a patient's wishes and our conditions for coverage

in the ambulatory surgery centers, we have conditions for coverage, which are similar to conditions for participation in the hospital.

We are mandated to ask already about advance directives, unlike the Outpatient Quality Reporting.

The concern and the reason that we brought up about the ambulatory setting is that this measure, as currently specified, on your screen you call see all patients age 65 and older, but we did confirm with the developer and there is also an eligible subset, it's a list of CPT codes that are actually evaluation and management codes.

And as Erin had alluded to, those are not used in an ambulatory surgery center. We actually have an approved list of CPT codes from CMS and those are not on the list. So right off the top, if this measure was used in an ambulatory surgery center, it would be zero, because there is no denominator.

Secondly, as I said or haven't said

yet, but under our Code of Federal Registration, ambulatory surgery centers operate exclusively for the purpose of providing surgical services. We are excluded providing -- we are only allowed to do surgical services and, as I said, these evaluation and management codes are not on the approved list.

This is already a standard of care in our industry. And I don't know, I can read to you very quickly what our conditions for coverage say. Provide the patient or, as appropriate, the patient's representative in advance of the date of the procedure with information concerning its policies on advance directives.

Inform the patient or, as appropriate, the patient's representative of the patient's right to make informed decisions regarding the patient care. Document in a prominent part of the patient's current medical record whether or not the individual has executed an advance directive. It also says that the documentation as it applies in the ASCs has to be in a

prominent part of the medical record.

So that being said, that's why I'm asking for a do not support, because it seems like this is already in our conditions for coverage and I feel like this is not a critical measurement topic for us.

CHAIR OPELKA: I'll open it up for further comments. Mitchell?

DR. LEVY: So I'm just not -- I would not face this before. This measure seems that it is in error, so is it true that the codes actually don't apply to -- I would like clarification. And then I would also like clarification of if this is kind of double-dipping, so to speak, that ambulatory service clinics are already asked to do this.

I'm not sure what the purpose of this measure is. If those aren't true, then I think we have to have a different discussion.

MS. SLOSBURG: If you would like, I can show you the actual codes in the --

DR. LEVY: No, it's not that I don't

believe you.

MS. SLOSBURG: Oh, oh.

DR. LEVY: I'm just not used to a measure being brought to us that seems completely off-base. So it's not just a matter of opinion of whether we think it is a good idea. This seems like it is being applied incorrectly.

DR. YONG: Yes, I don't think we were aware of that particular issue that Donna raised before. This is the first time this has come to our attention.

MS. FOSTER: Thanks. And this perhaps has just clarified that, but for anybody who is not aware, the conditions of coverage that Donna alluded to, if you violate them, you are given an opportunity to correct your behavior. And if you don't, you can be excluded from the Medicare programs. So it's really something people pay a lot of attention to. And perhaps even more so than they do the measures.

CHAIR OPELKA: Any other comments? Good. Okay. Having heard that, the motion on

the table is to move it to do not support. This should be a binary vote. A yes vote would mean you support the motion. A no vote would mean you would not support the motion.

MS. SLOSBURG: Can you say that again?

CHAIR OPELKA: Yes. So the yes is not about the measure. The motion on the table, we learned once from this already this morning. The motion on the table is to move it to do not support. A yes vote supports that motion, which will be 1. A 2 is no, you do not support the motion.

(Voting)

MS. IBRAGIMOVA: The results are 92 percent yes, eight percent no.

CHAIR OPELKA: So advance care plan will be moved down to Calendar 3 and we will get to calendar 3 in just a second.

So Calendar 2 is the conditional support. It has two measures. These we heard earlier. Is there discussion about the -- is there a discussion and a wish to move either of

those issues off that calendar, Unplanned Anterior Vitrectomy and Normothermia Outcome?

We will hear from Donna and Cristie. Donna first.

MS. SLOSBURG: I just wanted to update the panel that these measures are fully tested now. And also, they are being used throughout the industry.

MS. FOSTER: From my perspective, I think these are two important measures. They are filling specific gaps that the MAP has identified around ambulatory surgery outcomes. The normothermia is kind of an intermediate outcome measure, but we think it is a good one to start with.

Obviously, the complications that are actually caused by that condition would be something that we hope that we would move toward actually measuring, but this is really a good movement in, what we have identified as a priority area.

CHAIR OPELKA: Nancy?

MS. FOSTER: Just a question. Is it conditional upon both NQF-endorsement and review of the liability testing to ensure that they are reliably collected? I'm comforted by Donna's assertion that they are being broadly collected right now, but I want -- but there were questions earlier about the reliability of these data. So thank you.

MR. AMIN: Yes. The condition is pending completion of the reliability testing. That's the most recent update that we have from CMS, but that would obviously need to go through NQF-endorsement review.

CHAIR OPELKA: If there is no more discussion, we will move on to Calendar 3. We already have one measure moved onto Calendar 3. Is there any discussion about the do not support measure on Calendar 3, which is ambulatory surgery patients with appropriate method of hair removal?

First Mitchell?

DR. LEVY: So this, I think, is fairly

straightforward. It's basically topped out at 97 percent and it has been removed from inpatient quality reporting and there are no plans for moving it forward from CMS that we know of. So it seems that recommendation that we do not support this is very appropriate at this point.

CHAIR OPELKA: Martin?

MR. HATLIE: I just noticed that we did have one very positive comment about retaining this and it actually came from Donna's organization. Donna, I don't know if you want to speak to it? That's basically it was low-burden and widespread use.

I don't mean to put you on the spot, but it was your organization.

MS. SLOSBURG: You know, it has been used in our industry for the last few years and we have had about 1200 surgery centers out of the 5,000 reporting on our website and it is now right about between 97 and 98 percent. It was a measure that we had and had wanted in the program.

MR. HATLIE: Yes.

MS. SLOSBURG: But it didn't make it through comment, but we are, you know, still collecting data on it. I'm okay with it not being in the program.

CHAIR OPELKA: Okay. There is currently no motion on the table to move anything out of this calendar. Is there any more discussion? Okay. No.

Calendar 4. Let's take those first, okay? Yes, let's do that. To do a vote on the Consent Calendar and we will refresh it or what it is -- sorry.

MR. AMIN: Operator, can we open the line for public comments? Are there any public comments in the room?

OPERATOR: If you would like to make a public comment, please press star and then the number one. Okay. At this time, there are no public comments.

MR. AMIN: There are no public comments in the room and there are no public

comments on the webchat.

MS. IBRAGIMOVA: So we will be voting on ASCQR Consent Calendar 2, Conditional Support Pending the Completion of Reliability Testing and NQF-Endorsement for Unplanned Anterior Vitrectomy and Normothermia Outcome.

Do you agree with the conditional support pending the completion of reliability testing and NQF-endorsement calendar? 1, yes; 2, no.

(Voting)

MS. IBRAGIMOVA: The results are 100 percent yes and zero percent no.

CHAIR OPELKA: It's called a consent calendar.

MS. IBRAGIMOVA: So ASCQR Consent Calendar 3, do not support Ambulatory Surgery Patients with Appropriate Method of Hair Removal and Advance Care Plan.

Do you agree with do not support calendar? 1, yes; 2, no.

(Voting)

MS. IBRAGIMOVA: The results are 100 percent yes, zero percent no.

DR. LEVY: This is too easy. We should talk about advance care plan again.

(Laughter)

MS. O'ROURKE: Okay. Calendar 4 is for the measures under development. These are again, the O/ASPECS survey elements that we had discussed previously for OQR. We did receive a public comment for this measure for this program, so I won't repeat our preliminary analysis, but I did want to read this comment for you.

The ASC Quality Collaboration submitted a comment supporting the idea of a patient survey experience, but noted the survey instrument has yet to be finalized and made public. The commenter noted concerns regarding the cost of implementing and using the survey.

The commenter noted the survey was -- that they were assured by CMS the survey would be voluntary, but is now on the list for inclusion in ASCQR.

CHAIR OPELKA: So let's do our lead discussants first. Amanda?

DR. STEFANCYK OBERLIES: (No audible response.)

CHAIR OPELKA: Jack? Amanda are you --

DR. STEFANCYK OBERLIES: So I believe the measure looks good the way it is stated. I know this is very similar to the outpatient one that we had and the motion was to do a composite, so I would be interested to hear from the group if a composite is suggested for this one as well.

CHAIR OPELKA: We will talk about all four or five.

MS. O'ROURKE: So just to clarify, this is another one that CMS had asked us to consider as a set. So if you want to pull one element, we would ask that you pull them all.

DR. FOWLER: Well, I mean, I think the same argument is in favor of the ones that we supported in the outpatient center. The issue about confusion between ambulatory surgical

centers and other kinds of ambulatory care aren't supposed to be discussed, but it seems like these are built on CAHPS work. There is work to be done. I don't think this is right forum to worry about individual questions. I assume more work will be done, but it did seem like a reasonable -- it seems reasonable to me to support continued development.

CHAIR OPELKA: Okay. Are there any other comments? Let's open for public comments.

MS. GINSBURG: Hi, this is Karen Ginsburg from CMS. Can I just update the panel, please? The measures are fully tested now. They were recently -- the testing was recently completed, so they are full tested. They have one more step which is to go through the CAHPS consortium to be able to use the CAHPS trademark.

CHAIR OPELKA: Okay. So this is Frank, just commenting with my Chair hat off. We had made comments about this set in the previous discussion. Now, we are just hearing those comments over that -- that this is a

collaborative effort with all these patients are being instruments that we try and efficiently and economically put these forward, you know, so that the patients aren't inundated with all of this.

So encourage continued development. Karen, thank you for all the great work you are doing. And then put this in play with all the other CAHPS instruments as to how we put all this together.

Okay. A show of hands for those in favor of Calendar 5?

DR. MORRISON: My hand is up, Frank.

MS. IBRAGIMOVA: General consensus?

CHAIR OPELKA: No. General consensus. Okay. We will use the voters. All right. Does somebody have a motion, by the way, for this consent calendar?

MR. AMIN: Can I just clarify? There was no motion to change the preliminary recommendation?

CHAIR OPELKA: Right.

MR. AMIN: So --

CHAIR OPELKA: A formal vote for the consent calendar.

MR. AMIN: -- at this -- yes. So now, it is just a formal vote.

CHAIR OPELKA: Okay.

MR. AMIN: Yes.

CHAIR OPELKA: So 1, yes and 2 is no.

MR. AMIN: Yes, thanks.

CHAIR OPELKA: Ready? Well, it's a consent calendar.

MS. IBRAGIMOVA: So voting on do you agree with encourage for continued development calendar for the survey measures?

(Voting)

MS. IBRAGIMOVA: If you haven't voted, can you vote again? Technically, yes. The results are 100 percent yes, zero percent no.

CHAIR OPELKA: Okay. So we will try and get the voting machines fixed. I don't know what is wrong with them. But so what we are going to do between now and break for lunch is just intro the Medicare Shared Savings Program.

And then we are going to ask you to get your lunch, take a few minutes, chew, don't digest, before you digest, we will dive back in and then you can do that portion of your digesting while we are working, so it's a working lunch. Taroon?

MR. AMIN: Okay. So MSSP. We have seven consent calendars. The first five are for fully developed measures. The final two are for measures under development.

We will start with a quick orientation. Consent Calendars 2, 3 and 4 are all within support, conditional support. They just have different conditions. So I will walk through them individually.

Perioperative antiplatelet therapy. This is a fully developed measure and tested endorsed measure. It assesses the safety of patients by evaluating the appropriate use of medication before and after procedure.

One of the main program objectives that this group identified was around coordination and collaboration, so this does

require a level of coordination and collaboration within an ACO.

So again, the preliminary recommendation here was support. There were no comments on this measure.

The second measure in this calendar is Thorax CT: Use of Contrast Material. This measure promotes alignment across other quality reporting -- quality measurement reporting programs, including the Outpatient Quality Reporting Program, and identifies gaps related to imaging efficiency, utilization and patient safety.

In addition, this measure requires the use of administrative claims that will not pose an overly burdensome approach for providers. The Pulmonary and Critical Care Standing Committee noted in its 2013 review of this measure that this measure helps address over-use and patient safety through the reduction of radiation exposure and the potential reactions to contrast dye.

The third measure in this support category for the Consent Calendar 1 is In-Hospital Mortality following the elective open repair of AAAs. This measure represents and important cardiac outcome for a large number of Medicare beneficiaries. This measure is currently used by private sector registries and is under consideration for other PQRS-based programs.

While this measure does not address care across settings and providers, it does represent an important opportunity for the quality improvement in the Medicare fee- for-service population.

And finally within Consent Calendar No. 1 is the Payment-Standardized Medicare Spending Per Beneficiary Measure. This cost/resource use measure captures services delivered between three days prior to an inpatient hospitalization through 30 days post-discharge.

This measures a high impact area of

measurement identified by the gap or by the MAP and addresses -- and seeks to incentivize hospitals to improve care coordination and reduce fragmentation across the healthcare delivery system.

This measure also promotes alignment across quality reporting programs and since it's used in the Hospital Inpatient Quality Reporting Program and the Hospital Value-Based Purchasing Program. This measure was also identified by the MAP-affordability families of measures and the MAP-duals family of measures.

There was one comment received on this measure that specifically noted concern around the cost attribution methodology that I would just note for the Committee in its review. Those are the four within Consent Calendar No. 1.

I'll continue moving on, so please note if you have any concerns about these as we go forward. Let me just walk through them and then you guys can break for lunch, because that will probably be a little bit easier, maybe not.

So Calendar No. 2. This is Conditional support pending the resolution of data concerns. This is the quality outcome measure. This is the first one, conditional support pending resolution of data concerns. The MSSP program may have difficulty accessing NHSN data and would need to coordinate with the CDC to be able to obtain this information.

I just want to point out that this is an update to an existing measure, so that's really what is under consideration, not the full measure. It's just considering whether the updates -- Erin, can you just confirm that?

MS. O'ROURKE: So these measures are not in the MSSP program, at this time, so this is considering --

MR. AMIN: Okay.

MS. O'ROURKE: -- this measure for the MSSP program. When we see these later in the meeting, we will just be considering the update.

MR. AMIN: Okay. Thank you for that. All right. So again, this is the CAUTI measure

for this program and it is conditional support pending data concerns.

There was a significant number of comments received on this measure. The number that is listed there is six. Actually, six -- there was one comment that noted about four or five additional comments within one, so actually this is probably more on the order of 10 comments that were received that raised significant concerns regarding the inclusion of patients with spinal cord injuries.

There was a significant concern that using this measure with that patient population would -- is undesirable.

And then there is a CLABSI outcome measure with very similar conditions pending the resolution of data concerns and whether they would be able to obtain this information from CDC.

So moving forward, we have the Consent Calendar No. 3. This is conditional support pending NQF review and/or endorsement. The first

measure that we start here with is the proportion of patients sustaining bladder injury at the time of pelvic organ prolapse repair. This is conditional support pending NQF review.

This is an important outcome measure and it is fully-specified and tested and would contribute to the efficient use of measurement resources, if selected, for use across PQRS-based programs. However, it is not currently endorsed.

No. 2 within the Consent Calendar No. 3 is the proportion of patients sustaining major viscus injury at the time of pelvic organ prolapse repair. Again, this is a conditional support pending NQF review and endorsement, an important outcome measure and it's tested. Again, it would -- it is currently not endorsed.

Third in this list is the proportion of patients sustaining ureter injury at the time of pelvic organ prolapse repair. Again, this was a conditional support with many of the same concerns. It is an important outcome measure, but it is not currently endorsed.

And finally within this category is performing cystoscopy at the time of hysterectomy for pelvic organ prolapse to detect lower urinary tract injury. And this is a conditional support pending NQF review and endorsement. This is an important measure to detect urinary tract injury, which is a common complication for this type of surgery.

Moving on to Consent Calendar No. 4, this is only one measure in this category. This is conditional support pending resubmission to NQF for endorsement review. And there are no comments received on this measure.

Finally, MSSP Calendar No. 5, do not support. This is performing an intraoperative rectal examination at the time of prolapse repair. So this is a process measure that does not address any of the identified gaps by this work group for the Medicare Shared Savings Program and does not encourage coordination or shared accountability across multiple settings that the patients receive care.

So those are the five consent calendars for the measures that are fully-specified. I will go through the remaining two consent calendars for the measures that are still under development.

So that includes the Medicare Shared Savings Program Consent Calendar No. 6, which is encourage continued development. And this is door to puncture time for endovascular stroke treatments. This is an intermediate clinical timeliness of appropriate stroke treatment outcome measure that is important -- that is an important leading cause of mortality and disability for the Medicare fee- for-service population.

And the measure also does promote alignment across PQRS-based programs. There was one comment on this measure that was generally supportive noting the need for appropriate risk adjustment.

The next measure is the prevention of post-operative nausea and vomiting combination.

This is a measure that addresses an important area for potential surgical improvement for Medicare beneficiaries. And there was one generally supportive comment on this measure.

The third measure in Calendar No. 6 is Post-Anesthetic Transfer of Care, the use of a checklist or protocol for direct transfer of care from procedure room to intensive care unit. This measure addresses an important subset of beneficiaries who have been cared for in the OR and are transferred to the ICU and encourages coordination within an acute care facility among providers.

This measure has the potential to improve surgical and anesthesia care for Medicare population and does address the transition of care between providers, even though it's within the care setting.

And finally within this consent calendar is the Post-Anesthetic Transfer of Care measure from the procedure room to the post-anesthesia care unit, the PACU.

This has a very similar preliminary analysis in that it addresses an important area of care and does address coordination of care among providers within a care setting. And there were also generally supportive comments on this measure.

There were two measures that -- three measures on the final Medicare Spending for Beneficiary Calendar No. 7, which were -- the preliminary analysis result was do not encourage further consideration.

The first of that -- of those measures was the Pre-Operative Use of Aspirin for Patients with Drug-Eluting Coronary Stents. While an important clinical measure, this does not address an identified gap by this work group for the Medicare Shared Savings Program nor does it encourage coordination or shared accountability across settings, across multiple settings in which these patients seek care.

There were generally supportive comments by the American Society of

Anesthesiology.

The second measure under this consent calendar is the perioperative temperature management and this measure has been retired by the measure steward, CMS. And so this is why this was not supported. This measure did receive generally supportive comments during the comment review.

And finally of this Medicare Shared Savings Program is the Anesthesiology Smoking Abstinence measure. And while smoking cessation is an important area of measurement, there was a concern that was raised around whether a single day abstinence reflects the value of measuring high-risk follow-up and whether it does represent a high value measure of health risk with follow-up interventions.

This measure also received three supportive comments from two different commenters. So those are the seven consent calendars that were -- are up for discussion for the Medicare Shared Savings Program.

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

CHAIR OPELKA: Great. All those in favor? We're voting -- this is purely a vote on lunch. So let's take a break and grab your lunch. Take about 10 or 15 minutes and you can keep eating, but, at that point in time, I would like us to get into the consent calendar. You can see we have got a lot in front of us.

MR. AMIN: So we will reconvene at 12:45, for those on the phone and those in the room.

(Whereupon, the above-entitled matter went off the record at 12:20 p.m. and resumed at 12:47 p.m.)

A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

12:47 p.m.

CHAIR OPELKA: All right. So we have got our agenda before us on the Medicare Shared Savings Program that Taroon walked us through. And we are beginning by moving the various aspects off one consent calendar to another beginning with the first consent calendar, which is the support calendar and it included perioperative antiplatelet therapy for carotid thoracic CT use of contrast in hospitality mortality related to AAA and the payment standardized Medicare spending per beneficiary measure.

MR. AMIN: Frank, I'm sorry, I should have mentioned this before we started. We had a request to go through the program summary for this program. In my introduction I skipped that, just going over the program as designed and the gaps that are identified during the fall web meeting.

So if I could turn -- if we could --

if you could turn it over to Poonam, she will take care of that before we get started on the individual calendars.

MS. BAL: Okay. Thank you, Taroon. So the Medicare Shared Savings Program, also known as MSSP, is a combination pay-for-reporting and pay-for-performance program. The goal is to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce the rate of growth in healthcare costs.

The critical program objectives that we found during the October meeting were:

To improve the overall health for the population of Medicare fee-for-service beneficiaries ensuring that care improvements and health outcomes are widely shared across sub-populations.

To improve quality and health outcomes by lowering the rate of growth of healthcare spending.

To encourage coordination and shared

accountability by including measures relevant to individuals with multiple chronic diseases -- conditions, measures in all settings that patients receive care and measures that span across settings.

Also to promote alignment across other quality measurement reporting programs and to include more high level measures such as patient reported outcome measures in the areas of depression remission, functional status and smoking.

Patient reported outcome measures for medically complex patients. A measure of high-risk with follow-up interventions, cost and resource use measures and appropriate use measures.

CHAIR OPELKA: Are we back? Are we on track now? Thanks so much. I appreciated that overview. Andrea?

DR. BENIN: If I understand correctly, I don't know that we have gone through this program in the past, so I just want to make sure

that I have this correctly in my mind, because I don't deal with Medicare a lot, needless to say.

But the -- this looks to me as though the organization has to hit certain thresholds on the metrics in order to get their shared statements. Is that how this -- is that how these -- these are the metrics that we are -- these metrics will determine that. So these are the metrics that determine how much of the shared savings they get back.

And it looks, as best we can tell, as though these are graded like tournament style. So it's a decile if you are an X, Y, Z decile, you get X, Y, Z percentage or something along those lines.

MS. GOODRICH: So this is Kate. I don't know if we have anybody from the MSSP program on the phone. I think Rabia Khan is on the phone. I'll start and then Rabia can add in.

MS. KHAN: Sure.

MS. GOODRICH: So these measures that are on the list and that are currently in the

program do have to be reported by all ACOs that are part of the MSSP program. Some of the measures are, when they are introduced, just pay-for-reporting, so they don't get scored based upon their performance, but then some of the measures are currently in a pay-for-performance mode and there are benchmarks for each measure.

And but I'm going to let Rabia talk to you a little bit more about that. So, Rabia, do you want to talk about the benchmarks?

MS. KHAN: Sure. And just reiterating what you said, thank you, Kate. So in the first year in the agreement period, ACS enters into it's pay-for-reporting year, so they must -- in order to be eligible and earning their shared savings that they would generate, they need to completely and accurately report on all 33 measures across the four domains in the program.

And like Kate mentioned, we transition them with phasing in pay-for-performance. So as we move through the agreement period, so now that we are in performance year two, a number of the

measures are now pay-for-performance, meaning that ACS in order to be eligible and earning their shared savings, they must meet the minimum attainment.

And minimum attainment is set at -- it's based on the benchmarks that we have established. And we used all Medicare fee-for-service data that we had available to set benchmarks using 24 there and we have those available online for ACOs. And if you meet the 30th percentile, that's the minimum attainment, on at least one of the pay-for-performance measures in each domain, you will be eligible to earn in the shared savings.

But it is correct that depending on performance thresholds that we have established based on the benchmarks will determine the level of shared savings they may be able to earn. But to be eligible in a pay-for-performance year, they need to, one, completely and accurately report and then, two, meet the minimum attainment of the 30th percentile benchmark for one pay-for-

performance measure in each of the four domains.

MS. GOODRICH: The 30th percentile from 2012 is the data.

MS. KHAN: Yes. Yes, so we established benchmarks for 2014 and 2015 using the 2012 data we had available. And we have recently finalized in the Physician Fee Schedule a rule that we'll be setting benchmarks every two years to provide ACOs with consistent targets to work toward.

MS. GOODRICH: Okay. That's helpful to me.

CHAIR OPELKA: Michael?

DR. PHELAN: I had one question about the mortality for AAA. Why did they pick an open AAA and not all-comers?

CHAIR OPELKA: Okay. Can we hold on that for a minute?

DR. PHELAN: Sure.

CHAIR OPELKA: We are just trying to get these administrative programmatic questions handled and then we will come back to the

calendar itself. Cristie?

MS. TRAVIS: I guess just a clarifying question. Are these measures setting specific? So like if we are looking at a particular measure within an ACO, is it a hospital measure or is it kind of patient and cross-cutting in general? And then the other question, I guess, is if some of these are in IQR or in value-based purchasing and everything, how does all this kind of coordinate, I guess, is my question?

MS. O'ROURKE: So I can take the first pass at answering that. Just to clarify, we gave the hospital group the measures that are for hospital settings. So the clinician group will be looking at the clinician level measures and the PAC LTC measure will be -- work group will deal with PAC LTC measures with the Coordinating Committee taking an overarching view of the program and how everything interacts with each other and how measures cut across populations.

But to inform their guidance, we wanted to take a look at the hospital measures.

CHAIR OPELKA: And the second question you had?

MS. TRAVIS: I guess I was just trying to think through, you know, if some of these are also -- and I don't know whether they are, but if they are an IQR or value-based purchasing, let's say they are hospital measures and then there are these other programs, do you report it once or do you have to report it several times?

I'm trying to figure out how it works if it's the same measure in more than one program.

CHAIR OPELKA: The advance care plan in multiple programs, I gather.

MS. TRAVIS: Well, we can have that conversation, but --

MS. GOODRICH: So a couple of things. So for a measure that, for example, is, you know, claims-based, we would, obviously, calculate that separately.

For some of the measures on here like the antiplatelet therapy for patients undergoing

carotid endarterectomy, so for the measures that are clinically-oriented measures like this, what we would do for this program, if it were to be included in the program, is we would include it as part of our CMS web interface where we basically send a sample of Medicare beneficiaries to the ACO and they populate that web interface with the quality measure information on that sample of patients. That's how that works.

I will say there are a few measures on here like the antiplatelet therapy one and the open repair of AAAs that are actually physician level measures. I suspect they got put on the hospital work group because they occurred in hospitals, but they are currently specified at the physician level.

And many of the measures that are in the shared savings program that are reported through the CMS web interface, also known as the G Pro Web Interface, are physician level measures as well that are used in ACO programs, have been validated there.

So just to make that clear for some of these on here, they could still be in PQRS, and individual vascular surgeons could report on that measure through whatever mechanisms there are, but then if there are also in the ACO program, then that ACO program would be reporting on their sample of Medicare beneficiaries.

MS. KHAN: Right. And, Kate, I just wanted to add that for these measures, although they might also be in IQR and other programs, we report them at an ACO level. So we are not providing this information to each individual hospital that may be the case for some of these other hospital programs.

CHAIR OPELKA: So we are going to -- Kate, based on what you just said, we may have falsely placed these in these programs. So while we are having this discussion, we are going to look at the specs now and if something specs out to be a clinician level, we will drop it from the consent calendar.

If you want to consider it within your

gap that you would want it respecified, you can. But we will check on that right now. There is a lot up here. Nancy?

MS. FOSTER: So, Kate or Rabia, I'm not sure who is best to answer this question. I'm looking at this set of measures that was put in front of us and maybe it's because I don't see the entire set of it, but I'm not getting the sort of mental model of how one anticipates holding a shared savings program where the identification of which patients are in that shared savings program is calculated after the treatment year is over, how you are anticipating holding the shared savings program accountable for some of these things.

What's the, well, the Medicare Shared Savings Program, the Medicare Shared Savings organization. Yes, the ACO, yes. And why -- it sort of looks like the cat and dog set up measures. So help me understand what the framework was for this, because it would be very useful to me in this conversation.

MS. GOODRICH: So, Rabia, do you want to start with that one and I can add in, if need be?

MS. KHAN: Sure. So I guess I'll tackle the second item first about sort of the framework around what we were thinking when we were adding measures to this list.

So we start off by taking a look at some key gaps in our measure sets. Currently, we have 33 measures and I note just generally there is a challenge for identifying more population level measures that can address a broad range of conditions and categories that we would like to.

But in looking at previous MAP feedback that we had received, it has been suggested to us to also consider cost or resource use measures. And we do have a cost component for the program, the side of -- the financial side of generating and sharing in the savings.

So we did include some existing cost measures that are CMS quality reporting programs for -- you know, to get inside those two, whether

you think this would a good measure to include in the program. I think an area that we have largely been interested in is appropriate use and looking at, for instance, imaging efficiency, so that's why you will see measures here. And also, I think they have been divided into the other work groups and then for appropriate use measures or efficiency measures.

And then we have also looked at, you know, focusing on outcome measures. And in terms of identifying patient safety, outcome measures, that's where you will see we have included the CLABSI accounting measures. And then broadly the majority of measures that are on the shared saving program set are really there to align with other quality reporting programs.

So we would like to see more post-acute care measures. That was a gap and that's where we are seeing some savings occurring from a lot of ACOs is coordination with some of these post-acute care facilities. And so we want to also be able to look at the quality of care.

And a lot of these measures like Kate mentioned are under consideration for PQF and the physician feedback on value-based modified programs.

So as part of the program, we would like that to continue alignment with those programs, so in considering measures that could be reported through our G Pro Web Interface, it would be great if we had measures that aligned across the different programs for the eligible professionals to get credit and avoid different payment adjustments by reporting through the shared -- through their ACO.

MS. GOODRICH: So this is Kate. I may just high-level a few points.

MS. KHAN: Yes.

MS. GOODRICH: I agree with everything Rabia has said. Alignment with the National Quality Strategy in filling in those gaps, measures that really help to focus on care coordination, which you will see for example the post-acute care work group is going to be

considering the home health readmission measure, for example.

We had this -- we just finalized the SNF Readmission measure for the program.

Trying to address what many stakeholders including most recently MedPAC have recommended for the program, which, as Rabia said, is a focus on population level outcome measures as well as appropriate use measures. They called that out specifically.

And then fourth is alignment with the other programs. And I think in particular with something like PQRS, but I would argue also with IQR, a lot of the measures that are in those programs are in the safety and the clinical effectiveness and prevention domain, so that's where you are seeing mostly those types of measures within the ACO program.

So just to sort of high-level some of those priorities.

CHAIR OPELKA: Richard?

DR. BANKOWITZ: Is it time to make a

motion?

CHAIR OPELKA: We are on these administrative understandings of the program. And I want to make sure we are all there. And if we are, then we can move on to the specific consent calendar. But while we are doing that, we are trying to understand I think the issue that we have logistically on our data set is the site of setting, site of service, this facility, the level of analysis has got to be also consistent with our work group.

So if the level of analysis is hospital and the site of service is facility, then it belongs in our domain. If the level of analysis is clinician, then we are -- I believe it does not belong in this work group. I think that it belongs in the physician work group, even though the site of service may be facility.

So we know this first one perioperative antiplatelets for the carotid is a clinician level measure, as it is specified. We are checking on the next one, the thorax.

MS. O'ROURKE: Thorax. We would keep the Thorax CT. This one is a facility level measure.

CHAIR OPELKA: Then the in-hospital mortality for the AAA? I think that's right.

MS. O'ROURKE: So we have as the level of analysis individual practice, group practice and facility.

CHAIR OPELKA: And facility?

MS. O'ROURKE: We do have and facility on the -- but it is also going to be reviewed by clinicians, so perhaps it is more appropriate for there.

CHAIR OPELKA: So it's on our list. So the question I guess is how does CMS look at it? Was it all specs?

MS. GOODRICH: This was one that was -- I don't know the specs by heart, but this was one that was submitted to us for consideration by SVS for the physician programs. So I believe that it should probably be in the clinician work group.

CHAIR OPELKA: Okay. So we will pull it off our list. Ron, you are hesitating.

CO-CHAIR WALTERS: So the clinician work group currently does not review the Medicare Shared Savings Program measures.

MS. GOODRICH: Yes, it does.

CO-CHAIR WALTERS: It does?

MS. GOODRICH: Yes, yes.

CO-CHAIR WALTERS: They do?

MS. GOODRICH: Yes.

CO-CHAIR WALTERS: I take back what I said.

CHAIR OPELKA: So then we have two on this current list, the Thorax CT and the payment standards Medicare spending per beneficiary. And, Richard, now it is time.

DR. BANKOWITZ: Thank you, Frank. Those two remaining measures, the contrast for Thoracic CT and the per beneficiary spent, are the two measures I was going to move we put into the do not support category. Not because I don't think they are good measures. They are good

measures, but I don't think they are appropriate for this program, which is the Medicare Shared Savings Program.

And the reason for that is everyone in this program is trying very hard to be efficient and to reduce cost and that's how they get paid. And that's probably one of the strongest motivators you can have.

So recognizing that there is a potential to sort of skimp on care, CMS has put in a set of quality measures, I think very appropriately so, to make sure that we are not under-utilizing services.

These two measures seem to deal with over-utilization. And it seems that they are on the wrong side of the ledger that these measures are not guarding against under-utilization of care and they are measuring something that is being measured very, very explicitly on the shared savings side.

So it is not clear why, especially, Medicare Spending Per Beneficiary would be in

here. It's almost impossible to conceive that you would have shared savings and this measure would go up. It just doesn't seem possible. So that's why I think these are inappropriate for this shared savings program.

CHAIR OPELKA: So second?

PARTICIPANT: Second it.

CHAIR OPELKA: All right. So then shall we open this up for discussion with these two being moved to the do not support and that's the entire consent calendar. Nancy?

MS. FOSTER: Thank you, Richard. I think you commented very well about both of the measures actually.

I just wanted to add on the payment -- the Medicare Spending Per Beneficiary measure; I think one of the most important ways in which all of the ACO models are trying to be more judicious about the use of resources is to prevent hospitalizations, to do the early interventions.

So it seems odd to me that we would be looking at them and trying to measure this based

on the cost for patients who were hospitalized, rather than looking at the broader picture. And I believe, Kate, in the assessment CMS does already of the program, they look at the broader picture, but this would -- this is just a strange take, I think, on holding an individual ACO accountable for cost when you are only talking about the cost of the hospitalized patient and not about the broader.

And I can envision that if you are successful in driving down the number of hospitalizations, that, in fact, the number -- the cost per hospitalization might go up because those people who are hospitalized then are -- tend to be sicker.

CHAIR OPELKA: Emma?

MS. KOPLEFF: I'm wanting to offer an alternative perspective on these measures. One at a time, if I may. With the Payment Standardized Medicare Spending Per Beneficiary measure -- actually, allow me to just back up for one minute and respond to the concept of under-

utilization.

And we had some of that discussion earlier today when we were talking about efficiency measures. And there is a time and a place for talking about those issues with regards to patient safety, which is an issue I'm very passionate about.

But with regards to system level measures that are trying to coordinate care from the patient line, that really doesn't -- the concept of under-utilization doesn't resonate with me.

Patients would like to be at home, healthy, with their families and not eager to enter the system and stay there. And I think one of the objectives in coordinating care through this program helps achieve that ability for patients. And I think we need a way to measure it.

And so now speaking to the Payment Standardized Medicare Spending measure, I understand Nancy's point and it's relevant, but I

-- it's relevant to the degree that we are -- the point of that measure is to hold hospitals accountable and provide meaningful information about costs in the hospital setting.

But I think having that information as a starting point to evaluate not just the hospital, but a bigger system is essential to know whether we are improving care. And if we don't measure it, we don't have a basis for those comparisons.

Secondly, on the efficiency measure, I think we could repeat some of the same conversations we had previously, but I'll note that it's my understanding the Thorax measure is in the Hospital Outpatient Program, so there is an effort to align with other programs there, which is something MAP has identified as a goal.

And I also think harkening back to our earlier conversation, there are issues to consider around over-use and patient safety. Thanks.

DR. PHELAN: I would support Emma's

contention that these are measures they need. And I'm not exactly sure of all the details of the ACO model, but are they allowed to select different measures and different domains? I think these ACOs may be looking for more measures in this space to help them drive the improvement that they are looking for.

And the same thing for the CT utilization and the Medicare Spending Per Beneficiary, now, and I'm not familiar with all the measures, but is there a cost measure already affiliated with the ACO measures? And I wonder if CMS could address that? Because if there is, why do we need this one? And if there isn't, this would be a good fit for it, because it's really good data and hospitals are able to drive some of their improvement based on some of this data.

And the data includes, I think it is, two days before the hospitalization and then 30 days after, if I'm not mistaken if it's an episode of paying them. So it includes some

things in the outpatient arena that you were talking about after the hospitalization, but it starts with the hospitalization, if I'm not -- is that correct or no?

MS. GOODRICH: The measure is three days before hospitalization, up to 30 -- and then through 30 days after, so that is the episode.

DR. PHELAN: Okay.

MS. GOODRICH: So there are no other cost measures in the shared savings program. The cost "measure" is related to the sharing and savings. So but Rabia maybe you could talk a little bit about how that works. And I think it might help the Committee to hear why this is being considered for the MSSP.

DR. PHELAN: Yes.

MS. KHAN: Right. So we work closely with ACS. We have a separate -- I can't speak to all the financials, that's a separate team that works on it. But ACO selects a track to participate in and depending on whether they generate shared savings or will be eligible to

earn it -- in it or in losses.

So in terms of adding this measure to or considering this measure for this program, the MSPB is being used for other value-based programs. And so in terms of, you know, the feedback that we have received to consider cost and resource use as an additional measure to include in our measures, that we considered really just looking at the measures that are already aligned with other programs.

But I understand the concerns raised about the focus, whether it be under- or over-utilization and what the concerns are. So we do have -- we do look at cost as a part of how -- whether ACOs are generating any shared savings and how much they would be eligible to share in it and where they are generating it from as far as what activities they are pursuing.

But I mean, we don't have any cost measure quality metrics within our measure set or any resource use really. We do have a lot of preventive health and primary care and care

coordination focus measures. We are trying to work on the measures with more outcomes and really looking at what beneficiaries and providers will also feel is useful.

CHAIR OPELKA: Nancy? Richard, she yields.

DR. BANKOWITZ: Okay. Well, once again, I do want to remind everyone this is the Medicare Shared Savings Program. So cost is a big focus. Now, these ACOs are using a ton of data. They are looking at their use of post-acute care. They are looking at the efficient use of specialists. They are looking at the radiographic costs.

They are looking at all of this at an operational level, because if they don't, they can't achieve or hope to achieve the shared savings. So it's not that these are going unmeasured. They are being measured.

What we are doing here is we are putting them in as a basis of payment. So in addition to achieving the shared savings, we are

saying now you have got to focus on CT use. Maybe some organizations are focusing on CT use, because they know they have an issue there.

But to tie payment to an efficiency measure when the whole program is geared to achieve efficiency just doesn't seem logical to me. It doesn't seem as if we are using these measures properly.

CHAIR OPELKA: Nancy?

MS. FOSTER: So yes, then to put a finer point on what Richard just said, if you were trying to, Michael, use this measure to direct your care, it would be not driving looking in the rear view mirror. It would be driving looking in the rear view mirror of the car that is a half a mile behind you, because there is such a delay in getting this data.

In addition, I'm not sure how this would be calculated, because this measure is specified for a hospital population, but Medicare Shared Savings Program model ACOs have people who go to a variety of hospitals and they don't

control which hospital they go to.

They are allocated to that ACO based on their primary care utilization, not based on their hospital utilization, not based on anything else. So it is how one can conceptually hold a Medicare Shared Savings Program accountable for this measure is a little bit beyond me.

It seems it is right to measure cost? This isn't the right measure.

CHAIR OPELKA: Other comments? So taking my Chair hat off, Richard, I'm not -- I'm trying to understand where you are coming from on your point, because I don't know that I accept it. If I'm in an ACO and I'm not, I live in a hospital that has a global payment. Once a year we get funded and I don't get funded again for another year.

But there is nothing more important to me than to know my key areas of spend.

DR. BANKOWITZ: Yes.

CHAIR OPELKA: I mean, nothing. So I would look at this in my global payment. And if

I got the per hospital beneficiary cost, that would be valuable to me.

DR. BANKOWITZ: Yes.

CHAIR OPELKA: If I got the pharmacy cost, that would be valuable to me.

DR. BANKOWITZ: Yes.

CHAIR OPELKA: If I got the outpatient cost, that would be valuable to me. If I got my CT cost for thoracic surgery, that would be valuable to me.

Now, I'm not saying -- I guess what I'm looking at is which one of these costs would I put in a program because I think it is going to help the program achieve the savings. It's going to get them to focus on a key area, because there are so many costs you can chase. If you chase the wrong cost, you put all your resources -- if you look 10 FTEs and that's all you had to manage your ACO and they all chased 1 percent of the income, of the revenue, they are not going to end up helping the ACO.

DR. BANKOWITZ: Right.

CHAIR OPELKA: But if they are chasing the right 30 percent, that there is variation and there is opportunity, they are going to help the ACO.

DR. BANKOWITZ: Right.

CHAIR OPELKA: So I look at both of these measures. And that's the question I ask. On these efficiency measures, which one of these efficiency measures would be valuable to a management team of an ACO that I, CMS, am guiding them to say put your effort here. And I personally don't think it is in Thoracic CT. I've got to be honest with you.

I don't know that for a fact, but I don't think it is where the difference is going to be made in the ACO. But the Medicare Spending Per Beneficiary on the hospital, I don't know how you do it without it.

DR. BANKOWITZ: So if I could respond, I think we are in alignment and that I agree pretty much completely with what you have said for the need for the information. And believe

me, these ACOs are tracking everything.

What I disagree with is that CMS will guide the ACO by its selection of performance measures on which they will be paid in addition to the savings, because I think each individual ACO needs to understand where to focus.

When I think of the beauty of the program is we have this large goal, which is reduce the cost and you figure out how to do it, and you know where your costs are and get them down, but don't sacrifice quality; that's why we have those measures. I don't think these quality measures are meant to be operational directive and maybe that's where we disagree.

CHAIR OPELKA: Emma?

MS. KOPLEFF: I am just having a little trouble understanding sort of how ACOs use this wealth of data they have. And again, I don't know that we need to decide whether this measure is or isn't operationally sort of dictating how ACOs are improving.

But just sort of a basic tenet of

measurement, I think we need a standardized way to measure cost, not just for each individual ACO to monitor those costs, but globally for improving cares across ACOs. We need that standardization. And in this measure, we have a standardized NQF-endorsed measure that has been through a rigorous multi-stakeholder discussion.

And I think we need it. And I would think operationally ACO leadership would need it too to identify best practices, complete root cause analyses and sort of really run with the point of quality measurement, which is to identify opportunities for improvement and capitalize on those.

CHAIR OPELKA: Wei?

DR. YING: I think this measure basic host of a fundamental question under the global payment that under the global payment, are we going to allow or do you think it should be allowed for double-dipping, in terms of global payments and then on top of that pay on efficiency measure?

From our test run in Massachusetts, what we are thinking is we try to avoid that from the very beginning. We didn't put any efficiency measure under our global payment structure.

But recently our thinking has been shifted. Currently, what our thought is efficiency measure we will pay on it if it also has consequences in patient safety or also represent some level of quality of care.

So when I look at this, I would think the hospitals with lower standardized care may be representing a better care coordination, either pre-surgery or pre-admission and probably more importantly post-hospital discharge.

So it's not necessarily just a cost measure. It also has the implication on the quality side.

CHAIR OPELKA: Thank you. So we have taken everything off the support consent calendar. Two we removed because they are clinician and two we have suggested move to do not support. So I think we have to vote on

whether or not to move these to do not support. And I'm wondering can we vote on them separately? So let's vote on Thorax CT and yes means you agree with the motion to move to do not support and then we will take the next one.

Wait for it.

MS. IBRAGIMOVA: Okay. So the question is Thorax CT use of contrast material do you agree with the motion to put under do not support? 1, yes; 2, no.

(Voting)

MS. IBRAGIMOVA: The results are 67 percent yes, 33 percent no.

CHAIR OPELKA: Okay. And then the second one, which is the Spending Per Beneficiary to the hospital specific spend.

MS. IBRAGIMOVA: So the question is Payment Standardized Medicare Spending Per Beneficiary, MSPB, do you agree with the motion to put under do not support? 1, yes; 2, no.

(Voting)

MS. IBRAGIMOVA: The results are 38

percent yes, 63 percent no.

CHAIR OPELKA: All right. So my interpretation is that that remains on the support list. Okay.

So then we have a calendar update. This is a flash news coming in. So Calendar 2, which were the two NHSN, the CAUTI and the CLABSI measures, those remain in -- because those are hospital/facility-based measures for the inclusion in the Medicare Shared Savings Program.

Calendar 3 is all clinician, so that comes off our project list.

Calendar 4, which was MR for lumbar spine/low back pain remains. That was a conditional support.

Calendar 5, 6 and 7 all moved to clinician, so they come off our list.

So with that update, we are now on the Medicare Shared Savings Conditional Support for CAUTI and CLABSI. And the condition that was put forward was that there were data concerns about gaining access to this data from primary data

sources in the NHSN CDC.

So any motion to move these or leave them in conditional support for the Medicare Shared Savings Program? Yes, Michael?

DR. PHELAN: Conditional support.

CHAIR OPELKA: Conditional. So keep it where they are? Okay. All right. So we will keep those where they are.

Then let's move to MR. So this was the -- I'm sorry? We didn't move it, so the consent calendar remains.

So we are now on the conditional support requiring NQF-endorsement for the MRI lumbar spine for low back pain. So it's conditional support, NQF-endorsement. And remains. I'm getting a nod to keep it where it is. Okay.

So that completes our assessment of the consent calendars and now we can move to the voting on the consent calendars.

So before we do so, let's open up for public comment. Kathy, are you still there?

OPERATOR: Yes, sir. If you would like to make a public comment, please, press star and then the number one.

CHAIR OPELKA: And in the room as well.

OPERATOR: One moment for your first comment. Okay. You have a comment from Matthew Davis.

MR. DAVIS: Hi. This is Matt Davis. I'm a spinal cord injury sub-specialist with TIRR Memorial Herman. I'm not sure if I'm calling into the right group or not, but I just know we have had a lot of frustration with the CAUTI measure in the spinal cord injury sub-population due to kind of an adverse series, you know, adverse patient outcomes.

What's the best way to get feedback to the people that are involved in endorsing the measure as a whole, not just the provisions of the measure?

CHAIR OPELKA: So thank you for your comment. The endorsement process is different

from the application process.

MR. DAVIS: Yes.

CHAIR OPELKA: So the endorsement process looks at the code or the measure as it has been developed and that process is separately held by the NQF. This would be the application and by pointing out difficulties with the applied measure, we communicate back to the remainder of the developer and the endorsement process.

So if there is a difficulty in the application, that would be helpful.

MR. DAVIS: Okay. Yes, so I have kind of coordinated. I called into one of these, into the Patient Safety Standing Committee, last April and they kind of put me in touch with the CDC regarding this measure.

And what I have, you know, and what we kind of have done over the last several months, I mean, it's -- I was pointing out at that time some real safety concerns with this measure for just this small sub-population of people that are paralyzed with spinal cord injuries and pulling

out their catheters is something that we are seeing a lot of going on in these acute care hospitals. And they are not well-prepared to deal with, you know, this patient population that is putting them at risk for hypertensive emergencies and things like strokes and seizures.

And you know, I felt like the CDC was listening for a little while and they kind of realized that it was going to be administratively challenging or might be administratively challenging to make a change in the measure and they kind of shuffled this off somewhere else. I felt like I was being placated for a while.

Since then, I have been able to recruit like the president of the American Spinal Injury Association and the president of the Association for Spinal Injury Professionals and some really big names in spinal cord medicine. And yet, I feel like this measure is just kind of marching forward, despite the fact that we have some really highly-respected people in the field of spinal cord injury medicine speaking out about

this as being an adverse patient safety event, when we are really asking for very simple change, so that spinal cord patients could be in listed exclusions.

Is there any way that, you know, you guys or that the NQF can kind of add some fuel to the fire to the CDC on this?

CHAIR OPELKA: So I'm not sure that we can give you all the oomph you are looking for, but our -- my interpretation of what you are stating is that in our terms, which is the group that applies measures, we would note caution in the use of this measure as it is currently specified for a subset of the population who has unintended consequences due to this measure.

MR. DAVIS: Yes. And so you guys could comment on this measure in that way and maybe somebody would look at it and say hey, you know, we've got to think about this a little more?

CHAIR OPELKA: So we vote the measure up or down and we vote for it --

MR. DAVIS: Yes.

CHAIR OPELKA: -- to be included in the program or not included in the program. And these caveats can be added to that vote either way.

MR. DAVIS: Okay.

CHAIR OPELKA: So we will --

MR. DAVIS: Yes. I would --

CHAIR OPELKA: -- take your comments and add it to our general comments with regard to this measure, so that we inform CDC and the measure endorsement process and CDC is with us today and does hear what you are saying.

MR. DAVIS: Okay. Well, I don't know if Dan Pollock is somewhere on the line and can hear what I'm saying, he is the one that I have been talking with lately. You know, he has kind of provided us some potential -- is he there?

CHAIR OPELKA: Dan is in the room.

MR. DAVIS: Oh, okay.

CHAIR OPELKA: We're holding him down right now.

MR. DAVIS: Okay. Well, he is well-aware of the conversations we have been having. And I guess there is kind of a disagreement between him and some of the other folks on the spinal cord injury side of things. It's kind of what does and does not constitute a practically feasible solution to this problem?

And you know, I guess I just want to appeal to the National Quality Forum on this, separate from the CDC, because, you know, I -- the field of spinal cord injury medicine is such a small field that for us to try to educate, you know, all of the acute care hospitals around the country as to how to recognize when patients need intermittent catheterizations, how to recognize autonomic dysreflexia and deal with these hypertensive emergency-type states that these people get into.

And which patients really are most appropriate for, you know, continued endone catheterization. It's a prodigious task. And I know that there are some, you know, potential

challenges with, or at least I heard there could be some potential challenges with, adding spinal cord patients to a list of patients that are excluded, you know, just like in the same what that suprapubic catheters are excluded.

But I think that would be probably less challenging than trying to educate people well enough so that we can avoid the dangers of bladder over-distention in spinal cord patients. Because I am seeing that. I am seeing patients that are coming to me with two and one patient even with almost three liters of urine in her bladder and that does drive up people's blood pressures into the systolic, you know, blood pressures of 200s, which, you know, you can see things like strokes and seizures with that.

CHAIR OPELKA: I want --

MR. DAVIS: So --

CHAIR OPELKA: -- to thank you for your comments. I think we have gotten a very clear picture of the difficulty you have presented, but unfortunately we need to move on

with our agenda today.

MR. DAVIS: Yes, okay. Well, thank you very much. And like I said, I just would love to see either a conditional support or, you know, non-endorsement of this measure, at least in its current state.

CHAIR OPELKA: Thank you.

MR. DAVIS: Thank you.

CHAIR OPELKA: Appreciate it.

MR. DAVIS: All right. Bye.

CHAIR OPELKA: Any other comments?

OPERATOR: There are no comments at this time.

CHAIR OPELKA: Any in the room? Okay. Andrea, did you want to make a comment?

DR. BENIN: You know, I can briefly echo the concern about unintended consequences about this metric. There are -- you know, I was on service last week. There is, you know, incredibly ill children and we are highly incentivized to take out the catheter. And then when you need to put it back in, it can be

problematic and you can cause a lot of problems trying to get a catheter back into a, you know, desperately edematous child.

But I think that the tradeoffs are complicated to try to figure out where this lies. And the methodology using the SIR means that you have this observe to expected ratio that you can deal with. So in theory, there is some risk adjustment around how many are expected.

But the benchmarks right, now certainly in pediatrics, are incredibly low. And so it's very -- people are highly incentivized right now to take out these catheters and so there may be some, I don't know, further consideration of this. I would be very interested in hearing more about the directionality around that.

CHAIR OPELKA: One last comment? And we need to get on to a vote or we are going to be here until Christmas.

MS. FOSTER: That's not that far off, Frank. Just one --

CHAIR OPELKA: That's very far off.

MS. FOSTER: -- quick comment or additional concern that I wanted to raise was these measures are in the midst of a transition to move from just ICU-based measures to whole population in the hospital-based measures.

And we will hear more about this as they come up in the hospital population, but I wonder about the timing of moving these into the Medicare Shared Savings Program when we will be transitioning the measures to more appropriate broad-based population. But it presents some measurement challenges in so doing.

CHAIR OPELKA: All right. So the motion before you is the Consent Calendar 2, which has CAUTI and CLABSI on it.

PARTICIPANT: What was in this?

CHAIR OPELKA: I'm sorry? We have gone through and we are now voting on the consent calendars. Right.

PARTICIPANT: Yes, okay.

CHAIR OPELKA: Right. I mean, that's

where we are. I'm sorry?

MS. IBRAGIMOVA: So MSPB we have support, in the support calendar.

CHAIR OPELKA: Oh, we have to go back to Calendar 1? I'm sorry.

MS. IBRAGIMOVA: So just to read for the record, MSSP Consent Calendar 1 support Payment Standardized Medicare Spending Per Beneficiary, MSPB. Do you agree with the support calendar? 1, yes; 2, no.

(Voting)

MS. IBRAGIMOVA: The results are 78 percent yes, 22 percent no.

CHAIR OPELKA: So then we are on Calendar 2, the CAUTI, CLABSI measures.

MS. IBRAGIMOVA: MSSP Calendar 2, conditional support pending resolution of data concerns, National Healthcare Safety Network (NHSN), Catheter Associated Urinary Tract Infection outcome, CAUTI, and the National Healthcare Safety Network (NHSN), Central Line-Associated Bloodstream Infection outcome measure,

CLABSI.

Do you agree with the conditional support pending resolution of data concerns calendar? 1, yes; 2, no.

(Voting)

MS. IBRAGIMOVA: The results are 87 percent yes, 13 percent no.

CHAIR OPELKA: And the last one is what was previously Calendar 4, conditional support with resubmission of NQF, the MRI lumbar spine for the low back pain.

MS. IBRAGIMOVA: Just to repeat for the record, MSSP Calendar 4, conditional support pending resubmission to NQF for endorsement review MRI lumbar spine for low back pain.

Do you agree with the conditional support pending resubmission to NQF for endorsement review calendar? 1, yes; 2, no.

(Voting)

MS. IBRAGIMOVA: The results are 91 percent yes and 9 percent no.

MSSP Consent Calendar, do not support

Thorax CT, use of contrast material.

Do you agree with the do not support calendar? 1, yes; 2, no.

(Voting)

MS. IBRAGIMOVA: The results are 65 percent yes, 35 percent no.

CHAIR OPELKA: All right. Well, I want to thank everybody for walking through that. We have done a lot to catch up on our day and we are now only about 20 minutes behind.

So we are moving into the HAC Reduction Program and those sets, so if we could walk through that program?

MS. IBRAGIMOVA: Okay. So the next measure is the Hospital Acquired Condition or also known as HAC Reduction Program. And this is a pay-for-performance and public reporting program. The HAC scores will be reported on the Hospital Compare website beginning December 2014, so now.

So the basic goals are just to heighten awareness of HAC and eliminate the

incidents of HAC that could be reasonably prevented by applying evidence-based clinical guidelines and also just basically to reduce incidents of HAC as much as possible and drive improvement.

The clinical project objectives that were determined in October were focus on reducing the major drivers of patient harm, overlap in measures between the HAC Reduction Program and the Hospital Value-Based Purchasing Program can help to focus attention on critical safety issues.

And in the 2013/2014 approval gaps that were identified, were PSI-5 to address foreign bodies retained after surgery and development of measures to address wrong site and wrong site surgery and so this is behind post-operative infections.

MS. O'ROURKE: So we have one consent calendar for you for the HAC Reduction Program. These are updates to two measures that are currently in the program.

So the question before MAP is would you support the updated version of the measure or should we maintain -- or would we support maintaining the current version of the measure?

To give you a brief summary of what these updates are: The measures have been expanded to settings beyond the ICU and we have also had -- the measure also had another risk adjustment method added. And I did want to introduce Ed Septimus, the Chair of the Patient Safety Standing Committee. He is on the line.

The Standing Committee reviewed these measures and recommended these updated measures be NQF-endorsed. So these updates are now NQF-endorsed.

That's it for this program. We did receive similar comments on the CAUTI measure as we did for MSSP regarding the potential adverse consequences for patients with spinal cord injuries.

CHAIR OPELKA: So this is the only calendar for this, the HAC, this entire HAC

Program?

MS. O'ROURKE: Yes.

CHAIR OPELKA: So the question before you is: is there any desire to move these from their current calendar? Nancy?

MS. FOSTER: I have a question. Timing on movement into the HAC Program? And I say this because of the comment I made previously. These measures are in transition. Will just begin -- we just -- we will just begin reporting full house on January 1st. So we are endorsing this for when?

DR. YONG: So as you know, all these programs would go through rulemaking, so we would certainly be very transparent in terms of the rules, in terms of when these measures would go into effect for any of these programs.

But these measures are also part of the IQR Program, so, you know, we would think through how we would do it, because these measures are in existence in those -- both programs as well as in HVBP as well. So I think

at this point, it's -- there are no set time lines exactly for implementation.

MS. O'ROURKE: Yes, exactly. We could do it as early as next year for any of the programs certainly, but we would be open to feedback from MAP as to sequencing, you know, the timing of -- I know for instance, obviously, with Hospital Value-Based Purchasing, they go to IQR first and then to HVBP.

There has been discussion at the MAP in past years that measures -- some members prefer that measures for the HAC Program get publicly reported first in a similar vein, that is something we would be open to considering as well. So we are certainly open to the MAP's input on that.

MS. FOSTER: So let me suggest then that although we haven't dealt with the IQR Program yet, that there is some logic to having them reported first for a year to make sure there aren't any issues like the one that was being raised earlier about the spinal cord individuals.

So we are moving them into public reporting before we are moving them into a penalty program. It makes a lot of sense to me.

MS. DANFORTH: I just have a couple of questions.

The first question is if you have a sense of which value you would use in the HAC Reduction Program? Since the new measure calculates kind of like a standard SIR and then this suggested SIR, which is more of a ranking. Do you envision using that ranking SIR for -- in the scoring methodology for the HAC Reduction Program or the standard SIR?

DR. YONG: So again like Kate said, we would welcome input on this. You know, the reason we put it on the MUC list this year was because it was going through NQF-endorsement and they did, the CDC did, include this additional ARM methodology as well as the standard beyond ICUs.

So like I said before, we didn't have specific plans, at this point, in terms of how we

would sequence or implement this, at this point, but we would certainly welcome input on it.

MS. DANFORTH: Okay. The only point I would add then, given your response, is for the purposes of public reporting, I actually agree with Nancy in that I think when you make the transition to publicly report the new updated measure, which includes the additional units on Hospital Compare, because of four other infection measures are being reported out as standard SIRs.

For people, consumers, to actually understand what they are looking at, I think there is some value to having the SIR value be sort of consistent between the six different infection measures.

I think the concept of the SIR is really confusing, if not impossible, to understand for a consumer anyway, even in our best attempts to describe it. And we use the measure, so we are guilty as well. But I think having these two different SIRs, these hospital acquired infection measures, because they are all

reported out together, could potentially be even an additional challenge, so I would just add that.

DR. LEVY: Yes. I would also agree with Nancy and strongly recommend about the timing of this in term -- also for public reporting before performance, in particular because moving CLABSI from geographically separated areas, like critical care units, into the hospital really requires a lot of pre-engineering and a lot of change in process measures.

And doing it in critical care units is very different than doing it on the general wards. And it is seems to me we need benchmarking of how well that can be done and how that transformation can happen. So it makes sense to do public reporting before we do a performance.

CHAIR OPELKA: Andrea?

DR. BENIN: I would just also agree with that. I also think that the definitions are

changing this year, as of January, both of these measures, I believe, have pretty -- have decent sized definitional changes that I don't know that we fully understand how they are going to apply. I'm not sure whether I'm going to have more or less when I recalculate. And that is a little -- you know, that is hard to -- it adds this other layer to the payment penalty that is -- maybe the timing is the issue.

CHAIR OPELKA: Emma?

MS. KOPLEFF: One note just regarding public reporting. I know that CMS is moving towards a STAR rating system. And just to sort of -- I'm not disagreeing with you, Missy, but I am just saying I'm not convinced yet that having sort of different ways that -- treating these two measures differently from the other infection measures would absolutely have a result in something negative from a public reporting perspective, given that the whole way Hospital Compare's public reporting is really getting a facelift. But definitely something to think

about.

And the other thing again not disagreeing with the statements that have been made about the need for consistency and using public reporting to understand how these new versions of the measures work, but I would just sort of remind us that the previous versions of the measure have been tremendously successful in reducing hospital acquired infections.

One could argue through their use in payment programs as well as public reporting programs, so I do think that sort of staging of this needs to find a way to continue to capitalize on that and not lose the old measures and the work that has been done because of those measures, again, arguably, in the phasing.

CHAIR OPELKA: Missy, is your card back up?

MS. DANFORTH: Right. One other important thing about when a new measure -- you know, potentially when the new CLABSI and CAUTI measures get rolled in, if at any point you

decide to move to the ARM calculation, my team actually got a bunch of information and tried to do the calculation. And it is clear that without certain pieces of information, coefficients, et cetera, from the CDC, no one could replicate those measures.

So I think it is fairly important if CMS moves to the new ARM calculation that they make every element of the calculation transparent, so hospitals and other national organizations can replicate them.

Leapfrog, in particular, collects information from hospitals at the facility level. And so if we wanted to be consistent with you, which we do, and with CDC and calculate ARM at the facility level, we would need those, the coefficients. And right now, I haven't been able to find a donator.

CHAIR OPELKA: Seeing no others, this is the one calendar that moves forward for voting for support.

MS. IBRAGIMOVA: So HAC Calendar 1,

support, National Healthcare Safety Network (NHSN), Catheter-Associated Urinary Tract Infection outcome measure and the National Healthcare Safety Network (NHSN), Central Line Associated Bloodstream Infection outcome measure.

Do you agree with the support calendar? 1, yes; 2, no.

(Voting)

MS. IBRAGIMOVA: The results are 96 percent yes, 4 percent no for support calendar.

CHAIR OPELKA: Okay. So we are going to transition back to 100 percent Ron and move on to the inpatient psychiatric facilities.

MS. O'ROURKE: Actually, Frank, before we do that, I did want to introduce Ed Septimus. He is the Chair of the Patient Safety Standing Committee and the Antibiotic Stewardship Action Team. They wanted to just present some of their work on the Action Team to consider how some of this increased attention on infection rates, while obviously very important and great work, could have a potential unintended consequence of

poor antibiotic stewardship in creating more strains of antibiotic resistance, like MRSA and C. diff, that we are dealing with now.

So Ed, I wanted to let you present that work and opportunities for potential alignment across NQF.

MR. SEPTIMUS: Well, I thank you. I know you are running behind, so I'll try to be brief. I do believe there is a high priority measurement gap around antimicrobial stewardship. And I am just briefly going to kind of bring you up to date about what special group was considering last month, that many of you may know the recent PCAST report, and PCAST stands for the Present Council on Advisors and Science and Technology, came out a report on a strategy of combating antimicrobial resistance.

And this was signed by an executive order. I don't think I need to tell anybody in the room about the significance of this impact, the cost, poor outcomes in a world that I'm considering almost going into a post-antibiotic

effect.

As part of the report, what the executive order strongly defines is defining communicating and implementing stewardship programs, not just in hospitals, but office-based practices, outpatient settings, emergency departments, institutionalized at long-term care facilities and that includes like nursing homes and correctional facilities.

And that CMS use reimbursement incentives to drive stewardship. And this is supposed to take place within the next couple of years.

But the reason for discussing this today in front of the MAP Group is that one of the major barriers to implementing effective stewardship is the available and reliable measures which reflect intervention effectiveness.

And stewardship must establish process and outcome measures to the impact of these programs not only outcomes, but also on

resistance patterns and the unintended consequences which were just alluded to, such as increasing rates of clostridium difficile, which is directly -- goes back to over-use and miss-use of antibiotic.

C. diff in the last point prevalent study by the CDC now has become the number one healthcare associated pathogen. You are all aware of antimicrobial resistance, but more importantly, it impacts rates on healthcare associated infections and it also impacts readmission rates for certain multi-drug resistant organisms are associated with readmissions. And you all know how readmissions affect value-based purchasing.

To this date, there are no NQF-endorsed measures either now or even on the near horizon on this topic. And this measure-related barrier includes lack of definition of what appropriate use is, lack of adjustment measurements and benchmarking. And is also a lack of accountability of prescribers and

misalignment of incentives.

So recognizing all this, the CDC does have a module in the NHSN space called the Antibiotic Use and Resistance Module, but to date, there are very few organizations that are reporting into this module. But under the PCAST report, this will increase significantly since it's going to be a priority.

There are some other examples out there. Ron Paloka who is at Virginia Commonwealth has come out with some very nice metrics and risk adjustment benchmarking using UHC data.

So the question I think for us in front of NQF, and certainly might be the committee that I co-chair, is what measures do we need? And are there examples to build upon? Because as you all know, an NQF-endorsed measure accelerates measurement and accountability if the right measures are adopted.

And that link measure is to better outcomes and reduce unintended consequences. So

I would like to -- at least in my mind, and I think also in the measurement application partnership, this clearly should be a high priority and it's a gap currently in the NQF portfolio.

So I'll stop there and I know that you have plenty of other stuff. If there is a question that I can answer, I'm happy to, but I just want to put this issue in front of you, which I think is a big gap in the NQF portfolio.

MS. O'ROURKE: Dan?

MR. POLLOCK: Yes. This is Dan Pollock. Thank you very much for that. I --

MR. SEPTIMUS: Well, hi, Dan. How are you?

MR. POLLOCK: I'm well. Thank you. A week without Ebola. So --

MR. SEPTIMUS: Yes, it's that nice?

MR. POLLOCK: It's nice. So as you know, we are currently at NHSN developing an antimicrobial use clinical quality measure proposal that we expect to submit to NQF for

consideration next calendar year. So we are on that.

And we will be using data from the 60 or so hospitals that are already reporting antimicrobial use data to NHSN to address the scientific criteria of the NQF measure requirements.

But I appreciate your excellent overview of the situation and just wanted the group to know that this is an area that we are actively working on.

MR. SEPTIMUS: And, Dan, we will work along with you.

CHAIR OPELKA: Well, thank you very much. I think we are going to probably try and capture those comments and summary thoughts to go along in the document. They are very helpful in the gap analysis.

MR. SEPTIMUS: Well, I certainly appreciate the time. I know that you are running a little bit behind, but I did feel that this was a major gap that we have and I knew that Dan and

other colleagues at CDC were working on trying to get something hopefully to the Patient Safety Committee in the next cycle.

But I do believe that having an NQF-endorsed measure really does accelerate and drive change, if it's the right measure.

CHAIR OPELKA: Thank you.

MR. SEPTIMUS: We have seen this in cervical prophylaxis and so many other examples of public reporting.

CHAIR OPELKA: All right. Thank you very much.

MR. SEPTIMUS: Thank you. You all have a great meeting.

CHAIR OPELKA: Thank you very much to everyone for participation in the process today. I think we have learned as the days go on. And I do want to apologize for all that apparent confusion that was going on during the shared savings discussion as we were sorting out what to do with the physician level measures. So that did pay off actually even though it was a little

disruptive at times during that.

We will move now into the Inpatient Psychiatric Quality Reporting Program. The summary, please?

MS. BAL: As Ron said, we are going to talk about the Inpatient Psychiatric Facility Quality Reporting Program. This is a pay-for-reporting program. Information will be reported on the Hospital Compare website. It focuses on inpatient psychiatric hospitals or units that do not report data on the acquired measures.

I'm sorry, those who do not report data on acquired measures, will receive a 2 percent reduction. It is also -- so the critical program objectives that we came up with for this program were to ensure measures in the program were meaningful to patients, improve person-centered psychiatric care, such as assessing patient and family/caregiver experience and engagement and establishing relationships with community resources. Those are some of our main gaps.

We also listed step-down care, behavioral health assessments, care in the ED, remissions, identification and management of general medical conditions, partial hospitalization or day programs, another CAHPS program as gaps.

MR. AMIN: Okay. Thank you, Poonam. So we will go through the preliminary analysis and the consent calendars for this program.

There are four measures under consideration, three of which fall in the first consent calendar, which is under support. The second one is under conditional support upon harmonization.

So I'll begin with the first measure. Transition Record with Specified Elements Received by Discharged Patients. This is a fully-specified tested and endorsed measure that is impactful and fits -- fulfills a gap in care coordination by ensuring that patients receive important transition information.

There were some comments on this

measure. Comments noted the importance of this measure, but noted that instructions must be in the language that is written and understandable to a patient and sensitive to needs of psychiatric patients at discharge.

Commenters also noted the need for additional exclusions for patients with unplanned discharges and patients refusing after-care.

The second measure is the Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge.

This is also an endorsed measure, which fulfills a gap in patient centered psychiatric care through the identification and management of general medical conditions. This is fully-specified and tested at the facility level.

There were two comments received on this measure that were generally supportive with commenters noting that tobacco use was -- actually, I'm not entirely sure whether these are supported. Actually, I'll take -- let me -- we

had a -- I'll take another look at this, because -- anyway, I'll tell you what the comment said and then I'll look back at it.

There were two comments that also raised concern about whether tobacco use -- noting that tobacco use was generally not the primary focus of psychiatric hospital stays and the measure should be used with caution.

Again, I'll take a look back at those two comments during our discussion.

And finally, the SUB-2 Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention Received. Again, this is also a fully-specified and tested endorsed measure that fulfills a gap in person centered psychiatric care and the management of general medical conditions.

The commenter were generally supportive of this measure with one commenter noting that a larger proportion of patients presenting in inpatient psychiatric care have co-occurring substance abuse diagnoses, not simply

unhealthy alcohol use. For these patients, more intensive substance abuse treatments must be provided.

If CMS is to adopt this measure, a commenter suggested modification to the definition of brief identification to also include more intensive interventions. CMS should also consider modification to this measure to address the issue of brief intervention may not be an optable intervention for persons identified with alcohol disorders.

Finally, this program's second consent calendar is Timely Transmission of Transition Record. This is a fully-specified and tested NQF-endorsed process measure that contributes to the efficient use of measurement resources and addresses a critical program objective identified by the MAP Hospital Work Group and is highly impactful to improving person centered care by facilitating care coordination and the potential to reduce readmissions.

However, this measure is duplicative

of an existing measure, which is the HBIPS-7, post-discharge continuing care plan transmission to next level care provider upon discharge, which is developed and specified for psychiatric facilities. The two measures should be harmonized before being used in the program.

I'll just point out that -- go ahead, go ahead.

DR. YONG: I just want to make it clear why we put this measure on this particular -- on the MUC list for IPS. We are fully aware that it overlaps with the measure intent for HBIPS-7. HBIPS-7 which is post-discharge continuing care plan transmission, how their HBIPS-7 does not specify a time period for the transmission, while this measure on the MUC list does.

So the thought was if we were to implement this and the MAP were supportive of the measure, we would actually think about removing the other existing measure.

MR. AMIN: Okay. That's helpful. I

would just point out before we get into detailed discussion on this measure, we did receive one comment on this measure that noted again the concern around the measure competes with existing measure.

There was also concern that the measure does not clearly state all the components that need to be covered in this measure. And also, there was concern around the 24 hour time frame whether -- noting that that was too inflexible not being able to provide necessary time for certain clinical specialties to be available to the same extent on weekends, holidays to complete the transition record. So that was a comment that was received on this measure.

So I'll turn it over to Ron to facilitate conversation around the first consent calendar and then we can go onto the second.

CO-CHAIR WALTERS: Okay. We will head into the first consent calendar. There is three measures. Delores, did you join us by phone?

No. Lead discussant then is Wei.

DR. YING: I'm in support of this on the first measure the record transition. I think right now there is already a measure the one -- the No. 7 measure that we just talked about the record transition to the facility. I think this one is just closing the loop to make sure not just next level of care provider is receiving the record, but also the patient and their own caregivers are aware of what the next steps should be.

For the next two measures about the tobacco and substance abuse, I share the concern from one of the public comments about the alcohol abuse. In this environment, alcohol abuse is probably not a dominant factor in what we case substance abuse, other drug abuse these days are more prevalent.

And if we look at the SUB-1, 2, 3, 4, as noted on the discussion guide, 1 and 2 is alcohol-specific and 3 and 4 actually expanded to alcohol and other drug. I'm reading it

literally. I'm not sure whether actually they mean the same thing.

But if it is true, I would recommend SUB-3 instead of SUB-2 to pull in the other drug, which also be consistent with the recommendation of tobacco use, Measure 3, because it confused me why tobacco use we say the treatment should be offered at the discharge, but then for alcohol use, we recommend the intervention being done during the inpatient stay.

I kind of feel if we pick -- these are the paired measures. If we pick one, it should be consistent either 2 or 3 for both tobacco and substance abuse. And in order to pull in the other drug, I would recommend SUB-3. So I would agree with the tobacco SUB.

CO-CHAIR WALTERS: Okay. Open to any other discussion? Nancy, you are quick.

MS. HANRAHAN: I would like to support all three, all of these measures. And this is probably more to add to the list for the gap, but we are talking about psychiatric

hospitalizations. People with mental illness also enter general hospitals and we know that about 30 percent of them have some kind of major illness that is related to their readmission to hospitals.

So these kinds of measures I'm not sure why they have to be so exclusive to psychiatric hospitals and why can't we also transfer these measures into a general hospital environment? So again, that may be a gap place that we go to, but there has been very little discussion about psychiatric illness or behavioral health illness within medical surgical environments. And I think we want to address that. Thanks.

CO-CHAIR WALTERS: Other Nancy?

MS. FOSTER: Thanks. Let me first support what Nancy has said that we need to get to a point where we are talking about important measures to be used in the acute care condition environment around psychiatric care.

I'm not sure I would start or focus on

tobacco and alcohol use as much as the under-screening for depression and a variety of other things, but all of it is important. So sorting that out and how we get from here to there would be a really important conversation to have.

The confusion I have about these measures, it's not that I don't support the concepts, but I'm curious as to why one didn't just tweak HBIPS-7 to get the time frame in rather than create a whole new measure around -- if that was your concern, that in fact the existing measure of tobacco screening use -- tobacco screening didn't include the time frame. So, you know, sort of why throw that out and then move to this new measure?

And then secondly, how do the other measures transition? How does the transition record measure square with one HBIPS-1? Is that right? No, I've got them mixed up. It's 7 and 1, sorry. HBIPS-7.

And secondly, isn't there a condition of participation that requires the patient to

have a -- to leave with discharge treatment information and the care plan to go on? So aren't we back in that space where we were this morning where we are measuring something that is already required?

DR. BUCK: Thank you. First of all, I should introduce myself. I'm not Kate Goodrich. I'm Jeff Buck. I am the program lead for this program and let me try to respond to you.

I think we are going to have a separate discussion for HBIPS-7, so I have a few remarks on that and I'll hold them for the moment.

With regards to your other remarks, first of all, just to talk about the comparison between 0647 and HBIPS-6, we wanted to start moving in this direction, because, in essence, HBIPS-6, pretty much for the most part, incorporates components for discharge record that are already required, as you pointed out in conditions of participation. So it's really a

very minimal type of measure.

This other measure, one that was developed as a result of the consensus statement, when that has been endorsed by the MAP for both use in Medicaid populations and the duals population, which is the majority of the Medicare population using inpatient psychiatric facilities.

And I also want to note that -- well, actually, I'm sorry, that's incumbent for HBIPS excuse me, for the other measure. But it's also endorsed by the NQF Care Coordination Steering Committee and it differs from HBIPS-6 mostly be specifying the number of additional elements that should be in the transition record that are not incorporated HBIPS-6.

As I said HBIPS-6 just says you've got to show reason for hospitalization, principal diagnosis, discharge meds and the next level of care recommendation, that said and you get credit for being in the HBIPS-6 standard.

This transition record measure

includes in the record the results of tests and procedures, identification of studies that were still pending at discharge, advance directives, and this is a population that has been shown to have a life expectancy of 25 years less than the general population, patient instructions, 24 hour and seven day contact information, contact information for pending studies, any plan for follow-up care and the identification of the physician and follow-up site.

So it has a number of additional features as well as the requirement for consultation with the patient that is not in HBIPS-6 and why we think it is moving this along in a higher quality standard risk and raising the bar from what we have today.

And as Pierre pointed out, if we were to adopt this, we would basically use it to replace HBIPS-6.

Concerning the other two measures related to tobacco and alcohol, the primary reason for these is that both these conditions

are common comorbid issues. The rate of smoking in a psychiatric population is much higher than the general population. In fact, one study showed that approximately half of all deaths attributed to smoking are people with mental illnesses.

Alcohol also is of much higher prevalence in this population than others and it is usually recommended that even if somebody is being focused on for depression or schizophrenia, that their alcohol use also be assessed.

We already adopted an alcohol screening measure in the program. This is the follow-on measure that says if you have been identified as having an alcohol use disorder, were you offered and provided, if possible, a brief intervention within the hospital concerning that alcohol use?

MS. FOSTER: So I'm not sure that answered my question.

DR. BUCK: Okay.

MS. FOSTER: Because to me, and

thinking operationally, it is much easier for hospitals to take and adapt a measure that is already implemented, where they have already got their mechanisms set up for collecting the basic data, working with whatever vendors they want. If they need to tweak it, it is easier than throwing that one out and replacing it with a different measure. So why not tweak the existing measures to include some of the additional things that you want?

And secondly the elements that you were talking about for the discharge plan seemed to me to be so fundamentally necessary that, and I don't recall what the specifics are in the conditions of participation around it for psychiatric facilities.

But it would seem to me that that level of information ought to be specified as required for a good discharge plan and that that ought to be the level of expectation, rather than trying to measure it where there is sort of an implication that gee, an 80 percent performance

rate is okay.

You know, if they are essential, then 80 percent is not okay. So how do we get to the right answer?

DR. BUCK: I have not -- I guess I understand the remark. I think we are, I guess, implicitly saying that the way to get the right answer is to start using the measure and to have people see how they perform on it.

We do think this is raising the bar from where it is now. And also, another thing we are trying to avoid here is we are trying to move, to just talk about very general directions for the program, away from, as much as possible, boutique measures that are only used for or solely specified for the inpatient psychiatric setting.

As much as possible, we want to adopt standards where they are applicable and I think this is what I understand the MAP's objective to be, too, with alignment to try to get measures that are -- that have value across multiple

programs.

And so by adopting a measure that we believe has good application to this setting and that is also available for use and at least is under consideration for uses in other inpatient settings, we think we are going in that direction.

CO-CHAIR WALTERS: We will take any other comments about the three measures in Calendar 1. Okay. Hearing none, let's move on to are there any motions about the measures in Calendar 1, either to move all of them or one of them or two of them or all three? No motions for any changes to Calendar 1.

Let's move now to Calendar 2. Are there comments about the conditional support for the measure in Calendar 2, dependent upon harmonization with the measures.

DR. BUCK: Yes, thank you. These are my comments on the transition, excuse me, timely transmission of the transition record measure. There is a couple of major reasons for adopting

this.

As I already mentioned, this is a measure that is recommended for use by the MAP with Medicaid and then for duals. And I think very importantly from the issue of alignment, this measure has already been adopted as a core measure in Medicaid. We would like to be in alignment with Medicaid in its use of core measures.

And in particular, I think, we think that this has the potential of reducing some of the reporting burden on hospitals that have to report most of their State Medicaid agencies and to the IPFQR Program.

And the one thing I was going to mention is that this particular measure is endorsed by the Substance Abuse and Mental Health Services Administration as part of its national quality frame work.

And I also -- and the key difference, I think somebody already mentioned, but I want to emphasize it again, the current HBIPS-7 that we

use doesn't have any time standard for transmission of a discharge record or a transition record. The usual kind of standard expected is roughly 30 days.

This one has a 24 hour transmission requirement. And we would not only think that's a good quality measure and one that would then align with other quality measure programs, but in addition, we are very concerned about issues of transition for this population. This population has a relatively high readmission rate.

It has -- even of those readmissions, the majority of them, roughly three-quarters, are for the same reason they were originally admitted, meaning they are coming back again within 30 days for a psychiatric reason.

The large majority of those are duals. As you might imagine, younger persons that have both Medicaid and Medicare coverage. And to have a standard that basically says that somebody -- and a significant number of them are multiple readmissions within the 30 day period.

So the idea that somebody could go out, be readmitted, maybe be readmitted more than once before the transition record even arrives at the follow-up provider's office, seems inconsistent to us. So it's for those reasons that we would like to adopt this measure.

And why we think that developing a new harmonized measure or a measure that is different than that already in use in the Medicaid Program as recommended by the MAP would be problematic.

CO-CHAIR WALTERS: Is there any other discussion about the measure in Calendar 2? Yes, Cristie?

MS. TRAVIS: I guess just for clarification, it seemed to me when we were first going through this measure that the reason, the rationale for harmonization with HBIPS-7 was that it is already in -- well, one of the reasons was that it was already in the program and clearly it didn't seem to make sense to have two measures in the same program that measured the same thing, slightly differently.

I guess what I'm taking away from this is that it would be your preference at CMS to have this new -- this measure that we are considering today be the measure that is in the inpatient psychiatric hospital set and that you would remove the HBIPS-7 measure. And am I interpreting that that would be your preference or your thinking?

CO-CHAIR WALTERS: That's correct.

MS. TRAVIS: So it would seem to me that one thing we may want to think about as we move forward would be, one option could be, just moving this into the support category or keeping a condition on it that the HBIPS-7 be removed from the program or that we harmonize it.

I mean, I'm just trying to put -- think about what our options are a little bit differently perhaps than we might have thought about them at the beginning.

MR. AMIN: Yes, Ron, if I may? I would submit that the preliminary analysis here, this recommendation actually needs to change.

So, Cristie, I would second what you were saying and I would say that we should change this before we move forward, because this doesn't -- it's not really that clear any more.

Either the first two that you presented or others, I think should be considered by the Committee.

CO-CHAIR WALTERS: So that is not to change the category conditional support. It's just that conditions --

MR. AMIN: Right. As we specifically outlined what the condition would be here, Ron. And I don't even think that staff could defend that, at this point, so I would submit -- I would ask for a motion to change either the condition or change the category.

DR. PHELAN: I'll second the motion to support change the category from conditional support to just support.

CO-CHAIR WALTERS: We can -- so there is a motion now on the table to change Calendar 2 in the measure, the one measure from conditional

support to support and ask for a second.

MS. TRAVIS: Second.

CO-CHAIR WALTERS: And any vote for that? Any discussion?

DR. MORRISON: I'm sorry, Ron, I can't hear you. Sorry, Sean.

CO-CHAIR WALTERS: So the motion to move it from conditional support to support has been seconded. Are there any other discussions about that motion? Nancy?

MS. FOSTER: So just to be clear, we are not considering it a condition that, in fact, this replace the HBIPS measure that is similar to it? In other words, we could set it up as a conditional support conditional on it replacing HBIPS-7, rather than simply supporting. Would that be an appropriate condition to offer up?

MR. ENGLER: Okay.

MS. FOSTER: I'll ask if it's a friendly amendment.

CO-CHAIR WALTERS: Would you like to rephrase that?

MR. ENGLER: Maybe there is an amendment. I'll revise my -- let's change it to conditional support on Nancy's recommendation. If that's all right?

MS. FOSTER: Yes, it is.

MS. TRAVIS: And I'll say second again.

CO-CHAIR WALTERS: Okay. That did not move it to Calendar 1 then.

MR. ENGLER: It left --

CO-CHAIR WALTERS: It left it.

MR. ENGLER: -- it changed the condition, but it left it.

CO-CHAIR WALTERS: Yes, yes. Okay. Any other comments? Public comment? Operator, are there any public comments?

OPERATOR: If you would like to make a public comment, please, press star one on your telephone keypad. We have a public comment from Pat Quigley.

MR. QUIGLEY: Thank you. May I proceed?

CO-CHAIR WALTERS: Please.

MR. QUIGLEY: Thank you so much. This is Pat Quigley and I did try to comment as well on the prior indicator related to transmission of the record, timely transmission of the record for psychiatry.

I'm Pat Quigley. I'm a nurse in the Department of Veterans Affairs and I do work on fall and fall injury prevention. And I am so -- well, I was hoping to be able to ask a question to make sure, because I couldn't see the measure specifications.

Is this content included discussion in this transition record of fall risks and fall history in this case and population?

You know, the inpatient psychiatry population is so vulnerable and they have a higher repeat of fall rate. And they also have more serious injuries. And while this is so important, I was just so hoping that discussion of fall and fall injury rates or fall occurrence was part of this important discussion.

Knowing that the outcome is to help everyone be safe, but to also reduce readmissions that could occur because someone falls after discharge.

So thank you so much for this opportunity for this comment.

CO-CHAIR WALTERS: Okay. Thank you for that comment. We will have to check to see if that is in the specs. Yes?

MS. HART CHAMBERS: Hi, I'm Jane Hart Chambers with the Federation of American Hospitals. And I'm a little confused about the discussion on the last measure, on the HBIPS-7.

It's my understanding that reporting HBIPS-7 is part of what is required for accreditation. So for a facility to be able to stay in business, it has to report that measure. And I don't understand why we would want a new measure that is similar, that couldn't be harmonized with it and keep HBIPS-7 in place, so that you could actually keep your accreditation and continue to treat patients. Thank you.

CO-CHAIR WALTERS: Can you respond to that? I think the point is a good one that they don't want to lose their accreditation just because a new measure comes along.

DR. BUCK: Well, once again, I'm going to point out a couple of things. First of all, we think that the standard is a good one, independent about how it compares with other similar measures that may be around.

And second, I think our immediate objective is to align measures within the CMS quality reporting programs. This is a measure, this potential conflict that has just been mentioned is one that already exists in states that are starting to collect a solution within their Medicaid programs.

So it's not as if this is a hypothetical problem that exists. It's a problem that will increase -- if it is a problem to the extent it's a problem, it's a problem that already exists.

As we were saying before, we -- well,

let's put it this way. Certainly if you have met the requirements for this measure, you have also met the requirement for HBIPS-7, because every element of HBIPS-6 and 7 are incorporated in these measures.

So it's not as if one somehow prohibits you or it can't be used in certain something or the other. That's all I would say. I realize they are not the same, but this measure is the one that has been promoted by both -- by the MAP. It has been promoted by NQF. It has been promoted by SAMHSA, not HBIPS-6 or not HBIPS-7 anyway.

So that's why we are going that way. So it's not that it isn't a valid concern. I understand that for some of these there may be a concern, but we don't think that overcomes other criteria and other objectives from the program.

CO-CHAIR WALTERS: Nancy?

MS. FOSTER: So I'm confused, Jeff. We are the MAP, right?

DR. BUCK: Yes.

MS. FOSTER: So we are deciding whether we are promoting this measure, not that we have promoted this measure.

DR. BUCK: Well, when I say that you are promoting it, I'm referring to documents and reports that you have already produced where you have the one about the family of measures for duals and for measures that you have recommended in the past for the Medicaid Program, that's what I'm referring to. I'm not necessarily referring to past meetings of this particular group but for--

MS. FOSTER: So the content?

DR. BUCK: No. We actually read that stuff. And so when we promote -- so when we propose some of these measures, we are going to mind that oh, this is something that MAP recommended be used for this purpose. So that's what I'm referring to.

MS. FOSTER: Okay. So Jayne has raised a very important point around harmonization for use of this measure between the

major accreditors and CMS, because to have discord between your accreditor and your major payer is really problematic.

It seems to me that we are actually trying to struggle with an issue that is an NQF endorsement issue, if I may be so bold as to say that, which is to say the NQF process ought to choose between whether HBIPS-1, 6, 7 or 15 is the right measure for each of these things and/or this or something else that I'm not even thinking of, so that these important concepts are being measured, if you will, or being required in the COPs.

But these important concepts are being measured, but they are being measured using the measure that the NQF has endorsed as being the best available national standard. And at this point, since they haven't gone head-to-head at the NQF, we don't know what that is and that's sort of my struggle here is to know how to vote.

CHAIR OPELKA: So this is easy. First, let's take the Consent Calendar 1, which

is -- we will come back to that, yes.

So I'm trying to reconcile where we are with this one and with what the Federation just called for. And I'm not so sure we can't. I mean, we can conditionally qualify our support.

So why can't our qualification be that it is inclusive of maintaining compliance with accreditation programs? You know, that there is harmonization replacement, substitution, whatever it is of this measure with 7 to resolve or maintain the accreditation program as our condition. And we are basically calling for the original request of harmonization.

MS. FOSTER: I think we are on the same page, Frank. I would agree with you that that is important. I'm only reluctant to substitute our judgment for what I see as an NQF endorsement question.

CHAIR OPELKA: Well, I don't think it's endorsement. I think it is accreditation. It's the accrediting body, except that this measure, then this would go away.

MS. FOSTER: Well, at least --

CHAIR OPELKA: So that's not an NQF problem. That's an accreditation body problem.

MS. FOSTER: And the Joint Commission at least speaking for that major accreditor uses NQF-endorsed measures whenever they are fairly committed to it.

CHAIR OPELKA: But my point is it's the harmonization question.

MS. FOSTER: Yes.

CHAIR OPELKA: It's not an NQF endorsement question. It's all parties in the room have to come together assessing what Jeff has put forward, assessing what currently stands and say what is the efficient way to measure this?

MS. FOSTER: I'll ride with you on that one. That's fine.

CHAIR OPELKA: I mean, but I think that's -- I think the likeness --

MS. FOSTER: We want the same outcome.

CHAIR OPELKA: We want the same

outcome. So can we substitute our current, certainly modified, conditional back to where it was? Cristie?

MS. TRAVIS: Just a question on that. I mean, it could be possible the Joint Commission would just say we are going to use whatever this new measure is. I mean, so when we say harmonization somehow it implies to me that we have got to bring too different measures together, you know, versus -- I mean, are we open to the fact that what if Joint Commission said yes, I'm fine using the new measure and they used it moving forward?

I just want to be sure we are not making more work than we need to, but that we leave it open enough to where people can do whatever.

CHAIR OPELKA: No. Harmonization does not mean the measure changes.

MS. TRAVIS: Okay.

CHAIR OPELKA: It could mean the measure has to change.

MS. TRAVIS: But it may not.

CHAIR OPELKA: It may not. I mean, there is a give and take. You have to put all parties in the room and everybody has to look at all of the current sea of measures and decide whether there is a good measure and throw the others out or whether there is a need to respec the measures and bring it forward again.

And that's the challenge of harmonization. Everyone has skin in the game. They all own their own measure and they have gone through some thinking of how they got there. And it's the ownership issue that really creates the challenge.

DR. BUCK: I do have a question if you are going that way. If you are intent is to create a measure then that will apply across all inpatient settings, that would be our concern.

So are you recommending then that this measure also be mod -- if it changes in any way in the course of harmonization, would your recognition -- recommendation encompass that then

would the new measure also be applied to and changed in the Medicaid core measure SUB?

Because if it wouldn't encompass that sort of recommendation, I think that's problematic for us.

CHAIR OPELKA: I think that's the harmonization process. We don't develop the measure, that's got to be the give and take of the negotiation of harmonization. That's the challenge of harmonization, that you have a set of standards you are trying to reach. The accrediting body has a set of standard they are trying to reach.

And what we are saying is, what the MAP is saying is we don't want to see two measures this close. We want you to come together and figure out how there is one measure.

DR. BUCK: Yes, but the issue is that this measure that is currently used on the Joint Commission only applies to psychiatric settings. We are trying to get to the use of a measure that applies across all standards, not just

psychiatric settings. See what I'm saying?

It doesn't move in a direction we think is desirable if we end up with a measure that is now different than it is in other measure programs and in other inpatient settings. That's -- I just want to raise that issue. So if --

CHAIR OPELKA: Thank you. So the measure still is in Calendar 2, which is conditional support. Nancy?

MS. FOSTER: I was just going to say, yes, Jeff, preference would be for if that's the right measure to be using, it be used across settings, whichever measure or whatever version of whatever measure comes out across applicable settings.

MR. HATLIE: If this is the stronger measure or the stronger version of the earlier measure, I think we should adopt the strongest position of support we can to send a signal to the rest of the field, including your accreditors that this is a superior measure.

I don't know how to work that out, but

I think that, you know, people look at what we are doing here. And so if others looked at intention that we put some support behind it. So I guess I think it's a motion to support, but I'm not sure.

DR. PHELAN: I would favor what Martin is saying. I'm hearing from CMS that they would favor this measure, barring any utilization across all areas. If this is the measure that they would favor, asking them to harmonize with a not so good measure with the best measure is kind of not doing our job as the MAP.

We should say this is a better measure. We support this measure and move forward. They can decide how they are going to utilize it going forward. You know, if they want to keep the older measure or move into the new realm, what we are saying clearly better measure is one that has got a timing element.

So asking them to go and harmonize with all the same elements except for the timing element or going with Martin's recommendation to

support and move forward, of the two options, I would support what Martin says. Take the better measure and move forward.

CHAIR OPELKA: Well, harmonization doesn't mean that that doesn't happen. Harmonization could mean that you choose the better measure. It's that there are measures that are so close they are competing and you've got to figure out which one you are going to go with.

If you decide you cannot go with one or the other and you respec the measure for whatever reason, then you are back to square one. You have got to take the measures through testing and endorsement and all of that.

So the preferred harmonization is to choose one measure over the other. And what we are calling for is to say that there is an accrediting body that these institutions are bound to in order to be paid and then there is a payment body which says we are going to reward quality if you do this.

So there is competing business models that need to be addressed and it's stuck on the overlap between these two measures. So we are not saying that you have to change this measure. This may be the end result, that this is the preferred measure. We are saying by virtue of this motion, that you have got to put the bodies in a room and come to conclusion about this measure.

MS. FOSTER: And, Michael, I think the reason I commented to Frank it was an NQF problem is we haven't actually done a head-to-head comparison. We have had one expressed opinion about whether this is a better measure than the other.

With due respect to that opinion, there may be others who want to weigh in differently. And until we have that opportunity for a more robust conversation, I don't feel I have the information I need to judge whether this is, in fact, the better measure.

CO-CHAIR WALTERS: So where we are is

we supported Calendar 1 and to this point, there is not a formal motion to move this measure into Calendar 1. It currently resides in Calendar 2, which is conditional support. Taroon?

MR. AMIN: I'm obviously not making a motion. I just want to address the procedural semantics, I think, that we are dealing with here. And would submit that the question here would be that will just keep it as conditional support and then I'll describe what the conditions that I have heard are putting in NQF language.

So it's a conditional support based on a selection of a best-in-class measure or a harmonized measure based on the Appropriate Standing Committee review. Between this measure and HBIPS-7, for the purposes of reporting and accreditation, this measure should also be harmonized for all acute care settings, if possible and appropriate.

That's what I have heard. Feel free to disagree with that. That's what I have heard.

MR. HATLIE: So that wouldn't require a motion to support that, right? That is already conditional support. It's on that calendar.

MR. AMIN: We reframed what our preliminary analysis is to reflect that, so it's a conditional support.

MS. HANRAHAN: This is for information, but I hope that we would support these measures ultimately. And I don't really know being in one category conditional support versus support if that will affect how this will roll out or be interpreted by other bodies. It does matter.

Well, then I would argue that, you know, this measure should be -- I would like to see us support them. Support the measures. The measures have been vetted. I have been in rooms where they have been vetted and they are really important measures.

Behavioral health is a very difficult field to develop measures and these measures finally came through. And if there is a

conditional support attached to it, it may create a barrier that is really not necessary given the kind of support that I have heard people say about the measure.

CO-CHAIR WALTERS: Is there a motion there? Did you say a motion? A motion by someone on Nancy's behalf?

MR. HATLIE: I'll move on Nancy's behalf to change this to a support recommendation, because of the strength of the measure and the importance of sending a signal that it is a strong measure in a needed area.

CO-CHAIR WALTERS: Okay. Is there any other discussion about that motion?

MR. AMIN: So the vote is to support?

CO-CHAIR WALTERS: Moving it to support.

MR. AMIN: Yes.

CO-CHAIR WALTERS: So is there a second?

DR. BANKOWITZ: Mindful of the importance of setting the signal that this is a

very important measure, I also think by establishing the condition as we framed it, that doesn't in any way diminish our support of this. It simply says we need the stakeholders in the room to help make that decision. The stakeholders being the accrediting bodies and the payers.

I don't think that diminishes the strength of our support in any way.

CO-CHAIR WALTERS: Okay. Let's move on to voting for the -- oh, sorry.

DR. FIELDS: So I have been on the endorsement side before. And my -- the process was we would endorse a measure and then let NQF go back and do the homework of harmonizing the measure separately. Why wouldn't we want that kind of strategy?

I understood, but we are still going to say that we recommend a measure and NQF still has to be responsible for endorsing or for harmonizing.

CHAIR OPELKA: Just so we are clear.

For support, no requirement of harmonization or we conditionally support with a requirement of harmonization. Those are two different --

DR. FIELDS: And we don't leave harmonization of measures up to NQF?

CHAIR OPELKA: Well, the MAP is giving guidance.

DR. FIELDS: Okay.

CHAIR OPELKA: We support without any condition.

DR. FIELDS: Yes.

CHAIR OPELKA: We support conditionally and there was an array of conditions.

DR. FIELDS: Right. And I understand that. It's just --

CHAIR OPELKA: That's it.

DR. FIELDS: -- leaving the --

CHAIR OPELKA: That's it. You just take it face value. It is what it is.

DR. FIELDS: Yes.

CHAIR OPELKA: Or do you want to put

on a requirement that it has to meet a set of conditions?

DR. FIELDS: Again, I think we are saying the same thing.

MR. HATLIE: Just a clarifying point. The array of conditions that we encapsulated here would go in the minutes to the body that we were making the recommendation to support to. So they would be apprised of this very rich conversation that we had this afternoon. All right?

CHAIR OPELKA: Sure.

MR. AMIN: But I mean it would be in the minutes, but it wouldn't -- I mean, I just -- that's the distinction between the conditional support and the support. The conditional support carries all of those criteria as your conditions of support.

The support is, on its own, as you have described already, Marty, just, you know, it is the support without any of the conditions.

MR. HATLIE: But it's still depends. I mean, they are not required to follow our

conditions. So getting the thoughts to them one way or another to get the strongest signal is kind of where I'm going and supporting Nancy in that.

CO-CHAIR WALTERS: Okay. We have a motion on the table to move this measure from conditional support to support. We will entertain a vote now for that motion or not.

MS. IBRAGIMOVA: So to repeat for the record, timely transmission of transition record discharges from an inpatient facility to home/self-care or any other site of care.

Do you agree with the motion to move to support? 1, yes; 2, no.

(Voting)

MS. IBRAGIMOVA: The results are 67 percent yes, 33 percent no.

CO-CHAIR WALTERS: Okay. We no longer have a Calendar 2.

So now, we will vote on Calendar 1, which has all four measures in it.

MS. IBRAGIMOVA: IPFQR Calendar 1,

support transition record with specified elements received by discharge patients, discharges from an inpatient facility to home/ self-care or any other site of care.

TOB-3, tobacco use of treatment provided or offered at discharge and TOB-3a, tobacco use of treatment at discharge.

SUB-2, alcohol use of brief intervention provided or offered. SUB-2a, alcohol use brief intervention received.

And timely transition of transition records, discharges from an inpatient facility to home/self-care or any other site of care.

Do you agree with the support calendar? 1, yes; 2, no.

(Voting)

MS. IBRAGIMOVA: The results are 83 percent yes and 17 percent no.

CO-CHAIR WALTERS: Okay. Are we going to take a break? 10 minutes, 15 minutes. We have one more program to talk about. 10 minutes break. Reconvene about 3:10.

MR. AMIN: So for those of you on the phone, we will be back at 3:10. Thank you.

(Whereupon, the above-entitled matter went off the record at 2:59 p.m. and resumed at 3:10 p.m.)

CHAIR OPELKA: All right. So in our last one for today, we are looking at the Medicare and Medicaid EHR incentive program for hospitals and critical access hospital's meaningful use. And so, we will go into the overview of the program first.

MS. BAL: Okay, so we're doing Medicare and Medicaid, the Electronic Health Record incentive program for hospitals and critical access hospitals. This is a pay for reporting program. Also, this is known as meaningful use as the short form, or MU.

And it provides incentives to eligible professionals, eligible hospitals, and critical access hospitals to adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

And some of the goals are to promote widespread adoption of certified EHR technology and to incentivize meaningful use of EHRs by improving quality, safety, efficiency, and reduced health disparities, engaged patients and family, improved care coordination, and population public health, and maintain privacy and security of patient health information.

The critical program directives that were determined to given preference should be given to NQF endorsed quality measures, select measures that represent the future of measurement such as facilitating information exchange and measures that monitor a change in patient's condition over time, also to align the measure set with other hospital performance measurement programs, and to ensure eMeasures in the program are reliable and provide comparable results to paper-based measures.

MS. O'ROURKE: So we have one consent calendar for the meaningful use program. We have four measures where the preliminary analysis was

to encourage continued development.

The first is the hospital-wide, all-cause, unplanned readmission hybrid eMeasure. Just a caveat, we wanted everyone to know that this is the eMeasure version. There is a claims version of this measure that is NQF endorsed.

That's 1789, the hospital-wide, all cause, unplanned readmission measure. But this is the eMeasure. It's still in alpha testing and has not been reviewed as an eMeasure for NQF endorsement.

We received one comment that was generally supportive noting the importance of NQF endorsement of this measure and appropriate risk adjustment.

The second measure under consideration is perinatal care cesarean section, PC O2, nulliparous woman with a term, singleton baby in vertex position delivered by cesarean section.

Again, there is an NQF endorsed claims and paper record version of this measure. However, we are being asked to consider the

implementation of this measure as an eMeasure.

The endorsed version, just to give you some background, is a disparity sensitive outcome measure. It's included in the MAP safety family of measures. And this eMeasure is also under review for the IQR program.

We received a number of public comments. One commenter noted three areas of concern. First, the measure included women who have contraindications for vaginal birth. Second is the measure assumes that all nulliparous women with a term, single fetus in the vertex position, NTSV, have the same risk for a cesarean birth after adjusting for age.

And third, there's a major flaw found in the direct standardization technique being used to create risk adjustment for age.

The third measure is adverse drug events, inappropriate renal dosing of anticoagulants. This adverse drug event measure, which is also under consideration for IQR, focuses on an important safety issue. However,

it's not fully specified as an eMeasure and has not been reviewed as an eMeasure for endorsement. We received one public comment in support of this measure.

Finally, a measure addressing timely evaluation of high-risk individuals in the emergency department. This efficiency measure affects a high-impact population and captures important clinical data.

It's also under review for IQR. However, still the same caveat that this is still under development as an eMeasure. We did not receive any public comments on this measure.

CHAIR OPELKA: So we have before us this calendar which is under our encouragement for continued development as opposed to do not encourage further development. Are there any requests to move any of the items off the calendar? What do you -

DR. EISENBERG: Frank, could I ask a clarifying question first of Erin? You mentioned that one of the comments had to do with a major

error in the calculation. Is that so? Could you explain what that is?

MR. AMIN: Yes, so, do you want me to go in on that, Erin?

MS. O'ROURKE: Sure.

MR. AMIN: So the comment wasn't actually being very specific besides the fact that the direct standardization technique for the risk adjustment was flawed.

But beyond that, it wasn't clear exactly what the flaw was that the commenter identified. So I just wanted to be clear there wasn't an NQF staff evaluation.

CHAIR OPELKA: Okay.

MS. FOSTER: I would like to propose that we put the readmissions measure on the list of things that we would not support continued development of. I forgot what the list is called.

CHAIR OPELKA: Do not encourage continued development.

MS. FOSTER: Do not encourage further

development of it.

CHAIR OPELKA: It does not do anything to the readmission measure. It removes an eMeasure.

MS. FOSTER: Right, I'm -

CHAIR OPELKA: So you're saying -

MS. FOSTER: I'm saying for this eMeasure that is under - that's on this MUC list, I would like to move it into the list where we do not encourage further development.

CHAIR OPELKA: Okay.

MS. FOSTER: And on the - just a question for Erin. You indicated there was one comment on the ADE, on the adverse drug event, but it says here there were two, so I'm just a little confused.

MS. O'ROURKE: Apologies, that might have been an error. I can pull up the comment sheet and verify that for you.

MS. FOSTER: Thank you.

MS. O'ROURKE: If the spreadsheet has two, the spreadsheet is the authoritative source.

CHAIR OPELKA: Jack?

DR. FOWLER: Erin, or Taroon, or whoever, just an update. I know there's been quite a controversy about the readmission issue and what to do about adjusting for different populations in one way or another.

This one seems to propose to do some kind of a model adjustment that somebody has done that adjusts everybody. Could you update me or tell me what it is that's being proposed here?

CHAIR OPELKA: So Erin and Taroon, you may have to correct me. It's my understanding that the measure is - there's no change to the measure other than it's being e-specified. So the former measure as it stood, remains, but it's being e-spec'd. It's being specified as an electronic measure. That's all that this is.

DR. FOWLER: The center says it's going to be risk adjusted. Is it real, or am I misreading it?

DR. YONG: Can I just clarify? And Yale, who has helped us with our measure

development can also clarify. So this is what we call a hybrid eMeasure. So it's - it would - it's a mixture of a claims-based measure using what we call core clinical data elements or CCDEs, which are extracted from EHRs, to help with the risk adjustment.

So we'd incorporate clinical data into the risk adjustment methodology, but we would still use, at the core of the measure, claims data in order to identify admissions and readmissions. Suzanne, I don't know if you have anything to add on that?

DR. FOWLER: So just - a lot of the controversy has been issues over and above clinical characteristics such as socioeconomic characteristics that make the environment in which people are discharged or trying to cope more complicated, and that that has been the particular challenge of whether or not people can get it right. It looks like you're going to say something.

DR. YONG: Yes, so certainly this has

been a hot topic of discussion at NQF as well as in other environments. So certainly we are interested in and actively want to participate with NQF on sort of the pilot regarding SCS and risk adjustment.

Folks may also be aware that recently passed the IMPACT Act that mostly deals with post-acute care, but portions of that also require ASPE, which is the Office of the Assistant Secretary for Planning and Evaluation at HHS, who conducts some studies looking at the impact of risk adjustment for SVS in outcome measures.

NCMS is working with ASPE on this work and will take, and we are required by law to consider their final analysis and recommendations and how it applies to our outcomes measures.

CHAIR OPELKA: Missy?

MS. DANFORTH: Can I just ask why it's only the NTSV measure that's being considered for an eMeasure and why they may not, considering this is for critical access hospitals, that early

elective delivery wouldn't be considered for eMeasure as well?

DR. YONG: I'm sorry, can you say that one more time?

MS. DANFORTH: Sure. So the only maternity care measure is the NTSV C-section measure being developed into an eMeasure. So I'm asking why the early elective delivery measure also isn't being looked at as an eMeasure for this program since it's already being used in the IQR?

CHAIR OPELKA: This is a gap question. It is not a measure question. These measures, you're not asking a question. You're asking about a gap. You're - okay.

DR. YONG: So, I'll have to check. Betsy, are you on the line?

MS. RICKSICKER: Yes, Pierre, I'm on the line.

DR. YONG: Did you hear that question from Missy?

MS. RICKSICKER: No, I'm sorry. Could

the person please repeat the question?

MS. DANFORTH: I'm just wondering why the early elective delivery measure wasn't being considered for eMeasure development along with the NTSV C-section measure?

MS. RICKSICKER: I don't believe that we had that slated for the previous contract which just ended over the summer. I believe that all of the measures that we had slated for development under that contract, all of the measure slots that were available for development were utilized.

But that's certainly a measure development area that we could look into under our new contract for the future as far as concept areas.

DR. YONG: Yes -- go ahead.

MS. DANFORTH: And just a follow-up question. The adverse drug event lists CMS as the measure steward. Is that a measure that came out of the work that the hospital engagement networks are doing? I know they have developed

some adverse drug event measures.

MS. RICKSICKER: So that measure was developed out of the medication measures special innovation project where FMQAI was our contractor. And we have FMQAI here in the room, and the lead for that, Dr. Kyle Campbell, could speak to that measure.

If you have specific questions about that measure, we have the measure developers on the phone to answer.

MS. DANFORTH: No, I didn't have questions about the measure, just the origins. I thank you.

MS. RICKSICKER: You're welcome.

DR. YONG: Sorry, one, if I may. Going back to Missy's first question about the elective delivery, certainly we welcome input about priorities and gaps for future development areas for eCQMs.

CHAIR OPELKA: David?

DR. ENGLER: Thanks. So, I've been very quiet up until now, and I think you'll

probably know where I'm coming from on this one. It's the same issue that we raised last year when this was not an eMeasure, but it was a paper and pencil measure, I suppose, and it has to do with the impact that sociodemographic factors have on readmissions.

And what we would strongly encourage is, first of all, to get that right before we put it into an eMeasure. And we're very thankful and want to compliment CMS's moves on the IMPACT stuff. We also want to compliment NQF for moving forward with the notion of a robust pilot project regarding the look at readmissions and the impact that sociodemographic factors have.

So those are my two comments. And my question relating to the comments were - would be, what would be the problem of waiting on an eMeasure, okay, until such time that the admission measures are looked at for the impact on sociodemographic factors? In other words, getting it right on that side before we put it into an e-metric.

There is clear, convincing, and compelling evidence that sociodemographic factors do impact readmission rates. The analysts just came up last week with a major study showing the impact of that.

I also am very aware that the ROCs on readmission rates has hovered around 60 percent, and we still don't have that accurately. And the penalties that that has on hospitals that serve vulnerable populations are large, and we've testified about that in this committee and others as well.

So we would support moving forward with an eMeasure if under the circumstances it was first tested, okay, and approved, and look through the pilot project with sociodemographic factors associated with it. So that's my presentation. And I'm sorry the CMS folks left on the psychiatric data.

I would really welcome - and I know we're going to be talking hopefully, Frank, tomorrow about the gap, but if there's anything

we can do for next year's MAP when we discover that we can come back and look at behavioral health integration in primary care and physical medicine, that would be really very appropriate. I'd like to have that happen next year as well. So those are my comments relative to this measure.

CHAIR OPELKA: So the last part of your comment was to our previous discussion, and it's part - it's something that we need to capture in our gap section.

DR. ENGLER: Yes, I would hope it'd be captured tomorrow in the gap discussion.

CHAIR OPELKA: Okay, all right. So I need to - a formality. Nancy had moved that the hospital unplanned readmission hybrid measure move to do not support, and I need a second.

DR. ENGLER: I'll second that.

CHAIR OPELKA: All right, thank you. Any other comments. Nancy?

MS. FOSTER: David, could you turn yours off? Thank you. So I have a couple of

questions about this measure and then a couple of comments. One is Pierre, could you help me understand how this measure will, in fact, cover all readmissions?

Because the claims-based measure, in fact, looks at all readmissions whether they're to your hospital or to another hospital. And in that respect, it is a more robust measure than simply looking at readmissions to your own hospital.

So does this capture that? And if so, how do you get the health - the electronic health record pieces of that into this measure? My key concern is, is this actually going to be capturing the readmissions that we all know as readmissions now?

DR. YONG: This is Susannah Bernheim. She is on contract with us. She works for Yale CORE, and I'm going to - she's going to address that question.

DR. BERNHEIM: Hi, Nancy. Yeah, so as Pierre said, and just to explain for the group,

this is a hybrid measure so the claims are still used to identify the cases.

The EHR data is brought in to enhance the risk adjustment because people have been really interested in having clinical factors as part of risk adjustment.

We keep some of the claims risk adjustment as well because there are certain things that you can't yet capture well in the EHR.

So the hybrid piece is claims plus EHR data for risk adjustment. But the outcome, the 30-day unplanned readmissions are still coming from the claims data.

So it's really an enhancement or -- there is a word for this. It's not respecification, re- anyway, it's a new version.

CHAIR OPELKA: Retooling.

DR. BERNHEIM: Retooling - no, we don't like that word - of the previous measure to bring in additional risk adjustment variables to enhance the measure.

MS. FOSTER: So in that regard, Susannah, I know several of the comments around the other measures, particularly the condition specific measures, had - made by clinicians, had really pointed out that there were problems with the readmissions measures because they failed to take into account information that was unavailable from the claims, but that really spoke to the propensity for readmission or mortality, such as the severity of the heart attack, the severity of - and so forth.

Is that - are you really, as Frank described it, simply retooling the old measure, or e-specifying the old measure, or are you impacting it to include some of those critically important clinical aspects?

DR. BERNHEIM: Right, it's the latter. It maintains many of the same characteristics of the previous measure, but it now brings in additional risk adjustment variables that we've found you can feasibly extract from almost any EHR, but that give you more clinical information

about how the patient looked when they arrived at the hospital.

MS. FOSTER: Thank you. So in that regard then, I would join in saying the condition in which - I would actually suggest we might want to move this into conditional support with the -

CHAIR OPELKA: No, this isn't conditional support. This is, "I don't want you to do what you're doing anymore," or, "I want to encourage you to do what you're doing now."

This is they're doing work to improve this measure, and you're voting to say, "Continue doing your work," or, "Stop. Cease." It's not support for a program. It's support this -

DR. BERNHEIM: You are correct.

CHAIR OPELKA: - iterative work you're doing now. So let's be clear about that. You're all asking very good and detailed questions, but the motion on the floor is, "Stop."

MS. FOSTER: Can it be stop and tell as David had expressed?

CHAIR OPELKA: Well, it's - we don't

have a conditional stop. It's stop or keep going. And keep going means you're going to be taking in all these other factors that are out there, but - and you could advise them about factors that are important to you, and I think you're doing that.

We're not supporting this. We're encouraging the continued work they're doing or telling them, "We don't think this is work you should be continuing to do." Pierre?

DR. YONG: Thank you. I just wanted to ask one clarification question which I think is related to what you were just saying.

So is the right interpretation if it's on the support continued development sort of - what do you call it - calendar, we would take that input, but that we'd continued development understanding there may be issues around SCS or other issues that we would need to take into factor.

And once it's completed development, we would bring it back to the MAP for discussion

about whether it belongs on support, conditional support, do not support.

CHAIR OPELKA: That's exactly right. This is a - you're doing this groundwork for the next MAP not -- you're out of this cycle. And you're asking the question of the MAP, "Is this the right direction?" to continue your efforts.

So we're encouraging you or not encouraging you, and the motion on the floor right now is we do not encourage you. Richard?

DR. BANKOWITZ: Well, this discussion here is proving very helpful because I'm struggling with how to send the proper message here as well. Because it is, I think, important to get better clinical data into these measures, and I think we need to encourage developers to do that.

And at the same time, we need to encourage them to look at the results of the very important data that's coming in on socioeconomic and demographic factors, and we can't ignore them. There's nothing in this measure that

addresses it.

So I just want to make sure we can send that message as well as our support of looking at the clinical measures that are buried in the electronic medical record.

CHAIR OPELKA: Dan?

DR. POLLOCK: I was wondering if the developer could provide some additional information about the clinical factors that are being brought into the model, how they were selected, both from a clinical perspective as well as a statistical methodologic perspective?

DR. BERNHEIM: I'll try to do all of that briefly. Yes, so we had a year-long project prior to starting to work on this measure in which we were aiming to identify clinical factors using a TEP and some testing that were present at the time of admission across a wide range of adult hospitalized patients and could be feasibly extracted from most EHRs, because we wanted to start where hospitals could actually begin without asking for things that nobody was able to

extract.

So the clinical factors are primarily initial vital signs and laboratory values. And then we did - I can share with you the longer version, but we did a number of things to bring them into the hospital-wide measure, testing a number of different models, and selected those that, you know, most enhanced the model.

I don't know how much detail you want. I can provide more.

DR. POLLOCK: So the initial vital signs and lab values are a surrogate or indicator of severity of illness, or why were those focused on?

DR. BERNHEIM: Both, because they were felt to be very clinically important. I mean, as people have seen, there's lots of parsimonious models out there that tell you a lot about a patient's status when they arrive using initial vital signs and lab values, and then they were tested for this particular measure.

DR. POLLOCK: So these are initial

vital signs on the readmission or the first admission?

DR. BERNHEIM: No, admission, like the crucial piece of the risk adjustment is to understand when this hospital accepts a patient when they initially bring a patient in, how sick that patient was.

DR. POLLOCK: Okay, so the vital signs and lab values are intended to serve as an indicator of the patient's severity at the time of admission to the index hospitalization.

DR. BERNHEIM: Exactly, like the other risk adjustment programs.

DR. POLLOCK: Any thought about using lab values or -

CHAIR OPELKA: Dan, I'm going to say we can't go into measure development. It's out of scope for us.

DR. POLLOCK: Okay.

CHAIR OPELKA: So focus on, "How is this going to apply to a program?"

DR. POLLOCK: Right, I was just trying

to elucidate a little bit more information that I think is relevant to whether we want to encourage going forward.

CHAIR OPELKA: But I don't want us to get lost in the measure development. We'll be here for a day and a half.

DR. POLLOCK: Right, but just understanding where the clinical data are coming from and where - what type of rationale is being applied I think is relevant to whether to encourage going forward. I'm getting a sense of that, and -

CHAIR OPELKA: It's a little far afield. I'm just putting a warning out there. We cannot get into development and you're getting into that. Emma?

MS. KOPLEFF: I have three short issues I want to address. One is the timeline question David brought up. The second is just clarifying the statement Pierre made about what we would be voting for in continuing development as our categorization. And third, offer an

alternative support continued development motion.

So on the first, just with the time line, and this is related to what Pierre said about bringing this measure back, I do think the cesarean measure has been a priority gap for improving quality care for women and babies for a long time.

And the fact that this Medicare program has all claims payer data to allow us to do that and set sort of a standard or provide some leadership in addressing this quality issue is a valuable opportunity.

And I mean, ACOG has recognized that the cesarean rates are off the wall in this country. And when we think about bringing this measure back to MAP, which I'm not disagreeing with, but also that we're right now just in the development phase.

So all of these issues about what clinical factors, or sociodemographic factors, or other factors are included, that's all part of the development. And at some point, this will

also need to be brought back for NQF endorsement.

So where I'm going with this is a, making a statement that I think we're a long way from there, and I commend CMS for heading in the right direction.

And in order to move forward, I strongly think that we need to at least support continued development and have faith that this measure will be brought back to NQF. And I say that differentiating from bringing it back to MAP because either way, per the conversations we've been having, we're seeing that this group is very supportive and we can agree on the value of the NQF endorsement process.

And I don't want the pace at which this measure could potentially be used one day, if it is scientifically valid and vetted thoroughly, to be slowed down by the timing of when MAP is or when an endorsement committee is.

So, the motion I'm making is encourage continued development with the definition of that reflecting this measure coming back for a

thorough scientific review by NQF, whether that's the endorsement committee, MAP, or both, and I hope we can do that swiftly. Thank you.

CHAIR OPELKA: We cannot accept your motion. There's a motion on the floor. But you can make that motion subsequent --

MS. KOPLEFF: Okay, thank you.

CHAIR OPELKA: -- to any other motion. But I think you made your point. Wei?

DR. YING: I would encourage the continued development of the readmission measure for a couple of reasons. One is I think it was stated as part of the preliminary analysis for all the other condition specific measures, they only cover a small portion of the total hospital discharge each year. In order to get an overview of a systematic outcome of a facility, we really want something at the all-cause readmission level. That's one comment.

The second thing is I think the developer is trying to consider the comment received from various sources in terms of the

risk adjustment methodology. Including available clinical indicators into risk adjustment factors is definitely one step in the right direction.

And maybe from this process they will learn how to get the information on SES later on as they further development down the road. If we stop them on the track right now, I highly doubt that SES will later even come into the picture.

MS. KOPLEFF: Correct, in case people got lost, I referenced ACOG. I had my caesarean measures and my readmission measures talking points mixed, but I was referring to the readmissions measure. So, for those who got lost in those comments, it still fits the mold of a high priority area.

MS. FOSTER: So Frank, I thank you all for the clarification about what this category means. And I was under the apparent misperception that we needed to ask for a stop essentially in order to address some of these vital issues. What I really wanted was a pause button.

And I think what I've heard you say is that if that's what we want to drive home the point that we really should not be bringing these measures -- the readmission measure forward for endorsement for further inclusion until we've solved the issue around SES.

That's the point I want to make. And if that's where it is, then I will gladly withdraw my motion and make sure that that point just gets recorded.

CHAIR OPELKA: So if that's the case, then this would stand with all these points as we're encouraging it to go forward, but with all of these SES points and everything else, the clinical adjustments, everything everyone has said, and bringing it back through the NQF process, and the MAP.

Well, I was inclusive of everything at NQF. So - if that's okay, all right? Well, then we have this calendar before us as it's proposed for continuing for - encouragement for continued development. Before we vote on it, can we go to

public comment? Kathy?

OPERATOR: If you would like to comment, please press star then the number one.

CHAIR OPELKA: Any in the room?

OPERATOR: And there are no comments from the phone lines at this time. I apologize, you do have a comment from Don Casey.

MR. CASEY: Hi, can you hear me?

CHAIR OPELKA: Hi, Don.

MR. CASEY: Hi, Frank. I've been listening in all day. The public comment I think covers quite a bit of ground which you've covered. I think this is the first time since the morning. Am I right?

CHAIR OPELKA: No, we've actually had public comment before every vote.

MR. CASEY: I didn't hear it in the second go around. I don't think you asked for it. Maybe I'm wrong, but I don't think you did. Did I miss it?

CHAIR OPELKA: You missed it. It's been prior to every vote.

MR. CASEY: Okay, I apologize. Well, relative to this then, the discussion of the eMeasure for readmissions, I would simply get in that this continues to be solely focused on using the hospital-related data. And it seems to me as though we're at a point where we ought to be considering in our measure development the possibility of putting in more data regarding antecedent and intercurrent care between and amongst the admissions and the rehospitalizations. So that's my comment.

CHAIR OPELKA: Thank you. Any in the room? Okay, so you have before you for voting this encouraged continued development consent calendar.

MS. IBRAGIMOVA: The meaningful use consent calendar one encouraged for continued development hospital-wide all-cause unplanned readmission hybrid eMeasure, perinatal care C-section, PC 02, nulliparous women with a term, singleton baby in vertex position delivered by cesarean section; adverse drug events,

inappropriate renal dosing of anticoagulants; and timely evaluation of high-risk individuals in the emergency department.

Do you agree with the encouraged for continued development calendar? One, yes, two, no. The results are 100 percent yes, zero percent no.

CHAIR OPELKA: My first one. I'm catching up. Okay, so we are actually just about on time for day one. Very quickly, I think we've learned a lot today about trying to walk through a different process within the MAP, and it's been an education.

And I think, at least my sense is, you're getting more familiar with how to walk through it, and how to make it work in the right way to get the outcome you wish.

I'm not so sure we started off that way, but I think you're getting into the swing of it. So I think that helps a lot.

We've gone through OQR which we thought was going to be a walk in the park and

that's where we cut our teeth, then the ACS which was actually pretty smooth.

The Medicare Shared Savings Program, we ended up moving a lot of that over into the physician area, the clinician work groups, so they will have that a week from today. And so, if any of you have comments relative to that, you may want to follow-up in that work group.

And then the HAC reduction program, psychiatry, and this last one in meaningful use. And in each one, there were many major features that I think were very important to our comment.

I'm a little worried that we've only captured spotty pieces here and there of gaps. And so, I'm just wondering if we shouldn't quickly walk through these programs that we've put up here and ask if there's any outstanding issue in gaps that we left off the table that we want to try and make sure we capture.

And if we're too harried at the end of the day, it's something we can also start with tomorrow to make sure while you're sleeping on it

we're not missing any gaps.

So if we could, I'm just going to ask you to look at all of the programs. There's OQR, there's ambulatory surgery, Medicare chaired savings, HAC, inpatient psychiatry, and meaningful use. And there have been many gaps mentioned, but we didn't formally go through it.

And I'll ask you now, is there something that you had on the back of your mind in any one of these programs we want to capture and at least put on our list? Nancy?

MS. FOSTER: I think we ought to be thinking, as my friend Nancy has said, we ought to be thinking about the appropriateness of mental health measures in virtually all of these programs.

I'm not sure the same mental health measures work across all of the programs, but let's be thinking about that and the need to integrate mental health care in with physical care as David said earlier.

Secondly, I think that as we think

about disparities in care, we really haven't teased out anything here in terms of how would we effectively measure that, and that is an area where I think we have an enormous gap.

And third, just getting to the e-specified measures, it seems to me there's enormous potential there for us to do something even more broad-based than just the one adverse drug event measure that was brought forward here.

We know that adverse drug events, falls, and other harms to patients are critically important, and we do not yet have good ways to capture all of that. And I would push us to think beyond that one ADE measure.

CHAIR OPELKA: Thank you. Michael?

DR. PHELAN: I'm sorry, me or David?

CHAIR OPELKA: I didn't know David was up, so --

DR. PHELAN: Just to support Nancy's recommendations for maybe getting a little bit of focus on psychiatric care, in emergency medicine particularly, patients spend an inordinate amount

of time.

And if you have followed any of the things that are going on on the West Coast, you know, the Supreme Court of Washington had, you know, made holding patients in the ED, you know, unconstitutional. And how far that will go, I don't know.

But for any of us that work in this space understand that there's the lack of resources, lack of bed availability, and no magnifying glass looking at some of the issues that are happening to this group of patients.

And it covers a broad spectrum of some of the issues that occur in both the IQR and the OQR, getting adequate outpatient resources for the mentally ill and inpatient resources when someone comes into your hospital and they spend two days in your ED waiting for an available bed.

I think shining that type of light is - would be something that I would recommend as part of the gap work that we do on this committee.

CHAIR OPELKA: I share the same sentiments. I think the first order of quality of care is access to care, and that population suffers from the lowest form of access. Therefore, the first order of quality is missing. David?

DR. ENGLER: I would agree, thank you. Adverse drug events, behavioral health integration in particular, and I'm really looking forward to the opportunity to look at antibiotic stewardship and its impact on infections in our hospitals.

CAUTI continues to be a major problem nationwide, and anything that we can do to refine the metrics of those. C. diff is a real huge problem, a growing problem, a high mortality problem, and I'm encouraged by the work that's going to be conducted on antibiotic stewardship.

CHAIR OPELKA: Thank you.

DR. ENGLER: And I really do hope that our friends from our developers and our CMS folks have a really clear message going forward to do

something on behavioral health would be a great thing.

CHAIR OPELKA: Great, thank you. Wei?

DR. YING: Two things, one is the OB outcome measure. I'm not sure whether it's high on the CMS to-do list, but when we try to do anything for the OB population we just can't find anything related to the OB outcome. That's one area.

The other thing is, in general, patient reported outcome. There's no measure being proposed. And we think down the road, fundamentally, that's where the quality should go. If the patients think it's good, then that's good.

CHAIR OPELKA: Thank you. Marty?

MR. HATLIE: I wanted to build on the comments already made about mental illness and just, we saw a connection here between mental illness and substance abuse that was mentioned, and I thought that was really important to pay attention to as we go forward.

Socioeconomic factors, David, I remember you speaking to this very eloquently last year. I really appreciate the comments of Rich and Nancy.

I was just briefed by safety net hospitals in Chicago right before I came here, and they're just really, really struggling over this, especially the small, independent ones in neighborhoods that nobody else serves. So I think we've got to pay attention to that.

And then the Partnership for Patients that Missy mentioned actually ended yesterday. Yesterday was the last day of it. And what we learned in the Partnership is that it's not just patient and family engagement that leads to culture change, it's leadership engagement, and that came up in our health literacy discussion as well.

And I think we need to look at kind of the connection between patient and family engagement, leadership engagement, and sort of engagement of clinicians as creating the cultures

that are going to sustain all of this improvement work.

I don't know how to get that. It goes across all the programs. But it was one of the major lessons learned from the partnership of patients that that really is important to do. And you find a lot of alignment when you educate all of those audiences about the work we're doing.

CHAIR OPELKA: Thank you.

MR. HATLIE: You're welcome. Thank you.

MS. KOPLEFF: To second the patient reported outcomes measures gap, specifically for the cancer program, I know that ASCO is working on some patient reported outcome measures, so it would be great if we could continue to track those, and when they are ready, have them come forward to the group.

CHAIR OPELKA: Great. Nancy?

DR. HANRAHAN: Well, I'd like to thank my colleague for mentioning disparities. There

is growing evidence that people that have these mental illnesses in medical surgical hospitals don't get the procedures in the same way that other people get.

And this may be contributing to that 25-year difference in the death rates in the population. And it's very understandable why they may not because of capacity.

Secondly, the other thing I'd like to encourage, I don't know where this fits, but human resources. You know, there is quite a bit of - there is a growing mass of literature about, and research about nurse staffing and skill mix.

And there's also with the Affordable Care Act we're seeing a different kind of work force evolving. And so, the relationship between the workforce and outcomes I think is a really major factor that could be tracked in a measure.

CHAIR OPELKA: All right. Well, I think that's really helpful and a great way actually to finish the day by walking through, you know, some of your early thoughts on gaps.

Looking ahead to tomorrow, we truly have saved the best for last. I guarantee it.

So please take a look at the agenda for tomorrow. And having learned today how you're working through these consent calendars, start to give some early thought to this so that we can walk through that.

And kind of take your lessons learned from today and apply them tomorrow. I think it will be really the only way we'll get through a complicated agenda tomorrow.

So tomorrow we've got, you know, just as much work before us, and some of it may be even more critical to the way some of you are thinking so we want to walk through that. So that's really our list of work for tomorrow and where we're going to go for this. Nancy, be brief, one last comment.

MS. FOSTER: One last comment is I just wanted to thank staff. I said this to Taroon earlier, but I think the materials provided for this iteration, for those of us who

have been around the table any number of years, are so superior to the previous years that it is incredibly helpful. Thank you.

CHAIR OPELKA: All right, everybody, what time do we start tomorrow? Yeah, 8:00 is the continental and 8:30 is the launch of the meeting. So, we will see you then. Thank you again. Kathy, close the line, please.

(Whereupon, the above-entitled matter went off the record at 3:57 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: Measure Application Partnership

Before: NQF

Date: 12-09-14

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