

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

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

2 8:37 a.m.

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

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

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

18 Ann, welcome and thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



1 Health Professionals Division, and I have nothing  
2 to disclose.

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

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

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

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

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

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

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

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

3 MS. HAMMERSMITH: You're an  
4 organizational representative.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 MS. HAMMERSMITH: The next subject

1 matter expert? That might be you, Michael  
2 Phelan.

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

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

12 Do we have any more subject matter  
13 experts here?

14 Co-Chairs, you're subject matter  
15 experts.

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

22 CO-CHAIR WALTERS: Ron Walters. I

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

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

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

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

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

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

1 Health Assessment Group at CMS.

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

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

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

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

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



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

4                   Okay. Thank you.

5                   CHAIR OPELKA: Ann, thank you very  
6                   much.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 Go ahead, Emma.

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



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

14                   MS. KOPLEFF: Thank you for  
15 clarifying.

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

18                   CHAIR OPELKA: Okay. Nancy?

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

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

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

18 CHAIR OPELKA: Richard?

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

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

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

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

1 consideration in a different program.

2 Daniel?

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

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

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

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

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

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

14 DR. POLLOCK: Okay.

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

1 carry with it the application of an endorsement  
2 rigor.

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

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

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

22 CHAIR OPELKA: Okay.

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

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

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

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

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

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

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

22 And then finally step 5. As you can



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 public comment period.

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

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

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



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

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

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

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

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

4 So, yes, Marty?

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

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

17 OPERATOR: Yes, ma'am. We have about  
18 13 on line.

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

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

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

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

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

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

1 All right. So let's jump in.

2 Hospital Outpatient Quality Reporting Program is  
3 first up.

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

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

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

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

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

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

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

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

6                   Go ahead, Poonam. Thanks.

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

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

22                  So, the critical program objectives

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

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

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

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

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

7 DR. MORRISON: Thank you.

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

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



1 generally supportive of including it in the OQR  
2 Program.

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

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

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

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

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

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

17  
18 We did receive three comments on this  
19 measure. One was generally supportive. Two  
20 commenters noted similar concerns, specifically  
21 noting there is not a clinical evidence base to  
22 support performance measurement of CT imaging in

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

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

22           So the first addresses Administrative

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

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

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

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

1 conversation.

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

8 Michael?

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

1 CT that have a complication related to that  
2 visit.

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

8 CHAIR OPELKA: All right. Second?

9 Thank you. Nancy?

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

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

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

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

22 MS. FOSTER: You'd like to know where

1       they go?

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

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

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

17                  MS. FOSTER:   Right.

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

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

22                  CHAIR OPELKA:  So it's now moving to

1 conditional support pending development of a  
2 composite.

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

5 CHAIR OPELKA: It's already there.

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

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

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

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



1 CHAIR OPELKA: Okay.

2 MS. FOSTER: I will pull my

3 pull --

4 CHAIR OPELKA: So the consent calendar

5 --

6 MS. FOSTER: -- if that works.

7 CHAIR OPELKA: As it stands in the

8 consent calendar. Okay?

9 Any other aspects of this? Jack?

10 DR. FOWLER: I just have a quick

11 question. On the Brain Tomography one a low

12 score is good score, is that right? That is the

13 fewer X-rays you have, the better? Is that the

14 way it works?

15 CHAIR OPELKA: Yes, I don't have the

16 specifications of the measure.

17 PARTICIPANT: Yes.

18 DR. FOWLER: Thank you.

19 CHAIR OPELKA: All right. So, Emma?

20 MS. KOPLEFF: With the Brain

21 Tomography measure, I just -- thank you for

22 sharing the evidence based around the guidelines,

1       that's helpful.

2                   CHAIR OPELKA:   Emma.   I'm sorry.

3       We're only at a point of pulling --

4                   MS. KOPLEFF:   Oh, thank you.

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

7                   MS. KOPLEFF:   Okay.   Thank you.

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

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

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

19                   CHAIR OPELKA:   So we're starting?

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

1 support.

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

4 MS. O'ROURKE: Start at the top?

5 MR. AMIN: Advance Care Plan.

6 CHAIR OPELKA: So --

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

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

11 So, Jamie, any comments? David?

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

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

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

21 CHAIR OPELKA: Sure.

22 MS. FOSTER: So we actually are very

1 supportive of the notion that patients should  
2 have Advance Care Plans. The question is its  
3 application in the outpatient care setting,  
4 broad-based for any patient that comes in that's  
5 65, because hospital outpatient clinics and other  
6 services are a wide variety of activities.

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

22 And so, we would like to see this

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

5 CHAIR OPELKA: Thank you. Mitchell?

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

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

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

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

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

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

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

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

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

7 CHAIR OPELKA: Ron?

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

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

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

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

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

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

21 CHAIR OPELKA: Nancy?

22 MS. FOSTER: Actually, Ron, I agree



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

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

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

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

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

9 CHAIR OPELKA: Richard?

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

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

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

3 CHAIR OPELKA: Marty?

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

16 CHAIR OPELKA: Mitchell?

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

22 I feel that I agree with Sean, that

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

13 CHAIR OPELKA: Donna?

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

16 CHAIR OPELKA: Sean, hold on just a  
17 second.

18 DR. MORRISON: You got it.

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

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

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

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

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

18              CHAIR OPELKA: Sean?

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

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

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

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

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

18 CHAIR OPELKA: All right.

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

21 CHAIR OPELKA: Andrea?

22 DR. BENIN: It looks to me as though

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

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

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

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

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

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

20           Dana?

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



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

9 Correct?

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

14 MS. ALEXANDER: Okay.

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

17 MS. ALEXANDER: Thank you.

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

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

6               Most recent performance, which is  
7       2013, looks like it's at about 42 percent. So  
8       for clinicians who choose this measure, on  
9       average, that is the performance rate. Obviously  
10      higher is better.

11             CHAIR OPELKA: Christie?

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

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

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

10 So I guess I'm trying to understand  
11 why we wouldn't want to know that? Why the  
12 facility wouldn't want to know that so that they  
13 could follow it if the patient has one, and if  
14 they don't have one, it seems to me that somebody

15 I would hope, might be able to say, well, if  
16 something happens to me when I'm getting my  
17 colonoscopy, this is what I want.

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

1 decisions if they have been made.

2 CHAIR OPELKA: Shelley?

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

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

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

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

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

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

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

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

1 here.

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

8 CHAIR OPELKA: Wei?

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

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

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

9 CHAIR OPELKA: Richard?

10 DR. BANKOWITZ: So I do agree that  
11 there needs to be a cultural shift. The question  
12 is is the payment system the way to establish  
13 that cultural shift? I don't think so. If we  
14 tie payment to a measure like this, you have to  
15 understand there are adverse consequences. If  
16 you want this to be 100 percent, you'll get it to  
17 100 percent by having everyone comment and do a  
18 proforma at the front desk. And I don't know if  
19 that is moving us in the right direction. It's  
20 not going to change the culture. I think we're  
21 relying on the payment system here to do more  
22 than it can do. And so, I think we need to



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

3               CHAIR OPELKA:   Brock?

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

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

22              CHAIR OPELKA:   Okay.   So, we are not

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

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

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

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

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

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

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

6 MS. IBRAGIMOVA: Oh, but --

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

9 MS. IBRAGIMOVA: Yes.

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

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

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

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

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

11 MS. IBRAGIMOVA: Yes.

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

15 MS. ALEXANDER: And yes is one?

16 MS. IBRAGIMOVA: Yes.

17 MR. AMIN: Yes is one.

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

20 MS. ALEXANDER: And what is three?

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

1 MR. AMIN: There's no three.

2 MS. IBRAGIMOVA: -- in this voting.

3 MS. ALEXANDER: Okay.

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

11 CHAIR OPELKA: Marty?

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

17 CHAIR OPELKA: We can't change a  
18 measure.

19 MR. HATLIE: Okay.

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

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

3 MR. HATLIE: Okay.

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

8 MR. HATLIE: Thank you.

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

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

14 (Voting)

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

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

22 CHAIR OPELKA: So this category moved

1 to do not support.

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

5 (Laughter)

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

8 So what's our next one?

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

11 Nancy, you had motioned to move this  
12 measure?

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

1       you anticipated would help them make that right  
2       choice?

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

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

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



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

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

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

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

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

10 CHAIR OPELKA: Okay. All right. I  
11 understand.

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

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

16 DR. MORRISON: You got it.

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

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

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

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

19 CHAIR OPELKA: Marty? Sean?

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

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

9 CHAIR OPELKA: Great. Thank you.  
10 Pierre?

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

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

1 fractions of XRT.

2 CHAIR OPELKA: Karen?

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

12 CHAIR OPELKA: Nancy?

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

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

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

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

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

19 All right. What do we have next?

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

1 of the C-CAT to a do not support.

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

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

16 CHAIR OPELKA: Other comments?  
17 Richard?

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

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

3 CHAIR OPELKA: Jack?

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

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

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



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

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

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

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

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

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

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

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

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

17                   CHAIR OPELKA:   Ron?

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

1       stewarded by the AMA.

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

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

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

3 CHAIR OPELKA: Woody?

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

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

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

11 CHAIR OPELKA: Michael?

12 DR. EISENBERG: Can I just --

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

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

21 CHAIR OPELKA: Michael?

22 DR. PHELAN: I think it's moving the

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

16 CHAIR OPELKA: Dana?

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

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

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

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

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

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

17              CHAIR OPELKA: Emma?

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

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

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

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

14 Brock?

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

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

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

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

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

22 CHAIR OPELKA: It is a pay-for-



1 reporting program. Andrea?

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

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

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

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

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

11 CHAIR OPELKA: Mitchell?

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

18 DR. YONG: There is --

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

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

1 DR. LEVY: Right. Exactly.

2 DR. YONG: -- which is our

3 payment --

4 DR. LEVY: Yes.

5 DR. YONG: Which is payment program.

6 That's true that measures need to be publicly

7 reported on Hospital Compare for one year.

8 There's no - beyond HVBP, the only other payment

9 penalty programs are the HAC Reduction Program

10 and the Hospital Readmission Program, the

11 Hospital Readmission Reduction Program. There is

12 no specific payment program for outpatient

13 quality patient departments.

14 DR. LEVY: Okay.

15 CHAIR OPELKA: Jack?

16 DR. FOWLER: Just to be clear, and

17 maybe I guess this is for CMS. We're going to

18 talk about CAHPS questions when we get to the

19 next thing, and so there is going to be a new

20 CAHPS that's for outpatient hospitals, and that

21 looks like what's proposed. They have a

22 communication section, though I don't think they

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

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

6 CHAIR OPELKA: Nancy?

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

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

21 CHAIR OPELKA: Marty?

22 MR. HATLIE: I think this is more than

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

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

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

22 (Voting)

1 CHAIR OPELKA: Did we get the online  
2 votes?

3 (No audible response)

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

10 All right. And next?

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

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

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

21 DR. YONG: So, thank you.

22 CHAIR OPELKA: For those of you on the

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

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

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

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

22 However, in our analyses there's also

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

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

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

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



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

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

14             And to that end, there was I think a  
15      pretty solid piece of work reported in the Annals  
16      of Emergency Medicine two years ago involving  
17      data from 21 U.S. hospital emergency departments,  
18      about 750 visits. And the bottom line was that  
19      65 percent of the patients had a documented  
20      indication for a head CT that was not identified  
21      in the administrative data.

22             A company editorial by Harold Sox, who

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

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

1 purpose at this time.

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

4 Richard?

5 DR. BANKOWITZ: So, discussant number  
6 2 agrees completely with moving this to do not  
7 support, and I think you articulated the reasons  
8 exceptionally well. Some of these exclusions are  
9 very difficult to code. Coding of focal  
10 neurological deficit with administrative claims  
11 data is going to be very, very difficult.

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

19 CHAIR OPELKA: Nancy?

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

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

10 CHAIR OPELKA: Emma?

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

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

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

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

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

22 DR. YONG: I was just going to say it

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

3 MR. AMIN: That's correct.

4 DR. YONG: This is an updated version.

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

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

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

22 CHAIR OPELKA: Michael?

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

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

22 And there's not good clinical

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

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

18 CHAIR OPELKA: Wei?

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



1 push and pull between the safety and the  
2 efficiency.

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

14 CHAIR OPELKA: Dan?

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

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

8                    CHAIR OPELKA:    Taroon?

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

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

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

5 And I think one of the things we need  
6 to understand from the MAP is this a concept that  
7 we should continue to push forward on in some  
8 fashion or another, whether it's potentially  
9 working on an electronic measure that is all  
10 payer, so captures multiple age groups, not just  
11 65 and over? I'm not sure what the right answer  
12 is, but we certainly hear from our purchaser  
13 colleagues and our consumer colleagues that this  
14 concept and other concepts of appropriate use are  
15 really important.

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

1 should really continue to pursue or not.

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

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

12 Michael?

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

22 And just going back, we understand

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

15               CHAIR OPELKA: Nancy?

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

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

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

9 CHAIR OPELKA: Wei, is your card back  
10 up?

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

1 We can only tell them in concept.

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

8 CHAIR OPELKA: Richard?

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

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

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

9 MS. IBRAGIMOVA: You can begin voting.

10 (Voting)

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

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

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



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

3 CHAIR OPELKA: Depends on where it  
4 goes.

5 CO-CHAIR WALTERS: Yes.

6 CHAIR OPELKA: We need 51 percent.

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

9 (Laughter)

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

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

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

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

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

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

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

22 (Laughter)

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

4 (Voting)

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

9 (Laughter)

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

16  
17 MR. SLABACH: I'll make a motion to  
18 that effect, if that's appropriate at this time.

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

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

1 CHAIR OPELKA: No, I think that  
2 is --

3  
4 MR. SLABACH: Oh, that is the motion?

5 CHAIR OPELKA: -- the motion.

6 MR. SLABACH: Okay.

7 CHAIR OPELKA: So any discussion?

8 (No audible response)

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

12 (Show of hands)

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

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

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

1 composite.

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

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

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

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

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

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

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

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

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

3 MS. FOSTER: So the CAHPS survey -- I  
4 don't have as clear a picture of the ambulatory  
5 CAHPS survey, but I know the inpatient HCAHPS  
6 survey asks very clearly about communication with  
7 your physician, with your nurse, communication  
8 about discharge and so forth. I'm leaping to the  
9 conclusion the ambulatory CAHPS asks similar  
10 questions and I'm concerned that we seemingly are  
11 going to be fielding two surveys to the same  
12 group of patients that may ask similar but  
13 slightly different questions. And that makes me  
14 crazy.

15 And also thinking about  
16 administratively inside the hospital, how do you  
17 bring the information together and use it in a  
18 useful way when you've got two different  
19 competing surveys? I'm just saying take these  
20 questions and integrate them into the CAHPS  
21 survey as opposed --

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

1 or address that for you?

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

4 CHAIR OPELKA: Please. Thank you.

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

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



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

4               CHAIR OPELKA: Thank you. Jack?

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

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

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

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

1 All right. Andrea?

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

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

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

5 Then let's move on.

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

10 Just one second while we cue those up  
11 for you.

12 CHAIR OPELKA: All right.

13 MS. O'ROURKE: So for consent calendar  
14 1, support, we have external beam radiotherapy  
15 for bone metastases and the health literacy  
16 measure derived from the health literacy domain  
17 of the C-CAT. For consent calendar 2,  
18 conditional support pending NQF endorsement, we  
19 have use of brain-computed tomography in the  
20 emergency department for atraumatic headache.  
21 For consent calendar 3, conditional support  
22 pending the development of a single composite

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

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

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

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

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

16 And there are no public comments at  
17 this time.

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

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

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

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

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

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

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

17                  CHAIR OPELKA: Thank you. Any other  
18       comments?

19                  (No audible response)

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

1 yes and no on the consent calendars.

2 Question about the vote?

3 DR. BENIN: About the logistics of the  
4 voting.

5 CHAIR OPELKA: Please?

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

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

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

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

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



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

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

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

8               CHAIR OPELKA: Michael?

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

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

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

17              CHAIR OPELKA: We will.

18              DR. PHELAN: Each consent calendar  
19      separately.

20              CHAIR OPELKA: Okay. We can do so.

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

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

5 PARTICIPANT: What was consent  
6 calendar 1?

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

10 MS. IBRAGIMOVA: Now you can vote.

11 (Voting)

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

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

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

1 yes, two no.

2 (Voting)

3 MS. IBRAGIMOVA: So the results are --

4 CHAIR OPELKA: So this also passes.

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

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

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

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

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

17 (Voting)

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

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

22 MS. O'ROURKE: So the fourth calendar

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

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

12 (Voting)

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

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

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

22 (Voting)

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

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

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

20 (Whereupon, the above-entitled matter  
21 went off the record at 11:16 a.m. and resumed at  
22 11:33 a.m.)

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

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

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

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

21 All right. Any questions? Nancy?

22 MS. FOSTER: What's the condition?

1 CHAIR OPELKA: Is this one NQF-  
2 endorsed?

3 AUDIENCE MEMBER: Yes.

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

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

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

1 All right? Okay. Shall we vote?

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

4 CHAIR OPELKA: Dana?

5 MS. ALEXANDER: It's not sinking in.

6 So conditional support is we're saying what?

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

9 MS. ALEXANDER: Oh.

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

13 MS. ALEXANDER: Okay.

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

16 MS. ALEXANDER: Okay. Thank you.

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

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



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

3 DR. LEVY: Okay. Okay.

4 CHAIR OPELKA: Marty?

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

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

12 MR. HATLIE: Yes. Thank you.

13 CHAIR OPELKA: Okay.

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

18 (Voting)

19 (Laughter)

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

1 MS. IBRAGIMOVA: This is a technical  
2 difficulty.

3 MS. BAL: -- default.

4 MS. IBRAGIMOVA: We are going to  
5 revote.

6 CHAIR OPELKA: But I like it.

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

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

11 DR. MORRISON: Thank you.

12 MS. IBRAGIMOVA: Okay. Try voting  
13 again.

14 (Voting)

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

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

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

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

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

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

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

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

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

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

22 Finally, the commenter noted that the

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

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

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

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

1 complications.

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

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

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

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

22 Calendar 3 deals with measures that

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

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

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

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

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

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

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

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

13 Emma?

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

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



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

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

11 Does anybody have a motion regarding  
12 this measure? Donna?

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

17 CHAIR OPELKA: Please do.

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

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

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

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

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

22 Secondly, as I said or haven't said

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

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

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

1 prominent part of the medical record.

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

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

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

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

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

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

1 believe you.

2 MS. SLOSBURG: Oh, oh.

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

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

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

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

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

5 MS. SLOSBURG: Can you say that again?

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

13 (Voting)

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

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

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

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

3               We will hear from Donna and Cristie.  
4       Donna first.

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

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

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

22              CHAIR OPELKA: Nancy?

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

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

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

21 First Mitchell?

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



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

7 CHAIR OPELKA: Martin?

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

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

16 MS. SLOSBURG: You know, it has been  
17 used in our industry for the last few years and  
18 we have had about 1200 surgery centers out of the  
19 5,000 reporting on our website and it is now  
20 right about between 97 and 98 percent. It was a  
21 measure that we had and had wanted in the  
22 program.

1 MR. HATLIE: Yes.

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

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

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

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

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

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

1 comments on the webchat.

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

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

11 (Voting)

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

14 CHAIR OPELKA: It's called a consent  
15 calendar.

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

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

22 (Voting)

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

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

5 (Laughter)

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

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

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

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

3 DR. STEFANCYK OBERLIES: (No audible  
4 response.)

5 CHAIR OPELKA: Jack? Amanda are you  
6 --

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

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

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

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

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

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

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

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

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

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

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

12 DR. MORRISON: My hand is up, Frank.

13 MS. IBRAGIMOVA: General consensus?

14 CHAIR OPELKA: No. General consensus.

15 Okay. We will use the voters. All right. Does  
16 somebody have a motion, by the way, for this  
17 consent calendar?

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

21 CHAIR OPELKA: Right.

22 MR. AMIN: So --

1 CHAIR OPELKA: A formal vote for the  
2 consent calendar.

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

5 CHAIR OPELKA: Okay.

6 MR. AMIN: Yes.

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

8 MR. AMIN: Yes, thanks.

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

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

14 (Voting)

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

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



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

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

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

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

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

1 require a level of coordination and collaboration  
2 within an ACO.

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

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

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

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

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

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

22           This measures a high impact area of

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

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

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

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

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

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

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

17                   MR. AMIN: Okay.

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

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

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

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

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

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

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

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

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

10 No. 2 within the Consent Calendar No.  
11 3 is the proportion of patients sustaining major  
12 viscus injury at the time of pelvic organ  
13 prolapse repair. Again, this is a conditional  
14 support pending NQF review and endorsement, an  
15 important outcome measure and it's tested.  
16 Again, it would -- it is currently not endorsed.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

21          There were generally supportive  
22          comments by the American Society of

1 Anesthesiology.

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

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

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

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

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

10                  MR. AMIN: So we will reconvene at  
11                  12:45, for those on the phone and those in the  
12                  room.

13                  (Whereupon, the above-entitled matter  
14                  went off the record at 12:20 p.m. and resumed at  
15                  12:47 p.m.)

16  
17  
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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 --

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

4 MS. BAL: Okay. Thank you, Taroon.

5 So the Medicare Shared Savings Program, also  
6 known as MSSP, is a combination pay-for-reporting  
7 and pay-for-performance program. The goal is to  
8 facilitate coordination and cooperation among  
9 providers to improve the quality of care for  
10 Medicare fee-for-service beneficiaries and reduce  
11 the rate of growth in healthcare costs.

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

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

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

22 To encourage coordination and shared

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

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

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

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

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



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

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

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

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

20                      MS. KHAN: Sure.

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

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

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

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

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

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

5 And minimum attainment is set at --  
6 it's based on the benchmarks that we have  
7 established. And we used all Medicare fee-for-  
8 service data that we had available to set  
9 benchmarks using 24 there and we have those  
10 available online for ACOs. And if you meet the  
11 30th percentile, that's the minimum attainment, on  
12 at least one of the pay-for-performance measures  
13 in each domain, you will be eligible to earn in  
14 the shared savings.

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

1 performance measure in each of the four domains.

2 MS. GOODRICH: The 30th percentile from  
3 2012 is the data.

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

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

13 CHAIR OPELKA: Michael?

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

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

19 DR. PHELAN: Sure.

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

1 calendar itself. Cristie?

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

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

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

1 CHAIR OPELKA: And the second question  
2 you had?

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

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

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

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

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

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

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

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

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

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

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

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

22                  If you want to consider it within your



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

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

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

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

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

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

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

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

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

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

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

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

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

14                  MS. GOODRICH: So this is Kate. I may  
15 just high-level a few points.

16                  MS. KHAN: Yes.

17                  MS. GOODRICH: I agree with everything  
18 Rabia has said. Alignment with the National  
19 Quality Strategy in filling in those gaps,  
20 measures that really help to focus on care  
21 coordination, which you will see for example the  
22 post-acute care work group is going to be

1 considering the home health readmission measure,  
2 for example.

3 We had this -- we just finalized the  
4 SNF Readmission measure for the program.

5 Trying to address what many  
6 stakeholders including most recently MedPAC have  
7 recommended for the program, which, as Rabia  
8 said, is a focus on population level outcome  
9 measures as well as appropriate use measures.  
10 They called that out specifically.

11 And then fourth is alignment with the  
12 other programs. And I think in particular with  
13 something like PQRS, but I would argue also with  
14 IQR, a lot of the measures that are in those  
15 programs are in the safety and the clinical  
16 effectiveness and prevention domain, so that's  
17 where you are seeing mostly those types of  
18 measures within the ACO program.

19 So just to sort of high-level some of  
20 those priorities.

21 CHAIR OPELKA: Richard?

22 DR. BANKOWITZ: Is it time to make a

1 motion?

2 CHAIR OPELKA: We are on these  
3 administrative understandings of the program.  
4 And I want to make sure we are all there. And if  
5 we are, then we can move on to the specific  
6 consent calendar. But while we are doing that,  
7 we are trying to understand I think the issue  
8 that we have logistically on our data set is the  
9 site of setting, site of service, this facility,  
10 the level of analysis has got to be also  
11 consistent with our work group.

12 So if the level of analysis is  
13 hospital and the site of service is facility,  
14 then it belongs in our domain. If the level of  
15 analysis is clinician, then we are -- I believe  
16 it does not belong in this work group. I think  
17 that it belongs in the physician work group, even  
18 though the site of service may be facility.

19 So we know this first one  
20 perioperative antiplatelets for the carotid is a  
21 clinician level measure, as it is specified. We  
22 are checking on the next one, the thorax.

1 MS. O'ROURKE: Thorax. We would keep  
2 the Thorax CT. This one is a facility level  
3 measure.

4 CHAIR OPELKA: Then the in-hospital  
5 mortality for the AAA? I think that's right.

6 MS. O'ROURKE: So we have as the level  
7 of analysis individual practice, group practice  
8 and facility.

9 CHAIR OPELKA: And facility?

10 MS. O'ROURKE: We do have and facility  
11 on the -- but it is also going to be reviewed by  
12 clinicians, so perhaps it is more appropriate for  
13 there.

14 CHAIR OPELKA: So it's on our list.  
15 So the question I guess is how does CMS look at  
16 it? Was it all specs?

17 MS. GOODRICH: This was one that was  
18 -- I don't know the specs by heart, but this was  
19 one that was submitted to us for consideration by  
20 SVS for the physician programs. So I believe  
21 that it should probably be in the clinician work  
22 group.

1 CHAIR OPELKA: Okay. So we will pull  
2 it off our list. Ron, you are hesitating.

3 CO-CHAIR WALTERS: So the clinician  
4 work group currently does not review the Medicare  
5 Shared Savings Program measures.

6 MS. GOODRICH: Yes, it does.

7 CO-CHAIR WALTERS: It does?

8 MS. GOODRICH: Yes, yes.

9 CO-CHAIR WALTERS: They do?

10 MS. GOODRICH: Yes.

11 CO-CHAIR WALTERS: I take back what I  
12 said.

13 CHAIR OPELKA: So then we have two on  
14 this current list, the Thorax CT and the payment  
15 standards Medicare spending per beneficiary.  
16 And, Richard, now it is time.

17 DR. BANKOWITZ: Thank you, Frank.  
18 Those two remaining measures, the contrast for  
19 Thoracic CT and the per beneficiary spent, are  
20 the two measures I was going to move we put into  
21 the do not support category. Not because I don't  
22 think they are good measures. They are good



1 measures, but I don't think they are appropriate  
2 for this program, which is the Medicare Shared  
3 Savings Program.

4 And the reason for that is everyone in  
5 this program is trying very hard to be efficient  
6 and to reduce cost and that's how they get paid.  
7 And that's probably one of the strongest  
8 motivators you can have.

9 So recognizing that there is a  
10 potential to sort of skimp on care, CMS has put  
11 in a set of quality measures, I think very  
12 appropriately so, to make sure that we are not  
13 under-utilizing services.

14 These two measures seem to deal with  
15 over-utilization. And it seems that they are on  
16 the wrong side of the ledger that these measures  
17 are not guarding against under-utilization of  
18 care and they are measuring something that is  
19 being measured very, very explicitly on the  
20 shared savings side.

21 So it is not clear why, especially,  
22 Medicare Spending Per Beneficiary would be in

1 here. It's almost impossible to conceive that  
2 you would have shared savings and this measure  
3 would go up. It just doesn't seem possible. So  
4 that's why I think these are inappropriate for  
5 this shared savings program.

6 CHAIR OPELKA: So second?

7 PARTICIPANT: Second it.

8 CHAIR OPELKA: All right. So then  
9 shall we open this up for discussion with these  
10 two being moved to the do not support and that's  
11 the entire consent calendar. Nancy?

12 MS. FOSTER: Thank you, Richard. I  
13 think you commented very well about both of the  
14 measures actually.

15 I just wanted to add on the payment --  
16 the Medicare Spending Per Beneficiary measure; I  
17 think one of the most important ways in which all  
18 of the ACO models are trying to be more judicious  
19 about the use of resources is to prevent  
20 hospitalizations, to do the early interventions.

21 So it seems odd to me that we would be  
22 looking at them and trying to measure this based

1 on the cost for patients who were hospitalized,  
2 rather than looking at the broader picture. And  
3 I believe, Kate, in the assessment CMS does  
4 already of the program, they look at the broader  
5 picture, but this would -- this is just a strange  
6 take, I think, on holding an individual ACO  
7 accountable for cost when you are only talking  
8 about the cost of the hospitalized patient and  
9 not about the broader.

10 And I can envision that if you are  
11 successful in driving down the number of  
12 hospitalizations, that, in fact, the number --  
13 the cost per hospitalization might go up because  
14 those people who are hospitalized then are --  
15 tend to be sicker.

16 CHAIR OPELKA: Emma?

17 MS. KOPLEFF: I'm wanting to offer an  
18 alternative perspective on these measures. One  
19 at a time, if I may. With the Payment  
20 Standardized Medicare Spending Per Beneficiary  
21 measure -- actually, allow me to just back up for  
22 one minute and respond to the concept of under-

1 utilization.

2 And we had some of that discussion  
3 earlier today when we were talking about  
4 efficiency measures. And there is a time and a  
5 place for talking about those issues with regards  
6 to patient safety, which is an issue I'm very  
7 passionate about.

8 But with regards to system level  
9 measures that are trying to coordinate care from  
10 the patient line, that really doesn't -- the  
11 concept of under-utilization doesn't resonate  
12 with me.

13 Patients would like to be at home,  
14 healthy, with their families and not eager to  
15 enter the system and stay there. And I think one  
16 of the objectives in coordinating care through  
17 this program helps achieve that ability for  
18 patients. And I think we need a way to measure  
19 it.

20 And so now speaking to the Payment  
21 Standardized Medicare Spending measure, I  
22 understand Nancy's point and it's relevant, but I

1 -- it's relevant to the degree that we are -- the  
2 point of that measure is to hold hospitals  
3 accountable and provide meaningful information  
4 about costs in the hospital setting.

5 But I think having that information as  
6 a starting point to evaluate not just the  
7 hospital, but a bigger system is essential to  
8 know whether we are improving care. And if we  
9 don't measure it, we don't have a basis for those  
10 comparisons.

11 Secondly, on the efficiency measure,  
12 I think we could repeat some of the same  
13 conversations we had previously, but I'll note  
14 that it's my understanding the Thorax measure is  
15 in the Hospital Outpatient Program, so there is  
16 an effort to align with other programs there,  
17 which is something MAP has identified as a goal.

18 And I also think harkening back to our  
19 earlier conversation, there are issues to  
20 consider around over-use and patient safety.  
21 Thanks.

22 DR. PHELAN: I would support Emma's

1           contention that these are measures they need.  
2           And I'm not exactly sure of all the details of  
3           the ACO model, but are they allowed to select  
4           different measures and different domains? I  
5           think these ACOs may be looking for more measures  
6           in this space to help them drive the improvement  
7           that they are looking for.

8                       And the same thing for the CT  
9           utilization and the Medicare Spending Per  
10          Beneficiary, now, and I'm not familiar with all  
11          the measures, but is there a cost measure already  
12          affiliated with the ACO measures? And I wonder  
13          if CMS could address that? Because if there is,  
14          why do we need this one? And if there isn't,  
15          this would be a good fit for it, because it's  
16          really good data and hospitals are able to drive  
17          some of their improvement based on some of this  
18          data.

19                      And the data includes, I think it is,  
20          two days before the hospitalization and then 30  
21          days after, if I'm not mistaken if it's an  
22          episode of paying them. So it includes some

1 things in the outpatient arena that you were  
2 talking about after the hospitalization, but it  
3 starts with the hospitalization, if I'm not -- is  
4 that correct or no?

5 MS. GOODRICH: The measure is three  
6 days before hospitalization, up to 30 -- and then  
7 through 30 days after, so that is the episode.

8 DR. PHELAN: Okay.

9 MS. GOODRICH: So there are no other  
10 cost measures in the shared savings program. The  
11 cost "measure" is related to the sharing and  
12 savings. So but Rabia maybe you could talk a  
13 little bit about how that works. And I think it  
14 might help the Committee to hear why this is  
15 being considered for the MSSP.

16 DR. PHELAN: Yes.

17 MS. KHAN: Right. So we work closely  
18 with ACS. We have a separate -- I can't speak to  
19 all the financials, that's a separate team that  
20 works on it. But ACO selects a track to  
21 participate in and depending on whether they  
22 generate shared savings or will be eligible to

1           earn it -- in it or in losses.

2                       So in terms of adding this measure to  
3           or considering this measure for this program, the  
4           MSPB is being used for other value-based  
5           programs. And so in terms of, you know, the  
6           feedback that we have received to consider cost  
7           and resource use as an additional measure to  
8           include in our measures, that we considered  
9           really just looking at the measures that are  
10          already aligned with other programs.

11                      But I understand the concerns raised  
12          about the focus, whether it be under- or over-  
13          utilization and what the concerns are. So we do  
14          have -- we do look at cost as a part of how --  
15          whether ACOs are generating any shared savings  
16          and how much they would be eligible to share in  
17          it and where they are generating it from as far  
18          as what activities they are pursuing.

19                      But I mean, we don't have any cost  
20          measure quality metrics within our measure set or  
21          any resource use really. We do have a lot of  
22          preventive health and primary care and care



1 coordination focus measures. We are trying to  
2 work on the measures with more outcomes and  
3 really looking at what beneficiaries and  
4 providers will also feel is useful.

5 CHAIR OPELKA: Nancy? Richard, she  
6 yields.

7 DR. BANKOWITZ: Okay. Well, once  
8 again, I do want to remind everyone this is the  
9 Medicare Shared Savings Program. So cost is a  
10 big focus. Now, these ACOs are using a ton of  
11 data. They are looking at their use of post-  
12 acute care. They are looking at the efficient  
13 use of specialists. They are looking at the  
14 radiographic costs.

15 They are looking at all of this at an  
16 operational level, because if they don't, they  
17 can't achieve or hope to achieve the shared  
18 savings. So it's not that these are going  
19 unmeasured. They are being measured.

20 What we are doing here is we are  
21 putting them in as a basis of payment. So in  
22 addition to achieving the shared savings, we are

1 saying now you have got to focus on CT use.  
2 Maybe some organizations are focusing on CT use,  
3 because they know they have an issue there.

4 But to tie payment to an efficiency  
5 measure when the whole program is geared to  
6 achieve efficiency just doesn't seem logical to  
7 me. It doesn't seem as if we are using these  
8 measures properly.

9 CHAIR OPELKA: Nancy?

10 MS. FOSTER: So yes, then to put a  
11 finer point on what Richard just said, if you  
12 were trying to, Michael, use this measure to  
13 direct your care, it would be not driving looking  
14 in the rear view mirror. It would be driving  
15 looking in the rear view mirror of the car that  
16 is a half a mile behind you, because there is  
17 such a delay in getting this data.

18 In addition, I'm not sure how this  
19 would be calculated, because this measure is  
20 specified for a hospital population, but Medicare  
21 Shared Savings Program model ACOs have people who  
22 go to a variety of hospitals and they don't

1 control which hospital they go to.

2 They are allocated to that ACO based  
3 on their primary care utilization, not based on  
4 their hospital utilization, not based on anything  
5 else. So it is how one can conceptually hold a  
6 Medicare Shared Savings Program accountable for  
7 this measure is a little bit beyond me.

8 It seems it is right to measure cost?  
9 This isn't the right measure.

10 CHAIR OPELKA: Other comments? So  
11 taking my Chair hat off, Richard, I'm not -- I'm  
12 trying to understand where you are coming from on  
13 your point, because I don't know that I accept  
14 it. If I'm in an ACO and I'm not, I live in a  
15 hospital that has a global payment. Once a year  
16 we get funded and I don't get funded again for  
17 another year.

18 But there is nothing more important to  
19 me than to know my key areas of spend.

20 DR. BANKOWITZ: Yes.

21 CHAIR OPELKA: I mean, nothing. So I  
22 would look at this in my global payment. And if

1 I got the per hospital beneficiary cost, that  
2 would be valuable to me.

3 DR. BANKOWITZ: Yes.

4 CHAIR OPELKA: If I got the pharmacy  
5 cost, that would be valuable to me.

6 DR. BANKOWITZ: Yes.

7 CHAIR OPELKA: If I got the outpatient  
8 cost, that would be valuable to me. If I got my  
9 CT cost for thoracic surgery, that would be  
10 valuable to me.

11 Now, I'm not saying -- I guess what  
12 I'm looking at is which one of these costs would  
13 I put in a program because I think it is going to  
14 help the program achieve the savings. It's going  
15 to get them to focus on a key area, because there  
16 are so many costs you can chase. If you chase  
17 the wrong cost, you put all your resources -- if  
18 you look 10 FTEs and that's all you had to manage  
19 your ACO and they all chased 1 percent of the  
20 income, of the revenue, they are not going to end  
21 up helping the ACO.

22 DR. BANKOWITZ: Right.

1 CHAIR OPELKA: But if they are chasing  
2 the right 30 percent, that there is variation and  
3 there is opportunity, they are going to help the  
4 ACO.

5 DR. BANKOWITZ: Right.

6 CHAIR OPELKA: So I look at both of  
7 these measures. And that's the question I ask.  
8 On these efficiency measures, which one of these  
9 efficiency measures would be valuable to a  
10 management team of an ACO that I, CMS, am guiding  
11 them to say put your effort here. And I  
12 personally don't think it is in Thoracic CT.  
13 I've got to be honest with you.

14 I don't know that for a fact, but I  
15 don't think it is where the difference is going  
16 to be made in the ACO. But the Medicare Spending  
17 Per Beneficiary on the hospital, I don't know how  
18 you do it without it.

19 DR. BANKOWITZ: So if I could respond,  
20 I think we are in alignment and that I agree  
21 pretty much completely with what you have said  
22 for the need for the information. And believe

1 me, these ACOs are tracking everything.

2 What I disagree with is that CMS will  
3 guide the ACO by its selection of performance  
4 measures on which they will be paid in addition  
5 to the savings, because I think each individual  
6 ACO needs to understand where to focus.

7 When I think of the beauty of the  
8 program is we have this large goal, which is  
9 reduce the cost and you figure out how to do it,  
10 and you know where your costs are and get them  
11 down, but don't sacrifice quality; that's why we  
12 have those measures. I don't think these quality  
13 measures are meant to be operational directive  
14 and maybe that's where we disagree.

15 CHAIR OPELKA: Emma?

16 MS. KOPLEFF: I am just having a  
17 little trouble understanding sort of how ACOs use  
18 this wealth of data they have. And again, I  
19 don't know that we need to decide whether this  
20 measure is or isn't operationally sort of  
21 dictating how ACOs are improving.

22 But just sort of a basic tenet of

1 measurement, I think we need a standardized way  
2 to measure cost, not just for each individual ACO  
3 to monitor those costs, but globally for  
4 improving cares across ACOs. We need that  
5 standardization. And in this measure, we have a  
6 standardized NQF-endorsed measure that has been  
7 through a rigorous multi-stakeholder discussion.

8 And I think we need it. And I would  
9 think operationally ACO leadership would need it  
10 too to identify best practices, complete root  
11 cause analyses and sort of really run with the  
12 point of quality measurement, which is to  
13 identify opportunities for improvement and  
14 capitalize on those.

15 CHAIR OPELKA: Wei?

16 DR. YING: I think this measure basic  
17 host of a fundamental question under the global  
18 payment that under the global payment, are we  
19 going to allow or do you think it should be  
20 allowed for double-dipping, in terms of global  
21 payments and then on top of that pay on  
22 efficiency measure?

1                   From our test run in Massachusetts,  
2                   what we are thinking is we try to avoid that from  
3                   the very beginning. We didn't put any efficiency  
4                   measure under our global payment structure.

5                   But recently our thinking has been  
6                   shifted. Currently, what our thought is  
7                   efficiency measure we will pay on it if it also  
8                   has consequences in patient safety or also  
9                   represent some level of quality of care.

10                  So when I look at this, I would think  
11                  the hospitals with lower standardized care may be  
12                  representing a better care coordination, either  
13                  pre-surgery or pre-admission and probably more  
14                  importantly post-hospital discharge.

15                  So it's not necessarily just a cost  
16                  measure. It also has the implication on the  
17                  quality side.

18                  CHAIR OPELKA: Thank you. So we have  
19                  taken everything off the support consent  
20                  calendar. Two we removed because they are  
21                  clinician and two we have suggested move to do  
22                  not support. So I think we have to vote on



1           whether or not to move these to do not support.  
2           And I'm wondering can we vote on them separately?  
3           So let's vote on Thorax CT and yes means you  
4           agree with the motion to move to do not support  
5           and then we will take the next one.

6                       Wait for it.

7                       MS. IBRAGIMOVA: Okay. So the  
8           question is Thorax CT use of contrast material do  
9           you agree with the motion to put under do not  
10          support? 1, yes; 2, no.

11                      (Voting)

12                     MS. IBRAGIMOVA: The results are 67  
13          percent yes, 33 percent no.

14                     CHAIR OPELKA: Okay. And then the  
15          second one, which is the Spending Per Beneficiary  
16          to the hospital specific spend.

17                     MS. IBRAGIMOVA: So the question is  
18          Payment Standardized Medicare Spending Per  
19          Beneficiary, MSPB, do you agree with the motion  
20          to put under do not support? 1, yes; 2, no.

21                      (Voting)

22                     MS. IBRAGIMOVA: The results are 38

1 percent yes, 63 percent no.

2 CHAIR OPELKA: All right. So my  
3 interpretation is that that remains on the  
4 support list. Okay.

5 So then we have a calendar update.  
6 This is a flash news coming in. So Calendar 2,  
7 which were the two NHSN, the CAUTI and the CLABSI  
8 measures, those remain in -- because those are  
9 hospital/facility-based measures for the  
10 inclusion in the Medicare Shared Savings Program.

11 Calendar 3 is all clinician, so that  
12 comes off our project list.

13 Calendar 4, which was MR for lumbar  
14 spine/low back pain remains. That was a  
15 conditional support.

16 Calendar 5, 6 and 7 all moved to  
17 clinician, so they come off our list.

18 So with that update, we are now on the  
19 Medicare Shared Savings Conditional Support for  
20 CAUTI and CLABSI. And the condition that was put  
21 forward was that there were data concerns about  
22 gaining access to this data from primary data

1 sources in the NHSN CDC.

2 So any motion to move these or leave  
3 them in conditional support for the Medicare  
4 Shared Savings Program? Yes, Michael?

5 DR. PHELAN: Conditional support.

6 CHAIR OPELKA: Conditional. So keep  
7 it where they are? Okay. All right. So we will  
8 keep those where they are.

9 Then let's move to MR. So this was  
10 the -- I'm sorry? We didn't move it, so the  
11 consent calendar remains.

12 So we are now on the conditional  
13 support requiring NQF-endorsement for the MRI  
14 lumbar spine for low back pain. So it's  
15 conditional support, NQF-endorsement. And  
16 remains. I'm getting a nod to keep it where it  
17 is. Okay.

18 So that completes our assessment of  
19 the consent calendars and now we can move to the  
20 voting on the consent calendars.

21 So before we do so, let's open up for  
22 public comment. Kathy, are you still there?

1 OPERATOR: Yes, sir. If you would  
2 like to make a public comment, please, press star  
3 and then the number one.

4 CHAIR OPELKA: And in the room as  
5 well.

6 OPERATOR: One moment for your first  
7 comment. Okay. You have a comment from Matthew  
8 Davis.

9 MR. DAVIS: Hi. This is Matt Davis.  
10 I'm a spinal cord injury sub-specialist with TIRR  
11 Memorial Herman. I'm not sure if I'm calling  
12 into the right group or not, but I just know we  
13 have had a lot of frustration with the CAUTI  
14 measure in the spinal cord injury sub-population  
15 due to kind of an adverse series, you know,  
16 adverse patient outcomes.

17 What's the best way to get feedback to  
18 the people that are involved in endorsing the  
19 measure as a whole, not just the provisions of  
20 the measure?

21 CHAIR OPELKA: So thank you for your  
22 comment. The endorsement process is different

1 from the application process.

2 MR. DAVIS: Yes.

3 CHAIR OPELKA: So the endorsement  
4 process looks at the code or the measure as it  
5 has been developed and that process is separately  
6 held by the NQF. This would be the application  
7 and by pointing out difficulties with the applied  
8 measure, we communicate back to the remainder of  
9 the developer and the endorsement process.

10 So if there is a difficulty in the  
11 application, that would be helpful.

12 MR. DAVIS: Okay. Yes, so I have kind  
13 of coordinated. I called into one of these, into  
14 the Patient Safety Standing Committee, last April  
15 and they kind of put me in touch with the CDC  
16 regarding this measure.

17 And what I have, you know, and what we  
18 kind of have done over the last several months, I  
19 mean, it's -- I was pointing out at that time  
20 some real safety concerns with this measure for  
21 just this small sub-population of people that are  
22 paralyzed with spinal cord injuries and pulling

1 out their catheters is something that we are  
2 seeing a lot of going on in these acute care  
3 hospitals. And they are not well-prepared to  
4 deal with, you know, this patient population that  
5 is putting them at risk for hypertensive  
6 emergencies and things like strokes and seizures.

7 And you know, I felt like the CDC was  
8 listening for a little while and they kind of  
9 realized that it was going to be administratively  
10 challenging or might be administratively  
11 challenging to make a change in the measure and  
12 they kind of shuffled this off somewhere else. I  
13 felt like I was being placated for a while.

14 Since then, I have been able to  
15 recruit like the president of the American Spinal  
16 Injury Association and the president of the  
17 Association for Spinal Injury Professionals and  
18 some really big names in spinal cord medicine.  
19 And yet, I feel like this measure is just kind of  
20 marching forward, despite the fact that we have  
21 some really highly-respected people in the field  
22 of spinal cord injury medicine speaking out about

1           this as being an adverse patient safety event,  
2           when we are really asking for very simple change,  
3           so that spinal cord patients could be in listed  
4           exclusions.

5                     Is there any way that, you know, you  
6           guys or that the NQF can kind of add some fuel to  
7           the fire to the CDC on this?

8                     CHAIR OPELKA:   So I'm not sure that we  
9           can give you all the oomph you are looking for,  
10          but our -- my interpretation of what you are  
11          stating is that in our terms, which is the group  
12          that applies measures, we would note caution in  
13          the use of this measure as it is currently  
14          specified for a subset of the population who has  
15          unintended consequences due to this measure.

16                    MR. DAVIS:   Yes.   And so you guys  
17          could comment on this measure in that way and  
18          maybe somebody would look at it and say hey, you  
19          know, we've got to think about this a little  
20          more?

21                    CHAIR OPELKA:   So we vote the measure  
22          up or down and we vote for it --

1 MR. DAVIS: Yes.

2 CHAIR OPELKA: -- to be included in  
3 the program or not included in the program. And  
4 these caveats can be added to that vote either  
5 way.

6 MR. DAVIS: Okay.

7 CHAIR OPELKA: So we will --

8 MR. DAVIS: Yes. I would --

9 CHAIR OPELKA: -- take your comments  
10 and add it to our general comments with regard to  
11 this measure, so that we inform CDC and the  
12 measure endorsement process and CDC is with us  
13 today and does hear what you are saying.

14 MR. DAVIS: Okay. Well, I don't know  
15 if Dan Pollock is somewhere on the line and can  
16 hear what I'm saying, he is the one that I have  
17 been talking with lately. You know, he has kind  
18 of provided us some potential -- is he there?

19 CHAIR OPELKA: Dan is in the room.

20 MR. DAVIS: Oh, okay.

21 CHAIR OPELKA: We're holding him down  
22 right now.



1 MR. DAVIS: Okay. Well, he is well-  
2 aware of the conversations we have been having.  
3 And I guess there is kind of a disagreement  
4 between him and some of the other folks on the  
5 spinal cord injury side of things. It's kind of  
6 what does and does not constitute a practically  
7 feasible solution to this problem?

8 And you know, I guess I just want to  
9 appeal to the National Quality Forum on this,  
10 separate from the CDC, because, you know, I --  
11 the field of spinal cord injury medicine is such  
12 a small field that for us to try to educate, you  
13 know, all of the acute care hospitals around the  
14 country as to how to recognize when patients need  
15 intermittent catheterizations, how to recognize  
16 autonomic dysreflexia and deal with these  
17 hypertensive emergency-type states that these  
18 people get into.

19 And which patients really are most  
20 appropriate for, you know, continued endone  
21 catheterization. It's a prodigious task. And I  
22 know that there are some, you know, potential

1 challenges with, or at least I heard there could  
2 be some potential challenges with, adding spinal  
3 cord patients to a list of patients that are  
4 excluded, you know, just like in the same what  
5 that suprapubic catheters are excluded.

6 But I think that would be probably  
7 less challenging than trying to educate people  
8 well enough so that we can avoid the dangers of  
9 bladder over-distention in spinal cord patients.  
10 Because I am seeing that. I am seeing patients  
11 that are coming to me with two and one patient  
12 even with almost three liters of urine in her  
13 bladder and that does drive up people's blood  
14 pressures into the systolic, you know, blood  
15 pressures of 200s, which, you know, you can see  
16 things like strokes and seizures with that.

17 CHAIR OPELKA: I want --

18 MR. DAVIS: So --

19 CHAIR OPELKA: -- to thank you for  
20 your comments. I think we have gotten a very  
21 clear picture of the difficulty you have  
22 presented, but unfortunately we need to move on

1 with our agenda today.

2 MR. DAVIS: Yes, okay. Well, thank  
3 you very much. And like I said, I just would  
4 love to see either a conditional support or, you  
5 know, non-endorsement of this measure, at least  
6 in its current state.

7 CHAIR OPELKA: Thank you.

8 MR. DAVIS: Thank you.

9 CHAIR OPELKA: Appreciate it.

10 MR. DAVIS: All right. Bye.

11 CHAIR OPELKA: Any other comments?

12 OPERATOR: There are no comments at  
13 this time.

14 CHAIR OPELKA: Any in the room? Okay.  
15 Andrea, did you want to make a comment?

16 DR. BENIN: You know, I can briefly  
17 echo the concern about unintended consequences  
18 about this metric. There are -- you know, I was  
19 on service last week. There is, you know,  
20 incredibly ill children and we are highly  
21 incentivized to take out the catheter. And then  
22 when you need to put it back in, it can be

1           problematic and you can cause a lot of problems  
2           trying to get a catheter back into a, you know,  
3           desperately edematous child.

4                       But I think that the tradeoffs are  
5           complicated to try to figure out where this lies.  
6           And the methodology using the SIR means that you  
7           have this observe to expected ratio that you can  
8           deal with. So in theory, there is some risk  
9           adjustment around how many are expected.

10                      But the benchmarks right, now  
11           certainly in pediatrics, are incredibly low. And  
12           so it's very -- people are highly incentivized  
13           right now to take out these catheters and so  
14           there may be some, I don't know, further  
15           consideration of this. I would be very  
16           interested in hearing more about the  
17           directionality around that.

18                      CHAIR OPELKA: One last comment? And  
19           we need to get on to a vote or we are going to be  
20           here until Christmas.

21                      MS. FOSTER: That's not that far off,  
22           Frank. Just one --

1 CHAIR OPELKA: That's very far off.

2 MS. FOSTER: -- quick comment or  
3 additional concern that I wanted to raise was  
4 these measures are in the midst of a transition  
5 to move from just ICU-based measures to whole  
6 population in the hospital-based measures.

7 And we will hear more about this as  
8 they come up in the hospital population, but I  
9 wonder about the timing of moving these into the  
10 Medicare Shared Savings Program when we will be  
11 transitioning the measures to more appropriate  
12 broad-based population. But it presents some  
13 measurement challenges in so doing.

14 CHAIR OPELKA: All right. So the  
15 motion before you is the Consent Calendar 2,  
16 which has CAUTI and CLABSI on it.

17 PARTICIPANT: What was in this?

18 CHAIR OPELKA: I'm sorry? We have  
19 gone through and we are now voting on the consent  
20 calendars. Right.

21 PARTICIPANT: Yes, okay.

22 CHAIR OPELKA: Right. I mean, that's

1 where we are. I'm sorry?

2 MS. IBRAGIMOVA: So MSPB we have  
3 support, in the support calendar.

4 CHAIR OPELKA: Oh, we have to go back  
5 to Calendar 1? I'm sorry.

6 MS. IBRAGIMOVA: So just to read for  
7 the record, MSSP Consent Calendar 1 support  
8 Payment Standardized Medicare Spending Per  
9 Beneficiary, MSPB. Do you agree with the support  
10 calendar? 1, yes; 2, no.

11 (Voting)

12 MS. IBRAGIMOVA: The results are 78  
13 percent yes, 22 percent no.

14 CHAIR OPELKA: So then we are on  
15 Calendar 2, the CAUTI, CLABSI measures.

16 MS. IBRAGIMOVA: MSSP Calendar 2,  
17 conditional support pending resolution of data  
18 concerns, National Healthcare Safety Network  
19 (NHSN), Catheter Associated Urinary Tract  
20 Infection outcome, CAUTI, and the National  
21 Healthcare Safety Network (NHSN), Central Line-  
22 Associated Bloodstream Infection outcome measure,

1 CLABSI.

2 Do you agree with the conditional  
3 support pending resolution of data concerns  
4 calendar? 1, yes; 2, no.

5 (Voting)

6 MS. IBRAGIMOVA: The results are 87  
7 percent yes, 13 percent no.

8 CHAIR OPELKA: And the last one is  
9 what was previously Calendar 4, conditional  
10 support with resubmission of NQF, the MRI lumbar  
11 spine for the low back pain.

12 MS. IBRAGIMOVA: Just to repeat for  
13 the record, MSSP Calendar 4, conditional support  
14 pending resubmission to NQF for endorsement  
15 review MRI lumbar spine for low back pain.

16 Do you agree with the conditional  
17 support pending resubmission to NQF for  
18 endorsement review calendar? 1, yes; 2, no.

19 (Voting)

20 MS. IBRAGIMOVA: The results are 91  
21 percent yes and 9 percent no.

22 MSSP Consent Calendar, do not support

1 Thorax CT, use of contrast material.

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

4 (Voting)

5 MS. IBRAGIMOVA: The results are 65  
6 percent yes, 35 percent no.

7 CHAIR OPELKA: All right. Well, I  
8 want to thank everybody for walking through that.  
9 We have done a lot to catch up on our day and we  
10 are now only about 20 minutes behind.

11 So we are moving into the HAC  
12 Reduction Program and those sets, so if we could  
13 walk through that program?

14 MS. IBRAGIMOVA: Okay. So the next  
15 measure is the Hospital Acquired Condition or  
16 also known as HAC Reduction Program. And this is  
17 a pay-for-performance and public reporting  
18 program. The HAC scores will be reported on the  
19 Hospital Compare website beginning December 2014,  
20 so now.

21 So the basic goals are just to  
22 heighten awareness of HAC and eliminate the



1 incidents of HAC that could be reasonably  
2 prevented by applying evidence-based clinical  
3 guidelines and also just basically to reduce  
4 incidents of HAC as much as possible and drive  
5 improvement.

6 The clinical project objectives that  
7 were determined in October were focus on reducing  
8 the major drivers of patient harm, overlap in  
9 measures between the HAC Reduction Program and  
10 the Hospital Value-Based Purchasing Program can  
11 help to focus attention on critical safety  
12 issues.

13 And in the 2013/2014 approval gaps  
14 that were identified, were PSI-5 to address  
15 foreign bodies retained after surgery and  
16 development of measures to address wrong site and  
17 wrong site surgery and so this is behind post-  
18 operative infections.

19 MS. O'ROURKE: So we have one consent  
20 calendar for you for the HAC Reduction Program.  
21 These are updates to two measures that are  
22 currently in the program.

1                   So the question before MAP is would  
2                   you support the updated version of the measure or  
3                   should we maintain -- or would we support  
4                   maintaining the current version of the measure?

5                   To give you a brief summary of what  
6                   these updates are: The measures have been  
7                   expanded to settings beyond the ICU and we have  
8                   also had -- the measure also had another risk  
9                   adjustment method added. And I did want to  
10                  introduce Ed Septimus, the Chair of the Patient  
11                  Safety Standing Committee. He is on the line.

12                  The Standing Committee reviewed these  
13                  measures and recommended these updated measures  
14                  be NQF-endorsed. So these updates are now NQF-  
15                  endorsed.

16                  That's it for this program. We did  
17                  receive similar comments on the CAUTI measure as  
18                  we did for MSSP regarding the potential adverse  
19                  consequences for patients with spinal cord  
20                  injuries.

21                  CHAIR OPELKA: So this is the only  
22                  calendar for this, the HAC, this entire HAC

1 Program?

2 MS. O'ROURKE: Yes.

3 CHAIR OPELKA: So the question before  
4 you is: is there any desire to move these from  
5 their current calendar? Nancy?

6 MS. FOSTER: I have a question.  
7 Timing on movement into the HAC Program? And I  
8 say this because of the comment I made  
9 previously. These measures are in transition.  
10 Will just begin -- we just -- we will just begin  
11 reporting full house on January 1st. So we are  
12 endorsing this for when?

13 DR. YONG: So as you know, all these  
14 programs would go through rulemaking, so we would  
15 certainly be very transparent in terms of the  
16 rules, in terms of when these measures would go  
17 into effect for any of these programs.

18 But these measures are also part of  
19 the IQR Program, so, you know, we would think  
20 through how we would do it, because these  
21 measures are in existence in those -- both  
22 programs as well as in HVBP as well. So I think

1 at this point, it's -- there are no set time  
2 lines exactly for implementation.

3 MS. O'ROURKE: Yes, exactly. We could  
4 do it as early as next year for any of the  
5 programs certainly, but we would be open to  
6 feedback from MAP as to sequencing, you know, the  
7 timing of -- I know for instance, obviously, with  
8 Hospital Value-Based Purchasing, they go to IQR  
9 first and then to HVBP.

10 There has been discussion at the MAP  
11 in past years that measures -- some members  
12 prefer that measures for the HAC Program get  
13 publicly reported first in a similar vein, that  
14 is something we would be open to considering as  
15 well. So we are certainly open to the MAP's  
16 input on that.

17 MS. FOSTER: So let me suggest then  
18 that although we haven't dealt with the IQR  
19 Program yet, that there is some logic to having  
20 them reported first for a year to make sure there  
21 aren't any issues like the one that was being  
22 raised earlier about the spinal cord individuals.

1                   So we are moving them into public  
2                   reporting before we are moving them into a  
3                   penalty program. It makes a lot of sense to me.

4                   MS. DANFORTH: I just have a couple of  
5                   questions.

6                   The first question is if you have a  
7                   sense of which value you would use in the HAC  
8                   Reduction Program? Since the new measure  
9                   calculates kind of like a standard SIR and then  
10                  this suggested SIR, which is more of a ranking.  
11                  Do you envision using that ranking SIR for -- in  
12                  the scoring methodology for the HAC Reduction  
13                  Program or the standard SIR?

14                  DR. YONG: So again like Kate said, we  
15                  would welcome input on this. You know, the  
16                  reason we put it on the MUC list this year was  
17                  because it was going through NQF-endorsement and  
18                  they did, the CDC did, include this additional  
19                  ARM methodology as well as the standard beyond  
20                  ICUs.

21                  So like I said before, we didn't have  
22                  specific plans, at this point, in terms of how we

1 would sequence or implement this, at this point,  
2 but we would certainly welcome input on it.

3 MS. DANFORTH: Okay. The only point  
4 I would add then, given your response, is for the  
5 purposes of public reporting, I actually agree  
6 with Nancy in that I think when you make the  
7 transition to publicly report the new updated  
8 measure, which includes the additional units on  
9 Hospital Compare, because of four other infection  
10 measures are being reported out as standard SIRs.

11 For people, consumers, to actually  
12 understand what they are looking at, I think  
13 there is some value to having the SIR value be  
14 sort of consistent between the six different  
15 infection measures.

16 I think the concept of the SIR is  
17 really confusing, if not impossible, to  
18 understand for a consumer anyway, even in our  
19 best attempts to describe it. And we use the  
20 measure, so we are guilty as well. But I think  
21 having these two different SIRs, these hospital  
22 acquired infection measures, because they are all

1 reported out together, could potentially be even  
2 an additional challenge, so I would just add  
3 that.

4 DR. LEVY: Yes. I would also agree  
5 with Nancy and strongly recommend about the  
6 timing of this in term -- also for public  
7 reporting before performance, in particular  
8 because moving CLABSI from geographically  
9 separated areas, like critical care units, into  
10 the hospital really requires a lot of pre-  
11 engineering and a lot of change in process  
12 measures.

13 And doing it in critical care units is  
14 very different than doing it on the general  
15 wards. And it is seems to me we need  
16 benchmarking of how well that can be done and how  
17 that transformation can happen. So it makes  
18 sense to do public reporting before we do a  
19 performance.

20 CHAIR OPELKA: Andrea?

21 DR. BENIN: I would just also agree  
22 with that. I also think that the definitions are

1 changing this year, as of January, both of these  
2 measures, I believe, have pretty -- have decent  
3 sized definitional changes that I don't know that  
4 we fully understand how they are going to apply.  
5 I'm not sure whether I'm going to have more or  
6 less when I recalculate. And that is a little --  
7 you know, that is hard to -- it adds this other  
8 layer to the payment penalty that is -- maybe the  
9 timing is the issue.

10 CHAIR OPELKA: Emma?

11 MS. KOPLEFF: One note just regarding  
12 public reporting. I know that CMS is moving  
13 towards a STAR rating system. And just to sort  
14 of -- I'm not disagreeing with you, Missy, but I  
15 am just saying I'm not convinced yet that having  
16 sort of different ways that -- treating these two  
17 measures differently from the other infection  
18 measures would absolutely have a result in  
19 something negative from a public reporting  
20 perspective, given that the whole way Hospital  
21 Compare's public reporting is really getting a  
22 facelift. But definitely something to think



1           about.

2                       And the other thing again not  
3           disagreeing with the statements that have been  
4           made about the need for consistency and using  
5           public reporting to understand how these new  
6           versions of the measures work, but I would just  
7           sort of remind us that the previous versions of  
8           the measure have been tremendously successful in  
9           reducing hospital acquired infections.

10                      One could argue through their use in  
11           payment programs as well as public reporting  
12           programs, so I do think that sort of staging of  
13           this needs to find a way to continue to  
14           capitalize on that and not lose the old measures  
15           and the work that has been done because of those  
16           measures, again, arguably, in the phasing.

17                      CHAIR OPELKA: Missy, is your card  
18           back up?

19                      MS. DANFORTH: Right. One other  
20           important thing about when a new measure -- you  
21           know, potentially when the new CLABSI and CAUTI  
22           measures get rolled in, if at any point you

1 decide to move to the ARM calculation, my team  
2 actually got a bunch of information and tried to  
3 do the calculation. And it is clear that without  
4 certain pieces of information, coefficients, et  
5 cetera, from the CDC, no one could replicate  
6 those measures.

7 So I think it is fairly important if  
8 CMS moves to the new ARM calculation that they  
9 make every element of the calculation  
10 transparent, so hospitals and other national  
11 organizations can replicate them.

12 Leapfrog, in particular, collects  
13 information from hospitals at the facility level.  
14 And so if we wanted to be consistent with you,  
15 which we do, and with CDC and calculate ARM at  
16 the facility level, we would need those, the  
17 coefficients. And right now, I haven't been able  
18 to find a donator.

19 CHAIR OPELKA: Seeing no others, this  
20 is the one calendar that moves forward for voting  
21 for support.

22 MS. IBRAGIMOVA: So HAC Calendar 1,

1 support, National Healthcare Safety Network  
2 (NHSN), Catheter-Associated Urinary Tract  
3 Infection outcome measure and the National  
4 Healthcare Safety Network (NHSN), Central Line  
5 Associated Bloodstream Infection outcome measure.

6 Do you agree with the support  
7 calendar? 1, yes; 2, no.

8 (Voting)

9 MS. IBRAGIMOVA: The results are 96  
10 percent yes, 4 percent no for support calendar.

11 CHAIR OPELKA: Okay. So we are going  
12 to transition back to 100 percent Ron and move on  
13 to the inpatient psychiatric facilities.

14 MS. O'ROURKE: Actually, Frank, before  
15 we do that, I did want to introduce Ed Septimus.  
16 He is the Chair of the Patient Safety Standing  
17 Committee and the Antibiotic Stewardship Action  
18 Team. They wanted to just present some of their  
19 work on the Action Team to consider how some of  
20 this increased attention on infection rates,  
21 while obviously very important and great work,  
22 could have a potential unintended consequence of

1 poor antibiotic stewardship in creating more  
2 strains of antibiotic resistance, like MRSA and  
3 C. diff, that we are dealing with now.

4 So Ed, I wanted to let you present  
5 that work and opportunities for potential  
6 alignment across NQF.

7 MR. SEPTIMUS: Well, I thank you. I  
8 know you are running behind, so I'll try to be  
9 brief. I do believe there is a high priority  
10 measurement gap around antimicrobial stewardship.  
11 And I am just briefly going to kind of bring you  
12 up to date about what special group was  
13 considering last month, that many of you may know  
14 the recent PCAST report, and PCAST stands for the  
15 Present Council on Advisors and Science and  
16 Technology, came out a report on a strategy of  
17 combating antimicrobial resistance.

18 And this was signed by an executive  
19 order. I don't think I need to tell anybody in  
20 the room about the significance of this impact,  
21 the cost, poor outcomes in a world that I'm  
22 considering almost going into a post-antibiotic

1 effect.

2 As part of the report, what the  
3 executive order strongly defines is defining  
4 communicating and implementing stewardship  
5 programs, not just in hospitals, but office-based  
6 practices, outpatient settings, emergency  
7 departments, institutionalized at long-term care  
8 facilities and that includes like nursing homes  
9 and correctional facilities.

10 And that CMS use reimbursement  
11 incentives to drive stewardship. And this is  
12 supposed to take place within the next couple of  
13 years.

14 But the reason for discussing this  
15 today in front of the MAP Group is that one of  
16 the major barriers to implementing effective  
17 stewardship is the available and reliable  
18 measures which reflect intervention  
19 effectiveness.

20 And stewardship must establish process  
21 and outcome measures to the impact of these  
22 programs not only outcomes, but also on

1 resistance patterns and the unintended  
2 consequences which were just alluded to, such as  
3 increasing rates of clostridium difficile, which  
4 is directly -- goes back to over-use and miss-use  
5 of antibiotic.

6 C. diff in the last point prevalent  
7 study by the CDC now has become the number one  
8 healthcare associated pathogen. You are all  
9 aware of antimicrobial resistance, but more  
10 importantly, it impacts rates on healthcare  
11 associated infections and it also impacts  
12 readmission rates for certain multi-drug  
13 resistant organisms are associated with  
14 readmissions. And you all know how readmissions  
15 affect value-based purchasing.

16 To this date, there are no NQF-  
17 endorsed measures either now or even on the near  
18 horizon on this topic. And this measure-related  
19 barrier includes lack of definition of what  
20 appropriate use is, lack of adjustment  
21 measurements and benchmarking. And is also a  
22 lack of accountability of prescribers and

1 misalignment of incentives.

2 So recognizing all this, the CDC does  
3 have a module in the NHSN space called the  
4 Antibiotic Use and Resistance Module, but to  
5 date, there are very few organizations that are  
6 reporting into this module. But under the PCAST  
7 report, this will increase significantly since  
8 it's going to be a priority.

9 There are some other examples out  
10 there. Ron Paloka who is at Virginia  
11 Commonwealth has come out with some very nice  
12 metrics and risk adjustment benchmarking using  
13 UHC data.

14 So the question I think for us in  
15 front of NQF, and certainly might be the  
16 committee that I co-chair, is what measures do we  
17 need? And are there examples to build upon?  
18 Because as you all know, an NQF-endorsed measure  
19 accelerates measurement and accountability if the  
20 right measures are adopted.

21 And that link measure is to better  
22 outcomes and reduce unintended consequences. So

1 I would like to -- at least in my mind, and I  
2 think also in the measurement application  
3 partnership, this clearly should be a high  
4 priority and it's a gap currently in the NQF  
5 portfolio.

6 So I'll stop there and I know that you  
7 have plenty of other stuff. If there is a  
8 question that I can answer, I'm happy to, but I  
9 just want to put this issue in front of you,  
10 which I think is a big gap in the NQF portfolio.

11 MS. O'ROURKE: Dan?

12 MR. POLLOCK: Yes. This is Dan  
13 Pollock. Thank you very much for that. I --

14 MR. SEPTIMUS: Well, hi, Dan. How are  
15 you?

16 MR. POLLOCK: I'm well. Thank you.  
17 A week without Ebola. So --

18 MR. SEPTIMUS: Yes, it's that nice?

19 MR. POLLOCK: It's nice. So as you  
20 know, we are currently at NHSN developing an  
21 antimicrobial use clinical quality measure  
22 proposal that we expect to submit to NQF for



1 consideration next calendar year. So we are on  
2 that.

3 And we will be using data from the 60  
4 or so hospitals that are already reporting  
5 antimicrobial use data to NHSN to address the  
6 scientific criteria of the NQF measure  
7 requirements.

8 But I appreciate your excellent  
9 overview of the situation and just wanted the  
10 group to know that this is an area that we are  
11 actively working on.

12 MR. SEPTIMUS: And, Dan, we will work  
13 along with you.

14 CHAIR OPELKA: Well, thank you very  
15 much. I think we are going to probably try and  
16 capture those comments and summary thoughts to go  
17 along in the document. They are very helpful in  
18 the gap analysis.

19 MR. SEPTIMUS: Well, I certainly  
20 appreciate the time. I know that you are running  
21 a little bit behind, but I did feel that this was  
22 a major gap that we have and I knew that Dan and

1 other colleagues at CDC were working on trying to  
2 get something hopefully to the Patient Safety  
3 Committee in the next cycle.

4 But I do believe that having an NQF-  
5 endorsed measure really does accelerate and drive  
6 change, if it's the right measure.

7 CHAIR OPELKA: Thank you.

8 MR. SEPTIMUS: We have seen this in  
9 cervical prophylaxis and so many other examples  
10 of public reporting.

11 CHAIR OPELKA: All right. Thank you  
12 very much.

13 MR. SEPTIMUS: Thank you. You all  
14 have a great meeting.

15 CHAIR OPELKA: Thank you very much to  
16 everyone for participation in the process today.  
17 I think we have learned as the days go on. And I  
18 do want to apologize for all that apparent  
19 confusion that was going on during the shared  
20 savings discussion as we were sorting out what to  
21 do with the physician level measures. So that  
22 did pay off actually even though it was a little

1 disruptive at times during that.

2 We will move now into the Inpatient  
3 Psychiatric Quality Reporting Program. The  
4 summary, please?

5 MS. BAL: As Ron said, we are going to  
6 talk about the Inpatient Psychiatric Facility  
7 Quality Reporting Program. This is a pay-for-  
8 reporting program. Information will be reported  
9 on the Hospital Compare website. It focuses on  
10 inpatient psychiatric hospitals or units that do  
11 not report data on the acquired measures.

12 I'm sorry, those who do not report  
13 data on acquired measures, will receive a 2  
14 percent reduction. It is also -- so the critical  
15 program objectives that we came up with for this  
16 program were to ensure measures in the program  
17 were meaningful to patients, improve person-  
18 centered psychiatric care, such as assessing  
19 patient and family/caregiver experience and  
20 engagement and establishing relationships with  
21 community resources. Those are some of our main  
22 gaps.

1                   We also listed step-down care,  
2                   behavioral health assessments, care in the ED,  
3                   remissions, identification and management of  
4                   general medical conditions, partial  
5                   hospitalization or day programs, another CAHPS  
6                   program as gaps.

7                   MR. AMIN: Okay. Thank you, Poonam.  
8                   So we will go through the preliminary analysis  
9                   and the consent calendars for this program.

10                  There are four measures under  
11                  consideration, three of which fall in the first  
12                  consent calendar, which is under support. The  
13                  second one is under conditional support upon  
14                  harmonization.

15                  So I'll begin with the first measure.  
16                  Transition Record with Specified Elements  
17                  Received by Discharged Patients. This is a  
18                  fully-specified tested and endorsed measure that  
19                  is impactful and fits -- fulfills a gap in care  
20                  coordination by ensuring that patients receive  
21                  important transition information.

22                  There were some comments on this

1           measure. Comments noted the importance of this  
2           measure, but noted that instructions must be in  
3           the language that is written and understandable  
4           to a patient and sensitive to needs of  
5           psychiatric patients at discharge.

6                       Commenters also noted the need for  
7           additional exclusions for patients with unplanned  
8           discharges and patients refusing after-care.

9                       The second measure is the Tobacco Use  
10          Treatment Provided or Offered at Discharge and  
11          Tobacco Use Treatment at Discharge.

12                      This is also an endorsed measure,  
13          which fulfills a gap in patient centered  
14          psychiatric care through the identification and  
15          management of general medical conditions. This  
16          is fully-specified and tested at the facility  
17          level.

18                      There were two comments received on  
19          this measure that were generally supportive with  
20          commenters noting that tobacco use was --  
21          actually, I'm not entirely sure whether these are  
22          supported. Actually, I'll take -- let me -- we

1 had a -- I'll take another look at this, because  
2 -- anyway, I'll tell you what the comment said  
3 and then I'll look back at it.

4 There were two comments that also  
5 raised concern about whether tobacco use --  
6 noting that tobacco use was generally not the  
7 primary focus of psychiatric hospital stays and  
8 the measure should be used with caution.

9 Again, I'll take a look back at those  
10 two comments during our discussion.

11 And finally, the SUB-2 Alcohol Use  
12 Brief Intervention Provided or Offered and  
13 Alcohol Use Brief Intervention Received. Again,  
14 this is also a fully-specified and tested  
15 endorsed measure that fulfills a gap in person  
16 centered psychiatric care and the management of  
17 general medical conditions.

18 The commenter were generally  
19 supportive of this measure with one commenter  
20 noting that a larger proportion of patients  
21 presenting in inpatient psychiatric care have co-  
22 occurring substance abuse diagnoses, not simply

1           unhealthy alcohol use. For these patients, more  
2           intensive substance abuse treatments must be  
3           provided.

4                       If CMS is to adopt this measure, a  
5           commenter suggested modification to the  
6           definition of brief identification to also  
7           include more intensive interventions. CMS should  
8           also consider modification to this measure to  
9           address the issue of brief intervention may not  
10          be an optable intervention for persons identified  
11          with alcohol disorders.

12                      Finally, this program's second consent  
13          calendar is Timely Transmission of Transition  
14          Record. This is a fully-specified and tested  
15          NQF-endorsed process measure that contributes to  
16          the efficient use of measurement resources and  
17          addresses a critical program objective identified  
18          by the MAP Hospital Work Group and is highly  
19          impactful to improving person centered care by  
20          facilitating care coordination and the potential  
21          to reduce readmissions.

22                      However, this measure is duplicative

1 of an existing measure, which is the HBIPS-7,  
2 post-discharge continuing care plan transmission  
3 to next level care provider upon discharge, which  
4 is developed and specified for psychiatric  
5 facilities. The two measures should be  
6 harmonized before being used in the program.

7 I'll just point out that -- go ahead,  
8 go ahead.

9 DR. YONG: I just want to make it  
10 clear why we put this measure on this particular  
11 -- on the MUC list for IPS. We are fully aware  
12 that it overlaps with the measure intent for  
13 HBIPS-7. HBIPS-7 which is post-discharge  
14 continuing care plan transmission, how their  
15 HBIPS-7 does not specify a time period for the  
16 transmission, while this measure on the MUC list  
17 does.

18 So the thought was if we were to  
19 implement this and the MAP were supportive of the  
20 measure, we would actually think about removing  
21 the other existing measure.

22 MR. AMIN: Okay. That's helpful. I



1 would just point out before we get into detailed  
2 discussion on this measure, we did receive one  
3 comment on this measure that noted again the  
4 concern around the measure competes with existing  
5 measure.

6 There was also concern that the  
7 measure does not clearly state all the components  
8 that need to be covered in this measure. And  
9 also, there was concern around the 24 hour time  
10 frame whether -- noting that that was too  
11 inflexible not being able to provide necessary  
12 time for certain clinical specialties to be  
13 available to the same extent on weekends,  
14 holidays to complete the transition record. So  
15 that was a comment that was received on this  
16 measure.

17 So I'll turn it over to Ron to  
18 facilitate conversation around the first consent  
19 calendar and then we can go onto the second.

20 CO-CHAIR WALTERS: Okay. We will head  
21 into the first consent calendar. There is three  
22 measures. Delores, did you join us by phone?

1           No.   Lead discussant then is Wei.

2                       DR. YING:   I'm in support of this on  
3           the first measure the record transition.   I think  
4           right now there is already a measure the one --  
5           the No. 7 measure that we just talked about the  
6           record transition to the facility.   I think this  
7           one is just closing the loop to make sure not  
8           just next level of care provider is receiving the  
9           record, but also the patient and their own  
10          caregivers are aware of what the next steps  
11          should be.

12                      For the next two measures about the  
13          tobacco and substance abuse, I share the concern  
14          from one of the public comments about the alcohol  
15          abuse.   In this environment, alcohol abuse is  
16          probably not a dominant factor in what we case  
17          substance abuse, other drug abuse these days are  
18          more prevalent.

19                      And if we look at the SUB-1, 2, 3, 4,  
20          as noted on the discussion guide, 1 and 2 is  
21          alcohol-specific and 3 and 4 actually expanded to  
22          alcohol and other drug.   I'm reading it

1           literally. I'm not sure whether actually they  
2           mean the same thing.

3                       But if it is true, I would recommend  
4           SUB-3 instead of SUB-2 to pull in the other drug,  
5           which also be consistent with the recommendation  
6           of tobacco use, Measure 3, because it confused me  
7           why tobacco use we say the treatment should be  
8           offered at the discharge, but then for alcohol  
9           use, we recommend the intervention being done  
10          during the inpatient stay.

11                      I kind of feel if we pick -- these are  
12          the paired measures. If we pick one, it should  
13          be consistent either 2 or 3 for both tobacco and  
14          substance abuse. And in order to pull in the  
15          other drug, I would recommend SUB-3. So I would  
16          agree with the tobacco SUB.

17                      CO-CHAIR WALTERS: Okay. Open to any  
18          other discussion? Nancy, you are quick.

19                      MS. HANRAHAN: I would like to support  
20          all three, all of these measures. And this is  
21          probably more to add to the list for the gap, but  
22          we are talking about psychiatric

1 hospitalizations. People with mental illness  
2 also enter general hospitals and we know that  
3 about 30 percent of them have some kind of major  
4 illness that is related to their readmission to  
5 hospitals.

6 So these kinds of measures I'm not  
7 sure why they have to be so exclusive to  
8 psychiatric hospitals and why can't we also  
9 transfer these measures into a general hospital  
10 environment? So again, that may be a gap place  
11 that we go to, but there has been very little  
12 discussion about psychiatric illness or  
13 behavioral health illness within medical surgical  
14 environments. And I think we want to address  
15 that. Thanks.

16 CO-CHAIR WALTERS: Other Nancy?

17 MS. FOSTER: Thanks. Let me first  
18 support what Nancy has said that we need to get  
19 to a point where we are talking about important  
20 measures to be used in the acute care condition  
21 environment around psychiatric care.

22 I'm not sure I would start or focus on

1 tobacco and alcohol use as much as the under-  
2 screening for depression and a variety of other  
3 things, but all of it is important. So sorting  
4 that out and how we get from here to there would  
5 be a really important conversation to have.

6 The confusion I have about these  
7 measures, it's not that I don't support the  
8 concepts, but I'm curious as to why one didn't  
9 just tweak HBIPS-7 to get the time frame in  
10 rather than create a whole new measure around --  
11 if that was your concern, that in fact the  
12 existing measure of tobacco screening use --  
13 tobacco screening didn't include the time frame.  
14 So, you know, sort of why throw that out and then  
15 move to this new measure?

16 And then secondly, how do the other  
17 measures transition? How does the transition  
18 record measure square with one HBIPS-1? Is that  
19 right? No, I've got them mixed up. It's 7 and  
20 1, sorry. HBIPS-7.

21 And secondly, isn't there a condition  
22 of participation that requires the patient to

1           have a -- to leave with discharge treatment  
2           information and the care plan to go on? So  
3           aren't we back in that space where we were this  
4           morning where we are measuring something that is  
5           already required?

6                       DR. BUCK: Thank you. First of all,  
7           I should introduce myself. I'm not Kate  
8           Goodrich. I'm Jeff Buck. I am the program lead  
9           for this program and let me try to respond to  
10          you.

11                      I think we are going to have a  
12          separate discussion for HBIPS-7, so I have a few  
13          remarks on that and I'll hold them for the  
14          moment.

15                      With regards to your other remarks,  
16          first of all, just to talk about the comparison  
17          between 0647 and HBIPS-6, we wanted to start  
18          moving in this direction, because, in essence,  
19          HBIPS-6, pretty much for the most part,  
20          incorporates components for discharge record that  
21          are already required, as you pointed out in  
22          conditions of participation. So it's really a

1 very minimal type of measure.

2 This other measure, one that was  
3 developed as a result of the consensus statement,  
4 when that has been endorsed by the MAP for both  
5 use in Medicaid populations and the duals  
6 population, which is the majority of the Medicare  
7 population using inpatient psychiatric  
8 facilities.

9 And I also want to note that -- well,  
10 actually, I'm sorry, that's incumbent for HBIPS  
11 excuse me, for the other measure. But it's also  
12 endorsed by the NQF Care Coordination Steering  
13 Committee and it differs from HBIPS-6 mostly be  
14 specifying the number of additional elements that  
15 should be in the transition record that are not  
16 incorporated HBIPS-6.

17 As I said HBIPS-6 just says you've got  
18 to show reason for hospitalization, principal  
19 diagnosis, discharge meds and the next level of  
20 care recommendation, that said and you get credit  
21 for being in the HBIPS-6 standard.

22 This transition record measure

1 includes in the record the results of tests and  
2 procedures, identification of studies that were  
3 still pending at discharge, advance directives,  
4 and this is a population that has been shown to  
5 have a life expectancy of 25 years less than the  
6 general population, patient instructions, 24 hour  
7 and seven day contact information, contact  
8 information for pending studies, any plan for  
9 follow-up care and the identification of the  
10 physician and follow-up site.

11 So it has a number of additional  
12 features as well as the requirement for  
13 consultation with the patient that is not in  
14 HBIPS-6 and why we think it is moving this along  
15 in a higher quality standard risk and raising the  
16 bar from what we have today.

17 And as Pierre pointed out, if we were  
18 to adopt this, we would basically use it to  
19 replace HBIPS-6.

20 Concerning the other two measures  
21 related to tobacco and alcohol, the primary  
22 reason for these is that both these conditions



1 are common comorbid issues. The rate of smoking  
2 in a psychiatric population is much higher than  
3 the general population. In fact, one study  
4 showed that approximately half of all deaths  
5 attributed to smoking are people with mental  
6 illnesses.

7 Alcohol also is of much higher  
8 prevalence in this population than others and it  
9 is usually recommended that even if somebody is  
10 being focused on for depression or schizophrenia,  
11 that their alcohol use also be assessed.

12 We already adopted an alcohol  
13 screening measure in the program. This is the  
14 follow-on measure that says if you have been  
15 identified as having an alcohol use disorder,  
16 were you offered and provided, if possible, a  
17 brief intervention within the hospital concerning  
18 that alcohol use?

19 MS. FOSTER: So I'm not sure that  
20 answered my question.

21 DR. BUCK: Okay.

22 MS. FOSTER: Because to me, and

1 thinking operationally, it is much easier for  
2 hospitals to take and adapt a measure that is  
3 already implemented, where they have already got  
4 their mechanisms set up for collecting the basic  
5 data, working with whatever vendors they want.  
6 If they need to tweak it, it is easier than  
7 throwing that one out and replacing it with a  
8 different measure. So why not tweak the existing  
9 measures to include some of the additional things  
10 that you want?

11 And secondly the elements that you  
12 were talking about for the discharge plan seemed  
13 to me to be so fundamentally necessary that, and  
14 I don't recall what the specifics are in the  
15 conditions of participation around it for  
16 psychiatric facilities.

17 But it would seem to me that that  
18 level of information ought to be specified as  
19 required for a good discharge plan and that that  
20 ought to be the level of expectation, rather than  
21 trying to measure it where there is sort of an  
22 implication that gee, an 80 percent performance

1 rate is okay.

2 You know, if they are essential, then  
3 80 percent is not okay. So how do we get to the  
4 right answer?

5 DR. BUCK: I have not -- I guess I  
6 understand the remark. I think we are, I guess,  
7 implicitly saying that the way to get the right  
8 answer is to start using the measure and to have  
9 people see how they perform on it.

10 We do think this is raising the bar  
11 from where it is now. And also, another thing we  
12 are trying to avoid here is we are trying to  
13 move, to just talk about very general directions  
14 for the program, away from, as much as possible,  
15 boutique measures that are only used for or  
16 solely specified for the inpatient psychiatric  
17 setting.

18 As much as possible, we want to adopt  
19 standards where they are applicable and I think  
20 this is what I understand the MAP's objective to  
21 be, too, with alignment to try to get measures  
22 that are -- that have value across multiple

1 programs.

2 And so by adopting a measure that we  
3 believe has good application to this setting and  
4 that is also available for use and at least is  
5 under consideration for uses in other inpatient  
6 settings, we think we are going in that  
7 direction.

8 CO-CHAIR WALTERS: We will take any  
9 other comments about the three measures in  
10 Calendar 1. Okay. Hearing none, let's move on  
11 to are there any motions about the measures in  
12 Calendar 1, either to move all of them or one of  
13 them or two of them or all three? No motions for  
14 any changes to Calendar 1.

15 Let's move now to Calendar 2. Are  
16 there comments about the conditional support for  
17 the measure in Calendar 2, dependent upon  
18 harmonization with the measures.

19 DR. BUCK: Yes, thank you. These are  
20 my comments on the transition, excuse me, timely  
21 transmission of the transition record measure.  
22 There is a couple of major reasons for adopting

1           this.

2                       As I already mentioned, this is a  
3           measure that is recommended for use by the MAP  
4           with Medicaid and then for duals. And I think  
5           very importantly from the issue of alignment,  
6           this measure has already been adopted as a core  
7           measure in Medicaid. We would like to be in  
8           alignment with Medicaid in its use of core  
9           measures.

10                      And in particular, I think, we think  
11           that this has the potential of reducing some of  
12           the reporting burden on hospitals that have to  
13           report most of their State Medicaid agencies and  
14           to the IPFQR Program.

15                      And the one thing I was going to  
16           mention is that this particular measure is  
17           endorsed by the Substance Abuse and Mental Health  
18           Services Administration as part of its national  
19           quality frame work.

20                      And I also -- and the key difference,  
21           I think somebody already mentioned, but I want to  
22           emphasize it again, the current HBIPS-7 that we

1 use doesn't have any time standard for  
2 transmission of a discharge record or a  
3 transition record. The usual kind of standard  
4 expected is roughly 30 days.

5 This one has a 24 hour transmission  
6 requirement. And we would not only think that's  
7 a good quality measure and one that would then  
8 align with other quality measure programs, but in  
9 addition, we are very concerned about issues of  
10 transition for this population. This population  
11 has a relatively high readmission rate.

12 It has -- even of those readmissions,  
13 the majority of them, roughly three-quarters, are  
14 for the same reason they were originally  
15 admitted, meaning they are coming back again  
16 within 30 days for a psychiatric reason.

17 The large majority of those are duals.  
18 As you might imagine, younger persons that have  
19 both Medicaid and Medicare coverage. And to have  
20 a standard that basically says that somebody --  
21 and a significant number of them are multiple  
22 readmissions within the 30 day period.

1                   So the idea that somebody could go  
2 out, be readmitted, maybe be readmitted more than  
3 once before the transition record even arrives at  
4 the follow-up provider's office, seems  
5 inconsistent to us. So it's for those reasons  
6 that we would like to adopt this measure.

7                   And why we think that developing a new  
8 harmonized measure or a measure that is different  
9 than that already in use in the Medicaid Program  
10 as recommended by the MAP would be problematic.

11                  CO-CHAIR WALTERS: Is there any other  
12 discussion about the measure in Calendar 2? Yes,  
13 Cristie?

14                  MS. TRAVIS: I guess just for  
15 clarification, it seemed to me when we were first  
16 going through this measure that the reason, the  
17 rationale for harmonization with HBIPS-7 was that  
18 it is already in -- well, one of the reasons was  
19 that it was already in the program and clearly it  
20 didn't seem to make sense to have two measures in  
21 the same program that measured the same thing,  
22 slightly differently.

1 I guess what I'm taking away from this  
2 is that it would be your preference at CMS to  
3 have this new -- this measure that we are  
4 considering today be the measure that is in the  
5 inpatient psychiatric hospital set and that you  
6 would remove the HBIPS-7 measure. And am I  
7 interpreting that that would be your preference  
8 or your thinking?

9 CO-CHAIR WALTERS: That's correct.

10 MS. TRAVIS: So it would seem to me  
11 that one thing we may want to think about as we  
12 move forward would be, one option could be, just  
13 moving this into the support category or keeping  
14 a condition on it that the HBIPS-7 be removed  
15 from the program or that we harmonize it.

16 I mean, I'm just trying to put --  
17 think about what our options are a little bit  
18 differently perhaps than we might have thought  
19 about them at the beginning.

20 MR. AMIN: Yes, Ron, if I may? I  
21 would submit that the preliminary analysis here,  
22 this recommendation actually needs to change.



1           So, Cristie, I would second what you were saying  
2           and I would say that we should change this before  
3           we move forward, because this doesn't -- it's not  
4           really that clear any more.

5                     Either the first two that you  
6           presented or others, I think should be considered  
7           by the Committee.

8                     CO-CHAIR WALTERS: So that is not to  
9           change the category conditional support. It's  
10          just that conditions --

11                    MR. AMIN: Right. As we specifically  
12          outlined what the condition would be here, Ron.  
13          And I don't even think that staff could defend  
14          that, at this point, so I would submit -- I would  
15          ask for a motion to change either the condition  
16          or change the category.

17                    DR. PHELAN: I'll second the motion to  
18          support change the category from conditional  
19          support to just support.

20                    CO-CHAIR WALTERS: We can -- so there  
21          is a motion now on the table to change Calendar 2  
22          in the measure, the one measure from conditional

1 support to support and ask for a second.

2 MS. TRAVIS: Second.

3 CO-CHAIR WALTERS: And any vote for  
4 that? Any discussion?

5 DR. MORRISON: I'm sorry, Ron, I can't  
6 hear you. Sorry, Sean.

7 CO-CHAIR WALTERS: So the motion to  
8 move it from conditional support to support has  
9 been seconded. Are there any other discussions  
10 about that motion? Nancy?

11 MS. FOSTER: So just to be clear, we  
12 are not considering it a condition that, in fact,  
13 this replace the HBIPS measure that is similar to  
14 it? In other words, we could set it up as a  
15 conditional support conditional on it replacing  
16 HBIPS-7, rather than simply supporting. Would  
17 that be an appropriate condition to offer up?

18 MR. ENGLER: Okay.

19 MS. FOSTER: I'll ask if it's a  
20 friendly amendment.

21 CO-CHAIR WALTERS: Would you like to  
22 rephrase that?

1 MR. ENGLER: Maybe there is an  
2 amendment. I'll revise my -- let's change it to  
3 conditional support on Nancy's recommendation.  
4 If that's all right?

5 MS. FOSTER: Yes, it is.

6 MS. TRAVIS: And I'll say second  
7 again.

8 CO-CHAIR WALTERS: Okay. That did not  
9 move it to Calendar 1 then.

10 MR. ENGLER: It left --

11 CO-CHAIR WALTERS: It left it.

12 MR. ENGLER: -- it changed the  
13 condition, but it left it.

14 CO-CHAIR WALTERS: Yes, yes. Okay.  
15 Any other comments? Public comment? Operator,  
16 are there any public comments?

17 OPERATOR: If you would like to make  
18 a public comment, please, press star one on your  
19 telephone keypad. We have a public comment from  
20 Pat Quigley.

21 MR. QUIGLEY: Thank you. May I  
22 proceed?

1 CO-CHAIR WALTERS: Please.

2 MR. QUIGLEY: Thank you so much. This  
3 is Pat Quigley and I did try to comment as well  
4 on the prior indicator related to transmission of  
5 the record, timely transmission of the record for  
6 psychiatry.

7 I'm Pat Quigley. I'm a nurse in the  
8 Department of Veterans Affairs and I do work on  
9 fall and fall injury prevention. And I am so --  
10 well, I was hoping to be able to ask a question  
11 to make sure, because I couldn't see the measure  
12 specifications.

13 Is this content included discussion in  
14 this transition record of fall risks and fall  
15 history in this case and population?

16 You know, the inpatient psychiatry  
17 population is so vulnerable and they have a  
18 higher repeat of fall rate. And they also have  
19 more serious injuries. And while this is so  
20 important, I was just so hoping that discussion  
21 of fall and fall injury rates or fall occurrence  
22 was part of this important discussion.

1                   Knowing that the outcome is to help  
2                   everyone be safe, but to also reduce readmissions  
3                   that could occur because someone falls after  
4                   discharge.

5                   So thank you so much for this  
6                   opportunity for this comment.

7                   CO-CHAIR WALTERS:   Okay.   Thank you  
8                   for that comment.   We will have to check to see  
9                   if that is in the specs.   Yes?

10                  MS. HART CHAMBERS:   Hi, I'm Jane Hart  
11                  Chambers with the Federation of American  
12                  Hospitals.   And I'm a little confused about the  
13                  discussion on the last measure, on the HBIPS-7.

14                  It's my understanding that reporting  
15                  HBIPS-7 is part of what is required for  
16                  accreditation.   So for a facility to be able to  
17                  stay in business, it has to report that measure.  
18                  And I don't understand why we would want a new  
19                  measure that is similar, that couldn't be  
20                  harmonized with it and keep HBIPS-7 in place, so  
21                  that you could actually keep your accreditation  
22                  and continue to treat patients.   Thank you.

1 CO-CHAIR WALTERS: Can you respond to  
2 that? I think the point is a good one that they  
3 don't want to lose their accreditation just  
4 because a new measure comes along.

5 DR. BUCK: Well, once again, I'm going  
6 to point out a couple of things. First of all,  
7 we think that the standard is a good one,  
8 independent about how it compares with other  
9 similar measures that may be around.

10 And second, I think our immediate  
11 objective is to align measures within the CMS  
12 quality reporting programs. This is a measure,  
13 this potential conflict that has just been  
14 mentioned is one that already exists in states  
15 that are starting to collect a solution within  
16 their Medicaid programs.

17 So it's not as if this is a  
18 hypothetical problem that exists. It's a problem  
19 that will increase -- if it is a problem to the  
20 extent it's a problem, it's a problem that  
21 already exists.

22 As we were saying before, we -- well,

1           let's put it this way. Certainly if you have met  
2           the requirements for this measure, you have also  
3           met the requirement for HBIPS-7, because every  
4           element of HBIPS-6 and 7 are incorporated in  
5           these measures.

6                       So it's not as if one somehow  
7           prohibits you or it can't be used in certain  
8           something or the other. That's all I would say.  
9           I realize they are not the same, but this measure  
10          is the one that has been promoted by both -- by  
11          the MAP. It has been promoted by NQF. It has  
12          been promoted by SAMHSA, not HBIPS-6 or not  
13          HBIPS-7 anyway.

14                      So that's why we are going that way.  
15          So it's not that it isn't a valid concern. I  
16          understand that for some of these there may be a  
17          concern, but we don't think that overcomes other  
18          criteria and other objectives from the program.

19                      CO-CHAIR WALTERS: Nancy?

20                      MS. FOSTER: So I'm confused, Jeff.  
21          We are the MAP, right?

22                      DR. BUCK: Yes.

1 MS. FOSTER: So we are deciding  
2 whether we are promoting this measure, not that  
3 we have promoted this measure.

4 DR. BUCK: Well, when I say that you  
5 are promoting it, I'm referring to documents and  
6 reports that you have already produced where you  
7 have the one about the family of measures for  
8 duals and for measures that you have recommended  
9 in the past for the Medicaid Program, that's what  
10 I'm referring to. I'm not necessarily referring  
11 to past meetings of this particular group but  
12 for--

13 MS. FOSTER: So the content?

14 DR. BUCK: No. We actually read that  
15 stuff. And so when we promote -- so when we  
16 propose some of these measures, we are going to  
17 mind that oh, this is something that MAP  
18 recommended be used for this purpose. So that's  
19 what I'm referring to.

20 MS. FOSTER: Okay. So Jayne has  
21 raised a very important point around  
22 harmonization for use of this measure between the



1 major accreditors and CMS, because to have  
2 discord between your accreditor and your major  
3 payer is really problematic.

4 It seems to me that we are actually  
5 trying to struggle with an issue that is an NQF  
6 endorsement issue, if I may be so bold as to say  
7 that, which is to say the NQF process ought to  
8 choose between whether HBIPS-1, 6, 7 or 15 is the  
9 right measure for each of these things and/or  
10 this or something else that I'm not even thinking  
11 of, so that these important concepts are being  
12 measured, if you will, or being required in the  
13 COPs.

14 But these important concepts are being  
15 measured, but they are being measured using the  
16 measure that the NQF has endorsed as being the  
17 best available national standard. And at this  
18 point, since they haven't gone head-to-head at  
19 the NQF, we don't know what that is and that's  
20 sort of my struggle here is to know how to vote.

21 CHAIR OPELKA: So this is easy.  
22 First, let's take the Consent Calendar 1, which

1 is -- we will come back to that, yes.

2 So I'm trying to reconcile where we  
3 are with this one and with what the Federation  
4 just called for. And I'm not so sure we can't.  
5 I mean, we can conditionally qualify our support.

6 So why can't our qualification be that  
7 it is inclusive of maintaining compliance with  
8 accreditation programs? You know, that there is  
9 harmonization replacement, substitution, whatever  
10 it is of this measure with 7 to resolve or  
11 maintain the accreditation program as our  
12 condition. And we are basically calling for the  
13 original request of harmonization.

14 MS. FOSTER: I think we are on the  
15 same page, Frank. I would agree with you that  
16 that is important. I'm only reluctant to  
17 substitute our judgment for what I see as an NQF  
18 endorsement question.

19 CHAIR OPELKA: Well, I don't think  
20 it's endorsement. I think it is accreditation.  
21 It's the accrediting body, except that this  
22 measure, then this would go away.

1 MS. FOSTER: Well, at least --

2 CHAIR OPELKA: So that's not an NQF  
3 problem. That's an accreditation body problem.

4 MS. FOSTER: And the Joint Commission  
5 at least speaking for that major accreditor uses  
6 NQF-endorsed measures whenever they are fairly  
7 committed to it.

8 CHAIR OPELKA: But my point is it's  
9 the harmonization question.

10 MS. FOSTER: Yes.

11 CHAIR OPELKA: It's not an NQF  
12 endorsement question. It's all parties in the  
13 room have to come together assessing what Jeff  
14 has put forward, assessing what currently stands  
15 and say what is the efficient way to measure  
16 this?

17 MS. FOSTER: I'll ride with you on  
18 that one. That's fine.

19 CHAIR OPELKA: I mean, but I think  
20 that's -- I think the likeness --

21 MS. FOSTER: We want the same outcome.

22 CHAIR OPELKA: We want the same

1 outcome. So can we substitute our current,  
2 certainly modified, conditional back to where it  
3 was? Cristie?

4 MS. TRAVIS: Just a question on that.  
5 I mean, it could be possible the Joint Commission  
6 would just say we are going to use whatever this  
7 new measure is. I mean, so when we say  
8 harmonization somehow it implies to me that we  
9 have got to bring too different measures  
10 together, you know, versus -- I mean, are we open  
11 to the fact that what if Joint Commission said  
12 yes, I'm fine using the new measure and they used  
13 it moving forward?

14 I just want to be sure we are not  
15 making more work than we need to, but that we  
16 leave it open enough to where people can do  
17 whatever.

18 CHAIR OPELKA: No. Harmonization does  
19 not mean the measure changes.

20 MS. TRAVIS: Okay.

21 CHAIR OPELKA: It could mean the  
22 measure has to change.

1 MS. TRAVIS: But it may not.

2 CHAIR OPELKA: It may not. I mean,  
3 there is a give and take. You have to put all  
4 parties in the room and everybody has to look at  
5 all of the current sea of measures and decide  
6 whether there is a good measure and throw the  
7 others out or whether there is a need to respect  
8 the measures and bring it forward again.

9 And that's the challenge of  
10 harmonization. Everyone has skin in the game.  
11 They all own their own measure and they have gone  
12 through some thinking of how they got there. And  
13 it's the ownership issue that really creates the  
14 challenge.

15 DR. BUCK: I do have a question if you  
16 are going that way. If you are intent is to  
17 create a measure then that will apply across all  
18 inpatient settings, that would be our concern.

19 So are you recommending then that this  
20 measure also be mod -- if it changes in any way  
21 in the course of harmonization, would your  
22 recognition -- recommendation encompass that then

1 would the new measure also be applied to and  
2 changed in the Medicaid core measure SUB?

3 Because if it wouldn't encompass that  
4 sort of recommendation, I think that's  
5 problematic for us.

6 CHAIR OPELKA: I think that's the  
7 harmonization process. We don't develop the  
8 measure, that's got to be the give and take of  
9 the negotiation of harmonization. That's the  
10 challenge of harmonization, that you have a set  
11 of standards you are trying to reach. The  
12 accrediting body has a set of standard they are  
13 trying to reach.

14 And what we are saying is, what the  
15 MAP is saying is we don't want to see two  
16 measures this close. We want you to come  
17 together and figure out how there is one measure.

18 DR. BUCK: Yes, but the issue is that  
19 this measure that is currently used on the Joint  
20 Commission only applies to psychiatric settings.  
21 We are trying to get to the use of a measure that  
22 applies across all standards, not just

1 psychiatric settings. See what I'm saying?

2 It doesn't move in a direction we  
3 think is desirable if we end up with a measure  
4 that is now different than it is in other measure  
5 programs and in other inpatient settings. That's  
6 -- I just want to raise that issue. So if --

7 CHAIR OPELKA: Thank you. So the  
8 measure still is in Calendar 2, which is  
9 conditional support. Nancy?

10 MS. FOSTER: I was just going to say,  
11 yes, Jeff, preference would be for if that's the  
12 right measure to be using, it be used across  
13 settings, whichever measure or whatever version  
14 of whatever measure comes out across applicable  
15 settings.

16 MR. HATLIE: If this is the stronger  
17 measure or the stronger version of the earlier  
18 measure, I think we should adopt the strongest  
19 position of support we can to send a signal to  
20 the rest of the field, including your accreditors  
21 that this is a superior measure.

22 I don't know how to work that out, but

1 I think that, you know, people look at what we  
2 are doing here. And so if others looked at  
3 intention that we put some support behind it. So  
4 I guess I think it's a motion to support, but I'm  
5 not sure.

6 DR. PHELAN: I would favor what Martin  
7 is saying. I'm hearing from CMS that they would  
8 favor this measure, barring any utilization  
9 across all areas. If this is the measure that  
10 they would favor, asking them to harmonize with a  
11 not so good measure with the best measure is kind  
12 of not doing our job as the MAP.

13 We should say this is a better  
14 measure. We support this measure and move  
15 forward. They can decide how they are going to  
16 utilize it going forward. You know, if they want  
17 to keep the older measure or move into the new  
18 realm, what we are saying clearly better measure  
19 is one that has got a timing element.

20 So asking them to go and harmonize  
21 with all the same elements except for the timing  
22 element or going with Martin's recommendation to



1 support and move forward, of the two options, I  
2 would support what Martin says. Take the better  
3 measure and move forward.

4 CHAIR OPELKA: Well, harmonization  
5 doesn't mean that that doesn't happen.  
6 Harmonization could mean that you choose the  
7 better measure. It's that there are measures  
8 that are so close they are competing and you've  
9 got to figure out which one you are going to go  
10 with.

11 If you decide you cannot go with one  
12 or the other and you respect the measure for  
13 whatever reason, then you are back to square one.  
14 You have got to take the measures through testing  
15 and endorsement and all of that.

16 So the preferred harmonization is to  
17 choose one measure over the other. And what we  
18 are calling for is to say that there is an  
19 accrediting body that these institutions are  
20 bound to in order to be paid and then there is a  
21 payment body which says we are going to reward  
22 quality if you do this.

1                   So there is competing business models  
2                   that need to be addressed and it's stuck on the  
3                   overlap between these two measures. So we are  
4                   not saying that you have to change this measure.  
5                   This may be the end result, that this is the  
6                   preferred measure. We are saying by virtue of  
7                   this motion, that you have got to put the bodies  
8                   in a room and come to conclusion about this  
9                   measure.

10                  MS. FOSTER: And, Michael, I think the  
11                  reason I commented to Frank it was an NQF problem  
12                  is we haven't actually done a head-to-head  
13                  comparison. We have had one expressed opinion  
14                  about whether this is a better measure than the  
15                  other.

16                  With due respect to that opinion,  
17                  there may be others who want to weigh in  
18                  differently. And until we have that opportunity  
19                  for a more robust conversation, I don't feel I  
20                  have the information I need to judge whether this  
21                  is, in fact, the better measure.

22                  CO-CHAIR WALTERS: So where we are is

1 we supported Calendar 1 and to this point, there  
2 is not a formal motion to move this measure into  
3 Calendar 1. It currently resides in Calendar 2,  
4 which is conditional support. Taroon?

5 MR. AMIN: I'm obviously not making a  
6 motion. I just want to address the procedural  
7 semantics, I think, that we are dealing with  
8 here. And would submit that the question here  
9 would be that will just keep it as conditional  
10 support and then I'll describe what the  
11 conditions that I have heard are putting in NQF  
12 language.

13 So it's a conditional support based on  
14 a selection of a best-in-class measure or a  
15 harmonized measure based on the Appropriate  
16 Standing Committee review. Between this measure  
17 and HBIPS-7, for the purposes of reporting and  
18 accreditation, this measure should also be  
19 harmonized for all acute care settings, if  
20 possible and appropriate.

21 That's what I have heard. Feel free  
22 to disagree with that. That's what I have heard.

1 MR. HATLIE: So that wouldn't require  
2 a motion to support that, right? That is already  
3 conditional support. It's on that calendar.

4 MR. AMIN: We reframed what our  
5 preliminary analysis is to reflect that, so it's  
6 a conditional support.

7 MS. HANRAHAN: This is for  
8 information, but I hope that we would support  
9 these measures ultimately. And I don't really  
10 know being in one category conditional support  
11 versus support if that will affect how this will  
12 roll out or be interpreted by other bodies. It  
13 does matter.

14 Well, then I would argue that, you  
15 know, this measure should be -- I would like to  
16 see us support them. Support the measures. The  
17 measures have been vetted. I have been in rooms  
18 where they have been vetted and they are really  
19 important measures.

20 Behavioral health is a very difficult  
21 field to develop measures and these measures  
22 finally came through. And if there is a

1 conditional support attached to it, it may create  
2 a barrier that is really not necessary given the  
3 kind of support that I have heard people say  
4 about the measure.

5 CO-CHAIR WALTERS: Is there a motion  
6 there? Did you say a motion? A motion by  
7 someone on Nancy's behalf?

8 MR. HATLIE: I'll move on Nancy's  
9 behalf to change this to a support  
10 recommendation, because of the strength of the  
11 measure and the importance of sending a signal  
12 that it is a strong measure in a needed area.

13 CO-CHAIR WALTERS: Okay. Is there any  
14 other discussion about that motion?

15 MR. AMIN: So the vote is to support?

16 CO-CHAIR WALTERS: Moving it to  
17 support.

18 MR. AMIN: Yes.

19 CO-CHAIR WALTERS: So is there a  
20 second?

21 DR. BANKOWITZ: Mindful of the  
22 importance of setting the signal that this is a

1 very important measure, I also think by  
2 establishing the condition as we framed it, that  
3 doesn't in any way diminish our support of this.  
4 It simply says we need the stakeholders in the  
5 room to help make that decision. The  
6 stakeholders being the accrediting bodies and the  
7 payers.

8 I don't think that diminishes the  
9 strength of our support in any way.

10 CO-CHAIR WALTERS: Okay. Let's move  
11 on to voting for the -- oh, sorry.

12 DR. FIELDS: So I have been on the  
13 endorsement side before. And my -- the process  
14 was we would endorse a measure and then let NQF  
15 go back and do the homework of harmonizing the  
16 measure separately. Why wouldn't we want that  
17 kind of strategy?

18 I understood, but we are still going  
19 to say that we recommend a measure and NQF still  
20 has to be responsible for endorsing or for  
21 harmonizing.

22 CHAIR OPELKA: Just so we are clear.

1 For support, no requirement of harmonization or  
2 we conditionally support with a requirement of  
3 harmonization. Those are two different --

4 DR. FIELDS: And we don't leave  
5 harmonization of measures up to NQF?

6 CHAIR OPELKA: Well, the MAP is giving  
7 guidance.

8 DR. FIELDS: Okay.

9 CHAIR OPELKA: We support without any  
10 condition.

11 DR. FIELDS: Yes.

12 CHAIR OPELKA: We support  
13 conditionally and there was an array of  
14 conditions.

15 DR. FIELDS: Right. And I understand  
16 that. It's just --

17 CHAIR OPELKA: That's it.

18 DR. FIELDS: -- leaving the --

19 CHAIR OPELKA: That's it. You just  
20 take it face value. It is what it is.

21 DR. FIELDS: Yes.

22 CHAIR OPELKA: Or do you want to put

1 on a requirement that it has to meet a set of  
2 conditions?

3 DR. FIELDS: Again, I think we are  
4 saying the same thing.

5 MR. HATLIE: Just a clarifying point.  
6 The array of conditions that we encapsulated here  
7 would go in the minutes to the body that we were  
8 making the recommendation to support to. So they  
9 would be apprised of this very rich conversation  
10 that we had this afternoon. All right?

11 CHAIR OPELKA: Sure.

12 MR. AMIN: But I mean it would be in  
13 the minutes, but it wouldn't -- I mean, I just --  
14 that's the distinction between the conditional  
15 support and the support. The conditional support  
16 carries all of those criteria as your conditions  
17 of support.

18 The support is, on its own, as you  
19 have described already, Marty, just, you know, it  
20 is the support without any of the conditions.

21 MR. HATLIE: But it's still depends.  
22 I mean, they are not required to follow our



1 conditions. So getting the thoughts to them one  
2 way or another to get the strongest signal is  
3 kind of where I'm going and supporting Nancy in  
4 that.

5 CO-CHAIR WALTERS: Okay. We have a  
6 motion on the table to move this measure from  
7 conditional support to support. We will  
8 entertain a vote now for that motion or not.

9 MS. IBRAGIMOVA: So to repeat for the  
10 record, timely transmission of transition record  
11 discharges from an inpatient facility to  
12 home/self-care or any other site of care.

13 Do you agree with the motion to move  
14 to support? 1, yes; 2, no.

15 (Voting)

16 MS. IBRAGIMOVA: The results are 67  
17 percent yes, 33 percent no.

18 CO-CHAIR WALTERS: Okay. We no longer  
19 have a Calendar 2.

20 So now, we will vote on Calendar 1,  
21 which has all four measures in it.

22 MS. IBRAGIMOVA: IPFQR Calendar 1,

1 support transition record with specified elements  
2 received by discharge patients, discharges from  
3 an inpatient facility to home/ self-care or any  
4 other site of care.

5 TOB-3, tobacco use of treatment  
6 provided or offered at discharge and TOB-3a,  
7 tobacco use of treatment at discharge.

8 SUB-2, alcohol use of brief  
9 intervention provided or offered. SUB-2a,  
10 alcohol use brief intervention received.

11 And timely transition of transition  
12 records, discharges from an inpatient facility to  
13 home/self-care or any other site of care.

14 Do you agree with the support  
15 calendar? 1, yes; 2, no.

16 (Voting)

17 MS. IBRAGIMOVA: The results are 83  
18 percent yes and 17 percent no.

19 CO-CHAIR WALTERS: Okay. Are we going  
20 to take a break? 10 minutes, 15 minutes. We  
21 have one more program to talk about. 10 minutes  
22 break. Reconvene about 3:10.

1 MR. AMIN: So for those of you on the  
2 phone, we will be back at 3:10. Thank you.

3 (Whereupon, the above-entitled matter  
4 went off the record at 2:59 p.m. and resumed at  
5 3:10 p.m.)

6 CHAIR OPELKA: All right. So in our  
7 last one for today, we are looking at the  
8 Medicare and Medicaid EHR incentive program for  
9 hospitals and critical access hospital's  
10 meaningful use. And so, we will go into the  
11 overview of the program first.

12 MS. BAL: Okay, so we're doing  
13 Medicare and Medicaid, the Electronic Health  
14 Record incentive program for hospitals and  
15 critical access hospitals. This is a pay for  
16 reporting program. Also, this is known as  
17 meaningful use as the short form, or MU.

18 And it provides incentives to eligible  
19 professionals, eligible hospitals, and critical  
20 access hospitals to adopt, implement, upgrade, or  
21 demonstrate meaningful use of certified EHR  
22 technology.

1                   And some of the goals are to promote  
2                   widespread adoption of certified EHR technology  
3                   and to incentivize meaningful use of EHRs by  
4                   improving quality, safety, efficiency, and  
5                   reduced health disparities, engaged patients and  
6                   family, improved care coordination, and  
7                   population public health, and maintain privacy  
8                   and security of patient health information.

9                   The critical program directives that  
10                  were determined to given preference should be  
11                  given to NQF endorsed quality measures, select  
12                  measures that represent the future of measurement  
13                  such as facilitating information exchange and  
14                  measures that monitor a change in patient's  
15                  condition over time, also to align the measure  
16                  set with other hospital performance measurement  
17                  programs, and to ensure eMeasures in the program  
18                  are reliable and provide comparable results to  
19                  paper-based measures.

20                  MS. O'ROURKE: So we have one consent  
21                  calendar for the meaningful use program. We have  
22                  four measures where the preliminary analysis was

1 to encourage continued development.

2 The first is the hospital-wide, all-  
3 cause, unplanned readmission hybrid eMeasure.  
4 Just a caveat, we wanted everyone to know that  
5 this is the eMeasure version. There is a claims  
6 version of this measure that is NQF endorsed.

7 That's 1789, the hospital-wide, all  
8 cause, unplanned readmission measure. But this  
9 is the eMeasure. It's still in alpha testing and  
10 has not been reviewed as an eMeasure for NQF  
11 endorsement.

12 We received one comment that was  
13 generally supportive noting the importance of NQF  
14 endorsement of this measure and appropriate risk  
15 adjustment.

16 The second measure under consideration  
17 is perinatal care cesarean section, PC 02,  
18 nulliparous woman with a term, singleton baby in  
19 vertex position delivered by cesarean section.

20 Again, there is an NQF endorsed claims  
21 and paper record version of this measure.  
22 However, we are being asked to consider the

1 implementation of this measure as an eMeasure.

2 The endorsed version, just to give you  
3 some background, is a disparity sensitive outcome  
4 measure. It's included in the MAP safety family  
5 of measures. And this eMeasure is also under  
6 review for the IQR program.

7 We received a number of public  
8 comments. One commenter noted three areas of  
9 concern. First, the measure included women who  
10 have contraindications for vaginal birth. Second  
11 is the measure assumes that all nulliparous women  
12 with a term, single fetus in the vertex position,  
13 NTSV, have the same risk for a cesarean birth  
14 after adjusting for age.

15 And third, there's a major flaw found  
16 in the direct standardization technique being  
17 used to create risk adjustment for age.

18 The third measure is adverse drug  
19 events, inappropriate renal dosing of  
20 anticoagulants. This adverse drug event measure,  
21 which is also under consideration for IQR,  
22 focuses on an important safety issue. However,

1           it's not fully specified as an eMeasure and has  
2           not been reviewed as an eMeasure for endorsement.  
3           We received one public comment in support of this  
4           measure.

5                       Finally, a measure addressing timely  
6           evaluation of high-risk individuals in the  
7           emergency department. This efficiency measure  
8           affects a high-impact population and captures  
9           important clinical data.

10                      It's also under review for IQR.  
11           However, still the same caveat that this is still  
12           under development as an eMeasure. We did not  
13           receive any public comments on this measure.

14                      CHAIR OPELKA: So we have before us  
15           this calendar which is under our encouragement  
16           for continued development as opposed to do not  
17           encourage further development. Are there any  
18           requests to move any of the items off the  
19           calendar? What do you -

20                      DR. EISENBERG: Frank, could I ask a  
21           clarifying question first of Erin? You mentioned  
22           that one of the comments had to do with a major

1 error in the calculation. Is that so? Could you  
2 explain what that is?

3 MR. AMIN: Yes, so, do you want me to  
4 go in on that, Erin?

5 MS. O'ROURKE: Sure.

6 MR. AMIN: So the comment wasn't  
7 actually being very specific besides the fact  
8 that the direct standardization technique for the  
9 risk adjustment was flawed.

10 But beyond that, it wasn't clear  
11 exactly what the flaw was that the commenter  
12 identified. So I just wanted to be clear there  
13 wasn't an NQF staff evaluation.

14 CHAIR OPELKA: Okay.

15 MS. FOSTER: I would like to propose  
16 that we put the readmissions measure on the list  
17 of things that we would not support continued  
18 development of. I forgot what the list is  
19 called.

20 CHAIR OPELKA: Do not encourage  
21 continued development.

22 MS. FOSTER: Do not encourage further



1 development of it.

2 CHAIR OPELKA: It does not do anything  
3 to the readmission measure. It removes an  
4 eMeasure.

5 MS. FOSTER: Right, I'm -

6 CHAIR OPELKA: So you're saying -

7 MS. FOSTER: I'm saying for this  
8 eMeasure that is under - that's on this MUC list,  
9 I would like to move it into the list where we do  
10 not encourage further development.

11 CHAIR OPELKA: Okay.

12 MS. FOSTER: And on the - just a  
13 question for Erin. You indicated there was one  
14 comment on the ADE, on the adverse drug event,  
15 but it says here there were two, so I'm just a  
16 little confused.

17 MS. O'ROURKE: Apologies, that might  
18 have been an error. I can pull up the comment  
19 sheet and verify that for you.

20 MS. FOSTER: Thank you.

21 MS. O'ROURKE: If the spreadsheet has  
22 two, the spreadsheet is the authoritative source.

1 CHAIR OPELKA: Jack?

2 DR. FOWLER: Erin, or Taroon, or  
3 whoever, just an update. I know there's been  
4 quite a controversy about the readmission issue  
5 and what to do about adjusting for different  
6 populations in one way or another.

7 This one seems to propose to do some  
8 kind of a model adjustment that somebody has done  
9 that adjusts everybody. Could you update me or  
10 tell me what it is that's being proposed here?

11 CHAIR OPELKA: So Erin and Taroon, you  
12 may have to correct me. It's my understanding  
13 that the measure is - there's no change to the  
14 measure other than it's being e-specified. So  
15 the former measure as it stood, remains, but it's  
16 being e-spec'd. It's being specified as an  
17 electronic measure. That's all that this is.

18 DR. FOWLER: The center says it's  
19 going to be risk adjusted. Is it real, or am I  
20 misreading it?

21 DR. YONG: Can I just clarify? And  
22 Yale, who has helped us with our measure

1 development can also clarify. So this is what we  
2 call a hybrid eMeasure. So it's - it would -  
3 it's a mixture of a claims-based measure using  
4 what we call core clinical data elements or  
5 CCDEs, which are extracted from EHRs, to help  
6 with the risk adjustment.

7 So we'd incorporate clinical data into  
8 the risk adjustment methodology, but we would  
9 still use, at the core of the measure, claims  
10 data in order to identify admissions and  
11 readmissions. Suzanne, I don't know if you have  
12 anything to add on that?

13 DR. FOWLER: So just - a lot of the  
14 controversy has been issues over and above  
15 clinical characteristics such as socioeconomic  
16 characteristics that make the environment in  
17 which people are discharged or trying to cope  
18 more complicated, and that that has been the  
19 particular challenge of whether or not people can  
20 get it right. It looks like you're going to say  
21 something.

22 DR. YONG: Yes, so certainly this has

1           been a hot topic of discussion at NQF as well as  
2           in other environments. So certainly we are  
3           interested in and actively want to participate  
4           with NQF on sort of the pilot regarding SCS and  
5           risk adjustment.

6                       Folks may also be aware that recently  
7           passed the IMPACT Act that mostly deals with  
8           post-acute care, but portions of that also  
9           require ASPE, which is the Office of the  
10          Assistant Secretary for Planning and Evaluation  
11          at HHS, who conducts some studies looking at the  
12          impact of risk adjustment for SVS in outcome  
13          measures.

14                      NCMS is working with ASPE on this work  
15          and will take, and we are required by law to  
16          consider their final analysis and recommendations  
17          and how it applies to our outcomes measures.

18                      CHAIR OPELKA: Missy?

19                      MS. DANFORTH: Can I just ask why it's  
20          only the NTSV measure that's being considered for  
21          an eMeasure and why they may not, considering  
22          this is for critical access hospitals, that early

1 elective delivery wouldn't be considered for  
2 eMeasure as well?

3 DR. YONG: I'm sorry, can you say that  
4 one more time?

5 MS. DANFORTH: Sure. So the only  
6 maternity care measure is the NTSV C-section  
7 measure being developed into an eMeasure. So I'm  
8 asking why the early elective delivery measure  
9 also isn't being looked at as an eMeasure for  
10 this program since it's already being used in the  
11 IQR?

12 CHAIR OPELKA: This is a gap question.  
13 It is not a measure question. These measures,  
14 you're not asking a question. You're asking  
15 about a gap. You're - okay.

16 DR. YONG: So, I'll have to check.  
17 Betsy, are you on the line?

18 MS. RICKSICKER: Yes, Pierre, I'm on  
19 the line.

20 DR. YONG: Did you hear that question  
21 from Missy?

22 MS. RICKSICKER: No, I'm sorry. Could

1 the person please repeat the question?

2 MS. DANFORTH: I'm just wondering why  
3 the early elective delivery measure wasn't being  
4 considered for eMeasure development along with  
5 the NTSV C-section measure?

6 MS. RICKSICKER: I don't believe that  
7 we had that slated for the previous contract  
8 which just ended over the summer. I believe that  
9 all of the measures that we had slated for  
10 development under that contract, all of the  
11 measure slots that were available for development  
12 were utilized.

13 But that's certainly a measure  
14 development area that we could look into under  
15 our new contract for the future as far as concept  
16 areas.

17 DR. YONG: Yes -- go ahead.

18 MS. DANFORTH: And just a follow-up  
19 question. The adverse drug event lists CMS as  
20 the measure steward. Is that a measure that came  
21 out of the work that the hospital engagement  
22 networks are doing? I know they have developed

1           some adverse drug event measures.

2                   MS. RICKSICKER: So that measure was  
3 developed out of the medication measures special  
4 innovation project where FMQAI was our  
5 contractor. And we have FMQAI here in the room,  
6 and the lead for that, Dr. Kyle Campbell, could  
7 speak to that measure.

8                   If you have specific questions about  
9 that measure, we have the measure developers on  
10 the phone to answer.

11                  MS. DANFORTH: No, I didn't have  
12 questions about the measure, just the origins. I  
13 thank you.

14                  MS. RICKSICKER: You're welcome.

15                  DR. YONG: Sorry, one, if I may.  
16 Going back to Missy's first question about the  
17 elective delivery, certainly we welcome input  
18 about priorities and gaps for future development  
19 areas for eCQMs.

20                  CHAIR OPELKA: David?

21                  DR. ENGLER: Thanks. So, I've been  
22 very quiet up until now, and I think you'll

1           probably know where I'm coming from on this one.  
2           It's the same issue that we raised last year when  
3           this was not an eMeasure, but it was a paper and  
4           pencil measure, I suppose, and it has to do with  
5           the impact that sociodemographic factors have on  
6           readmissions.

7                       And what we would strongly encourage  
8           is, first of all, to get that right before we put  
9           it into an eMeasure. And we're very thankful and  
10          want to compliment CMS's moves on the IMPACT  
11          stuff. We also want to compliment NQF for moving  
12          forward with the notion of a robust pilot project  
13          regarding the look at readmissions and the impact  
14          that sociodemographic factors have.

15                      So those are my two comments. And my  
16          question relating to the comments were - would  
17          be, what would be the problem of waiting on an  
18          eMeasure, okay, until such time that the  
19          admission measures are looked at for the impact  
20          on sociodemographic factors? In other words,  
21          getting it right on that side before we put it  
22          into an e-metric.



1                   There is clear, convincing, and  
2                   compelling evidence that sociodemographic factors  
3                   do impact readmission rates. The analysts just  
4                   came up last week with a major study showing the  
5                   impact of that.

6                   I also am very aware that the ROCs on  
7                   readmission rates has hovered around 60 percent,  
8                   and we still don't have that accurately. And the  
9                   penalties that that has on hospitals that serve  
10                  vulnerable populations are large, and we've  
11                  testified about that in this committee and others  
12                  as well.

13                  So we would support moving forward  
14                  with an eMeasure if under the circumstances it  
15                  was first tested, okay, and approved, and look  
16                  through the pilot project with sociodemographic  
17                  factors associated with it. So that's my  
18                  presentation. And I'm sorry the CMS folks left  
19                  on the psychiatric data.

20                  I would really welcome - and I know  
21                  we're going to be talking hopefully, Frank,  
22                  tomorrow about the gap, but if there's anything

1 we can do for next year's MAP when we discover  
2 that we can come back and look at behavioral  
3 health integration in primary care and physical  
4 medicine, that would be really very appropriate.  
5 I'd like to have that happen next year as well.  
6 So those are my comments relative to this  
7 measure.

8 CHAIR OPELKA: So the last part of  
9 your comment was to our previous discussion, and  
10 it's part - it's something that we need to  
11 capture in our gap section.

12 DR. ENGLER: Yes, I would hope it'd be  
13 captured tomorrow in the gap discussion.

14 CHAIR OPELKA: Okay, all right. So I  
15 need to - a formality. Nancy had moved that the  
16 hospital unplanned readmission hybrid measure  
17 move to do not support, and I need a second.

18 DR. ENGLER: I'll second that.

19 CHAIR OPELKA: All right, thank you.  
20 Any other comments. Nancy?

21 MS. FOSTER: David, could you turn  
22 yours off? Thank you. So I have a couple of

1 questions about this measure and then a couple of  
2 comments. One is Pierre, could you help me  
3 understand how this measure will, in fact, cover  
4 all readmissions?

5 Because the claims-based measure, in  
6 fact, looks at all readmissions whether they're  
7 to your hospital or to another hospital. And in  
8 that respect, it is a more robust measure than  
9 simply looking at readmissions to your own  
10 hospital.

11 So does this capture that? And if so,  
12 how do you get the health - the electronic health  
13 record pieces of that into this measure? My key  
14 concern is, is this actually going to be  
15 capturing the readmissions that we all know as  
16 readmissions now?

17 DR. YONG: This is Susannah Bernheim.  
18 She is on contract with us. She works for Yale  
19 CORE, and I'm going to - she's going to address  
20 that question.

21 DR. BERNHEIM: Hi, Nancy. Yeah, so as  
22 Pierre said, and just to explain for the group,

1           this is a hybrid measure so the claims are still  
2           used to identify the cases.

3                   The EHR data is brought in to enhance  
4           the risk adjustment because people have been  
5           really interested in having clinical factors as  
6           part of risk adjustment.

7                   We keep some of the claims risk  
8           adjustment as well because there are certain  
9           things that you can't yet capture well in the  
10          EHR.

11                   So the hybrid piece is claims plus EHR  
12          data for risk adjustment. But the outcome, the  
13          30-day unplanned readmissions are still coming  
14          from the claims data.

15                   So it's really an enhancement or --  
16          there is a word for this. It's not  
17          respecification, re- anyway, it's a new version.

18                   CHAIR OPELKA: Retooling.

19                   DR. BERNHEIM: Retooling - no, we  
20          don't like that word - of the previous measure to  
21          bring in additional risk adjustment variables to  
22          enhance the measure.

1 MS. FOSTER: So in that regard,  
2 Susannah, I know several of the comments around  
3 the other measures, particularly the condition  
4 specific measures, had - made by clinicians, had  
5 really pointed out that there were problems with  
6 the readmissions measures because they failed to  
7 take into account information that was  
8 unavailable from the claims, but that really  
9 spoke to the propensity for readmission or  
10 mortality, such as the severity of the heart  
11 attack, the severity of - and so forth.

12 Is that - are you really, as Frank  
13 described it, simply retooling the old measure,  
14 or e-specifying the old measure, or are you  
15 impacting it to include some of those critically  
16 important clinical aspects?

17 DR. BERNHEIM: Right, it's the latter.  
18 It maintains many of the same characteristics of  
19 the previous measure, but it now brings in  
20 additional risk adjustment variables that we've  
21 found you can feasibly extract from almost any  
22 EHR, but that give you more clinical information

1 about how the patient looked when they arrived at  
2 the hospital.

3 MS. FOSTER: Thank you. So in that  
4 regard then, I would join in saying the condition  
5 in which - I would actually suggest we might want  
6 to move this into conditional support with the -

7 CHAIR OPELKA: No, this isn't  
8 conditional support. This is, "I don't want you  
9 to do what you're doing anymore," or, "I want to  
10 encourage you to do what you're doing now."

11 This is they're doing work to improve  
12 this measure, and you're voting to say, "Continue  
13 doing your work," or, "Stop. Cease." It's not  
14 support for a program. It's support this -

15 DR. BERNHEIM: You are correct.

16 CHAIR OPELKA: - iterative work you're  
17 doing now. So let's be clear about that. You're  
18 all asking very good and detailed questions, but  
19 the motion on the floor is, "Stop."

20 MS. FOSTER: Can it be stop and tell  
21 as David had expressed?

22 CHAIR OPELKA: Well, it's - we don't

1 have a conditional stop. It's stop or keep  
2 going. And keep going means you're going to be  
3 taking in all these other factors that are out  
4 there, but - and you could advise them about  
5 factors that are important to you, and I think  
6 you're doing that.

7 We're not supporting this. We're  
8 encouraging the continued work they're doing or  
9 telling them, "We don't think this is work you  
10 should be continuing to do." Pierre?

11 DR. YONG: Thank you. I just wanted  
12 to ask one clarification question which I think  
13 is related to what you were just saying.

14 So is the right interpretation if it's  
15 on the support continued development sort of -  
16 what do you call it - calendar, we would take  
17 that input, but that we'd continued development  
18 understanding there may be issues around SCS or  
19 other issues that we would need to take into  
20 factor.

21 And once it's completed development,  
22 we would bring it back to the MAP for discussion

1           about whether it belongs on support, conditional  
2           support, do not support.

3                   CHAIR OPELKA: That's exactly right.  
4           This is a - you're doing this groundwork for the  
5           next MAP not -- you're out of this cycle. And  
6           you're asking the question of the MAP, "Is this  
7           the right direction?" to continue your efforts.

8                   So we're encouraging you or not  
9           encouraging you, and the motion on the floor  
10          right now is we do not encourage you. Richard?

11                   DR. BANKOWITZ: Well, this discussion  
12          here is proving very helpful because I'm  
13          struggling with how to send the proper message  
14          here as well. Because it is, I think, important  
15          to get better clinical data into these measures,  
16          and I think we need to encourage developers to do  
17          that.

18                   And at the same time, we need to  
19          encourage them to look at the results of the very  
20          important data that's coming in on socioeconomic  
21          and demographic factors, and we can't ignore  
22          them. There's nothing in this measure that



1 addresses it.

2 So I just want to make sure we can  
3 send that message as well as our support of  
4 looking at the clinical measures that are buried  
5 in the electronic medical record.

6 CHAIR OPELKA: Dan?

7 DR. POLLOCK: I was wondering if the  
8 developer could provide some additional  
9 information about the clinical factors that are  
10 being brought into the model, how they were  
11 selected, both from a clinical perspective as  
12 well as a statistical methodologic perspective?

13 DR. BERNHEIM: I'll try to do all of  
14 that briefly. Yes, so we had a year-long project  
15 prior to starting to work on this measure in  
16 which we were aiming to identify clinical factors  
17 using a TEP and some testing that were present at  
18 the time of admission across a wide range of  
19 adult hospitalized patients and could be feasibly  
20 extracted from most EHRs, because we wanted to  
21 start where hospitals could actually begin  
22 without asking for things that nobody was able to

1 extract.

2 So the clinical factors are primarily  
3 initial vital signs and laboratory values. And  
4 then we did - I can share with you the longer  
5 version, but we did a number of things to bring  
6 them into the hospital-wide measure, testing a  
7 number of different models, and selected those  
8 that, you know, most enhanced the model.

9 I don't know how much detail you want.  
10 I can provide more.

11 DR. POLLOCK: So the initial vital  
12 signs and lab values are a surrogate or indicator  
13 of severity of illness, or why were those focused  
14 on?

15 DR. BERNHEIM: Both, because they were  
16 felt to be very clinically important. I mean, as  
17 people have seen, there's lots of parsimonious  
18 models out there that tell you a lot about a  
19 patient's status when they arrive using initial  
20 vital signs and lab values, and then they were  
21 tested for this particular measure.

22 DR. POLLOCK: So these are initial

1 vital signs on the readmission or the first  
2 admission?

3 DR. BERNHEIM: No, admission, like the  
4 crucial piece of the risk adjustment is to  
5 understand when this hospital accepts a patient  
6 when they initially bring a patient in, how sick  
7 that patient was.

8 DR. POLLOCK: Okay, so the vital signs  
9 and lab values are intended to serve as an  
10 indicator of the patient's severity at the time  
11 of admission to the index hospitalization.

12 DR. BERNHEIM: Exactly, like the other  
13 risk adjustment programs.

14 DR. POLLOCK: Any thought about using  
15 lab values or -

16 CHAIR OPELKA: Dan, I'm going to say  
17 we can't go into measure development. It's out  
18 of scope for us.

19 DR. POLLOCK: Okay.

20 CHAIR OPELKA: So focus on, "How is  
21 this going to apply to a program?"

22 DR. POLLOCK: Right, I was just trying

1 to elucidate a little bit more information that I  
2 think is relevant to whether we want to encourage  
3 going forward.

4 CHAIR OPELKA: But I don't want us to  
5 get lost in the measure development. We'll be  
6 here for a day and a half.

7 DR. POLLOCK: Right, but just  
8 understanding where the clinical data are coming  
9 from and where - what type of rationale is being  
10 applied I think is relevant to whether to  
11 encourage going forward. I'm getting a sense of  
12 that, and -

13 CHAIR OPELKA: It's a little far  
14 afield. I'm just putting a warning out there.  
15 We cannot get into development and you're getting  
16 into that. Emma?

17 MS. KOPLEFF: I have three short  
18 issues I want to address. One is the timeline  
19 question David brought up. The second is just  
20 clarifying the statement Pierre made about what  
21 we would be voting for in continuing development  
22 as our categorization. And third, offer an

1 alternative support continued development motion.

2 So on the first, just with the time  
3 line, and this is related to what Pierre said  
4 about bringing this measure back, I do think the  
5 cesarean measure has been a priority gap for  
6 improving quality care for women and babies for a  
7 long time.

8 And the fact that this Medicare  
9 program has all claims payer data to allow us to  
10 do that and set sort of a standard or provide  
11 some leadership in addressing this quality issue  
12 is a valuable opportunity.

13 And I mean, ACOG has recognized that  
14 the cesarean rates are off the wall in this  
15 country. And when we think about bringing this  
16 measure back to MAP, which I'm not disagreeing  
17 with, but also that we're right now just in the  
18 development phase.

19 So all of these issues about what  
20 clinical factors, or sociodemographic factors, or  
21 other factors are included, that's all part of  
22 the development. And at some point, this will

1           also need to be brought back for NQF endorsement.

2                       So where I'm going with this is a,  
3           making a statement that I think we're a long way  
4           from there, and I commend CMS for heading in the  
5           right direction.

6                       And in order to move forward, I  
7           strongly think that we need to at least support  
8           continued development and have faith that this  
9           measure will be brought back to NQF. And I say  
10          that differentiating from bringing it back to MAP  
11          because either way, per the conversations we've  
12          been having, we're seeing that this group is very  
13          supportive and we can agree on the value of the  
14          NQF endorsement process.

15                      And I don't want the pace at which  
16          this measure could potentially be used one day,  
17          if it is scientifically valid and vetted  
18          thoroughly, to be slowed down by the timing of  
19          when MAP is or when an endorsement committee is.

20                      So, the motion I'm making is encourage  
21          continued development with the definition of that  
22          reflecting this measure coming back for a

1 thorough scientific review by NQF, whether that's  
2 the endorsement committee, MAP, or both, and I  
3 hope we can do that swiftly. Thank you.

4 CHAIR OPELKA: We cannot accept your  
5 motion. There's a motion on the floor. But you  
6 can make that motion subsequent --

7 MS. KOPLEFF: Okay, thank you.

8 CHAIR OPELKA: -- to any other motion.  
9 But I think you made your point. Wei?

10 DR. YING: I would encourage the  
11 continued development of the readmission measure  
12 for a couple of reasons. One is I think it was  
13 stated as part of the preliminary analysis for  
14 all the other condition specific measures, they  
15 only cover a small portion of the total hospital  
16 discharge each year. In order to get an overview  
17 of a systematic outcome of a facility, we really  
18 want something at the all-cause readmission  
19 level. That's one comment.

20 The second thing is I think the  
21 developer is trying to consider the comment  
22 received from various sources in terms of the

1 risk adjustment methodology. Including available  
2 clinical indicators into risk adjustment factors  
3 is definitely one step in the right direction.

4 And maybe from this process they will  
5 learn how to get the information on SES later on  
6 as they further development down the road. If we  
7 stop them on the track right now, I highly doubt  
8 that SES will later even come into the picture.

9 MS. KOPLEFF: Correct, in case people  
10 got lost, I referenced ACOG. I had my caesarean  
11 measures and my readmission measures talking  
12 points mixed, but I was referring to the  
13 readmissions measure. So, for those who got lost  
14 in those comments, it still fits the mold of a  
15 high priority area.

16 MS. FOSTER: So Frank, I thank you all  
17 for the clarification about what this category  
18 means. And I was under the apparent  
19 misperception that we needed to ask for a stop  
20 essentially in order to address some of these  
21 vital issues. What I really wanted was a pause  
22 button.



1                   And I think what I've heard you say is  
2                   that if that's what we want to drive home the  
3                   point that we really should not be bringing these  
4                   measures -- the readmission measure forward for  
5                   endorsement for further inclusion until we've  
6                   solved the issue around SES.

7                   That's the point I want to make. And  
8                   if that's where it is, then I will gladly  
9                   withdraw my motion and make sure that that point  
10                  just gets recorded.

11                  CHAIR OPELKA: So if that's the case,  
12                  then this would stand with all these points as  
13                  we're encouraging it to go forward, but with all  
14                  of these SES points and everything else, the  
15                  clinical adjustments, everything everyone has  
16                  said, and bringing it back through the NQF  
17                  process, and the MAP.

18                  Well, I was inclusive of everything at  
19                  NQF. So - if that's okay, all right? Well, then  
20                  we have this calendar before us as it's proposed  
21                  for continuing for - encouragement for continued  
22                  development. Before we vote on it, can we go to

1 public comment? Kathy?

2 OPERATOR: If you would like to  
3 comment, please press star then the number one.

4 CHAIR OPELKA: Any in the room?

5 OPERATOR: And there are no comments  
6 from the phone lines at this time. I apologize,  
7 you do have a comment from Don Casey.

8 MR. CASEY: Hi, can you hear me?

9 CHAIR OPELKA: Hi, Don.

10 MR. CASEY: Hi, Frank. I've been  
11 listening in all day. The public comment I think  
12 covers quite a bit of ground which you've  
13 covered. I think this is the first time since  
14 the morning. Am I right?

15 CHAIR OPELKA: No, we've actually had  
16 public comment before every vote.

17 MR. CASEY: I didn't hear it in the  
18 second go around. I don't think you asked for  
19 it. Maybe I'm wrong, but I don't think you did.  
20 Did I miss it?

21 CHAIR OPELKA: You missed it. It's  
22 been prior to every vote.

1 MR. CASEY: Okay, I apologize. Well,  
2 relative to this then, the discussion of the  
3 eMeasure for readmissions, I would simply get in  
4 that this continues to be solely focused on using  
5 the hospital-related data. And it seems to me as  
6 though we're at a point where we ought to be  
7 considering in our measure development the  
8 possibility of putting in more data regarding  
9 antecedent and intercurrent care between and  
10 amongst the admissions and the  
11 rehospitalizations. So that's my comment.

12 CHAIR OPELKA: Thank you. Any in the  
13 room? Okay, so you have before you for voting  
14 this encouraged continued development consent  
15 calendar.

16 MS. IBRAGIMOVA: The meaningful use  
17 consent calendar one encouraged for continued  
18 development hospital-wide all-cause unplanned  
19 readmission hybrid eMeasure, perinatal care C-  
20 section, PC 02, nulliparous women with a term,  
21 singleton baby in vertex position delivered by  
22 cesarean section; adverse drug events,

1 inappropriate renal dosing of anticoagulants; and  
2 timely evaluation of high-risk individuals in the  
3 emergency department.

4 Do you agree with the encouraged for  
5 continued development calendar? One, yes, two,  
6 no. The results are 100 percent yes, zero  
7 percent no.

8 CHAIR OPELKA: My first one. I'm  
9 catching up. Okay, so we are actually just about  
10 on time for day one. Very quickly, I think we've  
11 learned a lot today about trying to walk through  
12 a different process within the MAP, and it's been  
13 an education.

14 And I think, at least my sense is,  
15 you're getting more familiar with how to walk  
16 through it, and how to make it work in the right  
17 way to get the outcome you wish.

18 I'm not so sure we started off that  
19 way, but I think you're getting into the swing of  
20 it. So I think that helps a lot.

21 We've gone through OQR which we  
22 thought was going to be a walk in the park and

1           that's where we cut our teeth, then the ACS which  
2           was actually pretty smooth.

3                   The Medicare Shared Savings Program,  
4           we ended up moving a lot of that over into the  
5           physician area, the clinician work groups, so  
6           they will have that a week from today. And so,  
7           if any of you have comments relative to that, you  
8           may want to follow-up in that work group.

9                   And then the HAC reduction program,  
10          psychiatry, and this last one in meaningful use.  
11          And in each one, there were many major features  
12          that I think were very important to our comment.

13                   I'm a little worried that we've only  
14          captured spotty pieces here and there of gaps.  
15          And so, I'm just wondering if we shouldn't  
16          quickly walk through these programs that we've  
17          put up here and ask if there's any outstanding  
18          issue in gaps that we left off the table that we  
19          want to try and make sure we capture.

20                   And if we're too harried at the end of  
21          the day, it's something we can also start with  
22          tomorrow to make sure while you're sleeping on it

1 we're not missing any gaps.

2 So if we could, I'm just going to ask  
3 you to look at all of the programs. There's OQR,  
4 there's ambulatory surgery, Medicare chaired  
5 savings, HAC, inpatient psychiatry, and  
6 meaningful use. And there have been many gaps  
7 mentioned, but we didn't formally go through it.

8 And I'll ask you now, is there  
9 something that you had on the back of your mind  
10 in any one of these programs we want to capture  
11 and at least put on our list? Nancy?

12 MS. FOSTER: I think we ought to be  
13 thinking, as my friend Nancy has said, we ought  
14 to be thinking about the appropriateness of  
15 mental health measures in virtually all of these  
16 programs.

17 I'm not sure the same mental health  
18 measures work across all of the programs, but  
19 let's be thinking about that and the need to  
20 integrate mental health care in with physical  
21 care as David said earlier.

22 Secondly, I think that as we think

1           about disparities in care, we really haven't  
2           teased out anything here in terms of how would we  
3           effectively measure that, and that is an area  
4           where I think we have an enormous gap.

5                     And third, just getting to the e-  
6           specified measures, it seems to me there's  
7           enormous potential there for us to do something  
8           even more broad-based than just the one adverse  
9           drug event measure that was brought forward here.

10                    We know that adverse drug events,  
11           falls, and other harms to patients are critically  
12           important, and we do not yet have good ways to  
13           capture all of that. And I would push us to  
14           think beyond that one ADE measure.

15                    CHAIR OPELKA: Thank you. Michael?

16                    DR. PHELAN: I'm sorry, me or David?

17                    CHAIR OPELKA: I didn't know David was  
18           up, so --

19                    DR. PHELAN: Just to support Nancy's  
20           recommendations for maybe getting a little bit of  
21           focus on psychiatric care, in emergency medicine  
22           particularly, patients spend an inordinate amount

1 of time.

2 And if you have followed any of the  
3 things that are going on on the West Coast, you  
4 know, the Supreme Court of Washington had, you  
5 know, made holding patients in the ED, you know,  
6 unconstitutional. And how far that will go, I  
7 don't know.

8 But for any of us that work in this  
9 space understand that there's the lack of  
10 resources, lack of bed availability, and no  
11 magnifying glass looking at some of the issues  
12 that are happening to this group of patients.

13 And it covers a broad spectrum of some  
14 of the issues that occur in both the IQR and the  
15 OQR, getting adequate outpatient resources for  
16 the mentally ill and inpatient resources when  
17 someone comes into your hospital and they spend  
18 two days in your ED waiting for an available bed.

19 I think shining that type of light is  
20 - would be something that I would recommend as  
21 part of the gap work that we do on this  
22 committee.



1 CHAIR OPELKA: I share the same  
2 sentiments. I think the first order of quality  
3 of care is access to care, and that population  
4 suffers from the lowest form of access.  
5 Therefore, the first order of quality is missing.  
6 David?

7 DR. ENGLER: I would agree, thank you.  
8 Adverse drug events, behavioral health  
9 integration in particular, and I'm really looking  
10 forward to the opportunity to look at antibiotic  
11 stewardship and its impact on infections in our  
12 hospitals.

13 CAUTI continues to be a major problem  
14 nationwide, and anything that we can do to refine  
15 the metrics of those. C. diff is a real huge  
16 problem, a growing problem, a high mortality  
17 problem, and I'm encouraged by the work that's  
18 going to be conducted on antibiotic stewardship.

19 CHAIR OPELKA: Thank you.

20 DR. ENGLER: And I really do hope that  
21 our friends from our developers and our CMS folks  
22 have a really clear message going forward to do

1 something on behavioral health would be a great  
2 thing.

3 CHAIR OPELKA: Great, thank you. Wei?

4 DR. YING: Two things, one is the OB  
5 outcome measure. I'm not sure whether it's high  
6 on the CMS to-do list, but when we try to do  
7 anything for the OB population we just can't find  
8 anything related to the OB outcome. That's one  
9 area.

10 The other thing is, in general,  
11 patient reported outcome. There's no measure  
12 being proposed. And we think down the road,  
13 fundamentally, that's where the quality should  
14 go. If the patients think it's good, then that's  
15 good.

16 CHAIR OPELKA: Thank you. Marty?

17 MR. HATLIE: I wanted to build on the  
18 comments already made about mental illness and  
19 just, we saw a connection here between mental  
20 illness and substance abuse that was mentioned,  
21 and I thought that was really important to pay  
22 attention to as we go forward.

1                   Socioeconomic factors, David, I  
2           remember you speaking to this very eloquently  
3           last year. I really appreciate the comments of  
4           Rich and Nancy.

5                   I was just briefed by safety net  
6           hospitals in Chicago right before I came here,  
7           and they're just really, really struggling over  
8           this, especially the small, independent ones in  
9           neighborhoods that nobody else serves. So I  
10          think we've got to pay attention to that.

11                  And then the Partnership for Patients  
12          that Missy mentioned actually ended yesterday.  
13          Yesterday was the last day of it. And what we  
14          learned in the Partnership is that it's not just  
15          patient and family engagement that leads to  
16          culture change, it's leadership engagement, and  
17          that came up in our health literacy discussion as  
18          well.

19                  And I think we need to look at kind of  
20          the connection between patient and family  
21          engagement, leadership engagement, and sort of  
22          engagement of clinicians as creating the cultures

1           that are going to sustain all of this improvement  
2           work.

3                   I don't know how to get that. It goes  
4           across all the programs. But it was one of the  
5           major lessons learned from the partnership of  
6           patients that that really is important to do.  
7           And you find a lot of alignment when you educate  
8           all of those audiences about the work we're  
9           doing.

10                   CHAIR OPELKA: Thank you.

11                   MR. HATLIE: You're welcome. Thank  
12           you.

13                   MS. KOPLEFF: To second the patient  
14           reported outcomes measures gap, specifically for  
15           the cancer program, I know that ASCO is working  
16           on some patient reported outcome measures, so it  
17           would be great if we could continue to track  
18           those, and when they are ready, have them come  
19           forward to the group.

20                   CHAIR OPELKA: Great. Nancy?

21                   DR. HANRAHAN: Well, I'd like to thank  
22           my colleague for mentioning disparities. There

1 is growing evidence that people that have these  
2 mental illnesses in medical surgical hospitals  
3 don't get the procedures in the same way that  
4 other people get.

5 And this may be contributing to that  
6 25-year difference in the death rates in the  
7 population. And it's very understandable why  
8 they may not because of capacity.

9 Secondly, the other thing I'd like to  
10 encourage, I don't know where this fits, but  
11 human resources. You know, there is quite a bit  
12 of - there is a growing mass of literature about,  
13 and research about nurse staffing and skill mix.

14 And there's also with the Affordable  
15 Care Act we're seeing a different kind of work  
16 force evolving. And so, the relationship between  
17 the workforce and outcomes I think is a really  
18 major factor that could be tracked in a measure.

19 CHAIR OPELKA: All right. Well, I  
20 think that's really helpful and a great way  
21 actually to finish the day by walking through,  
22 you know, some of your early thoughts on gaps.

1 Looking ahead to tomorrow, we truly have saved  
2 the best for last. I guarantee it.

3 So please take a look at the agenda  
4 for tomorrow. And having learned today how  
5 you're working through these consent calendars,  
6 start to give some early thought to this so that  
7 we can walk through that.

8 And kind of take your lessons learned  
9 from today and apply them tomorrow. I think it  
10 will be really the only way we'll get through a  
11 complicated agenda tomorrow.

12 So tomorrow we've got, you know, just  
13 as much work before us, and some of it may be  
14 even more critical to the way some of you are  
15 thinking so we want to walk through that. So  
16 that's really our list of work for tomorrow and  
17 where we're going to go for this. Nancy, be  
18 brief, one last comment.

19 MS. FOSTER: One last comment is I  
20 just wanted to thank staff. I said this to  
21 Taroon earlier, but I think the materials  
22 provided for this iteration, for those of us who

1 have been around the table any number of years,  
2 are so superior to the previous years that it is  
3 incredibly helpful. Thank you.

4 CHAIR OPELKA: All right, everybody,  
5 what time do we start tomorrow? Yeah, 8:00 is  
6 the continental and 8:30 is the launch of the  
7 meeting. So, we will see you then. Thank you  
8 again. Kathy, close the line, please.

9 (Whereupon, the above-entitled matter  
10 went off the record at 3:57 p.m.)  
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